El Camino Health

AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, September 17, 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: 927 9654 4054# 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	**MEDICAL STAFF VERBAL REPORT**	Steven Xanthopoulos, MD, Chief of Staff, Mountain View Shahram Gholami, MD, Chief of Staff, Los Gatos	Information	**5:30 – 5:35**
6	**RECEIVE QUALITY COMMITTEE REPORT** - Quality Deep Dive - FY25 Q4 STEEEP Dashboard	Carol Somersille, MD, Quality Committee Chair Shreyas Mallur, MD, CQO	Information	**5:35 – 5:55**
7	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**5:55**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
8	**EL CAMINO HEALTH MEDICAL NETWORK SEMI-ANNUAL REPORT** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Mark Adams, CMO Peter Goll, ECHMN CAO	Discussion	**5:55 – 6:30**
9	**LOS GATOS REDEVELOPMENT UPDATE** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Tracey Lewis-Taylor, COO	Discussion	**6:30 – 6:45**
10	**PRE-AUDIT FY2025 FINANCIAL, OPERATIONAL AND STRATEGIC OVERVIEW AND REHAB HOSPITAL CONSTRUCTION PROJECT UPDATE** *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	Discussion	**6:45 – 6:55**
11	**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**	**6:55 – 7:00**
12	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS** - Minutes of the Closed Session of the ECHB Meeting (08/13/25) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Bob Rebitzer, Board Chair	**Motion Required**	**7:00 – 7:05**
13	**EXECUTIVE SESSION** -Expansion Strategy Update *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Bob Rebitzer, Board Chair	Discussion	**7:05 – 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 – 7:35**
15	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**7:35**
16	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Gabe Fernandez, Governance Services Coordinator	Information	**7:35 – 7:40**
17	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (08/13/25) b. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee	Bob Rebitzer, Board Chair	**Motion Required**	**7:40 – 7:45**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	c. Receive FY26 ECHB Pacing Plan d. Receive Period 1 Financials			
18	**CEO REPORT**	Dan Woods, CEO	Information	**7:45 – 7:55**
19	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:55 – 8:00**
20	**ADJOURNMENT** **POLICIES APPENDIX**	Bob Rebitzer, Board Chair	**Motion Required**	**8:00**

NEXT MEETINGS: October 8, 2025; November 12, 2025; December 10, 2025; February 11, 2026; March 18, 2026; May 13, 2026; June 17, 2026

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EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, MBA, Chief Quality Officer
Date: September 17, 2025
Subject: Quality Deep Dive Topic – Driving Better Surgical Outcomes by Decreasing Surgical Site Infections

Purpose:

To provide the Board with an overview and context of El Camino Health's Surgical Site infection rates, which are consistently low (favorable) relative to National published benchmarks. The presentation also provides identified opportunities for improvement as well as prevention initiatives and highlighted interventions.

Summary:

- Surgical Site Infections (SSIs) remain a leading cause of post-operative complications, increased length of stay, and cost escalation.
- El Camino Health continues to outperform national benchmarks and is implementing evidence-based practices to drive further reductions in SSI rates.
- Preventing SSI's gives measurable wins in Quality, Safety and Cost avoidance
- SSIs have a profound impact on patient outcomes and hospital reputation.
- Comprehensive, evidence-based strategies and bundles—implemented consistently—dramatically reduce SSI rates.
- Leadership commitment, ongoing staff education, and robust surveillance are essential for sustained success.

List of Attachments:

1. Quality Deep Dive Board presentation.

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Driving Better Surgical Outcomes by Decreasing Surgical Site Infections

El Camino Hospital Board of Directors
Shreyas Mallur, M.D., MBA
September 17, 2025

Introduction

Surgical site infections (SSIs) are a significant cause of morbidity, prolonged hospital stays, and increased healthcare costs. Despite advances in surgical techniques, sterilization procedures, and infection control protocols, SSIs remain a leading complication following surgery.

0.5-3% of patients undergoing surgery experience infections(CDC data)

Length of stay increased by 7-11 days

Cost per infection up to $90,000 (CDC)

$3.5-$10 billion in healthcare costs (CDC)

Board Relevance: Strategic Priority for Quality, Safety and Top Decile performance (CMS Star rating, Leapfrog, Vizient)

A Brief History of Antisepsis in Surgery

1860s

Joseph Lister introduced carbolic acid spray → dramatic reduction in post-op infections.

1

Early 20th century

Adoption of sterile technique (gloves, gowns, masks, drapes)

Mid 20th century

Antibiotics introduced (penicillin, 1940s) → major drop in surgical mortality

2

1970s–1990s

Infection surveillance & standardized prevention bundles emerge.

3

2000s–Today

Evidence-based Surgical Site Infection Prevention bundles: CHG bathing, antibiotic stewardship, normothermia.

4

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Risk Factors for SSI

Procedure Related Factors

Surgery type (wound class)

Duration of surgery

Open vs robotic

Presence of drains

Presence of implants

Antibiotic prophylaxis

Patient Related Factors Modifiable

Diabetes

Obesity

Malnutrition

Tobacco use

Preoperative Infections

Patient Related Factors Non-Modifiable

Age

Prior infections

Radiation therapy

External Factors

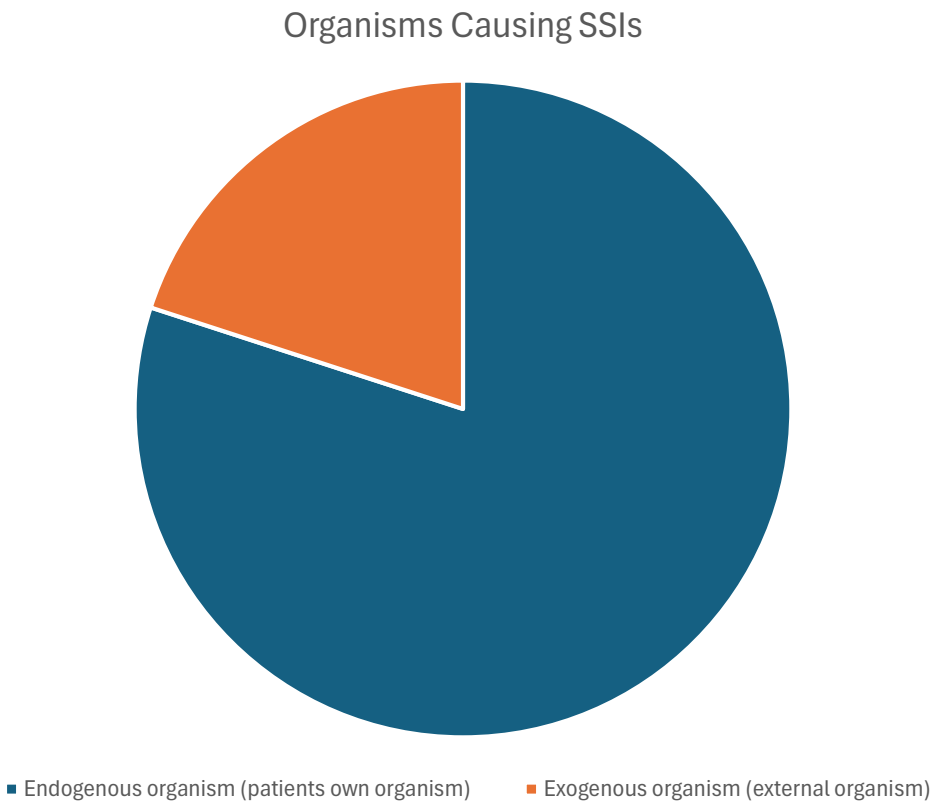
Sterilization of instruments, equipment, & personnel

Operating room ventilation

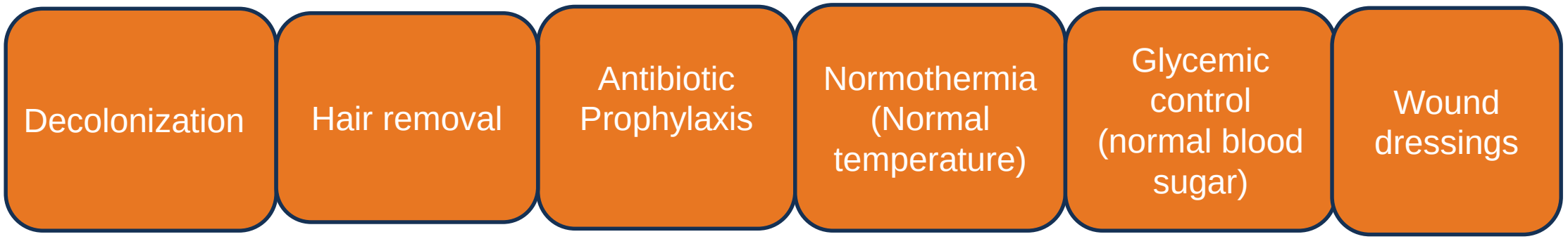
Operating room traffic

Where do SSI's come from?

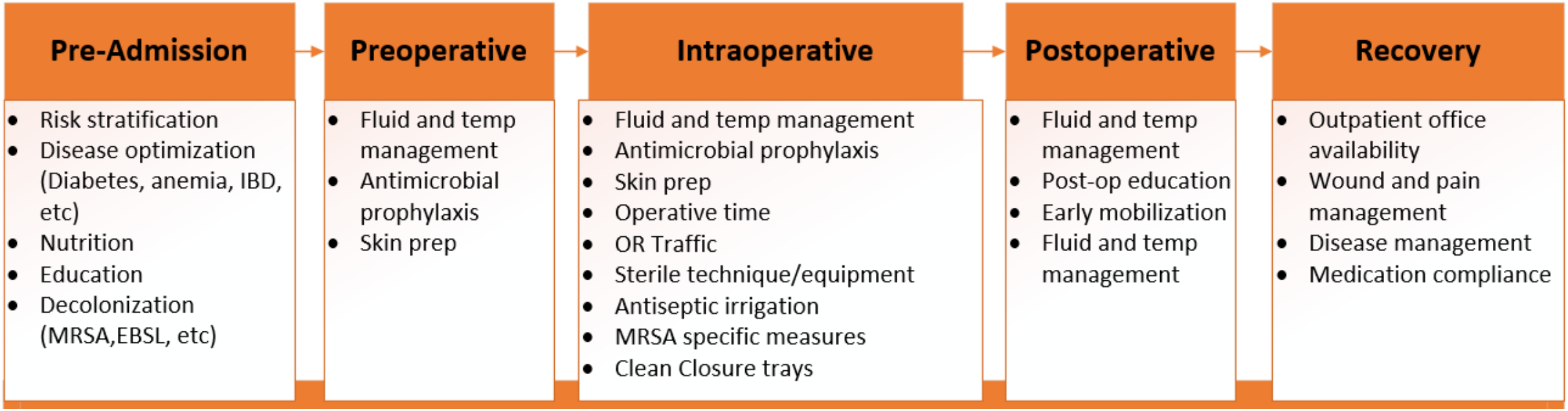
- 70-80% of SSI's are from patients own organisms (endogenous: skin/bowel)
- 20-30% of SSI's are from external organisms (exogenous: environment, contamination)
- Most SSIs are preventable by controlling the patient's own flora **before, during, and after surgery** with evidence-based bundles.



Evidence Based Practices to Prevent SSIs

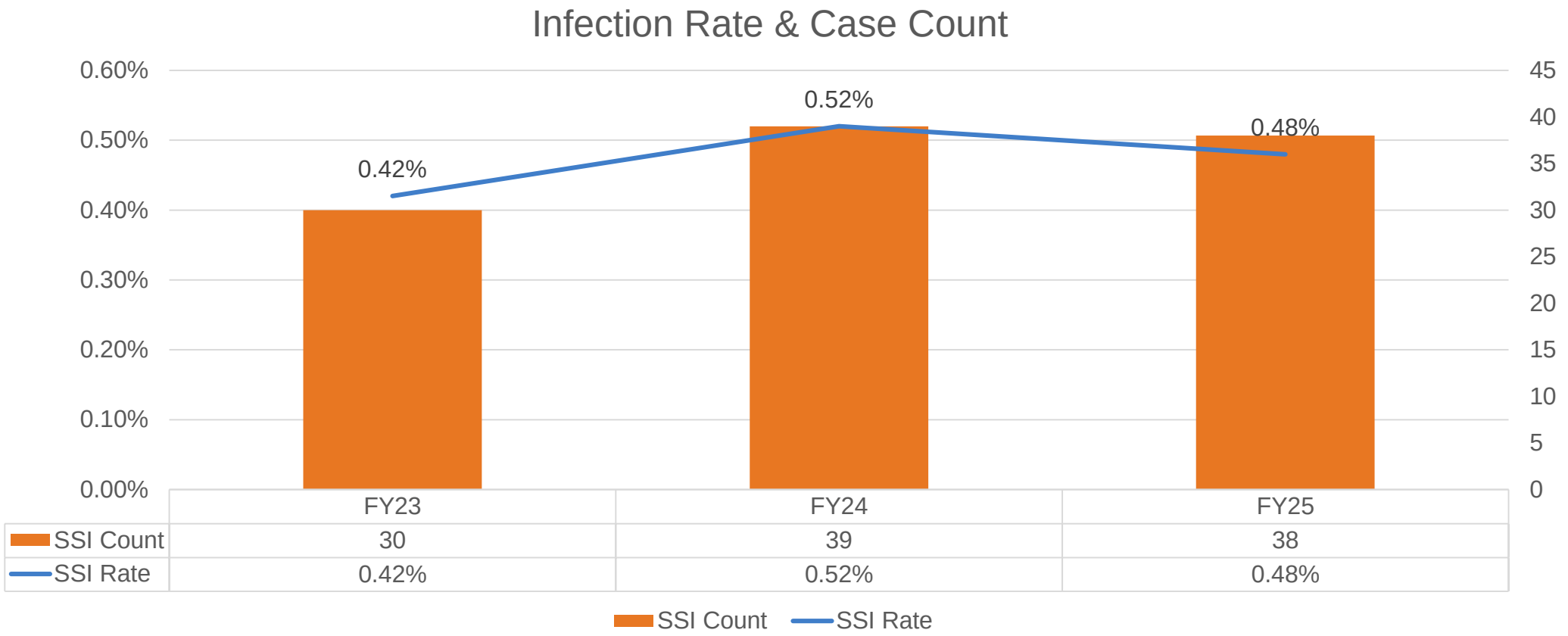


Evidence Based Practices to Prevent SSIs



ECH Infection Rate – Deep Incisional or Organ Space SSIs

Published National Data shows surgical site infection rates of 0.5%-3%



Surgical Site Infection Rate
- Number of infections ÷ Number of procedures
- Adjusts for increased volume of procedures

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Root Cause Deep Dive (Opportunities Identified)

Opportunities	Improvement Measures	Expected Impact
Temperature Management	Reduce variation in practice	Moderate
Antibiotic	EPIC enhancements: Re-dose reminders & Initial dosing/type recommendations	Moderate
Clean Closure Trays	Increase utilization compliance to reduce SB/COLO SSI	High
Case Review Process	Develop a process that engages the Surgeon	High
Glucose Management	EPIC enhancements: Identify/Signal diabetic patients	High

SSI Prevention Initiative Timeline

Previous Initiates -FY 2024	Current State - FY 2025	Next Steps - FY 2026
SSI Count:39 Infection Rate: 0.52%	SSI Count:38 Infection Rate: 0.48%	*10% Reduction* *Target SSI Count:34* *Target Infection Rate: 0.43%*
• **OR Attire** – staff and vendor attire compliance with long sleeves and hair coverage • **OR Traffic** – reduce operating room traffic in orthopedic cases • **Irrigation Practices** – Optimize irrigation technique in orthopedic cases	• **Normothermia** - Standardize temperature management practices • **Antibiotic Prophylaxis** – EPIC enhancements to optimize re-dosing timing • **Clean Closure Tray** – Increase utilization • **Case Review Process** – Surgeon engagement in every reported case	• **Glucose Management** - EPIC enhancements to increase screening for diabetes risk factors and glucose monitoring. • **Whipple and Bowel Prep Best Practices** • **Standardize Inpatient Prep**

Highlight of FY25 Interventions

Interventions	Results/ Impact	Next Steps/Sustainment
Standardize temperature management practices	>40% increase in intra-op monitoring within 90 days.	Opportunity to study and evaluate trends of patients that are received in the PACU <35.5C
Increase antibiotic initial administration, Re-dose, & dosing/type compliance	January Sample 90% (155/172) with initial antibiotic type/dose. 89% (153/172) with initial dose timing. No SSI cases since Oct 2024 with antibiotic redosing concerns	Shared documentation of incision time between nursing and anesthesia
Proactively identify case needs and have clean closure trays available	Jan 2025 77% (7/9) Feb 2025100% (7/7) March 2025 100% (11/11)	Enhance reporting to support sustainment – EPIC Reporting will need to be revisited once procedure naming conventions are standardized.
Case Review Process	Case Review sessions concluded with further practice assessment needs: Whipple documentation and intra-op culture collection, Diabetic patient identification & glucose management, assessment of bowel prep standardization needs.	Emphasis of case review timeliness

Highlight of FY26 Interventions

Interventions	Expected Results/ Impact	Next Steps
Glucose Management EPIC enhancements	Increase screening for diabetes risk factors and glucose monitoring.	EPIC Build Complete, currently educating staff to new procedures, Go Live Sept 2025
Whipple procedure & Bowel Prep Best Practices	Reduction abdominal procedure related SSIs	Surgeon champion and CQO will lead efforts to share and standardize best practices with surgeons across the organization.

Conclusion

- El Camino Health has consistently performed better than National published benchmarks for Surgical Site infection rates.
- El Camino Health is executing evidence-based practices that align with national best-in-class standards to achieve zero preventable surgical site infections.
- Preventing SSI's gives measurable wins in Quality, Safety and Cost avoidance
- SSIs have a profound impact on patient outcomes and hospital reputation.
- Comprehensive, evidence-based strategies—implemented consistently—dramatically reduce SSI rates.
- Leadership commitment, ongoing staff education, and robust surveillance are essential for sustained success.

El Camino Health

El Camino Hospital Board of Directors Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, MBA Chief Quality Officer and Lyn Garrett, MHA, MS, CPHQ
Date: September 17, 2025
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through July 2025

Purpose:

To provide the Hospital Board of Directors with an update on quality, safety, and patient experience performance through July 2025 (unless otherwise noted). This memo summarizes results from both the STEEEP and Enterprise Quality Dashboards and includes the final FY25 STEEEP (Safe, Timely, Effective, Efficient, Equitable, Patient-Centered) data.

Situation: The FY 25 Enterprise Quality, Safety, and Experience Dashboard is updated monthly and tracks eighteen quality measures. The STEEEP dashboard is updated each quarter and contains seventeen measures. The STEEEP dashboard is intended to be a Governance Level report, which is shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter. Most measures are tracked on both the Enterprise monthly and STEEEP quarterly dashboards.

Assessment:

A. Safe Care

1. **C. Difficile Infection:** There have been 2 (2 cases per month) (Goal: </= 26 infections FY 2026 or less than 2.17 cases/month) Hospital Acquired C=Diff infections YTD 2026. Areas of focus to decrease C. Diff are four-fold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program has been implemented. Third, a robust antibiotic stewardship program is in place. Fourth, testing of C. Diff samples will follow CDC and IDSA guidelines.
   Timeline for improvement: We have measures described above in place which we believe will impact this rate. The benchmarked C Diff rate is per 10,000 patient days.

2. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 0 CAUTI cases year-to-date in FY2026, against a target of ≤12 for the fiscal year. Our process improvement efforts focus on:
   Removing catheters promptly when clinically appropriate.
   Ensuring best practices are followed for insertion and maintenance.
   To reduce catheter duration, the infection prevention team reviews every patient with a catheter in place for more than three days. They collaborate with the nurse and physician to confirm clinical indications and emphasize the importance of timely removal.
   Timeline for improvement: While we are currently on track to meet the FY2026 goal, we continue to implement additional measures aimed at sustaining and further improving performance in the next fiscal year. Ongoing monitoring remains essential.

3. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for YTD FY2026 (0) is favorable to target of 5 cases for FY 26 (0.42 cases per month).
   Timeline for improvement: We are on track to meet target

4. **Surgical Site Infection**. The number of cases/month of surgical site infections for FY 26 (1) is favorable to target of </= 34 cases (2.83 cases/month). Process improvement has included implementing evidence based best practices shown to decrease SSIs: maintain Perioperative normothermia, timing and choice of preoperative antibiotics, clean closure tray utilization in the OR and glucose control in diabetics.
   Timeline for improvement: We are seeing a downward trend in the last few months and are confident that this will continue.

5. **Hand Hygiene Combined Compliance rate:** Performance for YTD FY2026 is Unfavorable (83.7%) to target of 84%.
   Timeline for improvement: We are instituting real time coaching for failures in compliance, as well as socializing this in our nursing and physician councils.

6. **Hand Hygiene % of Departments Meeting Audit Compliance target:** Performance for FY26 YTD is favorable (100%) to target of 80% of units.

B. Timely

1. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance YTD FY 2025 (73.9%) is unfavorable to target (84%). The root cause of the delays relates to multiple factors, primary being radiology staffing issues experienced by the contracted vendor. In addition, there have been issues with the transfer of images and interface with our system which are being worked on.
   Timeline for improvement: Realistically, we anticipate improvement in the Turnaround times by Q3 2026.

C. Effective

1. **30 Day Readmission Observed Rate:** Performance through FY26 (10.3%) is unfavorable to target (</=9.8%). El Camino Health remains committed to ensuring timely follow-up care for patients under primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital. In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital.
   Timeline for improvement: This is only one month of data, however we are confident we will continue to maintain our FY 25 trend.

2. **Risk Adjusted Mortality Index.** Performance YTD FY25 (1.10) is unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. We will be closely monitoring this since the system changes introduced in documentation integrity, reduction in clinical variation and institution of earlier hospice and GIP are just in the initial

phases of implementation. In addition, we are optimizing O/E measure to accurately reflect the acuity of illness of our patients.
Timeline for improvement: Q1-Q2 FY 2026. The trendline over the last few months has been positive for this index.

3. **Sepsis Mortality Index.** Performance through FY2025 (1.11) is unfavorable to target (1.00). Patients often arrive in the ED in Septic Shock. We are working to increase Social Work and/or Palliative Care support in the ED for goals of care discussions. Pursue hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change internally was that the sepsis coordinators provide concurrent sepsis bundle compliance to ED physicians and staff in the real time. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program.
Timeline for improvement: The GIP program is planned for go-live in first week of September 2025. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation. This alone, "Palliative care consult" increases the expected risk of mortality 6-fold.

4. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV)**. FY25 performance through May of 2025 (26.4%) is unfavorable to target of 23.9%. The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback.
Timeline for improvement: This metric has been challenging for the organization as well as like hospitals in California. We will continue with our efforts to reduce this metric.

D. Efficient

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance FY25 is (1.02) is at target of (1.02). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams are optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:
    - Within Epic a centralized care plan was created that pulls together important information about the patients care plan. This tool increased efficiency and allows the care team to obtain pertinent information in a timely way. Additionally, interdisciplinary team members can track internal and external delays which will offer insight into the primary reasons for delays in patient throughput.
    - Since the initiation of Multidisciplinary rounds (MDR) in December 2023, there have been significant improvements in LOS within the pilot program for patients who stay in nursing unit 2C. The data indicates a noteworthy decrease of -1.1 days in LOS. The MDR process has been rolled out to multiple units in the hospital and is showing sustained benefits.
    - We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4

patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements.
Timeline for improvement: We anticipate improvement due to the changes implemented by Q1 of FY26.

2. **Median Time from ED Arrival to ED Departure (Enterprise).** Performance through FY25 (152.4 minutes) is favorable to the target of < 160 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

E. Equitable

1. **Social Drivers of Health Screening rate:** FY 25 performance YTD is (41.3%) is unfavorable to target of 50%. This is a new measure and steps taken to improve our screening rate includes creating a new tool for staff to document required elements of the metric. Our team including care coordinators, nurses and informatics teams are working to implement this tool in the next few months.
This metric continues to improve and we should be on track to meet this target by Q2 FY26.

2. **Voyce Interpretation Minutes Used:** FY 2025 performance (515,606 minutes). We are in the process of establishing a target for this metric. This is the first year that we are using this metric, hence there is no benchmark either locally or nationally. We believe that this metric is an important proxy for communication with patients who do not have English as their primary language.

3. **Homeless Planning Discharge Compliance Rate:** New measure for FY26. This measure was chosen because of new CMS regulations on monitoring our efforts on homeless discharge compliance rates.

F. Patient Centered:

1. **FY25 Performance Highlights**

Domain	National Percentile	California Percentile	Bay Area Percentile
Inpatient (HCAHPS)	84th	81st	92nd
Medical Network (ECHMN)	26th	36th	34th

FY25 closed with mixed performance across El Camino Health (ECH) and El Camino Health Medical Network (ECHMN). ECH inpatient performance remained nationally competitive, while ECHMN continues to improve, and is aiming to be at the 50th percentile by the end of FY27. FY26 targets have been established using statistically valid methodologies, with a focus on achievable improvement. New initiatives—including the Patient Experience Action Team, updated Playbook, and reestablishment of Patient and Family Advisory Groups—aim to strengthen system-wide accountability and culture around patient experience.

2. **Patient Comments and Feedback Process**
    - Identify feedback type (positive, negative, safety, staff-specific)
    - Escalate service concerns immediately and initiate service recovery using WeCare standards
    - Distinguish isolated versus recurring issues; systemic concerns prompt corrective action plans
    - Close the loop by communicating back to patients and sharing themes with staff

3. **Fiscal Year 2026 Patient Experience Focus Areas**
    - Patient Experience Action Team – multi-disciplinary oversight body
    - PX Playbook – standardized guide for leaders and staff
    - Patient and Family Advisory Groups – reestablished to amplify patient voice
    - Refresher Training – WeCare service recovery training for all employees
    - PX Reporting – creation of comprehensive, system-level reports
    - Physician Partnership Program – engagement of providers in PX improvement

Attachments:

1. Enterprise Quality Dashboard through July 2025
2. STEEEP Dashboard through June of 2025 and the updated STEEEP Dashboard FY26

El Camino Health Quality Board: FYTD25 STEEEP

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Date: 7/1/2024 06/30/2025

Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator		Last 12 Months Trend
Safe Care	FY 25Q1	FY 25Q2	FY 25Q3	FY 25Q4	FY24	FYTD25			Trend Chart Period: 7/1/2024 to 06/30/2025
C-Diff Clostridioides Difficile Infection	6	10	6	6	28	**28**	🔴	<= 27 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	3	3	7	1	11	**14**	🔴	<=10 cases	Lower is Better
CLABSI (Central Line-Associated Bloodstream Infection)	0	1	3	0	3	**4**	🟢	<=5 cases	Lower is Better
SSI (Surgical Site Infection)	15	12	7	4	38	**38**	🔴	<=30 cases	Lower is Better
Hand Hygiene Audit Compliance (Leapfrog measure)	85.3%	81.5%	80.9%	86.6%	84.1%	**83.2%**	🔴	>=85%	Higher is Better
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	74.0%	69.4%	77.7%	76.9%	77.7%	**74.6%**	🔴	>=84.0%	Higher is Better
Effective									
30-Day Readmission Rate (Based on Vizient Risk Model)	9.2%	9.8%	9.1%	10.4%	9.8%	**9.6%**	🟢	<=9.8%	Lower is Better
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	0.87	1.06	1.04	0.92	1.16	**0.98**	🟢	<= 1.0	Lower is Better
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.06	1.10	1.17	0.96	1.35	**1.07**	🔴	<=1.0	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure)	24.2%	27.5%	25.4%	29.1%	24.7%	**26.4%**	🔴	<=23.9%	Lower is Better
Efficient									
Length of Stay (LOS) O/E Index (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.01	1.03	1.03	0.98	1.03	**1.01**	🟢	1.02	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	151	152	154	153	155.8	**152.4**	🟢	<=160	Lower is Better
Equitable									
Social Driver of Health (SDOH) Screening Rate	4.0%	21.0%	82.6%	87.8%	2.1%	**41.3%**	🔴	50%	Higher is Better
Voyce Interpretation Minutes Used	57,925	53,919	60,025	57,337	617,023	**687,616**	⚪	TBD	
Patient-Centered									
Inpatient Hospital: Likelihood to Recommend Press Ganey	80.7	81.5	82.0	89.0	86	**84**	🟢	81.9	Higher is Better
ED: Likelihood to Recommend Press Ganey	78.9	78.3	75.1	80.7	75.5	**78.2**	🟢	77.2	Higher is Better
MCH - INPATIENT Press Ganey	82.8	80.5	83.0	76.3	82.0	**80.8**	🔴	82.0	Higher is Better

El Camino Health Quality Board: FYTD26 STEEEP

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Date: 10/1/2024 09/30/2025

Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator	Last 12 Months Trend
Safe Care	FY 25Q2	FY 25Q3	FY 25Q4	FY 26Q1	FY25	FYTD26		Trend Chart Period: 10/1/2024 to 09/30/2025
C-Diff Clostridioides Difficile Infection	10	6	6	2	28	**2**	<= 26 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	3	7	1	0	14	**0**	<=12 cases	Lower is Better
HAPI (Stage 3, 4 & Unstageable)	6	7	0	0	14	**0**	<= 12 cases	Lower is Better
CLABSI (Central Line-Associated Bloodstream Infection)	1	3	0	0	4	**0**	<=5 cases	Lower is Better
SSI (Surgical Site Infection)	12	7	4	1	38	**1**	<=34 cases	Lower is Better
Hand Hygiene Audit Compliance (Leapfrog measure)	81.5%	80.9%	86.6%	83.7%	83.2%	**83.7%**	>=84%	Higher is Better
Timely								
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	69.4%	77.7%	76.9%		73.9%		>=84.0%	Higher is Better
Effective								
30-Day Readmission Rate (Based on Vizient Risk Model)	9.8%	9.1%	10.4%		9.6%		<=9.8%	Lower is Better
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.06	1.04	0.92	1.10	0.98	**1.10**	<= 0.97	Lower is Better
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.10	1.17	0.96	1.19	1.11		<= 1.00	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure)	27.5%	25.4%	29.1%		26.4%		<=23.9%	Lower is Better
Efficient								
Length of Stay (LOS) O/E Index (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.03	1.04	0.99	0.99	1.02		1.02	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	152	154	153	155	152.4	**154.5**	<=160	Lower is Better
Equitable								
Social Driver of Health (SDOH) Screening Rate	21.0%	82.6%	87.8%		41.3%		50%	Higher is Better
Homeless Planning Discharge Compliance Rate	21.0%	82.6%	87.8%	(Mock Data)	41.3%		TBD	
Patient-Centered								
LTR Composite Score Press Ganey	81.5	82.0	89.0	(Mock Data)	86	**84**	81.9	Higher is Better

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

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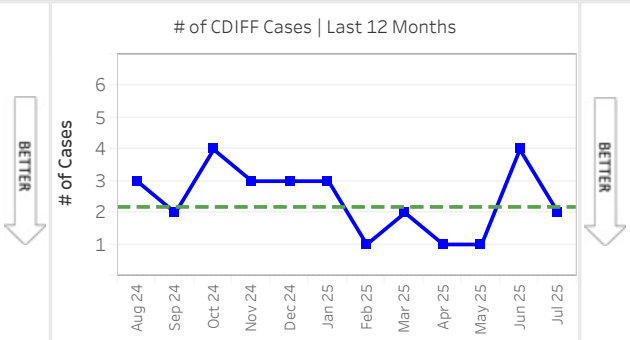
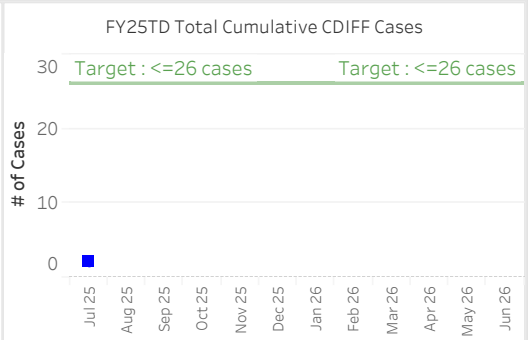
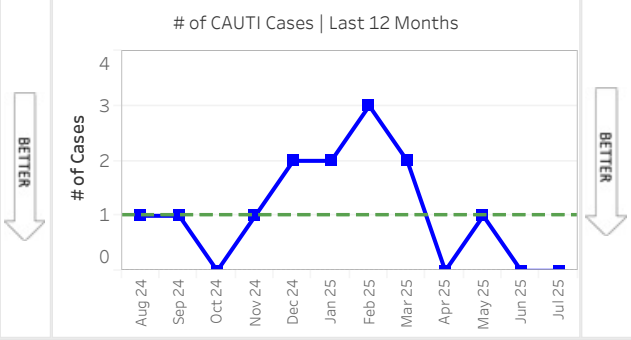
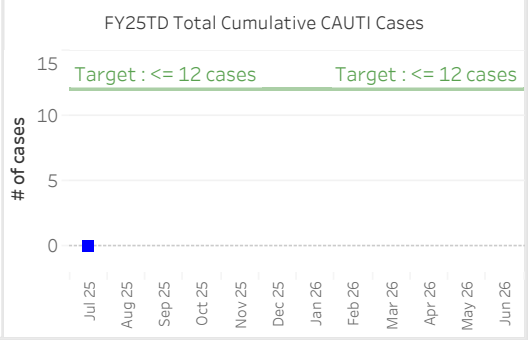
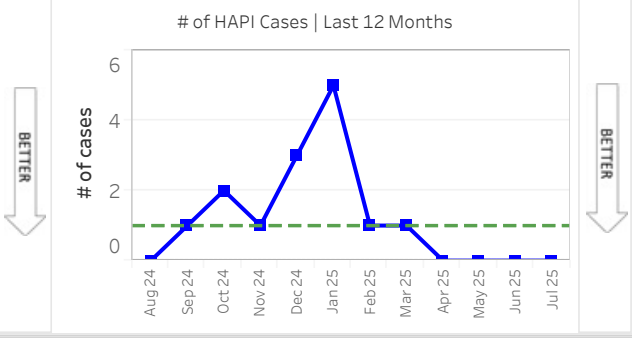
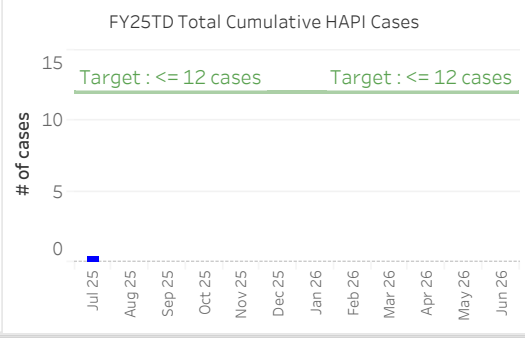
Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases Latest Month : July 2025	2 cases	2.00 cases/mo	2.33 cases/mo	2.17 cases/mo		
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases Latest Month : July 2025	0 cases	0.00 cases/mo	1.17 cases/mo	1.00 cases/mo		
*Organizational Goal Hospital Acquired Pressure Injury (HAPI) cases Latest Month : July 2025	0 cases	0.00 cases/mo	1.17 cases/mo	1.00 cases/mo		

Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Dashboard Managed by
Quality Data Analyst : **Jeffery Jair**
jeffery_jair@elcaminohealth.org

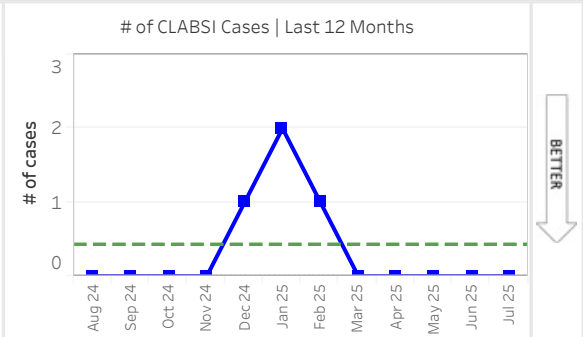
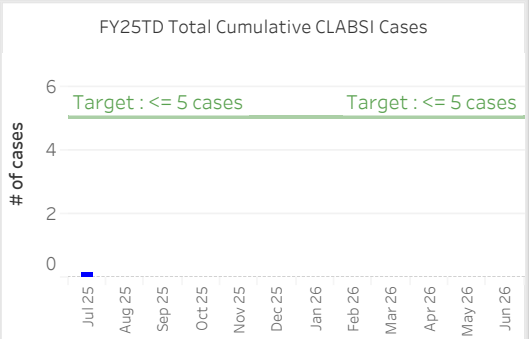
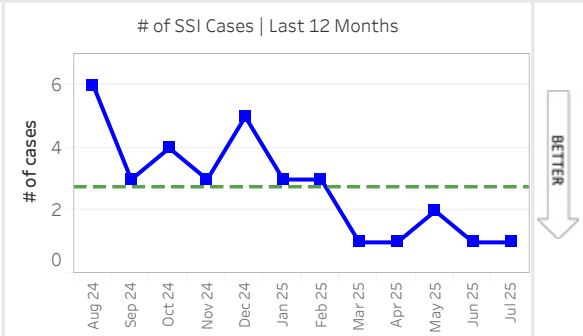
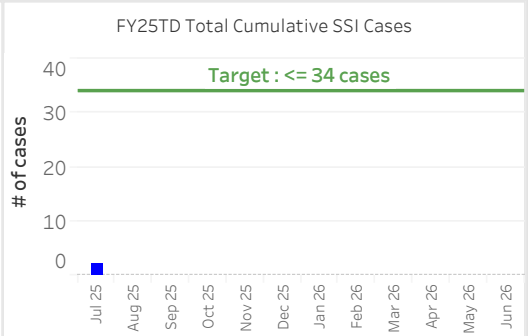
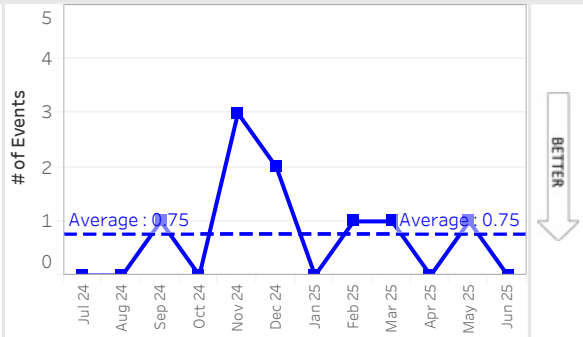
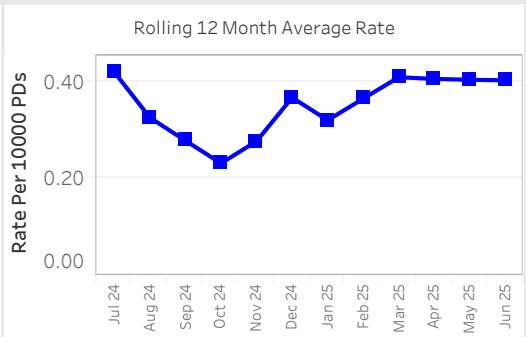
Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Hospital Acquired Pressure Injury (HAPI) cases	Ann Aquino	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Epic Report** (ECH Pressure Injuries - By Department (RWSQL) with manual chart reviews

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Central Line Associated Blood Stream Infection (CLABSI) cases Latest Month : July 2025	0 cases	0.00 cases/mo	0.33 cases/mo	0.42 cases/mo		
Surgical Site Infections (SSI) cases Latest Month : July 2025	1 cases	1.00 cases/mo	3.17 cases/mo	2.83 cases/mo		
Serious Safety Event Rate (SSER) Latest Month : June 2025	0 events	0.40 (9 / 223616)	0.61 (13 / 214277)	n/a		

Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Dashboard Managed by
Quality Data Analyst : **Jeffery Jair**
jeffery_jair@elcaminohealth.org

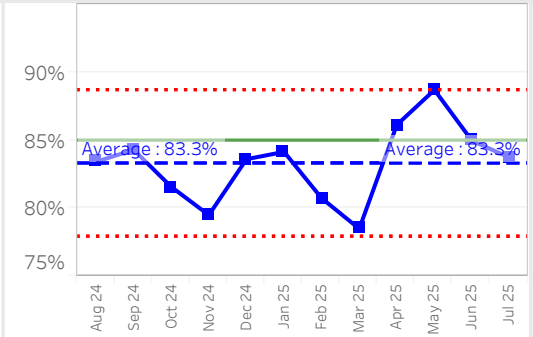
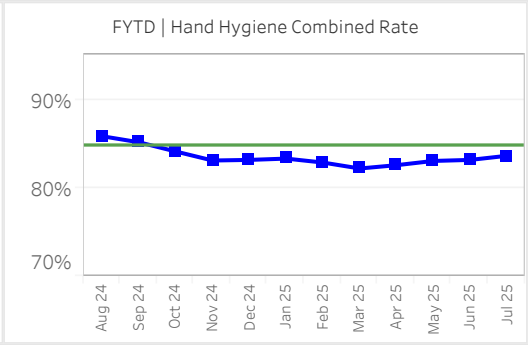
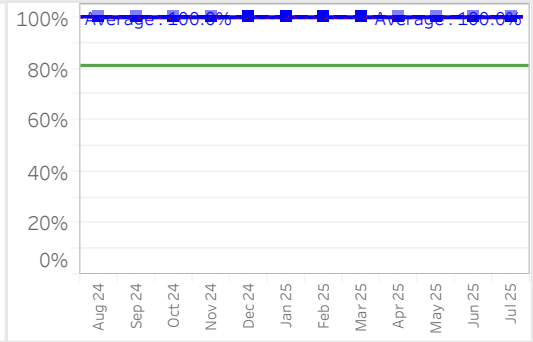
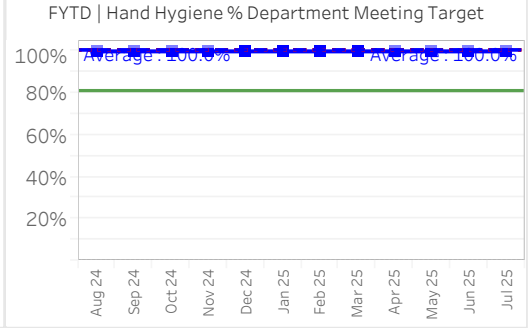
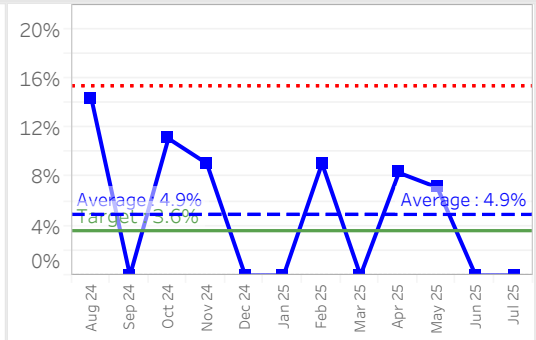
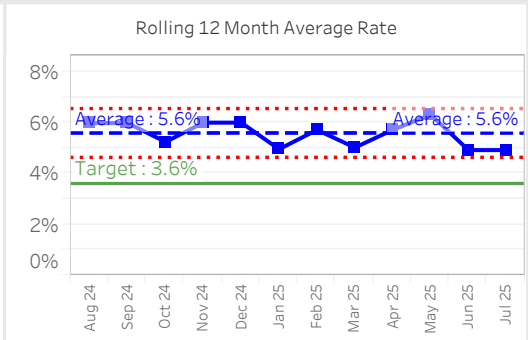
Measure	Definition Owner	Metric Definition	Data Source
Central Line Associated Blood Stream Infection (CLABSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Surgical Site Infections (SSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems Safety Event Tableau Dashboard maintained by: **Indu Adhikary**

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Hand Hygiene Combined Compliance Rate Latest Month : July 2025	83.7% (8700 / 10393)	83.7% (8700 / 10393)	83.2% (171444 / 205958)	>=84% (1% improve of FY25)		
Hand Hygiene % of Departments Meeting Target Latest Month : July 2025	100.0% (25 / 25)	100.0% (25 / 25)	100.0% (300 / 300)	80% of units		
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : July 2025	0.0% (0 / 6)	0.0% (0 / 6)	4.8% (6 / 126)	<= 4.3% (10% reduction of FY25)		

Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Dashboard Managed by
Quality Data Analyst : Jeffery Jair
jeffery_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Hand Hygiene Combined Compliance Rate	S. Mallur, MD / Lyn Garrett	% of yes Cleaning Before Entering or Exit	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: Hsiao-Lan Shih
Hand Hygiene % of Departments Meeting Target	S. Mallur, MD / Lyn Garrett	Number of Unit done Audit according to their Target (Only Leapfrog units)	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: Hsiao-Lan Shih
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure)	S. Mallur, MD	Based on the Center for Medicare and Medicaid Services (CMS) Metric criteria, complications following an elective primary total hip arthoplasty (THA), total knee arthoplasty (TKA) procedure. Numerator : Distinct count of patients having complications / Total Cases. Patients with complications are counted in the numerator only once, regardless of the number or type of complication. Denominator : Eligible index admissions who have undergone a qualifying elective primary THA or TKA procedure. 2.) Based upon Vizient Risk Model 2024 Community + AHRQ Version 2024 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Nonviable Neonate & Normal Newborn)	Vizient Clinical Database

El Camino Health

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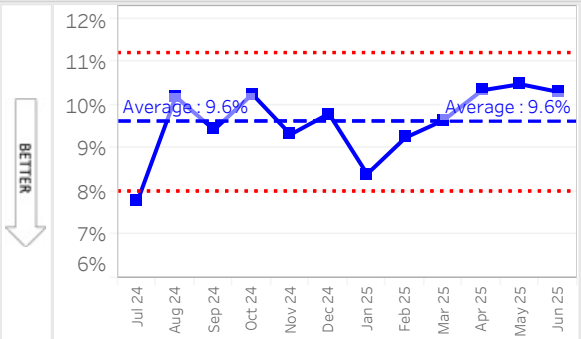
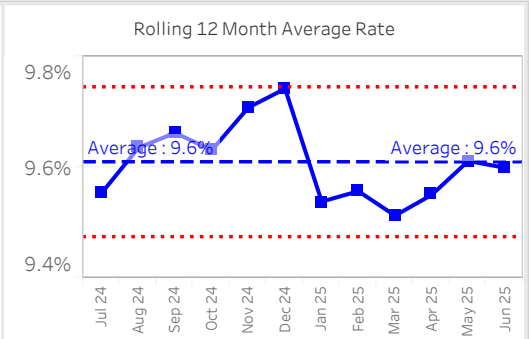
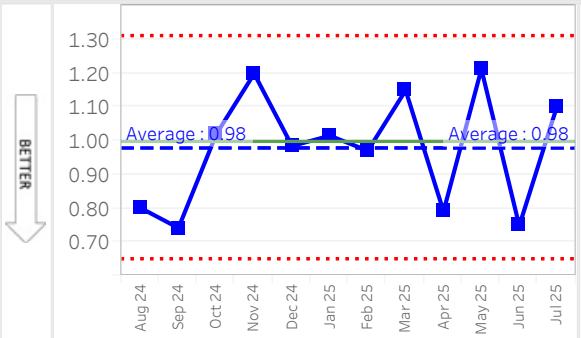
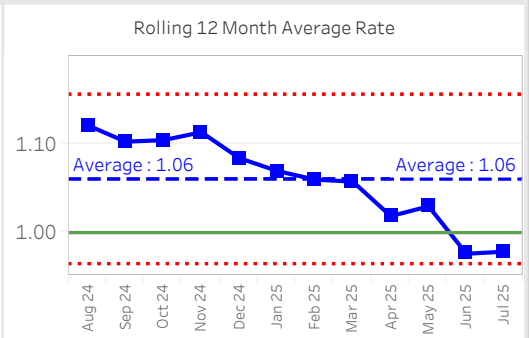
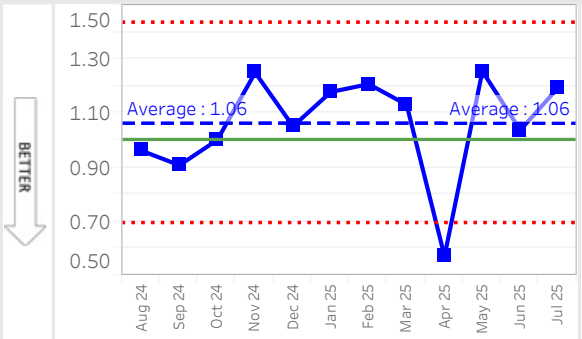
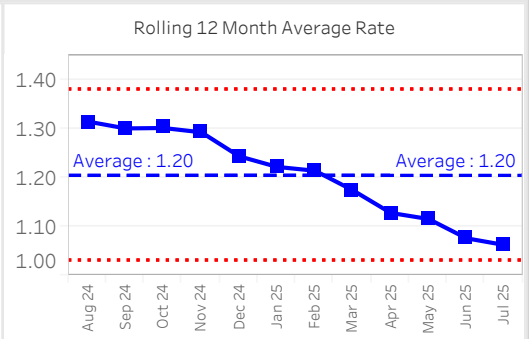
July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
30-Day Readmission Observed Rate Vizient Risk Model Latest Month : June 2025	10.3% (133 / 1291)	9.6% (1562 / 16264)	9.8% (1624 / 16488)	<= 9.8%		
Mortality Index Observed / Expected Vizient Risk Model Latest Month : July 2025	1.10 (2.49% / 2.26%)	1.10 (2.49% / 2.26%)	0.98 (2.22% / 2.27%)	<= 0.97		
Sepsis Mortality Index Observed / Expected Vizient Risk Model Latest Month : July 2025	1.19 (11.29% / 9.45%)	1.19 (11.29% / 9.45%)	1.07 (10.63% / 9.98%)	<= 1.00		

Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Dashboard Managed by
Quality Data Analyst : Jeffery Jair
jeffery_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
30-Day Readmission Observed Rate Vizient Risk Model	S. Mallur, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Vizient Risk Model 2024 Community + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn)	Vizient Clinical Database Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD	1) Based upon Vizient Risk Model 2024 Community for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Vizient Clinical Database
Sepsis Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD Maria Consunji	1) Numerator inclusions: Patient Type = Inpatient (exclude Rehab, Hospice, Nonviable Neonate & Normal Newborn + Behavioral Health (based on Vizient Service Line = Behavioral Health), Prin or 2nd diagnosis of sepsis (SEP-1 list of codes) & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Vizient Clinical Database

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

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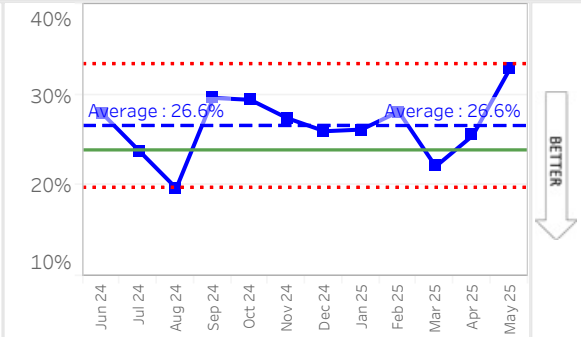
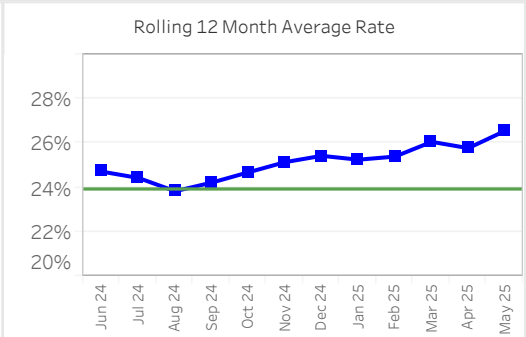
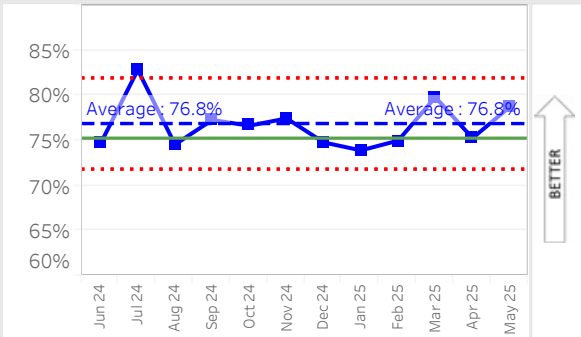
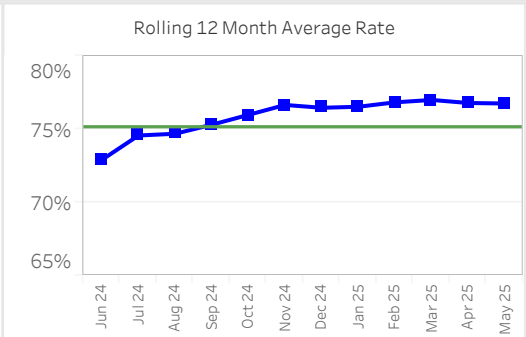
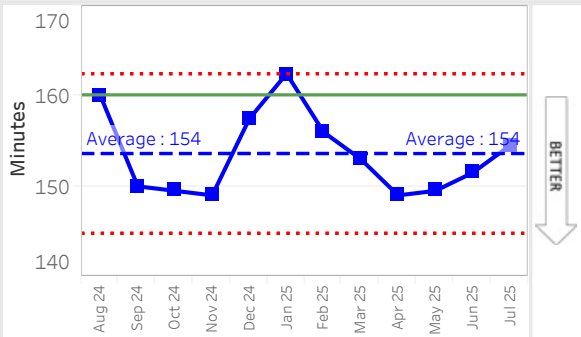
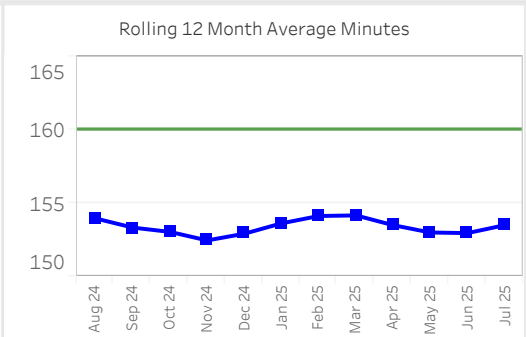
Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 33.3% (55 / 165)	MV : 27.2% (471 / 1729)	MV : 27.6% (516 / 1870)	23.9% (FY24 ENT Target)		
	LG : 30.3% (10 / 33)	LG : 21.9% (69 / 315)	LG : 19.4% (62 / 320)			
Latest Month : May 2025	ENT : 32.8% (65 / 198)	ENT : 26.4% (540 / 2044)	ENT : 26.4% (578 / 2190)			
PC-05 : Exclusive Breast Milk Feeding	MV : 77.7% (247 / 318)	MV : 75.5% (2427 / 3214)	MV : 58.1% (1998 / 3437)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 84.1% (53 / 63)	LG : 84.6% (509 / 602)	LG : 68.4% (428 / 626)			
Latest Month : May 2025	ENT : 78.7% (300 / 381)	ENT : 76.9% (2936 / 3816)	ENT : 59.7% (2426 / 4063)			
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	MV : 167 mins	MV : 167 mins	MV : 169 mins	FY25 Goals = MV ED = 180 min LG ED = 140 min ENT = 160 min		
	LG : 142 mins	LG : 142 mins	LG : 137 mins			
Latest Month : July 2025	ENT : 155 mins	ENT : 155 mins	ENT : 153 mins	Goals still TBD by ED Leadership		

Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

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Quality Data Analyst : **Jeffery Jair**
jeffery_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard ED Tableau Dashboard maintained by: **Hsiao-Lan Shih**

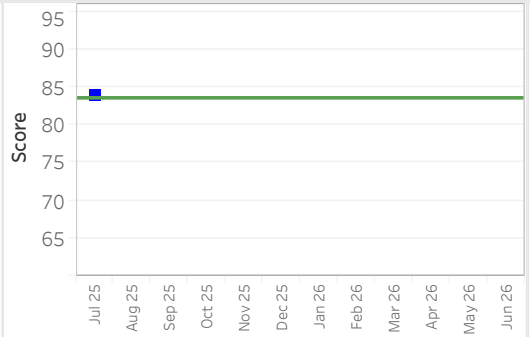
El Camino Health

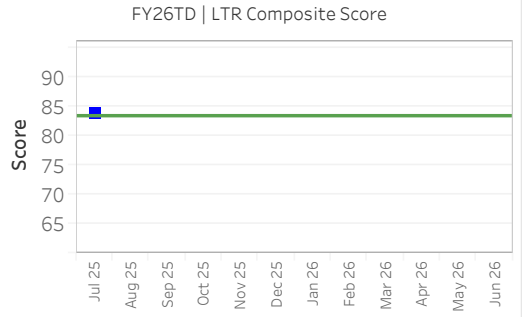
FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
LTR Composite Score Latest Month : July 2025	83.8	83.8	83.4	>= 83.4	BETTER	BETTER





Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Dashboard Managed by
Quality Data Analyst : Jeffery Jair
jeffery_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
LTR Composite Score	Ryan Lockwood	The LTR Composite Score is a single, combined performance goal that reflects multiple metrics or data points - such as department-level patient experience scores - aggregated into one overall score for the fiscal year. It is calculated based on Likelihood to Recommend (LTR) performance from the previous fiscal year. Weighting is applied based on patient volume or prioerity areas to ensure a fair representation of each department's contribution.	HCAHPS

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, August 13, 2025

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

Board Members Present
Bob Rebitzer, Chair
John Zoglin, Secretary/Treasurer
Lanhee Chen
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

Staff Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Mark Adams, CMO
Deanna Dudley, CHRO
Theresa Fuentes, CLO
Peter Goll, CAO, ECHMN
Ken King, CASO**
Tracey Lewis Taylor, COO
Shreyas Mallur, MD, CQO
Cheryl Reinking
Jeff Missad, VP, Facilities Development and Real Estate
Jon Cowan, Executive Director, Government Relations and Community Partnerships

Staff Present (cont.)
Omar Chughtai, CGO**
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 5:33 p.m. Roll call was taken and Director Po was absent at roll call. A quorum was present.	***The meeting was called to order at 5:33 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. RECOGNITION OF FORMER COMPENSATION COMMITTEE CHAIR BOB MILLER	Chair Rebitzer and Dan Woods recognized Bob Miller's years of service since 2012, and as Chair of the Executive Compensation Committee. Directors Zoglin, Doiguchi, and Miller also acknowledged Bob Miller's leadership and contributions. The Board also formally recognized Melora Simon, Vice Chair of the Quality Committee for her more than 10 years of service. **Motion:** To approve Resolution 2025-03. **Movant**: Miller **Second**: Watters **Ayes**: Chen, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Po **Recused**: None	

6. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 5:47 p.m. **Movant**: Doiguchi **Second**: Fung **Ayes**: Chen, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Po **Recused**: None	***Recessed to closed session at 5:47 p.m.***
7. AGENDA ITEM 15: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:37 p.m., and Agenda Items 7-14 were addressed in the closed session. 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 7:37 p.m.***
8. AGENDA ITEM 17: APPROVAL OF PROPERTY ACQUISITION: 399 EL CAMINO REAL, MOUNTAIN VIEW, CA; APN# 193-04-040	**Motion:** To approve property acquisition: 399 El Camino Real, Mountain View; APN# 193-04-040 **Movant**: Fung **Second**: Miller **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: **Abstentions**: None **Absent**: Po **Recused**: None	
9. AGENDA ITEM 18: APPROVAL OF CAPITAL REQUEST: MOUNTAIN VIEW CAMPUS COMPLETION: WING J PROJECT	**Motion:** To approve capital request: Mountain View Campus Completion: Wing J Project **Movant**: Zoglin **Second**: Doiguchi **Ayes**: Chen, Doiguchi, Fung, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: Miller **Abstentions**: None **Absent**: Po **Recused**: None	
10. AGENDA ITEM 19: CONSENT CALENDAR ITEMS	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Item e was removed for discussion. Dir Zoglin wanted to recognize Melora Simon as a longstanding member of the Quality Committee. Dr. Somersille also highlighted Melora's deep knowledge of regulatory, social determinants of health, and how to approach the quality measures. We are thankful that she spent so much time elevating the quality here. **Motion:** To approve the consent calendar minus item e **Movant**: Chen **Second**: Somersille **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Po **Recused**: None	***Consent calendar items were approved except for item e: Recognition for Melora Simon.*** - ***Consent calendar item e was approved.***

	Motion: To approve the consent calendar item e **Movant**: Zoglin **Second**: Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Po **Recused**: None	
11. AGENDA ITEM 20: CEO REPORT	Mr. Woods provided an update on the heart and vascular institute being named one of the best hospitals in the country, and winning the platinum aware from American College of Cardiology for 8 years in a row. Dr. Tran Ho, Co-Director of the Breast Cancer Program was recognized as Silicon Valley Business Journal's 40 under 40 stars. The Annual Men's Health Fair in Los Gatos was a success. Dir Doiguchi attended and had heard wonderful feedback from attendees on ECH. Dir Miller said that attendees enjoyed talking to physicians. The Chinese Health Initiative delivered diabetes prevention webinar to over 70 participants. And the South Asian Heart Center engaged 249 participants to provide screening, diabetes and heart disease prevention and wellness.	
12. AGENDA ITEM 21: BOARD ANNOUNCEMENTS	Dr. Fung invited the board to the KTSF launch party on August 28th at 4-6pm at ECH. Director Miller praised today's intern presentations. Many ECH executives attended included CEO, COO, CFO, CNO, CMO. Dr. Somersille commented that she had asked for the intern program when she first started. The students come from underserved families. The presentations were outstanding. It's a 12 week internship, and she would like the full board to be invited next year. Director Miller acknowledged that she has rolled off of the Foundation board liaison. She was on for 7 years, and $14M was raised. She challenged Dr. Fung to outraise the fundraising amount.	
13. AGENDA ITEM 22: ADJOURNMENT	**Motion:** To adjourn at 7:49 p.m. **Movant**: Watters **Second**: Miller **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: 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
September 17, 2025

Department	Document Name	Origin Date	Last Reviewed	Revised?	Doc Type	Document Details | Approval Workflow
Medical Staff	Medical Staff Code of Conduct and Professional Behavior	10-1-08	12-11-24	Major	Policy	• All sections were updated Medical Staff Leadership Committee > ePolicy > MEC > Board
Executive Summary – Updates to the Medical Staff Code of Conduct and Professional Behavior • **Clarified Definitions** – Restructured "Disruptive or Inappropriate Behavior" into four clear categories (Inappropriate Behavior, Deviation from Policy/Bylaws, Disruption in Care, and Abuse/Assault), with added examples for sexual harassment, inappropriate language, and neglect. • **Assault/Abuse Handling** – New requirement that alleged assault or abuse incidents be referred to the Chief of Staff (or designee) and handled per Article 7 of the Medical Staff Bylaws. • **Investigation Process** – Streamlined reporting and documentation steps; clarified roles for informal counseling and Levels 1–3 interventions, with explicit escalation criteria. • **Monitoring & Reporting** – Added ongoing monitoring of conduct for patterns/trends and CMO responsibility to report to the MEC; all records stored in confidential electronic files. • **References** – Updated citations, adding Vanderbilt Center for Patient and Professional Advocacy.						
Quality	FY2026 Quality Improvement & Patient Safety (QIPS) Plan	5-1-18	2-5-25	Minor	Plan	• Updated all FY25 areas to reflect new FY26 PESC > Quality Council > ePolicy > MEC Quality Committee > Board
Executive Summary – FY2026 QIPS Plan Updates • **Organizational Overview** – Updated facility and program descriptions to reflect current bed counts, certifications, and expanded list of specialties. • **Quality Council Goals** – FY2026 organizational quality priorities now explicitly include reduction of C. difficile, CAUTI, and HAPI, plus improved hand hygiene compliance; references updated reporting calendar and expanded role of Quality Council as steering body. • **Patient Experience** – Strengthened commitment language; expanded description of *WeCare* service standards and their integration into daily operations, with emphasis on coaching, trust, and personalization of care. • **Patient Safety Enhancements** – Added expectations for reporting discrimination/racism incidents, clarified event classification using HPI methodology, and reinforced Fair & Just Culture protections for staff involved in adverse events. • **Governance & Committee Structure** – More detailed description of responsibilities for Enterprise Patient & Employee Safety Committee (PESC), Cause Analysis Oversight, and Safety Oversight Committees, including dashboard use and escalation processes. • **Process & Performance Methodology** – Reaffirmed use of the Model for Improvement (PDSA), Lean principles, and SMART goal framework; expanded auditing methodology to ensure statistically valid sampling. • **Monitoring & Reporting** – Emphasized ongoing tracking of patterns/trends in safety data, integration of sociodemographic data in safety analysis, and broader transparency of lessons learned. • **Attachments & References** – Updated dashboards, governance flow charts, data registry lists, and safety toolkits to reflect FY2026 standards.						
Foundation	Tribute Gift Policy	10-1-22	N/A	Unchanged	Policy	• Unchanged Finance Committee > Executive Committee. Foundation Board > ePolicy > Board

El Camino Health

BOARD OF DIRECTORS
Documents for Review
September 17, 2025

Supply Chain	Vendor Sanction Screening Policy	8-1-22	N/A	Minor	Policy	• Updated Reference section ePolicy > Board

Executive Summary – Vendor Sanction Screening Policy

- **Reference Updates** – Clarified and reformatted reference list; added updated OIG and SAM.gov resource links and refined citations for compliance guidance documents.
- **No Substantive Procedural Changes** – Core requirements remain the same:
  - Pre-engagement and quarterly screening of vendors, contractors, and related entities against OIG's LEIE and GSA SAM exclusion lists.
  - Immediate termination of relationships with excluded parties, with compliance officer notification.
  - Reinstated vendors may be reconsidered upon proof and due diligence.
  - Prohibition on engaging with individuals/entities under sanction, criminal conviction, or pending exclusion.
- **Minor Wording Clarifications** – Adjusted language for consistency and readability (e.g., "reasonable due diligence" phrasing, explicit mention of guidance from GSA and CMS in debarment cases).

Patient Care Services	Interventional Services-Mountain View Scope of Service	6-1-16	6-23-21	Major	Scope of Service	• Majority of sections updated Med Dir | Dept Dir > ePolicy > MEC > Board

Executive Summary – Interventional Services (Mountain View) Scope of Service

- **Clarified Service Descriptions** – Expanded and reorganized the list of diagnostic, interventional, and hybrid procedures to explicitly include cardiac, structural heart, electrophysiology, interventional radiology, peripheral-vascular, neurological, pulmonary, and hybrid cases; confirmed on-site cardiothoracic surgery backup.
- **Refined Patient Criteria** – Maintained service to adults and adolescents (≥13 years old and ≥80 lbs), with minor language updates for clarity.
- **Assessment & Staffing Updates** – Clarified roles of proceduralists, technologists, and RNs in patient assessment and monitoring; specified credentialing and moderate sedation privileges unless anesthesia is used.
- **Terminology Adjustments** – Minor typographical and wording changes for clarity (e.g., "lab" references replaced with "IS department").
- **No Procedural Changes** – Standards of practice, appropriateness/timeliness review processes, and regulatory compliance references remain consistent with prior version.

Nursing Services	Scope of Service: Inpatient Surgical Services – Mountain View	1-1-2011	4-13-22	Major	Scope of Service	• Majority of sections updated Med Dir | Dept Dir > ePolicy > MEC > Board

Executive Summary – Inpatient Surgical Services (Mountain View) Scope of Service

- **Patient Population Update** – Revised age criteria for pediatric patients from "infant" to **minimum age 3 years**; pediatric service references largely removed.
- **Workflow Updates** – Clarified discharge planning process with active coordination by care coordinators; updated rounding language to "Multidisciplinary Rounds (MDR) Monday–Friday" and clarified daily discharge rounds.
- **Assessment & Staffing Language** – Minor clarifications in RN supervision of LVNs, CNAs, and PSAs; refined staffing determinations based on census, nursing intensity, mandated ratios, and workload scores.
- **Performance Evaluation** – Expanded language to include patient satisfaction and family satisfaction as part of performance improvement measures.
- **No Major Procedural Changes** – Standards of practice, admission/discharge criteria, and regulatory compliance references remain consistent with prior version.

El Camino Health

BOARD OF DIRECTORS
Documents for Review
September 17, 2025

Imaging Services	Scope of Service – Imaging Services	2-1-17	2-5-25	Minor	Scope of Service	• Updated Sections: Patient Types, Reference Med Dir | Dept Dir > ePolicy > MEC > Board

Executive Summary – Scope of Service: Imaging Services

- **Age Range & Clinical Scope Change** – Added formal pediatric definition (patients under 14 years per CA Department of Health) and specified that Interventional Radiology serves adolescents ≥13 years and ≥80 lbs.
- **OR Imaging Coverage** – Added shift/day coverage details, sequential (not concurrent) scheduling when reduced staffing, escalation process (Charge Tech → Ops Manager/Manager on Call), and noted 15–20 minute setup time once called.
- **Turnaround Time Standards** – Established specific TAT goals (e.g., ED 45 min, inpatient STAT 2 hrs, outpatient routine 24 hrs, PET 72 hrs) and STAT exam start expectations (≤1 hr, except Nuclear Medicine 2–3 hrs for isotope procurement).
- **Mammography Communication Standards** – Defined patient/provider notification timelines for suspicious or highly suggestive results (patient ≤5 business days, provider ≤3 business days) and lay letter requirements.
- **Protocol & Dose Transparency** – Requires biennial modality protocol review by section chiefs and inclusion of expected CT dose ranges.
- **Service Hours & Modalities by Campus** – Clarified available modalities per campus and Nuclear Medicine on-call procedures (GI bleed, V/Q, HIDA).
- **Governance & Safety Oversight** – Noted SVDI contract for 24/7 coverage, Radiation Safety Officer/Committee oversight, and referenced applicable ACR, CDPH Title 17/22, and Joint Commission standards.

Pharmacy	Multidisciplinary Drug Diversion Surveillance	11-1-20	6-8-22	Minor	Policy	• Updated Sections: Purpose, Definitions, References P&T > ePolicy > MEC > Board

Executive Summary – Multidisciplinary Drug Diversion Surveillance (August 2025 Revision)

- **Purpose Statement Update** – Minor edits for clarity in the purpose section; no change to overall scope or objectives of the program.
- **Committee Structure** – Reaffirmed required MDT members (Administration, Anesthesiologists, Nursing Leadership, Pharmacy, Risk, Compliance/Legal) and ad hoc members (HR, Employee Health, Diversion Specialist, Environmental Care, Security); clarified quarterly minimum meeting frequency and required use of updated meeting minutes template.
- **Surveillance Process** – Confirmed comprehensive monitoring across procurement, storage, dispensing, administration, wastage/returns, inventory counts, and IRIS high-risk user reviews; detailed reconciliation timelines (e.g., open alerts within 3 days) and escalation procedures for suspected diversion.
- **Chain of Custody & Override Monitoring** – Retained strict chain-of-custody requirements, override removal reviews, anesthesia audit expectations, and pain score documentation standards.
- **Investigation & Reporting** – Reiterated immediate reporting of suspected diversion to Pharmacist in Charge/MDT, defined investigation triggers (e.g., unresolved discrepancies, significant losses), and confirmed regulatory reporting requirements to DEA, State Board, law enforcement.
- **Culture & Prevention Measures** – Continued emphasis on staff empowerment to report concerns, pre-employment background checks for CS access, and proactive use of physical security measures (secured waste containers, badge-controlled access, secured transport).
- **Future Planning** – Added plan for camera surveillance at stationary ADCs for deterrence and investigative support (excluding patient care areas in compliance with HIPAA), with 90-day video retention.

El Camino Health

BOARD OF DIRECTORS
Documents for Review
September 17, 2025

Infection Prevention	FY2025 Infection Control Plan	1-1-96	10-9-24	Major	Plan	• Updated Sections: Mountain View / Santa Clara Demographics, TB Risk Assessment Infection Prevention > Med Dept Exec > ePolicy > MEC > Board

Executive Summary – FY2025 Infection Control Plan

- **Plan Overview** – Annual update to the enterprise-wide program for prevention, surveillance, and control of healthcare-associated and communicable infections; incorporates latest community risk data, TB profile, seasonal influenza strategy, and emerging infectious disease trends.
- **Risk Assessment Data** – Updated demographic and epidemiologic profiles for Mountain View, Los Gatos, and Santa Clara County; refreshed TB risk data (facility remains "Medium Risk") and seasonal influenza/COVID-19 monitoring.
- **Program Goals** – Reaffirmed NHSN-based targets for key HAI metrics (e.g., CLABSI, CAUTI, C. diff, SSI by procedure type, MRSA, MDROs, hand hygiene compliance ≥85%), regulatory reporting compliance, and ICRA adherence for construction projects.
- **Surveillance & Reporting Enhancements** – Continued daily targeted and active disease surveillance for HAIs, MRSA, MDROs, TB, COVID-19 clusters, CRE, Candida auris, and mold in construction areas; refined triggers for mandated reporting to public health and regulatory agencies.
- **Committee Structure** – Infection Control Committee (ICC) composition and authority reaffirmed; quarterly meeting requirement maintained; oversight responsibilities for outbreak investigation, policy updates, and preventive/corrective programs clarified.
- **Education & Engagement** – Ongoing staff training upon hire and annually (hand hygiene, isolation, prevention standards), quarterly in-services for Infection Control Resource Groups, and unit-specific guidance.
- **Environmental & Safety Measures** – Maintained ICRA requirements for construction, SPD sterilization and disinfection monitoring, endoscope reprocessing audits, and dialysis water testing.

Patient Experience	Auxiliary Scope of Service	2-1-18	9-22-21	Unchanged	Scope of Service	• Unchanged ePolicy > MEC > Board

Patient Experience	Interpreting Services	12-1-93	6-12-24	Minor	Policy	• Updated Reference section ePolicy > MEC > Board

Executive Summary – Interpreting Services

- **Policy Purpose & Scope** – Reaffirms commitment to providing effective communication for patients, families, and visitors with limited/no English proficiency or disabilities, in compliance with ADA and state/federal laws.
- **Interpreter Availability** – Certified medical interpreter services available 24/7 via contracted vendor, including telephone and secure video remote interpretation; American Sign Language provided via video connection.
- **Assessment & Documentation** – Interpreter needs assessed at admission and throughout stay; documented in EHR under Communication or Cares/Safety tab. Patients informed of service availability; refusal documented with prohibition on using minors as interpreters.
- **Special Populations** – Procedures outlined for hearing-impaired patients (e.g., ASL services, TTY phone upon request) and vision-

impaired patients (braille forms, audio files, authorized representative consent).

- **Staff Resources** – Communication cards with images and translations available on intranet; instructions provided for accessing interpreter services and devices.
- **Updates in Revision** – Primarily formatting and reference updates; reinforced documentation requirements and clarified processes for hearing- and vision-impaired patient accommodations.

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		✓	✓	✓	✓	✓		✓	✓		✓	✓
Annual Enterprise Patient Safety Report			✓									
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 08/142025

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: September 17, 2025
Subject: Financials: FY2026 - Period 1 (as of 07/31/2025) – Consent Calendar

Purpose: The Finance Committee is recommending that the Board approve the financial results for FY2026 Period 1.

Executive Summary – Period 1 (July 2025):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 304 which is 12 / 4.0% favorable to budget and 16 / 5.6% higher than the same period last year.
- **Adjusted Discharges:** 4,019 which are 324 / 8.8% favorable to budget and 475 / 13.4% higher than the same period last year.
- **Emergency Room Visits:** 6,718 which are 40 / 0.6% unfavorable to budget and 328 / 5.1% lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 14,541 which are 1,688 / 13.1% favorable to budget and 2,260 / 18.4% higher than the same period last fiscal year.

Financial performance for Period 1 was unfavorable to budget, but higher than the period last fiscal year. This is mainly attributable to higher than budgeted government payor mix of 61.0% vs. 58.5% budget.

Total Operating Revenue ($):	$148M is favorable to budget by $0M / 0.1% and $14M / 10.2% higher than the same period last fiscal year.
Operating EBIDA ($):	$19M is unfavorable to budget by $2M / 7.4%, but $0M / 1.2% higher than the same period last fiscal year.
Net Income ($):	$26M is favorable to budget by $11M / 69.4%, but $5M / 15.9% lower than the same period last fiscal year.
Operating Margin (%):	7.5% (actual) vs. 7.9% (budget)
Operating EBIDA Margin (%):	12.9% (actual) vs. 13.9% (budget)
Net Days in A/R (days):	51.0 days are favorable to budget by 3.0 days / 5.6% and 0.8 days / 1.6% better than the same period last year.

Recommendation:

- Recommend Board approval of Period 1 - FY2026 financials.

List of Attachments:

- Presentation: Period 1 - FY2026 financials.

El Camino Health

Summary of Financial Operations

Fiscal Year 2026 – Period 1

7/1/2025 to 07/31/2025

Operational / Financial Results: YTD FY2026 (as of 07/31/2025)

($ 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	304	292	12	4.0%	288	16	5.6%	---	---	---	---
	Adjusted Discharges	4,019	3,695	324	8.8%	3,543	475	13.4%	---	---	---	---
	OP Visits / OP Procedural Cases	14,541	12,853	1,688	13.1%	12,281	2,260	18.4%	---	---	---	---
	Percent Government (%)	61.0%	58.5%	2.5%	4.3%	57.5%	3.5%	6.0%	---	---	---	---
	Gross Charges ($)	670,367	618,357	52,010	8.4%	561,898	108,469	19.3%	---	---	---	---
Operations	Cost Per CMI AD	23,145	21,724	1,422	6.5%	20,478	2,667	13.0%	---	---	---	---
	Net Days in A/R	51.0	54.0	(3.0)	(5.6%)	51.8	(0.8)	(1.6%)	47.5	49.7	47.8	
Financial Performance	Net Patient Revenue ($)	141,147	141,917	(770)	(0.5%)	128,476	12,671	9.9%	363,045	669,435	---	
	Total Operating Revenue ($)	147,728	147,605	122	0.1%	134,012	13,716	10.2%	428,467	697,582	368,408	
	Operating Margin ($)	**11,037**	**11,679**	**(642)**	(5.5%)	**10,357**	**680**	6.6%	**8,569**	**24,415**	**12,526**	
	Operating EBIDA ($)	**19,023**	**20,532**	**(1,509)**	(7.4%)	**18,804**	**219**	1.2%	**24,851**	**56,504**	**31,315**	
	Net Income ($)	25,854	15,262	10,591	69.4%	30,755	(4,901)	(15.9%)	23,566	54,411	20,631	
	Operating Margin (%)	**7.5%**	**7.9%**	**(0.4%)**	(5.6%)	**7.7%**	**(0.3%)**	(3.3%)	**2.0%**	**3.5%**	**3.4%**	
	Operating EBIDA (%)	**12.9%**	**13.9%**	**(1.0%)**	(7.4%)	**14.0%**	**(1.2%)**	(8.2%)	**5.8%**	**8.1%**	**8.5%**	
	DCOH (days)	315	275	40	14.6%	271	44	16.4%	258	315	311	

Moody's Medians: Not-for-profit and public healthcare annual report; August 2025. 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 2025. Dollar amounts have been adjusted to reflect monthly averages.
Fitch Ratings: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 2025. 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 07/31/2025)

($000s)

ASSETS

CURRENT ASSETS	July 31, 2025	Unaudited June 30, 2025
Cash	406,989	407,140
Short Term Investments	100,072	98,926
Patient Accounts Receivable, net	234,564	240,895
Other Accounts and Notes Receivable	24,180	23,615
Intercompany Receivables	25,864	23,136
Inventories and Prepaids	49,890	54,047
Total Current Assets	**841,559**	**847,759**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	18,434	18,467
Plant & Equipment Fund	541,594	541,377
Women's Hospital Expansion	59,208	45,895
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	17,332	17,476
Workers Compensation Reserve Fund	12,374	13,086
Postretirement Health/Life Reserve Fund	22,028	23,009
PTO Liability Fund	42,854	41,558
Malpractice Reserve Fund	1,713	1,713
Catastrophic Reserves Fund	41,530	41,019
Total Board Designated Assets	**967,760**	**954,294**
FUNDS HELD BY TRUSTEE	-	-
LONG TERM INVESTMENTS	**767,325**	**753,548**
CHARITABLE GIFT ANNUITY INVESTMENTS	**1,292**	**1,279**
INVESTMENTS IN AFFILIATES	**51,293**	**51,293**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,068,874	2,067,886
Less: Accumulated Depreciation	(966,626)	(959,828)
Construction in Progress	229,488	228,708
Property, Plant & Equipment - Net	**1,331,737**	**1,336,766**
DEFERRED OUTFLOWS	41,197	41,289
RESTRICTED ASSETS	48,991	50,154
OTHER ASSETS	210,815	204,109
TOTAL ASSETS	**4,261,969**	**4,240,492**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	July 31, 2025	Unaudited June 30, 2025
Accounts Payable	52,817	77,103
Salaries and Related Liabilities	49,643	39,837
Accrued PTO	72,946	71,612
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	8,838	8,509
Intercompany Payables	17,209	18,745
Malpractice Reserves	1,713	1,713
Bonds Payable - Current	15,615	15,615
Bond Interest Payable	1,108	5,651
Other Liabilities	20,730	17,992
Total Current Liabilities	**242,920**	**259,076**
LONG TERM LIABILITIES		
Post Retirement Benefits	22,028	22,028
Worker's Comp Reserve	12,374	12,374
Other L/T Obligation (Asbestos)	25,838	25,939
Bond Payable	523,242	524,470
Total Long Term Liabilities	**583,482**	**584,811**
DEFERRED REVENUE-UNRESTRICTED	**1,601**	**1,538**
DEFERRED INFLOW OF RESOURCES	**84,379**	**84,379**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	3,049,013	3,020,914
Minority Interest	-	-
Board Designated	236,282	225,482
Restricted	64,293	64,292
Total Fund Bal & Capital Accts	**3,349,588**	**3,310,689**
TOTAL LIABILITIES AND FUND BALANCE	**4,261,969**	**4,240,492**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT | September 17, 2025

FINANCIALS

FY2026 - Period 1: July 2026

- **Total Operating Revenue: $147.7MM**
  - $0.1MM / 0.1% vs. favorable to budget
  - $13.7MM / 10.2% higher than the same period last year
- **Operating EBIDA: $19.0MM**
  - $1.5MM / 7.4% vs. unfavorable to budget
  - $0.2MM / 1.2% higher than the same period last year
- **Net Income: $25.9MM**
  - $10.6MM / 69.4% vs. favorable to budget
  - $4.9MM / 15.9% lower than the same period last year

CLINICAL SERVICES

El Camino Health continues to expand and enhance specialized care offerings through clinical excellence, advanced technology, and nationally recognized quality programs. Recent highlights include:

Neuroscience – Stroke Center Re-Certification: El Camino Health earned re-certification from The Joint Commission for Primary Stroke and Advanced Thrombectomy-Capable Stroke Centers at both Los Gatos and Mountain View. The three-day on-site survey, conducted in collaboration with the American Heart Association/American Stroke Association, reaffirmed ECH's adherence to evidence-based standards, clinical guidelines, and performance measures designed to improve care and outcomes for stroke patients.

Robotic Orthopedic Surgery Expansion: New robotic technology is now supporting orthopedic procedures in Mountain View and Los Gatos, including hip and knee replacements, future shoulder replacements, and hip fracture repairs. This advancement enhances surgical precision and broadens the range of orthopedic services available to the community.

Next-Generation Robotic Surgery – Da Vinci 5 Launch: ECH invested in four next-generation Intuitive Da Vinci 5 (DV5) surgical systems to advance minimally invasive surgery at both campuses. Innovations include improved ergonomics, next-gen 3D imaging, Force Feedback technology for tactile precision, and enhanced computing power for surgeon-specific analytics. Los Gatos Hospital Chief of Staff, **Dr. Shahram Gholami**, performed the first DV5 case in Los Gatos, and Gynecologic Oncologist **Dr. Albert Pisani** performed the first in Mountain View—both celebrated with ribbon-cutting ceremonies. With seven Da Vinci robots in operation and over 60 trained robotic surgeons, ECH is recognized as a regional leader in community-based robotic surgery, attracting surgeons across specialties for training and collaboration.

FOUNDATION

El Camino Health Foundation continues to advance philanthropic support for programs and initiatives that enhance patient care and strengthen community connections:

Fundraising Progress: In July, the Foundation secured $661,682 in donations, representing 7% of the FY26 fundraising goal.

Major Gift – Healing Arts Endowment: A $500,000 gift established the *Tamako Lu and Sam Hwang Healing Arts Program Endowment*. Tamako, a new donor, made this contribution in

fulfillment of her late husband Sam's wish—expressed 11 years ago—to recognize the exceptional care he received at El Camino Health. The couple deeply valued the compassion of ECH physicians and nurses, as well as the comfort provided by Healing Arts musicians.

29th Annual El Camino Heritage Golf Tournament: Scheduled for October 20, 2025, at Silver Creek Valley Country Club, this year's *California Dreamin'*-themed tournament is experiencing strong early sponsorship sales

MARKETING

In August 2025, El Camino Health's marketing and communications team focused on expanding community partnerships, increasing brand awareness and driving new patient growth through targeted campaigns and media outreach. Using predictive targeting strategies, digital advertising campaigns focused on primary care, men's health and cancer care drove new patient appointment volumes. Strategic sponsorships with local organizations, including the San Jose Earthquakes, strengthened El Camino Health's presence in the region and fostered deeper community engagement. The team advanced content marketing by producing new blog articles and physician profile videos and celebrated external recognition for Dr. Tran Ho in the Silicon Valley Business Journal's 40 Under 40. Media relations secured coverage in prominent local and national outlets, further enhancing brand visibility. Social media performance, particularly on LinkedIn, continues to see significant gains in impressions and interactions compared to peers in the market. Internally, communications maintained high engagement through timely executive messages and employee newsletters and ongoing support for organizational initiatives.

INFORMATION SERVICES

National Recognition: El Camino Health shared key learnings and best practices on implementing Social Determinants of Health within the electronic health record at the national Epic User Group Meeting.

Epic Payor Platform Growth: A second payor, Aetna/CVS, is now live on the Epic Payor Platform, enabling automated, real-time sharing of patient care documentation upon discharge—prior to claims submission. This reduces manual faxing, improves claims process efficiency, and strengthens the security of patient information.

CORPORATE HEALTH SERVICES

El Camino Health continues to broaden its preventive health and wellness offerings for employees, community members, and partner organizations through innovative programs and targeted outreach:

Relationship Wellness – New Program Launch: Concern introduced *Our Relationship*, an online program for couples designed to improve communication, conflict resolution, and trust. Offered as a self-directed course or guided by a coach, the program is backed by 10 years of research showing a 91% improvement in relationship satisfaction. Customer response has been highly positive, reflecting strong demand for relationship-focused resources.

Chinese Health Initiative (CHI): CHI launched the fall cohort of its four-month *Diabetes Prevention Series*, enrolling 120 participants in lifestyle change programs emphasizing diet, exercise, sleep, and stress management. In partnership with the Taipei First Girls' High School Alumni Association, CHI also introduced the *Emotional Well-Being Guide* to promote mental wellness in the community.

South Asian Heart Center: The Center provided screening, education, and coaching to 296 participants aimed at preventing heart disease and diabetes, delivering 625 consultations and coaching sessions. Additionally, 16 lifestyle workshops and health information events attracted 464 attendees, furthering the Center's mission to reduce cardiovascular risk in the South Asian community.

ACCOLADES AND RECOGNITION

El Camino Health has been named one of the **Best Hospitals for 2025–2026** by *U.S. News & World Report*, earning the distinction of **top community hospital in the San Jose metropolitan area**. The annual *Best Hospitals* list—now in its 36th year—recognizes hospitals for excellence in clinical outcomes, nursing care, and patient safety practices.

Top Rankings: Mountain View was recognized as the **#1 Community Hospital** and **#2 Overall** in the San Jose metro area.

Statewide Recognition: El Camino Health ranked **16th in California**, advancing 24 spots from the previous year. This achievement reflects high performance ratings in 18 adult procedures and conditions, including multiple cancer specialties, cardiovascular care (heart attack, heart failure), maternity care, and more.

AUXILIARY

In June, Auxiliary members contributed **3,784 volunteer hours** across the Mountain View and Los Gatos campuses. Total volunteer hours for FY2025 stand at 41,648. Cumulative hours since the Auxiliary's inception now exceed 6.2 million.

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A17b. Board Summary - September 2025

El Camino Health

BOARD OF DIRECTORS
Documents for Review
September 17, 2025

Department	Document Name	Origin Date	Last Reviewed	Revised?	Doc Type	Document Details | Approval Workflow
Medical Staff	Medical Staff Code of Conduct and Professional Behavior	10-1-08	12-11-24	Major	Policy	• All sections were updated Medical Staff Leadership Committee > ePolicy > MEC > Board
Quality	FY2026 Quality Improvement & Patient Safety (QIPS) Plan	5-1-18	2-5-25	Minor	Plan	• Updated all FY25 areas to reflect new FY26 PESC > Quality Council > ePolicy > MEC Quality Committee > Board
Foundation	Tribute Gift Policy	10-1-22	N/A	Unchanged	Policy	• Unchanged Finance Committee > Executive Committee. Foundation Board > ePolicy > Board
Supply Chain	Vendor Sanction Screening Policy	8-1-22	N/A	Minor	Policy	• Updated Reference section ePolicy > Board
Patient Care Services	Interventional Services-Mountain View Scope of Service	6-1-16	6-23-21	Major	Scope of Service	• Majority of sections updated Med Dir | Dept Dir > ePolicy > MEC > Board
Nursing Services	Scope of Service: Inpatient Surgical Services – Mountain View	1-1-2011	4-13-22	Major	Scope of Service	• Majority of sections updated Med Dir | Dept Dir > ePolicy > MEC > Board
Imaging Services	Scope of Service – Imaging Services	2-1-17	2-5-25	Minor	Scope of Service	• Updated Sections: Patient Types, Reference Med Dir | Dept Dir > ePolicy > MEC > Board
Pharmacy	Multidisciplinary Drug Diversion Surveillance	11-1-20	6-8-22	Minor	Policy	• Updated Sections: Purpose, Definitions, References P&T > ePolicy > MEC > Board
Infection Prevention	FY2025 Infection Control Plan	1-1-96	10-9-24	Major	Plan	• Updated Sections: Mountain View / Santa Clara Demographics, TB Risk Assessment Infection Prevention > Med Dept Exec > ePolicy > MEC > Board
Patient Experience	Auxiliary Scope of Service	2-1-18	9-22-21	Unchanged	Scope of Service	• Unchanged ePolicy > MEC > Board

El Camino Health

BOARD OF DIRECTORS
Documents for Review
September 17, 2025

Patient Experience	Interpreting Services	12-1-93	6-12-24	Minor	Policy	• Updated Reference section ePolicy > MEC > Board

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A17b1a. Memorandum - Medical Staff Code of Conduct and Professional Behavior (Signed by Dr. Mark Adams)

El Camino Health

Hospital Campuses

2500 Grant Road
Mountain View, CA 94040
650-940-7000

815 Pollard Road
Los Gatos, CA 95032
408-378-6131

elcaminohealth.org

Memorandum

To: All Medical Staff
From: Mark Adams, MD
Date: August 22, 2025
Subject: Implementation of the Medical Staff Code of Conduct and Professional Behavior

As of August 22, 2025, the attached Medical Staff Code of Conduct and Professional Behavior policy is in effect. This action is being taken to ensure that processes at El Camino Hospital are up to date and consistent with current regulatory requirements.

The policy will be in effect via this executive directive until the formal approval process is complete, at which time the final approved version will be available.

Please review the policy and ensure compliance within your respective area. If you have any questions or require clarification, please contact the Medical Staff Office.

Sincerely,

Mark Adams, MD, FACS
Chief Medical Officer

Status **Pending** PolicyStat ID **18627367**

Origination	10/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2025
Next Review	3 years after approval
Owner	Raquel Barnett: Sr. Director Medical Staff Services
Area	Medical Staff
Document Types	Policy

Medical Staff Code of Conduct and Professional Behavior

COVERAGE:

El Camino Hospital Medical Staff and Allied Health ~~Clinicians~~Practitioners (Practitioner)

PURPOSE:

The purpose is to ensure a safe, cooperative, and professional health care environment that will ensure optimum patient care and prevent or eliminate (to the extent possible) conduct defined as disruptive or unacceptable behavior as defined below ~~in IV B~~.

POLICY STATEMENT:

It is the policy of the Medical Staff of El Camino Hospital that ~~the physicians and allied health~~ practitioners treat all individuals within its facilities with courtesy, respect, and dignity. To that end, the Board of Directors requires ~~physicians and privileged licensed~~ practitioners will conduct themselves in a professional and cooperative manner in all El Camino Health facilities and understand and agree to adhere to a code of conduct and professional behavior. New and current practitioners of the El Camino Hospital ~~Medical Staff~~ will sign an acknowledgement of receipt of this policy at the time of appointment and reappointment, respectively.

DEFINITIONS:

- ~~**Acceptable behavior**~~Acceptable behavior is defined as behavior that enables others to perform their duties and responsibilities effectively, promotes the orderly conduct of the organization, and results in respectful and constructive communication. Examples of acceptable behavior include, but are not necessarily limited to:

Medical Staff Code of Conduct and Professional Behavior

- Demonstration of dignity, respect, courtesy, cooperation and presentation of a positive and professional image when dealing with all patients and coworkers.
- Respectful communication in a calm and professional manner.
- Addressing disagreements professionally, factually and timely.
- Communication with department and intradepartmental team members that is accurate and timely.

- ~~**Disruptive or inappropriate behavior** is defined as behavior that disrupts the operation of the hospital, affects the ability of others to do their jobs or to practice competently, or creates a hostile work environment for hospital employees, physicians, allied health practitioners, patients or other individuals. The Medical Staff will not tolerate disruptive behavior, which may include but is not limited to:~~
  - ~~Rude, vulgar or abusive conduct, verbal and/or physical, toward, or in the presence of, patients, nurses, hospital employees, other practitioners or visitors.~~
  - ~~Non-constructive criticism or disparagement addressed to, or about, a recipient in a way as to intimidate, belittle or to infer stupidity or incompetence.~~
  - ~~Impertinent and/or inappropriate comments written or illustrated in the patient's medical records or other official documents that impugn the quality of care in the hospital or malign particular practitioners, employees or hospital policy.~~
  - ~~Deliberate destruction or stealing of hospital property, including medical records.~~
  - ~~Disrupting hospital case management, committee or peer review functions.~~
  - ~~Disrupting hospital personnel's ability to perform their assigned functions.~~
  - ~~Refusal to accept medical staff assignments when required or refusal to participate in committee or departmental affairs in a professional and appropriate manner.~~
  - ~~Harassment by a medical staff or Allied Health Staff member against any individual (other medical staff member, Allied Health Staff member, hospital employee, patient or visitor) on the basis of race, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, age, religion, or sexual orientation.~~
  - ~~"Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment may include, but is not limited to, unwelcome advances, requests for sexual favors, and any other verbal, visual or physical conduct of a sexual nature when 1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or 2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment.~~

  Disruptive or inappropriate behavior refers to actions or conduct (verbal, non-verbal, or physical) that interfere with the effective delivery of patient care, undermine a culture of safety, or negatively impact collaboration and communication among healthcare professionals. This

Medical Staff Code of Conduct and Professional Behavior

includes, but is not limited to:

- Inappropriate Behavior:
  - Use of rude, vulgar or abusive language directed toward, or used in the presence of, patients, nurses, hospital staff, other practitioners or visitors.
  - Non-constructive criticism or disparagement addressed to, or about, a recipient to intimidate, belittle or to infer stupidity or incompetence.
  - Harassment by a practitioner on the basis of race, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, age, religion, or sexual orientation.
  - Unwelcome language of a sexual nature that creates an intimidating, hostile, or offensive environment. This includes comments, jokes, or conversations that are sexual in nature or that target a person's gender, sexual orientation, or appearance in a sexualized way.
- Deviation from hospital policy and/or Medical Staff Bylaws:
  - Deliberate destruction or stealing of hospital property, including medical records.
  - Refusal to accept medical staff assignments when required or refusal to participate in committee or departmental affairs in a professional and appropriate manner.
  - Impertinent and/or inappropriate comments written or illustrated in the patient's medical records or other official documents that impugn the quality of care in the hospital or malign particular practitioners, employees or hospital policy
- Disruption in Care:
  - Disrupting hospital case management, committee or peer review functions.
  - Disrupting hospital personnel's ability to perform their assigned functions.
- Abuse or Assault (Refer to Alleged Assault or Abuse of Patients Receiving Care at ECH Policy):
  - Abuse or assault is 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.

REFERENCES:

- California Business and Professions Code 805.8
- Adverse Event Reporting to Regulatory or State Licensing Agencies Procedure

Medical Staff Code of Conduct and Professional Behavior

- Title VII of the Civil Rights Act of 1964, the California Fair Employment and Housing Act, specifically Government Code §12940(a), (h) and (i), and the Ralph Civil Rights Act
- Vanderbilt Center for Patient and Professional Advocacy. (n.d.). *Vanderbilt Health Center for Patient and Professional Advocacy.* Vanderbilt University Medical Center. https://www.vumc.org/cppa/

PROCEDURE:

A. Reporting and Initiation of Complaint. Any physician, allied health practitioner, employee, patient, or visitor may report potential unprofessional conduct of a medical staff member through the following channels: submission of an incident report or communication with hospital or medical staff leadership which can be verbal, by email, in writing or in person.

B. The report shall be forwarded to the Quality, Safety and Risk Department for documentation. Such documentation shall include:

1. The date, time, and place of the questionable behavior.
2. A statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient.
3. The circumstances that precipitated the situation.
4. A factual and objective description of the questionable behavior.
5. The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations.
6. A record of any actions taken to remedy the situation including the date, time, place, and name(s) of those intervening.

C. Investigation:

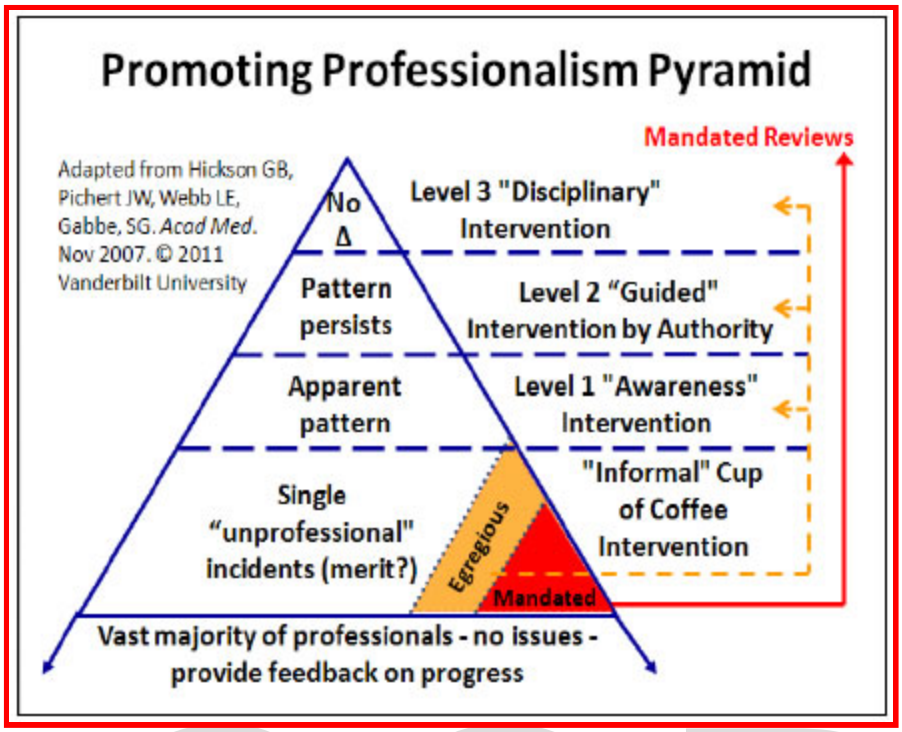
1. Once a report of unprofessional behavior regarding a medical staff member is reported, the matter will be referred to the Chief Medical Officer or his/her designee to investigate the incident. Investigation should include discussion with involved medical staff member and others as deemed appropriate. The medical staff member shall have a full opportunity to respond to the concerns during the entirety of the investigative process. The Chief Medical Officer or designee shall make a determination of whether the incident requires any action.
2. If no further action is required, then the Chief Medical Officer or designee shall document this outcome and file that in the practitioner's quality file.
3. Initial collegial intervention will be informal among the provider and the campus and department specific vice chair. A copy of this policy will be provided, the need for compliance will be emphasized and the discussion documented in the practitioner's Quality file along with a simple email that will be sent to the provider. A communication of such meeting shall be delivered to the appropriate Department Chair.
    a. In the spirit of an informal collegial intervention, an administrative representation in the meeting with the practitioner may be present only at the discretion of the campus and department specific vice chair

Medical Staff Code of Conduct and Professional Behavior

4. ~~Level 1 is defined as an apparent or recurrent incidence of disruptive behavior. If the single incident is egregious and/or the incident along with past events signifies a developing pattern of disruptive behavior, the Chief Medical Officer designee and the Department specific Chair will meet with the practitioner to discuss the next intervention. They will provide the practitioner with a copy of this policy and inform the practitioner that the Board requires compliance with the policy and failure to comply shall be grounds for summary suspension.~~
    a. ~~The Chief Medical Officer designee or one the Department specific Chairs shall document this meeting and write a follow up letter to the practitioner to document the content of the discussions and the actions that the practitioner has agreed to perform with possible ramifications of compliance failure. This letter shall be kept on file~~
5. ~~Level 2 is defined as a persistent pattern of disruptive behavior and will be addressed by the Leadership Council. The practitioner will be present at the time that the behavior is discussed. Appropriate recommendation will be recommended.~~
    a. ~~Involved practitioner may submit a rebuttal to the charge which will also be kept in the practitioner's quality file~~
    b. ~~Documentation of the discussion will be contained in the Leadership Council minutes~~
    c. ~~Documentation of the discussion will be placed in the practitioner's file with a certified letter sent to the practitioner of the recommendations~~
6. ~~Level 3 is defined as a single egregious behavior and/or a persistent pattern of disruptive behavior despite prior counsellings. The matter will be referred to the MEC for review. Possible actions include:~~
    a. ~~Development of a behavior contract setting zero tolerant goals for the practitioner or~~
    b. ~~Recommending other appropriate actions in accordance with the Medical Staff Bylaws, including possible Summary Suspension, to the Board of Directors~~
    c. ~~Appropriate documentation shall be entered in the practitioner's file~~

D. ~~Conclusions~~

Medical Staff Code of Conduct and Professional Behavior



~~1. If the Single Incident is egregious, then move to Level 3~~

~~Incident or Pattern~~	~~Administrative~~	~~Medical Staff~~
~~Single Incident~~	~~Optional~~	~~Campus and Department Specific Vice Chair~~
~~Level 1~~	~~CMO designee~~	~~Department Specific Chair~~
~~Level 2~~	~~Leadership Council~~	~~Leadership Council~~
~~Level 3~~	~~MEC~~	~~MEC~~

A. Reporting and Initiation of Complaint. Any physician, allied health practitioner, employee, patient, or visitor may report potential unprofessional conduct through the following channels: submission of an incident report or communication with hospital or medical staff leadership which can be verbal, by email, in writing or in person.

B. The report shall be forwarded to the Quality, Safety and Risk Department for documentation. Such documentation shall include:

1. The date, time, and place of the questionable behavior.
2. A statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient.
3. The circumstances that precipitated the situation.
4. A factual and objective description of the questionable behavior.

C. Investigation:

Once a report of unprofessional behavior regarding a practitioner is received, the matter will be referred to the Chief Medical Officer or designee to investigate the incident. Events related to alleged assult or

Medical Staff Code of Conduct and Professional Behavior

abuse will be referred to the Chief of Staff or designee. Investigation shall include discussion with involved practitioner and others as deemed appropriate. The practitioner shall have an opportunity to respond to the concerns during the entirety of the investigative process. All reports of physical abuse and assult shall follow the process outline in Article 7 of the Medical Staff Bylaws. The medical staff leader assigned to the event shall make a determination using the following criteria:

1. No concerns identified; no further action required.
2. Informal collegial intervention: Verbal counseling: an informal discussion with the practitioner and the Department Vice Chair. A copy of this policy will be provided, the need for compliance will be emphasized and evidence of the discussion is documented in the practitioner's file.
3. Level 1: Single egregious event or recurrent incidents of disruptive behavior; meeting with Department Chair and Chief Medical Officer. If the single incident is egregious and/or the incident along with past events signifies a developing pattern of disruptive behavior, the Chief Medical Officer or designee and the Department Chair will meet with the practitioner to discuss the event. A copy of this policy will be provided to the practitioner. Failure to comply may result in suspension of privileges.
    i. The Chief Medical Officer, their designee, or the Department Chair shall document the meeting and prepare a follow-up letter to the practitioner summarizing the discussion, outlining the agreed-upon actions, and noting any potential consequences of non-compliance.
    ii. Documentation of the discussion and recommended action(s) are placed in the practitioner's file.
4. Level 2: Persistent pattern of disruptive behavior; referral to the Leadership Council. The practitioner has the opportunity to be present at the time the event is discussed.
    i. Practitioner has the opportunity to respond.
    ii. Documentation of the discussion is detailed in the Leadership Council minutes.
    iii. Documentation of the discussion and recommended action(s) are placed in the practitioner's file.
    iv. If determined necessary, escalate to Medical Staff Executive Committee.
5. Level 3: A single egregious incident and/or continued disruptive behavior despite prior counseling; request for corrective action to the Medical Staff Executive Committee. Possible actions include but are not limited to:
    i. Development of a behavior contract setting zero tolerant goals for the practitioner
    ii. Recommending other appropriate actions in accordance with Article 7 of the Medical Staff Bylaws.
    iii. Documentation of the discussion and recommended action(s) are placed in the practitioner's file.

D. Ongoing Monitoring and Reporting: All documentation related to a conduct review will be stored in the practitioner's confidential electronic file, managed by the Medical Staff Office (MSO). All conduct events shall be monitored for patterns or trends. The Chief Medical Officer shall be responsible for reporting to the Medical Staff Executive Committee.

Medical Staff Code of Conduct and Professional Behavior

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

Code of Conduct - Acknowledgement of Receipt

Approval Signatures

Step Description	Approver	Date
MEC	Michael Coston: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2025
Medical Staff Leadership Committee	Raquel Barnett: Sr. Director Medical Staff Services	07/2025
	Raquel Barnett: Sr. Director Medical Staff Services	07/2025

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A17b2a. (Memo) Board QIPS Plan FY26

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: September 17, 2025
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QIPS) for 2026

Recommendation: Recommend El Camino Hospital Board approval of the Quality Improvement and Patient Safety Plan (QIPS). The Quality Committee recommended for Board approval at its meeting on September 8, 2025.

Authority: The Board Quality, Patient Care and Patient Experience Committee is responsible for the oversight of the QIPS program through its periodic review of the program, including, the development of a plan to implement and maintain the QIPS program, the review of the progress of QIPS projects, the determination of annual QIPS projects, and the evaluation of the effectiveness of improvement actions that the hospital has implemented. *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*

Background: The Centers for Medicare and Medicaid Services (CMS) requires hospitals to have a well-designed and well-maintained QIPS program as a condition of participation. CMS requires that a hospital's QIPS program "provides a process by which a hospital can fully examine the quality of care it delivers and implement specific improvement activities and projects on an ongoing basis for all of the services provided by the hospital, while considering the scope and complexity of those services and the patient populations it serves." *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*. The ECH QIPS program is updated annually to reflect, timely, the systems we have in place to identify and correct problematic events, policies or practices to ensure we are effective in improving performance, quality and safety.

Assessment: The El Camino Hospital QIPS plan describes our ability to develop, implement, and maintain an effective, ongoing, hospital-wide, and data-driven quality improvement and patient safety program, which also includes tracking and monitoring of adverse events and medical errors.

Other Reviews: Reviewed and approved by the Quality Council, Patient and Employee Safety Committee and the Medical Executive Committee.

Outcome: The Board will approve the QIPS Plan. There are no changes to the plan to report or review. Some update for FY 26 includes:

- Updated Quality Organizational Goals for FY26:
  - CDIFF
  - CAUTI
  - HAPI
  - Hand Hygiene compliance
- Minor updates to Patient Experience, PI, & Patient Safety sections with edits for FY 26

List of attachments:

1. Quality Improvement and Patient Safety Plan with referenced QIPS addendums.

Status **Pending** PolicyStat ID **18507752**

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Effective	Upon Approval
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Next Review	1 year after approval

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

FY2026 Quality Improvement & Patient Safety (QIPS) Plan

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a ~~275~~292-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View (MV), California and a 143-bed acute hospital in Los Gatos (LG), California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip, Knee, & Shoulder, Hip Fracture, for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center, in Joint Replacement for Hip, Knee & Shoulder, Spinal Fusion, Sepsis and Patient Blood Management, and as a "baby friendly hospital" by WHO/UNICEF.

The ECH Medical Staff includes over ~~1100~~1400 active, telemedicine, provisional ~~and~~ consultant, ~~353~~and affiliate physicians~~, and 116 independent practitioners~~ with representation covering ~~nearly every~~over seventy (70) clinical ~~specialty~~specialties (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

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

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El CAMINO HEALTH VISION

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

El CAMINO HOSPITAL VALUES

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

Safety: We put safety first in each decision and process, to achieve our mission of zero harm for our patients, visitors and team members.

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

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

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

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

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

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

DEFINITIONS:

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

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

SERVICES/PROGRAMS

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

Acute Inpatient Services:	Emergency Services	Outpatient Services
Acute Rehabilitation	Basic	Advanced Care & Diagnostics Center

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

Section I Quality Improvement Plan

PURPOSE

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

OBJECTIVES

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

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

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

Governing Board

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

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

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

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

Medical Executive Committee (MEC)

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

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

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

Medical Staff Departments and Divisions

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

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

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

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

Leadership and Support

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

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

Medical Staff, Employees, and Contracted Services

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

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is chaired by the delegated Medical Staff Leader, and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY ~~2025~~2026 includes the reduction of C.difficile and CAUTI infections, Hospital Acquired Pressure Injuries (HAPI) , and increased Hand Hygiene ~~audits~~compliance. Quality Council receives a monthly report on the progress of the Quality Teams that work to address this goal. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY ~~25~~26 Quality Council report schedule.

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Quality Services Department

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

The Quality Services Department is also responsible for:

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

and safety data

Hospital Services

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

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

IMPROVING ORGANIZATIONAL PERFORMANCE

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

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

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

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Performance Processes

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

B. **Measurement**
ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and safety. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.
Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

1. Consistent with the organization's mission, vision, goals, objectives, and plans;
2. Meeting the needs of individuals served, staff and others;
3. Clinically sound and current;
4. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
5. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
6. Incorporated into the results of performance improvement activities.
7. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs
   Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:
   a. Establish a performance baseline;
   b. Describe process performance or stability;
   c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
   d. Identify areas for more focused data collection to achieve and sustain improvement.

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

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

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

Improvement Model and Methodology

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

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

The model has two parts:

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

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

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it, trying it, observing the results, and acting on what is learned.

~~**Step 1: Plan**~~

~~Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?~~

~~**Step 2: Do**~~

~~Try out the test on a small scale. What did we observe that was not a part of our plan?~~

~~**Step 3: Study**~~

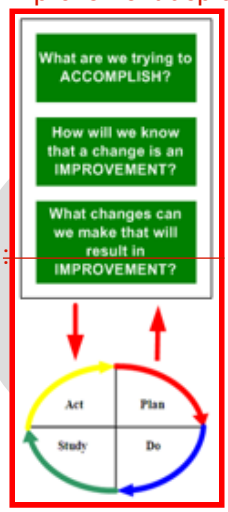
~~Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?~~

~~Summarize and reflect on what was learned.~~

~~**Step 4: Act**~~

~~Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.~~

~~In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:~~



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

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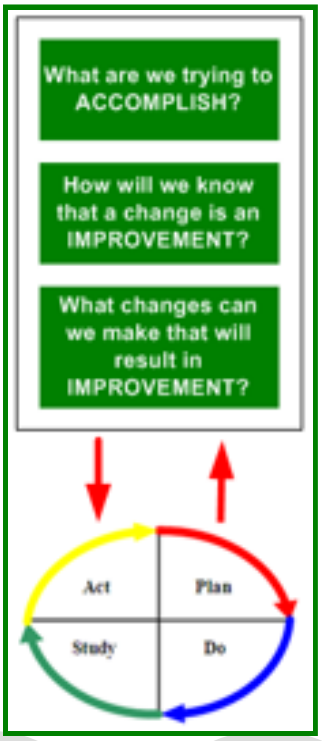

C. ***Goal Setting and Auditing Methodology***

1. ~~S.M.A.R.T.~~ **S.M.A.R.T.** Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.

   The acronym stands for:

   S – Specific
   When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
   Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
   What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
   When – You'll get more specific about this question under the "time-bound" section of defining S.M.A.R.T. goals, but you should at least set a time frame.
   Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
   Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking

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business."
Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

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

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

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

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

2. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.
   Measure of Success (MOS) auditing process has specified the following minimums:
   a. Sample all cases for a population size of fewer than 30 cases
   b. Sample 30 cases for a population size of 30–100 cases
   c. Sample 50 cases for a population size of 101–500 cases
   d. Sample 70 cases for a population size of more than 500 cases
   e. Sample 100 cases for a population greater than 500 cases
      To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

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Process Improvement

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

The Process Improvement department has been in existence since 2012. Our goal is to support a culture of continuous improvement to create problem-solvers at every level and together to make health care better using Lean methodology and techniques as the foundation of our interventions. We also use tools from Six Sigma, Change Management, and PDSA to achieve both incremental and breakthrough improvements.

The Process Improvement department provides resources to the organization for problem solving, as well as deployment of our Daily Engagement System. Our dedicated team is comprised of Process Improvement Advisors and Project Managers with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization. The PI team partners with Executive leaders in the Strategic Goal Deployment and Catchball process that support leaders in cascading and translating organizational targets to the front line. In this way we enhance the ability of all employees to feel connected to our True North Strategic Goals.

The El Camino Health Daily Engagement System is the framework in which we manage our business. It is comprised of the processes, methods and tools that we use to run the various functions of our work. It includes leader behaviors that support our teams and visual management to create transparency. It is the way that we lead and accomplish work at El Camino Health.

The success and sustainment of Process Improvement is dependent on robust education and training programs. We provide focused training of Lean /~~PI~~ Process Improvement tools and methods within improvement projects and workshops throughout the enterprise. We also offer specific topic training sessions via PI ~~Talks~~Topic talks to teams and small groups designed to encourage and support our culture of continuous improvement.

The ECH True North incorporates our mission, vision and values, and is supported by our True North pillars. Daily Engagement is our foundation. It is built on the Lean principles of respect for people and pursuit of continuous improvement. These concepts, methods and tools, support our overall Management System and define how we:

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

Quality Improvement Link with Organizational Goals

ECH's Quality Improvement Plan focuses on specific quality measures in two areas: quality & safety, and service. See below for the Fiscal Year ~~2025~~2026 Organizational Performance Goals.

FY2026 Quality Improvement & Patient Safety (QIPS) Plan

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the FY ~~25~~26 Organization Quality Goals ECH formed ~~three~~four teams to address opportunities with C. Difficile infections, Catheter-Associated Urinary Tract Infection (CAUTI), Hospital Acquired Pressure Injuries (HAPI), and Hand Hygiene ~~Audits~~compliance rate. Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.

~~Fiscal Year 2025 Goals~~

Pillar	Goal	Target
Quality & Safety	CAUTI	< 10
	C.Diff	< 27
	Hand Hygiene Audits	30,744
Service	Likelihood to Recommend (LTR) – Inpatient	81.9
	LTR – El Camino Health Medical Network	84.5
People	Employee Engagement	4.23
Finance	Operating EBIDA	$232.8M

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Fiscal Year 2026 Goals

Pillar	Goal	Target
Quality & Safety	C.Diff	≤ 26
	CAUTI	≤ 12
	HAPI	≤ 14
	Hand Hygiene Compliance	≥ 84%
Services	Likelihood to Recommend (LTR) Composite Score	≥ 83.4
People	Employee Engagement	4.23
Finance	Operating EBIDA	$251 M

Commitment to Patient Experience

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

To deliver upon our goal for exceptional, personalized care, always, ECH established the WeCare service standards. Exceptional patient experience is not a one size fits all – it is a focus on understanding and tailoring care and services to meet patient needs and engage them as a part of the care team. The WeCare

FY2026 Quality Improvement & Patient Safety (QIPS) Plan

~~service standards highlights the importance of personalizing our interactions to help bridge relationships and establish trust. They are the framework of standards that guide behaviors and communication with our patients, their families and our colleagues. By embedding these service standards across the organization and enterprise, ECH is dedicated to provide a consistent message of compassion and respect through every interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.~~

At El Camino Health (ECH), delivering an exceptional patient experience is foundational to everything we do. We strive to build trusting partnerships between patients, families, and our care teams—partnerships that are proven to improve outcomes, safety, and satisfaction.

To ensure the voice of our patients and families is always present, ECH regularly collects feedback through comment cards and satisfaction surveys. This input is shared with departments and service lines to recognize outstanding care and guide improvement efforts. Listening to the patient experience across the care continuum is essential to our journey toward high reliability.

To support our goal of delivering exceptional, personalized care, ECH has implemented the WeCare service standards. These standards guide how we communicate and interact—with patients, families, and one another—and emphasize empathy, personalization, and trust. Through consistent coaching and monthly messaging, the WeCare standards remain central to our culture and reinforce our commitment to compassion and respect in every interaction.

SECTION II: Patient Safety Plan

PURPOSE

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

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

The intent of this Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk and promote a culture of safety that protects patients from harm. The Patient Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures and performance are aligned, supports Strategic Plan priorities, the Quality Improvement Plan and ongoing quality and patient safety initiatives. In addition, the Patient Safety program at ECH strives to accomplish the requirements listed out in Leapfrog and the NQF Safe Practices in implementation of its program.

FY2026 Quality Improvement & Patient Safety (QIPS) Plan

GUIDING PRINCIPLES

A. We believe that patient safety is at the core of a quality healthcare system.

B. We value the perspectives, experiences and contributions of all staff, medical staff, volunteers, patients, caregivers and the public in their role in patient safety.

C. Patient Safety is a continuous pursuit and is embedded in how we do all of our work.

D. Accountability for patient safety is everyone's business: from the Board of Directors to frontline staff to volunteers.

E. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.

F. We will foster a culture that respects diversity and inclusivity as a shared responsibility promoting access and equity for our workforce and patients.

OBJECTIVES

A. Deliver high quality safe care for every patient.

B. Engage our workforce and patients in safe practices at work at all levels of the organization using SAFETY skills (universal skills).

C. Promote a culture of safety.

D. Build processes that improve our capacity to identify and address patient safety issues.

E. Classify patient safety events and perform cause analysis to better understand causes of errors and areas of improvement using the root cause or apparent cause analysis tools as delineated in the Safety Management and Cause Analysis procedure.

F. Educate workforce, patients and caregivers about the Patient Safety program and initiatives that are aimed at improving patient safety and preventing harm.

G. Encourage organizational learning about medical/health care errors.

H. Incorporate recognition of patient safety as an integral job responsibility.

I. Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame.

J. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions. Where available, patient safety data shall be evaluated by socio demographic data such as age, race, ethnicity, gender identity, sexual orientation, preferred language spoken, disability status, payor and sex, that is voluntarily provided by patients.

K. Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk.

L. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

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

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Governing Board

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

Quality Committee of the Board

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

Enterprise Hospital Committees

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

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

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

Risk Management and Patient Safety Department

El Camino Hospital has a Risk Management and Patient Safety Department consisting of a Senior Director of

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

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

- Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure.
- Coordination of any requested Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.
- Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
- Review National Patient Safety Goal (NPSG) and collaborate with Accreditation to conduct gap analyses.
- Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach
- In partnership with ~~Risk Management and~~ Quality, performance of Failure and Effects Mode Analysis (FMEA).
- ~~In partnership with Risk Management, implementation~~Implementation of performance improvement related to culture of safety, patient safety based on trends or needed risk mitigation.
- Regulatory follow up needed related to patient safety
- Promote transparency of errors and mistakes through sharing lessons learned
- ~~Regular~~Annual assessment of culture of safety~~, defined as least every 2 years from prior survey,~~ and identification of opportunities for improvement
- Assist and ~~facilt ate~~facilitate the coordination and delivery of any needed training and education related to improving the culture of safety based on the hospital's culture of safety results

PATIENT SAFETY PLAN

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

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

    1. Staff are encouraged to report patient safety concerns involving allegations of racism

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and discrimination of patients. These events shall be reviewed by relevant leadership and interventions taken as needed.

B. All staff and medical staff upon hire are provided training on Safety First/Mission Zero safety program which includes training on SAFETY skills. Staff receive annual refreshers and medical staff receive refreshers at time of recredentialing. The Board of Directors receive training on patient safety curriculum.

C. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment J) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.

D. As this organization supports the concept that errors occur due to a breakdown in systems and processes and a fair and just culture, workforce members involved in an event with an adverse outcome will be supported by:

1. A non-punitive approach and without fear of reprisal, as evidenced by the Fair and Just Culture policy.
2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
3. Resources such as Support our Staff (SOS) or EAP should the need exist to provide support for our workforce after an event
4. Culture of Safety surveys about their willingness to use our safety reporting systems

E. PESC Dashboard and Patient Safety Targets, Refer to Attachment G. The PESC establishes a dashboard annually to monitor patient and employee safety events with desired quality targets based on any available benchmarks and organizational goals.

F. Patient Safety Priorities are based on the following:

1. Serious Safety Events as identified by the Safety Event Classification team whose process is described in the Safety Event Management and Cause Analysis procedure
2. Other patient safety events that are not classified as an SSE but raise concerns due to aggregate trend or potential for harm
3. Information from internal assessments related to patient safety such as tracers
4. Information from external organizations related to patient safety such as the Joint Commission Sentinel Event Alerts, ISMP
5. Accreditation and regulatory requirements related to patient safety
6. Fallouts from PESC dashboard.

Patient Safety Initiatives

• Safety First Mission Zero SAFETY skill program • Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis • Hand Hygiene Audits • Monthly Leader and Executive Rounding using 4C	

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

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

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

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Confidentiality

The Quality Improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Quality Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable, California's Evidence Code 1157.

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

Annual Evaluation

Patient Safety: The Senior Director of Risk Management and Patient Safety shall provide an annual evaluation and presentation of the Patient Safety program to the Patient and Employee Safety Committee, the Quality committee of the Board, and the Governing Board. The annual appraisal shall address the program's effectiveness in preventing harm to patients and visitors, improving patient care and safety, resolving problems, and achieving program objectives.

Quality: The Chief Quality Officer or the Sr. Director of Quality Services, shall coordinate the annual evaluation of the Quality program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee, the Quality Committee of the Board, and the Governing Board. The annual appraisal shall address both program's effectiveness in improving patient care, and clinical performance, resolving problems, and achieving program objectives. The annual report of the Quality program will be done at the end of each fiscal year reviewing the organization goals, and enterprise quality dashboard.

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

~~Attachments~~

ATTACHMENTS:

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY~~25~~26)

Att C Enterprise Quality, Safety and Experience Dashboard FY25

Att D Board Quality and Safety Dashboard FY25

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Att E Abbrev Registries List

Att F External Regulatory Compliance Indicators

Att G Patient and Employee Safety Dashboard (FY~~25~~26) (FY26 dashboard wont be approved until this coming September)

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

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

Attachments

- Att A - Governance Information Flow.pdf
- Att B - Quality Council Reporting Calendar (FY26)
- Att C - Enterprise Quality, Safety and Experience Dashboard.pdf
- Att D - STEEEP FY26 MOCK (Exclude ED and MCH LTR).pdf
- Att E - Abbrev Registries List.pdf
- Att F - External Regulatory Compliance Indicator.pdf
- Att H - Leader Skills Toolkit.pdf
- Att I - Universal Skills Toolkit.pdf
- Att J - HPI Classification Tools for SEC.pdf
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- b64_95ffd793-45d3-4612-978d-dc8c17e63050
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Approval Signatures

Step Description	Approver	Date
Quality Council	Michael Coston: Director Quality and Public Reporting	Pending

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Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	07/2025
	Michael Coston: Director Quality and Public Reporting	07/2025

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A17b3. Tribute Gifts Policy-History

Status **Pending** PolicyStat ID **18674465**

Origination	10/2022
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2022
Next Review	3 years after approval
Owner	Dakota Atley: Dir Foundation Operations
Area	Foundation
Document Types	Policy

Tribute Gifts Policy

COVERAGE:

El Camino Hospital Staff and Affiliates.

POLICY STATEMENT:

It is the policy of El Camino Health Foundation that all tribute gifts made to El Camino Health are recorded and tracked via the Foundation's donor management system. All tribute gifts are to be spent in accordance with the donor's intent.

PROCEDURE:

The donor who gave the gift will choose the fund designation. If the donor does not designate a fund, the gift will support the unrestricted El Camino Fund.

A. When a family member of the tribute notifies the Foundation and requests for the gift to be re-designated to a different fund, ECHF will inform the family member that only the donor may make the fund change request.

B. ECHF will notify the designated contact to receive the notification that a tribute donation has been made with the name of donor(s) and mailing address (unless they wish to be anonymous). The dollar amount of each donor will remain confidential.

    1. When the designated contact requests for a report of how much was received, we will honor the request and disclose the total amount and count of how many gifts were received.

    2. Notifications will be sent to the designated contact on a per gift basis unless

Tribute Gifts Policy

requested differently by the designated contact. (Example: once a week, every 5 gifts received, etc).

3. For Circle of Caring Program honorees, the designated individual or group will be notified of their outstanding care. This will include the donor's name (unless they wish to be anonymous) and message (if any).
    a. When the honoree is a physician, the physician will be notified directly.

C. When ECHF receives notification that a tribute gift is coming, the Program Manager, Gift Accounting staff will be notified to make the necessary updates to ensure timely tribute notifications are satisfied.

D. ECHF will not take further action when a tribute gift does not have a designated contact. The gift will still be linked to the tribute name.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy	Patrick Santos: Policy and Procedure Coordinator	08/2025
Foundation Board	Dakota Atley: Dir Foundation Operations	08/2025
Executive Committee	Dakota Atley: Dir Foundation Operations	08/2025
Finance Committee	Dakota Atley: Dir Foundation Operations	08/2025
	Dakota Atley: Dir Foundation Operations	08/2025

History

Sent for re-approval by Atley, Dakota: Dir Foundation Operations on 8/5/2025, 6:27PM EDT

Last Approved by Atley, Dakota: Dir Foundation Operations on 8/5/2025, 6:28PM EDT

Tribute Gifts Policy

> No recommended changes are needed

Last Approved by Atley, Dakota: Dir Foundation Operations on 8/5/2025, 6:28PM EDT

> No recommended changes are needed

Last Approved by Atley, Dakota: Dir Foundation Operations on 8/5/2025, 6:28PM EDT

> No recommended changes are needed

Last Approved by Atley, Dakota: Dir Foundation Operations on 8/5/2025, 6:29PM EDT

> No recommended changes are needed

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 8/11/2025, 12:25PM EDT

> ePolicy 8/8/25 - Approved

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A17b4. Vendor Sanction Screening Policy-History-Changes

Status **Pending** PolicyStat ID **18493585**

Origination	08/2022	Owner	Abigail Robles: Director Materials Management
Last Approved	N/A	Area	Supply Chain
Effective	Upon Approval	Document Types	Policy
Last Revised	08/2025		
Next Review	3 years after approval		

Vendor Sanction Screening Policy

COVERAGE:

Supply Chain Department

PURPOSE:

- To ensure that all contractor and vendors with whom El Camino Hospital does business with are properly screened for exclusions and are authorized to participate in federal and State healthcare programs.

DEFINITIONS

List of Excluded Individuals/Entities (LEIE): The OIG established a program to exclude individuals and entities who have been found to have violated federal law and/or regulations. The OIG has been granted a number of legal authorities under the Social Security Act to affect sanctions and maintains a list of excluded individuals and Entities (LEIE). The effect of an OIG exclusion from Federal health care programs is that no Federal health care program payment may be made for any items or services (1) furnished by an excluded individual or entity, or (2) director or prescribed by an excluded physician (42 CFR 1001.1901). This payment ban applies to all methods of Federal program reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system (PPS). Any items and services furnished by an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner or supplier that is not excluded.

General Services Administration (GSA) Sanction List: The GSA maintains the sanction list to provide a

Vendor Sanction Screening Policy

single comprehensive list of individuals and firms excluded by Federal government agencies from receiving federal contracts or federally approved subcontracts and from certain types of federal financial and nonfinancial assistance and benefits. The sanction list was created for information and use by Federal agencies.

Medicaid State Sanction Data: Many states maintain their own database of individuals and entities they sanction. Several call for or require health care entities to screen against this list. This is in addition to and not in lieu of screening against the Federal sanction information.

REFERENCES:

42 U.S.C ss1320A-7B (2006); http://frwebate2.access.gpo.gov/cgibin/TEXTgate.cgi?WAISdocID=cEcmOi/ 0/1/0&WAISaction=retrieve

Department of Health and Human Services Office of Inspector General. OIG Supplemental Compliance Guidance for Hospitals; http://oig.hhs.gov/fraud/docs/complianceguidance/012705hospsupplementalguidance.pdf

Department of Health and Human Services Office of Inspector General. Publication of the OIG Compliance Program Guidance for Hospitals, http://oig.hhs.gov/authorities/docs/cpghosp.pdf

Department of Health and Human Services Office of Inspector General. Special Advisory Bulletin, http://oig.hhs.gov/exclusions/files/sab-0592013.pdf>

Centers for Medicaid and CHIP Services. "Migration of the Excluded Parties List System (EPLS) to the System for Award Management (SAM)." CMCS Informational Bulletin (8.1.2012)

Centers for Medicare & Medicaid Service. State Medicaid Director Letter (SMDL #09-001), http://www/cms.gov/SMDL/downloads/SMD011609.pdf

Department of Health and Human Services Office of Inspector General. "The Effect of Exclusion from Participation in Federal Health Care Programs." Special Advisory Bulletin, Health Care Programs." Special Advisory Bulletin, http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp

Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities, http://oig.hhs.gov/fraud/exclusions.asp

U.S. General Services Administration's System for Award Management, www.sam.gov/portal/public/SAM/

- Department of Health and Human Services Office of Inspector General. OIG Supplemental Compliance Guidance for Hospitals, Compliance Guidance | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services
- Department of Health and Human Services Office of Inspector General. Publication of the OIG Compliance Program Guidance for Hospitals, http://oig.hhs.gov/authorities/docs/cpghosp.pdf
- Department of Health and Human Services Office of Inspector General. "The Effect of Exclusion from Participation in Federal Health Care Programs." Special Advisory Bulletin, Health Care Programs." sab-05092013.pdf

Vendor Sanction Screening Policy

- Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities, http://oig.hhs.gov/fraud/exclusions.asp
- U.S. General Services Administration's System for Award Management, Home | SAM.gov

PROCEDURE:

A. Prior to establishing employment or a business relationship with any individuals, medical professionals, or outside entities, El Camino Hospital will screen them against the current List of Excluded Individuals and Entities (LEIE) of the OIG.

B. El Camino Hospital shall also screen on a quarterly basis those individuals and entities whom it has engaged or otherwise has a business relationship.

C. If it is determined upon reasonable due diligence that an individual or entity is listed as excluded by the OIG, the relationship shall be immediately terminated and the El Camino Hospital Compliance Officer will be notified.

D. Prospective employees and vendors who have been officially reinstated into the Medicare and Medicaid programs by the OIG may be considered for employment, medical privileges or a contractual relationship upon proof of such reinstatement and a determination that there are no other impediments to such action.

E. El Camino Hospital shall screen all contractors, consultants, vendors, join venture parties and affiliates providing ancillary medically related services or products against the General Services Administration (GSA) System for Award Management (SAM) exclusion list. If it is determined that an individual or entity is under debarment, we shall follow the guidance offered by the GSA on their website and by CMS.

F. El Camino Hospital will exercise reasonable due diligence to verify that any party found on an exclusion list is the same individual or entity noted.

G. El Camino Hospital will not employ or engage in a business relationship with anyone who is currently under sanction or exclusion by the Department of Health and Human Services Office of Inspector General (OIG) and any other duly authorized enforcement agency or licensing and disciplining authority.

H. El Camino Hospital shall not engage in a business relationship with any individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as excluded or otherwise ineligible for participation in federal healthcare programs.

I. El Camino Hospital shall remove individuals or terminate business with individuals with direct responsibility for or involvement in any federal healthcare program, as well as those pending the resolution of any criminal charges or proposed exclusion sanction. Contractors under pending criminal charges shall be suspended from continued work until the matter is resolved in the court of law.

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.

Vendor Sanction Screening Policy

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2025
	Abigail Robles: Director Materials Management	07/2025

History

Sent for re-approval by Robles, Abigail: Director Materials Management on 7/8/2025, 10:39AM EDT

Bulk Last Approved by Robles, Abigail: Director Materials Management on 7/21/2025, 11:14AM EDT

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> Updated reference per ePolicy feedback; received updated version from owner.

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> ePolicy 8/8/25 - Approved

Separator Page

A17b5. Interventional Services-Mountain View Scope of Service-History-Changes

Status **Pending** PolicyStat ID **18293595**

Origination	06/2016
Last Approved	N/A
Effective	Upon Approval
Last Revised	06/2025
Next Review	3 years after approval
Owner	Will Roden: Interim Dir Interventional Services
Area	Patient Care Services
Document Types	Scope of Service

Interventional Services-Mountain View Scope of Service

Types and Ages of Patients Served

The Interventional Services (IS) serves adult inpatients and outpatients, and adolescent patients who are at least 13 years of age AND weigh 80 pounds (36.4 kg) or more.

Assessment Methods

The diagnostic and therapeutic ~~Interventional Services~~interventions provided to patients ~~that~~ are assessed by ~~cardiologists~~the proceduralist, ~~nephrologists~~interventional radiology technologists, ~~cardiac and peripheral vascular surgeons, interventional radiologists, cardiac cath lab technicians, and~~ registered nurses (RNs) who monitor the patients' response to procedures, contrast reactions, complications, and internal quality controls; and external proficiency testing for equipment.

Scope and Complexity of Services Offered

~~The IS provides care and services for Diagnostic and interventional cardiac, peripheral vascular and neurological procedures, Cardiac Rhythm management procedures including electrophysiology studies and cardiac ablations, interventional radiological procedures including line placements, drains, tubes, kyphoplasty and vertebralplasty and embolizations.~~
~~The IS has provisions for the routine and emergency transfer of patients for cardiac surgery.~~

The Interventional Services (IS) department performs diagnostic, interventional, and hybrid procedures. It includes, but is not limited to cardiac, structural heart, electrophysiology, interventional radiology, peripheral-vascular, neurological, pulmonary, and hybrid procedures. Cardiothroracic surgery backup on-site.

Interventional Services-Mountain View Scope of Service

Appropriateness, Necessity and Timeliness of Services

The ~~lab~~IS department assesses the appropriateness and necessity of diagnostic and therapeutic procedures by reviewing specific criteria for each procedure prior to initiation of the procedure. Cases, which do not meet criteria, are subject to review by the Interventional Services Leadership Committee. The IS adheres to contraindications for scheduling as defined in the department's policies and procedures to ensure that no other inappropriate cases are scheduled.

~~The timeliness of lab~~Timeliness of IS services is addressed in departmental policies and procedures which describe the hours of operation as well as performance of routine procedures.

Staffing

~~The IS has five procedural rooms each staffed by registered nurses and cardiac cath lab technicians as needed. Types of staff providing care and services include invasive cardiologists, nephrologists, cardiac and peripheral vascular surgeons, interventional radiologists, registered nurses, cardiac cath lab technicians, qualified respiratory care practitioners and project specialist.~~

The IS procedural rooms are staffed by registered nurses and interventional radiology technologists based on the complexity of the case. All cases are performed by a proceduralist who has approved credentials by the Medical Staff and also has moderate sedation privileges; unless utilizing anesthesia services during the procedure.

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 staff.

The Interventional 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 IS meets patient needs.

Standards of Practice

The Interventional Service is governed by state regulations as outlined in Title 22 and standards established by the Joint Commission on Accreditation of Healthcare Organizations. The department also follows guidelines set forth by the American College of Cardiology. Additional practices are described in the Patient Care Policies and Procedures, departmental policies and procedures, and Clinical Practice Standards.

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Interventional Services-Mountain View Scope of Service

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	08/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2025
Department Medical Director or Director for non-clinical Departments	Will Roden: Interim Dir Interventional Services	06/2025
	Will Roden: Interim Dir Interventional Services	06/2025

History

Draft saved by Thomas, Rita: Dir Interventional Services on 11/1/2024, 1:41PM EDT

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Draft saved by Roden, Will: Interim Dir Interventional Services on 6/3/2025, 4:54PM EDT

Edited by Roden, Will: Interim Dir Interventional Services on 6/3/2025, 4:55PM EDT

> Minor typographical changes for clarity. Rita updated portions for clarity back in March 2025 but did not move document into the approval process.

Last Approved by Roden, Will: Interim Dir Interventional Services on 6/3/2025, 4:55PM EDT

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Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 7/16/2025, 4:17PM EDT

> ePolicy 7/11/25 - Approved; next MEC meeting is in August (Dark Month in July)

Last Approved by Coston, Michael: Director Quality and Public Reporting on 8/28/2025, 12:13PM EDT

> MEC 8/28/25 - Approved

Separator Page

A17b6. Scope of Service- Inpatient Surgical Services - Mountain View-History-Changes

Status **Pending** PolicyStat ID **18304590**

Origination	01/2011
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Last Revised	06/2025
Next Review	3 years after approval
Owner	Paula Crespin: Director Medical/ Surgical/ Oncology Nursing Service
Area	Nursing
Document Types	Scope of Service

Scope of Service: Inpatient Surgical Services – Mountain View

Types and Ages of Patients Served

Inpatient Surgical ~~& Pediatric~~ Services~~,~~ is a 37 bed unit located on 4A~~,~~ and provides care to patients ranging in age from ~~infant~~age 3 years to geriatric. The unit provides services to a wide spectrum of surgical ~~& pediatric~~ patients who meet departmental admission, discharge and transfer criteria.

Assessment Methods

Nursing care is provided by a ~~registered nurse~~Registered Nurse (RN) utilizing the nursing process. ~~Registered nurses~~RNs provide direct supervision to ~~LVNs and clinical support caregivers~~Certified Nursing Assistants (CNA) and Patient Support Assistants (PSA) in the provision of patient care. Reassessment is performed after interventions as part of the evaluation process.

The staff participate in performance improvement processes related to patient care delivery.

Scope and Complexity of Services Offered

The unit provides comprehensive nursing care primarily to surgical ~~& pediatric~~ patients. Medical patients are admitted as overflow. Care is given as directed and prescribed by the physician. All non-nursing orders are communicated to the appropriate ancillary departments via the electronic medical record. Nursing staff communicate specific patient needs and coordinate treatment and plan of care with all ancillary departments. The discharge planning process is initiated on admission, in collaboration with the physician, care coordinators, social workers, patient and family. Multi-~~disciplinary care rounds~~Disciplinary Rounds (MDR) are ~~performed once a week~~held Monday-Friday, at which time the

Scope of Service: Inpatient Surgical Services – Mountain View

plans of care are reviewed and revised. ~~Discharge Rounds are completed daily~~Care Coordinators actively work with ~~the Nursing~~nursing staff ~~and Care Coordinators~~to coordinate discharges.

Appropriateness, Necessity and Timeliness of Services

The Clinical Manager and shift charge nurses assess the appropriateness, necessity and timeliness of service. The appropriateness of services is addressed in hospital and department specific policies and procedures ~~and in the department~~. Admission, discharge and transfer criteria are established in collaboration with the medical staff. Patient progression is evaluated by physicians, nurses, and members of other heath disciplines.

A performance improvement process is in place to identify opportunities for improvement in patient care processes and measure performance for compliance on an on-going basis. ~~The patient's progress~~Patient satisfaction is ~~evaluated by physicians, nurses, members of other health disciplines, and patient and family satisfaction~~measured to ensure care experiences and to identify performance improvement opportunities.

Staffing/Skill Mix ~~IUW~~

Inpatient Surgical Nursing ~~& Pediatric~~ Services has a skill mix of RNs, ~~LVNs~~CNAs, ~~clinical~~and administrative support ~~and administrative support~~ to provide care and service to patients. Staffing is based on budgeted hours of care, patient census ~~and nursing intensity measurements (NIMS)~~, ~~our~~state mandated ratios, and patient ~~classification system~~workload scores. The charge nurse for each shift determines the prospective staffing needs for the oncoming shift, utilizing staffing tools incorporating these factors. The competency of the staff is evaluated through observation of performance and skills competency validation. Staff education and training is provided to assist in achieving performance expectation standards.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the medical staff. The department is designed to meet the level of care needs of the patient.

Performance assessment and improvement processes are evaluated through performance improvement activities in conjunction with the multi-disciplinary health care professionals who provide services to the unit.

Standard of Practice

Inpatient Surgical Nursing ~~& Pediatric~~ Services is governed by State regulations as outlined in Title 22 and Joint Commission on Accreditation of ~~Healthcare Organizations~~Health Care Organization standards~~, and adhere to the recommendations from the American Academy of Pediatrics~~. Additional practices are described in the Patient Care Policies and Procedures, departmental policies and procedures, and Clinical Practice standards.

Scope of Service: Inpatient Surgical Services – Mountain View

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	08/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2025
Department Medical Director or Director for non-clinical Departments	Paula Crespin: Director Medical/Surgical/Oncology Nursing Service	06/2025
	Paula Crespin: Director Medical/Surgical/Oncology Nursing Service	06/2025

History

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Edited by Crespin, Paula: Director Medical/Surgical/Oncology Nursing Service on 6/4/2025, 5:58PM EDT

> Updated workflows.
> Deleted pediatric service references

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Scope of Service: Inpatient Surgical Services – Mountain View

> Age range change to 3 years

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> Updated Doc Type and Area

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> MEC 8/28/25 - Approved

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A17b7. Scope of Service - Imaging Services-History-Changes

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Effective	Upon Approval
Last Revised	04/2025
Next Review	3 years after approval

Owner	Aletha Fulgham: Dir Diagnostic Imaging Svcs
Area	Imaging Services
Document Types	Scope of Service

Scope of Service - Imaging Services

Scope:

The Imaging Department Scope of Service is provided by ECH to ensure that all patients treated will receive high quality care in an expedient and professional manner. Performance standards and quality initiatives are in place to measure outcomes and meet patient and clinician needs. Patient reports and exam records can be accessed upon request and are stored indefinitely as part of the patient's Electronic Health Record (EHR). Images are stored in the hospital's Picture Archiving and Communication System (PACS).

Patient Types

Exams and procedures are performed on inpatients, outpatients and emergency department patients. Patient age groups served are neonatal, pediatric, adolescent, adult and geriatric.

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.

Imaging Services provides support to all departments located within the two El Camino campuses. Imaging studies are performed upon receipt of a written or electronic request from a physician or licensed independent practitioner.

Scope of Service - Imaging Services

Services Offered

Imaging Modalities on the **Mountain View** Campus are:

General Diagnostic Radiography
Magnetic Resonance Imaging (MRI)
Nuclear Medicine
Ultrasound
Mammography
Fluoroscopy
Computerized Tomography (CT)
PET/CT
Vascular Imaging
Interventional Radiology

Imaging Modalities on the **Los Gatos** Campus are:

General Diagnostic Radiography
Magnetic Resonance Imaging (MRI)
Nuclear Medicine
Vascular Imaging
Interventional Radiology
Fluoroscopy
Computerized Tomography (CT)
PET/CT
Ultrasound
Mammography

Nuclear Medicine-Specifics

On-call services are provided on a limited basis on weekends. The following exams are approved for on-call services:

A. **GI Bleed:** Patient must be actively bleeding in order for the study to render diagnostic value.
B. **Lung V/Q Scan**
C. **Gallbladder (HIDA Scan)**

Interventional Radiology

Types and ages of patients served:
Adult inpatients and outpatients. Adolescent patients who are at least 13 years of age AND weigh 80 pounds (36.4 kg) or more.

Staffing Guidelines for Operating Room

Scope of Service - Imaging Services

Coverage

From Monday through Friday, three (3) radiologic technologists are scheduled to provide imaging support in the operating room from 7:00 AM to 4:30 PM at both campuses. From 4:30 PM to 11:30 PM on weekdays, two (2) radiologic technologists are available per campus. On weekends, imaging support is provided by one (1) radiologic technologist per campus.

Surgeries should be scheduled sequentially rather than concurrently to ensure imaging support when there is reduced coverage. This approach minimizes scheduling conflicts and ensures the availability of the radiologic technologist.

If additional radiologic technologist support is required, the Surgery Department should coordinate with the onsite Diagnostic Charge Technologist. If further escalation is needed, the Modality Operations Manager or the Manager on Call will be contacted. Any requests for additional support for the OR should be made as far in advance as possible, allowing time to reach out to staff not currently on shift for assistance if necessary.

Once a case has been coordinated and a radiologic technologist is called to assist, please allow 15–20 minutes for staff to be relieved from other assignments, set up the necessary equipment, and prepare for the procedure.

Appropriateness, Necessity and Timeliness of Services

Imaging Services assesses the appropriateness and necessity of diagnostic and therapeutic procedures by evaluating the patient's clinical history for pertinence to the exam ordered, as well as evaluating the exam history in order to avoid unnecessary duplication of procedures. Prior to interventional or special procedures, the technologist and/or Imaging Services RN will review exam indications as well as any possible contraindications, and bring these concerns to the Radiologist.

The timeliness of radiologic services is addressed in departmental procedures which describe how to contact a radiologist after hours, as well as performance of routine and stat procedures.

STAT exams are to be started within 1 hour of the physician's order, with the exception of Nuclear Medicine studies. Due to the time required to procure the radioisotopes, the time from order to start may be 2 to 3 hours.

Imaging Services follows hospital-wide policies for reporting incidents by utilizing the electronic incident reporting system.

Interpreting Physicians

Diagnostic and therapeutic radiologic services are interpreted by board-certified or board-eligible radiologists. Silicon Valley Diagnostic Imaging (SVDI) is contracted to ensure radiology services are available 24 hours a day. Licensure information of contracted radiologists is maintained in the Medical Staff office. SVDI provides a Radiation Safety Officer to oversee the Radiation Protection Plan and

Scope of Service - Imaging Services

Radiation Safety Committee.

Cardiac CT, NM, PET and MRI studies are interpreted by a group of ECH credentialed cardiologists.

Service Hours: Hours of service are according to the Radiologists' posted schedule, which includes call hours to provide additional consultation or to perform emergency procedures on site. Teleradiology is available after posted hours seven days a week.

Imaging Reports: Reports for all Imaging exams are generally available within 24 hours; exceptions include the unavailability of comparison exams. STAT interpretations are available for all imaging studies; exceptions include when there are multiple stat patients, issues with patient condition, and/or a delay in securing radioisotopes. Referring physicians may denote their preference for obtaining reports, e.g., fax or electronic distribution.

Turnaround Times (TAT)	
Patient Class	End Exam to Results
ED	45 mins
IP STAT	2 hours
IP Routine	6 hours
OP STAT	4 hours
OP Routine (except mammo)	24 hours
PET	72 hours

Mammography Reports:

A. All BIRADS Results
   1. A written lay summary is provided to all patients, and report provided to health care provider within 30 days of examination.
   2. Copy of lay letter to patient included in patient's EHR.

B. "Suspicious" or "Highly suggestive of malignancy"
   1. Communicated to patient within five (5) business days from the interpretation date.
   2. Communicated to health care provider within three (3) business days from the interpretation date.

C. BIRADS 0 "Incomplete" or "Needs additional imaging"
   1. Communicated to patient within five (5) business days from the interpretation date.
   2. Report provided to health care provider within three (3) business days of the interpretation date.

Modality Protocols:

All modality protocols are established based on current standards of practice and other key criteria, which include clinical indication, contrast administration, age, patient size and body habitus. In addition

to these key criteria, CT Protocols include the expected radiation dose range.

Protocols are reviewed by the modality Quality Teams and approved by the Radiologist section chief biennially (every 2 years). Protocols are revised as needed in between the regular review period. Modality protocols are maintained by the department and are accessible by all clinical staff members. Clinical situations often warrant protocol adaptation due to unique patient circumstances or presentation.

Staffing/Skill Mix and Requirements

The Imaging Director has oversight of entire Imaging Service line. The Assistant Director oversees department Operations. The director is further supported by clinical managers. The daily work of each modality is organized by the Charge Technologist in each modality and/or shift.

This department has a Coordinator of Quality and Education that supports the director related to quality, regulatory and compliance activities. The Imaging Services Education Coordinator oversees students from the Foothill College Radiologic Technology Program and assists with onboarding of new staff. Specific sonographers are assigned to work directly with students from the Foothill College Diagnostic Medical Sonography Program.

RNs are assigned from the nursing division to provide nursing care, Monday through Sunday, either scheduled or on call. Off-hour nursing coverage for emergent cases may be provided by direct care nursing staff assigned by the nursing supervisor. Radiology Nurses hold current Advanced Cardiac Life Support (ACLS)certification.

Technologists have graduated from an accredited Radiologic Technology program and are registered by the American Registry of Radiologic Technologists (ARRT) in their respective modalities. All Radiologic Technologists hold current Certified Radiologic Technologist (CRT) licenses as required by the State of California, Title 17. In addition, all technologists who perform fluoroscopy or mobile fluoroscopy hold a current Fluoroscopy permit, and Mammographers hold a current state Mammography certificate. Ultrasound procedures are performed or supervised by Sonographers who are registered by the American Registry of Diagnostic Medical Sonographers (ARDMS). Nuclear Medicine procedures are performed by Nuclear Medicine Technologists who hold a current Certified Nuclear Medicine (CNMT) certificate as required by the State of California, Title 17. Scope of Practice or Practice Standards for technologists are established by the professional societies that represent them.

Other clinical and support staff providing services to patients in this area may include, but are not limited to:

Consulting Services, Interventional Radiologists: Routine and emergent interventional procedures are performed by contracted physicians at both campuses.

Consulting Services, Medical Physicists: Imaging Services maintains a contract for consultation on an "as needed" basis and for routine quarterly surveys in Nuclear Medicine, as well as annual surveys for all other equipment, as required. Medical physics assessment requests, such as fetal dose calculation or personnel badge review, may be requested. The Imaging Department retains survey records and annual physics surveys, which are available for review. Physicists supervise equipment monitoring activities, review the findings, and make recommendations regarding radiation exposure factors, ACR quality

Scope of Service - Imaging Services

guidelines, and quality analysis.

Radiation Safety Officer (RSO) AND Radiation Safety Committee:

SVDI provides a Radiation Safety Officer (RSO) for hospital-wide needs. The RSO oversees the Radiation Protection Plan and the Radiation Safety Committee. The Radiation Safety Committee has a multidisciplinary membership that meets quarterly to review any radiation safety concerns.

Clinical Engineering (Imaging Services Equipment):

The Clinical Engineering Department works closely with vendors to provide all equipment preventive maintenance based on the manufacturer's recommendations. These records are retained for review.

Standards of Practice

Radiation and radioactive materials are governed by California Department of Public Health, Radiologic Health Branch, state regulations Titles 17 and 22, and the Nuclear Regulatory Commission. The Department follows guidelines set forth by these agencies as well as the American College of Radiology (ACR), and standards established by the Joint Commission..

Security Considerations

Imaging Services follows all hospital security policies and procedures to ensure compliance with hospital security mandates. Radiology applications and PACS user access is available to Imaging Services staff, Radiologists contracted with El Camino Hospital, students, and other El Camino Hospital staff as deemed appropriate by Imaging Services leadership.

Hours of Operation

Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On–Call Services
Diagnostic Imaging	24/7	**Mountain View Campus** M - F: 7am - 7pm Sat: 8a - 4p **Los Gatos Campus** M - F: 7am - 7pm	None	OR Cases or Influx of Patients
Computed Tomography	24/7	**Mountain View Campus** M - F: 7am to 10pm Sat: 8:30am -	None	N/A

Scope of Service - Imaging Services

Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On–Call Services
		4:30pm		
		Los Gatos Campus M - F: 7:30am - 10:30pm Sat: 8:30am - 12pm		
Ultrasound	24/7	**Mountain View Campus** M – F: 8am - 4:30pm	**Mountain View Campus** None	Stat US in order of priority: 1. Suspected Ruptured AAA, aortic aneurysm 2. Scrotal US: torsion, pain 3. Pelvic US: ectopic, ruptured ectopic, torsion, bleeding in pregnancy
		Los Gatos Campus M - F: 8am - 10pm *excludes holidays	**Los Gatos Campus** Sa/Su: 7am - 12am	
Magnetic Resonance Imaging	24/7	**Mountain View Campus** M - F: 8am - 7:30pm S: 8am - 4:30pm	**Mountain View Campus** None	*MV & LG ED physicians triage and prioritize requests. Stat MRI in order of priority:* 1. *R/O cord compression* 2. *Stroke/Bleed* 3. *Compression fracture spine* 4. *Appendicitis in pregnant patients* 5. *Others as they come on first come first serve*
		Los Gatos Campus M - F: 7am - 10:30pm	**Los Gatos Campus** Sa/Su: 10a - 6p	
Mammography	N/A	**Mountain View Campus** M - F: 7:30am - 4:30pm	N/A	*N/A*
		Los Gatos Campus Select Fridays: 8am - 3pm		

Scope of Service - Imaging Services

Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On–Call Services
Nuclear Medicine	M - F: 7am - 3:30pm	**Mountain View Campus** M - F: 8am - 3:30pm **Mountain View Campus** Th - F: 7am - 3:30pm PET F only: 7am - 3:30pm	Sa/Su: 7a - 7p	*GI Bleed* *Lung V/Q Scan* *Gallbladder (HIDA Scan)*
Interventional Radiology (MV)	M - F 7:30am-5:30pm Off-Hours: Cath Lab and/or OR	M - F 7:30am-5:30pm Off-Hours: Cath Lab and/or OR	Holidays and Weekends (Varies) 8:00am-6:30pm	*Stat Interventional Exams*
Interventional Radiology (LG)	M - F 7:30am - 5:30pm Off-hours: OR	M - F 7:30am - 5:30pm Off-hours: OR	S/S: 7am - 7pm Off-hours: OR	*Stat Interventional Exams*
Radiologist	Review the current Radiologist's schedule for hours and call. https://app.qgenda.com/landingpage/svdi			*Stat Fluoroscopy cases after hours*

REFERENCES

- American College of Radiology – Radiation Safety
- The American Registry of Radiologic Technologists (ARRT)
- California Department of Public Health- Radiologic Health Branch
- Title 17, the California Code of Regulations, Title 10, Code of Federal Regulations, Part 20
- California Code of Regulations: Title 22, Division 5, Chapter 1, Article 6, section 70537

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

Scope of Service - Imaging Services

Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	08/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2025
Department Medical Director or Director for non-clinical Departments	Aletha Fulgham: Dir Diagnostic Imaging Svcs	04/2025
	Aletha Fulgham: Dir Diagnostic Imaging Svcs	04/2025

History

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> Added pediatric definition.

Last Approved by Fulgham, Aletha: Dir Diagnostic Imaging Svcs on 4/30/2025, 3:08PM EDT

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Comment by Santos, Patrick: Policy and Procedure Coordinator on 5/15/2025, 12:03PM EDT

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

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 7/16/2025, 4:18PM EDT

> ePolicy 7/11/25 - Approved; next MEC meeting is in August (Dark Month in July)

Last Approved by Coston, Michael: Director Quality and Public Reporting on 8/28/2025, 12:14PM EDT

> MEC 8/28/25 - Approved

Separator Page

A17b8. Multidisciplinary Drug Diversion Surveillance-History-Changes

Status **Pending** PolicyStat ID **18497960**

Origination	11/2020
Last Approved	N/A
Effective	Upon Approval
Last Revised	08/2025
Next Review	3 years after approval
Owner	Jen Huang: Senior Director Pharmacy
Area	Pharmacy
Document Types	Policy

Multidisciplinary Drug Diversion Surveillance

COVERAGE:

All El Camino Health Staff, Anesthesiologists and Patient Care Providers.

PURPOSE:

To have a Multidisciplinary Team (MDT) for Medication Diversion Prevention that is charged with developing a coordinated and systematic approach to prevent, detect and report medication diversion. MDT must meet periodically, at a minimum, 4 times a year.

A comprehensive drug diversion prevention and detection program includes core administrative elements (e.g. legal and regulatory requirements, organizational oversight and accountability), system-level controls (human resource management, automation and technology, monitoring and surveillance, and investigation and reporting), and provider level controls (e.g. chain of custody; storage and security; internal pharmacy controls; prescribing and administration; returns, waste, and disposal).

- To ensure patient safety related to Controlled Substances (CS) administration with appropriate dosing regimen and assessments.
- To provide a consistent process for surveillance of early detection of drug diversion, medication control irregularities and effective actions taken.
- To ~~describes~~describe measures to ensure safe controlled substance management for all processes related from procurement to wastage.
- To monitor controlled substances by utilizing technology tools such as Diversion Detection software.
- To train employees ~~on~~in their roles in CS management and diversion prevention.

Multidisciplinary Drug Diversion Surveillance

- To comply with federal and state -controlled substance laws and ~~regulation~~regulations. The MDT Committee has the responsibilities and oversight on CS management at El Camino Health.

Establishing a sustainable drug diversion prevention program requires engaged leadership oversight that promotes a culture of organizational awareness, implements and evaluates the effectiveness of systems and processes, and works toward continuous improvement. With this approach, we will improve patient and provider safety and benefit the community we serve.

~~DEFINITIONS:~~

- ~~MDT: Multidisciplinary Team~~
- ~~CS: Controlled Substances per FDA Scheduled medication~~
- ~~ADCs: Automated Dispensing Cabinets~~
- ~~EHR: Electronic Health Record~~
- ~~Drug Diversion: the transfer of a prescription drug from a lawful to an unlawful channel of distribution or use.~~
- ~~Chain-of-custody: Chain-of-custody procedures and documentation are utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations.~~
- ~~HIPAA: Health Insurance Portability & Accountability Act~~

REFERENCES:

- ~~Condition of Participation: (State Operations Manual Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals)~~
- ~~§482.13 (c)(2) – The patient has the right to receive care in a safe seting– Hospital must protect vulnerable patients and identify and evaluate problems and patterns of incidents.~~
- ~~§482.25(a)(3) – Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.~~
- ~~DEA: https://www.deadiversion.usdoj.gov/crim_admin_actions/~~
- ~~Use of Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis) PolicyStat ID: 7660821 Revised 5/2020~~
- ~~Pyxis Anesthesia System PolicyStat ID: 7624626 Revised 5/2020~~
- ~~Reporting by Pharmacy Personnel of Theft of Controlled Substances or Impairment PolicyStat ID: 7380242~~
- ~~https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=1301.76~~
- ~~https://www.deadiversion.usdoj.gov/fed_regs/rules/2005/fr0812.htm~~
- Title 42 § CFR 482.13 Conditions of participation: Patient Rights
- Title 42 § 482.25 Condition of participation: Pharmaceutical services.
- PolicyStat - Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis)
- PolicyStat - Pyxis Anesthesia System

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- eCFR :: 21 CFR 1301.76 -- Other security controls for practitioners. accessed 8/8/2025

PROCEDURE:

System specific and appropriate actions required to effective management of ALL stages of medication use process to prevent drug diversion prevention.

A. MDT must meet periodically, at a minimum, 4 times a year.

B. The following individuals are required MDT members: Administration, Physician (anesthesiologists), Nursing Leadership, Pharmacy, Risk Management and Compliance/Legal.

C. The following individuals are Ad Hoc members: HR & Employee Health, Diversion Specialist, Environmental Care and Security,

D. MDT meeting minutes clearly capture discussion about events, actions to be taken, and follow-up of prior month's unresolved issues. MDT meeting minutes, including ad hoc meetings, are documented on most up-to-date MDT Meeting Minutes Template and capture all required audits/reviews.

E. Proactive Diversion Reporting and Reviews utilizing Diversion Detection Software are conducted pursuant to the Medication
Diversion Prevention MDT.

1. Drug surveillance software will compare activities with prescribed doses, MAR documentation and Automated Dispensing Cabinets wastage.
2. Managers will attempt to reconcile open alerts within 3 days of the initial event. Findings will be documented within the event contained in the surveillance software.
3. Pharmacy will review documented responses and close alerts that are reconciled for appropriateness.
4. For discrepancies that could not be reconciled, these cases will be brought to the Committee for discussion/follow -up.

F. All suspected, active, and confirmed diversions ~~are reported~~must notify immediately to the Pharmacist in Charge and/or members of MDT, who will determine the next course of actions.

G. Surveillance of Controlled Substance Procurement: The receiving process includes a reconciliation of controlled substances received against the invoice of purchase and subsequently load to the Narc Vault. Note and document any shortage, breakage, or discrepancy on the invoice / Controlled Substance received.

1. Maintaining the purchasing summary available from drug suppliers, or a written history of all controlled substance purchases made by the facility for the month, sorted by date

H. Surveillance of Controlled Substances Storage:

1. Controlled substances and PCA keys in patient care areas, pharmacy and/or designated storage areas are maintained in Automated Dispensing Cabinets (ADCs), or mobile storage ~~device~~devices (clear box secured on IV pole for IVPBs containing Controlled Substances).
2. Controlled substances administered via Patient-Controlled Analgesia (PCA) pumps

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and epidural pumps are administered in locked systems.

3. During delivery of Controlled Substances to the units, the cart is lockable, and the technicians attend to the cart.

I. Surveillance of Controlled Substances Dispensing:

1. Override Monitoring: Controlled substances removed utilizing the override functionality are reviewed and reconciled to ensure the existence of a valid corresponding order. (also refer to Policy: PolicyStat ID: ~~7660841~~14410726: Use of Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis)
2. Chain of Custody: Chain-of-custody is utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations of Controlled Substances Administration.
3. Anesthesia Audit: Assess medication dispensed, medication documented, dose documented, amount wasted, witness signature, Chain of Custody (if appropriate), appropriate variance reporting and follow up if necessary.

J. Surveillance of Controlled Substance Administration Time:

1. Timely Administration of CS: Ensure the time retrieval from ADC to the administration to the patients meet the policy requirement (within 30 minutes for stat medication and within 60 minutes for routine medication).
2. Monitoring Patients' Response: Ensure medication administered in compliance with pain scale prescribed.
   Conduct pain assessments per pain assessment policy.
3. Pain score assessments and ~~documentations~~documentation to be recorded timely and accurately in iCare.

K. Surveillance of Controlled Substances Wastage, Returns and Disposal.

1. Non-retrievable Waste Container ~~in~~is compliant with TJC Standards and DEA non-retrievable requirement. Pro-actively swap out as needed or no longer than every 90 days by the vendor per agreement regardless of fill levels.
2. Expired controlled substances removed from the inventory are placed in a designated expired controlled substances drawer/bin in a locked area separate from non-controlled medications until the time of removal.
3. At Pharmacy, expired controlled substances are reconciled by the person holding a DEA Power of Attorney (POA) with the DEA-222 form provided by the reverse distributor.

L. IRIS (Individual Risk Identifier Score) Monitoring and Surveillance for High Ranked Users Flagged by Software

1. IRIS report is conducted monthly ~~at~~during the 1st week of the month to review statistical deviations from the previous month.
2. Pharmacy will initiate investigation for all users flagged as red (IRIS score >=4.6)
3. Nursing/anesthesia directors/managers will respond to investigations initiated by the pharmacy~~.~~, as requested through the Diversion Software program (with analytics

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and ~~documentations~~documentation of all activities of the investigation).

a. For the IRIS investigation checklist and training for nurses or steps to take during their review of high ranked IRIS users to look at the different analytics that made that user high that month.

b. ~~Pharmacist~~Pharmacists can provide an objective consistent process to investigate based on all the different analytics.

c. Require Nurse Managers to have conversations with ~~employee~~employees, even if no diversion is suspected, to coach to practice and to document date and time of conversation can be noted in the investigation portfolio under "Nurse Manager reviewed all pertinent reports~~'~~.

4. If diversion is not suspected, rationale will be documented and investigation closed.
5. If diversion is suspected, the Committee will be notified and activated. Individuals who repeatedly appear as outliers should be reviewed by the multidisciplinary drug diversion prevention committee and a recommended process (e.g., drug test) from the committee for escalation of identified high risk individuals.

M. Patient's Own Medication: Patient-owned controlled substances must have a documented chain of custody from the
time of receipt to the time of return. Logging the patient~~'~~s ~~-~~controlled substances consists of counting and verifying the
controlled substances by two licensed workforce members count and verification of the medications.

N. Surveillance of Controlled Substances Inventory Count: The compliance rates will be reported to the monthly MDT meetings.

1. Weekly nursing inventory is completed by the unit's Nurse Manager/Supervisor or designee. Inventory is completed for all accessed controlled substances. If the unit is closed, notify pharmacy to deactivate access and notify pharmacy for opening. Without deactivation, weekly inventory count is still required on units that are temporarily closed.
2. Monthly CS Inventory Count: CII Safe/ Pharmacy Vault Monthly Inventory, including keys, conducted with two authorized
witness: signature and date of inventory is documented.
3. 90-day CII inventory count conducted per Board of Pharmacy.

O. Investigation and Reporting

1. A drug diversion investigation may be conducted in the following instances~~;~~:
a. Discovered or suspected diversion based on IRIS reports
b. A significant loss of drug
c. Continued unresolved discrepancies
d. Users identified/observed as having erratic or strange behavior
2. Information Collection, Gathering and sharing: Pharmacy will initiate investigations. Documentation of investigations will be conducted through Software for Controlled Substances Investigation Portfolio. If diversion is suspected, the Human Resources department will be notified and ~~the~~ represented by the Director of Pharmacy, the

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Inpatient Pharmacy Supervisor, Nursing Administration, Anesthesia, Human Resources, and Employee Health. This team will provide consultation for suspected diversion incidents

3. Reporting at the conclusion of investigations
    a. Health care workers suspected of being impaired will be removed from delivering patient care as to prevent further access to drugs and ensure safe care of patients.
    b. Report of significant loss:
    When a significant loss occurs, the Pharmacist in Charge will complete a DEA-106 report there by notifying the DEA as well as the State Board of Pharmacy.
    c. Report of Theft: Theft will be reported to the DEA regardless of a significant ~~losses~~loss or not. Based on the regulations, all ~~theft~~thefts regardless of volume should be reported to DEA.
    d. Diversion incidences will also be ~~report~~reported to local law enforcement and appropriate State Boards

P. Culture, Education, Competency and Experiences
    1. Pre-employment background checks for those with controlled substances access in their job descriptions.
    2. The organization~~''~~s culture must support empowerment of staff to stop, question and act. Health care workers must be expected and empowered to speak up when something seems abnormal or unsafe.
        a. Observation: recognizing clear signals such as abnormal behaviors, altered physical appearance, and poor job performance, are vital to detecting diversion and often the only way to identify an impaired colleague.

Q. Resources of hardware deterrent for drug diversion prevention and surveillance
    1. Current hardware deterrent:
        a. Secured waste containers, badges system for medication room entry for retrievable entry history, IV-to Pole secured CS IV bags/admixtures and secured CS transportation carts are utilized for CS security.
        b. Community ~~drug~~drugs take back to limit unnecessary access in community, a secured medication take back kiosk is located at El Camino Health Outpatient Pharmacy for secure disposal of CS for the customers.
    2. Next phase in the planning stage: camera video surveillance as deterrent and also to support investigation:
        a. Ensure all stationary ADCs have cameras installed at the appropriate angle to visualize actions being taken at the station, the scope captures return bin activities.
        This does not include ADCs placed in patient care areas (Surgical, ER Trauma, patient rooms…) in compliance with ~~HIPAA~~HIPA, Health Insurance

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Portability & Accountability Act. Within the pharmacy department, ensure all areas of packaging, storage, waste and areas where medications are placed to be checked, or pending delivery are under adequate camera surveillance.

b. Ensure camera video recorded 24 hours per day and retention is ~~recording 24 hours per day and retention is~~ set to 90 days

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

RoadmapSummary.pdf

SoftwareOnePageInstruction.pdf

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	08/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2025
P&T	Mojgan Nodoushani: Senior Manager-Clinical Pharmacy	07/2025
	Jen Huang: Senior Director Pharmacy	07/2025

History

Sent for re-approval by Huang, Jen: Senior Director Pharmacy on 7/8/2025, 2:03PM EDT

> No changes, approved by Drug Diversion Prevention and Surveillance Committee in May 2025, start approval process

Multidisciplinary Drug Diversion Surveillance

Last Approved by Huang, Jen: Senior Director Pharmacy on 7/8/2025, 2:03PM EDT

Last Approved by Nodoushani, Mojgan: Senior Manager-Clinical Pharmacy on 7/31/2025, 6:22PM EDT

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Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 8/15/2025, 3:31PM EDT

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> Confirmed changes w/ doc owner; pulled draft changes to pending.

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> Minor update to purpose.

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> Uploaded Jen's word revision to pending (excluding Reference section - I already updated this).

Last Approved by Coston, Michael: Director Quality and Public Reporting on 8/28/2025, 12:14PM EDT

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Separator Page

A17b9. FY2025 Infection Control Plan-History

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Owner	Catherine Nalesnik: Director Infection Prevention
Area	Infection Prevention
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COVERAGE:

All El Camino Hospital staff

PURPOSE:

The El Camino Hospital Infection Prevention & Control Program's primary function is to prevent transmission of infectious agents among patients, staff and visitors. It is the goal of the Infection Prevention and Control Department:

- To reduce infection risk by implementing strategic policies and procedures for surveillance and control of healthcare-associated infection and other contagious infection
- To monitor and identify drug-resistant pathogens and emerging pathogens.
- To provide education to staff upon hire and as needed in developing practices which reflect current infection control guidelines and standards of care.
- To conduct an annual evaluation of the Infection Control Risk Assessment for acquiring and transmitting infections within the hospital environment and set goals to reduce infections.

STATEMENT:

The El Camino Hospital Infection Control and Prevention Plan include policies and procedures that are created on evidence based guidelines or expert consensus. At least annually, and whenever risks significantly change, an evaluation of the effectiveness of the infection prevention and control plan will be completed. Assessment of the prevention strategies will be based on their effectiveness at preventing and controlling infection. The Infection Prevention Nurses report all communicable diseases to the

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Public Health Departments to help prevent spread of certain infections within the public at large.

The Infection Prevention and Control Plan evaluate the risk of communicable disease transmission based on the following:

- El Camino Hospital Mountain View and Los Gatos: location and services provided
- Santa Clara County geographic location and demographics
- Mountain View and Los Gatos demographics
- Santa Clara County Community health status assessment
- Tuberculosis (TB) Risk Assessment: California and Community profiles
- Seasonal Influenza Activity
- Threats facing Santa Clara County
- National trends and novel infections and International outbreaks
- COVID-19 Pandemic
- California Department of Public Health Alerts

El Camino Hospitals: Mountain View and Los Gatos

Geographic location, patient volume and services provided:

- Hospital geographic location – 2 hospital campuses in a large urban areas
- MV beds: 274 General Acute Care
- LG beds: 143 General Acute Care
- Patient volume: greater than 18,000 discharges per year
- Enterprise admissions: FY 24: 31182 (FY23 31, 084)
- Enterprise Patient Days: (FY24: 104, 704 (FY 23 105,388)
- Patient population served: multicultural
- Hospital clinical focus – emergency services, maternal child services, cancer services, Adult & neonatal critical care services, diagnostic services, medical/surgical services, cardiac services, cyber knife & radiosurgery center, acute rehab center, behavioral health services and out-patient services

Mountain View Demographics:

https://www.census.gov/quickfacts/fact/table/mountainviewcitycalifornia,santaclaracountycalifornia/

The resident population of Mountain View is approximately 80,447. More than half the population is between 18 and 65. The largest racial/ethnic groups are White alone (46.1%) followed by Asian alone (33.2%) and Hispanic (18.3%)

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Los Gatos Demographics:

https://www.homefacts.com/demographics/California/Santa-Clara-County/Los-Gatos.html

The resident population of Los Gatos is approximately 29,816. The median age resident is 46 years young. The largest racial/ethnic groups are White (78.9%) followed by Asian (14.1%) and Hispanic (6.4%)

Santa Clara Geographic Location and Demographics:

https://www.census.gov/quickfacts/fact/table/santaclaracountycalifornia/PST045216

With 1.9 million residents, Santa Clara County is the sixth most populated of California's 58 counties and the most populous in the Bay Area. More than one-third (37%) of county residents are foreign-born. The largest percentage of foreign-born residents were born in Mexico (21%), followed by Vietnam (15%), India (13%), the Philippines (9%), and China (8%), excluding Hong Kong and Taiwan. Santa Clara County encompasses 1,312 square miles and runs the entire length of the Valley from north to south, ringed by the rolling hills of the Diablo Range on the east, and the Santa Cruz Mountains on the west. Nearly 92% of the population lives in suburban areas The local industry of the County of Santa Clara is dominated by the technology sector. The County has three main interstate highways; 280, 680, and 880, one U.S. Route (101), and the following CA State Routes; 9, 17, 82, 85, 87, 130, and 237. Airports include: Norman Y. Mineta International Airport, Moffett Federal Airfield, and three County airports: Reid Hillview, Palo Alto, and South County.

TB Risk Assessment: *(based on CY 2024)*

California Overview: California Department of Public Health

https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-TB-Snapshot-2024.pdf

- California reported 2,100 new TB cases in 2024 compared to 2,110 cases in 2023.
- California's annual TB incidence was 5.4 cases per 100,000 persons, which is nearly double the national incidence rate of 2.9.
- More than 2 million Californians (6% of the population) have Latent TB Infection (LTBI) which can progress to active TB without diagnosis and treatment.
- The vast majority of TB cases (83%) were attributable to progression of LTBI to active TB. An estimated 8% of cases were in persons who arrived in California with active TB disease, and another 9% results from recent transmission.
- The TB rate among people born outside the U.S. (16.1 per 100,000) was 13 times higher than the rate among U.S.-born persons (1.2 per 100,000).

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COMMUNITY TB PROFILE 2024

www.SCCPHD.ORG

- Santa Clara County (SCC) has the third highest number of cases among all jurisdictions in California, after Imperial and San Francisco counties.
- SCC had 140 cases of tuberculosis (TB) disease in 2024, which decreased compared with 2023 (168 TB cases).
- This represents a case rate of 7.5 per 100,000 residents

El Camino TB Profile CY 2024 : Medium Risk Facility

- 19 total cases: 12 In-patients and 7 Out-patients which increased from 15 cases in 2023.
- Designated as a “Medium Risk Facility” for TB based on the community rate of infection.
- El Camino Hospital and their Infectious Disease Specialists are considered the 2nd largest provider of TB care in Santa Clara County next to the SCC TB Clinic.

Seasonal Influenza Activity

Infection Prevention and Control: Seasonal Influenza Procedure

The Infection Prevention Department has a Seasonal Influenza Plan procedure in place to protect all staff, patients and visitors from potential exposure to seasonal influenza virus and to prevent an outbreak of health-care-associate influenza.

Annual Seasonal Influenza Plan Procedure (located in Policies and Procedures)

Threats facing Santa Clara County:

- **COVID-19:** While COVID-19 data is no longer being as closely tracked, and the SCC PHD has paused their weekly updates due to limited data, COVID-19 cases continue to occur in our County with several surges throughout the year. The risk of severe outcomes has improved, either because of improved population immunity (from vaccination and/or prior infection), or attenuation of newer viral strains. Current CDC data March 2025 indicates the rate of hospitalization from COVID is only 2 per 100,000 population and the percent of all deaths in the U.S. from COVID is 0.8%. Among 130,263 Department of Veteran Affairs patients with COVID-19 between September 2023 and October 2024, the risk of hospitalization and death with newer strains was substantially lower than historical figures (2.0% vs 0.03%, respectively). Nonetheless, the COVID-19 epidemic continues to impact the hospital, with a peak of 42 COVID-related hospitalizations at ECH in May 2024. Newer variants continue to circulate, including derivatives of the Omicron virus, which are two-times more transmissible than earlier strains. Waste water continues to be monitored for respiratory viruses on a weekly basis, and current levels remain low, relative to May - June 2024 and Dec - Jan 2025.
- **Major Earthquake**
  The Operational Area is in the vicinity of several known active and potentially active earthquake faults including the San Andreas, Hayward, and Calaveras faults.

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- **Wild land Urban/Interface Fire**
  The months of August, September and October have the greatest potential for wild land fires as vegetation dries out, humidity levels fall, and off shore winds blow.
- **Hazardous Material Incident**
  There are four major highways in the county that carry large quantities of hazardous materials: U.S. 101, I-880, and I-680, and I-280. Truck, rail, and pipeline transfer facilities are concentrated in this region, and are involved in considerable handling of hazardous materials.
- **Flood**
  There are approximately 700 miles of creeks and rivers in the County, all of which are susceptible to flooding. An Emergency Action Plan exists for the Anderson Dam and a general Dam Plan exists which includes other dams within Santa Clara County. These plans are maintained by the Santa Clara Valley Water District.
- **Landslide**
  For Santa Clara, the hillside areas in the Los Gatos areas have the greatest potential for economic loss due to landslides. The winters of 1982, 1983, 1986, and 1996/1997 provided a reminder of the degree of hazard from landslides in Santa Clara County

PROCEDURE:

A. **Goals**

1. Maintain Enterprise hospital acquired Central Line Associated Bloodstream Infections (CLABSI) at or below National Healthcare Safety Network (NHSN) Standardized Infection Ratio (SIR) SIR < 0.50.
2. Maintain Enterprise hospital acquired Catheter Associated Urinary Tract Infection (CAUTI) at or below NHSN SIR ≤ 0.75.
3. Maintain Enterprise hospital acquired Clostridium difficile (C.diff) infections at or below NHSN SIR ≤ 0.70
4. Maintain hospital acquired Pacemaker Surgical Site Infections (SSI) at or below NHSN SIR <1.00
5. Maintain hospital acquired Total Knee SSI at or below NHSN SIR <1.00.
6. Maintain hospital acquired Total Hip SSI at or below NHSN SIR <1.00.
7. Maintain hospital acquired Laminectomy SSI at or below NHSN SIR <1.00.
8. Maintain hospital acquired Spinal fusion /Re-fusion SSI at or below NHSN SIR < 1.00.
9. Maintain Enterprise hospital acquired Methicillin Resistant Staphylococcus aureus (MRSA) infection rate to ≤ 0.90 /10,000 patient days.
10. Maintain Enterprise MRSA screening compliance rate to 92% or more.
11. Maintain Enterprise hospital onset Multi- Drug Resistant Organisms (MDRO) infection rate to ≤ 0.50 / 10,000 patient days.
12. Maintain hand hygiene compliance at ≥ 85%.
13. Maintain reporting compliance with regulatory and accrediting agencies
14. Maintain compliance with Infection Control Risk Assessment (ICRA) for all new

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construction projects

15. Maintain compliance with Seasonal Influenza Procedure

B. **Objectives**

1. Perform daily targeted surveillance for the following:
    a. Surgical Site Infections
    b. CAUTI: Catheter Associated Urinary Tract Infections -hospital-wide
    c. CLABSI: Central LIne Associate Blood Stream Infections - hospital-wide
    d. Hospital-acquired *Clostridium difficile (C.diff)* infections
    e. Hospital-acquired Methicillin resistant Staph aureus (MRSA)
    f. Hospital-acquired Multi-Drug Resistant Organisms (MDRO)
    g. MRSA Nares screening compliance per CDPH regulatory guidelines
2. Perform daily active disease surveillance for the following:
    a. Daily surveillance of the following: MRSA, C.difficile, Multi-Drug Resistant Organisms (MDRO)
    b. Tuberculosis and other communicable diseases
    c. Daily COVID-19 surveillance and reporting: internal monitoring for cluster cases in Clinical Units and for patients admitted with COVID-19, to include Skilled Nursing Facilities (SNF) with COVID-19 outbreaks.
    d. Carbapenem-resistant Enterobacteriaceae (CRE) surveillance and Candida auris surveillance: for 1) patients hospitalized outside the U.S. within 12 months or 2)patients admitted to any Long Term Acute Care (LTACH) and Ventilator Skilled Nursing Facility vSNF 3)Patients with vent or trach 4)SNF identified as high risk for CRE/ Candida auris
    e. CRE surveillance: for Skilled Nursing Facilities (SNFs) with increased risk of CRE in their patient population
    f. Perform specialized response to exposure and outbreaks including COVID-19 contact exposure tracing
    g. Perform review and tracking for mold-related organisms in construction areas
3. Report mandated conditions to the following accrediting agencies:
    a. Report all required data monthly to Center for Disease Control (CDC) NHSN data base
    b. Report mandated disease conditions, non-Covid-19 (86 possible) to SCC PHD
    c. Report all suspected or active Tuberculosis cases to the Santa Clara County TB Control
    d. Report unusual infectious disease occurrences to CDPH and CDC

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4. Educate staff on hand hygiene standards and measure compliance outcomes
    a. Upon hire, educate all staff on how to correctly perform hand hygiene (HH)
    b. During isolation rounding by IP staff, observe compliance with hand hygiene and provide immediate feedback to staff with non-compliance.
    c. Track monthly HH compliance with the HAI committee and strategize on performance improvement activities.
    d. Review monthly hand hygiene compliance data from the clinical nursing units dashboard.
5. Perform Infection Control Risk Assessments (ICRA) for all hospital construction activities
    a. Conduct a risk assessment for all new construction projects and sign permit
    b. Perform daily rounding on all construction sites for compliance to ICRA permit standards
    c. Conduct ICRA permit for construction projects for unexpected water intrusion and mold issues
6. Attend the following hospital committee meetings to represent IC
    a. HAI (Hospital Acquired Infection) Committee
    b. Critical Care Committee
    c. Antimicrobial Stewardship
    d. Emergency Management
    e. Patient Care Value Analysis
    f. Clinical Microbiology Lab, Pharmacy and Infection Prevention (MIPP)
    g. Central Safety
    h. E-policy
    i. Safety Event Classification Team (SEC)
    j. Patient Employee and Safety Committee
    k. Hospital Surge Planning
    l. Non-Ventilator Hospital Acquired Pneumonia (nvHAP)
    m. Enhanced Recovery after Surgery (ERAS)
7. Provide Infection Prevention and Control Education to the following:
    a. General Hospital Orientation
    b. Physician Orientation
    c. Ancillary Staff and any hospital department in-service as requested
    d. Environmental Services Department (EVS) yearly update
    e. Health Stream: annual Infection Prevention and Control Standards

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8. Initiate the Seasonal Influenza Procedure in August (prior to flu season)
    a. Meet with required departments to verify readiness for flu season
    b. Track daily numbers of influenza hospital admissions and deaths
    c. Monitor trends of influenza on the local, state and national level
    d. Institute visitor restrictions if widespread flu is present in the community
9. Perform Monthly Infection Control/ Quality tracers
    a. Attend monthly safety rounds at Mountain View and Los Gatos
    b. Educate staff on areas on infection control non-compliance
    c. Report outcomes to the Infection Control Committee Meeting

C. **Infection Prevention and Control Committee (ICC)**

1. The responsibility for monitoring the Infection Prevention and Control Program is invested in the Infection Control Committee (ICC). The Infection Control (IC) Medical Director has the authority to institute any appropriate control measures or studies when a situation is reasonably felt to be a danger to any patient, Healthcare Worker (HCW) or visitor, or in the event of an infection control crisis situation (The committee functions as the central decision and policymaking body for infection control). The Infection Control Committee shall meet not less than quarterly.
2. The ICC shall be a multi-disciplinary committee consisting of representatives from at least the Clinical Laboratory, Quality Department administration, Sterile Processing Department, Perioperative services, Nutrition Services, Environmental Services, Employee Wellness, Pharmacy and Health and the Infection Prevention Nurses. The Chairman is the Infection Control Medical Director, a physician with knowledge of and special interest in infectious disease. Representatives from key hospital departments shall be available on a consultative basis when necessary..
3. The Infection Prevention and Control Department in collaboration with the ICC shall develop a system for reporting, identifying and analyzing the incidence and cause of all hospital onset infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.
4. The Infection Prevention and Control Department in collaboration with the ICC shall develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating isolation precautions and cleaning and disinfection techniques. Such techniques shall be defined in written policies and procedures.
5. The Infection Prevention and Control Department shall develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.
6. The committee minutes shall be reviewed by the Medical Executive Committee.

D. **Scope of Services**

1. The infection control program is divided into functional groups of routine activities

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that address the integrated facets of surveillance and prevention of infections, monitoring and evaluation, epidemiological investigation, risk reduction, consultation and education.

2. Hospital Onset Infection Surveillance and Prevention
    a. For the purpose of surveillance, hospital onset infections shall be clinically active infections occurring in hospitalized patients in whom the infection was not present or incubating at the time of admission.
    b. Infections with endogenous organisms of the patient and those organisms transmitted either by healthcare workers or indirectly by a contaminated environment shall be included.
    c. Strict criteria shall be used for assessment in regard to targeted hospital onset infections. Not all hospital onset infections in the hospital shall be counted and presented for statistical analysis. The type of data collection to be used and analyzed shall be determined by the Infection Control Committee (ICC) based upon the annual Risk Assessment.
    d. The criteria written by the Center for Disease Control and Prevention (CDC) shall be used when calculating infection rates for statistical analysis.

E. **General Surveillance Activities**

1. Active infection surveillance within the hospital shall be an ongoing observation of the occurrence and distribution of disease or disease potential and of the conditions that increase or decrease the risk of disease transmission.
    a. The surveillance of patients, staff and environment shall ensure appropriate patient placement, initiation of appropriate isolation or special precautions, identification of patient care problems associated with hospital infection control, prevention of targeted hospital onset infections in high risk, high volume procedures, facilitation of data collection for selected quality indicators and the collection of required information for reporting to the Public Health Department.
    b. Daily laboratory reports, utilization review reports and verbal communications with staff shall be reviewed routinely by the Infection Prevention Nurses. Surveillance shall be a blend of routine physical presence in all areas of the facility and the use of clinical and laboratory computer information systems.

F. **Data Collection Methods**

1. All identified cases related to targeted infections and communicable diseases will be maintained in a database. Specific methods used by infection control to obtain surveillance data include daily lab reports, patient census reports, daily serological reports, patient charts, referred cases from case managers and verbal communication with staff and physicians.
2. Surveillance shall be a blend of routine physical presence in all area of the facility and use of clinical and laboratory computer information systems.

G. **Investigation of Disease Clusters (Outbreak Control)**

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1. The Infection Control Infection Control Medical Director in coordination with the Director of Infection Control shall have ultimate authority and responsibility for investigating epidemic/outbreak situations and implementing appropriate interventions in order to prevent and to control further disease and to identify factors that contributed to the outbreak. (See Infection Control Procedure Outbreak Investigation).

H. **Reporting to Outside Agencies**

1. Specified communicable diseases (in accordance with Title 17, California Code of Regulation) identified at El Camino Hospital shall be reported to the Santa Clara Department of Public Health (SCDPH) in the required timelines to prevent the spread of certain communicable diseases to the public at large. (See Infection Control Procedure on Communicable Disease Reporting).
2. El Camino Hospital shall provide follow-up management for pre-hospital caregivers who may have been exposed to a communicable disease during the performance of their duties and reporting of these exposures to the proper authorities. (See Infection Control Procedure Pre-hospital Communicable Disease Exposure).
3. El Camino Hospital shall report the mandated requirements to the National Healthcare Safety Network (NHSN) as required by CDPH and CMS.

I. **Education**

1. Orientation for all hospital employees shall include general information on potential infection risks, transmission routes, and infection prevention measures, proper hand hygiene, isolation precautions, and environmental cleaning and disinfection.
2. Annual review of infection control standards for hand hygiene, isolation guidelines and HAI prevention shall be done through a computer-based learning system (Health Stream) and tracked by the Education Department.
3. Department specific education shall be done as deemed necessary by the Infection Control Medical Director and/or the Infection Prevention Nurses, working in conjunction with department managers.
4. Quarterly In-service presentations are provided to the Infection Control Resource Groups (ICRG). The ICRG is comprised of staff members from all nursing departments and ancillary departments (Lab, RT, etc.).
5. Infection control isolation “Quick Reference Guide” (hard copy) is readily available in every department and clinical units of the hospital. This document summarizes the isolation guidelines for all infectious conditions and communicable diseases.

J. **Liaison**

1. Provide ongoing expert advice and consultation as appropriate to other departments including but not limited to Microbiology Laboratory, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
2. Coordinate Infection Control activities with other departments or units including but not limited to Dialysis Services, Patient Care Services, Microbiology Laboratory, Pathology, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.

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3. Function as a liaison to the Santa Clara Public Health Department and other agencies.
4. Function as a liaison to Infection Control Programs at other hospitals and long-term care facilities.

K. **Policy Formation**

1. Policies and procedures shall be reviewed on a regular basis with changes made as new guidelines and information become available.
2. Infection control departmental policies are found on the toolbox.

L. **Quality Improvement**

1. Provide ongoing evaluation and assessment of the goals and accomplishments of the Infection Control Program to ensure that it meets the needs of the hospital, employees, physicians, patient population, and visitors.
2. Evaluation of the Infection Control Plan shall be done at least annually or when a change in the scope of the Infection Control Program or in the Infection Control risk analysis occurs. Assessment of Infection Control strategies shall also be evaluated for their effectiveness at preventing infections.

M. **Environmental Conditions**

1. To ensure a safe environment during times of construction and or remodeling, protective measures shall be approved by the Infection Control Staff and implemented before the project commences. All construction projects will have an Infection Control Risk Assessment (ICRA) performed by the Infection Control staff prior to start of construction.
2. Sterile Processing Department (SPD): Cleaning, disinfection, high-level disinfection and sterilization standards will be maintained by the SP department. Manager of SP will present a quarterly report to the ICC.
3. Endoscopes, bronchoscopes, probes & TEE scopes: Instrument cleaning, disinfection and high level disinfection (HLD) shall be monitored by the SP and endoscopy departments. A quarterly Quality Report will be presented to the Infection Control and Committee meeting.
4. Dialysis water testing: Water used to prepare dialysis fluid shall be tested according to current AAMI standards and monitored monthly by the dialysis manager. A quarterly Quality Report will be presented to the Infection Control and Committee meeting.

N. **Reporting Mechanisms**

1. A report regarding all infection control activities shall be made each quarter to the Infection Control Committee. The report shall include appropriate results related to routine surveillance, sentinel organisms, emerging pathogens, public health issues, employee health issues, special studies, reports for endoscopy, lab, dialysis, construction, tracers and water quality. Copies of the committee meeting minutes shall be forwarded to the Medical Executive Committee. C. diff, CAUTIs, CLABSIs and MRSA Hospital Onset cases will be reported to the departmental manager on a

FY2025 Infection Control Plan

monthly basis. Hand hygiene compliance will be reported to the departmental managers monthly.

REFERENCES:

- Buetti, Niccolo et al. Strategies to prevent central line-associated bloodstream infections in acute-care hospitals: 2022 Update Infect Control Hosp Epidemiol. 2022 May; 43(5): 553–569.
- Klompas, Michael et al. Strategies to prevent ventilator-associated pneumonia, ventilator-associated events, and nonventilator hospital-acquired pneumonia in acute care hospitals: 2022 update. Infection Control & Hospital Epidemiology (2022), 1–27
- Patel, Payal et al. Strategies to prevent catheter-associated urinary tract infections in acute-care hospitals: 2022 Update. Infection Control & Hospital Epidemiology Volume 44 , Issue 8 , August 2023 , pp. 1209 - 123
- Seidelman, Jessica et al. Surgical Site Infection Prevention. *JAMA.* 2023;329(3):244-252
- Lev, Vered et al. Health care associated Clostridioides difficile infection: Learning the perspectives of health care workers to build successful strategies.American Journal of Infection Control. Volume 52, Issue 3,P284-292, March 2024
- Infection Control Risk Assessment - Please see Attachment

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

FY2025 Infection Control Risk Assessment.pdf

FY24 Evaluation of the IP Plan. Annual Report.pdf

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	08/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2025

FY2025 Infection Control Plan

Medicine Department Executive Committee	Patrick Santos: Policy and Procedure Coordinator	06/2025
Medicine Department Executive Committee	Catherine Nalesnik: Director Infection Prevention	05/2025
Infection Prevention Committee	Delfina Madrid: Quality Data Analyst	05/2025
	Catherine Nalesnik: Director Infection Prevention	05/2025

History

Draft saved by Nalesnik, Catherine: Director Infection Prevention on 3/17/2025, 6:48PM EDT

Draft saved by Madrid, Delfina: Quality Data Analyst on 3/24/2025, 4:58PM EDT

Draft saved by Nalesnik, Catherine: Director Infection Prevention on 4/29/2025, 3:32PM EDT

Edited by Santos, Patrick: Policy and Procedure Coordinator on 5/2/2025, 11:27AM EDT

> Submitting for review

Last Approved by Nalesnik, Catherine: Director Infection Prevention on 5/2/2025, 12:54PM EDT

Last Approved by Madrid, Delfina: Quality Data Analyst on 5/2/2025, 12:57PM EDT

> ICC approved 5.2.25

Last Approved by Nalesnik, Catherine: Director Infection Prevention on 5/2/2025, 3:16PM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 6/19/2025, 4:18PM EDT

> Med Dept Exec 6/19/25 - Approved

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 7/16/2025, 4:19PM EDT

> ePolicy 7/11/25 - Approved; next MEC meeting is in August (Dark Month in July)

Last Approved by Coston, Michael: Director Quality and Public Reporting on 8/28/2025, 12:16PM EDT

> MEC 8/28/25 - Approved

Separator Page

A17b10. Auxiliary Scope of Service-History

Status **Pending** PolicyStat ID **17337988**

Origination	02/2018
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2021
Next Review	3 years after approval
Owner	Ryan Lockwood: Vice President Patient Experience
Area	Patient Experience
Document Types	Scope of Service

Auxiliary Scope of Service

Types and Ages of Patients Served

The Auxiliary serves all age groups within the El Camino Hospital community, which consists of inpatients, outpatients, families, visitors, hospital employees, medical staff, and other volunteers.

Scope and Complexity of Service

We are a volunteer organization with a variety of services, whose mission it is to render volunteer service to El Camino Hospital, its patients, and the community; to grant scholarships in the health professions; and to provide financial support for approved projects.

Patient contact is included in the following services:

- Chairman of the Day
- Endoscopy
- Emergency Department
- Escort
- Hooks and Needs
- Information Desk
- Inpatient Rehab (LG)
- Java Junction
- Health Library
- Maternity

Auxiliary Scope of Service

- Med/Surg/Ortho Unit(LG)
- PACU (LG)
- Pinkies
- Rehabilitation Care Center (LG)
- Roadrunners
- Shuttle
- Surgery Center (LG)
- Telecare Service
- Patient Care Liaison
- Getting to Know You Program

Staffing

The Auxiliary is staffed by a Board of Directors, consisting of a President, an Executive Vice President/ President Elect, a Vice President of Senior Membership (MV), a Vice President of Junior Membership (MV & LG), a Director of Services (MV & LG), a Secretary, a Treasurer, an Associate Treasurer, a Parliamentarian, past Presidents ad hoc and a paid full-time Coordinator of Services.The administrative office is additionally staffed by six (6) volunteers.

Level of Service Provided

The determined level of service provided is determined by the service description for the patient contact area.

Standard of Practice

The Auxiliary adheres to state and federal guidelines provided in Title 22, the Joint Commission on Accreditation of Healthcare Organization, and the California Association of Hospitals and Healthcare Services.

El Camino Hospital Auxiliary Guidelines cover hospital and Auxiliary operational and safety protocols and are used as mandatory orientation for all volunteers.

Hospital volunteers additionally adhere to HR Policy on Hospital Volunteers and all applicable HR policies.

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Approval Signatures

Step Description	Approver	Date

Auxiliary Scope of Service

Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	08/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2025
Department Medical Director or Director for non-clinical Departments	Ryan Lockwood: Vice President Patient Experience	06/2025
	Ryan Lockwood: Vice President Patient Experience	06/2025

History

Comment by Cunningham, Christine: Chief Experience and Performance Improvement Offic on 1/6/2025, 1:02PM EST

> I did not know that this was over due - please send to me and I will update - thanks

Comment by Cunningham, Christine: Chief Experience and Performance Improvement Offic on 1/7/2025, 11:37AM EST

> approved

Sent for re-approval by Cunningham, Christine: Chief Experience and Performance Improvement Offic on 1/7/2025, 11:38AM EST

Comment by Cunningham, Christine: Chief Experience and Performance Improvement Offic on 3/31/2025, 4:16PM EDT

> APPROVED IN JANUARY 2025

Responsibilities transferred to new account by Santos, Patrick: Policy and Procedure Coordinator on 6/11/2025, 6:03PM EDT

> The previous owner's account (*Christine Cunningham: Chief Experience and Performance Improvement Offic*) was deactivated, so all of their responsibilities were transferred to *Ryan Lockwood: Vice President Patient Experience*.

Last Approved by Lockwood, Ryan: Vice President Patient Experience on 6/23/2025, 11:33PM EDT

Auxiliary Scope of Service

> Approved.

Last Approved by Lockwood, Ryan: Vice President Patient Experience on 6/23/2025, 11:34PM EDT

> Approved.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 7/16/2025, 4:22PM EDT

> ePolicy 7/11/25 - Approved; next MEC meeting is in August (Dark Month in July)

Last Approved by Coston, Michael: Director Quality and Public Reporting on 8/28/2025, 12:18PM EDT

> MEC 8/28/25 - Approved

Separator Page

A17b11. Interpreting Services-History

Status **Pending** PolicyStat ID **18501574**

Origination	12/1993
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2025
Next Review	1 year after approval

Owner	Ryan Lockwood: Vice President Patient Experience
Area	Patient Experience
Document Types	Policy

Interpreting Services

COVERAGE:

All El Camino Hospital Staff and Medical Staff

PURPOSE:

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

POLICY STATEMENT:

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

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

REFERENCES:

- California Health and Safety Code § 1259 (2025)

Interpreting Services

- The Joint Commission. (2025). Rights and responsibilities of the individual (RI.01.01.03). In Comprehensive Accreditation Manual for Hospitals. The Joint Commission.

PROCEDURE:

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

B. The need for an interpreter is assessed at the time of admission and throughout the patient's stay. This is documented in the electronic health record (EHR) under either the Communication or Cares/Safety tab under Interpreting Services. See Appendix for screenshot of sample documentation. Any patient who requires or requests interpreting services will be informed of the availability of the interpreter service.

C. Primary consideration will be given to the individual's preferred communication method or interpreter.

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

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

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

F. Hearing Impaired Patients:

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

G. Vision Impaired Patients:

   1. Audio and braille options available upon request for conditions of admission and required registration forms. Braille forms are available in select Registration / Patient Access areas. The Audio file deployed to Patient Access areas located in the shared drive.

Interpreting Services

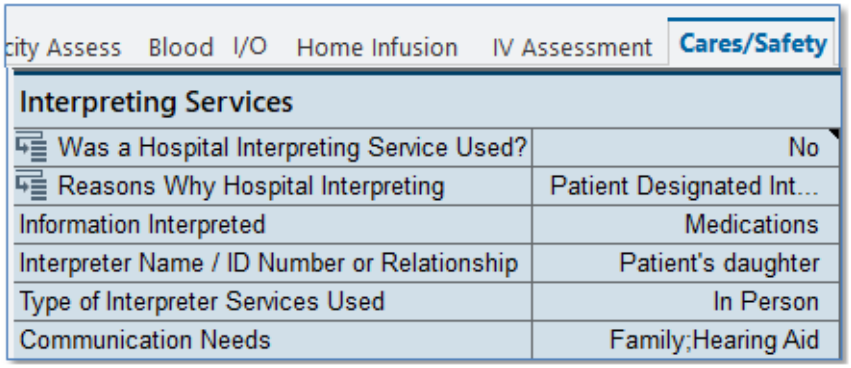
2. Patient can elect authorized representative for signature consent.

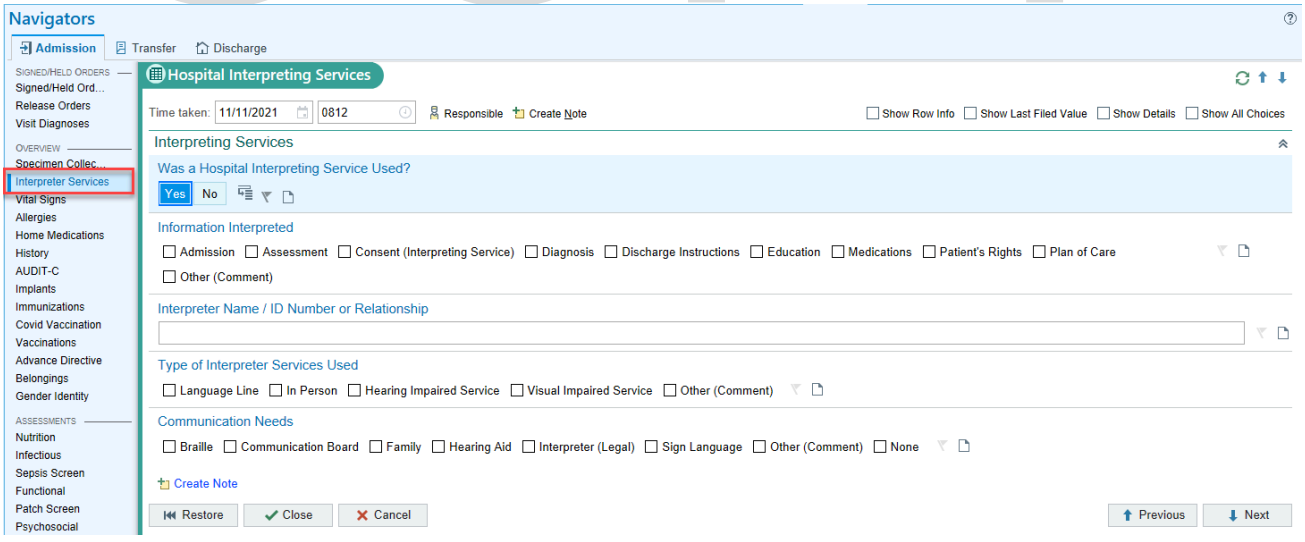
H. Documentation and Refusal of Interpreter:

1. The need for an interpreter is assessed at the time of admission and throughout the patient's stay. All use of interpreters shall be documented in the patient's EHR as outlined.
2. Patients may refuse to use the hospital interpreter services and request that an adult family member be used. Minor children are never allowed to be used as an interpreter regardless of patient preference. Staff must document in the EHR flow-sheet under either Communication or Cares/Safety tab under Interpreting Services, and patient refused and requested an adult family member.

APPENDIX

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





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Interpreting Services

Attachments

- Communication Board.pdf
- English_icon images.pdf
- iPad Voyce Instructions - One pager for devices.pdf
- Language Access Poster
- LanguageLine InSight Video Interpreting - iPad
- Pain Assessment Card.pdf
- Telephone Audio Interpretation Instructions
- TTY Phone_Ultratec Superprint 4425.pdf

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	08/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2025
	Ryan Lockwood: Vice President Patient Experience	07/2025

History

Sent for re-approval by Lockwood, Ryan: Vice President Patient Experience on 7/8/2025, 5:25PM EDT

Last Approved by Lockwood, Ryan: Vice President Patient Experience on 7/8/2025, 5:25PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 7/16/2025, 4:36PM EDT

> Updated Reference section w/ correct format; including years.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 7/16/2025, 4:38PM EDT

> ePolicy 7/11/25 - Approved; next MEC meeting is in August (Dark Month in July)

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Interpreting Services

> MEC 8/28/25 - Approved