El Camino Health

AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, March 18, 2026 – 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: 958 5653 1134 # 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.

TIME ESTIMATES: Except where noted as TIME CERTAIN, listed times are estimates only and are subject to change at any time, including while the meeting is in progress. The Board reserves the right to use more or less time on any item, to change the order of items and/or to continue items to another meeting. Particular items may be heard before or after the time estimated on the agenda. This may occur in order to best manage the time at a meeting.

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**	Jack Po, Vice Chair	Information	**5:30 pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Jack Po, Vice Chair	Information	**5:30 pm**
3.	**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 one (1) to three (3) minutes each depending on number of speakers.* 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.*	Jack Po, Vice Chair	Information	**5:30 pm**
4.	**RECESS TO CLOSED SESSION**	Jack Po, Vice Chair	**Motion Required**	**5:30**
5.	**STRATEGIC PARTNERSHIP PROPOSAL** *Health & Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Dan Woods, CEO	Discussion	**5:30 – 5:40**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
6.	**ECH STRATEGY** - Regional Strategy - Los Gatos Redevelopment Timeline – Informational/No Change - Preliminary Milestones and Targets FY27 - Brand Strategy *Health & Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Dan Woods, CEO AJ Reall, VP, Strategy Mark Klein, CCMO	Discussion	**5:40 – 6:55**
7.	**CAPITAL REQUEST: PROPERTY ACQUISITION: APN# 205-23-017** *Gov't Code Section 54956.8 - for a report and discussion involving negotiations prior to purchase, sale, exchange, or lease of real property.*	AJ Reall, VP of Strategy Ken King, CASO	Discussion	**6:55 – 7:05**
8.	**APPROVE CREDENTIALING AND PRIVILEGING REPORT** *Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters.*	Mark Adams, MD, CMO	**Motion Required**	**7:05 – 7:10**
9.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS** - Minutes of the Closed Session of the ECHB Meeting (02/11/26) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Jack Po, Vice Chair	**Motion Required**	**7:10 – 7:15**
10.	**EXECUTIVE SESSION** *Gov't Code Section 54957 Report regarding personnel performance – Chief Executive Officer*	Jack Po, Vice Chair	Discussion	**7:15 – 7:25**
11.	**RECONVENE TO OPEN SESSION**	Jack Po, Vice Chair	**Motion Required**	**7:25**
12.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Gabe Fernandez, Governance Services Coordinator	Information	**7:25 – 7:26**
13.	**APPROVAL OF CAPITAL REQUEST: PROPERTY ACQUISITION: APN# 205-23-017**	Jack Po, Vice Chair	**Motion Required**	**7:26 – 7:27**
14.	**DISCUSSION ON WHETHER THE BOARD SHOULD AUTHORIZE THE CURRENT BOARD CHAIR, IF WILLING, TO RUN FOR ELECTION FOR A THIRD TERM** -Possible approval of Resolution 2026-02	Lanhee Chen, Governance Committee Chair	**Possible Motion**	**7:27 – 7:40**
15.	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (02/11/26) b. Approve Q2 Financials as Reviewed and Discussed at the February 11 ECHB Meeting	Jack Po, Vice Chair	**Motion Required**	**7:40 – 7:45**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	c. Approve Governance Committee Charter as Reviewed and Recommended by the Governance Committee d. Approve Nominees for Governance Committee as Reviewed and Recommended by the Governance Committee i. Scott Barclay ii. Azar Khansari iii. Doug Scrivner e. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended by the Medical Executive Committee – February 2026 f. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended by the Medical Executive Committee – March 2026 g. Receive Period 7 Financials h. Receive FY26 ECHB Pacing Plan			
16.	**CEO REPORT**	Dan Woods, CEO	Information	**7:45 – 7:55**
17.	**BOARD ANNOUNCEMENTS**	Jack Po, Vice Chair	Information	**7:55 – 8:00**
18.	**ADJOURNMENT** **POLICIES APPENDIX – February** **POLICIES APPENDIX - March**	Jack Po, Vice Chair	**Motion Required**	**8:00**

NEXT MEETINGS: April 18, 2026 (Board Retreat); May 13, 2026; June 17, 2026

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
MEETING MEMO

To: El Camino Hospital Board of Directors
From: Andreu Reall, VP of Strategy
Ken King, CAO
Date: March 18, 2026
Subject: Property Purchase APN # 205-23-017 For Action

Recommendation:

The Finance Committee recommends approval by the Board of Directors, the purchase of a property located at 595 Lawrence Expressway in Sunnyvale at a cost not to exceed $20.1 million.

Summary: .

1. Situation: We have the opportunity to purchase a general office building in Sunnyvale that will extend the services of our medical network to a prominent location in the northeast portion of the city.

2. Authority: By policy, property acquisitions exceeding $5 million require the Finance Committee to recommend approval by the Board of Directors.

3. Background: Consistent with the growth objectives of the organization this property was identified as a key location for ECHMN services.

4. Assessment: The property consists of a two-story building that is approximately 33,500 square feet on a 2.1 Acre Site. The building is currently used as a school and will need to be completely renovated to serve the needs of ECHMN. The location is at the corner of Lawrence Expressway and E. Duane Ave., which is just south of Hwy. 101. The purchase price for the building is $19.3 million plus brokers' fees and closing costs. The cost per square foot is $576, which is less than the cost of similar size buildings in Sunnyvale.

5. Outcomes: We anticipate closing escrow in mid-April and begin programming and designing the needed tenant improvements soon thereafter.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
MEETING MEMO

To: ECH Board of Directors
From: Lanhee Chen, Governance Committee Chair
Theresa Fuentes, Chief Legal Officer
Date: March 18, 2026
Subject: Discussion on Whether the Board Should Authorize the Current Board Chair, if willing, to Run for Election for a Third Term

Purpose: The Governance Committee recommends the Board consider whether it should authorize the sitting Board Chair to run for election to a third term pursuant to Article 8.3 of the Hospital Bylaws. If approved by the Board, this would allow the current Board Chair to be eligible to serve a third term in FY27-29 and run for election alongside other interested candidates.

Possible Motion: To approve resolution determining that (a) extending the current sitting Board Chair's term for one additional two-year term is in the best interests of the Corporation based on the Board's good-faith business judgment and (b) if willing, the current sitting Board Chair is authorized to run for election to serve an extended term in FY27-29 alongside other interested candidates.

Background:

Bylaws Provision – Chair Term Extension

At the November 2025 ECHB meeting, the Board approved a revision to the Hospital Bylaws (which was subsequently approved by the District Board) adding the ability for the Board, by resolution adopted by majority vote, to extend the Chairperson's term for one additional two-year term if the Board determines, in its good-faith business judgment, that doing so is in the best interests of the Corporation.

Under Article 8.3 of the Bylaws:

> Article 8.3: Term of Corporation's Officers: Each officer shall hold office for a two (2) year term or until a successor is elected and qualified, subject to any employment agreement; provided that a Director may not serve more than two (2) consecutive full or partial terms as Chairperson. In the event the Chairperson fills an unexpired term of a vacant Chairperson, the officer's partial term shall count toward the officer's term limit. Notwithstanding the above, the Board of Directors may, by resolution adopted by majority vote, extend the term of the Chairperson for one additional two-year term if the Board, in its good-faith business judgment, determines it to be in the best interests of the Corporation.

As such, if a sitting Chair is nominated or expresses interest in serving a third term, the Board should determine whether, based on the criteria specified in the Bylaws (i.e., in its good-faith business judgment), the board determines the extension for a third term to be in the best interests of the corporation. The sitting Chair is recused from the discussion and voting on authorization to serve a third term but can facilitate and vote in the election.

At their meeting on March 3, 2026, the Governance Committee discussed and approved a recommendation to the Board to consider whether the Board should authorize the sitting Chair to run for a third term based on the Bylaws requirements.

Discussion on Board Chair Eligibility for Third Term
March 18, 2026

Outcomes:

If the Board determines it is in the best interest of the Corporation to authorize the current Board Chair to serve a third two-year term, then if willing, he will be included as a candidate in the board chair election process at the May board meeting. If the Board does not so determine, then the current board chair will not be permitted to participate in this year's election for Board Chair.

Additional Information:

The Hospital Board Officers Nomination and Selection Procedures are attached for reference. Note that in the last election process in May 2024, there was a simplified process implemented for officer elections. The Board may choose to follow the same simplified process for the FY26 election cycle.

- The names of directors who have stated their interest to the CEO by May 1, and the position in which they are interested, are identified on the meeting agenda.
- Each candidate will provide a brief verbal statement (10 minutes) regarding their interest, and their priorities and goals if elected to the position.
- The Board will ask any questions of the candidates.
- If there is only one candidate for a position, the board shall consider a motion to elect that candidate.
- If there is more than one candidate for a position, the balloting process will be as stated in Section 7 of the attached Nomination and Selection Procedures dated 5/11/22.

List of Attachments:

1. Hospital Board Officers Nomination and Selection Procedures (5/11/22).

El Camino Health

HOSPITAL BOARD OFFICERS
NOMINATION AND SELECTION PROCEDURES

Approved 05/2022

Any current Director of the El Camino Hospital Board is eligible to serve as a Hospital Board Officer. The new Hospital Board Officer terms begin the 1st day of July. El Camino Hospital Board Officer elections shall be held in June annually (if needed). Following the election, it shall be the role of the Board Chair-Elect to work with the Hospital CEO in May and June to develop a slate of Board Advisory Committee Chairs and members for the following fiscal year and to present the slate to the Board for approval in June.

Hospital Board Chair:

1. Interested Directors will declare their interest to the CEO or designee by no later than the 1st day of April. If requested by the CEO, interested Directors will prepare a one-page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the attached Hospital Board Chair competencies, no later than the 15th day of April.

2. Position Statements will be distributed to Board members along with other routine Hospital Board materials one week in advance of the June meeting.

3. Position Statements will be made available to the public and posted on the El Camino Hospital web-site when the Hospital Board materials are issued to the Board.

4. Standard questions for Hospital Board Chair:

    a. What do you see as the ECH strategic priorities over the coming two years?
    b. Name three defining roles of an effective Board Chair.
    c. How would you judge the success of your leadership and the Board at the end of your term?

5. At the June meeting, interested Directors will present the information below, in public session, in the sequence outlined. Approximately 25 minutes will be allocated to each interested Director: five (5) minutes for the Position Statement, ten (10) minutes for responses to standard questions, and (10) ten minutes to respond to general questions from the board and public:

    a. Each interested Director will read his or her Position Statement
    b. Each interested Director will provide responses to the standard questions. (Directors will present one question at a time in random order.)
    c. The Public will be invited to ask interested Directors any questions related to the candidate's interest in the position, and relevant experience as it relates to the Hospital Board Chair competencies
    d. The Board will be invited to ask interested Directors any additional questions related to an interested Director's candidacy.

6. Upon review and discussion of the candidates, the Board will vote in public session. The current Chair will facilitate the discussion and voting process.

7. The Hospital Board Chair will be elected by the Board in accordance with the following procedure at a meeting where a quorum is present.

    a. Preliminary Balloting

        i. Each Board member shall vote for a candidate via electronic submission or paper ballot simultaneously to a neutral party who will announce the vote cast by each Director.
        ii. In the event a majority is not achieved, the vote will be announced for each candidate and the candidate receiving the lowest number of votes will be dropped from the next ballot.
        iii. This procedure will continue until one candidate receives a majority of the votes cast.
        iv. In the event a tie vote occurs (e.g., 3-3 or 4-2-2), interested Directors may be asked additional questions by Hospital Board members and the balloting procedure will continue until a majority is achieved by one candidate.

    b. Selection of a Board Chair

        i. Following the preliminary balloting, the Board shall consider a motion to elect the candidate who has received the majority of the votes in his/her favor.
        ii. If a motion pursuant to Section 7(b)(i) is not adopted by a majority of the Board members present at the meeting when a quorum is present, the Board shall continue to consider motions until a Board Chair is elected.

Hospital Vice-Chair:

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

4. The Vice Chair is the presumptive Chair at the end of the current Chair's term.

Hospital Secretary/Treasurer:

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair and the Hospital Vice-Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
RESOLUTION 2026-02
APPROVING BOARD CHAIR ELIGIBILITY FOR THIRD TERM
March 18, 2026

At a meeting duly called on March 18, 2026, the Board of Directors (the "Board") of El Camino Hospital, a California nonprofit public benefit corporation ("ECH"), does hereby authorize, consent to, and adopt the following resolution:

WHEREAS, Article 8.3 of the El Camino Hospital Bylaws provides that the Chairperson of the Board may not serve more than two consecutive full or partial terms as Chairperson, except that the Board may, by resolution adopted by majority vote, extend the term of the Chairperson for one additional two-year term if the Board determines, in its good-faith business judgment, that doing so is in the best interests of the Corporation; and

WHEREAS, the Governance Committee reviewed the applicable Bylaws provision and, at its meeting on March 3, 2026, recommended that the Board consider whether it should authorize the sitting Board Chair to run for election to a third term pursuant to Article 8.3 of the Bylaws; and

WHEREAS, the Board has discussed the matter and considered whether authorization of the sitting Board Chair for one additional two-year term would be in the best interests of the Corporation; and

NOW THEREFORE, BE IT RESOLVED, that the Board hereby determines, in its good-faith business judgment and pursuant to Article 8.3 of the Bylaws, that extending the term of the sitting Chairperson for one additional two-year term, if the Chair is willing to run for election, is in the best interests of the Corporation; and

FURTHER RESOLVED, that the sitting Board Chair, if willing, is authorized to be considered as a candidate in the Board Chair election process for the FY27–FY29 term, alongside any other interested candidates, in accordance with the Board's officer nomination and election procedures.

DULY PASSED AND ADOPTED at a regular meeting held on March 18, 2026, by the following votes:

AYES:

NOES:

ABSENT:

RECUSED:

ABSTAIN:

_____
John Zoglin, Secretary
El Camino Hospital Board of Directors

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, February 11, 2026

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

Board Members Present
Bob Rebitzer, Chair
Jack Po, Vice-Chair
John Zoglin, Secretary/Treasurer
Lanhee Chen *(left at 7:02 p.m.)*
Wayne Doiguchi
Julia E. Miller
Carol A. Somersille, MD
George O. Ting, MD
Don Watters

Board Members Absent
Peter Fung, MD, MBA

Staff Present
Dan Woods, CEO
Omar Chughtai, CGO**
Theresa Fuentes, CLO
Raju Iyer, CFO
Mark Klein, CCMO
Tracey Lewis Taylor, COO
Shreyas Mallur, MD, CQO
Alan Muster, MD, President, ECHMN
Chery Reinking, CNO
Peter Goll, CAO, ECHMN
Andreu Reall, VP, Strategy

** *via teleconference*

Staff Present (cont.)
Tracy Fowler, Director, Governance Services
Gabe Fernandez, Governance Services Coordinator
Brian Richards, Audio Visual Services Program Manager

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 5:31 p.m. Roll call was taken and a quorum was present. Directors Fung and Po were absent at roll call. Director Po joined at 5:32 p.m.	***The meeting was called to order at 5:31 p.m.***
2. 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.	
3. 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.	
4. RECEIVE VERBAL MEDICAL STAFF REPORT	Dr. Xanthopoulos presented the Medical Staff Report. Dr. Gholami was unable to attend and sent his apologies. Dr. Xanthopoulos shared enthusiasm regarding ongoing growth opportunities across the medical staff and emphasized continued collaboration to support recruitment, retention, and infrastructure needs. Director Ting inquired about the status of physician recruiting and whether any concerns were emerging. Dr. Xanthopoulos indicated that efforts remain positive and thanked the Board for its continued support and engagement.	
5. QUALITY FOCUSED REVIEW - FY2026 Q2 STEEEP Update - Deep Dive Topic: Clinical Excellence	Dr. Mallur presented the FY2026 Q2 STEEEP Dashboard update and led a Quality Deep Dive on Clinical Excellence as a Strategic Asset. Chair Rebitzer noted that while several metrics remain below target, overall performance is trending in a positive direction, supported by strengthened leadership and focused improvement efforts. Dr. Mallur highlighted improvements in imaging turnaround times following the transition to a new radiology group, crediting coordinated implementation efforts across clinical	

	and operational teams. Dr. Somersille commended nursing leadership and frontline staff for strong performance in managing readmissions and patient education, noting the team's growing reputation for excellence beyond the organization. Dr. Mallur also reviewed progress related to social drivers of health screening and homeless discharge planning compliance, with the Board acknowledging continued focus on equity and regulatory expectations. During the Clinical Excellence deep dive, Dr. Mallur outlined how sustained investment in quality reduces preventable harm, mitigates financial risk under value-based reimbursement models, and strengthens long-term organizational resilience. Examples included reductions in hospital-acquired infections, improved value-based purchasing performance, participation in the Quality Incentive Pool program, and long-term savings generated through the Patient Blood Management Program. Director Miller encouraged broader community outreach and marketing related to initiatives such as blood drives to increase participation beyond employees.	
6. FY2025 Q2 FINANCIALS – QUARTERLY UPDATE	Chair Rebitzer congratulated Mr. Iyer on his first Board presentation and invited him to frame the discussion. Mr. Iyer reviewed favorable operating EBIDA performance driven by revenue growth and sustained labor efficiency, noting that outpatient activity continued to offset softness in inpatient volumes. Director Miller asked about a reference in the materials indicating Finance Committee approval rather than Board approval; Mr. Iyer clarified that this was a typographical error. Chair Rebitzer inquired about payer mix trends and whether shifts toward an aging population were reflected in the financial results. Mr. Iyer noted a gradual increase in Medicare volumes and discussed related strategic implications. Director Chen requested additional clarification regarding pharmaceutical cost impacts. Mr. Iyer explained that utilization shifts, contracting improvements, and cost controls had resulted in more favorable performance than originally budgeted. Director Miller raised questions regarding an ongoing underpayment issue and utilization management processes. Management clarified that the issue relates to underpayment rather than non-payment and noted that further discussion would occur in closed session.	***Action:*** *Staff to include Quarterly Financials on the March consent calendar for formal approval.*
7. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 6:16 p.m. **Movant**: Watters **Second**: Miller **Ayes**: Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Fung	***Recessed to closed session at 6:16 p.m.***

	Recused: None	
8. AGENDA ITEM 13: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:28 p.m., and Agenda Items 8 - 11 were addressed in the closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report and Closed Session Minutes.	
9. AGENDA ITEM 14: CONSENT CALENDAR ITEMS	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Director Miller asked for item (b) Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee to be removed. **Motion:** To approve the consent calendar items A and C. **Movant**: Miller **Second**: Po **Ayes**: Doiguchi, Miller, Po, Rebitzer, Ting, Watters, Zoglin **Nays**: None **Abstentions**: Somersille **Absent**: Chen, Fung **Recused**: None Director Somersille noted her abstention due to her absence from the December 10, 2025 meeting. Director Miller stated that she believed the full policies should be included within the Board packet rather than provided separately in Boardvantage. Management clarified that the current format reflects a process previously implemented to provide policy summaries within the packet, with full policies accessible in Boardvantage for review. After brief discussion, the Board agreed to defer Item (b) to the March meeting to allow the full policies to be attached to the Board packet.	***Consent calendar approved.*** *- Open Session Minutes of the November 12, 2025 Hospital Board meeting* *- FY26 ECHB Pacing Plan* ***Action**:* *Staff to bring policies back to March meeting for board approval with the full policies in the packet.*
10. AGENDA ITEM 15: CEO REPORT	Mr. Woods presented the CEO Report and highlighted recent organizational accomplishments and recognition. Mr. Woods recognized the nursing team's achievement of a fifth Magnet designation and noted the continued strength of the nursing organization. He also acknowledged Ms. Reinking's recent recognition by Becker's as a "CNO to Know," and highlighted the positive impact of her leadership and culture throughout the nursing division. Mr. Woods further acknowledged the ongoing contributions of the Hospital Auxiliary and their significant support of the organization through volunteerism and fundraising efforts.	
11. AGENDA ITEM 16: ANNOUNCEMENTS	Director Miller commented positively on the Service Awards event and expressed appreciation for the organization's volunteers. Director Miller also asked for an update regarding the installation of the donor recognition tiles at the Women's Hospital. Management noted that a follow-up update would	***Action:*** *Management to provide update on donor tiles for Women's*

	be provided.	*Hospital.*
12. AGENDA ITEM 23: ADJOURNMENT	**Motion:** To adjourn at 7:36 p.m. **Movant**: Miller **Second**: Po **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Meeting adjourned at 7:36 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: Tracy Fowler, Director, Governance Services
Reviewed by Legal: Theresa Fuentes, CLO; John Zoglin, Board Secretary/Treasurer

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Raju Iyer, CFO
Date: March 18, 2026
Subject: Financials: FY2026 – Period 6 (December 2025) & YTD FY2026 (as of 12/31/2025)

Purpose: To request approval of the FY2026 Period 6 (December 2025) and Year-to-Date FY2026 financials.

Summary: The Period 6 financial results and Year-to-Date FY2026 financial performance were presented to the Board at the February 11, 2026 meeting, where the materials were reviewed and discussed. Due to a procedural oversight, the financials were not listed as a motion-required item on the agenda at that meeting. The materials are therefore included on the March consent calendar to allow the Board to formally approve the Period 6 and Year-to-Date FY2026 financial results.

Recommendation: Management recommends the Hospital Board approve the Period 6 and YTD FY2026 financials.

List of Attachments:

1. Memo: Period 6 & YTD FY2026 financials
2. Presentation: Period 6 & YTD FY2026 financials

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Raju Iyer, CFO
Date: February 11, 2026
Subject: Financials: FY2026 – Period 6 (December 2025) & YTD FY2026 (as of 12/31/2025)

Purpose:

To provide the Board with an overview of financial results for Period 6 and YTD FY2026, including comparisons to Budget and Prior Year (PY), and to seek approval of the financials. This memo highlights key financial trends and governance-level considerations; detailed operational and variance analyses are provided in the attached materials.

Executive Summary – Period 6 (December 2025)

Overall Performance

Period 6 results reflect continued strength in outpatient and procedural activity, which more than offset modest inpatient volume softness. Revenue and operating margin performance exceeded budget expectations, supported by disciplined expense management and sustained labor productivity improvements. Net income significantly exceeded budget, driven mostly by favorable non-operating investment performance.

Key Volume Observations

- Inpatient average daily census (ADC) remained below Budget and Prior Year, consistent with ongoing utilization trends.
- Outpatient volumes, including emergency department visits and procedural cases, exceeded both Budget and Prior Year and were the primary contributors to favorable revenue performance.
- Detailed volume trends by service line are included in the **Detailed Volume and KPI Dashboard.**

Financial Performance

- **Total Operating Revenue:** $161.2M, favorable to Budget by $9.2M (6.1%) and higher than PY by $12.6M (8.4%).
- **Operating Margin:** $23.1M, favorable to Budget by $8.6M (59.3%) and slightly below PY by $0.7M (2.9%).
- **Operating EBIDA:** $31.2M, favorable to Budget by $8.2M (35.8%) and slightly below PY by $0.8M (2.5%).
- **Net Income:** $56.2M, favorable to Budget by $36.2M (180.6%) and higher than PY by $37.9M (207.4%).

YTD FY2026 Performance (as of December 31, 2025)

Year-to-Date Overview

Through December 31, 2025, financial performance remains ahead of Budget across all major operating metrics. Revenue growth continues to be driven by outpatient activity, while expense performance reflects effective management of labor productivity and premium pay. A portion of year-

to-date net income favorability is attributable to market-driven investment gains rather than recurring operating performance.

Key Results

- **Total Operating Revenue:** $917.9M, favorable to Budget by $16.6M (1.8%) and higher than PY by $71.0M (8.4%).
- **Operating Margin:** $100.3M, favorable to Budget by $25.8M (34.5%) and higher than PY by $15.2M (17.9%).
- **Operating EBIDA:** $151.6M, favorable to Budget by $23.8M (18.6%) and higher than PY by $16.3M (12.0%).
- **Net Income:** $227.9M, favorable to Budget by $122.4M (116.0%) and higher than PY by $70.6M (44.8%).

Key Volumes:

- **ADC:** CY 300.5 (1.8% unfavorable to Budget), PY 307.6 (2.3% lower)
- **Adjusted Discharges:** CY 23,316 (3.4% favorable to Budget), PY 22,239 (4.8% higher)
- **ED Visits:** CY 42,180 (6.0% favorable to Budget), PY 40,058 (5.29% higher)
- **OP Visits / Procedural Cases:** CY 84,704 (8.4% favorable to Budget), PY 75,523 (12.2% higher)

Recommendation: Management recommends the Finance Committee approve the Period 6 and YTD FY2026 financials.

List of Attachments:

1. Presentation: Period 6 & YTD FY2026 financials

El Camino Health

Summary of Financial Operations

Fiscal Year 2026 – Period 6

7/1/2025 to 12/31/2025

Financial Overview: YTD FY2026 (as of 12/31/2025)

Consolidated Financial Performance

- Operating EBIDA is $151.6 / 16.5% compared to the budget of 127.8 / 14.2% and $16.3M / 12.0% above prior year.
- Operating margin is $100.3M / 10.9% compared to the budget of $74.5M / 8.3% and $15.2M / 17.9% above prior year.
- Operating expense is $9.1M / 1.1% favorable to budget.
  - When adjusted for volume levels, Operating Expense per CMI Adjusted Discharge is $20,470 which is 5.7% favorable to budget.
    - **Note: Excludes depreciation and interest expense**
- Key operating drivers:
  - Year-over-year operating margin is $15.2M / 17.9% above the same period last year:
  - Favorable:
    - Continued strength in Interventional Services (12.1% fav to prior year), Outpatient Surgical Services (8.1% fav to prior year), and Outpatient Endoscopy Services (6.7% fav to prior year).
    - Expense management – Continued favorability in Labor Productivity and Premium Time.
  - Unfavorable
    - Uptick in Medicare Payor Mix: 0.2%
- Year-over-year net margin is $70.6M / 44.8% higher than the same period last year.

Operational / Financial Results: YTD FY2026 (as of 12/31/2025)

($ 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	301	306	(5)	(1.8%)	308	(7)	(2.3%)	---	---	---	---
	Adjusted Discharges	23,316	22,544	772	3.4%	22,239	1,077	4.8%	---	---	---	---
	OP Visits / OP Procedural Cases	84,704	78,152	6,552	8.4%	75,523	9,181	12.2%	---	---	---	---
	Percent Government (%)	58.6%	58.5%	0.1%	0.2%	58.4%	0.2%	0.4%	---	---	---	---
	Gross Charges ($)	4,061,750	3,899,307	162,443	4.2%	3,619,435	442,315	12.2%	---	---	---	---
Operations	Cost Per CMI AD	20,479	21,724	(1,245)	(5.7%)	19,822	657	3.3%	---	---	---	---
	Net Days in A/R	48.2	54.0	(5.8)	(10.7%)	50.4	(2.2)	(4.3%)	47.5	47.4	47.8	
Financial Performance	Net Patient Revenue ($)	887,992	867,282	20,710	2.4%	813,274	74,718	9.2%	2,178,271	4,016,609	---	
	Total Operating Revenue ($)	917,937	901,323	16,614	1.8%	846,939	70,998	8.4%	2,570,804	4,185,490	2,210,450	
	Operating Margin ($)	**100,281**	**74,543**	**25,738**	34.5%	**85,078**	**15,203**	17.9%	**51,416**	**146,492**	**75,155**	
	Operating EBIDA ($)	**151,600**	**127,778**	**23,822**	18.6%	**135,337**	**16,263**	12.0%	**149,107**	**339,025**	**187,888**	
	Net Income ($)	227,954	105,518	122,437	116.0%	157,404	70,551	44.8%	141,394	326,468	123,785	
	Operating Margin (%)	**10.9%**	**8.3%**	**2.7%**	32.1%	**10.0%**	**0.9%**	8.8%	**2.0%**	**3.5%**	**3.4%**	
	Operating EBIDA (%)	**16.5%**	**14.2%**	**2.3%**	16.5%	**16.0%**	**0.5%**	3.4%	**5.8%**	**8.1%**	**8.5%**	
	DCOH (days)	347	275	72	26.3%	276	71	25.8%	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; July 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.

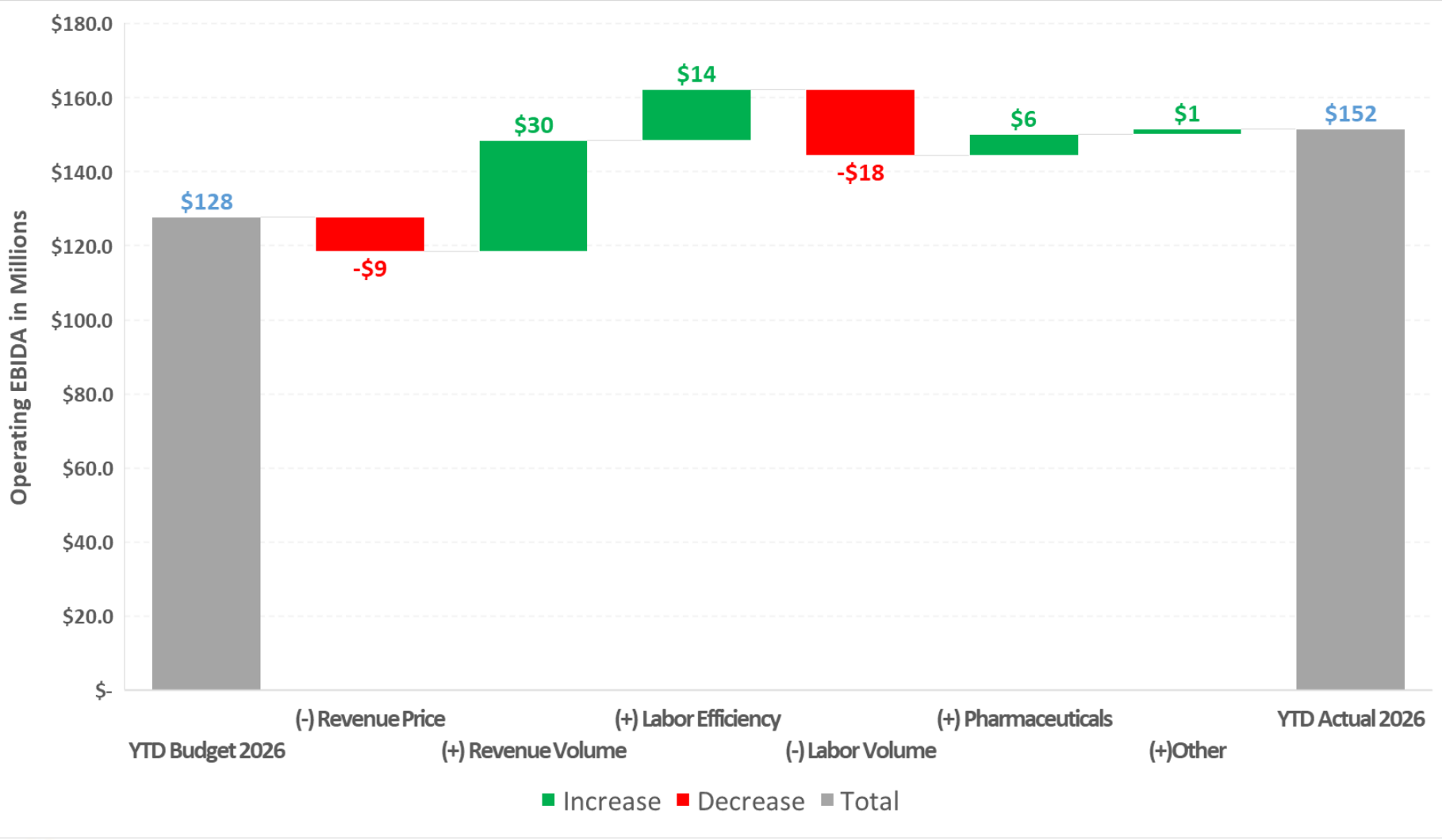
El Camino Health

Unfavorable Variance < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

FY2026 YTD P6: Factors driving favorable Operating EBIDA

(Dollars in Millions)

$152M (actual) vs. $128 (budget) = $24M / 18.6% favorable to budget



- **Revenue:**
  - Price: Change in IP/OP mix vs budgeted resulted in lower Revenue per Adjusted Discharge
  - Volume impact: Driven by 3.4% favorability to budget in hospital activity.
- **Labor:**
  - Efficiency: Consistent favorable performance versus budgeted productivity targets.
  - Volume impact: Driven by 3.4% favorability to budget in hospital activity.
- **Pharmaceuticals:** FY26 Budget was increased to account for specialty drugs used in new clinics. Utilization shifts, cost savings initiatives, and improved contracting has produced favorable results.

Operational / Financial Results: Period 6 – December 2025 (as of 12/31/2025)

($ 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	307	300	7	2.2%	322	(16)	(4.9%)	---	---	---	---
	Adjusted Discharges	3,945	3,752	193	5.1%	3,898	47	1.2%	---	---	---	---
	OP Visits / OP Procedural Cases	14,167	12,029	2,138	17.8%	12,593	1,574	12.5%	---	---	---	---
	Percent Government (%)	56.9%	58.7%	(1.8%)	(3.0%)	59.1%	(2.2%)	(3.7%)	---	---	---	---
	Gross Charges ($)	676,772	651,828	24,945	3.8%	637,395	39,378	6.2%	---	---	---	---
Operations	Cost Per CMI AD	20,298	21,724	(1,426)	(6.6%)	18,201	2,097	11.5%	---	---	---	---
	Net Days in A/R	48.2	54.0	(5.8)	(10.7%)	50.4	(2.2)	(4.3%)	47.5	49.7	47.8	
Financial Performance	Net Patient Revenue ($)	155,733	146,329	9,404	6.4%	142,994	12,739	8.9%	363,045	669,435	---	
	Total Operating Revenue ($)	161,166	151,964	9,202	6.1%	148,611	12,555	8.4%	428,467	697,582	368,408	
	Operating Margin ($)	**23,053**	**14,474**	**8,580**	59.3%	**23,753**	**(699)**	(2.9%)	**8,569**	**24,415**	**12,526**	
	Operating EBIDA ($)	**31,236**	**23,003**	**8,233**	35.8%	**32,029**	**(793)**	(2.5%)	**24,851**	**56,504**	**31,315**	
	Net Income ($)	56,161	20,012	36,150	180.6%	18,271	37,891	207.4%	23,566	54,411	20,631	
	Operating Margin (%)	**14.3%**	**9.5%**	**4.8%**	50.2%	**16.0%**	**(1.7%)**	(10.5%)	**2.0%**	**3.5%**	**3.4%**	
	Operating EBIDA (%)	**19.4%**	**15.1%**	**4.2%**	28.0%	**21.6%**	**(2.2%)**	(10.1%)	**5.8%**	**8.1%**	**8.5%**	
	DCOH (days)	347	275	72	26.3%	276	71	25.8%	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; July 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.

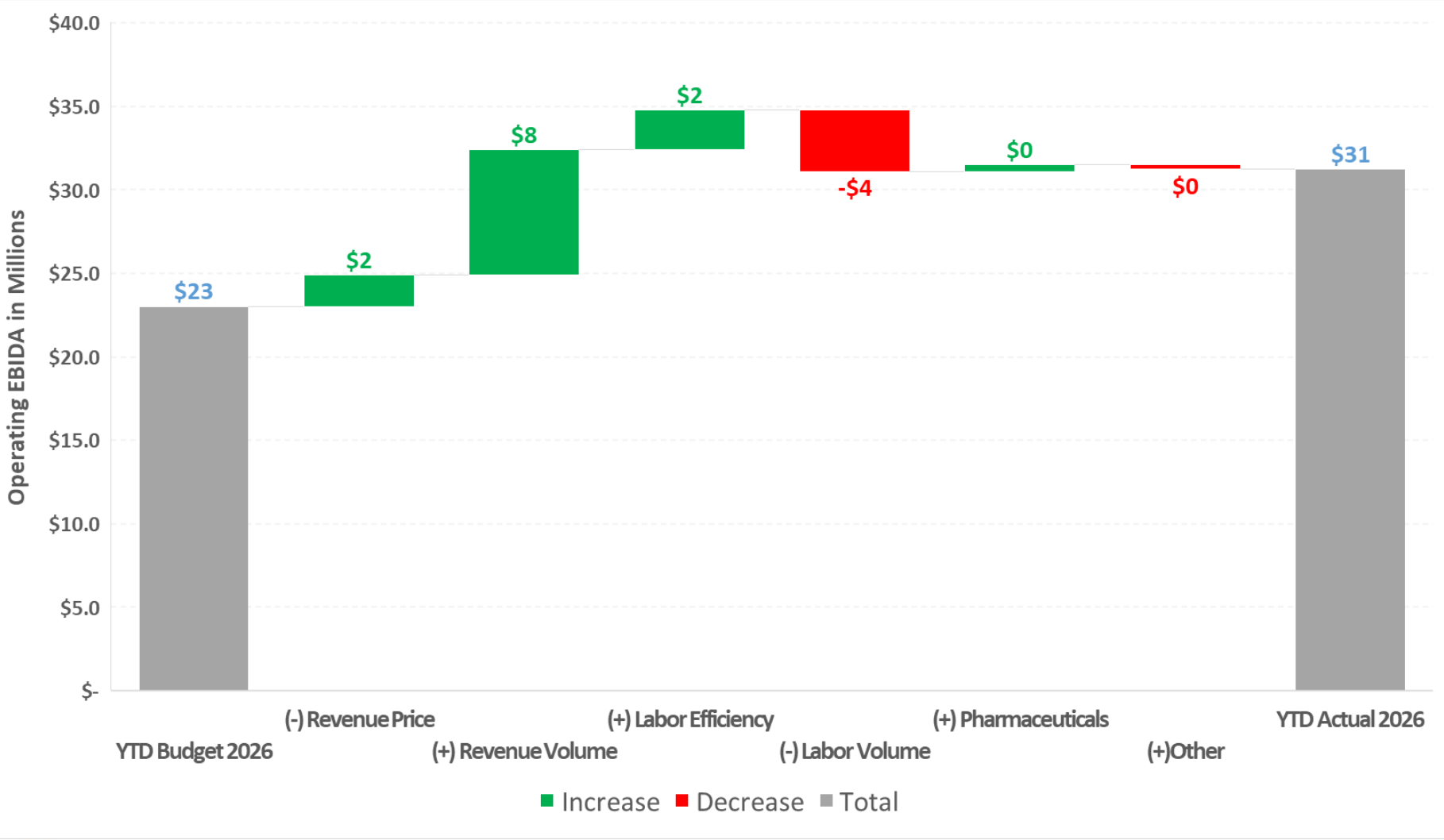
El Camino Health

Unfavorable Variance < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

FY2026 P6: Factors driving favorable Operating EBIDA

(Dollars in Millions)

$31M (actual) vs. $23 (budget) = $8M / 35.8% favorable to budget



- **Revenue:**
  - Price : Stronger IP activity drove Revenue per Adjusted Discharge up.
  - Volume impact: Driven by 5.1% favorability to budget in hospital activity.
- **Labor:**
  - Efficiency: Consistent favorable performance versus budgeted productivity targets.
  - Volume impact: Driven by 5.1% increase in hospital activity.

Consolidated Balance Sheet (as of 12/31/2025)

($000s)

ASSETS

CURRENT ASSETS	December 31, 2025	Audited June 30, 2025
Cash	448,295	407,140
Short Term Investments	162,617	98,926
Patient Accounts Receivable, net	241,477	240,895
Other Accounts and Notes Receivable	23,519	23,615
Intercompany Receivables	35,919	23,136
Inventories and Prepaids	55,768	54,047
Total Current Assets	**967,595**	**847,759**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	16,798	18,467
Plant & Equipment Fund	541,377	541,377
Women's Hospital Expansion	60,725	45,895
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	16,334	17,476
Workers Compensation Reserve Fund	12,374	13,086
Postretirement Health/Life Reserve Fund	19,813	23,009
PTO Liability Fund	45,365	41,558
Malpractice Reserve Fund	1,713	1,713
Catastrophic Reserves Fund	33,014	41,019
Total Board Designated Assets	**958,206**	**954,294**
FUNDS HELD BY TRUSTEE	-	-
LONG TERM INVESTMENTS	**804,484**	**753,548**
CHARITABLE GIFT ANNUITY INVESTMENTS	**1,335**	**1,279**
INVESTMENTS IN AFFILIATES	**53,780**	**51,293**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,132,999	2,067,886
Less: Accumulated Depreciation	(1,001,266)	(959,828)
Construction in Progress	253,426	228,708
Property, Plant & Equipment - Net	**1,385,158**	**1,336,766**
DEFERRED OUTFLOWS	40,733	41,289
RESTRICTED ASSETS	63,222	50,154
OTHER ASSETS	216,726	217,190
TOTAL ASSETS	**4,491,238**	**4,253,573**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	December 31, 2025	Audited June 30, 2025
Accounts Payable	54,430	77,122
Salaries and Related Liabilities	51,215	39,837
Accrued PTO	75,871	71,612
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	10,028	8,509
Intercompany Payables	31,242	18,745
Malpractice Reserves	1,713	1,713
Bonds Payable - Current	15,615	15,615
Bond Interest Payable	8,509	5,651
Other Liabilities	19,830	17,992
Total Current Liabilities	**270,752**	**259,096**
LONG TERM LIABILITIES		
Post Retirement Benefits	19,813	22,028
Worker's Comp Reserve	12,374	12,374
Other L/T Obligation (Asbestos)	25,755	25,939
Bond Payable	525,513	526,840
Total Long Term Liabilities	**583,455**	**587,180**
DEFERRED REVENUE-UNRESTRICTED	**1,471**	**1,538**
DEFERRED INFLOW OF RESOURCES	**80,563**	**88,430**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	3,252,226	3,027,555
Minority Interest	-	-
Board Designated	235,758	225,482
Restricted	67,013	64,292
Total Fund Bal & Capital Accts	**3,554,997**	**3,317,329**
TOTAL LIABILITIES AND FUND BALANCE	**4,491,238**	**4,253,573**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS MEMO

To: ECH Hospital Board of Directors
From: Theresa Fuentes, Chief Legal Officer
Anne Yang, Executive Director, Governance Services
Date: March 18, 2026
Subject: Board Approval of Revised Governance Committee Charter

Recommendation: The Governance Committee recommends for Board approval a revised Governance Committee Charter to increase the possible number of community members.

Authority: The Board of Directors reviews and approves changes to the committee charters. The revised Governance Committee Charter is reviewed by the Governance Committee prior to recommending for Board approval.

Summary: The current Governance Charter currently specifies 2-4 community members may serve on the Committee.

The Ad Hoc Recruitment Committee has selected three candidates for the Governance Committee's consideration as new community members to the Committee, in addition to the two existing community members. Given the possibility of having five total community members, the charter needs revision to allow for the additional community members to be appointed.

Governance Committee approved the revision on March 3, 2026, and the revised Charter is now submitted to the Board for approval.

List of Attachments:

- Governance Committee Charter (Marked)

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El Camino Hospital Board of Directors
Governance Committee Charter

Purpose

The purpose of the Governance Committee ("Committee") is to advise the El Camino Hospital ("Hospital") Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition (*i.e.*, the nomination and appointment/reappointment process and succession planning for the Board) for El Camino Hospital and the Hospital's affiliated entities where the Hospital is the sole corporate member pursuant to the operating agreements and governance documents of those entities ("the Organization"). The Governance Committee ensures the Organization is functioning at the highest level of governance standards.

Authority

The Committee is an Advisory Committee of the Board pursuant to Article VII of the Hospital Bylaws. All governing authority for the Organization resides with the boards of each entity except that which may be lawfully delegated to a specific board committee. The Committee will report to the Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on governance-related issues. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Governance Committee shall be comprised of two (2) or more Hospital Board members who shall be appointed and removed pursuant to the El Camino Hospital Board Committee Governance Policy.
- The Governance Committee may also include 2-54 Community members[1] with expertise in governance, organizational leadership or as a hospital or health system executive.
- All Committee members, Chairs, and Vice Chairs shall be appointed and removed in accordance with the El Camino Hospital Board Committee Governance Policy.
- All members of the Governance Committee shall be independent.

Staff Support and Participation

The CEO shall attend meetings and serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration.

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

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Additional members of the executive team may participate in the Committee meetings upon the recommendation of the CEO and at the discretion of the Committee Chair.

General Responsibilities

The Committee is responsible for recommending to the Board policies, processes and procedures related to board development, board effectiveness, board composition and other governance matters for the Organization.

Specific Duties

The specific duties of the Governance Committee include the following:

A. **Board Composition, Development, and Effectiveness:** Ensure that the Board and the boards of the affiliated entities are committed to the discipline of doing the right things the right way.

Composition

- Define the necessary skill sets, diversity and other attributes required for Board members to support Hospital strategy, goals, community needs and current market conditions.
- Make recommendations to the Board regarding Board Composition.
- Review and make recommendations to the Board regarding the Board Chair's appointments of Advisory Committee Chairs and Advisory Committee members.

Orientation, Education and Development

- Adopt the orientation program for newly-appointed members to the Hospital Board of Directors and newly-appointed Board Committee members.
- Recommend a policy, budget and annual plan for Hospital Board and Committee member education, training and development.

Board Evaluation

- Recommend an evaluation instrument and process to be used by the Hospital Board for evaluation of Board governance.
- Ensure there is a board performance evaluation completed on a regular basis, and as appropriate, evaluation of the individual directors, committees and their chairs, and the Board Chair.

Board Efficiency

- Monitor and recommend improvements or changes to the on-going governance process and procedures of the Hospital Board in order to enhance overall efficiency of the Board and Advisory Committee Structure.
- Ensure the Board develops a master Board meeting calendar to establish a cadence of information flow and dialogue, such that the Board has sufficient time to review the minutes and recommendations of the committees. The cadence must accommodate a flow of approvals from Committee to the full Board.

El Camino Health

B. Support of Board Advisory Committee Alignment with Organizational Strategy and Goals

Development of Process for Advisory Committee Review of Advisory Committee Goals and Charters

- Recommend process for the development of annual Board Advisory Committee goals which includes: 1) Linkage of committee goals to organizational goals and strategy, to the Board; and 2) the Board's review and approval.
- Ensure all Board Advisory committees conduct biennial review of Advisory committee charters and recommend any changes to the Board for approval.

Development of Board Advisory Committee Membership Succession Plan

- Ensure membership succession plan considers organizational strategy and goals.
- Develop process for Advisory committee use to identify a need for increase or change in membership to further alignment with organizational strategy and goals.

C. Articles of Incorporation, Bylaws, and Policies

- Provide for a review of the Hospital's Articles of Incorporation and Bylaws at least once every three years.
- Provide for a review of Articles of Incorporation and Bylaws of affiliated entities as needed
- Monitor legal and regulatory issues affecting governance of the Organization.
- Recommend updates to the Organization's governance policies where necessary and as required by legal and regulatory agencies.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and pacing plan in alignment with the Board and the Organization's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all Advisory committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of Advisory committees may also be called by resolution of the Board or the Committee Chair. Notice of any special meetings of the Committee requires a 24-hour notice.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS MEETING MEMO

To: ECH Board of Directors
From: Lanhee Chen and Mike Kasperzak, Governance Committee Recruitment Ad Hoc Committee
Date: March 18, 2026
Subject: FY26 Governance Committee Ad Hoc Recruitment Recommendation

Purpose:

To recommend the selection of candidates for Governance Committee membership.

Summary:

The Governance Committee Recruitment Ad Hoc Committee followed the approved recruitment timeline, including outreach through social media and local publications. The recruitment effort generated six strong candidate submissions.

The Ad Hoc Committee reviewed all candidate questionnaires and materials on December 5, 2025, and selected three finalists for interviews. Interviews were conducted on December 9 and December 11, 2025.

Following the interview process, the Ad Hoc Committee recommends all three finalists for appointment to the Governance Committee based on their governance experience, professional expertise, and alignment with Committee needs.

The Governance Committee approved the three selected candidates for review and approval by the Hospital Board of Directors. Following board approval, the appointed members will participate in onboarding and attendance in upcoming Governance Committee meetings.

List of Candidate Information Attachments:

1. Scott Barclay – Questionnaire and LinkedIn Profile
2. Azar Khansari – Questionnaire and Resume
3. Doug Scrivner – Questionnaire and Resume

From: El Camino Health
To: ECH Board Recruitment
Subject: New Submission: Call for Applications - Governance Committee Member
Date: Monday, December 1, 2025 7:31:14 AM

Submitted on Mon, 12/01/2025 - 07:30 AM

Submitted by: Anonymous

Submitted values are:

Full Name
Scott Barclay

Residence Address
[redacted] Palo Alto, CA 94301

Email Address
[redacted]

Phone Number:
[redacted]

a) Board Governance. Ability to guide and uphold effective governance practices, ensuring the board fulfills its legal, ethical, and functional responsibilities. Experience in developing, reviewing, and implementing governance policies and procedures, as well as evaluating board effectiveness and supporting board recruitment, orientation, and development.
I am a 25 year healthcare operator turned investor, currently as lead of Healthcare for Insight Partners, a $100bn AUM venture capital firm that invests at every stage of company development. I have been part of the BOD of ~25 companies in my professional career. I am currently on the board of Lantern, Cleerly, Calm, IDOVEN, Pictor, and Bamboo.

When part of a board, my goal is that we would be excellent stewards; that we would collaborate as a group and with leadership to "do the right thing"as aligned to our charter and the organizational mission.

As I learned in studying great boards at INSEAD (MBA, 2004, Fontainebleau Fr), great boards remove ego, make sure the right leadership is in place, and that the organizational leadership and firm's responsibilities are informed, alinged, and callibrated to long-term purpose.

b) Organizational Leadership. Experience in organizational leadership, with the ability

to provide strategic direction, foster a culture of accountability, and drive organizational performance.
My leadership style is one of removing ego, serving the team, and acting with a deeper spirit of creating long-term value, executing upon the long-term strategy, and being highly responsive to problems and challenges.

I also think leadership is context-dependent. I can be a strong alpha, when the knowledge, context, and situation requires. But I also think great leadership knows when to listen, when to be part of a group. Leadership is knowing when to listen, when to speak, when to encourage, and when to be aggressive.

c) Healthcare Executive Leadership. Experience in executive leadership roles within the healthcare sector, with a comprehensive understanding of healthcare systems, regulatory environments, and industry trends.
I have only worked in our vibrant but also oligopolistic and highly complex and regulatory-capture healthcare market since 2005.
- Youngest VP at CVS Health in 2006
- Helped create and then scaled the electronic prescription, including the creation and leadership of Surescripts, 2005-2012
- Have only worked as a healthcare executive and venture capitalist since 2012
- Most of my experience is across technology towards the "triple aim" across the provision of care in all settings and markets that touch providers and payers

Critical Characteristics
These attributes are true for me, though all of us have imperfections and learn from our mistakes.

It's easy to celebrate our successes. I'm proud of my board stewardship of a very challenging venture asset called Forta.

Forta is a full-stack new form of autism care that incorporates the family as caregivers. Since joining the board in 2022, I've helped navigate CEO impropriety investigations, a major regulatory shift, 12 months of product-market fit scale, a large market reversal, a shareholder revolt, and the CEOs departure. Amidst this journey, I'm very proud of my role at each step to steward the company through appropriate investigations, the allocation of capital and budgets, and strong leadership to protect all stakeholders. I view my role not as just a "fiduciary", but as someone safeguarding the board's role to do our best at each step, for all stakeholders, for long-term value.

And my evidence is that I remain in great relationship with the departed CEO ("you were always fair and honest with me"), the co-investors ("thank you for being steady amidst the storm"), the Administration ("this is the best way to handle an uncertain situation"), and my own team and LPs ("thanks for your presence and hard work")

a) Do you have any other skills, qualifications, or subject matter expertise that you believe would be an asset to the Committee? If so, please describe.
I just want to emphasize the importance of El Camino in the community and the multi-faceted stakeholders against a crystal-clear mission.

I also want to emphasize my desire to contribute is related to my own role in the community and my own experience in the challenges of healthcare. I have no ulterior motivations as a capitalist, or related to my firm or my healthcare technology investments.

5. Are there any civil, employment-related, or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigation for business or healthcare related issues (e.g. OIG)? (Note: Disclosure of a civil, employment-related, criminal incident (s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe with be taken into consideration.)

None

6. Are you able to make the necessary time commitment and in person attendance as laid out in the position description?

Yes

7. Describe any potential conflict of interest with any of your other commitments or activities? If none, please indicate.

I am an investor through our firm in ~55 healthcare technology companies, and ~20 bio therapeutic investments. I am a leader on ~20 of those technology investments, and on the Board of ~8 companies. I do not anticipate any conflicts but will be excessively transparent on any possible overlap, and recuse myself of any appropriate matters.

8. The El Camino Health Governance Committee Member position is non-compensated (i.e. volunteer) and has a three-year renewable term. Is this acceptable?

Yes

9. Please specify how you found out about this position.

Board member Lanhee Chen

10. Why are you interested in being considered for the Governance Committee Member position with El Camino Health?

I serve on multiple for-profit VC Boards and have significant experience in healthcare. My motivation here is to contribute in my own community, leveraging my experience to a higher calling and aligned with a wonderful institution that also aligns with my personal philosophy that is against dominant oligopolies in US healthcare

CV here: https://www.linkedin.com/in/scottbarclay/

Upload CV and optionally professional references as Word or PDF files

- Barclay LI CV.docx

Contact

[redacted]

www.linkedin.com/in/scottbarclay (LinkedIn)

Top Skills

Strategy Development
Product Strategy
Clinical innovation

Languages

Spanish

Scott Barclay

Managing Director, Healthcare, Insight Partners
Palo Alto, California, United States

Summary

My joy is to invest in and serve special founders rebuilding the future of health care

Experience

Insight Partners
Managing Director, Healthcare
November 2021 - Present (4 years 2 months)
Palo Alto, California, United States

Investing in and serving founders rebuilding healthcare, now as part of the world's best venture capital culture that is Insight Partners. Every stage, every time zone.

Clay VC
Founder and GP, Clay VC
May 2021 - January 2022 (9 months)
Palo Alto, California, United States

Clay VC is a new early-stage investing firm rebuilding the future of healthcare by finding and serving founders at the intersection of deep tech, data, and empathy. We call this next era Computational Care. Based in Palo Alto, CA and serving founders globally.

(This description is not a solicitation for investment or investment advice)

Point72 Ventures
Partner
August 2020 - May 2021 (10 months)
Palo Alto, California, United States

Building a special purpose diverse team to invest in and serve founders who themselves are technical, ambitious, and building the future of healthcare in the US and globally

Curative Inc.
Investor

March 2020 - August 2020 (6 months)
Los Angeles, California, United States

Jumped in to help catalyze & fund Fred Turner and a wonderful team to rapidly build a COVID19 Diagnostic oral-liquid diagnostic test

Freenome
Board Observer
July 2019 - August 2020 (1 year 2 months)
South San Francisco

Next-generation blood tests for early cancer detection powered by a machine-driven, multiomics platform. DCVC investor since 2015; Board Observer since July 2019

Carbon Health
Board Director
January 2019 - August 2020 (1 year 8 months)
San Francisco

Building the future of urgent care

Enzyme
Investor
May 2018 - August 2020 (2 years 4 months)
San Francisco

FDA compliance and submission offered as a machine-driven SaaS service

Primer AI
Board Observer
April 2018 - August 2020 (2 years 5 months)
San Francisco

"We build machines that read and write"

Swift Medical
Board Director
January 2018 - August 2020 (2 years 8 months)
Toronto, Canada Area

Computer vision at the bedside, on the smartphone, solving wound care

Subtle Medical
Investor
November 2017 - August 2020 (2 years 10 months)

Deep leaning to drastically improve imaging infrastructure, in PET and MR

DCVC (Data Collective)
5 years 4 months

Partner
August 2017 - August 2020 (3 years 1 month)
Palo Alto, CA

Investor in early-stage, deep-tech companies with technical founders, special teams, and emapthy; practice leader building DCVC's Computational Care portfolio, and an investor in industrial and enterprise AI

Operating Partner
May 2015 - August 2017 (2 years 4 months)
Palo Alto, CA

SafelyYou
Board Director
July 2017 - August 2020 (3 years 2 months)
San Francisco, CA

Computer vision as a service that is near magical in reducing falls and ER visits in assisted living & memory care

Medical Informatics Corp
Board Director
June 2017 - August 2020 (3 years 3 months)
Houston, Tx

Deep compute on top of the ICU, saving lives and advancing research

StartX Med
Founding Mentor
June 2012 - May 2020 (8 years)
Palo Alto, CA

Advise the leaders of Stanford's StartX incubation program for new entrepreneurs and companies focusing on changing the future of medicine

Karius, Inc.
Board Director
June 2016 - April 2020 (3 years 11 months)
Menlo Park, CA

Revolutionizing the world of understanding infectious disease with genomics and machine learning

Health Gorilla

Board of Directors
October 2014 - January 2020 (5 years 4 months)
Sunnyvale, CA

Health Gorilla breaks healthcare data siloes by replacing the fax machine and creating a transactional marketplace for lab and radiology orders and results

Element AI
Board Observer
July 2017 - July 2019 (2 years 1 month)
Montreal, Canada Area

World's best horizontal deep learning platform, building AI products for enterprise. AI for good.

BlueTalon
Chairman, Board of Directors
November 2012 - July 2019 (6 years 9 months)
Menlo Park, CA

Acquired by Microsoft, July 2019. BlueTalon enables data collaboration, governance and granular access control on any data stack, including Hadoop. We are enabling health care, finanical services, and big markets where data is complex, volumous and sensitive.

Innovation Norway
StartUp Mentor
September 2013 - April 2019 (5 years 8 months)
Palo Alto, CA and Oslo

Innovation Norway is a premier accelerator for Norwegian technology and talent entering and growing in US technology markets. I like to help the teams visiting silicon valley

Safeguard Scientifics
Senior Adviser
November 2014 - August 2017 (2 years 10 months)
Palo Alto, CA

Safeguard is a world-class provider of growth capital to technology and healthcare companies

Propeller Health
Strategic Adviser & Shareholder
April 2014 - August 2017 (3 years 5 months)
Madison, San Francisco

Acquired by ResMed in January 2019. Propeller Health is an elegant digital mobile solution for enabling chronic Asthma and COPD patients. Device sensors + feedback loops + patient and physician engagement.

Elation EMR
Strategic Adviser & Shareholder
August 2013 - August 2017 (4 years 1 month)
San Francisco Bay Area

Elation is a SAS based, best-in-class next generation clinical platform for doctors, caregivers, and patients; where others are terrible, Elation is an EMR + Population Health for a delighted ambulatory staff

Syapse Inc.
Strategic Adviser & Shareholder
March 2013 - August 2017 (4 years 6 months)
Palo Alto, CA

Syapse combines the molecular with the clinical to overlay the EMR and enable providers to practice precision medicine

Lumiata
Part of the early team, then adviser, still shareholder
December 2012 - August 2017 (4 years 9 months)
Palo Alto, CA

Clinical analytics company with the vision to optimize and personalize care by providing a real-time, predictive, clinically validated medical-graph, available by API and profound new products.

Kestrel Health
Executive Chairman
November 2015 - March 2017 (1 year 5 months)
San Mateo, CA

Acquired by Pokitdok in March 2017. Kestrel, the pivot from Oration Health, was an innovative start-up pharmacy and real-time medication pricing API that helps unlock medication costs for employers and those they surround the member along the journey.

CarePort Health
Strategic Adviser & Shareholder
October 2014 - January 2017 (2 years 4 months)
Boston, MA

Acquired by Allscripts in 2017. CarePort Health brings innovation, tools, and data to the moment of hospital discharge, helping patients and their families better navigate post-acute setting, and helping hospitals improve post-acute outcomes as the world shifts to value.

Historical advisory boards or advisory roles

Strategic Adviser in early Digital Health

July 2012 - December 2014 (2 years 6 months)

Palo Alto

Some historical advisory boards and assignments or work with friends, executed in trust, and delivered with quality: Doximity, NaviHealth (acquired Cardinal Health), HealthTap, Act.md, QualcommLife, QPID (acquired ESI), GetMyRx (acquired Dr First), MedImpact, IQVIA, GE incubations, Accenture digital health labs, M-3, DrFirst, DermLink, Medivo

Surescripts

Chief Strategy Officer

July 2009 - July 2012 (3 years 1 month)

Palo Alto, CA

While at CVS, I helped create the NewCo Surescripts in 2007, then joined full-time in July 2009 as Chief Strategy Officer. For the CEO and board, I lead an amazing team against Strategy, Innovation, Business Intelligence, Product Management, and new market incubation. Surescripts is the nation's e-Prescription network. During my three years, we grew revenue 10x and scaled the business from ~1% of prescriptions to ~60% of US prescriptions while expanding into new businesses of interoperability, Labs, public health, medication reconciliation, and (appropriate) new uses of data

CVS Caremark

4 years 7 months

General Manager, Physician Connectivity + iScribe

June 2008 - July 2009 (1 year 2 months)

- General manager of iScribe, CVS Caremark's industry leading and wholly owned ePrescribing company
- General manager of Physician Connectivity, CVS Caremark's strategic group for growing and stewarding the e-prescribing and eHealth industry

Senior Portfolio Manager, Innovation

December 2006 - June 2008 (1 year 7 months)

- Oversee all e-Prescribing strategy, operations, and partnerships for CVS/pharmacy
- Own all in-store pharmacy automation strategy, relationships, capital, and operational returns for 6,300 chain pharmacy
- Founding member of Pharmacy IS innovation group, tasked with driving pharmacy-based healthcare innvoation, from idea conception and capture through execution and implementation

Senior Manager, Store Ops, Special Projects
January 2005 - December 2006 (2 years)

Manager of strategic and operational projects for CVS/pharmacy from the platform of Store Operations

The Boston Consulting Group
Consultant
August 2004 - December 2004 (5 months)

Strategic and operational consulting in US consumer retail

SNL Financial
Wall Street Valuation & Research, Energy Group
December 2002 - August 2003 (9 months)

Montgomery Securities / Banc of America Securities
Investment Banking & Equity Capital Markets
July 1999 - July 2002 (3 years 1 month)
New York, San Francisco, London

New equity issuance (IPOs, follow-ons, PIPEs) in US and Europe across retail, technology, and health care sectors. Investment banking with specific focus on high-growth equity placements

Tri State Foam / Atlas EPS
Plant floor laborer, seasonal
June 1994 - December 1997 (3 years 7 months)
Martinsville, VA

Manual labor, styrofoam manufacturing plant- cutting, boxing, loading, shipping, molding, bagging

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Education

INSEAD

MBA, Case-based strategy & general management · (2003 - 2004)

University of Virginia

BA, History · (1995 - 1999)

Martinsville High School

HS · (1993 - 1995)

Magna Vista High School

· (1991 - 1993)

El Camino Health

Candidate Questionnaire

El Camino Hospital Board of Directors
Governance Committee Member

1. Identifying Information:

   Name: Azar Khansari Silver

   Residence Address: [redacted] Los Altos, CA 94024

   Email Address: [redacted]

   Phone Number: [redacted]

2. Please describe how your professional background demonstrates your knowledge and experience in **one or more** of the following areas:

   a. **Board Governance.** Ability to guide and uphold effective governance practices, ensuring the board fulfills its legal, ethical, and functional responsibilities. Experience in developing, reviewing, and implementing governance policies and procedures, as well as evaluating board effectiveness and supporting board recruitment, orientation, and development.

      Answer: As Associate General Counsel at NetScout Systems, Inc, a publicly traded company having revenue of $850M and a global workforce of 2100 people, I have extensive experience in governance practice at both board and managerial levels. At the board level, I work with the General Counsel to review, assess and propose updates to board committee charters on a bi-annual cycle. In addition, I provide a quarterly presentation to the NetScout Nominating and Corporate Governance Committee on governance topics including SEC updates, updates to corporate governance policies and climate risk disclosures. At the managerial level, I developed and led the initial implementation of NetScout's data privacy governance framework, inclusive of oversight and the underlying policies and procedures, in response to GDPR. I also developed NetScout's AI governance framework and currently serve as the co-chair of the AI governance council. I am the acting co-Chair of the company's Environment, Social, and Governance (ESG) program and manage both the ESG program itself and all associated reporting. My governance experience also extends to work I have done as a board member for local non-profit organizations. I served as the chair of the Nominating Committee during my tenure on the board of Fresh Lifelines for Youth (FLY), a non-profit serving over 2000 youths annually and with a budget of $11M. During that time, I developed and annually refined the Governance Committee charter, established the board calendar annually, and was responsible for board evaluations and development. Upon rolling off the FLY board, I was asked by the board to conduct their annual board assessments which I have done for the past 6 years. I currently serve on the board of the Los Altos Stage Company and am working with our board chair to establish and chair the Nominating and Governance Committee.

   b. **Organizational Leadership.** Experience in organizational leadership, with the ability to provide strategic direction, foster a culture of accountability, and drive organizational performance.

      Answer: In 2023 I transitioned my primary duties from legal to Chief of Staff to the CEO. In my current capacity I am responsible for accelerating decision-making, improving operational efficiency, succession planning, and ensuring clear communication across the company. I work with executive and senior leadership to develop and track annual KPIs to measure corporate

El Camino Health

Candidate Questionnaire

El Camino Hospital Board of Directors
Governance Committee Member

and department-level performance. I also currently lead the company's AI program and ESG program, both of which require a high-degree of cross-functional communication and collaboration. Under my leadership, the company has successfully transitioned to a new COO and CFO with minimal disruption to corporate productivity and morale, have implemented and continue to improve a sustainability program with published science based emission reduction targets, and have a program to systematically upskill our entire employee population on emerging technologies.

c. **Healthcare Executive Leadership.** Experience in executive leadership roles within the healthcare sector, with a comprehensive understanding of healthcare systems, regulatory environments, and industry trends.

Answer: While I do not have direct experience working in the healthcare sector, NetScout has a healthcare vertical which I have supported for most of my tenure at NetScout. I have developed the company's response to regulatory requirements impacting the health care industry and continue to monitor trends in the industry. Through my personal relationships with senior executives at El Camino Hospital and Sutter Health, I have an understanding of the complexities and interdependencies of healthcare systems at the macro level and also within our local community.

3. Below are critical characteristics and behaviors essential to being a successful Committee Member. Please provide an example that illustrates how you demonstrate **at least one of the following characteristics**:

- An impeccable reputation for honesty and integrity
- Collaborative nature
- Solid communication and interpersonal skills, with the ability to be effective with other Board and Committee members and executive management
- High energy and sense of urgency
- Innovative, creative, and imaginative
- Mission-driven
- Comfortable with change

Answer: I did not intend my tenure at NetScout to be as long as it has been, but the length of my tenure can be explained by my comfort with change, collaborative nature, interpersonal skills and imagination. I joined the company as part of an acquisition and went from being in a corporate headquarters having responsibility over the entire legal function, to being a remote-employee for a Boston-based having responsibility of a narrow segment of a larger legal team. While this was initially disappointing, I developed an excellent relationship with my new General Counsel and "proved" myself through suggesting and then driving process changes. Each year, I challenged myself to make an improvement with broader impact starting first with changes to legal department processes and then eventually to company-wide processes and procedures. Each proposed improvement required getting buy-in from multiple stakeholders and in some cases involved

El Camino Health

Candidate Questionnaire

El Camino Hospital Board of Directors
Governance Committee Member

transferring responsibilities (work) from one department to another. My success in doing so eventually led to my transitioning into the Chief of Staff to the CEO role. In addition, during my tenure we made 11+ acquisitions, and I established myself as part of each of the integration team because I have a passion for assessing talent and then matching skills with business needs. Our development of a comprehensive company-wide succession plan and an AI for productivity rollout is in part a result of my work through the integration process and the recognition that the company overall needs to change and upskill. Finally, NetScout's current purpose and mission statement is a direct result of an executive leadership program that I pitched, helped develop and pilot with an initial team of senior executives. I worked directly with consultants from the High Ambition Leadership Program (HALI) to create the initial curriculum, and the pilot team spent a year developing the corporate purpose statement which is now an integral part of the Netscout identity (Guardians of the Connected World). I attended and gave the keynote to the graduating class of our sixth cohort this past October.

4. Are there any other aspects of the position description that you have experience with that are not specifically listed above? If so, please describe that experience.
    a. Do you have any other skills, qualifications, or subject matter expertise that you believe would be an asset to the Committee? If so, please describe.

    Answer: As noted above, I help lead my company's ESG program. The topic of sustainability is one that I educate our board on quarterly because we are subject to CA SB261. I would be excited to share my knowledge and experience on the topic of emission reduction programs and climate risk considerations.

5. Are there any civil, employment-related, or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigation for business or healthcare related issues (e.g. OIG)? (Note: Disclosure of a civil, employment-related, criminal incident (s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe with be taken into consideration.)

    Answer: No

6. Are you able to make the necessary time commitment and in person attendance as laid out in the position description?

    Answer: Yes

7. Describe any potential conflict of interest with any of your other commitments or activities? If none, please indicate.

    Answer: None

El Camino Health

Candidate Questionnaire

El Camino Hospital Board of Directors
Governance Committee Member

8. The El Camino Health Governance Committee Member position is non-compensated (i.e. volunteer) and has a three-year renewable term. Is this acceptable?

   Answer: Yes

9. Please specify how you found out about this position.

   Answer: Cheryl Reinking and Dr. Rebecca Fazilat are personal friends and suggested it.

10. Why are you interested in being considered for the Governance Committee Member position with El Camino Health?

    Answer: I have always had a passion for working for and giving back to my local community. Beyond my work at FLY and Los Altos Stage Company, I was on the PTA board for Loyola Elementary School (serving as Executive Director, Vice ED, Secretary and Chair of Junior Olympics during my tenure) and Blach Middle School. Governance is a personal passion of mine and the area of law that I enjoy the most. I had both of my children at El Camino Hospital and believe it to be exceptional. I believe we are extremely lucky to live in this community and to have the quality healthcare that El Camino provides. It would be honor for me to serve and help steward its continued success in any way I can!

Azar Khansari
[redacted]
Los Altos, CA 94024
[redacted]

BAR ADMISSION

State Bar of California, Admitted December 1997

EDUCATION

University of California, Davis – Graduate School of Management, Davis, CA
Master of Business Administration, 2022

University of California, Hastings College of the Law, San Francisco, CA
Juris Doctor, 1997
Hastings International and Comparative Law Review, 1995-1996

University of California, San Diego
Bachelor of Arts, Sociology, cum laude, 1993

EXPERIENCE

NetScout Systems, Inc., San Jose CA
Chief of Staff to the CEO 4/2023 – current
Work with CEO, COO and General Counsel to define the strategy, approach, and agenda for key external and internal strategic initiatives, risk management and corporate governance. Oversee internal communications to ensure alignment of content with strategy and key points. Ghost-write CEO internal communications and assist CEO and General Counsel with content creation for quarterly Board meetings. Lead member of M&A diligence team and post-acquisition integration team. Manage strategic programs including company AI and ESG program, oversight of system integration effort to consolidate multiple ERP and CRM systems, and executive succession planning. Launched Executive Leadership Program resulting in improved coordination between functional leaders, stronger alignment with company purpose, mission and vision, and increased engagement.

Vice President, Associate General Counsel 8/2018 – 4/2023
Manage team of 14 attorneys and legal professionals responsible for supporting engineering, product management, sales, manufacturing, marketing, procurement and IT. Member of GDPR steering committee with lead role in products and sales workstreams. Provide hands-on counsel to all levels of the executive management team and all major departments. Assist General Counsel in the development and implementation of legal department strategies and goals. Responsible for establishing corporate licensing strategy for all inbound and outbound activities including sales contracts, third party procurement contracts, OEM contracts, and contract manufacturing contracts. Escalation point for contractual disputes. Manage IP and licensing due diligence in connection with corporate merger and acquisition activities. Develop policies and procedures associated with integration of newly acquired entities. Implemented and manage third party software review policy and procedures. Developed and grew legal operations function. Provide leadership and mentoring to members of the legal team.

Associate General Counsel 2/2014 – 8/2018
Director of Licensing 5/2010-2/2014
Senior Corporate Counsel 9/2007 – 5/2010
Lead licensing attorney responsible for establishing corporate licensing strategy and processes for all inbound and outbound activities including sales contracts, third party IP procurement contracts, OEM contracts, business alliance agreements, and technology alliance agreements. Draft and review commercial agreements, including complex technology sales agreements, data privacy and information security agreement, professional services agreements and statements of work, and third-party IP procurement contracts. Drafted and updated corporate legal forms and templates, clause library and negotiation playbook. Assisted in the resolution of complex business and legal issues.

Network General Corporation, San Jose, CA 8/2004 – 9/2007
Senior Counsel
Managed due diligence activities in connection with sale of Network General to NetScout Systems, Inc. including preparation of merger agreement and seller disclosure statement, third party software review and managing outside counsel. Developed corporate templates for both inbound and outbound license and purchase transactions. Assisted in the development of multiple corporate policies including contract administration and management policy, third party software policy, bookings policy and corporate signature and approval policy. Draft and review agreements for: inbound and outbound licensing, contract manufacturers, procurement, and services. Managed cross-functional team of 10 individuals to create internal communications initiatives for the company.

Aspect Communications Corporation, San Jose, CA 8/2000 – 8/2004
Senior Counsel

Draft and review agreements for: licensing, investment and acquisitions, procurement, services, and corporate loans. Serve as both lead transaction attorney and supervisor to contract analysts for major commercial transactions. Further duties include assisting in general corporate litigation, assisting General Counsel with quarter end activities and general department strategy, working with outside counsel as required, drafting and updating corporate legal forms and templates, developing contract management procedures and assisting in the resolution of complex business and legal issues.

foodline.com, Inc., San Francisco, CA
Attorney/ Northwest Regional Manager 1/2000– 8/2000
Opened, launched and managed West Coast headquarters of New York based software-licensing company of 175 employees nationwide. Drafted, negotiated, and managed all northwestern region license agreements. Advised Sales, Business Development and Marketing on general legal and contractual issues.

Santa Clara County Office of the Public Defender, San Jose, CA
Deputy Attorney I 9/1998 – 1/2000
Represented clients in misdemeanor jury trials, court trials, pretrial hearings and various pretrial motions including motions to suppress and motions for dismissal. Represented minors in Juvenile court proceedings including felony bench trials, detention hearings, uncontested hearings and contested jurisdictional and dispositional hearings.

Dependency Legal Services, San Jose, CA 1/1998 - 9/1998
Staff Attorney
Represented parents in juvenile dependency contested bench trials and uncontested hearings including jurisdictional/dispositional trials, termination of services trials, termination of parental rights trials, detention hearings, and review hearings. Caseload of over 500 clients.

ACTIVITES

Los Altos Stage Company 2024 - Present
Board of Directors
Member of the Board of Director of nonprofit organization whose mission it is to present theater that celebrates the rich diversity of American art and culture, and to foster an enduring commitment to the performing arts and artists. Chair, Nominating and Governance Committee.

Vice President and Treasurer, Board of Directors, Fresh Lifelines for Youth 2012 - 2016
Secretary, Board of Directors 2010 - 2012
President, Board of Directors 2001-2007
Founding board member of nonprofit organization serving at-risk youth through legal education, mentorship and peer leadership. Worked to successfully develop the organization from one-person staff with 25 clients operating on a $35,000 budget, to a 26 person staff with 1000 clients operating on a $1.3M budget in the period of 10 years.

PUBLICATION

Rethinking the Role of Corporate Counsel, ACC Docket volume 30 No.2 (Mar. 2012): 20-36 Copyright 2012, the Association of Corporate Counsel. (co-authored)

Searching for the Perfect Solution: International Dispute Resolutions and the New World Trade Organization, 20 Hastings International and Comparative Law Review (Winter 1996), *reprinted in* INTERNATIONAL BUSINESS TRANSACTIONS READER 663-5, Spring 1997.

AWARDS

NetScout Systems Inc. President's Club for Outstanding Achievement, 2010, 2014, 2016, 2018, 2022, 2023, 2025
Network General President's Club for Outstanding Achievement, 2006, 2007
Aspect President's Club for Outstanding Achievement, 2001-2003

From: El Camino Health
To: ECH Board Recruitment
Subject: New Submission: Call for Applications - Governance Committee Member
Date: Thursday, November 27, 2025 2:02:17 PM

Submitted on Thu, 11/27/2025 - 02:01 PM

Submitted by: Anonymous

Submitted values are:

Full Name
Douglas G. Scrivnere

Residence Address
[redacted] Los Altos Hills, CA 94022

Email Address
[redacted]

Phone Number:
[redacted]

a) Board Governance. Ability to guide and uphold effective governance practices, ensuring the board fulfills its legal, ethical, and functional responsibilities. Experience in developing, reviewing, and implementing governance policies and procedures, as well as evaluating board effectiveness and supporting board recruitment, orientation, and development.
I have extensive experience in the corporate world (as GC of Accenture in its first 10 years as a public company) in governance and board issues, playing a key role in defining the governance model in 2001 and supporting the board and key committees in initial years, which corresponded with passage of Sarbanes-Oxley. At the University of Denver, I was a key player in significant governance work, which included adoption of term limits, board assessment and other changes. As Chair, I led an effort to redefine the committee structure. Active in all my non-profit work with recruiting and assessment new members.

b) Organizational Leadership. Experience in organizational leadership, with the ability to provide strategic direction, foster a culture of accountability, and drive organizational performance.
As GC and Compliance Officer at Accenture, I was the architect of the ethics and compliance program, and key author of its Code of Business Ethics and various training and communication programs. Served as a member of senior leadership of a multi-billion dollar global business. Initiated and implemented a strategic patent and intellectual property program. Our lawyers were critical team members in acquiring new clients and projects, as

well as definition of new product and service lines.

c) Healthcare Executive Leadership. Experience in executive leadership roles within the healthcare sector, with a comprehensive understanding of healthcare systems, regulatory environments, and industry trends.
No direct health care experience but supported the service line in Accenture and have learned much through my association with El Camino, PAMF and Gladstone Institutes.

Critical Characteristics
My leadership efforts within Accenture as General Counsel to totally successfully recast itself from a private partnership into corporate form (including entity changes in 50 countries) on a global basis, rebrand from Andersen Consulting to Accenture in 4.5 months, a successful IPO in 2001 and seamless transformation into a leading global corporation called upon all the attributes listed above!

a) Do you have any other skills, qualifications, or subject matter expertise that you believe would be an asset to the Committee? If so, please describe.
In virtually every organization I have been involved with I have been asked to take on significant leadership roles, reflecting on my skills, character and commitment to those organizations and their missions. After only 5 years on the University of Denver board, I was asked to stand for, and was elected Chair-Elect (a new position that resulted from the governance work mentioned above) and then Chair for 4 years, the first non-Denver-based Chair in the history of DU to that point.

5. Are there any civil, employment-related, or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigation for business or healthcare related issues (e.g. OIG)? (Note: Disclosure of a civil, employment-related, criminal incident (s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe with be taken into consideration.)

None.

6. Are you able to make the necessary time commitment and in person attendance as laid out in the position description?

Yes.

7. Describe any potential conflict of interest with any of your other commitments or activities? If none, please indicate.

I serve on the Community Board of Trustees of PAMF (an advisory, community role, not a governance role). I would be prepared to step off that board if it is concluded that this would constitute a conflict of interest.

8. The El Camino Health Governance Committee Member position is non-compensated (i.e. volunteer) and has a three-year renewable term. Is this acceptable?

Yes.

9. Please specify how you found out about this position.

I initially saw an ad in the Palo Alto Weekly but have been involved with El Camino for many years and know several board members as well as senior leadership.

10. Why are you interested in being considered for the Governance Committee Member position with El Camino Health?

El Camino Health is a very special place and both my wife and I have been involved with the Foundation and its activities for many years. It was one of the truly impactful organizations serving our community. Given my background and experience, I think I can make a significant contribution in this role.

Upload CV and optionally professional references as Word or PDF files

- Scrivner CV 2025.pdf

DOUGLAS G. SCRIVNER

An active non-profit board member and leader, with emphasis on philanthropy and governance. A savvy, creative, business-oriented lawyer, who built an award-winning global legal department of 420 professionals in 35 countries from scratch, created a world-class ethics and compliance program, and helped guide Accenture through its arbitration with Arthur Andersen, its corporate reorganization and rebranding, its IPO and becoming a leading, mature public company on a global scale.

Professional Experience:

Accenture (San Jose and Palo Alto, CA 1996-2011; Chicago, IL, 1980-1996):

1996 to 2010, General Counsel & Secretary, and Compliance Officer (2001-2010) (also oversaw Government Relations [2002-2010] and Insurance, Security and Contract Management at various times; de facto chief corporate governance officer, primary support to Nominating & Governance and Audit Committees of the Board)

1990 to 1996, Associate General Counsel, Andersen Worldwide (de facto Andersen Consulting GC)

1980 to 1990, Counsel (made partner in 1986)

Oppenheimer Wolf & Donnelly (Minneapolis and St. Paul, MN):

1977-1979, Associate attorney

Education:

JD, 1977, University of Denver Sturm College of Law; Order of St. Ives and Editor-in-Chief, Denver Journal of International Law & Policy

MSc, 1974, London School of Economics, International Relations

AB, 1973, Duke University, Political Science and History

DOUGLAS G. SCRIVNER

Charitable and Professional Leadership:

University of Denver, Denver, CO:

Board of Trustees (2008 to present), Chair of the Board (2014-2018); Chair Emeritus (2018-present); Chair-Elect (2013-2014); Chair, University Advancement Committee (2010-2014); Chair, Nominating & Governance Committee (2018-2021); member, Audit, Advancement, Technology Futures, Faculty and Educational Affairs and other Committees

Co-chair, The Denver Difference campaign (2023-present), DU's $1 Billion fundraising campaign

Visiting Committee, Sturm College of Law (1999-2005), including Chair (2002-2005)

National Co-Chair, Second Century Campaign, Sturm College of Law (2002-2003)

Board of Advisors, Educating Tomorrow's Lawyers, SCOL and IAALS (2011 to 2020)

Executive Committee, Institute for the Advancement of the American Legal System (2014-present) and the Institute for Philanthropy and Social Enterprise (2014-2017), University of Denver

Chair, various DU search committees, including Chancellor search in 2014, Law Dean in 2016, General Counsel in 2022 , and member of other search committees

Adjunct Professor, Sturm College of Law, (occasional): Taught course in Corporate Governance, Risk & Compliance (2012, 2013, 2016); occasional guest speaker on governance, compliance and related issues at Daniels College of Business, University of Denver

Duke University, Durham, N.C.:

Sanford School of Public Policy, Board of Visitors (1991-2001, and 2007-2024); designated Emeritus in 2024); Co-Chair, Sanford Campaign Steering Committee in Duke Forward campaign (2014-2020)

Arts & Sciences Campaign Committee (2001-2005)

Gladstone Institutes, San Francisco:

Board of Directors, Gladstone Foundation (2010-present), Nominating Committee, Chair (2012-present)

Hoover Institution, Stanford, CA:

Member, Board of Overseers (2018-present); chair, Development Committee (2021-2025); member, Executive (2021-2025), Development, Nominating, and Finance Committees, Volker Fund Investment Committee

DOUGLAS G. SCRIVNER

Palo Alto Medical Foundation, Palo Alto, CA:

Member, Community Board of Trustees (2021-present)

El Camino Health, Mountain View, CA:

Member, Philanthropy Council, Mental Health & Addiction Services (2023-present)

AWARDS:

Corporate:

Employer of Choice Award, Minority Corporate Counsel Association, 2006 and 2009

Runner-up (to GE), Best Law Department, Corporate Counsel magazine, 2007

Top 10 Most Innovative Law Departments, Corporate Legal Times magazine, 2004 and 2009

World's Most Ethical Companies, Ethisphere Magazine, 2008, 2009 and 2010 (continuing to present)

Personal:

Thompson Marsh Award, U. of Denver Sturm College of Law, 2006 (for outstanding accomplishments)

John Evans Award, U. of Denver, 2012 (then highest alumni award of the University)

University of Denver Founders Award (with wife, Mary), 2025 (currently highest award of the University)

AREAS OF EXPERTISE:

Corporate and Non-profit Governance

Ethics and Compliance, Regulatory Matters

Global operations

Government Affairs and Public Policy Matters

Internal Start-ups and Innovation

M&A

Litigation and Risk Management

ERM, Internal controls (including Sox 404) and auditor relations

IP Strategy and Management

Non-profit Fundraising

[redacted]

Rev 11/27/25

El Camino Health

BOARD OF DIRECTORS
Policies for Approval
Full Summaries are in the
Policy Appendix
February 11, 2026

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Foundation	Endowed Fund Policy	9-1-22	N/A	Major	Policy	• All sections updated Finance Committee > Executive Committee. Foundation Board > ePolicy > Board

POLICY SUMMARY: Establishes the governance, investment, spending, and management framework for El Camino Health Foundation endowed funds to ensure donor intent, long-term capital preservation, and responsible use of earnings.

SUMMARY OF CHANGES: Policy was comprehensively updated and reorganized to clarify governance, fiduciary oversight, and operational processes for endowed funds.
Definitions, eligibility thresholds, investment treatment, spending methodology, and internal controls were refined and aligned across El Camino Health and the Foundation.
Roles and approval authorities (Foundation Board, Finance Committee, Allocations Committee, executives, and service line managers) were more clearly defined.
Administrative processes for fund setup, reporting, spending approvals, and exception handling were standardized.
Minor edits were made to improve clarity and consistency; no change to the fundamental purpose of endowed funds.

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Patient Accounts	Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)	4-1-00	2-5-25	Major	Policy	• All sections updated Asst VP > CFO > ePolicy > Board

POLICY SUMMARY: Defines El Camino Health's financial assistance and charity care program, including eligibility criteria, application and review procedures, and patient protections, in compliance with state and federal requirements to ensure access to medically necessary care regardless of ability to pay.

SUMMARY OF CHANGES: The policy was comprehensively updated and reorganized to align with current federal and California statutory and regulatory requirements related to charity care, discounted payment, and medical debt protections. Eligibility criteria, income definitions, and treatment of patients with high medical costs (up to 400% of the Federal Poverty Level) were clarified and standardized. Application, review, presumptive and circumstantial eligibility processes were clarified, including timelines, documentation standards, and appeal rights. Patient protections were strengthened, including limitations on collections activity, credit reporting prohibitions, refund requirements, and amounts generally billed (AGB) calculations. Administrative roles, approval authorities, and documentation requirements were clarified to support consistent and compliant implementation.

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Patient	Scope of Service – Interventional	N/A	N/A	New	Scope	• New document

Care Services	Services – Los Gatos				of Service	HVI > Med Dept Exec > Surgery > ePolicy > MEC > Board

POLICY SUMMARY: Defines the scope, level, and limitations of interventional services provided at the Los Gatos campus, including cardiac diagnostic and interventional procedures and interventional radiology services, to ensure services are delivered safely, appropriately, and in alignment with clinical standards and regulatory requirements.

SUMMARY OF CHANGES: This is a new Scope of Service document that formally establishes the services provided by the Los Gatos Interventional Services lab as a Level 1 cardiac catheterization lab without on-site cardiac surgery. The document defines eligible procedures, patient selection criteria, exclusion criteria for high-risk cases, transfer protocols to the Mountain View campus, staffing and skill mix requirements, and applicable clinical standards and oversight mechanisms to support safe and appropriate care delivery.

Patient Care Services	A14b4. Perioperative Services – Los Gatos	10-1-15	2-5-25	Minor	Scope of Service	• Staffing/Skill Mix section updated Med Dir | Dept Dir > ePolicy > MEC > Board

POLICY SUMMARY: Defines the scope, organization, staffing, and standards of care for perioperative services at the Los Gatos campus, including outpatient surgery, short stay, post-anesthesia care, operating room, and central sterile processing, to ensure safe, coordinated, and compliant surgical services delivery.

SUMMARY OF CHANGES: This Scope of Service document was updated to revise the staffing and skill mix section while maintaining the existing scope, service lines, and level of care provided at the Los Gatos campus. The update clarifies roles, staffing requirements, and competency expectations across perioperative units to support safe operations and alignment with regulatory and accreditation standards. No expansion of services or change in clinical scope is proposed.

Acute Rehab Unit	Scope of Service – Acute Rehab Center	5-1-2010	9-14-22	Unchanged	Scope of Service	• Unchanged ePolicy > MEC > Board

POLICY SUMMARY: Defines the scope, philosophy, patient population, and interdisciplinary rehabilitation services provided at the Acute Rehab Center to support medically necessary inpatient rehabilitation and successful reintegration of patients into the community, in compliance with applicable regulatory and accreditation standards.

SUMMARY OF CHANGES: This Scope of Service document remains unchanged. The content continues to describe the inpatient rehabilitation services provided to adult and geriatric patients, including patient eligibility, assessment processes, interdisciplinary care delivery, staffing availability, family involvement, discharge planning, and applicable standards of practice. No changes to services, patient population, or level of care are proposed.

Security	Workplace Violence Prevention	5-1-18	11-20-24	Minor	Plan	• ECH Plan section updated

Management	Plan					Central Safety > PESC > ePolicy > MEC > Board

POLICY SUMMARY: Establishes El Camino Health's Workplace Violence Prevention Plan in compliance with Cal/OSHA Title 8, Section 3342, defining prevention, reporting, training, response, and oversight requirements to protect employees, physicians, patients, visitors, and others on hospital premises from acts or threats of workplace violence.

SUMMARY OF CHANGES: The Workplace Violence Prevention Plan was comprehensively updated to align with current Cal/OSHA regulatory requirements for healthcare settings. Updates clarify required plan elements, definitions, roles and accountability, employee engagement, training requirements, reporting and investigation processes, environmental and patient-specific risk assessments, corrective action timelines, and post-incident response and review. The plan reinforces zero tolerance for workplace violence and integrates the required annual review and documentation processes. No change to the scope of coverage or regulatory intent is proposed.

Pharmacy	MERP – Medication Error Reduction Plan	11-1-20	12-11-24	Unchanged	Plan	• FY26 Plan in Attachments section Med Safety > P&T > ePolicy > MEC > Board

POLICY SUMMARY: Establishes El Camino Health's Medication Error Reduction Plan (MERP) in compliance with California Health and Safety Code requirements, defining the governance structure, reporting processes, and continuous improvement framework used to prevent, identify, analyze, and reduce medication-related errors across inpatient settings.

SUMMARY OF CHANGES: The Medication Error Reduction Plan was reviewed and updated to reflect current practices, committee structures, and reporting processes supporting medication safety across El Camino Health. The plan continues to address the required eleven medication-use elements, outlines multidisciplinary oversight and reporting pathways, and incorporates ongoing monitoring, non-punitive reporting, external safety alerts, and annual evaluation to support continuous improvement and regulatory compliance. No change to the statutory purpose or scope of the plan is proposed.

El Camino Health

BOARD OF DIRECTORS
Policies for Approval
Full Summaries are in the
Policy Appendix
March 18, 2026

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Risk Management & Patient Safety	**FY2026 Patient Safety Plan**	9-1-25	N/A	New	Plan	• Published and active; memorandum signed. PESC > Quality Council > ePolicy > MEC > Quality Committee > Board

POLICY SUMMARY: Establishes El Camino Health's enterprise Patient Safety Plan, outlining the organizational framework, governance oversight, and systemwide approach used to promote a culture of safety, prevent harm, and continuously improve quality and patient outcomes across all care settings. The plan aligns patient safety activities with the organization's strategic priorities, regulatory requirements, and high-reliability principles supporting the Mission Zero goal of eliminating preventable harm.

SUMMARY OF CHANGES: This annual Patient Safety Plan formalizes the organization's ongoing patient safety program and governance structure. Key elements include:

- Reinforces the **Safety First/Mission Zero** high-reliability framework and organizational safety culture expectations.
- Clarifies Board and Quality Committee oversight responsibilities for patient safety performance and reporting.
- Updates organizational structures supporting safety oversight, including enterprise committees, leadership accountability, and multidisciplinary review processes.
- Strengthens emphasis on non-punitive reporting, root cause analysis, and system-based improvement approaches.
- Aligns safety priorities, performance monitoring, and education initiatives with current regulatory, accreditation, and strategic requirements.

No change to the fundamental purpose of the Patient Safety Program; updates reflect annual review, organizational alignment, and continued regulatory compliance.

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Revenue Integrity	**Hospital Pricing and Chargemaster Policy**	3-1-11	4-7-21	Minor	Policy	• Minor update CFO > ePolicy > Board

POLICY SUMMARY: Establishes the framework governing El Camino Health's hospital pricing structure and chargemaster management to ensure charges are consistently related to the cost of care, applied uniformly across revenue-generating departments, and compliant with applicable billing, coding, and regulatory requirements. The policy defines controls and procedures for establishing, modifying, and maintaining charges for services, supplies, medications, and ancillary services.

SUMMARY OF CHANGES: The policy was reviewed and updated to clarify governance and operational controls supporting chargemaster integrity and regulatory compliance. Key updates include:

- Clarifies organizational oversight and approval processes for pricing updates and chargemaster maintenance.
- Reinforces requirements that charges remain reasonably related to cost and consistent across services.
- Updates procedures governing addition, modification, or removal of clinical services, supplies, and medications.

- Aligns policy language with current billing regulations and revenue integrity practices.
- Minor revisions to coverage and administrative language to improve clarity and consistency.

No change to the fundamental purpose of the policy or Board approval authority for annual pricing adjustments through the operating budget process.

Patient Accounts	**Uninsured Patient Discount Policy**	4-1-22	N/A	Minor	Policy	• Minor update (Coverage) CFO > ePolicy > Board

POLICY SUMMARY: Establishes El Camino Health's guidelines for providing standardized hospital charge discounts to uninsured patients to support access to medically necessary care while promoting responsible stewardship of organizational resources. The policy defines eligibility criteria, discount structure, and administrative processes governing uninsured patient billing and financial responsibility.

SUMMARY OF CHANGES: The policy was reviewed and updated to clarify eligibility requirements and administrative processes supporting consistent application of uninsured patient discounts. Key updates include:

- Clarifies eligibility definitions and applicability of uninsured discounts for hospital-billed services.
- Confirms standardized uninsured discount methodology applied to qualifying self-pay patients.
- Aligns policy language with related Financial Assistance and charity care policies to ensure consistent patient financial protections.
- Updates administrative procedures addressing insurance status changes and documentation requirements.
- Minor revisions to coverage language and approval workflow for clarity and consistency.

No change to the underlying purpose of providing discounted access to care for uninsured patients or to Board-established discount guidelines.

Utility Management	**Physical Environment Utility Management Plan**	2-1-18	2-5-25	Minor	Plan	• Minor update (Formatting, Reference Pes/Eps) Central Safety > PESC > ePolicy > MEC > Board

POLICY SUMMARY: Establishes El Camino Health's Utility Management Plan, defining the governance framework, oversight structure, and operational processes used to ensure the reliability, safety, and regulatory compliance of critical utility systems supporting patient care environments across all hospital campuses and outpatient facilities. The plan supports a safe physical environment by managing risks associated with electrical systems, medical gases, water systems, HVAC, communications, and emergency power infrastructure.

SUMMARY OF CHANGES: The plan was reviewed and updated as part of the annual Environment of Care program evaluation and to align with current regulatory and accreditation standards. Key updates include:

- Updates to reflect **current Joint Commission standards effective January 2026**.
- Clarifies program objectives, performance indicators, and oversight responsibilities for utility system management.
- Enhances monitoring and reporting processes related to system reliability, risk assessment, and incident review.
- Updates performance improvement goals related to staff awareness of emergency power systems and medical gas controls.
- Refines roles and coordination among Facilities Engineering, Environmental Health & Safety, and Central Safety Committee oversight.

No change to the overall scope or purpose of the Utility Management Program; updates reflect regulatory alignment and continuous improvement of the Environment of Care framework.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Raju Iyer, CFO
Date: March 18, 2026
Subject: Financials: FY2026 – Period 7 (January 2026) & YTD FY2026 (as of 1/31/2026)

Purpose: To provide the Board with an overview of financial performance for FY2026 Period 7 (January 2026) and Year-to-Date FY2026 results through January 31, 2026.

Summary: Year-to-date financial performance through January remains favorable to budget across key operating metrics.

Key Highlights

Operating EBIDA: $169.0M YTD, approximately $20M favorable to budget
Operating Margin: $109.6M YTD, $22M favorable to budget and $8.8M above prior year
Drivers: Strong activity in interventional and outpatient surgical services and continued labor productivity and expense management
January Results: Operating EBIDA of $17M, approximately $4M unfavorable to budget, reflecting slightly lower hospital activity relative to budget and timing-related expense impacts

Despite the January variance, overall year-to-date operating performance remains strong.

Additional detail regarding financial performance, operating drivers, and key operational metrics is included in the attached presentation.

Recommendation: This item is presented for information only. Consistent with our existing process, approval is requested only for quarterly and annual financial results.

List of Attachments:

1. Presentation: Period 7 & YTD FY2026 financials

El Camino Health

Summary of Financial Operations

Fiscal Year 2026 – Period 7

7/1/2025 to 01/31/2026

Financial Overview: YTD FY2026 (as of 1/31/2026)

Consolidated Financial Performance

- Operating EBIDA is $169.0 / 15.7% compared to the budget of $149.3 / 14.1% and $9.0M / 5.6% above prior year.
- Operating margin is $109.6M / 10.2% compared to the budget of $87.6M / 8.3% and $8.8M / 8.7% above prior year.
- Operating expense is $5.7M / 0.6% favorable to budget.
  - When adjusted for volume levels, Operating Expense per CMI Adjusted Discharge is $20,739 which is 4.5% favorable to budget.
    - **Note: Excludes depreciation and interest expense**
- Key operating drivers:
  - Year-over-year operating margin is $8.8M / 8.7% above the same period last year:
  - Favorable:
    - Continued strength in Interventional Services (12.9% fav to prior year), Outpatient Surgical Services (7.1% fav to prior year), and Outpatient Endoscopy Services (6.0% fav to prior year).
    - Expense management – Continued favorability in Labor Productivity and Premium Time.
  - Unfavorable
    - Continued shift to Governmental Payors although January was favorable
- Year-over-year net margin is $63.2M / 33.7% higher than the same period last year.

Operational / Financial Results: YTD FY2026 (as of 01/31/2026)

($ 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	305	309	(4)	(1.1%)	310	(5)	(1.6%)	---	---	---	---
	Adjusted Discharges	27,151	26,429	722	2.7%	25,982	1,169	4.5%	---	---	---	---
	OP Visits / OP Procedural Cases	98,556	91,000	7,556	8.3%	88,670	9,886	11.1%	---	---	---	---
	Percent Government (%)	59.0%	58.6%	0.4%	0.7%	59.0%	(0.0%)	(0.1%)	---	---	---	---
	Gross Charges ($)	4,749,382	4,567,315	182,067	4.0%	4,246,882	502,500	11.8%	---	---	---	---
Operations	Cost Per CMI AD	20,739	21,724	(985)	(4.5%)	19,841	898	4.5%	---	---	---	---
	Net Days in A/R	49.6	54.0	(4.4)	(8.1%)	50.0	(0.4)	(0.8%)	47.5	47.4	47.8	
Financial Performance	Net Patient Revenue ($)	1,038,526	1,017,788	20,738	2.0%	950,675	87,852	9.2%	2,541,316	4,686,044	---	
	Total Operating Revenue ($)	1,073,918	1,057,579	16,339	1.5%	990,822	83,096	8.4%	2,999,271	4,883,072	2,578,858	
	Operating Margin ($)	**109,610**	**87,558**	**22,052**	25.2%	**100,802**	**8,809**	8.7%	**59,985**	**170,908**	**87,681**	
	Operating EBIDA ($)	**169,012**	**149,272**	**19,740**	13.2%	**159,994**	**9,018**	5.6%	**173,958**	**395,529**	**219,203**	
	Net Income ($)	251,005	122,116	128,889	105.5%	187,761	63,244	33.7%	164,960	380,880	144,416	
	Operating Margin (%)	**10.2%**	**8.3%**	**1.9%**	23.3%	**10.2%**	**0.0%**	0.3%	**2.0%**	**3.5%**	**3.4%**	
	Operating EBIDA (%)	**15.7%**	**14.1%**	**1.6%**	11.5%	**16.1%**	**(0.4%)**	(2.5%)	**5.8%**	**8.1%**	**8.5%**	
	DCOH (days)	338	275	63	22.9%	277	61	22.1%	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; July 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.

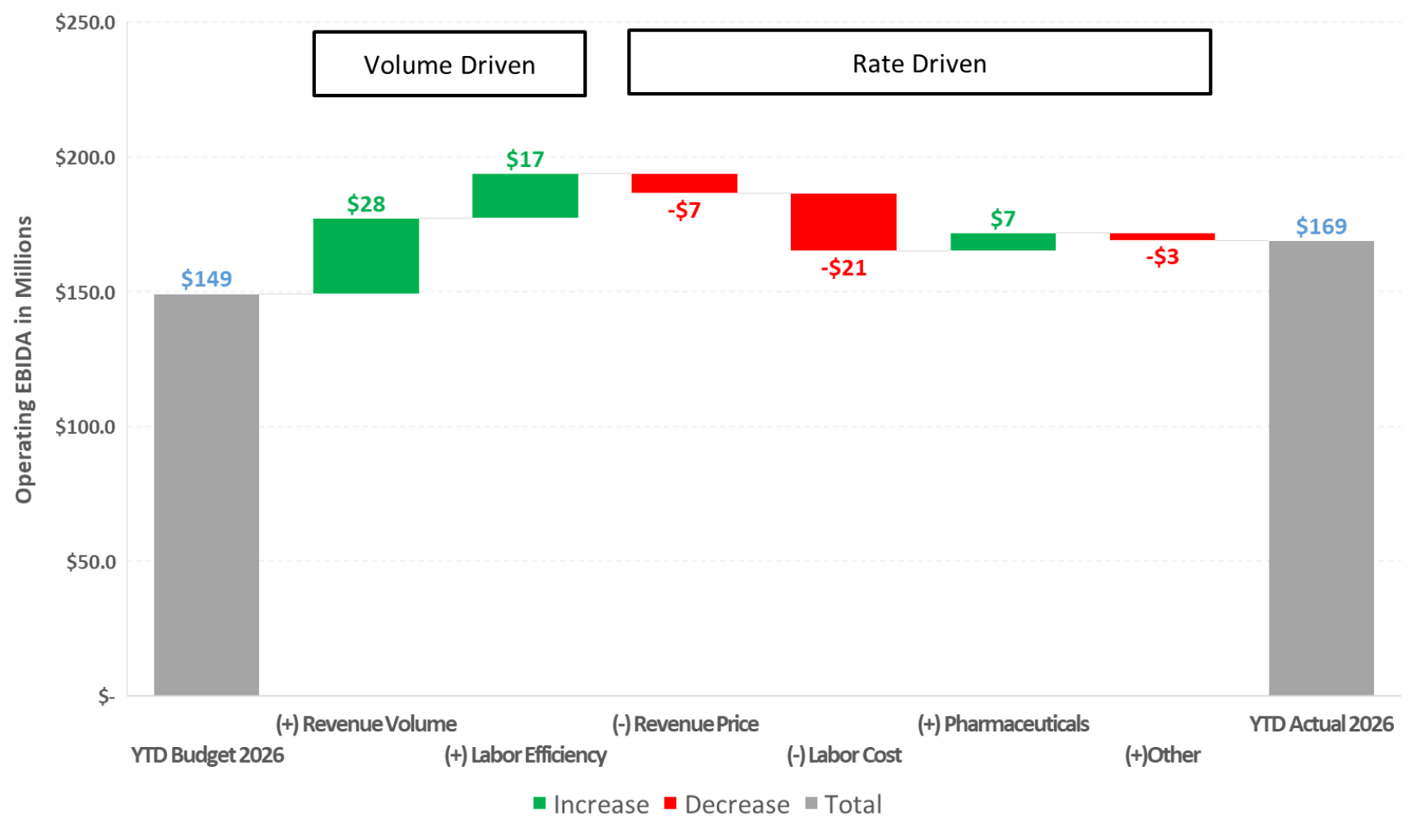
El Camino Health

Unfavorable Variance < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

FY2026 YTD P7: Factors driving favorable Operating EBIDA

(Dollars in Millions)

$169M (actual) vs. $149 (budget) = $20M / 13.2% favorable to budget



- **Revenue:**
  - Price: Change in IP/OP mix vs budgeted resulted in lower Revenue per Adjusted Discharge
  - Volume impact: Driven by 2.8% favorability to budget in hospital activity.
- **Labor:**
  - Efficiency: Consistent favorable performance versus volume adjusted budgeted productivity targets.
  - Cost impact: Cost per FTE above budget by 4%
- **Pharmaceuticals:** FY26 Budget was increased to account for specialty drugs used in new clinics. Utilization shifts, cost savings initiatives, and improved contracting has produced favorable results.

Operational / Financial Results: Period 7 – January 2026 (as of 01/31/2026)

($ 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	333	325	8	2.5%	326	7	2.1%	---	---	---	---
	Adjusted Discharges	3,835	3,885	(50)	(1.3%)	3,744	91	2.4%	---	---	---	---
	OP Visits / OP Procedural Cases	13,864	12,848	1,016	7.9%	13,147	717	5.5%	---	---	---	---
	Percent Government (%)	60.9%	59.1%	1.9%	3.1%	62.5%	(1.6%)	(2.6%)	---	---	---	---
	Gross Charges ($)	687,632	668,008	19,623	2.9%	627,446	60,185	9.6%	---	---	---	---
Operations	Cost Per CMI AD	22,281	21,724	557	2.6%	19,749	2,532	12.8%	---	---	---	---
	Net Days in A/R	49.6	54.0	(4.4)	(8.1%)	50.0	(0.4)	(0.8%)	47.5	49.7	47.8	
Financial Performance	Net Patient Revenue ($)	150,535	150,506	28	0.0%	137,401	13,134	9.6%	363,045	669,435	---	
	Total Operating Revenue ($)	155,982	156,256	(275)	(0.2%)	143,884	12,098	8.4%	428,467	697,582	368,408	
	Operating Margin ($)	**9,329**	**13,015**	**(3,686)**	(28.3%)	**15,724**	**(6,395)**	(40.7%)	**8,569**	**24,415**	**12,526**	
	Operating EBIDA ($)	**17,413**	**21,494**	**(4,082)**	(19.0%)	**24,657**	**(7,244)**	(29.4%)	**24,851**	**56,504**	**31,315**	
	Net Income ($)	23,050	16,599	6,452	38.9%	30,357	(7,306)	(24.1%)	23,566	54,411	20,631	
	Operating Margin (%)	**6.0%**	**8.3%**	**(2.3%)**	(28.2%)	**10.9%**	**(4.9%)**	(45.3%)	**2.0%**	**3.5%**	**3.4%**	
	Operating EBIDA (%)	**11.2%**	**13.8%**	**(2.6%)**	(18.8%)	**17.1%**	**(6.0%)**	(34.9%)	**5.8%**	**8.1%**	**8.5%**	
	DCOH (days)	338	275	63	22.9%	277	61	22.1%	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.
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Notes: DCOH total includes cash, short-term and long-term investments.
OP Visits / Procedural Cases includes Covid Vaccinations / Testing.

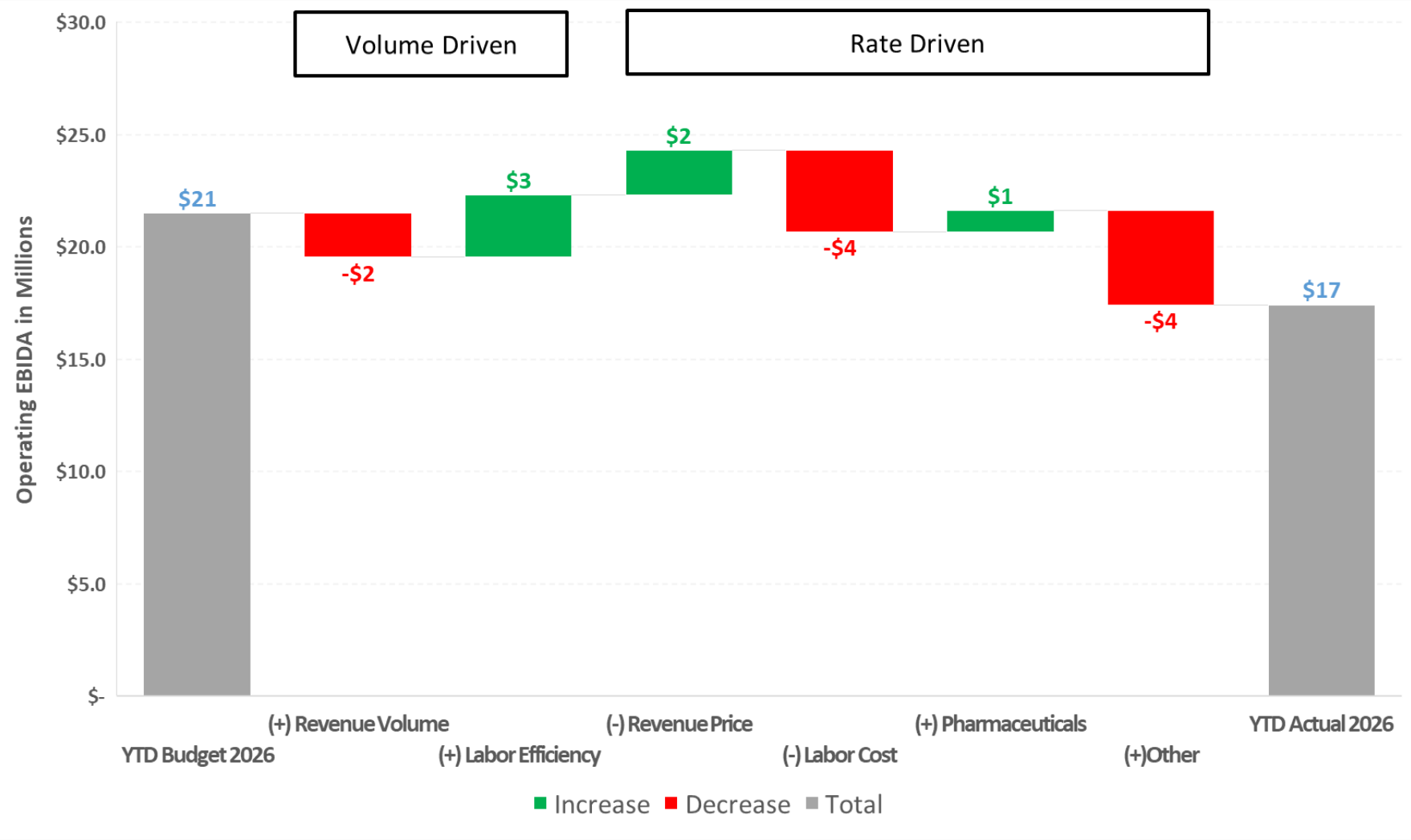
El Camino Health

Unfavorable Variance < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

FY2026 P7: Factors driving favorable Operating EBIDA

(Dollars in Millions)

$17M (actual) vs. $21 (budget) = $-4M / -19.0% unfavorable to budget



- **Revenue:**
  - Price : More balanced IP/OP activity drove the lower variance, still favorable.
  - Volume impact: Jan hospital activity 1% below budget.
- **Labor:**
  - Efficiency: Consistent favorable performance versus volume adjusted budgeted productivity targets.
  - Cost impact: Cost per FTE above budget by 4%
- **Other:**
  - Reclass of expense from S&W to Professional Fees.
  - Timing of expenses in the Repairs & Maintenance category.

El Camino Health

EL CAMINO HOSPITAL BOARD
FY2026 PACING PLAN / MASTER CALENDAR

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
APPROVALS AND CONSENT CALENDAR												
Board Minutes		✓	✓	✓	✓	✓		✓	✓		✓	✓
Committee Reports and Recommendations		✓	✓	✓	✓	✓		✓	✓		✓	✓
Community Benefit Plan												✓
Credentialing and Privileges Report		✓	✓	✓	✓	✓		✓	✓		✓	✓
Physician Agreements		✓	✓	✓	✓	✓		✓	✓		✓	✓
Policies		✓	✓	✓	✓	✓		✓	✓		✓	✓
FINANCE												
Audited Financial Report				✓								
Budget (Preview)											✓	
Budget Approval												✓
Period Financials (Consent)		✓	✓	✓	✓	✓		✓	✓		✓	✓
Quarterly Financials (Focus)					✓			✓			✓	
PHYSICIANS AND MEDICAL NETWORK												
ECHMN Report			✓								✓	
Medical Staff Report			✓		✓			✓			✓	
QUALITY												
Quality STEEEP Dashboard			✓		✓			✓			✓	
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 -Annual Patient Safety and Claims/Liabilities Report (from CAC)					✓							
Enterprise Risk Management											✓	✓
Board Assessment Results				✓								
Board Officer Elections (*Even Years*)												✓
Board Calendar												
Committee Goals												✓

Updated 09/30/2025

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT | March 18, 2026

This report highlights key developments, achievements, and organizational performance updates.

FINANCIALS

Financial performance through January (FY2026 Period 7) remains strong and continues to exceed budget expectations across key operating metrics. Year-to-date operating EBIDA reached $169.0 million, approximately $20 million above budget, while operating margin totaled $109.6 million, $22 million favorable to budget and $8.8 million higher than the same period last year. Performance continues to be supported by strong activity in interventional and outpatient surgical services, as well as sustained discipline in labor productivity and expense management. While the organization continues to experience a gradual shift toward governmental payors, overall operating expense remains favorable to budget, and net margin is $63.2 million higher than the prior year.

ACCOLADES AND RECOGNITION

Women Health Care Executives NorCal has announced **Deb Muro** as the **WHCE 2026 Innovation Leader of the Year**, recognizing her as a visionary executive who is redefining how technology advances patient care. This recognition is reserved for leaders whose work has demonstrably strengthened healthcare through transformative innovation and measurable enterprise impact. They will be honoring her at the upcoming Women of the Year Gala on April 25. WHCE is a Northern California organization dedicated to advancing women in healthcare through leadership, connection, and service across our region.

Congratulations to **Tracey Lewis Taylor**, who was named a **YWCA Golden Gate Silicon Valley 2026 Tribute to Women Awards Honoree**. The annual celebration recognizes exceptional women leaders whose work advances inclusion, integrity, and empowerment throughout the Bay Area and beyond. This year's awards ceremony will take place on April 30 in Santa Clara.

El Camino Health has been named one of the World's Best Hospitals 2026 by Newsweek. **El Camino Health's Mountain View hospital ranked #97 nationally and #15 in California**, highlighting its world-class care, advanced medical technology, and exceptional patient outcomes.

The annual list evaluates hospitals across 32 countries. The ranking is based on four rigorous data sources:

- Recommendations from medical experts (doctors, hospital managers, and healthcare professionals)
- Hospital quality metrics
- Patient experience data
- Implementation of Patient-Reported Outcome Measures (PROMs)

El Camino Health

MARKETING AND COMMUNICATIONS

The marketing and communications team advanced the promotion and registration support for the 15th annual Heart Forum, our hallmark community event, concluded with a new attendance record. Our signature Earthquakes soccer partnership started a new season and continued to elevate visibility of the El Camino Health brand through in-stadium media, radio ads and social media. Planning continued with KTSF on a second season of the award-winning healthcare series featuring El Camino Health. The program, one of the highest-rated shows on the Chinese-language channel, is being produced during the third and fourth quarters of FY26.

Content marketing efforts included the HealthPerks newsletter with new blog articles and ongoing physician profile videos. External communications secured prominent media coverage in Forbes, Runner's World and Becker's Hospital Review. Internal communications supported executive messaging, major events including kickoff planning for the Spring Town Hall, and operational updates, with weekly newsletters and our intranet maintaining strong engagement.

Additional accomplishments included supporting key sponsorships, upgrading digital signage and advancing market research initiatives, all contributing to enhanced visibility, engagement and brand consistency for El Camino Health.

CORPORATE HEALTH

Corporate Health and community programs continue to expand engagement with both employer partners and the broader community. **Concern** has strengthened relationships with major employer clients through a **new executive outreach process** led by Cecile Currier, creating opportunities to gather feedback and better align services with employer needs; participating organizations consistently describe Concern as highly responsive, innovative in its outreach, and a trusted clinical resource. The **Chinese Health Initiative** launched a new **emotional well-being webinar series**, *How Not to Get Swept In — Finding Your Own Rhythm at Different Stages of Life*, with its Wednesday Lunch Chat already drawing 97 registrations, and partnered with the City of Mountain View to provide outreach at the Lunar New Year celebration, engaging more than 150 community members. The **South Asian Heart Center** marked its 20th anniversary and was recognized by the El Camino Health District Board while continuing its prevention mission, engaging 171 participants in screening, education, and coaching programs and delivering 338 consultations along with 14 lifestyle workshops and health education events attended by 240 community members.

FOUNDATION

Philanthropic support for El Camino Health continues to progress strongly, with **$8.1 million raised through Period 8**—approximately **81% of the Foundation's $10.04 million FY26 fundraising goal**. A significant recent milestone was the announcement of the **Norma Melchor Nursing Excellence Endowment**, established by the Melchor family to support the ongoing professional development and advancement of El Camino Health nurses through education, certification, fellowships, and leadership opportunities.

The Foundation also hosted the **14th annual Norma's Literary Luncheon** in February, attended by approximately 180 supporters and featuring Pulitzer Prize finalist and New York Times bestselling author Karen Russell. Looking ahead, the **Foundation's Spring Benefit will take place June 2, 2026** at the Mountain View Center for the Performing Arts and will feature physician, author, and public health leader Atul Gawande as the keynote speaker.

AUXILIARY

In **January 2026**, Auxiliary volunteers contributed **4,242 hours** across the Mountain View and Los Gatos campuses, bringing the fiscal-year-to-date total to **33,585 hours**. Next month is Volunteer Month and we will be recognizing the Auxiliary and their valuable work with banners, balloons, and employee events.

El Camino Health

BOARD OF DIRECTORS
Policies for Approval
February 11, 2026

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Foundation	Endowed Fund Policy	9-1-22	N/A	Major	Policy	• All sections updated Finance Committee > Executive Committee. Foundation Board > ePolicy > Board
POLICY SUMMARY: Establishes the governance, investment, spending, and management framework for El Camino Health Foundation endowed funds to ensure donor intent, long-term capital preservation, and responsible use of earnings. **SUMMARY OF CHANGES**: Policy was comprehensively updated and reorganized to clarify governance, fiduciary oversight, and operational processes for endowed funds. Definitions, eligibility thresholds, investment treatment, spending methodology, and internal controls were refined and aligned across El Camino Health and the Foundation. Roles and approval authorities (Foundation Board, Finance Committee, Allocations Committee, executives, and service line managers) were more clearly defined. Administrative processes for fund setup, reporting, spending approvals, and exception handling were standardized. Minor edits were made to improve clarity and consistency; no change to the fundamental purpose of endowed funds.						
Patient Accounts	Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)	4-1-00	2-5-25	Major	Policy	• All sections updated Asst VP > CFO > ePolicy > Board
POLICY SUMMARY: Defines El Camino Health's financial assistance and charity care program, including eligibility criteria, application and review procedures, and patient protections, in compliance with state and federal requirements to ensure access to medically necessary care regardless of ability to pay. **SUMMARY OF CHANGES**: The policy was comprehensively updated and reorganized to align with current federal and California statutory and regulatory requirements related to charity care, discounted payment, and medical debt protections. Eligibility criteria, income definitions, and treatment of patients with high medical costs (up to 400% of the Federal Poverty Level) were clarified and standardized. Application, review, presumptive and circumstantial eligibility processes were clarified, including timelines, documentation standards, and appeal rights. Patient protections were strengthened, including limitations on collections activity, credit reporting prohibitions, refund requirements, and amounts generally billed (AGB) calculations. Administrative roles, approval authorities, and documentation requirements were clarified to support consistent and compliant implementation.						
Patient Care Services	Scope of Service – Interventional Services – Los Gatos	N/A	N/A	New	Scope of Service	• New document HVI > Med Dept Exec > Surgery > ePolicy > MEC > Board

POLICY SUMMARY: Defines the scope, level, and limitations of interventional services provided at the Los Gatos campus, including cardiac diagnostic and interventional procedures and interventional radiology services, to ensure services are delivered safely, appropriately, and in alignment with clinical standards and regulatory requirements.

SUMMARY OF CHANGES: This is a new Scope of Service document that formally establishes the services provided by the Los Gatos Interventional Services lab as a Level 1 cardiac catheterization lab without on-site cardiac surgery. The document defines eligible procedures, patient selection criteria, exclusion criteria for high-risk cases, transfer protocols to the Mountain View campus, staffing and skill mix requirements, and applicable clinical standards and oversight mechanisms to support safe and appropriate care delivery.

Patient Care Services	Perioperative Services – Los Gatos	10-1-15	2-5-25	Minor	Scope of Service	• Staffing/Skill Mix section updated Med Dir | Dept Dir > ePolicy > MEC > Board

POLICY SUMMARY: Defines the scope, organization, staffing, and standards of care for perioperative services at the Los Gatos campus, including outpatient surgery, short stay, post-anesthesia care, operating room, and central sterile processing, to ensure safe, coordinated, and compliant surgical services delivery.

SUMMARY OF CHANGES: This Scope of Service document was updated to revise the staffing and skill mix section while maintaining the existing scope, service lines, and level of care provided at the Los Gatos campus. The update clarifies roles, staffing requirements, and competency expectations across perioperative units to support safe operations and alignment with regulatory and accreditation standards. No expansion of services or change in clinical scope is proposed.

Acute Rehab Unit	Scope of Service – Acute Rehab Center	5-1-2010	9-14-22	Unchanged	Scope of Service	• Unchanged ePolicy > MEC > Board

POLICY SUMMARY: Defines the scope, philosophy, patient population, and interdisciplinary rehabilitation services provided at the Acute Rehab Center to support medically necessary inpatient rehabilitation and successful reintegration of patients into the community, in compliance with applicable regulatory and accreditation standards.

SUMMARY OF CHANGES: This Scope of Service document remains unchanged. The content continues to describe the inpatient rehabilitation services provided to adult and geriatric patients, including patient eligibility, assessment processes, interdisciplinary care delivery, staffing availability, family involvement, discharge planning, and applicable standards of practice. No changes to services, patient population, or level of care are proposed.

Security Management	Workplace Violence Prevention Plan	5-1-18	11-20-24	Minor	Plan	• ECH Plan section updated Central Safety > PESC > ePolicy > MEC > Board

POLICY SUMMARY: Establishes El Camino Health's Workplace Violence Prevention Plan in compliance with Cal/OSHA Title 8, Section 3342, defining prevention, reporting, training, response, and oversight requirements to protect employees, physicians, patients, visitors, and others on hospital premises from acts or threats of workplace violence.

SUMMARY OF CHANGES: The Workplace Violence Prevention Plan was comprehensively updated to align with current Cal/OSHA regulatory requirements for healthcare settings. Updates clarify required plan elements, definitions, roles and accountability, employee engagement, training requirements, reporting and investigation processes, environmental and patient-specific risk assessments, corrective action timelines, and post-incident response and review. The plan reinforces zero tolerance for workplace violence and integrates the required annual review and documentation processes. No change to the scope of coverage or regulatory intent is proposed.

Pharmacy	MERP – Medication Error Reduction Plan	11-1-20	12-11-24	Unchanged	Plan	• FY26 Plan in Attachments section Med Safety > P&T > ePolicy > MEC > Board

POLICY SUMMARY: Establishes El Camino Health's Medication Error Reduction Plan (MERP) in compliance with California Health and Safety Code requirements, defining the governance structure, reporting processes, and continuous improvement framework used to prevent, identify, analyze, and reduce medication-related errors across inpatient settings.

SUMMARY OF CHANGES: The Medication Error Reduction Plan was reviewed and updated to reflect current practices, committee structures, and reporting processes supporting medication safety across El Camino Health. The plan continues to address the required eleven medication-use elements, outlines multidisciplinary oversight and reporting pathways, and incorporates ongoing monitoring, non-punitive reporting, external safety alerts, and annual evaluation to support continuous improvement and regulatory compliance. No change to the statutory purpose or scope of the plan is proposed.

Status **Pending** PolicyStat ID **19400532**

Origination	09/2022
Last Approved	N/A
Effective	Upon Approval
Last Revised	12/2025
Next Review	3 years after approval
Owner	Dakota Atley: Dir Foundation Operations
Area	Foundation
Document Types	Policy

Endowed Fund Policy

COVERAGE:

~~All El Camino Health Staff.~~

El Camino Health, El Camino Health Foundation, El Camino Health Foundation Board and Committees, and All El Camino Health and its Subsidiaries Staff & Volunteers.

PURPOSE:

The purpose of this policy is to define the process for creating, investing, spending, and managing El Camino Health Foundation's ~~endowed funds~~Endowed Funds. The primary objectives of an ~~endowed fund~~Endowed Fund are to provide cash flow for El Camino Health's designated projects while managing long-term growth and capital preservation of the ~~fund~~Endowed Fund.

DEFINITIONS:

- El Camino Health and its Subsidiaries (ECH) – A health system ~~and~~that includes two not-for-profit acute care hospitals in Los Gatos and Mountain View and regional urgent care centers, providing multi-specialty care and primary care.
- El Camino Health Foundation (ECHF) – Is a not-for-profit corporation under the laws of the State of California and a tax-exempt organization under section 501(c)(3) ~~organization~~ of the Internal Revenue Code that receives substantial support from the public. Contributions to ECHF are tax -deductible as provided by law. ECH is the sole beneficiary of ECHF.
- Corpus – The original gift amount that funded the Endowed Fund.
- Endowed Fund ~~or Endowment~~ – An ~~endowed~~Endowed Fund is an established fund ~~or~~

Endowed Fund Policy

~~endowment is an established fund~~ of cash, securities, or other assets set aside for perpetuity to provide long-term funding for ~~the organization~~ECH and is created by a Donor from a gift containing a legal stipulation that the original gift amount (~~corpus~~Corpus) may never be expended. These gifts are held and invested in perpetuity by ECHF to generate a permanent expendable income stream from the return on the ~~corpus~~Corpus gift for the purpose the Donor designates. There are two types of Endowed Funds available at ECHF:

- Restricted — use of proceeds is determined by the donor.
- Unrestricted — use of proceeds is determined by the ECHF ~~allocation policies~~Allocations Committee and its governing policy.

- Endowed Spendable Fund – The portion of the Endowed Fund investment earnings that are available for expenditure.
- Planned Gift – a gift wherein ECHF will not necessarily receive the ~~"corpus"~~Corpus immediately; yet, will receive the entire ~~corpus~~Corpus at some future date(s). This is usually associated with estate planning ~~and~~or the settlement of an estate.
- ~~Corpus – The original gift amount that funded the endowed fund.~~
- Pooled Fund – A collection of gifts and their associated appreciation that have been gathered ("pooled") for the purpose of investing.
- ~~Spendable Fund – The portion of the gift that holds investment earnings that are available for expenditure. Every gift will have both an endowed and a corresponding "spendable" fund assigned to assist with management of funds.~~
- Spend Rate – The rate set annually by the ECHF Board~~,~~ - with the recommendation of the ECHF Finance Committee~~,~~ and its governing policy - which is used to determine what portion of the earnings will be made available for spending.
- Service Line Manager – Primary contact assigned by ~~the business line~~ECH to work with ECHF to manage the ~~endowed fund~~Endowed Fund(s) expenditures.

PROCEDURE:

A. **REQUIRED GIFT AMOUNT TO ESTABLISH AN ENDOWMENT FUND**

1. ~~Restricted Endowed Funds~~ **Restricted Endowed Fund**

   a. Donor(s) who make gifts of $100,000 or more are afforded the right to name a new restricted ~~endowed fund~~Endowed Fund (Example: The Atkins Family Endowed Fund for Cancer Patient Care). Proceeds from that fund will be used as the donor designates.

   b. Donor(s) who make a single one-time gift of $10,000 or more may endow that gift and assign it to a previously established (Named) restricted ~~endowed~~Endowed Fund. If no fund~~. If no fund~~ exists for the intended purpose, the donor may assign the gift to another fund or increase the gift amount to the $100,000 threshold and name a new restricted ~~endowment fund~~Endowed Fund.

   c. Every gift will have both an Endowed Fund and a corresponding Endowed Spendable Fund assigned to assist with management of funds.

Endowed Fund Policy

2. **Unrestricted Endowed Fund**
    a. ECHF accepts gifts of any amount to the El Camino Health Unrestricted Endowed Fund. ~~Annually, for grants in excess of $50,000, the ECHF Board, with the recommendation of the ECHF Allocations Committee, will determine the use of this fund's Spendable Fund.~~
    b. ~~For amounts of $50,000 and below, the~~The ECHF Allocations Committee and its governing policy determines distribution ~~through its internal allocation policy and process~~.
3. **Planned Gift ~~Endowment~~Endowed Fund**
    a. A Planned Gift ~~Endowment~~Endowed Fund can be either Restricted or Unrestricted if the gift is irrevocable, meets the criteria of establishing an Endowed Fund, and a notarized instrument of the gift is on record with ECHF.

B. **INVESTMENT OF FUNDS**
Endowed gifts to ECHF are combined with ECH's accounts for investment and oversight. The investment results and expenses of the pool are allocated to all the accounts proportionately – based on the percent each fund represents of the total fund. The ECH Investment Committee selects the investment vehicles.

C. **ESTABLISHING THE SPENDABLE FUND AMOUNT**
1. By the beginning of each fiscal year (July 1 to June 30), the ECHF Finance Committee sets the ~~spendable fund~~Endowed Spendable Fund amount for each of the ~~endowed funds~~Endowed Funds.
2. The ~~Endowment~~Endowed Fund's end-of-quarter market values are used to calculate the previous 12-quarter rolling average subject to the conditions of section i listed below. The 12-quarter rolling average is multiplied by the approved spend rate. Expense adjustments are subtracted for that result to determine the next fiscal year's ~~spendable fund~~Endowed Spendable Fund amount for each fund. As an example:
    a. If the approved spend rate is four and a half percent (4.5%) then the previous 12-quarter market value rolling average is multiplied by .045 to obtain the base ~~spendable fund~~Endowed Spendable Fund amount.
    b. The current year's forecasted investment management fees for the ~~endowed funds~~Endowed Funds are subtracted from the base ~~spendable fund~~Endowed Spendable Fund amount.
    c. This amount is allocated to each ~~fund~~Endowed Spendable Fund based on the percent each ~~fund~~Endowed Fund represents of the total fund.
    d. The resulting amount are the dollars or expenditures available to be used for each individual ~~endowment~~Endowed Spendable Fund award beginning each new fiscal year (July 1 to June 30).
    e. Once calculated, the rate should be no more than 4.5% of the 12-quarter moving average market value.
    f. A new Endowed Fund achieves Endowed status by fiscal year (July 1 to

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June 30) gift booked date.

g. Newly created ~~endowment funds~~Endowed Funds must be invested for at least one full calendar year (January 1 to December 31) before being eligible for payout to the Endowed Spendable Fund.

h. Gains and/or losses in the market value will accrue to each individual ~~endowment~~Endowed Fund based on the percent each fund represents of the total fund.

i. ~~Fund achieves endowment status by fiscal year award date.~~

j. In unusual market environments (prolonged down or up) the ECHF Finance Committee, with approval of the ECHF Board, reserves the right to review this policy and make appropriate adjustments ~~to the spending policy, if necessary~~.

D. **~~ONE-TIME ALLOWANCE~~**

~~If, prior to the adoption of this policy, the endowed fund value is more than the original donated corpus, that excess may be placed into a spendable fund. The excess can be spent pursuant to the previously established policies. Post December 31, 2022, any monies remaining in the endowed fund will added to the funds corpus; yet will not change the original corpus.~~

E. **RESTRICTIONS ON SPENDING BASED ON FUND VALUE**

~~If the Restricted endowed fund~~If the Endowed Fund balance is below the original corpus amount, ~~the Foundation~~ECHF will cease all spending from the Endowed Fund, except for fund~~, except for fund~~ management expenses, until the fund value returns to or is above its initial ~~corpus~~Corpus amount.

F. **FUND MANAGEMENT GENERAL POLICY**

It is the policy of ECHF that all gifts, pledges and private grants from individuals, corporations, foundations, and organizations made to ECHF for ~~endowed funds~~Endowed Funds are recorded and monitored by the ECHF's donor management system. All qualifying ~~endowed funds~~Endowed Funds are to be spent in accordance with the Donor's ~~intent~~restriction. If at some future time the use of this fund is not possible due to a change in ECH's programs or the healthcare environment, the ECHF Board, according to its ~~policies~~policy and applicable law, and in consultation with the original Donor(s) when available; reserves the right to adjust the usage of the fund towards a purpose that most closely meets the Donor's original intent. ~~Endowments~~ Endowed Funds shall be managed in a prudent and fiduciary manner, taking into consideration ~~the~~ ECH ~~Investment Policy~~policies, processes and attendant expenses.

G. **INTERNAL PROCESS**

1. **Setting Up Endowed Fund Internally**

To set-up a new named ~~endowed fund~~Endowed Fund, a minimum amount of $100,000 or a corpus less than $100,000 plus irrevocable pledged commitments to reach the $100,000 is required. Contributions are grouped together by their restrictions and are recorded in ECH's Activities Module of the ECH accounting system as Foundation Endowed Funds ~~or Grants~~. ECHF funds in the Activities module are monitored by both the ECH Controller and ECHF President. If the gift has no Donor-placed restrictions, then the endowed gift will go ~~toward the~~into the El Camino Health Unrestricted ~~Endowment~~Endowed Fund.

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2. **Procedure to Ensure Funds Will Be Used**
    a. Donations that are restricted by the Donor for a specific area or program will be placed in an appropriate Restricted Endowed Fund.
    b. If an ~~endowed fund~~Endowed Fund does not exist for the Donor's restrictions, the donation will be placed in the holding account until a new Restricted Endowed Fund is created.
    c. ~~Foundation~~ECHF staff responsible for securing the gift will submit a "New Fund Set-up Request Form" to the Program Manager, Gift Accounting.
    d. The Program Manager, Gift Accounting will submit a request to the ECH Finance ~~Team~~team to set-up the new ~~endowed fund~~Endowed Fund.
    e. Once created, the Endowed Fund will be assigned by Finance team, who will notify the Program Manager, Gift Accounting who will then notify the ECHF staff responsible for securing the gift.
    f. The ECHF staff responsible for securing the gift will then alert the Service Line Manager when a Restricted Endowed Fund has been assigned to them and what restrictions are ~~responsible for alerting the Service Line Manager when a Restricted Endowed Fund has been assigned to them and what restrictions are~~ on the activity.
    g. ~~Once created, the endowed fund will be assigned by Finance, who will notify both the Foundation and the appropriate Service Line Manager.~~
    h. ECH Finance ~~Department~~team will provide ~~a Quarterly~~to ECHF staff a monthly Endowed Spendable Fund Activity Report ~~(QAR) of ECHF's Endowed Funds~~ that summarizes fund activity ~~to ECHF and the assigned Service Line Manager~~.
    i. Any discrepancies on the monthly Endowed Spendable Fund Activity Report needs to be reported to the ECH Controller for oversight, who will make any necessary changes.
    j. Discrepancies must be reported to ECH and ECHF within thirty (30) days. Any requests for modifications to the ~~QAR~~monthly Endowed Spendable Fund Activity Report post-30 days will require the ECHF President's approval. Any approved changes will be reflected on the following ~~quarter's QAR~~monthly report.
    k. The Service Line Manager will be responsible for administering the allocated spend amount from the ~~Restricted~~ Endowed Spendable Fund and will have the authority and responsibility to request expenses/ purchases of their respective assigned ~~endowed funds~~Endowed Spendable Fund expenditures with the exceptions in sections p., q. and r. listed below.
    l. It is the responsibility of the Service Line Manager to ensure that the expenditure is in keeping with the restrictions of the ~~fund~~Endowed Spendable Fund. Questions regarding appropriate use should be directed to ECHF staff.

Endowed Fund Policy

m. All relevant ECH policies must be adhered to (catering, mileage reimbursement, etc.) ~~All~~and all item purchases must follow ECH's procurement policies.

n. ~~At the close of the second quarter of each fiscal year, all funds with no expenditures in the last six (6) months will be reviewed by the ECHF President, ECH Chief Financial Officer, ECH Controller and ECHF Director of Foundation Operations. The appropriate Service Line Manager will be alerted and asked to provide an update on expected expenditures for the remainder of the fiscal year.~~

o. At the end of each fiscal year, if monies are still available in the Endowed Spendable Funds, the ECHF President and ECH Chief Financial Officer will review those funds with relevant members of ECH Executive Management who will then discuss with their respective Service Line Manager(s) regarding any funds lacking activity to ensure the timely and responsible use of the funds.

p. If after the end of fiscal year review, there remains unspent monies in an ~~endowment spendable~~Endowed Spendable Fund the fund ~~account at the end of the~~will be reviewed by the ECHF President and ECH Chief Financial Officer to determine if funds should carry over to the next fiscal year ~~the fund will be reviewed by the ECHF President and the ECHF Finance Committee to determine if funds should carry over to the next fiscal year~~ for future expenditures or reinvested back into the Corpus Endowed Fund.

q. All ~~expenditures or endowed funds~~Endowed Spendable Funds used to fund a Full Time, Part Time, hourly or contract employee require both the ECH Chief Executive Officer and ECH Chief Operating Officer's pre-approval.

r. All ~~expenditures from Endowment~~Endowed Spendable Funds used for Capital equipment (as defined in the Asset Capitalization Policy) requires the ECH Chief Operating Officer's pre-approval.

s. After Service Line Manager(s) and their appropriate ECH Executive Team member(s) approvals, all expenditures must also be approved by the ECHF President or ECHF Director of Foundation Operations through ECH's financial management tracking system.

H. **Minimum Information Required to Establish a New Endowed Fund**

1. Endowed Fund Name (Short Description)
2. Program Name or Funding Description (Long Description)
3. Fund Class (Research, Care or Education)
4. Fund Category (Restricted or Unrestricted)
5. Assigned Service Line Manager Name
6. 2nd Person's Name to Receive Copy of Reports (if applicable)
7. Grant/Gift Start Date

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8. ~~Division~~Department/~~Department~~Service Line Name/Program Area
9. ~~Division~~Department/~~Department~~Service Line Head Name
10. Executive Manager Name Reporting to
11. Single Donor (Donor's Name) or Multiple Donors
12. Donor Intent Restrictions
13. Key Words for Searches

I. **Endowed Gift Into the Pooled Fund**
Endowed gifts are invested into the pool fund at the end of every quarter once the fund has a minimum balance of $100,000. If an ~~endowed fund~~Endowed Fund has a value of less than $100,000 (example: a Donor makes a five-year pledge of $20,000 per year to set-up an ~~endowed fund~~Endowed Fund), it will be held in an interest-generating instrument for capital preservation until a minimum balance of $100,000 is reached either through additional pledge payments and/or earned interest.

J. **Corresponding Endowed Spendable ~~Fun~~Fund**
An Endowed Fund must exist for a minimum of a full calendar year (January 1 to December 31) before any spendable funds are generated and available ~~to move into a~~for the corresponding ~~endowed spendable fund.~~Endowed Spendable Fund the following fiscal year (~~Example: The Endowed Fund is established in October 2022, the first spendable funds would be available after January~~July 1~~, 2024~~ to June 30).

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy	Patrick Santos: Policy and Procedure Coordinator	12/2025
Foundation Board	Dakota Atley: Dir Foundation Operations	12/2025
Executive Committee	Dakota Atley: Dir Foundation Operations	12/2025
Finance Committee	Dakota Atley: Dir Foundation Operations	12/2025
	Dakota Atley: Dir Foundation Operations	12/2025

Endowed Fund Policy

History

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> ePolicy 12/12/25 - Approved

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Area	Patient Accounts
Document Types	Policy

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

COVERAGE:

Individuals eligible to receive ~~financial assistance,~~Financial Assistance in the form of charity care ~~or discounts~~.

PURPOSE:

Consistent with its ~~Mission~~mission, El Camino Hospital (“ECH”) strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

POLICY STATEMENT:

ECH is committed to providing Financial Assistance to patients who are unable to pay for medically necessary care based on their individual financial ~~assistance to patients who are unable to pay for medically necessary care based on their individual financial~~ situation. ECH ~~offers this assistance to two classes of financially eligible patients based on income:~~meets the requirement of offering Charity Care or Discounted Payments to uninsured patients and ~~those~~ patients with high medical ~~cost~~costs whose family incomes are at or below 400 percent of the Federal Poverty Level by offering charity care (full discounted payment care) to all uninsured patients and patients with high medical costs whose family incomes are at or below 400 percent of the Federal Poverty Level. This ~~policy encompasses~~Financial Assistance Policy (“Policy”) acts as both ECH's charity ~~and discount~~care policy and discounted payment ~~policies~~policy required pursuant to Health and Safety Code ~~§§127400-127446~~§ 127405.

ECH's ~~financial assistance~~Financial Assistance programs are not substitutes for personal responsibility.

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

Patients are expected to cooperate with ECH's procedures for obtaining ~~financial assistance~~Financial Assistance and to contribute to the cost of their care based on their ability to pay. In order to manage its resources responsibly and to allow ECH to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors approves these guidelines for the provision of charity care.

This ~~policy~~Policy will be posted and distributed consistent with the ECH internal procedure document entitled "Distribution of Financial Assistance Procedure".

For patients who do not qualify for Financial Assistance based on the criteria in this Policy, ECH may take the actions outlined in the “Collection Practices and Collection Agency Management” policy, which may be obtained by contacting ECH customer service staff at 650-940-7220 or 800-665-6540.

REFERENCE:

- ~~Patient Protection and Affordable Care Act of 2010 and Hospital Fair Pricing Policies (~~Health and Safety Code §§127400-127446, 1339.585; California Code of Regulations, Title 22, ~~sections~~§§ 70959, 96040-96050; 26 U.S.C. § 501(r); 26 C.F.R. §§ 1-501(r)(0)-1.501(r)(7).

DEFINITIONS:

- **Charity Care**: free care.
- **Discounted Payment:** reduced charge, but not free.
- **Eligible Services:** Financial ~~assistance~~Assistance pursuant to this ~~policy~~Policy is only available for hospital services provided under the authority of ECH's general acute care license. This includes:
    - Emergency medical services provided in an emergency room setting
    - Services for a condition which, in the opinion of the treating physician or other health care professional, would lead to an adverse change in the health status of an individual if not treated promptly
    - Non-elective services provided in response to life-threatening or health-threatening circumstances

      The following services are excluded as ineligible for the application of Financial Assistance under this ~~policy~~Policy, except as required by law:
        - Purchases from ECH retail operations, such as gift shops & cafeteria;
        - Physician Services that are not billed by Hospital.
        - Services that are not licensed hospital services are not covered by this Policy.
    - ~~Purchases from ECH retail operations, such as gift shops & cafeteria;~~
    - ~~Physician Services that are not billed by Hospital.~~
    - ~~Services that are not licensed hospital services are not covered by this policy.~~
- **Essential Living Expenses**: Expenses for any of the following: rent, house payment and

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

maintenance, food, household supplies, utilities, telephone, clothing, medical and dental payment, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

- **Financial Assistance**: Charity Care authorized pursuant to this Policy.
- **Federal Poverty Level ("FPL")**: The Federal Poverty Level refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
- **Patient's Family**:
    - For persons 18 years of age and older: Patient's spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.
    - For persons under 18 years of age or for a dependent child 18-20 years of age: Patient's parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age, if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.
- **Patient with High Medical Costs**: A patient whose family income does not exceed 400 percent of the ~~Federal Poverty Level~~FPL, and ~~includes~~meeting any of the following:
    - Annual out-of-pocket costs incurred by the patient at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months. Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.
    - Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months. Out~~ of~~-of-pocket~~-~~ expenses means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.
- ~~**Patient's Family**:~~
    - ~~For Persons 18 years of age and older: Patient's spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.~~
    - ~~For Persons under 18 years of age or for a dependent child 18-20 years of age: Patient's parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age, if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.~~
- ~~**Family Income:** Family Income is determined using recent pay stubs or income tax returns. Other forms of documentation of income are acceptable, but not required. The following sources of income of a patient and the Patient's Family are considered when computing in~~

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

accordance with federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Disability Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Non-cash benefits (such as food stamps and housing subsidies), Supplemental, Security Income, veteran disability payments, alimony, workers' compensation, and child support do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- Includes the income of Patient's Family members as defined above.
- Excludes monetary assets.

- **Federal poverty level ("FPL"):** The federal poverty level refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
- **Essential Living Expenses**: Expenses for any of the following: rent, house payment and maintenance, food, household supplies, utilities, telephone, clothing, medical and dental payment, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses

PROCEDURE:

A. **Eligibility for Financial Assistance (Discounted Charity Care)**
ECH offers full charity care to patients who are uninsured or who have High Medical Costs who are at or below 400% of the federal poverty level. Full charity care means the patient liability after the application of any insurance, other health coverage, or third party assistance will be zero. No account associated with a patient who is determined to be eligible for charity care will be sent to collections, nor will adverse information be reported to a consumer credit reporting agency. The granting of charity care shall be based on an individualized determination of Family Income, and shall not take into account age, gender, race, health status, social or immigrant status, sexual orientation or religious affiliation.

B. **Medi-Cal (Medicaid) Denials**. Non-covered and denied Eligible Services provided to Medi-Cal eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability, and all charges related to Eligible Services not covered, including all denials, are charity care. Examples may include, but are not limited to:

1. Services provided to Medi-Cal beneficiaries with restricted Medi-Cal (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
2. Medi-Cal pending accounts
3. Medi-Cal or other indigent care program denials

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

4. Charges related to days exceeding a length-of-stay limit
5. Out-of-state Medicaid claims with "no payment"
6. Line item denials.

C. **Process to Determine Eligibility for Charity Care.** The cooperation of the patient and/or the Patient's Family is necessary in order for ECH to determine eligibility. A patient, or patient's legal representative, who requests charity care or other assistance in meeting their financial obligation to ECH shall make every reasonable effort to provide ECH with documentation of income and health benefits coverage.

1. **Application.** Eligibility will be determined in accordance with the following procedures to ensure an individual assessment of Family Income. The application process will require the following information from the patient submitted by e-mail, fax, or mail as specified in the application:
    a. Completed signed application and
    b. Proof of Income Tax return or most recent payroll stub. A patient who does not have an income tax return may submit SSA-1099 to qualify for charity care.
    Information obtained pursuant to this application shall not be used for collections activities.

2. **Eligibility**. In determining eligibility, ECH will:
    a. Document reasonable efforts by ECH to explore appropriate alternative sources of payment and coverage from public and private health insurance or sponsorship, such as Covered California plans, Medicare, or Medi-Cal, and to assist patients to apply for such programs. However, if the patient applies, or has a pending application for another health coverage program at the same time that he or she applies for ECH's charity care, neither application shall preclude eligibility for the other program. The patient shall not be required to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discount payment. However, when screening for eligibility for discount payment, ECH may require the patient to participate in a screening for Medi-Cal eligibility.
    b. Review the patient's outstanding accounts for any open accounts that may also be eligible for charity care for the approval timeframe.

3. **Presumptive Eligibility.** ECH reserves the discretion to grant presumptive charity care for individuals who are unable to complete the application or provide financial information by making a good faith effort to determine income from the patient's address, based on Experian presumptive eligibility tool, or based on prior eligibility determination.

4. **Circumstantial Eligibility**. ECH reserves the discretion to grant circumstantial eligibility based on an objective, good faith determination of financial need, taking into account the individual patient's circumstances, the local cost of living, a patient's income, a patient's family size, and/or the scope and extent of a patient's medical bills, based on reasonable methods to determine financial need. The Chief

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

Executive Officer, the Chief Financial Officer, or his/her/their designees shall be authorized to approve patients for circumstantial eligibility for charity or discounted care, and must ensure documentation of the basis upon which circumstantial eligibility was granted.

5. **Changed Circumstances.**
    a. If at any time information relevant to the eligibility of the patient changes, the patient may update the documentation related to income and provide to ECH with the updated information. ECH will consider the patient's changed circumstances in determining eligibility for charity care.
    b. Eligibility for financial assistance shall be revaluated every 12 months or at any time additional information relevant to the eligibility of the patient becomes known. If such information does change, it is the patient's responsibility to notify ECH of the updated information.
    c. ECH's values of respect and integrity shall be reflected in the application process, eligibility determination and granting of charity care write-off. Requests for Charity Care shall be processed promptly, and ECH shall notify the patient or applicant in writing of its decision on a completed application.
    d. ECH may deny an application for Financial Assistance and/or may reverse previously applied discounts if it learns of information which it believes supports a conclusion that information previously provided was inaccurate. In addition, ECH may elect to pursue legal actions against persons who it believes knowingly misrepresented their financial condition, including those who accept financial assistance after an improvement in their financial circumstances which was not made known to ECH.

6. **Timeline for Application for Financial Assistance**
    a. ECH shall accept and process a financial assistance application at any time, but will provide a minimum of 240 days after initial billing for a patient to submit the application before assuming any collections activities.
    b. When a patient submits an incomplete application, ECH shall notify the individual about how to complete the application and give the patient a reasonable opportunity to do so.
    c. When a patient submits a complete application during the 240-day application period, ECH shall determine whether the individual is eligible for financial assistance.
    d. Eligibility determination may be done at any point.
    e. ECH shall notify the patient in writing of the determination and the basis for the determination.

7. **Review of Determination of Application.** In the event of a dispute, a patient may seek review from the Chief Financial Officer by submitting an appeal by e-mail, fax, or mail

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

~~to the address/phone number specified in the application.~~

~~D.~~ ~~**Other Provisions**~~

1. ~~Any contracted emergency department physician or surgeon who provides emergency medical services at ECH is also required by law to provide discounts to uninsured patients or Patients with High Medical Costs who are at or below 400 percent of the federal poverty level. Patients who receive a bill from a contracted emergency department physician or surgeon should contact that physician's office and request financial assistance. This statement shall not be construed to impose any additional responsibilities upon ECH.~~
2. ~~ECH shall provide, without discrimination, care for emergency medical conditions to patients regardless of their eligibility under this policy.~~
3. ~~A patient shall not be denied financial assistance that would be available pursuant to the ECH policy published on the HCAI's internet website at the time of service.~~
4. ~~ECH shall maintain all records (including, but not limited to, claims, invoices, bills, litigation, notices, contracts, contact information, debt collections) relating to money owed to the hospital by a patient or a guarantor of the patient for at least 5 years.~~
5. ~~As required by law, Effective July 1, 2025, ECH contracts creating a medical debt will include the following term: "A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."~~

~~E.~~ ~~**Exceptions and Limitations**~~ ~~This policy is intended to be a statement of general intent, setting forth the basic principles to be followed by the organization in administration of its programs to provide financial assistance and charity care to its patients. However, because the complexities of human existence can present myriad possible individual circumstances, and because of the challenges present in managing a health care organization, it is recognized that some degree of flexibility is appropriate in administering these programs. Accordingly, the Chief Executive Officer and Chief Financial Officer of ECH or his/her/their designees are granted the authority to provide exceptions to these policies and procedures as appropriate to grant financial assistance based on an individual patient's circumstances and as appropriate to the financial ability and needs of ECH. The Chief Executive Officer and Chief Financial Officer of ECH are also each granted the authority to amend this policy to adjust the parameters of the financial assistance program in order to ensure the total amount of financial assistance provided is consistent with the organization's financial ability and to ensure ECH is able to meet its financial obligations.~~

~~In implementing this policy, ECH shall comply with all federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy, including Health and Safety Code sections 127400-127446 and 1339.585.~~

A. **Eligibility for Financial Assistance (Charity Care)**

ECH provides full Charity Care to uninsured patients whose family incomes are at or below

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

400% of the FPL or patients with high medical costs whose family incomes are at or below 400% of the Federal Poverty Level. This means eligible patients won't owe anything after insurance or other help is applied. Their accounts won't be sent to collections or reported to credit agencies.

B. **Process to Determine Eligibility for Financial Assistance**
Patients or their families need to cooperate with ECH to determine eligibility. Those requesting Charity Care or other financial help must provide documentation of their income and health benefits.

1. **Application**
Eligibility will be determined in accordance with the following procedures to ensure a good faith assessment of the patient's Family Income. Each patient seeking Financial Assistance must submit a completed Charity Care Program Application ("Application") by e-mail, fax, or mail as specified in the Application. Each Application must include proof of income in the form of:

    a. Recent tax returns (meaning tax returns that document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed); or

    b. Recent pay stubs (meaning paystubs within a 6-month period before or after the patient was first billed by ECH, or in the case of preservice, when the Application is submitted).

    Other forms of documentation of income are acceptable, but not required. Assets are not considered in determining eligibility for Charity Care pursuant to this Policy. These documents provided for the Application will only be used in reaching a determination of Financial Assistance and will not be used for collection activities.

    A patient, or patient's legal representative, who requests Financial Assistance shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. ECH may consider the failure to provide this information in making its determination.

2. Family Income. ECH will determine the income of a Patient's Family in accordance with federal poverty guidelines and consistent with the following:

    a. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Disability Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources for the Patient's Family as defined above;

    b. Excludes non-cash benefits (such as food stamps and housing subsidies), Supplemental, Security Income, veteran disability payments, alimony, workers' compensation, and child support;

    c. Determined on a before-tax basis;\

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

d. Excludes capital gains or losses; and

e. Considers health savings accounts ("HSAs") to the extent permitted by law.

3. Eligibility. In determining eligibility, ECH will:

   a. Document reasonable efforts by ECH to explore appropriate alternative sources of payment and coverage from public and private health insurance or sponsorship, such as Covered California plans, Medicare, or Medi-Cal, and to assist patients to apply for such programs. However, if the patient applies, or has a pending application for another health coverage program at the same time that he or she applies for ECH's Financial Assistance, neither application shall preclude eligibility for the other program. The patient shall not be required to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, Financial Assistance. However, when screening for eligibility for Financial Assistance, ECH may require the patient to participate in a screening for Medi-Cal eligibility. Eligibility for Financial Assistance will not be conditioned on applying for other coverage programs. However, if a patient qualifies for Financial Assistance and later enrolls in Medi-Cal, ECH may bill Medi-Cal in full.

   b. Review the patient's outstanding accounts for any open accounts that may also be eligible for Charity Care for the approval timeframe.

4. Presumptive Eligibility. ECH reserves the discretion to grant presumptive Charity Care for individuals who are unable to complete the Application or provide financial information by making a good faith effort to determine income from the patient's address, based on Experian presumptive eligibility tool, or based on prior eligibility determination. Presumptive eligibility is granted on the authority of the Chief Financial Officer or his/her/their designee.

5. Medi-Cal (Medicaid) Denials. Non-covered and denied Eligible Services provided to Medi-Cal eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability, and all charges related to Eligible Services not covered, including all denials, are charity care. Examples may include, but are not limited to:

   a. Services provided to Medi-Cal beneficiaries with restricted Medi-Cal (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)

   b. Medi-Cal pending accounts

   c. Medi-Cal or other indigent care program denials

   d. Charges related to days exceeding a length-of-stay limit

   e. Out-of-state Medicaid claims with "no payment"

   f. Line item denials.

6. Changed Circumstances.

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

a. If at any time information relevant to the eligibility of the patient changes, the patient may update the documentation related to income and provide to ECH with the updated information. ECH will consider the patient's changed circumstances in determining eligibility for Charity Care for services first billed in the year of newly submitted tax returns or the following year or services first billed six months before or after submitted paystubs.

b. If a patient who previously was awarded Charity Care becomes eligible for Medicare, Medi-Cal or other third-party coverage for the dates of service, ECH will follow its standard Billing and Collection Policy for billing Third Party Payers.

c. Eligibility for Financial Assistance shall be reevaluated every 12 months or at any time additional information relevant to the eligibility of the patient becomes known. If such information does change, it is the patient's responsibility to notify ECH of the updated information.

d. ECH's values of respect and integrity shall be reflected in the application process, eligibility determination and granting of charity care write-off. Requests for Charity Care shall be processed promptly, and ECH shall notify the patient or applicant in writing of its decision on a completed application.

e. ECH may deny an application for Financial Assistance and/or may reverse previously approved Financial Assistance if it learns of information which it believes supports a conclusion that information previously provided was inaccurate. In addition, ECH may elect to pursue legal actions against persons who knowingly misrepresented their financial condition, as required by the application requirements above.

7. Timeline for Application for Financial Assistance

a. ECH shall accept and process an application at any time. Patients will not be denied Financial Assistance solely because of when the application is submitted.

b. When a patient submits an incomplete application, ECH shall notify the individual about how to complete the application and give the patient a reasonable opportunity to do so.

c. When a patient submits a complete application, ECH shall determine whether the individual is eligible for Financial Assistance.

d. Eligibility determination may be done at any point.

e. ECH shall notify the patient in writing of the determination and the basis for the determination.

8. Effect of Financial Assistance Determination
If found eligible under this Policy, ECH shall adjust the patient's outstanding balance for the services subject to Financial Assistance to zero. Financial Assistance is applicable as follows: (1) if tax returns are submitted with the Application, the services first billed in the year covered by the tax return or the following year; or (2) if

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

paystubs are submitted with the Application, the services first billed in the six months before or after the paystubs. If appropriate, ECH shall refund the individual any amount he or she has paid for the care (whether to the hospital facility or any other party to whom the hospital facility has referred or sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying after Financial Assistance has been applied. ECH shall make any refunds under this section within 30 days of the determination of eligibility for Financial Assistance. Any interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, ECH may choose not to reimburse the patient if ECH determines the patient would have qualified for Financial Assistance at the time the patient was first billed and it has either (i) been five years or more since the last payment to the hospital, assignee or debt buyer or (ii) the patient's debt was sold before January 1, 2022, in accordance with the law at the time.

9. Review of Determination of Application
   In the event of a dispute, a patient may seek review from the Chief Financial Officer by submitting an appeal by e-mail, fax, or mail to the address/phone number specified in the Application.

C. Other Provisions

1. ECH makes information about its Financial Assistance Policy and Application available through numerous means in compliance with applicable state and federal laws and regulations. Information about this Policy is available on the ECH website home page and on any website where the patient pays a bill or accesses information about the patient's account, posted in hospital areas that are accessible to the public, and by plain language summaries provided in writing to all patients. Information regarding financial assistance programs and free copies of the Financial Assistance Policy and Application are available by mail or by calling ECH's customer service staff at 650-940-7220 or 800-665-6540. ECH shall ensure that this Policy is translated into each language spoken by the lesser of 1,000 people or five percent of the population that resides ECH's service area and is made accessible by interpretation or alternative formats to ensure access for limited English proficient and disabled individuals.
2. Any contracted emergency department physician or surgeon who provides emergency medical services at ECH is also required by law to provide discounts to uninsured patients or Patients with High Medical Costs who are at or below 400 percent of the Federal Poverty Level. Patients who receive a bill from a contracted emergency department physician or surgeon should contact that physician's office and request Financial Assistance. This statement shall not be construed to impose any additional responsibilities upon ECH.
3. A full list of physicians at ECH is available at https://www.getcare.elcaminohealth.org/providers.
4. ECH shall provide, without discrimination, care for emergency medical conditions to patients regardless of their eligibility under this Policy.

Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)

5. A patient shall not be denied Financial Assistance that would be available pursuant to the ECH policy published on the HCAI's internet website at the time of service.
6. ECH shall maintain all records (including, but not limited to, claims, invoices, bills, litigation, notices, contracts, contact information, debt collections) relating to money owed to the hospital by a patient or a guarantor of the patient for at least 5 years.
7. This Financial Assistance Policy authorizes full Charity Care. State law requires the negotiation of extended payment plans for patients that qualify for Discounted Payment, taking into account the patient's family income and essential living expenses, with a default to a reasonable payment plan with monthly payments capped at no more than 10% of family income, after excluding essential living expenses. Patients eligible for Charity Care have no balances left to apply extended or reasonable payment plans.
8. Patients that are eligible for Financial Assistance shall not be charged more than the amounts generally billed ("AGB") for emergency or other medically necessary care. ECH adopts the look-back method for the AGB. ECH determines AGB by multiplying the gross charges for any emergency or other medically necessary care it provides by AGB percentages, which are based on claims allowed under Medicare.

In implementing this Policy, ECH shall comply with all federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy, including Health and Safety Code sections 127400-127446 and 1339.585.

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Approval Signatures

Step Description	Approver	Date
Senior Director, Revenue Cycle	Brian Fong: Assistant VP, Revenue Cycle	Pending
	Johnna Mohun-Garvey: Director Patient Accounts	05/2025

Status **Pending** PolicyStat ID **18923680**

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

Scope of Service - Interventional Services - Los Gatos

Scope and Complexity of Services Offered

A. The Los Gatos Interventional Services lab provides a limited range of cardiac diagnostic and interventional services as a Level 1 cardiac cath lab without on-site cardiac surgery. Outpatient cardiac procedures include: Right and left heart catheterization, coronary angiography, fractional flow reserve (FFR), pulmonary artery pressure sensor implantation, thrombolysis, pericardiocentesis, cardioversion, TEE, IVUS, percutaneous coronary intervention (PCI), and intra-aortic balloon pump.

B. Provisions are in place so that patients needing urgent surgery will be transferred to a Cardiac Surgery Facility (e.g. Mountain View Campus).

C. The LG-IS Lab also provides interventional radiological procedures to include: pulmonary embolism thrombectomy, peripheral-vascular procedures, line placements, drains, tubes, kyphoplasty and vertebralplasty and embolizations.

Scope of Services Includes

A. The Los Gatos Interventional Services lab provides a limited range of cardiac diagnostic and interventional services as a Level 1 cardiac cath lab without on-site cardiac surgery. Considerations for Outpatient Case Selection is in accordance with the current SCAI/ACCF/AHA Guideline: High Risk patients below are excluded from being scheduled at LG and should be referred to Mountain View Campus

1. Elective high-risk patients:
    a. decompensated CHF (Killip Class 3, 4)

Scope of Service - Interventional Services - Los Gatos

b. high baseline respiratory risk
c. recent (<8 weeks) cerebrovascular accident
d. known clotting disorder or high transfusion risk
e. left ventricular ejection fraction ≤30%
f. high acute kidney injury risk (creatinine > 2.0 mg/dL or creatinine clearance < 60 mL/min)
g. serious ongoing ventricular arrhythmias
h. extensive peripheral arterial disease or high vascular complication risk

2. High-risk lesions identified during coronary angiography are referred to Coronary Artery Disease Heart Team for further treatment at Mountain View Campus
    a. left main stenosis > 50% or 3-vessel disease (>70% proximal or mid lesions) unprotected by prior bypass surgery diffuse disease
    b. last remaining vessel or target lesion that jeopardizes an extensive amount of myocardium
    c. extremely angulated segment or excessive proximal or in-lesion tortuosity (defined as > two 45 degree bends before the target stenosis
    d. greater than moderate calcification visible proximal and at the target stenosis
    inability to protect major side branches
    e. older degenerated vein grafts with friable lesions
    f. thrombus in the target vessel or at lesion site
    g. chronic total occlusions (defined as > 3 months in duration and or bridging collaterals)
    h. vessel characteristics that, in the operator's judgment, would impede stent deployment
    i. anticipated probable need for rotational or other atherectomy device, cutting balloon, or laser.

B. Patients to be admitted on the day of Interventional Services procedure are admitted through the OPS/SS Unit.
C. Los Gatos Interventional Services lab is not a full service cardiac cath lab; it is a STEMI Referral Center that does not perform primary percutaneous coronary intervention for patients with STEMI.

Types and Ages of Clients Served

Los Gatos 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.

Scope of Service - Interventional Services - Los Gatos

Assessment Methods

The assessment methods focus on ensuring the safety and efficacy of procedures. Diagnostic and therapeutic Interventional Services provided to patients are assessed by cardiologists, nephrologists, peripheral-vascular surgeons, interventional radiologists, cardiac cath lab technicians, and registered nurses (RNs) who monitor patients' response to procedures, contrast reactions, complications, and internal quality controls and external proficiency testing for equipment. Cardiac surgeons at Mountain View Campus or other institutions may be consulted as needed.

Appropriateness, Necessity and Timeliness of Services

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

B. Cases, which do not meet criteria, are subject to review by the Interventional Services Leadership Committee. IS staff adhere to contraindications for scheduling to ensure that no other inappropriate cases are scheduled.

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

D. Documentation of assessment and treatment of patients is completed per medical staff bylaws and unit specific documentation standards.

Staffing/Skill Mix

Minimum Staffing levels are established as:

A. Cardiac Cath Lab Procedures: Minimum of 3 Registered Nurses and 1 Radiologic Technologist
    1. Registered Nurses: Administers medications ordered for sedation and analgesia per moderate sedation procedure, monitors/records hemodynamics throughout the procedure, and circulate to assist the flow of the procedure outside of the sterile field
    2. Radiologic Technologist: manages fluoroscopy and performs duties of a scrub tech during procedures

B. Interventional Radiology Procedures: Minimum staffing based upon anesthesia type (General/ MAC or moderate sedation)
    1. Anesthesia, RN, and Tech
        a. Anesthesia provides MAC
        b. RN monitors and performs procedural documentation/hemodynamcis; and circulates as needed

Scope of Service - Interventional Services - Los Gatos

c. Radiologic Technologist: manages fluoroscopy and performs duties of a scrub tech during procedures

2. 2 RNs and Tech
    a. RN administers medications ordered for sedation and analgesia per moderate sedation procedure
    b. RN monitors and performs procedural documentation/hemodynamics; and circulates as needed
    c. Radiologic Technologist: manages fluoroscopy and performs duties of a scrub tech during procedures

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. Heart & Vascular Institute includes all patients receiving Cardiac Cath care in the LG IS into the National Cardiovascular Data Registry (NCDR) CathPCI Registry.

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, American Heart Association, Society of Cardiovascular Angiography & Interventions. Additional practices are described in the Patient Care Policies and Procedures, departmental policies and procedures, and Clinical Practice Standards.

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Approval Signatures

Step Description	Approver	Date
Department of Surgery	Will Roden: Interim Dir Interventional Services	Pending
Department of Surgery	Patrick Santos: Policy and Procedure Coordinator	Pending

Scope of Service - Interventional Services - Los Gatos

Medicine Department Executive Committee	Patrick Santos: Policy and Procedure Coordinator	01/2026
Medicine Department Executive Committee	Will Roden: Interim Dir Interventional Services	10/2025
HVI Medical Director/Program Meeting	Kathryn Jaramillo: Clinical Nurse Specialist	10/2025
	Will Roden: Interim Dir Interventional Services	10/2025

Status **Pending** PolicyStat ID **19011840**

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Owner	Nancy Billington: Dir Perioperative Svcs
Area	Patient Care Services
Document Types	Scope of Service

Perioperative Services - Los Gatos (Outpatient Surgery/ Short Stay Unit, Post Anesthesia Care Unit, Operating Room & Central Sterile Processing Department)

Scope of Services Offered

The Perioperative Service Line includes the Outpatient Surgery/Short Stay (OPS/SS) Unit, Operating Room (OR), Post Anesthesia Care Unit (PACU). The Outpatient admit area is located on the main floor. All Outpatient/AM admits procedure patients are admitted through OPS/SS Unit. The Short Stay Unit functions as a Pre-Operative Admission Unit, as well as a post operative same day surgery/ procedure area. A nursing clinical manager is responsible for services provided in the service line and reports to the Director of Perioperative Services. An OR Clinical Manager is responsible for the holding area and day-to-day coordination of services in the OR. The PACU/ Clinical Manager is responsible for day-to-day coordination of services in this unit. These individuals are responsible for the day-to-day coordination of services. The Clinical Manager contributes to the success of the departments by budget control and providing staffing to accommodate a fluctuating patient population. The Clinical Managers report to the Perioperative Services Director.

- **OPS/SS Unit Scope**
  - Admission – Patients to be admitted on the day of surgery/invasive procedure are admitted through the OPS/SS Unit.
  - Post Operative Procedure – patients on the day of the surgery/invasive procedure are returned to the OPS/SS Unit to complete their recovery and be discharged to home
- **PACU Scope**: The Post Anesthesia Care Unit provides intensive observation and care to

patients following an operative or non-invasive procedure, cardioversions, cardioversions with TEEs, or pain control procedure for which an anesthetic agent or sedative has been administered. It consists of ten beds and is located adjacent to the Operating Room.

- **OR Scope**: The Operating Room (OR) consists of eight suites, a center core for sterile instruments, supplies storage and Decontamination Room. Common procedures include: Laparoscopic Cholecystectomy Colon Resection Lumbar Laminectomy Major Spinal Fusion with Instrumentation Hysterectomy/Hysteroscopy Total Hip and Knee Joint Replacement Arthroscopy/ACL Endoscopic Carpal Tunnel Brachytherapy Lithotripsy Urological Procedures SWT elbow foot Ophthalmology Radical Prostatectomy Laparoscopy Assisted Procedures, e.g.: LAVH, Bowel Resection Laparoscopic and open General, Thoracic and GYN Oncology procedures Thoracoscopy, Thoracotomy, Bronchoscopy Robotic Procedures, e.g.: Da Vinci, Makoplasty, Rosa, Mazor, Omni, and Globus.

Assessment Methods

- Nursing Process
    - Assessment - Assessment begins in the Outpatient Surgery/PreOp Unit for Outpatients or AM admits, and in the nursing unit from which a surgery patient will come. An RN receives the patient and begins the assessment including the verification process to ensure the correct patient with complete and correct identification has informed consent for the anticipated procedure. Data collected by the admitting RNs and physician, test results and other information are reviewed to identify extraordinary needs. The circulating RN reviews the preoperative assessment and verifies the patient's name, birthdate, medical record number, history and physical, consents, patient's anticipated procedure and boarding pass are consistent. Care is then transferred to the O.R. RN. When Outpatient Surgery/ PreO is closed (nights, weekends and holidays), this assessment process is performed by the O.R. RN.
    - Nursing Diagnosis - Patients coming to the O.R. have these nursing diagnoses:
        - Potential for anxiety due to:
            - Loss of personal control
            - Knowledge deficit
            - Unfamiliar setting
        - Potential for injury due to:
            - Loss of protective reflexes
            - Loss of sensation
            - Immobility
            - Contact with high energy equipment
        - Potential for infection due to endogenous and exogenous sources.
        - Potential for hypothermia due to evaporation, conduction or radiation.
        - Potential for alteration in comfort due to surgical intervention.

- Planning

  The RN from the OPS/SS Unit or nursing floor reviews the medical record and assesses the patient to determine the degree of the patient's risk related to the nursing diagnoses and whether additional diagnoses apply. Specific areas of assessment are mental/emotional status, limitations to communication, limitations to mobility, hypothermia risk, nutritional status, and pain and skin condition. Additional data used in care planning include age, medications, allergies, type of surgery, anticipated length of surgery, co-morbidities, laboratory and test results, completion of medical orders and preoperative instructions. The medical plan of care is integrated in several ways. The surgeon will include special requests at the time the procedure is scheduled or contact the O.R. charge nurse before the case to communicate needs. The medical record and preference card are used to integrate the plan of care. The goals for perioperative nursing care include but are not limited to:

  - Maintain autonomy
  - Free of nosocomial infection
  - Maintain skin integrity
  - Free of injury
  - Maintain temperature
  - Experience minimal discomfort
  - Maintain adequate coping mechanisms
  - Experience a caring and supportive environment
  - Maintain patient's rights

  The initial care plan is either written on the Perioperative Nursing Record or communicated to the O.R. team.

- Intervention - Independent nursing actions may include:

  - Adherence to Universal Protocol and Correct Site Verification & Marking (Patient Site Marking occurs outside Surgical Suite. Time Out performed by MD in the Surgical Suite prior to start of procedure
  - Monitoring, proper positioning and security
  - Skin preparation
  - Maintaining aseptic field
  - Safety procedures
  - Providing information and emotion support
  - Facilitating communication
  - Accommodating physical limitations
  - Pain management
  - Selection of grounding sites for electrical devices
  - Performing surgical counts – sponges, needles and instruments

- Handling of specimens

- Evaluation

  The circulating RN evaluates patient care at the conclusion of each case. The extent of the evaluation depends on the level of consciousness of the patient. The skin is assessed for signs of injury. The patient's temperature is recorded in PACU. Adverse patient responses are reported either verbally or through the Quality Review Report.

  Documentation: All documentation of perioperative care is done on the Perioperative Nursing Record. Moderate sedation care is documented on the Moderate Sedation Record when an anesthesiologist is not present during the case.

Staffing/Skill Mix

- **OPS**
  - The OPS/SS utilizes RNs to provide direct patient care with the assistance of clinical support personnel (CNAs).
  - Staffing – Consists of RNs, CNAs, and Administrative Support.
  - Normal business hours are: Monday – Friday: 0530 hours to ~~2300 hours~~2100
  - Requirements for Staff – All staff must complete orientation as specified in the Department Specific Orientation Manual, as well as Healthstream Learning Center modules. Minimum requirements for RNs are: ~~BCLS~~Telemetry monitoring, ACLS, AccuCheck, Correct-Site Verification self-study (S-S) module, Surgical Consent S-S module, and age-specific competency. Minimum requirements for unlicensed clinical support staff are: ~~BCLS~~BLS, and age-specific competency.
- **PACU**
  - PACU utilizes ACLS certified RNs to provide direct patient care with the assistance of clinical support personnel. Clinical support personnel provide direct patient care under the supervision of the RN and provide patient transportation. A ratio of RN/PT is progressive, beginning at 1:1 until airway patency is stable, and then maintained at 1:2 until the patient is transferred out of the PACU. A charge nurse is assigned daily to make assignments and direct patient care.
  - Staffing: - Consists of RNs and CNAs.
  - Normal business hours are: Monday – Friday: 0700 hours to 2330 hours, on call only 2300 hours to 0700 hours. Saturday: on call 0700 hours to Monday 0700 hours. Sunday: on call 0700 hours to Monday 0700 hours.
  - Requirements for Staff: All staff must complete orientation as specified in the Department Specific Orientation Manual, as well as Healthstream Learning Center modules. Minimum requirements for RN staff are: ACLS, previous experience in PACU or Critical Care Unit, AccuCheck, Malignant Hyperthermia S-S module, Correct-Site Verification S-S module, Surgical Consent S-S module, and age-specific competency. Minimum requirements for CNA staff are: ~~BCLS~~BLS and age-specific competency.

- **OR**
    - The department staffing consists of RNs, operating room technicians, OR Assistants ORA and business office clerical personnel. There are staff nurses who have responsibility for being a resource to the staff regarding particular surgical specialties. RNs are assigned to coordinate instruments and supplies for the suites. An RN or a business office clerical person may be assigned to the OR front desk to coordinate the daily schedule and facilitate activities in the department, under the direction of the OR Manager. Every case is assigned two OR staff persons. An RN is always assigned to circulate. Either an RN or an ST may be assigned to scrub. If the patient is to receive moderate sedation without the presence of an anesthesiologist, an additional ACLS certified RN is assigned to monitor the patient and administer moderate sedation. If the laser is used, a laser-trained RN or ST is assigned to the case. ORA's and EVS personnel assist with room turnover, supply and equipment management, cleaning, transporting patients, and anesthesia cleanup and setup. Staffing in the OR is based on the minimum number of staff required to manage the projected schedule of surgeries.
    - Staffing: Consists of RNs, ST, ORA's, and Business Office personnel.
    - Normal business hours: Monday – Friday – 0645 hours to 2315 hours, on call only 2300 hours to 0700 hours. Saturday – Sunday – On Call 0700 hours to Monday 0700 hours.
    - Requirements for Staff: All staff must complete orientation as specified in the Department Specific Orientation Manual, as well as Healthstream Learning Center modules. Minimum requirements for RNs are: BCLS, age specific competencies, Malignant Hypertension S-S module, Moderate Sedation S-S module, Correct-Site Verification S-S module, Surgical Consent S-S module. Minimum requirements for STs are: Successful completion of ST training program, BCLS, age specific competencies. Minimum requirements for ORA's are: BCLS, successful completion of the anesthesia assistant training and ORA Aseptic Technique and Sterile IV System Setup program. A percentage of RNs are ACLS and CNOR certified
    - The Operating room consists of a mix of RNS, ORTs, and Ancillary Personnel. Activities are performed by the RN, ORT, ORA, and office personnel, all with appropriate training. The unit uses AORN Recommended Standards of Practice and Standards of Care established by the OR and approved by the Hospital administration, Chief of Surgery, and the Hospital Board of Directors. The department uses Title 22 and AORN standards as guidelines for staffing. Staffing levels are based on an acuity system which takes into account patient acuity, staff skill level, staffing training needs, equipment, OR protocols, infection control and patient safety requirements. The RN performs circulating duties. The RN and/or ORT perform scrub duties. RN assessments and nursing diagnoses are the basis for care planning for the surgical patient in the OR. Performance Improvement programs track data associated with SCIP measures, National Patient Safety Goals and Intradepartmental initiatives for improved patient care outcomes

Level of Service Provided

- Objectives

- Deliver safe, effective and appropriate care.
- Facilitate collaboration between all health care providers to assure that the community health care needs are met.
- Provide services in an efficient and timely manner.
- Continuously seek ways to improve patient outcomes, improve service, and reduce cost
- Maintain a work environment that is safe and supportive.

- Goals
  - Promote retention and recruitment practices to maintain a high level of proficiency in Surgical Services staff.
  - Utilize Operating Room Committee to increase collaboration and discuss operational and budgetary issues in the OR.
  - Work collaboratively with the Anesthesia Department to facilitate the OR schedule and accommodate urgent cases added to the schedule.
  - Increase utilization of Surgical Services by promoting opportunities for new business growth and efficient use of areas.
  - Provide ongoing educational opportunities for staff growth

The Operating Room suite is located on the second floor of the main building of the Hospital. The suite consists of eight operating rooms with support areas for instruments and equipment. Services using the Operating Room are, ENT, Plastic, Podiatry, Orthopedics, Urology, Ophthalmology, GYN, General, Neurosurgery, Vascular, Thoracic and Oral/Dentistry. Elective surgery is scheduled Monday through Friday from 0730 hours to 1530 hours, according to a block scheduling system. Surgery volume is a mix of both In and Out Patient populations. The Operating Room provides twenty-four hours nursing care to the patients requiring surgical intervention. The surgical patient is admitted to the hospital either as an outpatient, the same day of surgery (AM admit) as an inpatient, or from the Emergency Department.

Standards of Practice

- Scheduling
  - Elective Surgery and Procedures: OR's are scheduled by "Block" designation. Block holders are expected to maintain 70% utilization. Blocks have varying release times depending on the nature of the block assignment. Changes in block allocations are made by the Operating Room Committee based on results of utilization and requests for time. Elective surgeries are scheduled through the OR schedulers Monday through Friday between 0730 hours and 1730 hours. Special procedures are scheduled according to physician and staff availability i.e., Pain control and Cardioversions.
  - Urgent Surgery and Procedures: Definition of "Urgent" is: Case must be scheduled within 12-24 hours. Urgent cases are given the first available time slot. The surgeon notifies the OR schedulers or charge nurse when an urgent case arises.

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- Emergency Surgery and Procedures: OR Definition: Case must begin within 1-2 hours. When the surgery schedule does not accommodate an emergency case, the surgeon has the option of pre-empting other cases. The surgeon will accomplish this by communicating with the anesthesiologist and surgeon who will be bumped. Staff called in for emergencies will be ready to start case preparation within 30 minutes of notification. Physicians notify the OR charge nurse or the Hospital shift supervisor for emergency cases after hours.
- Endoscopy Center Definition: Procedure must begin within 1-2 hours. When the Endoscopy schedule does not accommodate an emergency procedure, the physician has the option of pre-empting another procedure. The physician is responsible for notifying the physician he is bumping. If the procedure occurs outside scheduled hours, the call system will be activated.
- Emergency Endoscopy cases are also performed in the Critical Care Unit, the Operating Room and the Emergency Department. The Endoscopy staff is available 24 hours a day for emergencies

- Staffing Patterns
  - **Operating Room**

    The staffing pattern describes core staffing. Adjustments to core staffing are made the previous day for the planned case schedule. Adjustments are made during the day as changes to the schedule arise and for the evening shift. The OR Director, and OR Manager or their designee makes adjustments. When immediate increase in staffing is required, staff assigned to rest/meal breaks may be assigned to a case/ patient care. At change of shift, staff may be assigned overtime to complete a case in progress. Excused time off is granted or assigned when staffing exceeds the need. This is done according to department guidelines and is classified as Hospital Convenience "HC" or Daily Cancellation "DC" time off. The O.R. Manager or designee makes patient care assignments each afternoon for the following day. Registry and traveler staff is used to supplement staffing when necessary. Shift reports take place in the morning, afternoon and evening There are resource nurses for each specialty available within the staffing matrix to support training and learning needs of the staff. Staffing is supplemented on weekends, holidays and sometimes on evening shift with the on-call and/or case rate on-call staff. Nurses and technicians are scheduled for call only after demonstrating competency in the types of cases usually performed on an urgent or emergent basis. Additional staff may be called to work to provide special skills or additional staff at the discretion of the charge nurse. The staffing pattern describes the usual number and skill mix required each day. It is based on projected caseload, patient acuity, and the block allocations. It is adjusted when blocks change, a permanent change in case load occurs, as staff training needs are identified, when patient acuity changes or O.R. protocols dictate. When staff members are scheduled, supervision is assigned to the OR Manager or charge nurse on the day shift and a charge nurse on the evening shift, weekends and holidays. No charge nurse is assigned when the O.R. is covered by call staff only. Weekend/holiday charge nurses have completed all competencies, have at least one year experience in the O.R. and have completed the charge nurse orientation. The Nursing Supervisor for the Hospital is available as a resource for both charge nurses

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and nurses on call. The charge nurse may be the circulating nurse. The variable is the level of activity in the department and the complexity of the case(s) and availability of other personnel. A registered nurse is always assigned as circulating nurse. For most cases, two staff members are assigned with an RN to circulate and an ORT to scrub. If a local case will involve moderate sedation and an anesthesiologist will not be present, a third RN will be assigned to exclusively monitor the patient during the procedure. The monitoring RN must be ACLS certified. The second RN may be an RN from the O.R., PACU, or Critical Care Unit. When the Laser is used, a laser trained staff member will be assigned to the laser procedure. When the laser is in "Active" use, the OR personnel needs to stay close to the laser unit to be able to switch the unit back to standby or adjust power as needed. An OR computer system (Surgical Information System) is utilized to schedule procedures and collect data for Perioperative Services. The ORA's are assigned to rooms and supports the activities of the O.R. staff and anesthesiologists

- Post Anesthesia Care Unit (PACU)

  The staff of PACU consists of RNs for direct patient care and one CNA who supports the nursing staff activities and transports patients. The RNs do not float to other units in the Hospital. (Except designated PACU to OPS/SS RNs) The RNs are responsible for the care of all patients in PACU. RNs are assigned two beds per shift and the charge nurse assigns patients to the beds based on patient needs and nurse availability. Each nurse is trained to provide care to any patients requiring post anesthesia recovery and is responsible for assigned patients from admission to PACU through discharge from PACU. The charge nurse is not assigned specific beds but acts as a float nurse to assist with patient flow, admissions, discharges, transports and break relief. When the charge nurse leaves the unit, another RN is assigned to direct patient flow. Clinical support staff transports patients, cleans and stocks supplies, assists nursing personnel with lifting and turning of patients, and with some clinical tasks. Students serve as observers in PACU and any care given in the department is provided only under the direct supervision of a staff nurse

- Responsibilities of On-Call Staff Members

  Staff members on-call for emergencies are responsible for maintaining communications with the Hospital. The department of Nursing Supervisor is to be notified each time a change in the communication link is made from pager to phone. Staff members must be able to arrive at the Hospital within 30 minutes from notification by phone. Patients will be recovered in the CCU when PACU is closed and staffing warrants coverage.

- Governing Rules for the Operating Room

  The operating rooms are scheduled by "block designation." Blocks are assigned to either a service, a group of physicians or to individual surgeons. The blocks are assigned in 4-hour or 8-hour increments. Blocks are assigned based on utilization needs, program requirements and requests from physicians. Demonstrated high utilization over time allows for allocation of additional block time. Conversely, under utilization over time will result in relinquishing of block time. The Operating Room

Committee is the governing body that will make the decisions regarding allocation of time in the operating room

- **Block Schedule -** The operating rooms are scheduled according to "Block Scheduling" designation.
    - Blocks are either 4-hour or 8-hour time increments.
    - Surgical cases may be scheduled as time in the block permits.
    - Blocks release at varying times based on the service need and agreed-upon release time by the O.R. Committee.
    - Blocks are suspended during holiday weeks. Open booking on a first-come basis occurs.
    - Surgeries added on to the schedule the same day of surgery are "on-call cases" and are done as O.R. rooms and resources are available. The surgeon is responsible for communicating start time limitations and urgency of the procedure or patient's condition (e.g.: within 2 hours, next available room, etc.)
    - When a physician must bump another physician on the schedule, it is the surgeon's responsibility to communicate with the other physician and state rationale for the disruption of the schedule.
    - The O.R. Committee based on results of utilization and requests for block time will make changes in block allocations on a quarterly basis.
    - Any issues regarding scheduling times must be discussed with O.R. management personnel, who will help facilitate scheduling options. Administration will not facilitate or make decisions that will impact the O.R. schedule

- **Utilization**
    - Block holders are expected to maintain 70% utilization.
    - Utilization is monitored on a monthly basis and reported at the O.R. Committee.
    - If utilization falls below 70%, the chair of the O.R. Committee will contact the physician or group to notify them of their utilization results for that month.
    - If utilization continues below 70% for three months, block time will be adjusted or relinquished and the time will be reassigned.
    - When block time is released prior to the designated release time, unused time is not counted against utilization (e.g.: vacations). This provides the O.R. the ability to open up this time for scheduling well in advance of the normal release time.
    - When block time is released for three consecutive months, the allocated block will be canceled.

Perioperative Services - Los Gatos (Outpatient Surgery/ Short Stay Unit, Post Anesthesia Care Unit, Operating Room & Central Sterile Processing Department)

- **Start Times**
    - Surgery "start time" is defined as "patient in-room time."
    - For surgeries starting at 7:30am, the anesthesiologist, surgeon and nursing personnel must arrive at a time that allows for all required procedures, processes and documentation to be completed in order for transport of the patients into the operating rooms to begin at 7:15am. The patient should be in the O.R. suites no later than 7:30am. All lab work, H&P and preoperative requirements must be ordered and completed to avoid delays in patient preparation.
    - Physicians are expected to arrive in the O.R. at their scheduled start time unless otherwise notified by the O.R. that their scheduled start time has changed. Surgeons should arrive at the time needed in order for patient preparation to be complete for transport to begin on time.
    - When a physician is consistently late for his/her scheduled surgery, the Chair of the O.R. Committee will contact the surgeon to discuss the expectations regarding start times and the implications of continued late arrival. After three warnings, the surgeon will no longer be allowed to schedule in the AM time slots. The surgeon will lose block time privileges and/or 7:30am start time privileges for three months. Late arrival is defined as 10 minutes.
    - The O.R. will postpone a surgery if the physician is more than 30 minutes late
- **Schedule Delays**
    - If a scheduled surgery is taking longer than originally scheduled and will be impacting the start time of the following physician, anesthesiologists and O.R. personnel will collaborate to find another room that can accommodate an earlier start time for the delayed surgeon.
    - The O.R. will make every attempt to notify a physician at least 30 minutes in advance if a delay in his/her starts time is anticipated.
- **Urgent/Emergent Add-On Cases**
    - In order to expedite the add-on surgery schedule and based on surgeon, room and equipment/ instrumentation availability, add-on cases will be scheduled into any of the staffed rooms during the day and evening shift.
    - The "Anesthesia Scheduler" will help expedite the flow of add-on cases as necessary.
    - A collaborative effort will be made to accommodate the requested start time for these ad-on cases.

- Any identified issues with start times will be discussed at the O.R. Committee

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Approval Signatures

Step Description	Approver	Date
Department of Surgery	Nancy Billington: Dir Perioperative Svcs	Pending
Department of Surgery	Patrick Santos: Policy and Procedure Coordinator	Pending
Owner | UPC | Staff Meeting	Nancy Billington: Dir Perioperative Svcs [PS]	12/2025

Status **Pending** PolicyStat ID **19579895**

Origination	05/2010
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Next Review	3 years after approval
Owner	Dan Lanari: Operations Consultant (Interim Program Director)
Area	Acute Rehab Unit
Document Types	Scope of Service

Scope of Service - Acute Rehab Center

COVERAGE:

All El Camino and Contracted Staff

PURPOSE:

To provide the framework for the scope of services provided at the Acute Rehab Center and describe the program philosophy).

STATEMENT:

It is the policy of El Camino Hospital to comply with all mandatory reporting requirements for provision of Acute Rehab Services.

PROCEDURE:

OUR COMMITMENT TO YOU

It is the policy of the Rehabilitation Center at El Camino Hospital Los Gatos that all team members will act in a manner consistent with the mission, philosophy, and operating policies of the program. In accordance with these principles and policies, team members will:

- Show respect for the dignity of the individual, whether patient, family member, co-worker, client, or any other person.
- Provide the highest quality clinical and customer-related services.

Scope of Service - Acute Rehab Center

- Demonstrate fairness and honesty in all interactions with the public.
- Adhere to their professional codes and practice guidelines
- Provide an accurate portrayal of the services and outcomes of the program.
- Be ethical in all marketing and public relations activities.

PERSONS SERVED

Comprehensive inpatient rehabilitation services are provided to adult and adult geriatric patients with neurological and other medical conditions of recent onset or regression and who have experienced a loss of function in activities of daily living, mobility, cognition, or communication. This program serves persons who are eighteen years of age or older and accepts persons served of varying cultural backgrounds. All patients are medically stable but have sufficient medical acuity to warrant an ongoing hospital stay.

Diagnoses of persons served include, but are not limited to, those who have experienced any of the following: cerebral vascular accident, spinal cord injury (Traumatic or Non-traumatic SCI, Complete or Incomplete at or below T1 level), traumatic brain injury, amputation, multiple traumas, hip fracture or joint replacement, arthritis, congenital deformity, burns, or other progressive, neurological syndromes such as Guillain-Barre, Parkinson's disease and Multiple Sclerosis.

METHODS USED TO ASSESS AND MEET PATIENT NEEDS

Pre-admission screening is provided prior to admission, during which current functional status is evaluated and discharge goals are delineated. A comprehensive assessment of each patient's medical, physical, and cognitive condition and psychosocial and cultural background is a prerequisite for the formation of a course of rehabilitation. A patient's psychological status is also considered when determining whether he or she could benefit from admission.

The Team Admission Assessment, including objective and subjective data, is initiated within:

- Eight (8) hours of admission by nursing
- Within thirty-six (36) hours by midnight of the day admitted to the rehabilitation unit for physical therapy, occupational therapy or speech-language pathology
- Within 72 hours of physician order for social work/discharge planning.

SCOPE AND COMPLEXITY OF PATIENT CARE NEEDS

As a result of the conditions and impairments leading to the admission of a patient, the patient is called upon to address activity limitations by developing new skills, and re-learning previous skills. Patient must also make a series of life adjustments. Such adjustments can best be facilitated by the combined efforts of the patient, family, and interdisciplinary professional rehabilitation staff. Coordination of the efforts of this interdisciplinary rehabilitation team leads to the highest possible rehabilitation outcomes attainable by each patient, limiting participation restrictions. Such treatment requires a highly individualized and holistic approach.

Scope of Service - Acute Rehab Center

A wide range of services is needed to address the multitude of treatment goals identified in the assessment. The goal of each service is to maximize the individual's potential in the restoration of function or adjustment by integrating with other services. Every effort is made to discharge persons served back into the community.

SCOPE OF FAMILY/SUPPORT SYSTEM SERVICES

The supportive involvement of family or other support networks is recognized as a key component in the success of the individuals return to the most independent and appropriate discharge environment. The team will assess the family's ability and willingness to support and participate in the plan of care. Education, physical training, advocacy training and supportive counseling will be provided to prepare them for the needs of the patient moving forward.

APPROPRIATENESS, CLINICAL NECESSITY, AND TIMELINESS OF SUPPORT SERVICES

Ancillary services are provided including, but not limited to, medical nutritional therapy/dietary services, pharmaceutical services, respiratory therapy, diagnostic radiology, dental services, pathology, laboratory services, audiology, driver education, and chaplaincy services/pastoral care. In addition, prosthetics, orthotics, vocational rehabilitation, audiology, and rehab engineering are provided when necessary through affiliate agreements or arrangements with external organizations. The time frame for provision of such services is determined by the interdisciplinary team.

AVAILABILITY OF NECESSARY STAFF

A minimum staff complement includes a Rehabilitation Physician (who visits patients a minimum of three times per week), nurses (available 24 hours per day, 7 days per week), and occupational therapy and physical therapy. Social work and speech-language pathology services are also available. Staffing patterns are based upon census, diagnosis, severity of illness, and intensity of services required by each patient admitted, as well as by state practice guidelines for each discipline. Contract staff is available for coverage. Therapy services are available at least 5 days per week from approximately 7:30am to 4:30pm. Based upon each patient's needs, therapy services are also available on the weekend. Social work/case management services are available 7 days per week with regular and on call staff. Patients will receive therapy treatments typically once or twice per day by each therapy discipline identified by their treatment plan. Staff competencies include growth and development for adult and adult geriatric patient, functional measurement scoring, cardiopulmonary resuscitation, and discipline-specific skills.

EXTENT TO WHICH LEVEL OF CARE OR SERVICES MEETS PATIENT NEEDS

It is the practice of this unit to seek input from persons served in the following manner:

- Patient Satisfaction Questionnaires (at discharge)
- Two-week follow-up calls for all patients

Scope of Service - Acute Rehab Center

- 90-Day Follow up calls for all patients
- Patient Complaint/Grievance Procedure
- Patient/family feedback through team conferences, support groups, etc.
- Stakeholder feedback

Reassessment of patients is conducted weekly and documented through the interdisciplinary treatment plan, progress notes, a clinical staffing summary, discharge summary.

The milieu of the Inpatient Rehabilitation Facility is warm, open, and supportive as patient, family, and the staff become partners in skill development. The emphasis throughout is on the accomplishment of treatment goals. Focusing on abilities rather than disabilities is promoted, as energy diverted to the disability hinders the lifelong rehabilitation process.

Successful rehabilitation requires reintegration of the individual and family into their home/community. The transition from hospital to home requires the support of the professional rehabilitation staff, and is accomplished via passes to home and within the community and through a formalized program that allows a gradual separation from the hospital with the development of community support systems.

By addressing the multiple effects that disability has on the patient and family, and by integrating the combined resources of patient, family, and interdisciplinary rehabilitation team, comprehensive rehabilitation programming can maximize the abilities and esteem of the patient and family and foster a healthy reintegration into the community. The prevention/minimization of participation restrictions is the ultimate goal of rehabilitation. As rehabilitation specialists, our focus is to help patients attain, maintain, or restore health and to maximize participation in order for patients to function in life's roles. The team will work closely with the patient and family to identify the most appropriate discharge environment for the patient at the completion of the acute rehabilitation phase of recovery. If additional therapeutic interventions are required, the team will assist in identifying sources for the services.

PAYERS/FEES

Inpatient rehabilitation services are typically covered by Medicare and Medicaid as well as commercial insurers based on qualifying criteria. Physicians are independent contractors and will bill for their services separate from the hospital services directly to your insurance carrier. Patients will receive information regarding any fees for which they might be responsible as part of the admission process.

STANDARDS OF PRACTICE

- Centers for Medicare/Medicaid Services
- Commission on Accreditation of Rehabilitation Facilities
- Joint Commission on Accreditation of HealthCare Organizations
- Association of Rehabilitation Nurses
- American Occupational Therapy Association
- American Physical Therapy Association
- American Speech-Language and Hearing Association

Scope of Service - Acute Rehab Center

- National Association of Social Workers
- State Licensure Boards

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Approval Signatures

Step Description	Approver	Date
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	Pending
Department Medical Director or Director for non-clinical Departments	Dan Lanari: Operations Consultant (Interim Program Director)	12/2025
	Dan Lanari: Operations Consultant (Interim Program Director)	12/2025

Status **Pending** PolicyStat ID **19081306**

Origination	05/2018	Owner	Matthew Scannell: Director Safety & Security Services
Last Approved	N/A	Area	Security Management
Effective	Upon Approval	Document Types	Plan
Last Revised	12/2025		
Next Review	1 year after approval		

Workplace Violence Prevention Plan

COVERAGE:

This plan covers all employees, physicians, contractors/supplemental workers, students, volunteers, members, patients, and visitors.

PURPOSE:

This WORKPLACE VIOLENCE PREVENTION PLAN is developed to meet our commitment to the safety and well-being of all employees. This Plan meets the requirements of Title 8 of the California Code of Regulations, Chapter 4, New Section 3342 (Cal/OSHA Workplace Violence Prevention in Health Care) regulations. The Plan is part of the overall Injury and Illness Prevention Program (IIPP), and includes assessment, violence incident log, annual review, training, reporting and record keeping.

The purpose of this Plan is to provide guidance to operationalize Cal/OSHA regulatory requirements aimed at preventing workplace violence.

PLAN STATEMENT:

El Camino Hospital (ECH) takes reasonable preventive measures to provide a safe environment for everyone on ECH premises. ECH has zero tolerance for acts or threats of violence, and/or intimidation that involve or affect ECH workers or that occur on ECH premises. See HR-Discrimination and Harassment Policy.

This plan outlines the prevention and management to safeguard all employees, physicians, contractors/ supplemental workers, students, volunteers, patients, and visitors to ECH premises from violence, threats, and/or intimidation by addressing threats and aggressive behavior at the earliest stage; define

Workplace Violence Prevention Plan

and mitigate inappropriate and unacceptable workplace behavior; and establish an effective process for responding to, managing, and reporting acts or threats of violence or aggressive behavior.

DEFINITIONS:

Regulatory Definitions as outlined by Cal/OSHA Title 8, Chapter 4, New Section 3342, Workplace Violence Prevention in Health Care

A. **Alarm**: a mechanical, electrical or electronic device that does not rely upon an employee's vocalization in order to alert others.

B. **Dangerous weapon**: an instrument capable of inflicting death or serious bodily injury.

C. **Engineering controls**: an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between the worker and the hazard. For purposes of reducing workplace violence hazards, engineering controls include, but are not limited to: electronic access controls to employee occupied areas; weapon detectors (installed or handheld); enclosed workstations with shatter-resistant glass; deep service counters; separate rooms or areas for high risk patients; locks on doors; furniture affixed to the floor; opaque glass in patient rooms (protects privacy, but allows the health care provider to see where the patient is before entering the room); closed-circuit television monitoring and video recording; sight-aids; and personal alarm devices.

D. **Environmental risk factors**: factors in the facility or area in which health care services or operations are conducted that may contribute to the likelihood or severity of a workplace violence incident. Environmental risk factors include risk factors associated with the specific task being performed, such as the collection of money.

E. **Field operation**: an operation conducted by employees that is outside of the employer's fixed establishment, such as mobile clinics, health screening and medical outreach services, or dispensing of medications.

F. **Intimidation or Harassing Behavior.** Threats or other conduct which in any way creates a hostile environment, impairs operations; or frightens, alarms, or inhibits others. Psychological intimidation or harassment includes making statements which are false, malicious, disparaging, derogatory, rude, disrespectful, abusive, obnoxious, insubordinate, or which have the intent to hurt others' reputations. Physical intimidation or harassment may include holding, impeding or blocking movement, following, stalking, touching, or any other inappropriate physical contact or advances.

G. **Patient contact**: providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient.

H. **Patient specific risk factors**: factors specific to a patient, such as use of drugs or alcohol, psychiatric condition or diagnosis, any condition or disease process that would cause confusion and/or disorientation or history of violence, which may increase the likelihood or severity of a workplace violence incident.

I. **Threat of violence**: a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured and that serves no legitimate purpose.

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J. **Work practice controls**: procedures, rules and staffing which are used to effectively reduce workplace violence hazards. Work practice controls include, but are not limited to: appropriate staffing levels; provision of dedicated safety personnel (i.e. security guards); employee training on workplace violence prevention methods; and employee training on procedures to follow in the event of a workplace violence incident.

K. **Workplace violence**: any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

1. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
2. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;
3. Four workplace violence types:
    a. **Type 1 violence**: workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
    b. **Type 2 violence:** workplace violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.
    c. **Type 3 violence**: workplace violence against an employee by a present or former employee, supervisor, or manager.
    d. **Type 4 violence:** workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

REFERENCES:

- ECH Policy: HR-Discrimination and Harassment Policy.
- Cal/OSHA Title 8, Chapter 4, New Section 3342, Workplace Violence Prevention in Health Care https://www.dir.ca.gov/Title8/3342.html

SCOPE:

A. The Plan covers all locations operated by El Camino Hospital. The Plan applies to all employees, physicians, Supplemental Workers, patients, and visitors and volunteers[1].

B. Cal/OSHA Regulation Title 8 NEW SECTION 3342 – "THE PLAN"

Below are the 11 provisions that are required in to be included in the Plan by Cal/OSHA. These provisions cannot change.

1. Site Specific Locations(s) and title of person(s) accountable for implementing the Plan.

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2. Procedures to obtain active involvement of physicians, employees and their representatives in developing, implementing and reviewing the Plan including their participation in identifying, evaluating and correcting workplace violence hazards, designing and implementing training and reporting and investigating incidents.
3. Methods to coordinate with other employers on site including training and reporting, investigating and recording of incidents.
4. A policy prohibiting the employee from disallowing an employee or taking punitive or retaliatory action against an employee for seeking assistance and intervention from local emergency services or law enforcement when an violent incident occurs.
5. Procedures to ensure that supervisory and non-supervisory employees comply with the plan.
6. Procedures to communicate with employees regarding workplace violence matters, including;
    a. How the employees will document and communicate between shifts and units regarding conditions that may increase potential for workplace violence incidents
    b. How an employee can report a violent incident, threat or concern
    c. How employees can communicate workplace violence concerns without fear of reprisal
    d. How employees concerns will be investigated and how employees will be informed of the results of the investigations and any corrective actions to be taken. The incident reporting process gives employees the ability to raise concerns in all areas including workplace violence.
7. Procedures to develop and provide training
8. Assessment procedures to identify and evaluate environmental risk factors, including community based risk factors for each facility unit, service or operation
9. Procedures to identify and evaluate patient specific risk factors and assess visitors
10. Procedures to correct workplace violence hazards in a timely manner.
11. Procedures for post incident response and investigation. The incident reporting process gives employees the ability to raise concerns in all areas including workplace violence. Additionally the Security report provide a detailed account of any reported workplace violence event.

ECH PLAN:

A. Plan Owner(s)

1. At El Camino Hospital, the responsibility for implementing the Workplace Violence Prevention Plan (Plan) lies with the Hospital Safety Officer.
2. Oversight of Plan and Workplace Violence Prevention Plan. The Behavioral Expectations and Workplace Violence Prevention Steering Committee is tasked with overseeing and enhancing the workplace violence prevention plan by reporting on

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progress, removing barriers, attaining necessary resources, and ensuring compliance with regulatory requirements. Additionally, the committee will evaluate pilot measures and monitor the effectiveness of implemented strategies to promote a safe and respectful workplace environment.

B. Engaging Employees and their Representative's

1. El Camino Hospital will use a variety of procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents.

C. Coordination with External Employers for Supplemental Workers

1. El Camino Hospital will coordinate implementation of the Plan with other employers whose employees work in the health Care facility, service, or operation, to ensure that those employers and employees have a role in implementing the Plan. These methods will ensure that employees of other employers and temporary employees are provided the appropriate training and will ensure that workplace violence incidents involving those employees are reported, investigated, and recorded.
    a. Training for Supplemental Workers: Supplemental Workers are required to have training based on their roles and responsibilities
        i. Initial/Basic Training
        ii. Specialized Training
            - Annual training for those involved with patient contact activities
            - Initial and Annual training for those involved in confronting or controlling persons exhibiting aggressive or violent behavior
            - Initial and annual for those assigned to respond to alarms or other notifications of violent behavior or threats.

D. Adherence to Retaliation Policy

1. The hospital's Human Resources policy (HR-Discrimination and Harassment) protects employees and other individuals who report misconduct and describe El Camino Hospitals obligation to take no retaliatory action against any person for reporting ethics issues or suspected violations of laws and regulatory requirements (including false claims acts), accreditation requirements, or El Camino Hospitals policies, or exercising their rights under federal or state laws.

E. Compliance

1. El Camino Hospital has established procedures to ensure that both supervisory and non-supervisory employees comply with the plan. The ECH Policy Security Management- Prevention of Workplace Violence sets expectations for compliance. **Managers will work with Human Resources and/or Labor Relations if the policies**

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are not followed.

F. Communication

1. El Camino Hospital has established procedures to communicate with employees regarding workplace violence matters. This includes how employees will document and communicate between shifts and units or at any time regarding conditions that may increase potential for workplace violence incidents.
2. Employees are encouraged to report workplace violence concerns to their managers or to the Safety and Security Department without fear of reprisal. This may involve director communication or submission of an iSAFE, Incident Report is filled out via Enterprise Health Employee Portal, or Security Incident reports.
3. To assure a timely response to situations involving an actual or potential physical threat to physicians, personnel, visitors or property, it is the policy of El Camino Hospital's security program that when dealing with a confrontational and/or combative patient, employee and/or visitor the following employee responses will be followed:
    a. Aggressor without a weapon: Activate a Code Gray (angry or violent patient) by calling the emergency line (55) to summon assistance from security services and trained staff. All personnel will be encouraged to recognize activities leading to actual or potential physical threats to personnel, visitors or property. Refer to Code Gray Policy (Security Management- Code Silver - Emergency Response to a Person with a Weapon or Hostage Situation)
    b. Aggressor with a weapon (excluding a gun): Activate Code Silver through the emergency line (55). Since Code Silver is used to inform Security that a patient, visitor, or employee has a weapon, it is important for the Safety of the staff, patients, and security personnel to respond accordingly. Refer to Code Silver Policy (Security Management- Code Silver - Emergency Response to a Person with a Weapon or Hostage Situation)
    c. Aggressor with a gun: Activate an Active Shooter through the emergency line (55). Upon notification of an Active Shooter, Security will contact local law enforcement for assistance. Refer to Active Shooter procedure (Security Management - Active Shooter).
4. Communication about threats or incidents will vary depending on the situation and the work environment. Utilize existing emergency notification communication and documentation procedures that apply to the following situations:
    a. Individual situations within departments
    b. Larger scale situations across departments
    c. Wide scale situations involving a significant portion of a facility/campus
    d. The following should be considered when determining the appropriate communication:
        i. Identify the party(ies) providing the communication
        ii. the urgency of the situation

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iii. the recipients of the communication

iv. The mode of transmission (overhead page, email, nurse shift exchanges, group text, etc.)

v. How an employee can report a violent incident, threat or concern

- The preferred notification process for all workplace violence incidents is through the following reports:
  - **Incident Reporting (Enterprise Health Employee Portal)**: The incident reporting system for hospital and medical staff to report clinical or safety related concerns. This may include information about workplace violence events..
  - **Security Incident Reports:** Security incident reports are generated for all security responses. If the report notes a workplace violent incident, it may be used to log the incident by the team as noted below.

The information collected will be used to complete the Violent Incident Log and providing the information needed for the 24/72 hour hospital report to Cal/OSHA.

vi. Cal/OSHA Reporting Hospital Reporting Requirements for Incidents Occurring in Hospitals

- Any incident involving physical violence against an employee will be reported regardless of whether this resulted in an injury to the employee or not.
  - If there are any questions of whether the incident should be reported, the *Workplace Violence Incident Reporting Team* will review the incident and make a determination.
- The designated person will then complete the internal WPV Reporting Log and the Cal-OSHA Workplace Violence Incident Online Report on the OSHA website.

G. Training

Employees will be assigned to complete Prevention of Workplace Violence Training based on their job description.

1. Awareness/Basic training:

Training for employees and supplemental workers is required initially when the ~~Plan~~plan is first established and when an employee is newly hired or newly assigned

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to perform duties for which training is required. Refresher training will be required whenever there is a change to the Plan or operations impacting the potential for workplace violence. Employees will be given the opportunity to submit questions and receive a response within 24 hours.

2. High Risk Training

   Advanced training is required for all employees and supplemental workers involved in confronting or controlling persons exhibiting aggressive or violent behavior. For El Camino Hospital, this includes high risk departments such as ED, Behavioral Health, ~~Hospital Supervisors~~,and Security Officers.This training will include the elements of the ~~Awareness and Patient Contact~~awareness and patient contact training and includes defensive techniques and controls for patients exhibiting violent physical behaviors. This training shall be completed once every two years by all identified employees.

H. Environmental Risk Assessment

The Director of Safety/Security and the EH&S Manager will assess and establish procedures to identify and evaluate environmental risk factors, including community based risk factors for each facility unit, service or operation. The assessment shall include a review of all workplace violence incidents that occurred within the previous year.

1. Department and area managers will participate in completing area assessments with staff to determine and list high and general risk areas.
   a. ***Workplace Violence Department Risk Assessment***

      This tool is to recognize and consider historical hazards and risks, as well as current hazards and risks, confronting staff. It is to be used to engage and solicit participation from department/service-line staff and representatives in order to develop, implement and review the workplace violence Plan, as well as gain greater insight and obtain solutions and/or alternatives for making the workplace a safer environment.

2. The Security Manager and Director may include campus/facility maps to create an assessment that addresses external risk factors that may have an adverse impact on the campus or services delivered (e.g., local law enforcement crime data, etc.).
3. The Security Manager and Director may also address risks and protective measures for the Facilities, Operations and Services including Common Areas, Hospital, clinics, and Administrative Buildings.

I. Procedures to identify and evaluate patient specific risk factors and assess visitors

1. Procedures are being developed to identify and evaluate patient-specific physical and mental risk factors, including;
   a. Patient's mental status and conditions that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively or aggressively.
   b. Patient's treatment and medication status, type, and dosage as it is

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known.

c. Patient's history of violence, as it is known.

d. Patient's disruptive or threatening behavior.

2. Department and services subject to higher behavioral risks may include the Emergency Department, Behavioral Health, and other high risks departments. Typical characteristics of patients and/or family members displaying threatening or disruptive behavior within these higher risk departments include:

    a. Emotionally charged over injury or injury of loved one

    b. Perceived delay in treatment

    c. History of aggressive behavior or violence

    d. Substance abuse

    e. Feels victimized blames others

    f. Emotionally depressed

    g. Behaving belligerently using harassing or abusive language and

    h. Unfavorable medical diagnosis

These higher risk departments and services are independently assessed as a result of the greater potential for escalated patient/family member behavioral encounters. Enhanced training and engineering and work practice controls are provided to increase staff's awareness, understanding and competency, for de-escalation/ protective practices in order to minimalize psychological and physical harm resulting from the higher likelihood of threatening behavior.

Procedures to identify, evaluate and remediate vulnerabilities based on behavioral risk factors for and visitors, include, but are not limited to implementation of enhanced staff training, enhanced engineering and enhanced work practice controls.

J. Procedures to correct workplace violence hazards in a timely manner

1. El Camino Hospital has developed the following procedures to correct workplace violence hazards in a timely manner. Risks identified during the environmental risk assessment, reported to managers or found as a result of a workplace violence incident must be addressed within the following time-frames:

    a. Imminent hazards – Employees must be protected immediately.

    b. Serious hazards – must be corrected within 7 days of discovery.

NOTE: Interim measures may be taken to abate the imminent or serious hazard while completing the permanent corrective action plan.

2. Corrective Action shall include Enhanced Engineering and Work Practice Controls

Engineering controls and Work Practice Controls are used to eliminate or minimize

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employee exposure to the identified workplace hazards. Remedial measures to protect employees from imminent hazards shall be taken immediately. Remediation activity (Engineering and Work Practice Controls) will be planned and implemented within 7-days following discovery of a serious hazard. If remediation cannot be completed during the specified time-frame, interim measures to abate imminent or seriousness of the hazard may be taken while completing permanent control measures. Enhanced Engineering and Work Practice Controls shall include, but not limited to:

a. Engineering Control considerations
    i. Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.
    ii. Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.
    iii. Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1 or Type 2 violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.

b. Work Practice Control considerations
    i. Minimizing, removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2* violence are reasonably anticipated to be present.
    ii. ~~Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.~~
    iii. Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.
    iv. Establishing an effective response plan for actual or potential workplace violence incidents emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to

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emergencies must not have other assignments that would prevent them from responding immediately to an alarm.

v. Assigning or placing minimum numbers of staff, to reduce patient-specific Type 2* workplace violence hazards.

vi. Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident.

Maintaining reasonable sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner.

A. Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1* or Type 2* violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.

B. Reviewing employees who work in locations isolated from other employees (including employees engaging in patient contact activities) because of being assigned to work alone or in remote locations, during night or early morning hours, or where an assailant could prevent entry into the work area by responders or other employees. Lack of escape routes and the storage of high
-value items, currency, or pharmaceuticals.

C. Incident Response and investigation

1. El Camino Hospital has procedures for post incident response and investigation based on the below language.

    a. Providing immediate medical care or first aid to all employees affected by the incident.

    b. Identifying all employees involved in the incident.

    c. Providing trauma counseling via Employee Assistance Program (EAP)[2].

    d. Conducting a post incident debriefing as soon as possible after the incident with all employees, supervisors and security involved.

    e. Reviewing any patient-specific risk factors and risk reduction measures that were specified for that patient.

    f. Reviewing whether appropriate corrective measures were effectively implemented.

    g. Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause and where any measure would have prevented the injury.

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NOTE: Ensure there is appropriate communication and coordination with the employers of supplemental workers.

D. Annual Review

1. The Plan must be reviewed annually, in conjunction with employees, regarding their respective work areas, services, operations as related to prevention of workplace violence. this includes:
    a. Staffing, staffing patterns, patient classification systems
    b. Sufficiency of security systems, including alarms, emergency response, and security personnel availability
    c. Job design, equipment and facilities
    d. Security risks associated with specific areas and times of day
    e. A review of the violent incident log
2. The annual review will take place via the Workplace Violence Prevention Committee and reported to the Central Safety Committee. Results of the annual review will be used to revise the Plan.

NOTE:

- [1] Volunteers are not employees and are not covered by the regulations. However, they should be oriented to the Prevention of Workplace Violence plan.
- [2] The EAP at El Camino Hospital is Concern: EAP (www.concern-eap.com

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

• Workplace Violence Prevention (WPV) Risk Assessment Checklist

Approval Signatures

Step Description	Approver	Date
ePolicy	Patrick Santos: Policy and Procedure Coordinator	Pending
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	11/2025

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Central Safety	Matthew Scannell: Director Safety & Security Services	10/2025
	Matthew Scannell: Director Safety & Security Services	10/2025

Status **Pending** PolicyStat ID **19159445**

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Next Review	1 year after approval
Owner	Poopak Barirani: Asst Director Pharmacy
Area	Pharmacy
Document Types	Plan

MERP - Medication Error Reduction Plan

COVERAGE:

El Camino Hospital Mountain View & Los Gatos

MERP (Medication Error Reduction Plan) OVERVIEW:

In 2001 the California legislature passed legislation resulting in HSC 1339.63 which required every general acute care hospital to adopt a formal plan to eliminate or substantially reduce medication-related errors. Ensuring that our patient population receives quality health care is and always has been of utmost importance to El Camino Hospitals.

Medication error reduction is one of our key areas of focus. This plan is an opportunity to evaluate our strategies for safe medical practices related to professional practice, or health care product, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

This plan outlines multiple methods for reducing medication errors and will address each of the following strategies:

- Evaluate, assess, and include a method to address the 11 elements: prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.

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- Annual review of the plan to assess the effectiveness of the implementation of procedures and systems related to the 11 elements.
- Modify the plan as warranted when vulnerabilities or deficiencies are noted to achieve the reduction of medication errors.
- Evaluate and assess ability and progress in implementing information technology requirements and how technology implementation is expected to reduce medication-related errors.
- Include a system or process to proactively identify actual or potential medication-related errors. The system or process shall include concurrent and retrospective review of clinical care.
- Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals, nursing, medical, information technology and administration to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.
- Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate e.g., ISMP and medication safety publications.

REFERENCE:

- SB1875 & HSC 1339.63(g)

OBJECTIVES:

- Create a common understanding of the current state of medication errors in the healthcare industry and to create a non-punitive system of reporting errors.
- Define medication processes that support medication safety throughout the 11 elements.
- Improve the clinical decision making process related to medication use.
- Improve communication among the health professionals and patients.
- Monitor Medication error events.
- Enterprise Medication Safety Committee, RN-RX Council MV and RN-RX Council LG and Pharmacy & Therapeutics Committee (P&T) review and evaluate various components of medication management: practices, processes, and usage, compliance and safety concerns.

STRUCTURE:

A. A collaborative multidisciplinary approach has been organized to ensure adequate participation of hospital personnel. Each of the following participate in the medication safety improvement process:

1. care staff. Pharmacy and Nursing Leadership coordinate the meetings. The councils make recommendations, advise, and provide guidance and recommendations related to nursing practice and operationalizing initiatives. RN-RX reviews ISMP newsletters as part of the agenda. RN-RX is also the approving body for Automated Dispensing Machines (ADM) override requests.

MERP - Medication Error Reduction Plan

2. Medication Safety Committee: The members of the committee include representatives of medical staff, pharmacy, nursing, and quality/patient safety and adhoc members. The committee is responsible for the evaluation and implementation of the MERP and reports directly to P&T. The Medication Safety Committee analyzes medication error reports, medication usage, medication shortages and participates in MERP. This is a committee that proposes action plans for process improvement and makes recommendations to P&T.
3. MERP subcommittee: The members include: Pharmacy, Nursing and other ad hoc members. MERP subcommittee will be directly working on the Medication Error Reduction Plan and will report to Medication Safety. Responsible for monitoring compliance and developing action plans related to 11 MERP elements.
4. Pharmacy and Therapeutics (P&T) Committee: Medical Staff Committee consisting of Physicians, Chief Nursing Officer (CNO), Senior Director of Quality , pharmacists, dietician, pharmacy informatics staff, nursing leadership and ad hoc members. P&T reviews a summary of medication error/event reports and adverse drug reactions, approves/monitors formulary deletions and additions, reviews recalls/medications in short supply, MERP plan, and approves policies and procedures.
5. Hospital Quality Committee & Patient/Employee Safety Committee: Medication Safety and Pharmacy Department reports medication safety activities to these committees.
6. Medical Executive Committee: Reviews P&T reports, reviews and approves policies and procedures.
7. Pharmacy Department: Review of medication use related to procedures and systems: prescribing, prescription order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use; medication errors.

B. Medication Error Reporting process:
    1. Errors, near misses, safety and system issues are reported by hospital staff using the electronic system for reporting of unusual occurrence and patient safety issues.
    2. The reports are reviewed by risk management and clinical leadership. Trends for medication errors will be identified and analyzed by Med Safety and MERP committee on a regular basis and takes actions as appropriate.
    3. Medication error trends and MERP plans are reported to P&T for review and approval.
    4. P&T refers physician specific issues to appropriate Medical Staff committees and process issues to Hospital Quality Committee as needed.

C. Communication of Medication Safety Information:
    1. Staff and Department Meetings
    2. Departmental or organizational newsletters such as Pharmacy Newsletter, and InTouch (nursing newsletter), Pharmacy-Nursing Connection Newsletter
    3. Resources provided include computer based drug information programs (e.g.,

MERP - Medication Error Reduction Plan

UpToDate, Micromedex/Lexicomp , as well as other available references in the intranet “Tool Box”)

4. Policies and Procedures: Policies and procedures are available online on the hospital’s intranet.
5. Director of Pharmacy sends monthly Nursing ISMP and biweekly overall Institute of Safe Medication Practices Acute Care Edition to all pharmacy and nursing staff.
6. External sources of information will be reviewed and shared with staff as appropriate. Examples of sources include but are not limited to the following: FDA Medwatch list serve, California State Board of Pharmacy list serve, The Joint Commission Sentinel Event Alert list serve, the ASHP Patient Safety News list serve, the Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI).

MEDICATION ERROR REPORTING AND MONITORING:

A. Definition: A “medication-related error” means any preventable medication-related event that adversely affects a patient and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to:

1. Prescribing
2. Prescription order communications
3. Product labeling
4. Packaging and nomenclature
5. Compounding
6. Dispensing
7. Distribution
8. Administration
9. Education
10. Monitoring
11. Use

B. Proactive identification of actual and potential medication related errors:

1. Medication Safety Committee: Continuous performance improvement review mechanism for medication errors both potential and actual. Reviews medication errors, performs regular assessments, and conducts ongoing evaluation of the medication systems and procedures.
2. Identification of the potential medication-related errors are done by reviewing a variety of patient safety related publications such as ISMP Medication Safety Newsletter, FDA MedWatch, The Joint Commission Sentinel Event Alerts, ASHP Patient Safety List-Serve and California Board of Pharmacy e-mail alerts, identifying any issues that are pertinent at the facility and then implementing suggested

MERP - Medication Error Reduction Plan

changes.

C. Voluntary Non-Punitive Reporting System:

1. Potential or actual medication-related errors are primarily identified via non-punitive unusual occurrence reporting system by hospital staff, which can be submitted anonymously.
2. Actual or potential (near miss) medication-related errors are identified by all staff and physicians.
3. Adverse Drug Reaction (ADR) reports may be done via unusual occurrence system, telephone hot-line or by pharmacy generating reports on reversal agents.

PROCESS:

A. Plan Development Process:

1. Multidisciplinary MERP subcommittee members evaluate the current plan and facilitate the assessment of MERP. Potential or actual medication errors and adverse medication events are discussed at Medication Safety Committee and then reported to Pharmacy & Therapeutics.
2. Analysis of Medication Errors: MERP sub-committee reviews medication errors to identify trends, categorize, and identified the opportunities for reductions of errors.
3. MERP Subcommittee is responsible for identifying annual goals for MERP.

B. Assessment:

1. Baseline assessment of medication related problems and annual review of the effectiveness of the plan are performed using an objective based critical review. If the plan is not effective in reducing medication errors, MERP will be revised to redesign actions to achieve goals.

C. Requirements for Assessing the Effectiveness of MERP:

1. Evaluate, assess, and include a method to address each of the procedures and systems listed under 1339, H&S, subdivision (d) to identify weaknesses or deficiencies that could contribute to errors in the administration of medications.
2. Categorize and focus on evaluating 11 elements of the MERP implementation for ongoing improvement.

Refer to ECH detailed Fiscal Year MERP Crosswalk (Medication Safety Committee)

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Attachments

MERP - Medication Error Reduction Plan

- Final-FY2023-Medication Safety and MERP Annual Report
- FY2025 MERP plan and Appendix.pdf
- FY24 MERP - FY25 Goals
- MERP FY2021 Annual and FY22 Plan.pdf
- MERP Trends and Accomplishments FY2020

Approval Signatures

Step Description	Approver	Date
MEC	Michael Coston: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2026
P & T Committee	Mojgan Nodoushani: Senior Manager-Clinical Pharmacy	11/2025
Medication Safety Committee	Poopak Barirani: Asst Director Pharmacy	11/2025
	Poopak Barirani: Asst Director Pharmacy	11/2025

El Camino Health

BOARD OF DIRECTORS
Policies for Approval
March 18, 2026

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Risk Management & Patient Safety	**FY2026 Patient Safety Plan**	9-1-25	N/A	New	Plan	• Published and active; memorandum signed. PESC > Quality Council > ePolicy > MEC > Quality Committee > Board

POLICY SUMMARY: Establishes El Camino Health's enterprise Patient Safety Plan, outlining the organizational framework, governance oversight, and systemwide approach used to promote a culture of safety, prevent harm, and continuously improve quality and patient outcomes across all care settings. The plan aligns patient safety activities with the organization's strategic priorities, regulatory requirements, and high-reliability principles supporting the Mission Zero goal of eliminating preventable harm.

SUMMARY OF CHANGES: This annual Patient Safety Plan formalizes the organization's ongoing patient safety program and governance structure. Key elements include:

- Reinforces the **Safety First/Mission Zero** high-reliability framework and organizational safety culture expectations.
- Clarifies Board and Quality Committee oversight responsibilities for patient safety performance and reporting.
- Updates organizational structures supporting safety oversight, including enterprise committees, leadership accountability, and multidisciplinary review processes.
- Strengthens emphasis on non-punitive reporting, root cause analysis, and system-based improvement approaches.
- Aligns safety priorities, performance monitoring, and education initiatives with current regulatory, accreditation, and strategic requirements.

No change to the fundamental purpose of the Patient Safety Program; updates reflect annual review, organizational alignment, and continued regulatory compliance.

Department	Document Title	Origin Date	Last Reviewed	Status	Type	Document Details | Approval Workflow
Revenue Integrity	**Hospital Pricing and Chargemaster Policy**	3-1-11	4-7-21	Minor	Policy	• Minor update CFO > ePolicy > Board

POLICY SUMMARY: Establishes the framework governing El Camino Health's hospital pricing structure and chargemaster management to ensure charges are consistently related to the cost of care, applied uniformly across revenue-generating departments, and compliant with applicable billing, coding, and regulatory requirements. The policy defines controls and procedures for establishing, modifying, and maintaining charges for services, supplies, medications, and ancillary services.

SUMMARY OF CHANGES: The policy was reviewed and updated to clarify governance and operational controls supporting chargemaster integrity and regulatory compliance. Key updates include:

- Clarifies organizational oversight and approval processes for pricing updates and chargemaster maintenance.
- Reinforces requirements that charges remain reasonably related to cost and consistent across services.
- Updates procedures governing addition, modification, or removal of clinical services, supplies, and medications.
- Aligns policy language with current billing regulations and revenue integrity practices.
- Minor revisions to coverage and administrative language to improve clarity and consistency.

No change to the fundamental purpose of the policy or Board approval authority for annual pricing adjustments through the operating budget process.

Patient Accounts	**Uninsured Patient Discount Policy**	4-1-22	N/A	Minor	Policy	• Minor update (Coverage) CFO > ePolicy > Board

POLICY SUMMARY: Establishes El Camino Health's guidelines for providing standardized hospital charge discounts to uninsured patients to support access to medically necessary care while promoting responsible stewardship of organizational resources. The policy defines eligibility criteria, discount structure, and administrative processes governing uninsured patient billing and financial responsibility.

SUMMARY OF CHANGES: The policy was reviewed and updated to clarify eligibility requirements and administrative processes supporting consistent application of uninsured patient discounts. Key updates include:

- Clarifies eligibility definitions and applicability of uninsured discounts for hospital-billed services.
- Confirms standardized uninsured discount methodology applied to qualifying self-pay patients.
- Aligns policy language with related Financial Assistance and charity care policies to ensure consistent patient financial protections.
- Updates administrative procedures addressing insurance status changes and documentation requirements.
- Minor revisions to coverage language and approval workflow for clarity and consistency.

No change to the underlying purpose of providing discounted access to care for uninsured patients or to Board-established discount guidelines.

Utility Management	**Physical Environment Utility Management Plan**	2-1-18	2-5-25	Minor	Plan	• Minor update (Formatting, Reference Pes/Eps) Central Safety > PESC > ePolicy > MEC > Board

POLICY SUMMARY: Establishes El Camino Health's Utility Management Plan, defining the governance framework, oversight structure, and operational processes used to ensure the reliability, safety, and regulatory compliance of critical utility systems supporting patient care environments across all hospital campuses and outpatient facilities. The plan supports a safe physical environment by managing risks associated with electrical systems, medical gases, water systems, HVAC, communications, and emergency power infrastructure.

SUMMARY OF CHANGES: The plan was reviewed and updated as part of the annual Environment of Care program evaluation and to align with current regulatory and accreditation standards. Key updates include:

- Updates to reflect **current Joint Commission standards effective January 2026**.
- Clarifies program objectives, performance indicators, and oversight responsibilities for utility system management.
- Enhances monitoring and reporting processes related to system reliability, risk assessment, and incident review.
- Updates performance improvement goals related to staff awareness of emergency power systems and medical gas controls.
- Refines roles and coordination among Facilities Engineering, Environmental Health & Safety, and Central Safety Committee oversight.

No change to the overall scope or purpose of the Utility Management Program; updates reflect regulatory alignment and continuous improvement of the Environment of Care framework.

Status **Active** PolicyStat ID **19957711**

Origination	09/2025
Last Approved	09/2025
Effective	09/2025
Last Revised	09/2025
Next Review	09/2026

Owner	Sheetal Shah: Sr Director Risk Management and Patient Safety
Area	Risk Management & Patient Safety
Document Types	Plan

FY2026 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 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 1400 active, telemedicine, provisional consultant, and affiliate physicians with representation covering over seventy (70) clinical 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 health care 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.

FY2026 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.

GUIDING PRINCIPLES

A. We believe that patient safety is at the core of a quality health-care 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 front-line 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).

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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, payer 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.

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

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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 Performance Goals (NPG), 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 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 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

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events and opportunities for improvement.

- Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
- Review National Performance Goals (NPG) 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 Quality, performance of Failure and Effects Mode Analysis (FMEA).
- 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
- Annual assessment of culture of safety and identification of opportunities for improvement
- Assist and 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 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:

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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 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	• Pressure Injuries • Transfusion reactions/ blood/blood product

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• Surgical site infections • Surgical Safety Checklist	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

ALLOCATION OF RESOURCES

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

CONFIDENTIALITY

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

Data, reports, and minutes of the Quality Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality, Risk Management and Patient Safety Departments

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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.

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

ATTACHMENTS

Att A Governance Information Flow

Att B Safety First / Mission Zero Leader Skill Toolkit

Att C Safety First / Mission Zero Universal Skill Toolkit

Att E HPI Safety Event Classification Algorithm

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

Attachments

- Att A - Governance Information Flow
- Att B - Safety First / Mission Zero Leader Skill Toolkit
- Att C - Safety First / Mission Zero Universal Skill Toolkit
- Att D - HPI Safety Event Classification Algorithm

Approval Signatures

Step Description	Approver	Date

FY2026 Patient Safety Plan

Patrick Santos: Policy and Procedure Coordinator 02/2026

Status **Pending** PolicyStat ID **17263820**

Origination	03/2011
Last Approved	N/A
Effective	Upon Approval
Last Revised	02/2026
Next Review	3 years after approval
Owner	Sandi Fujitani: Director Revenue Integrity
Area	Revenue Integrity
Document Types	Policy

Hospital Pricing and Chargemaster Policy

COVERAGE:

~~All El Camino Health (El Camino Hospital) staff~~

All revenue-generating departments.

PURPOSE:

The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls, that El Camino Health has an established charge rate structure which, within appropriate business parameters, is reasonably and consistently related to the overall cost of providing medical care and to ensure compliance with the billing regulations of Government and Accrediting entities. The steps in this policy must be followed before new clinical procedures/services are performed or new supplies or new medications are added. In addition, the steps in this policy must all be followed if modifications are made to existing procedures, supplies, or medications.

STATEMENT:

This policy is established to maintain the integrity of the chargemaster, to ensure competitive and consistent pricing, to ensure compliance with all pertinent billing and coding regulations, and to maintain integrity in system generated reports. The organization's objective is to establish consistent prices reasonably related to the cost of providing the service through effective chargemaster maintenance and pricing in all revenue producing departments. Annual changes to the rate structure will be determined in the budget process and approved by the Board of Directors through their approval of the operating budget. Other changes may be made from time to time by management if costs or other relevant factors

for a particular service change during the year.
Any changes to the rate structure – whether through the addition of new charges, deletion of existing charges or the modification of existing charges – will be reasonably and consistently related to the services. Charges will be rational and consider the complexity of the service rendered relative to other similar procedures. Guidelines related to charging for supplies, medications, room and board, and ancillary services are listed under "Procedure" below.

PROCEDURE:

Updates to the chargemaster and annual pricing adjustments will follow the guidelines prescribed in the Hospital Pricing and Chargemaster Change Management Procedures document, maintained by the Finance Division.

I. **ENFORCEMENT:**
VIOLATIONS OF THIS POLICY WILL BE ADDRESSED ACCORDING TO THE GUIDELINES OF THE ORGANIZATION'S DISCIPLINE AND DISCHARGE POLICY.

Supply Charges

Hospital supplies used for patient care can be separated into two categories: 1) supplies that are built into the room or procedure charge, 2) supplies charged separately from the room charge. In determining how to set up the supply charge in the Chargemaster, the department utilizing the supply must validate the cost of the supply and how it will be used.
Supplies charged per the first category (i.e. used on all patients and built into the room or procedures) are those supplies that are generally used for all patients for specific care. Such supplies include, but are not limited to, cotton swabs, gauze, etc. Equipment (non-disposable) is also included in this category and is not to be charged separately.
Supplies in the second category (i.e. charged to the patient separately) are necessary to patient care, necessary to the service/procedure being performed, separately identifiable to an individual patient, not reusable (with the exception of reposable supplies), and are not floorstock.

Medication Charges

Hospital medications used for patient care can be separated into two categories: 1) medications charged individually (separate from a procedure charge), 2) medications built into a procedure charge. In determining how to set up the medication charge in the Chargemaster, the clinical/ancillary department or Pharmacy department must validate the cost of the medication and any factors that affect billing.
Medications in the first category (charged to the patient individually) are necessary to patient care and are necessary to the procedure being performed and not included in the procedure charge (in compliance with appropriate requirements and billing regulations of Government and Accrediting entities).
Medications charged per the second category (built into the procedure charge) are those medications required by the billing regulations of Government and Accrediting entities to be included in the procedure charge.

Hospital Pricing and Chargemaster Policy

Inpatient Room Charges

The hospital's inpatient room charge (also known as the "Daily Hospital Service" charge) shall be considered inclusive of the following: reusable items, supplies, equipment that are routinely used or provided to all patients during their stay on the inpatient unit. The inpatient room charge is not inclusive of procedures performed at the bedside by medical personnel when such procedures are not routine / provided to all patients in the unit. Such procedures may be charged separately, in addition to the inpatient room charge.

Ancillary Charges

Ancillary charges (in addition to the aforementioned supplies and pharmaceuticals) are charges that may include, but are not limited to, diagnostic testing, surgical or interventional procedures, therapy, and other medical services rendered to patients. Ancillary charges shall be charged separately from inpatient room charges as applicable.

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2026
CFO	Raju Iyer: CFO	01/2026
Senior Director, Revenue Cycle	Brian Fong: Executive Director Revenue Cycle	12/2024
	Sandi Fujitani: Director Revenue Integrity	12/2024

History

Sent for re-approval by Fujitani, Sandi: Director Revenue Integrity on 12/20/2024, 3:08PM EST

Last Approved by Fujitani, Sandi: Director Revenue Integrity on 12/20/2024, 3:08PM EST

Last Approved by Fong, Brian: Assistant VP, Revenue Cycle on 12/31/2024, 6:29AM EST

Hospital Pricing and Chargemaster Policy

Last Approved by Iyer, Raju: CFO on 1/30/2026, 3:53PM EST

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 2/13/2026, 6:02PM EST

> Minor update to coverage, per ePolicy recommendation; agreed by Brian Fong.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 2/13/2026, 6:42PM EST

> ePolicy 2/13/26 - Approved

Status **Pending** PolicyStat ID **18386946**

Origination	04/2022
Last Approved	N/A
Effective	06/2028
Last Revised	02/2026
Next Review	3 years after approval
Owner	Johnna Mohun-Garvey: Director Patient Accounts
Area	Patient Accounts
Document Types	Policy

Uninsured Patient Discount Policy

COVERAGE:

~~Uninsured individuals requesting patient discount.~~

El Camino Hospital (ECH) Business Office Staff.

PURPOSE:

Consistent with its Mission, El Camino Hospital ("ECH" or "Hospital") strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. This can be initiated by the patient or Patient Accounting staff.

POLICY STATEMENT:

ECH is committed to providing access to healthcare for individuals without health insurance.

ECH's financial assistance programs are not substitutes for personal responsibility. Patients are expected to cooperate with ECH's procedures for obtaining financial assistance and to contribute to the cost of their care based on their ability to pay. In order to manage its resources responsibly and to allow ECH to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes these guidelines for the provision of uninsured discounts.

DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

Eligible Services: The following services are ineligible for discounts under this policy:

Uninsured Patient Discount Policy

- Purchases from ECH retail operations, such as gift shops & cafeteria;
- Any products or services that are:
    - Inconsistent with the symptom(s) or diagnosis and treatment of the condition, disease or injury
    - Primarily for the convenience of the patient, the patient's family, the physician or other provider
    - Not the most appropriate level of services that can safely be provided to the patient;
- Services which are programmatically bundled and discounted. Some examples of these bundled services include packages for Self-Pay Endometriosis and Maternity Services; and
- Physician Services that are not billed by Hospital.

Physician Services are not covered by this policy.

Excluding any services specifically listed as ineligible, hospital services provided and billed by ECH are eligible for ECH's uninsured patient discount policy.

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her health care payment obligations or has directed ECH to not submit a claim to his/her third-party insurance, as documented in patient's signature/agreement to Acknowledgement of Self-Pay Status form or another form of similar effect.

UNINSURED DISCOUNTS:

A. Uninsured Discounts
Patients who do not have third-party insurance and are not eligible for a government program will receive a published discount off ECH charges of 75% for Hospital/Facility billing.

A patient who directs ECH to not share health information to available commercial/private third-party insurance, e.g., who directs ECH to not submit a claim to such available third-party insurance, may receive an uninsured discount after executing an Acknowledgment of Self-Pay Status form or another form of similar effect.

Furthermore, the uninsured discount may be applied to billed charges that are deemed non-covered (not a covered benefit) by an insurance plan or policy or government program. However, this policy may not apply to patients with government benefits to the extent that such non-covered benefits have a direct or indirect relationship to services reimbursable by any government program

Additional uninsured discounts may be determined by ECH management. This uninsured discount policy is not for uninsured patients with a Family Income at or below 400% of the federal poverty level. Such patients will be eligible for charity care pursuant to the ECH policy entitled "Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)."

Amount written off of the patient account because of the Uninsured Patient Discount may not be classified as bad debt.

Uninsured Patient Discount Policy

B. **Changes in Insurance Status.** The eligibility for uninsured discounts shall be based on the patient's insured status at the time services are rendered, and shall give consideration to any retroactive denial or granting of insurance. That is, if the patient is believed to be insured at the time services are rendered but is subsequently found to have been uninsured at that time, then the patient may be eligible for an uninsured discount. Similarly, if the patient is believed to be uninsured at the time services are rendered but is subsequently found to have been insured at that time and has not executed an Acknowledgment of Self-Pay Status form or another form of similar effect, then the patient is not eligible for an uninsured discount. An uninsured discount will be reversed in these situations.

   Patients who decline to disclose his/her/their insurance status will be provided an uninsured discount until the hospital can establish whether the patient does have coverage.

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2026
CFO	Raju Iyer: CFO	01/2026
Senior Director, Revenue Cycle	Brian Fong: Assistant VP, Revenue Cycle	06/2025
	Johnna Mohun-Garvey: Director Patient Accounts	06/2025

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Uninsured Patient Discount Policy

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Owner	John Thompson: Chief Engineer
Area	Utility Management
Document Types	Plan

Physical Environment Utility Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, secure, accessible and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients, members, employees, physicians and visitors.

To that end, it is the overall intent of this plan to establish the framework, organization and processes for the development, implementation, maintenance and continuous improvement of a comprehensive Utility Management Program. The program objectives include:

- Promoting a safe, controlled, and comfortable environment
- Ensuring operational reliability of utility systems
- Reducing the potential for healthcare organization-acquired illness to be transmitted through the utility systems
- Assessing the reliability of utility systems and minimizing potential risks of utility system failures.

A. **Goals:**

Physical Environment Utility Management Plan

Based on areas of improvement noted in the FY~~-24~~ Annual Evaluation, the performance improvement indicators ~~for FY-25~~ will be:

1. Staff can describe where their emergency power (red) outlets are located.
2. Staff can describe who has the authorization to turn off medical gas controls.

B. **Objectives:**

Specific objectives of the FY~~-25~~ Utility Management Plan include the following:

1. Complete the remote critical power monitoring management system to see the power distribution of emergency power and the remote control of automatic transfer switches.
2. ~~Engineering will revise the elevator entrapment policy to include elevator locations, contact numbers to call into the elevator and which elevators are programmed to be operational during a PG&E power outage.~~
3. Maintain critical electrical systems through inspection and scheduled maintenance.
4. ~~Evaluate and manage Utility compliance with NFPA and Joint Commission compliance.~~

   Evaluate and manage Utility compliance with NFPA and Joint Commission compliance.
5. ~~Evaluate the water management plan for clarification on how water is distributed to specialty services i.e Dialysis and facility emergency water supply distribution.~~

SCOPE AND APPLICATION:

A. This plan applies to utility systems, components and the uses thereof, for the purposes of providing:
   1. Environmental control/comfort ventilation
   2. Mechanical ventilation for the purposes of infection/exposure control
   3. Life support
   4. Support to the diagnostic and therapeutic environments
   5. Communication systems
   6. Support to other critical processes and equipment

B. The items, processes and critical functions addressed in this plan include, but are not limited to the following:
   1. Heating, Ventilation and Air Conditioning (HVAC);
   2. Electrical distribution and emergency power;
   3. Vertical transport;
   4. Domestic Water and plumbing;

5. Boiler/steam;
6. Medical gases (Oxygen, Medical Air, Nitrous Oxide, Nitrogen, Vacuum); and
7. Communications (Phones, Nurse Call systems, Public Address).

REFERENCES:

- Joint Commission Accreditation Manual for Hospitals, Physical Environment ~~of Care, EC .02.05.01, .02.05.03, .02.05.05, .02.05.07, .02.05.09, (lighting and ventilation), .02.06.01~~; **PE.04.01.01, EP3, PE.04.01.03, EP1, PE.04.01.03, EP4, PE.04.01.03, EP3, PE.04.01.01, EP1 & EP2, PE.01.01.01, EP1 & EP2**
- California Code of Regulations, Title 22, Sections 70837, 70841, 70849, 70851, 70853, 70855;
- California Code of Regulations, Title 24 (UMC), Sections 330, 412, 413;
- California Code of Regulations, Title 8, Sections 5141, 5142, 5143, and 5154.

AUTHORITY:

The authority and responsibility for program strategic design, and the operational oversight has been assigned to the Facilities Director with operational implementation provided by the Chief Engineer. ~~Program implementation and day-to-day operational management has been delegated to the Chief Engineer under the authority of the Chief Administrative Officer (CAO).~~

The Chief Engineer works in concert with the Environmental Health and Safety (EH&S) Manager, and the Central Safety Committee to ensure the Utility Systems Management Program is in alignment with the direction of the comprehensive EOC program.

PROGRAM ORGANIZATION AND RESPONSIBILITIES:

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

B. **Facilities Engineering and Safety/Security Department**

Facilities Engineering and the Safety/Security department have been given the responsibility for the design, implementation and oversight of the Utility Systems Management Program. These responsibilities include:

1. Coordination of the initial and ongoing risk assessments
2. Development of written plans and operating procedures
3. Identifying training needs
4. Providing technical consultation and assistance with utilities end users, and emergency response training

5. Planning for and organizing initial response to utility failures
6. Investigation and reporting of related incidents and significant events
7. Evaluating overall program efficacy and performance

C. **Environmental, Health & Safety Manager, Clinical Laboratory, Chief Engineer**

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

D. **Central Safety Committee**

The Central Safety Committee (CSC) ensures the utility management program remains in alignment with the core values, direction and goals of the organization by providing leadership, determining priority and assessing the need for changes to the program. The CSC acts as a clearinghouse for action items, recommendations, leveraging issues and the development of program requirements and improvements.

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

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

E. **Employees**

Employees are responsible for participating in utilities training and demonstrating core competencies relative to safe, effective utility systems operations pertinent to their department. Employees must ensure their work practices, operations, and behaviors are safe, and in accordance with departmental procedures, the provisions of this plan, sound infection control principles, hygiene practices and clinical judgment.

Applicable employees are also responsible for knowing the locations of the shut off apparatus for critical utility system components, the proper use, capabilities and limitations of utility systems, and procedures for failures and outages.

RISK ASSESSMENT:

The risks associated with the management of Utility Systems are assessed and controlled through the following facility-wide processes:

- Ongoing Utilities management/Quality Control methods and protocols, including those designed to address user errors and system failures;
- Incident Report review/evaluation through the Quality Review Report (QRR) and Central Safety Committee;

- Identifying and mapping the layout of utility systems, and taking inventory of operating components, relative to their impact on critical systems and potential risks associated with system failure;
- Dust Control risk assessments through Infection Control
- Monitoring of ILSM and Methods of Procedures (MOP'S) during construction projects and planned utility shutdowns.
- Environmental rounds and hazard surveillance surveys;
- Communications with end users of utility systems; and
- Results of education and training skills assessments.

The profile of potential physical risks with respect to utilities management includes, patient impact/ adverse outcomes, occupational hazards (electrical, mechanical, etc.), and compromised system function/integrity.

Risks are evaluated and controlled through the review of risk management/incident reports, examination and analysis of pertinent data through the QRR, and the response to and correction of utility failures, systemic issues and user errors.

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE:

The following describes the implementation of El Camino Hospitals utility management program:

A. ~~The establishment of criteria for identifying, evaluating and taking inventory of critical operating components for inclusion in the utility management system. The basic criteria for designating systems that will be included in the management program are established through collaborative efforts between both Mountain View and Los Gatos campuses. This process begins with the identification of systems that are involved with sustaining a safe, homogenous environment within the facility. These criteria also address utility systems with impact on~~

   The establishment of criteria for identifying, evaluating and taking inventory of critical operating components for inclusion in the utility management system. The basic criteria for designating systems that will be included in the management program are established through collaborative efforts between both Mountain View and Los Gatos campuses. This process begins with the identification of systems that are involved with sustaining a safe, homogenous environment within the facility. These criteria also address utility systems with impact on

   1. Life safety systems;
   2. Infection Control systems;
   3. Environmental support systems;
   4. Equipment support systems; and
   5. Communication systems

   ~~Specific systems addressed in this maintenance plan include:~~

Physical Environment Utility Management Plan

Specific systems addressed in this maintenance plan include:

1. HVAC systems (e.g. comfort ventilation, general dilution and local exhaust ventilation, temperature and relative humidity, air balance and pressure relationships, Indoor Environmental Quality (IEQ))
2. Medical vacuum, air, oxygen, nitrogen and nitrous oxide
3. Electrical distribution
4. Emergency Power/UPS
5. Boiler/steam systems
6. Water distribution
7. Waste water, drains and vents
8. Nurse Call
9. Overhead page
10. Vertical lifts

B. Inspection, testing and maintaining critical operating components falls under the purview of the Engineering Department. For utility components that meet the above criteria, an equipment file form is completed. Each component included in the program is assigned a unique identification number. From there, it is included within scheduled preventive maintenance and testing activities, as indicated. Specific written procedures (instruction sets) are designed for utility inspection, testing and maintenance ~~(**EC.02.05.01, .02.05.03**)~~

1. All critical components of the facility's Piped Medical Gas system are inspected, maintained and tested through the engineering department. The general and routine inspection and maintenance of medical gas systems include:
    a. Visual inspections performed daily to monitor medical gas levels by Engineering. Engineers log and respond to any system alarms;
    b. Signaling panels and area alarm devices, inspected periodically by Engineering;
    c. Valves, pressure switches connectors and end-user service outlets, inspection by Engineering;
    d. Cross connection testing, purity testing and pressure testing will be coordinated through Engineering whenever the system is modified, repaired or otherwise breached, or at least annually (***22 CCR 70849***). Testing will be conducted in accordance with NFPA 99, section 4-5.
2. As part of the internal system to periodically verify the reliability of the Emergency Power Supply System (EPSS), monthly tests of the emergency generators and transfer switches for 30 continuous minutes are conducted under load by Engineering once per month. Each month, each generator will be exercised for at least 30 continuous minutes under a dynamic load that is at least 30% of the nameplate rating. If this requirement cannot be met, the following conditions shall be implemented (See below). ~~(***EC.02.05.01***)~~

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a. As an additional proactive measure to better ensure adequate exercising of the engines and to ensure the requirements for wet stacking are met: Los Gatos: A "load bank" test will be performed to test each generator with a graduated process of supplemental loads, in accordance with the Joint Commission standard annually on any engine not under a load of 30% or more during each monthly test. Every 36 months a four hour load bank test will be performed per the prescribed requirements.

b. These generator tests are documented and any discovered problem of deficiency is promptly addressed, reported through the safety function, as needed and tracked where applicable to overall system performance metrics.~~(EC.02.05.01)~~

3. The Engineering Department implements procedures to effectively reduce the risk of organizational-acquired illnesses through the control of biological agents in water sources. (Such as cooling towers) and other aerosolized water systems as indicated.~~(EC.02.05.01)~~

This aspect of the utilities program is fashioned after applicable portions of existing standards for the environmental control of *Legionella*. Effective *Legionella* control measures will also impact the colonization and proliferation of other water borne pathogens.

4. Mechanical ventilation systems designed for optimal control of airborne contaminants are maintained through Engineering.
5. ~~General air balancing and verification are conducted by Facilities Engineering. Engineering ensures the maintenance and verification of specific air pressure relationships and air exchange ratios, through routine systems maintenance and corrective actions. These specified conditions will be maintained to meet established standards for~~

   General air balancing and verification are conducted by Facilities Engineering. Engineering ensures the maintenance and verification of specific air pressure relationships and air exchange ratios, through routine systems maintenance and corrective actions. These specified conditions will be maintained to meet established standards for

   a. Negative pressure isolation rooms
   b. Positive pressure rooms
   c. Atmospheric isolation relative to preventing the transmission of TB
   d. Required pressure relationships for certain health facility areas

~~Additionally Engineering periodically ensures the verification and efficacy of:~~

Physical Environment Utility Management Plan

Additionally Engineering periodically ensures the verification and efficacy of:

a. Dilution air ventilation to limit the concentration of potential airborne contaminants
b. Air flow patterns within a room (such as laminar flow in the OR)
c. Proper Air flow direction (such as "clean" to "soiled" in Central Processing)
d. Filters

C. The Engineering Department has developed a Building Maintenance Program to address routine maintenance and inspection of site utility systems. In accordance with this program, Preventive Maintenance/Inspection schedules and instruction sets, P.M. completion rates, system reliability and functionality is ensured and relative risks controlled through routine preventive maintenance, testing and the identification and correction of deficiencies. ~~(EC.02.05.01)~~

D. Mapping the Layout of Utility Systems and Labeling Controls - A complete set of current mechanical drawings of utility systems are maintained in the Engineering Department, to help ensure system reliability, reduce failures and provide for effective response. The Engineers ensure system controls are consistently marked throughout the facility to ensure appropriate recognition for partial or complete emergency shutdown. Examples include valve tags, labeling of shut-off valves, numbering air handlers, distribution/disconnect panels and mechanical equipment, marking of overhead pipes, etc. ~~(EC.02.05.01)~~

E. Utility system problems, failures and user errors are investigated through Engineering. Each event as well as the corrective actions implemented is documented and reviewed by the Chief Engineer. From this process, training needs, significant events, true leveraging issues and information pertinent to the department's given performance dimensions are collected and communicated to the Central Safety Committee, as needed. ~~(EC.02.05.01)~~

F. ~~Education and Training for end users of utilities is provided through the individual department manager.~~

~~Training programs address the following:~~

Education and Training for end users of utilities is provided through the individual department manager.

Training programs address the following:

1. System capabilities, limitations and applications;
2. Emergency procedures in the event of failure;
3. Information needed to perform assigned maintenance duties;
4. Location and instructions for emergency shut-off controls;
5. Processes for reporting problems, failures or errors

~~Technical consultative support is provided through the Engineering Department.~~

Physical Environment Utility Management Plan

Technical consultative support is provided through the Engineering Department.

PERFORMANCE:

The standards and metrics by which Utility Management performance will be measured are based upon organizational experiences, customer expectations/satisfaction, regulatory requirements, discerned risks, Central Safety Committee and Quality Committee recommendations, and/or observed work practices and behaviors.

A. ~~**Performance Standard**~~
~~Based on opportunities for improvement identified in the FY-24 EOC Annual Evaluation the FY-25 Performance Improvement Indicators are as follows:~~

Performance Standard
Based on opportunities for improvement identified in the FY EOC Annual Evaluation the FY Performance Improvement Indicators are as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Utility Systems	Staff can describe where their emergency power (red) outlets are located.	Engineering & Department Managers	> 90%
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%

B. **Process and Frequency of Measurement**

Progress for this project will be reported out quarterly at the Central Safety Committee. Data will be collected during Hazard Surveillance rounds and Engineering Life Safety rounds.

PROGRAM EFFECTIVENESS:

The effectiveness of the utility management program includes the appropriateness of the program design, training, maintaining systems integrity, failures, emergency generator testing and performance and other pertinent issues will be monitored and assessed on an ongoing basis.

Relevant incident reports, failures and concurrent and retrospective data relative to the management of Utility Systems will be gathered and tracked through Engineering and the Central Safety Committee. The Central Safety Committee will receive periodic reports and give approvals or make recommendations, as indicated. Substance of reports includes, but is not limited to:

- Summaries of monitoring results relative to established Utility Systems Management performance dimensions and standards, including emergency power system performance levels and preventative maintenance; and
- Reports of system failures or sentinel events, issues, investigation and follow-up.

Physical Environment Utility Management Plan

ANNUAL PROGRAM EVALUATION:

On an annual basis, the Utility Systems Management Plan/Program is evaluated relative to its ***objectives, scope, effectiveness and performance*.** This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

- The continued appropriateness and relevance of program objectives, as well as whether or not these objectives were met.
- The Scope of the program, relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- The extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given scope and objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The performance dimensions, to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

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

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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]	02/2026
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2026
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst [PS]	02/2026
Central Safety	John Thompson: Chief Engineer	02/2026

Physical Environment Utility Management Plan

John Thompson: Chief Engineer 02/2026

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Physical Environment Utility Management Plan

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