El Camino Health

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

**Wednesday, May 13, 2026 – 6:00 pm**
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

*Bob Rebitzer will be participating via teleconference from 28 Seaverns Avenue, Apt. 1, Jamaica Plain, MA 02130*

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: 935 5055 5907# 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, MD, Vice Chair | Information | **6:00 pm** |
| **2.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Jack Po, MD, Vice Chair | Information | **6:00 pm** |
| **3.** | **PUBLIC COMMUNICATION**<br>a. **Oral Comments**<br>*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.*<br>b. **Written Public Comments**<br>*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, MD, Vice Chair | Information | **6:00 pm** |
| **4.** | **QUALITY FOCUSED REVIEW**<br>-Receive FY26 Q3 STEEEP Dashboard Update | Carol Somersille, MD Quality Committee Chair<br>Shreyas Mallur, MD, Chief Quality Officer | Information | **6:00 – 6:15** |
| **5.** | **RECESS TO CLOSED SESSION** | Jack Po, MD, Vice Chair | **Motion Required** | **6:15** |

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| **6.** | **ECH STRATEGY AND FINANCIAL UPDATE**<br>-External Ratings Review and Strategic Impact<br>-FY27 Strategy Preview and FY26 Q3 Strategic Plan Metrics<br>-FY27 Budget Preview<br>-Long Range Capital and Financial Plan<br><br>*Health & Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.* | Dan Woods, CEO<br>AJ Reall, VP, Strategy<br>Raju Iyer, CFO<br>Shreyas Mallur, MD, CQO | Discussion | **6:15 – 7:25** |
| **7.** | **LOS GATOS REDEVELOPMENT PROJECT UPDATE**<br><br>*Health & Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.* | Tracey Lewis Taylor, COO<br>Jeff Missad, VP, Facilities, Design & Real Estate | Discussion | **7:25 – 7:35** |
| **8.** | **APPROVE CREDENTIALING AND PRIVILEGING REPORT**<br><br>*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** | **7:35 – 7:40** |
| **9.** | **APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS**<br>- Minutes of the Closed Session of the Special ECHB Meeting (03/04/26)<br>- Minutes of the Closed Session of the ECHB Meeting (03/18/26)<br>- Minutes of the Closed Session of the Special ECHB Meeting (04/18/26)<br><br>*Report involving Gov't Code Section 54957.2 for closed session minutes.* | Jack Po, MD, Vice Chair | **Motion Required** | **7:40 – 7:45** |
| **10.** | **EXECUTIVE SESSION**<br><br>*Gov't Code Section 54957 Report regarding personnel performance – Chief Executive Officer.* | Jack Po, MD, Vice Chair | Discussion | **7:45 – 7:55** |
| **11.** | **RECONVENE TO OPEN SESSION** | Jack Po, MD, Vice Chair | **Motion Required** | **7:55** |
| **12.** | **CLOSED SESSION REPORT OUT**<br>To report any required disclosures regarding permissible actions taken during Closed Session. | Gabe Fernandez, Governance Services Coordinator | Information | **7:55 – 7:56** |
| **13.** | **APPROVAL OF FY26 Q3/PERIOD 9 FINANCIALS** | Jack Po, MD, Vice Chair | **Motion Required** | **7:56 – 7:57** |
| **14.** | **CONSENT CALENDAR ITEMS:**<br>a. Approve Special Hospital Board Open Session Minutes (03/04/26)<br>b. Approve Hospital Board Open Session Minutes (03/18/26)<br>c. Approve Special Hospital Board Open Session Minutes (04/18/26)<br>d. Approve Revised Medical Staff Rules and Regulations<br>e. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended | Jack Po, MD, Vice Chair | **Motion Required** | **7:57 – 8:00** |

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| | by Administration and the Medical Executive Committee<br>f. Receive FY26 ECHB Pacing Plan | | | |
| **15.** | **CEO REPORT** | Dan Woods, CEO | Information | **8:00 – 8:05** |
| **16.** | **BOARD ANNOUNCEMENTS** | Jack Po, MD, Vice Chair | Information | **8:05 – 8:10** |
| **17.** | **ADJOURNMENT**<br><br>**POLICIES APPENDIX** | Jack Po, MD, Vice Chair | **Motion Required** | **8:10** |

**NEXT MEETINGS:** June 17, 2026

El Camino Health

**EL CAMINO HEALTH BOARD OF DIRECTORS**
**MEETING COVER MEMO**

**To:** El Camino Hospital Board of Directors
**From:** Shreyas Mallur, M.D, Chief Quality Officer
**Date:** May 13, 2026
**Subject:** STEEEP Dashboard through March 2026

**Purpose:** To provide the Board with an update on quality, safety, and experience measure performance through **March 2026** (unless otherwise noted). This memo summarizes results from the STEEEP Dashboard for FY 26 YTD.

**Summary:**

The STEEEP dashboard is updated quarterly and contains 17 measures. The STEEEP dashboard is intended to serve as a Governance Level report, shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter.

**A. Safe Care:**

1. **C. Difficile Infection:** There have been 6(0.67 cases per month) (Goal: </= 27 infections FY 2026 or less than 2.25 cases/month) Hospital Acquired C.= Diff infections YTD 2026. Areas of focus to decrease C. Diff are four-fold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program has been implemented. Third, a robust antibiotic stewardship program is in place. Fourth, testing of C. Diff samples will follow CDC and IDSA guidelines. (**Timeline for improvement**: We are on track for this measure. We have measures described above in place, which we believe will impact this rate. The benchmarked C Diff rate is per 10,000 patient days.)

2. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 4 CAUTI's cases year-to-date in FY2026, against a target of ≤12 for the fiscal year. Prompt removal of urinary catheters, when clinically appropriate and consistent adherence to best practices for insertion and maintenance remain key focus areas. To minimize catheter duration, the frontline nursing managers and the infection prevention team review all patients with indwelling catheters in place for more than three days and collaborate with nursing and physician teams to confirm ongoing clinical indications and reinforce timely removal. (**Timeline for improvement**: While we are currently on track to meet the FY2026 goal, we continue to implement additional measures aimed at sustaining and further improving performance in the next fiscal year. Ongoing monitoring remains essential).

3. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for YTD FY2026 (2) is favorable to target of 5 cases for FY 26 (0.42 cases per month). (**Timeline for improvement**: We are on track to meet target).

4. **Surgical Site Infection**. The number of surgical site infections for FY 26 (26) is unfavorable to target of </= 34 cases (2.83 cases/month). Process improvement has included implementing evidence based best practices shown to decrease SSIs: maintain Perioperative normothermia, timing and choice of preoperative antibiotics, clean closure tray utilization in the OR and glucose control in diabetics. (**Timeline for**

**improvement**: Though the absolute number of SSIs are high, the rate of SSIs has been stable without a significant increase. However, we have implemented all evidence-based practices and are now monitoring specific SSI reduction measures for colon surgeries and biliary surgeries)

5. **Hand Hygiene Combined Compliance rate:** Performance for YTD FY2026 is favorable (86.7%) to the target of 84%. (**Timeline for improvement**: We are on track to meet this measure. We are instituting real-time coaching for failures in compliance, as well as socializing this in our nursing and physician councils)

**B. Timely:**

1. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes:** YTD FY2026 performance of 76.6% fell below the 84% target, driven primarily by radiology staffing challenges with the contracted physician reading services vendor. In response, management transitioned to a new radiology reading group, which began service on December 30, 2025. (**Timeline for improvement**: Early results are promising: Q2 FY2026 performance has improved to 90%, exceeding target. As this improved run rate is sustained through the remainder of the fiscal year, we anticipate YTD performance will normalize above target by Q3 FY2026).

**C. Effective:**

1. **30 Day Readmission Observed Rate:** Performance YTD through February of 2026 (10.9%) is unfavorable to target (</=10.6 %) El Camino Health remains committed to ensuring timely follow-up care for patients under primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital. In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital. (**Timeline for improvement:** We are close to our target and are confident we will continue to maintain our FY 25 trend)

2. **Risk Adjusted Mortality Index.** Performance YTD FY26 (0.90) is favorable to target (1.05). Mortality index tracks, and for this time frame, is driven by sepsis mortality. We will be closely monitoring this since the system changes introduced in documentation integrity, reduction in clinical variation and institution of earlier hospice and GIP. In addition, we are optimizing the expected mortality to accurately reflect the acuity of illness of our patients. (**Timeline for improvement:** We are on track to meet this measure.)

3. **Sepsis Mortality Index:** Performance through FY2026 is 1.12, which is favorable to the target of 1.15. Observed sepsis mortality is influenced by early goal-directed

therapy, and El Camino Health continues to perform strongly on SEP-1 measures compared with national benchmarks. Ongoing efforts remain focused on reliable execution of SEP-1 components, including timely antibiotic administration and appropriate fluid and vasopressor management. In parallel, we are implementing a more robust approach to expected mortality management to better reflect patient severity of illness. These combined efforts have resulted in a downward trend in the sepsis mortality index. (**Timeline for improvement:** We continue to see sustained improvement month over month and are on track to meet this measure)

**4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV)**. FY26 performance through January of 2026 (25.8%) is unfavorable to target of 23.9%.The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (**Timeline for improvement**: This metric has been challenging for the organization as well as like hospitals in California. We will continue with our efforts to reduce this metric)

**D. Efficient:**

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance FY26 is (0.99) is favorable to target of (1.02). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF.

   1.1. Multidisciplinary rounds with the hospitalist group have contributed to reductions in length of stay through improved care coordination, earlier identification of discharge barriers, and more timely insurance authorization for patients transitioning to skilled nursing facilities or home care.

   1.2. We now have skilled nursing facility transfer agreements in place to help us expedite discharge self-pay and MediCal patients. (**Timeline for improvement:** We are on track to meet this target; however, this metric, along with the readmission rate, will continue to be closely monitored to ensure sustained performance).

2. **Median Time from ED Arrival to ED Departure (Enterprise).** Performance YTD FY26 (152 minutes) is favorable to the target of < 159 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently, the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for

patients of lower acuity (treat to street). (**Timeline for improvement:** We are on track to meet this measure).

**E. Equitable:**

1. **Social Drivers of Health Screening rate:** FY 26 performance YTD is (84%) is favorable to target of 70%. This is a new measure and steps to improve our screening rate includes creating a new tool for staff to document required elements of the metric. Our team, including care coordinators, nurses and informatics teams are working to implement this tool in the next few months. (**Timeline for improvement**: We are on track to meet this target).

2. **Homeless Planning Discharge Compliance Rate:** This is a new measure for FY26. FY 26 YTD is (81.8%) is favorable to target of 77%. This measure was chosen because of new CMS regulations on monitoring our efforts on homeless discharge compliance rates. (**Timeline for improvement**: We are on track to meet this measure).

**F. Patient/Family Centered:**

1. **Inpatient Performance:** Inpatient patient experience performance continues to show sustained improvement across the enterprise, with the composite LTR reaching 84.6% YTD, exceeding the FY26 target of 83.4% and maintaining performance above baseline. Core drivers, including inpatient and emergency services, are demonstrating meaningful gains, with inpatient performance improving to 82.6% YTD (+1.1 vs baseline) and emergency department performance to 79.8% YTD (+1.6 vs baseline), alongside notable year over year improvements. High performing areas such as Maternal Child Health (86.6% YTD) continue to operate at top decile levels, while historically variable areas, including Los Gatos inpatient and lab services, are showing measurable improvement. Overall, performance reflects increased reliability, reduced variation, and stronger adoption of leader standard work, positioning inpatient experience as a consistent organizational strength.

2. **Medical Network Performance:** The El Camino Health Medical Network continues to perform above target and demonstrate strong national competitiveness, with an overall LTR of 86.1%, exceeding the FY26 target of 83.2%. Multiple clinics are achieving top box scores above 90%, with several ranking in the highest national percentiles, reinforcing a strong patient perception of care delivery. Urgent care performance remains stable at 84.3%, exceeding target and reflecting consistency across sites. These results indicate effective standardization across ambulatory settings, supporting both patient retention and growth. Continued focus on reducing variability and strengthening communication and care coordination will be key to sustaining performance and further enhancing market differentiation.

**Attachments:**

1. STEEEP Dashboard through March 2026

# El Camino Health Quality Board: FYTD26 STEEEP

El Camino Health

Show Filter

Date: 4/1/2025 03/31/2026

| Measures | Last 4 Fiscal Quarters | | | | Baseline | FYTD Result | Target Indicator | | Last 12 Months Trend |
|---|---|---|---|---|---|---|---|---|---|
| **Safe Care** | FY 25Q4 | FY 26Q1 | FY 26Q2 | FY 26Q3 | FY25 | FYTD26 | | | Trend Chart Period: 4/1/2025 to 03/31/2026 |
| **C-Diff**<br>Clostridioides Difficile Infection | 6 | 5 | 0 | 1 | 28 | **6** | | <= 27 cases | Lower Better |
| **CAUTI**<br>(Catheter-Associated Urinary Tract Infection) | 1 | 1 | 1 | 2 | 14 | **4** | | <=13 cases | Lower is Better |
| **HAPI**<br>(Stage 3, 4 & Unstageable) | 1 | 0 | 1 | 3 | 15 | **4** | | <= 13 cases | Lower is Better |
| **CLABSI**<br>(Central Line-Associated Bloodstream Infection) | 0 | 0 | 2 | 0 | 4 | **2** | | <=5 cases | Lower is Better |
| **SSI**<br>(Surgical Site Infection) | 4 | 10 | 11 | 5 | 38 | **26** | | <=34 cases | Lower is Better |
| **Hand Hygiene Combined Compliance** | 86.6% | 84.5% | 88.0% | 87.9% | 83.2% | **86.7%** | | >=84% | Higher is Better |
| **Timely** | | | | | | | | | |
| **Imaging TAT in ED**<br>Including Xray (target = % completed ≤ 45 min) | 76.9% | 70.9% | 67.3% | 90.0% | 73.9% | **76.6%** | | >=84.0% | Higher is Better |
| **Effective** | | | | | | | | | |
| **30-Day Readmission Rate**<br>(Based on Vizient Risk Model) | 11.5% | 10.7% | 10.8% | 11.3% | 10.6% | **10.9%** | | <=10.6% | Lower is Better |
| **Hospital Mortality O/E Index**<br>(Vizient Risk-Adjusted Mortality Model) | 0.98 | 1.03 | 0.84 | 0.83 | 1.06 | **0.90** | | <= 1.05 | Lower is Better |
| **Sepsis Mortality O/E Index**<br>(Vizient Risk-Adjusted Mortality Model) | 1.04 | 1.27 | 1.10 | 1.04 | 1.18 | **1.12** | | <= 1.15 | Lower is Better |
| **NTSV Cesarean Section**<br>(CMS PC-02 Measure) | 29.9% | 23.6% | 28.4% | 24.0% | 26.4% | **25.8%** | | <=23.9% | Lower is Better |
| **Efficient** | | | | | | | | | |
| **Length of Stay (LOS) O/E Index**<br>(Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service) | 0.99 | 0.99 | 0.99 | 0.95 | 1.02 | **0.99** | | <=1.00 | Lower is Better |
| **ED Arrival to Departure Time**<br>(For patients discharged from ED to home, Median time in minutes) | 153 | 154 | 154 | 152 | 153 | **152** | | <=159 min | Lower is Better |
| **Equitable** | | | | | | | | | |
| **Social Driver of Health (SDOH) Screening Rate**<br>(Exclusions : Patients < 18 y/o at the time of admission, MHAS, IP Rehab & OP services) | 87.8% | 84.3% | 84.4% | 83.3% | 41.3% | **84.0%** | | >=80% | Higher is Better |
| **Homeless Planning Discharge Compliance Rate**<br>(Exclusions : Patients that eloped, Expired, left AMA, and LWBS) | 75.1% | 78.3% | 80.6% | 86.4% | 73.6% | **81.8%** | | >=77.0% | Higher is Better |
| **Patient-Centered** | | | | | | | | | |
| **LTR Composite Score**<br>Press Ganey | | 83.9 | 85.0 | 84.9 | 83.4 | **84.6** | | >=83.4 | Higher is Better |

El Camino Health

# MEMORANDUM

ECH Board of Directors | Summary of Financial Operations

**TO:** El Camino Hospital Board of Directors
**FROM:** Raju Iyer, CFO
**DATE:** May 13, 2026
**RE:** YTD Financial Performance – FY2026 Period 9 (July 2025 – March 2026)

## Purpose

This memorandum provides the Board with a summary of the organization's year-to-date (YTD) financial performance through Period 9 (March 31, 2026) of Fiscal Year 2026. The attached presentation contains detailed financial schedules, KPI trend data, and rating agency benchmarks for Board review.

## Recommendation

Board approval of the FY2026 Q3/Period 9 financials.

## YTD FY2026 Financial Highlights (July 2025 – March 2026)

**Operating EBIDA**

- Actual: $211.4M (15.3% margin) vs. Budget: $188.6M (13.9% margin) — $22.8M / 12.1% favorable to budget.
- $8.4M / 4.1% favorable to prior year.

**Operating Margin**

- Actual: $135.8M (9.8% margin) vs. Budget: $110.1M (8.1% margin) — $25.7M favorable to budget.
- $9.8M / 7.5% favorable to the same period in the prior year.

**Operating Expense**

- $1.3M / 1.0% unfavorable to budget in aggregate.
- When adjusted for volume, Operating Expense per CMI Adjusted Discharge is $20,595 — 5.2% favorable to budget, reflecting effective cost management relative to patient acuity.

**Net Margin**

- YTD net margin is $66.6M / 32.1% above the same period last year.

## Key Operating Drivers

**Favorable Factors:**

- Volume: Hospital activity 3.7% favorable to budget, driving positive revenue and labor variance.
- Labor Productivity: Continued favorability in productivity metrics and premium time (overtime/agency) management.
- Pharmaceuticals: Favorable results driven by utilization shifts, cost savings initiatives, and improved contracting.

**Unfavorable Factors:**

- Payor Mix: Gradual shift toward Governmental payors (Medicare/Medicaid) is exerting pressure on net revenue realization.

## Summary Assessment

Overall, YTD FY2026 financial performance remains strong. The organization is tracking meaningfully ahead of budget on both Operating EBIDA and Operating Margin, driven by volume growth across key service lines and disciplined expense management. The single-month softness in Period 9 is primarily attributable to a timing difference in IGT receipts and does not reflect an underlying operational concern. The Board is encouraged to review the attached presentation for detailed schedules, monthly KPI trends, and comparisons to Moody's, S&P, and Fitch rating agency medians.

El Camino Health

# Summary of Financial Operations

*Fiscal Year 2026 – Period 9*

*7/1/2025 to 03/31/2026*

# Financial Overview: YTD FY2026 (as of 3/31/2026)

## Consolidated Financial Performance

- Operating EBIDA is $211.4M / 15.3% compared to the budget of $188.6M / 13.9% and $8.4M / 4.1% above prior year.
- Operating margin is $135.8M / 9.8% compared to the budget of $110.1M / 8.1% and $9.8M / 7.5% above prior year.
- Operating expense is $1.3M / 1.0% unfavorable to budget.
  - When adjusted for volume levels, Operating Expense per CMI Adjusted Discharge is $20,595 which is 5.2% favorable to budget.
    - **Note: Excludes depreciation and interest expense**
- Key operating drivers:
  - Year-over-year operating margin is $9.8M / 7.5% above the same period last year:
  - Favorable:
    - Continued strength in Interventional Services (12.3% fav to prior year), Outpatient Surgical Services (8.5% fav to prior year), and Outpatient Endoscopy Services (11.0% fav to prior year).
    - Expense management – Continued favorability in Labor Productivity and Premium Time.
  - Unfavorable
    - Gradual shift to Governmental Payors
- Year-over-year net margin is $66.6M / 32.1% higher than the same period last year.

# Operational / Financial Results: YTD FY2026 (as of 03/31/2026)

| ($ 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 | 307 | 311 | (5) | (1.5%) | 313 | (6) | (2.0%) | --- | --- | --- | --- |
| | Adjusted Discharges | 35,203 | 33,901 | 1,301 | 3.8% | 33,346 | 1,857 | 5.6% | --- | --- | --- | --- |
| | OP Visits / OP Procedural Cases | 127,184 | 116,606 | 10,578 | 9.1% | 114,730 | 12,454 | 10.9% | --- | --- | --- | --- |
| | Percent Government (%) | 59.2% | 58.7% | 0.5% | 0.9% | 59.4% | (0.2%) | (0.4%) | --- | --- | --- | --- |
| | Gross Charges ($) | 6,171,541 | 5,888,430 | 283,111 | 4.8% | 5,461,945 | 709,595 | 13.0% | --- | --- | --- | --- |
| Operations | Cost Per CMI AD | 20,595 | 21,724 | (1,128) | (5.2%) | 19,856 | 740 | 3.7% | --- | --- | --- | --- |
| | Net Days in A/R | 49.3 | 54.0 | (4.7) | (8.6%) | 51.8 | (2.4) | (4.7%) | 47.5 | 47.4 | 47.8 | |
| Financial Performance | Net Patient Revenue ($) | 1,332,398 | 1,303,076 | 29,323 | 2.3% | 1,221,236 | 111,162 | 9.1% | 3,267,406 | 6,024,914 | --- | |
| | Total Operating Revenue ($) | 1,381,826 | 1,358,537 | 23,288 | 1.7% | 1,272,932 | 108,894 | 8.6% | 3,856,206 | 6,278,235 | 3,315,675 | |
| | **Operating Margin ($)** | **135,811** | **110,136** | **25,676** | 23.3% | **126,023** | **9,788** | 7.8% | **77,124** | **219,738** | **112,733** | |
| | **Operating EBIDA ($)** | **211,428** | **188,598** | **22,830** | 12.1% | **203,036** | **8,391** | 4.1% | **223,660** | **508,537** | **281,832** | |
| | Net Income ($) | 274,398 | 155,771 | 118,628 | 76.2% | 207,780 | 66,618 | 32.1% | 212,091 | 489,702 | 185,678 | |
| | **Operating Margin (%)** | **9.8%** | **8.1%** | **1.7%** | 21.2% | **9.9%** | **(0.1%)** | (0.7%) | **2.0%** | **3.5%** | **3.4%** | |
| | **Operating EBIDA (%)** | **15.3%** | **13.9%** | **1.4%** | 10.2% | **16.0%** | **(0.6%)** | (4.1%) | **5.8%** | **8.1%** | **8.5%** | |
| | DCOH (days) | 348 | 275 | 73 | 26.6% | 281 | 67 | 23.7% | 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.

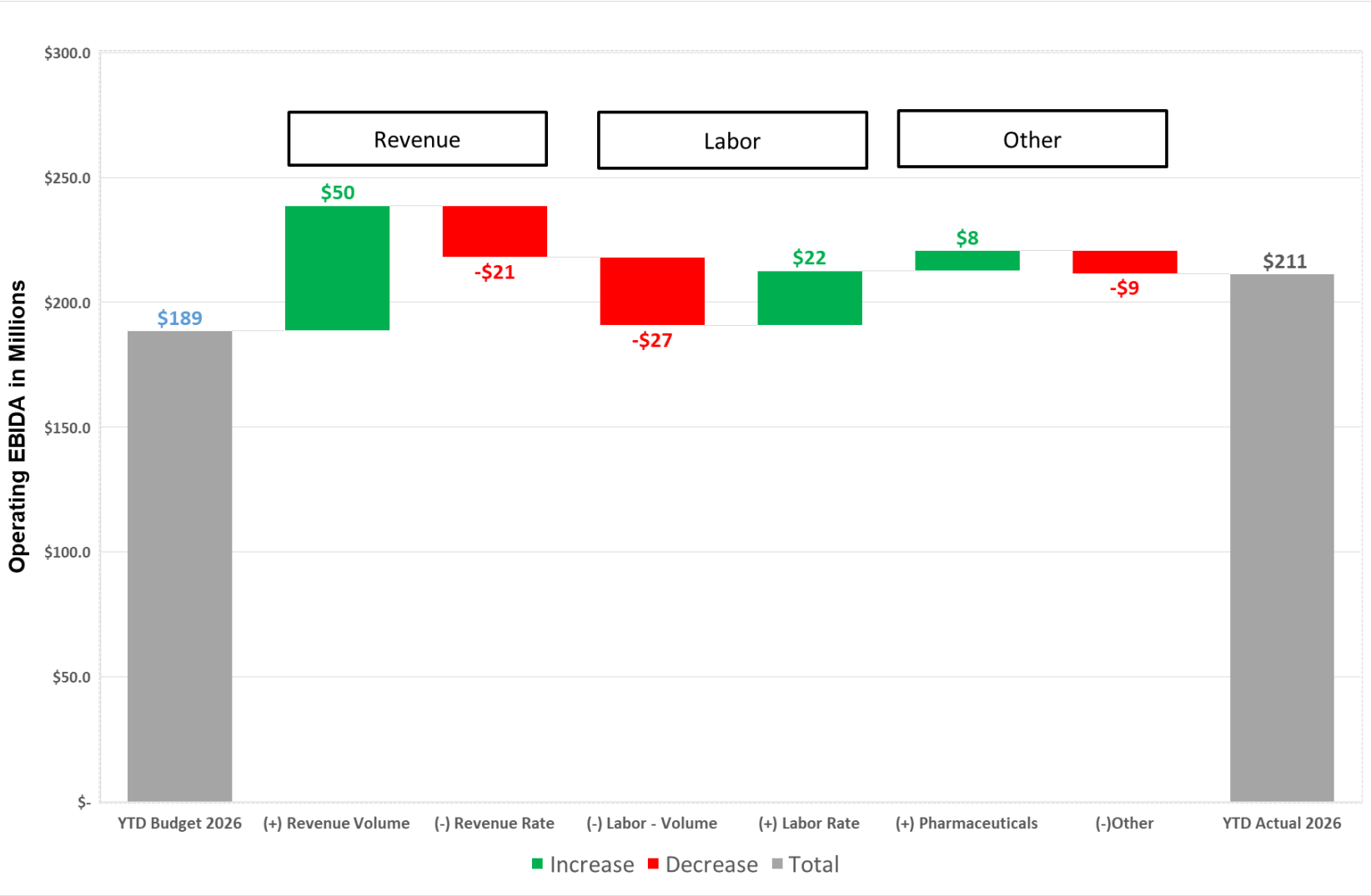
El Camino Health

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

# FY2026 YTD P9: Factors driving favorable Operating EBIDA

*(Dollars in Millions)*

**$211M (actual) vs. $189M (budget) = $22M / 12% favorable to budget**




- **Revenue:**
  - Rate: Higher OP activity vs budgeted resulted in 1.5% lower Revenue per Adjusted Discharge
  - Volume: Driven by 3.7% favorability to budget in hospital activity.
- **Labor:**
  - Rate: Rate per Adjusted Discharge 3.1% favorable to budget
  - Volume: Driven by 3.7% favorability to budget in hospital activity.
- **Pharmaceuticals:** Continued utilization shifts, cost savings initiatives, and improved contracting has produced favorable results.
- **Other:** Purchased Services, ECHMN and Repairs and Maintenance, Plant Operations and Facilities

# Operational / Financial Results: Period 9 – March 2026 (as of 03/31/2026)

| ($ 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 | 312 | 317 | (5) | (1.6%) | 314 | (2) | (0.7%) | --- | --- | --- | --- |
| | Adjusted Discharges | 4,294 | 3,866 | 428 | 11.1% | 3,792 | 502 | 13.2% | --- | --- | --- | --- |
| | OP Visits / OP Procedural Cases | 15,280 | 13,217 | 2,063 | 15.6% | 13,742 | 1,538 | 11.2% | --- | --- | --- | --- |
| | Percent Government (%) | 59.3% | 59.2% | 0.1% | 0.2% | 59.9% | (0.6%) | (1.1%) | --- | --- | --- | --- |
| | Gross Charges ($) | 757,871 | 690,866 | 67,006 | 9.7% | 639,119 | 118,753 | 18.6% | --- | --- | --- | --- |
| Operations | Cost Per CMI AD | 19,930 | 21,724 | (1,793) | (8.3%) | 21,868 | (1,938) | (8.9%) | --- | --- | --- | --- |
| | Net Days in A/R | 49.3 | 54.0 | (4.7) | (8.6%) | 51.8 | (2.4) | (4.7%) | 47.5 | 49.7 | 47.8 | |
| Financial Performance | Net Patient Revenue ($) | 152,008 | 146,722 | 5,285 | 3.6% | 140,266 | 11,741 | 8.4% | 363,045 | 669,435 | --- | |
| | Total Operating Revenue ($) | 157,746 | 156,672 | 1,074 | 0.7% | 146,041 | 11,705 | 8.0% | 428,467 | 697,582 | 368,408 | |
| | **Operating Margin ($)** | **12,208** | **13,147** | **(940)** | (7.1%) | **12,078** | **130** | 1.1% | **8,569** | **24,415** | **12,526** | |
| | **Operating EBIDA ($)** | **20,226** | **21,511** | **(1,286)** | (6.0%) | **21,289** | **(1,064)** | (5.0%) | **24,851** | **56,504** | **31,315** | |
| | Net Income ($) | (21,154) | 18,685 | (39,839) | (213.2%) | (9,120) | (12,034) | 132.0% | 23,566 | 54,411 | 20,631 | |
| | **Operating Margin (%)** | **7.7%** | **8.4%** | **(0.7%)** | (7.8%) | **8.3%** | **(0.5%)** | (6.4%) | **2.0%** | **3.5%** | **3.4%** | |
| | **Operating EBIDA (%)** | **12.8%** | **13.7%** | **(0.9%)** | (6.6%) | **14.6%** | **(1.8%)** | (12.0%) | **5.8%** | **8.1%** | **8.5%** | |
| | DCOH (days) | 348 | 275 | 73 | 26.6% | 281 | 67 | 23.7% | 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.

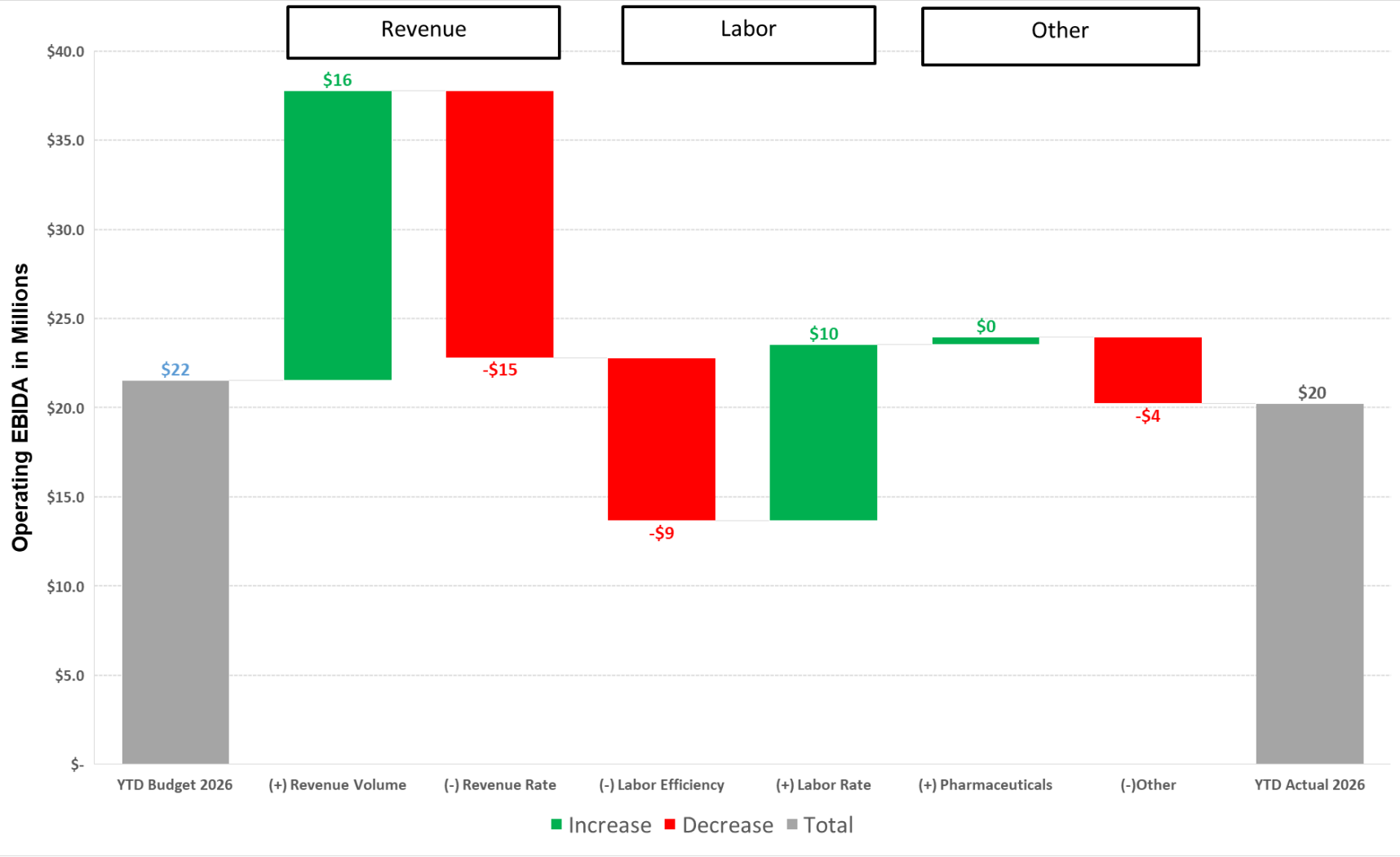
El Camino Health

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

# FY2026 P9: Factors driving unfavorable Operating EBIDA

*(Dollars in Millions)*

**$20M (actual) vs. $22M (budget) = -$2M / -6% favorable to budget**

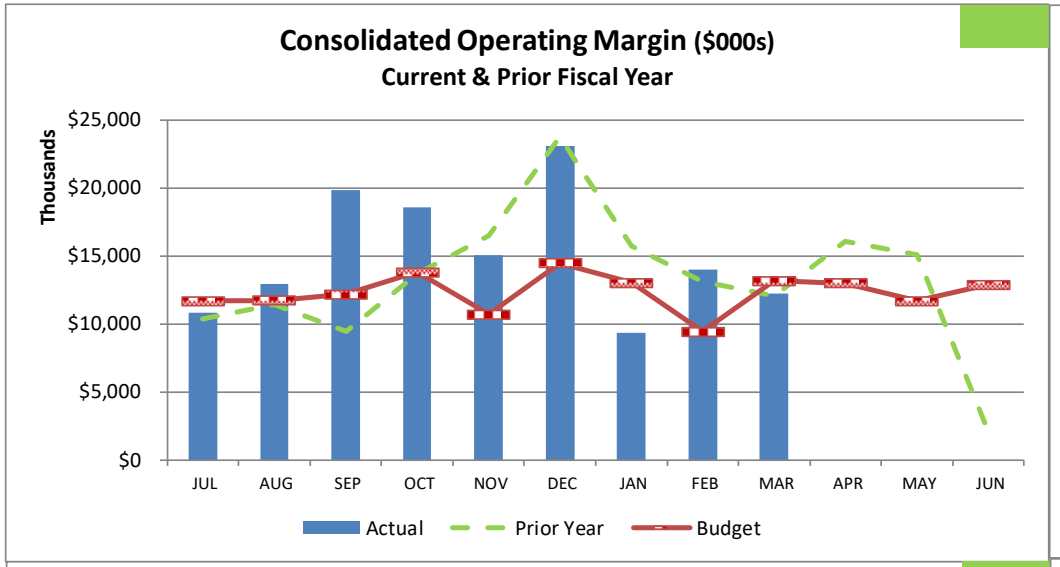


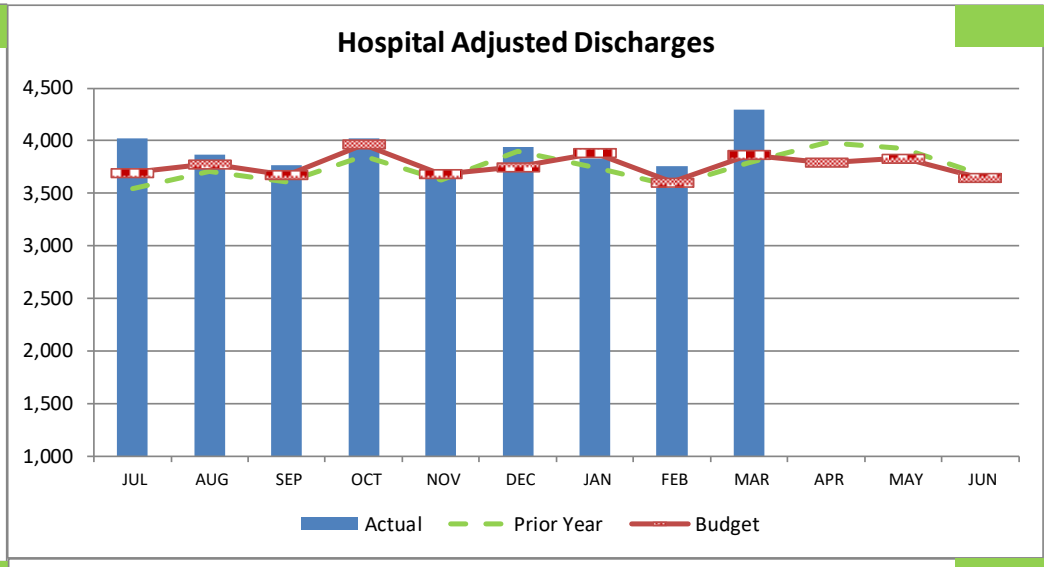

- **Revenue:**
  - Rate: OP activity significantly favorable in Mar.
  - Rate: $4M IGT budgeted in March, but not received
  - Volume impact: Mar hospital activity 10% higher than budget
- **Labor:**
  - Rate: Rate per Adjusted Discharge 12% favorable to budget
  - Volume: Mar hospital activity 10% higher than budget

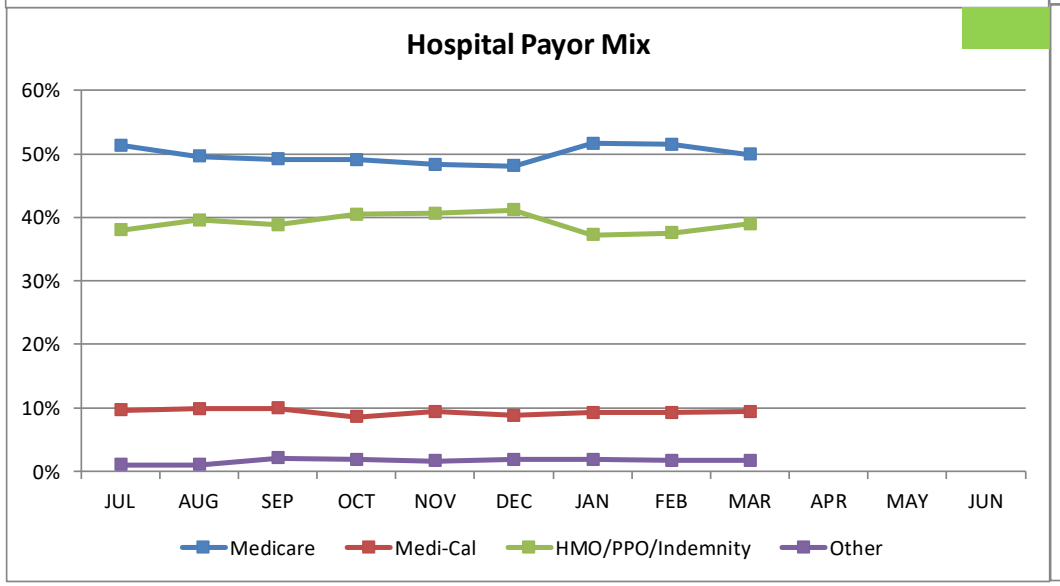
El Camino Health

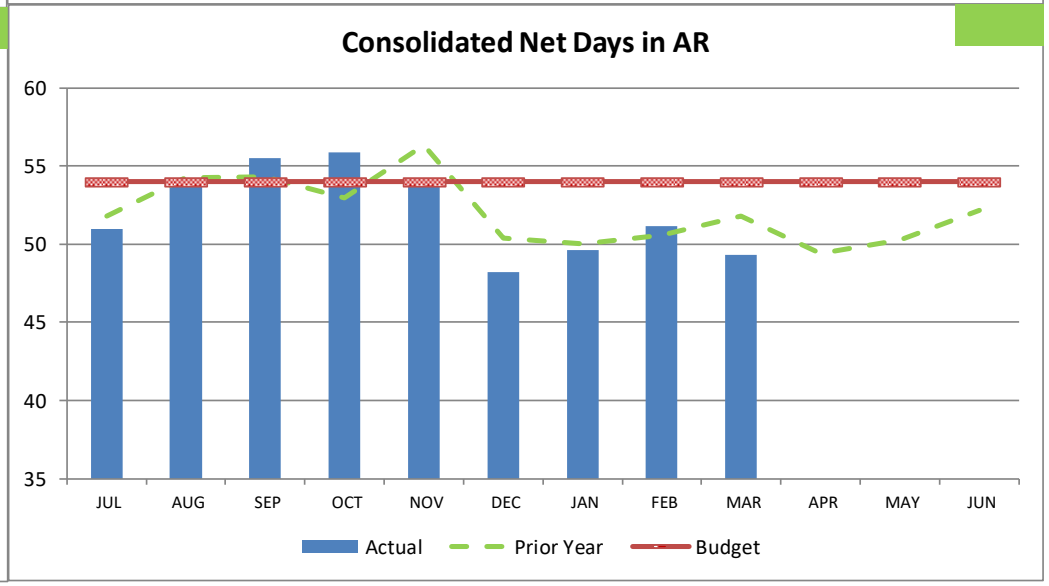
# APPENDIX

# YTD FY2026 Financial KPIs – Monthly Trends



El Camino Health

**Minutes of the Open Session of the**
**Special ECH Board Meeting**
**Wednesday, March 4, 2026**
**El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040**

**Members Present**
**Bob Rebitzer,** Chair
**John Zoglin,** Secretary/Treasurer
**Wayne Doiguchi**
**Peter Fung, MD, MBA** *(joined at 4:03pm)*
**Julia E. Miller**
**George O. Ting, MD**
**Don Watters**

**Members Absent**
**Lanhee Chen**
**Carol A. Somersille, MD**

**Members Recused**
**Jack Po,** Vice-Chair

**Staff Present**
**Dan Woods**, Chief Executive Officer
**Raju Iyer**, Chief Financial Officer
**Theresa Fuentes**, Chief Legal Officer
**Tracy Lewis Taylor**, Chief Operating Officer
**AJ Reall,** VP, Strategy
**Alan Muster, MD,** President, ECHMN
**Elizabeth Kim**, VP, Strategy, ECHMN
**Anne Yang,** Executive Director, Governance Services
**Tracy Fowler**, Director, Governance Services **
**Gabriel Fernandez**, Coordinator, Governance Services

**via teleconference

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | The open session of the Special Meeting of the Board of El Camino Hospital (the "Board") was called to order at 4:02 p.m. by Chair Rebitzer. A verbal roll call was taken. Directors Chen, Fung and Somersille were absent at roll call. Director Fung joined the meeting at 4:03pm. | ***The meeting was called to order at 4:02 p.m.*** |
| **2. POTENTIAL CONFLICT OF INTEREST** | Chair Rebitzer asked if any Board members had a conflict of interest with any of the items on the agenda. Director Po disclosed a potential relationship and out of an abundance of caution recused himself and left the meeting before any discussion on the agenda ensued. | |
| **3. PUBLIC COMMUNICATION** | Chair Rebitzer called for public comment on items not listed on the agenda. No public comments were made, and no written correspondence was received. | |
| **4. RECESS TO CLOSED SESSION** | **Motion**: To recess to closed session at 4:03 p.m.<br><br>**Movant:** Zoglin<br>**Second:** Watters<br>**Ayes:** Doiguchi, Fung, Miller, Rebitzer, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Chen, Somersille<br>**Recused:** Po | ***Recessed to closed session at 4:03 p.m.*** |
| **5. AGENDA ITEM 7: CLOSED SESSION REPORT OUT** | Mr. Fernandez reported that the Board did not take any reportable actions during the closed session. | ***Reconvened to Open Session at 4:40 pm*** |

| | | |
|---|---|---|
| **6. AGENDA ITEM 8: RECOMMEND BOARD APPROVAL OF RESOLUTION APPROVING TRANSACTION TO PURCHASE CERTAIN ASSETS OF CARBON HEALTH TECHNOLOGIES INC.** | **Motion**: To approve Board Resolution 2026-01 Approving Transaction to Purchase Certain Assets of Carbon Health Technologies, Inc.<br><br>**Movant:** Miller<br>**Second:** Watters<br>**Ayes:** Doiguchi, Fung, Miller, Rebitzer, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Chen, Somersille<br>**Recused:** Po | |
| **7. AGENDA ITEM 9: CLOSING COMMENTS** | There were no additional comments from the Board. | |
| **8. AGENDA ITEM 10: ADJOURNMENT** | **Motion:** To adjourn at 4:42 pm.<br><br>**Movant:** Ting<br>**Second:** Watters<br>**Ayes:** Doiguchi, Fung, Miller, Rebitzer, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Chen, Somersille<br>**Recused:** Po | ***Meeting adjourned at 4:42 pm.*** |

**Attest as to the approval of the foregoing 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

**Minutes of the Open Session of the**
**El Camino Hospital Board of Directors**
**Wednesday, March 18, 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**
**Wayne Doiguchi**
**Peter Fung, MD, MBA**
**Carol A. Somersille, MD**
**George O. Ting, MD**
**Don Watters**

**Board Members Absent**
**Julia E. Miller**

**Staff Present**
**Dan Woods,** CEO
**Omar Chughtai**, CGO**
**Theresa Fuentes**, CLO
**Raju Iyer**, CFO
**Mark Klein**, CCMO
**Tracey Lewis Taylor**, COO
**Alan Muster, MD**, President, ECHMN
**Mark Adams,** CMO
**Cheryl Reinking**, CNO
**Andreu Reall,** VP, Strategy
**Deb Muro**, CCO

*** via teleconference*

**Staff Present (cont.)**
**Anne Yang**, Executive 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 5:32 p.m. Roll call was taken and a quorum was present. Directors Miller and Somersille were absent at roll call. Director Somersille joined at 5:35 p.m. | ***The meeting was called to order at 5:32 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. Chair Rebitzer noted that he would recuse himself for item 14. | |
| **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. RECESS TO CLOSED SESSION** | **Motion:** To recess to closed session at 5:35 p.m.<br>**Movant**: Po<br>**Second**: Watters<br>**Ayes**: Chen, Doiguchi, Po, Rebitzer, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: Miller, Somersille<br>**Recused**: None | ***Recessed to closed session at 5:35 p.m.*** |
| **5. AGENDA ITEM 12: CLOSED SESSION REPORT OUT** | Chair Rebitzer reconvened the open session at 7:26 p.m., and Agenda Items 5 - 10 were addressed in the closed session.<br>Mr. Fernandez reported that during the closed session, the board approved the Credentialing and Privileges Report and Closed Session Minutes. | |
| **6. AGENDA ITEM 13: APPROVAL OF CAPITAL REQUEST: PROPERTY ACQUISITION: APN#** | Chair Rebitzer requested the following motion.<br>**Motion:** to approve the purchase of property at 595 Lawrence Expressway, Sunnyvale, not to exceed $20.1 million. | ***Property acquisition approved.*** |

| | | |
|---|---|---|
| **205-23-017** | **Movant**: Watters<br>**Second**: Fung<br>**Ayes**: Chen, Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: Miller<br>**Recused**: None | |
| **7. AGENDA ITEM 14: DISCUSSION ON WHETHER THE BOARD SHOULD AUTHORIZE THE CURRENT BOARD CHAIR, IF WILLING, TO RUN FOR ELECTION FOR A THIRD TERM** | Director Rebitzer recused himself and left the room before any discussion on this item. Governance Committee Chair Lanhee Chen facilitated the Board deliberation of Resolution 2026-02 regarding the authorization of the current Board Chair to stand for election for a third term. Discussion focused on the balance between maintaining leadership stability during significant strategic transitions and adhering to established term limits to facilitate leadership rotation. Members presented varying perspectives on whether current organizational challenges constituted the "extenuating circumstances" desired for such an extension. It was noted that the resolution would permit the Chair to participate as a candidate in the standard election process alongside other interested members. The motion failed for lack of a majority of the members present.<br><br>**Motion:** To approve resolution 2026-02.<br><br>**Movant**: Fung<br>**Second**: Doiguchi<br>**Ayes**: Chen, Doiguchi, Fung, Watters<br>**Nays**: Somersille, Ting, Zoglin<br>**Abstentions**: Po<br>**Absent**: Miller<br>**Recused**: Rebitzer | ***Motion failed for lack of a majority of members present*** |
| **8. AGENDA ITEM 15: CONSENT CALENDAR ITEMS** | Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Chair Rebitzer noted that staff pulled the Patient Safety Plan from item (f) for further revisions. Director Somersille pulled item (d), and noted that Doug Scrivner, nominee for Governance Committee, would resign from the Palo Alto Medical Foundation Board prior to appointment.<br><br>**Motion:** To approve the consent calendar minus items (d) and (f).<br><br>**Movant**: Chen<br>**Second**: Watters<br>**Ayes**: Chen, Doiguchi, Fung, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: Miller<br>**Recused**: None<br><br>**Motion:** To approve items (d) and (f) in the consent | ***Consent calendar approved minus the Patient Safety Plan.*** |

| | | |
|---|---|---|
| | calendar minus the Patient Safety Plan<br><br>**Movant**: Chen<br>**Second**: Doiguchi<br>**Ayes**: Chen, Doiguchi, Fung, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: Miller<br>**Recused**: None | |
| **9. AGENDA ITEM 16: CEO REPORT** | Mr. Woods presented the CEO Report and highlighted recent organizational accomplishments and recognition.<br><br>January patient activity was soft but year-to-date financials remain favorable. He congratulated recent award winners Deb Muro as Women's Healthcare Executive Northern California Innovation Leader of the Year, and Tracey Lewis Taylor for the YWCA Tribute to Women Award. El Camino Health ranked 97th nationally as World's Best Hospitals 2026 by Newsweek, 15th in California, and the highest ranked community hospital in the Bay Area. The Foundation has raised 81% toward a $10M annual goal. Mr. Woods announced Atul Gawande as keynote speaker at the Foundation's Spring Benefit on June 2, 2026. | |
| **10. AGENDA ITEM 17: ANNOUNCEMENTS** | Director Somersille announced she will be awarded at the district's annual Women's History Month Luncheon, the Liz Kniss Healthcare Champion Award from Supervisor Margaret Abe-Koga. No further announcements. | |
| **11. AGENDA ITEM 18: ADJOURNMENT** | **Motion:** To adjourn at 7:50 p.m.<br><br>**Movant**: Chen<br>**Second**: Po<br>**Ayes**: Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: Miller<br>**Recused**: None | ***Meeting adjourned at 7:50 p.m.*** |

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

_____
John Zoglin, Secretary/Treasurer

Prepared by: Anne Yang, Executive Director, Governance Services
Reviewed by Legal: Theresa Fuentes, CLO; John Zoglin, Board Secretary/Treasurer

El Camino Health

**Minutes of the Open Session of the**
**El Camino Hospital Board of Directors**
**Saturday, April 18, 2026**

**Hyatt Centric | 409 San Antonio Road, Mountain View, CA 94040 | Nano 2 Conference Room**

**Board Members Present**
**Bob Rebitzer,** Chair
**Jack Po,** Vice-Chair *(joined at 9:25am)*
**John Zoglin,** Secretary/Treasurer
**Lanhee Chen**
**Wayne Doiguchi**
**Peter Fung, MD, MBA**
**Julia E. Miller**
**Carol A. Somersille, MD**
**George O. Ting, MD**
**Don Watters**

**Board Members Absent**

**Staff Present**
**Dan Woods,** CEO
**Theresa Fuentes**, CLO
**Raju Iyer**, CFO
**Alan Muster, MD**, President, ECHMN
**Andreu Reall,** VP, Strategy

**Staff Present (cont.)**
**Anne Yang**, Executive Director, Governance Services

| 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 9:07 a.m. Director Po was absent at roll call, and a quorum was present. | ***The meeting was called to order at 9:07 a.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. No conflicts 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. RECESS TO CLOSED SESSION** | **Motion:** To recess to closed session at 9:11 a.m.<br>**Movant**: Miller<br>**Second**: Doiguchi<br>**Ayes**: Chen, Doiguchi, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: Po<br>**Recused**: None | ***Recessed to closed session at 9:11 a.m.*** |
| **5. AGENDA ITEM 7: CLOSED SESSION REPORT OUT** | Chair Rebitzer reconvened the open session at 10:29 a.m., and Agenda Items 5 was addressed in the closed session.<br>Ms. Yang reported that there were no approval items during the closed session. | |
| **6. AGENDA ITEM 8: CONSENT CALENDAR ITEMS** | Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion.<br>**Motion:** To approve the consent calendar.<br>**Movant**: Zoglin<br>**Second**: Doiguchi<br>**Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, | ***Consent calendar approved; FY27 ECHB Board dates approved.*** |

| | | |
|---|---|---|
| | Somersille, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | |
| **7. AGENDA ITEM 9: BOARD BEST PRACTICES** | Ms. Spalding and Mr. Bolt-Clark led an interactive session with directors focused on board best practices. The director discussions highlighted engagement, listening and self-awareness. The directors had the opportunity for role play and smaller group breakout sessions to discuss communicating for impact and board best practices including performance oversight and strategy. The final wrap-up session focused on key takeaways and a board action plan. | |
| **8. AGENDA ITEM 10: ADJOURNMENT** | **Motion:** To adjourn at 3:10 p.m.<br><br>**Movant**: Miller<br>**Second**: Somersille<br>**Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Nays**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Meeting adjourned at 3:10 p.m.*** |

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

_____
John Zoglin, Secretary/Treasurer

Prepared by: Anne Yang, Executive Director, Governance Services
Reviewed by Legal: Theresa Fuentes, CLO; John Zoglin, Board Secretary/Treasurer

El Camino Health

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

**To:** ECH Board of Directors
**From:** Mark Adams, MD – Chief Medical Officer
**Date:** May 13, 2026
**Subject:** Approve Revised Medical Staff Rules and Regulations

**Recommendation:**

To recommend board approval of the revised Medical Staff Rules and Regulations.

**Summary:**

Background: The proposed revisions described below are minor in nature. The revisions align the History & Physical rules with the bylaws and bring the Patient and Employee Safety Committee (PESC) into the Performance Improvement committee of the medical staff to assure CA Evidence Code Section 1157 protection.

Below is a high-level summary of the revisions on page 23 of the document:

**1. Updated name and composition**

Committee name update to Enterprise Patient Safety Committee (aka Patient and Employee Safety Committee PESC) from Performance Improvement (PI)/Safety Committee. The update reflects the enterprise level purview of the committee.

In addition to the Chief Nursing Officer, Chief Medical Officer, Chief Quality Officer, and Patient Safety representative, the PESC composition was updated to include the necessary departments more generally versus specific roles.

**2. Chairs update**

The committee will be co-chaired by the Chief Nursing Officer and the Senior Director for Patient Safety and Risk Management. Previously, in addition to the Chief Nursing Officer, the second co-chair was one of the physician members determined by the Chief of Staff. The change was made to the Senior Director for Patient Safety and Risk Management to align with the purpose and duties of the PESC.

**3. Duties**

The list was updated slightly in terms of ordering as well as to be more inclusive, referencing back to the full list of duties in the Patient Safety Plan.

**4. Meeting Frequency**

The meeting frequency was updated to note meeting at least quarterly vs quarterly.

**5. Two Subcommittees**

Two subcommittees are now designated in the PESC charter: the Patient Safety Oversight Committee and the Cause Analysis Oversight Committee.

**6. Periodic report out**

Memo: Approval of Revised Medical Staff Rules
May 13, 2026

The revision now reflects the PESC shall make periodic reports to the Quality Council of its activities.

**List of Attachments:**

- Medical Staff Rules and Regulations (Marked)


# MEDICAL STAFF

# RULES & REGULATIONS

**EL CAMINO HEALTH**
**MEDICAL STAFF**
**RULES AND REGULATIONS**

## A. ADMISSIONS/DISCHARGES

1. Patients shall be admitted only under the care of a qualified member of the Medical Staff. The attending physician must be available to the admitted patient at all times or must arrange such coverage.

Allied health practitioners may initiate arrangements for admission and complete charts and forms pertinent to the admission and the medical record if privileged to do so within their scope of practice and under the supervision of the attending physician (if applicable).

2. Except in an emergency, patients shall not be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.

3. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary or appropriate to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

4. According to policy of Medical Staff (see Operating Room Committee policy), pre-operative lab work shall be ordered at the discretion of the admitting surgeon. If pre-op lab work is ordered, the attending surgeon will be responsible for either including a copy of the lab work in the chart or in the dictated H&P or the admission note in the progress notes.

5. Potassium levels shall be obtained within 72 hours of surgery for all patients on potassium depleting diuretics.

6. All laboratory procedures, for patients being investigated or treated within the Hospital, shall be done in the Hospital except in those circumstances where the Hospital refers laboratory work outside the Hospital.

7. Decisions concerning the use of reference laboratories for studies not performed in the Hospital shall be delegated to the director of the medical laboratory services.

8. Each patient on admission shall be provided with a wristband unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient and the Hospital admission number.

9. Patients shall not be routinely admitted to a distinct part of the Hospital unless it is appropriate for the level of care required by those patients.

10. Patients with critical burns shall be treated in a Burn Center unless transfer of the patient to the center is contraindicated in the judgment of the attending physician.

11. Any outpatient psychotherapist arranging for inpatient psychiatric care of his/her patient at El Camino Hospital will share with the ECH treatment team all information

relevant to the patient's treatment. When the outpatient therapist is not the admitting psychiatrist, a special effort should be made to inform the admitting psychiatrist of all relevant treatment issues. This communication is for purposes of ensuring optimal short-term patient care. Information must be held in strict confidence within the treatment setting, but the availability of relevant information to the treatment team is essential to provide adequate and appropriate therapy.

12. A mentally competent adult shall not be detained in the Hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where the law permits an unemancipated minor to contract for medical care without the consent of his/her parent or guardian, he/she shall not be detained in the Hospital against his/her will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the Hospital in his own interest nor the detention of a mentally disordered patient for the protection of himself or others under the applicable provisions of the Welfare and Institutions Code, Section 5000, et seq., until transfer to an appropriate facility can be arranged.

13. Patients shall not be transferred or discharged for purposes of effecting a transfer from the Hospital to another health facility unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or after reasonable attempts have been made to notify the responsible person. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.

14. A minor shall be discharged only to the custody of his or her parent or to his legal guardian or custodian, unless such parent or guardian shall otherwise direct. This provision shall not be construed to preclude a minor legally contracting for medical care from assuming responsibility for himself upon discharge.

15. Patients may only be discharged upon the order of a Medical Staff member.

16. In the event that a hospitalized patient refuses treatment by a physician, the affected physician will:
a. Communicate with the patient with regard to what he/she needs (tests, follow-up care, etc).
b. Ask a physician in his/her call group or specialty to take over care of the patient ***or,***
c. Ask the chief of department or chief of staff for assistance in assigning another physician to care for the patient.

If the affected physician is acting as a consultant, the primary physician will find another consultant, absent an emergency situation. The primary physician is always responsible for the patient's care in the immediate emergency situation absent the patient's direct wishes to not be cared for in the interim.

17
a. Prior to initiation of definitive therapy at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, it is strongly recommended that review and report of the findings must be documented by an ECH pathologist.

b. Prior to initiation of definitive therapy for breast cancer at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, review and report of the findings must be documented by an ECH pathologist.

**B. RECORDS**

The responsible staff member shall be accountable for the preparation of a complete medical record for each patient. Unless otherwise provided in standing orders, protocols, or guidelines, a record shall include (a) identification data; (b) chief complaint; (c) details of present illness; (d) relevant past, social, and family histories; (e) inventory of body systems; (f) complete physical examination; (g) provisional diagnosis; (h) consultation reports; (i) reports from laboratory, i.e., pathology, radiology, etc.; (j) progress notes detailing medical surgical treatment that reflect any change in condition and results of treatment; (k) reports of procedures (also see below), e.g., nuclear medicine, radiology, anesthesia; (l) principal & secondary diagnosis(es); (m) discharge summary, discharge instructions; (n) follow-up plans; and (o) appropriate consents; and (p) autopsy results, if applicable. All entries shall be dated, timed, and authenticated by the appropriate practitioner. Any entries made for the practitioner (fellow, resident, physician assistant, etc.) must be dated, timed, and counter-signed by the practitioner, except emergency department (ED) reports. ED assessments may be dictated and signed by the responsible nurse practitioner or physician's assistant, and must include the name of the supervising ED physician. The ED physician must document in the ED record that he/she has reviewed the assessment and care provided.

Medical Records may be authenticated by a computer key code, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who has possession of the key code and the only person who will use the key code. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice.

**History & Physical (H&P)**

1. H&P must be completed by a practitioner privileged to perform H&Ps – these are defined as:
   a. MD/DO
   b. DDS/DMD
   c. DPM
   d. Nurse Practitioner – must be countersigned by supervising practitioner within 14 days of the patient's discharge.
   e. Certified Nurse Midwife
   f. Physician Assistant – must be countersigned by supervising practitioner within 14 days of the patient's discharge.

2. H&P must be completed and documented for each patient no more than 30 days before or ~~within~~ 24 hours ~~of~~ after admission ~~or registration~~, but prior to surgery or procedure requiring anesthesia services.

   **At a minimum, the following systems must be included in the H&P:**
   a. Heart and lungs
   b. Abdomen
   c. General appearance and orientation
   d. Vital signs (including blood pressure, heart rate, respiratory rate, and temperature – afebrile is acceptable) or reference to vital signs obtained elsewhere in the admission

process
e. Major integumentary
f. Musculoskeletal or sensory systems when problems such as blindness, deafness, missing limbs, or open sores and wounds exist
g. Rectal/pelvic examinations are recommended when pertinent to the admission diagnosis
h. Salient features of the case
i. Drug tolerances
j. Pertinent positive and negative findings that relate to the reason for admission.

**Outpatients** receiving local anesthesia or conscious sedation require, as a minimum, a current statement of present illness, a statement of absence of infection or intercurrent disease, a description of cardiorespiratory status, known allergies, current medications, and a preoperative diagnosis.

**Obstetrical records** should include all pertinent and significant prenatal information. A durable, legible original or reproduction of the office or clinical prenatal record is acceptable. The report of the physical examination shall reflect a comprehensive current physical assessment

**ECT Patients** - For patients receiving a series of ECT treatments, the history and physical must be within thirty (30) days prior to the initial treatment. For subsequent treatments within the same series, an update to the H&P will be required (the update must include auscultation of the lungs and heart and any significant change in condition or absence of any significant change). This may be documented on the anesthesiologist pre-anesthesia assessment form.

3. **Updates**: When the H&P is conducted within 30 days of admission (inpatient or outpatient), an updated examination, including any changes in the patient's condition, must be completed and documented by a qualified practitioner (see #1 in this section) within 24 hours of admission (inpatient or outpatient) ~~or registration~~, but prior to surgery or a procedure requiring anesthesia services when the H&P was completed within the previous 30 days.

    a. The update must include review of the H&P, updated examination including auscultation of the lungs and heart, and any significant change in condition or absence of any significant change from the previous report. If the patient is an inpatient, the update may be documented in the progress note or on the 'Procedure Notes' form.

4. If the reviewing practitioner finds the H&P incomplete, inaccurate, or otherwise unacceptable, he/she may disregard the H&P and perform a new H&P within 24 hours or prior to surgery/procedure as noted above.

**Other Medical Record Documentation:**

1. Pre-Anesthetic and Post-Anesthetic Notes
   There shall be pre-anesthetic and post-anesthetic notes documented in the medical record which include the anesthesiologist's pre-anesthetic evaluation, the patient's condition upon admission to the Post Anesthesia Care Unit, a description of the post-operative course, a description of any anesthesia complications, and a description of the patient's condition upon discharge from the Post Anesthesia Care Unit.

2. Operative Reports
The immediate procedure note must be entered in the medical record immediately after the procedure and before the patient is transferred to the next level of care for inpatients. This documentation includes the name(s) of the primary surgeon(s), co-surgeon(s) and assistant(s), and name of procedures performed, findings, estimated blood loss, specimens removed, and complications, if any; and postoperative diagnosis. This documentation must be documented in the electronic medical record on the 'post procedure note'. Downtime paper forms may be used when the EMR is not functional.

The comprehensive operative summary describing techniques, findings, and tissues removed or altered must be entered into the medical record or dictated immediately after the procedure and is considered delinquent if not completed within 24 hours of surgery and signed by the surgeon. The following are to be included in the operative summary:

- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.
- All discrepancies in surgical counts and efforts taken to reconcile such discrepancies shall be documented in the operative summary.

3. Progress notes shall be written/dated/timed/signed on each day of the hospital stay and within 24 hours of discharge by the attending physician, his/her associate, or his/her designated PA or NP with El Camino Hospital privileges.

4. Orders for treatment and tests must be entered into the computer system by the Medical Staff member or authorized person at the direction of the staff member. When ordering diagnostic CT, MRI, PET, or nuclear medicine imaging exams, the practitioner should consider the patient's age and recent imaging exams. Drug and treatment orders must be appropriately signed within forty-eight (48) hours. All other orders must be signed within seventy-two (72) hours or prior to the discharge or transfer of the patient. Telephone orders shall immediately be recorded and then read back to the staff member for confirmation, shall be signed by the person to whom dictated with the name of the Medical Staff member per his own name, and shall be signed by the Medical Staff member within the prescribed time limits.

Persons authorized to accept orders defined: Persons to accept and transcribe orders at the direction of Staff Member shall include the nursing staff, pharmacists, and those

persons designated by department guidelines or service protocols in conformity with applicable statutory provisions.

Orders and patient referrals for outpatient services shall be accepted from any member of the El Camino Hospital Medical Staff or Allied Health Professional Staff who holds a current, unrestricted California license and is privileged to do so.

Practitioners (physicians, podiatrists, dentists, and other allied health professionals) who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order outpatient services and refer patients for outpatient services in accordance with the provisions and condition set forth below.

a. If the ordering practitioner is not a member of the El Camino Hospital Medical Staff or Allied Health Professional Staff, verification that the practitioner is licensed and acting within his/her scope of practice in the State in which he/she sees the patient shall be obtained by the outpatient department(s) prior to performing or providing the test, study, or outpatient service. The license shall be verified via the appropriate website or by obtaining verbal verification from the appropriate licensing board by the department providing the service. In addition, a telephone number for the ordering practitioner will be verified by the outpatient department(s) prior to performing or providing the test, study, or outpatient service.
b. Orders for outpatient services must include the name of the patient, the date of the order, the test or treatment to be performed, and the reason for the test or treatment to be performed (symptoms or diagnosis). Orders for outpatient diagnostic tests (i.e., laboratory, radiology exams, EKG, etc.) may be submitted on a requisition form, a prescription/order form from the practitioner's office, or may be telephoned to the appropriate department by the practitioner's office staff with follow-up written orders.
c. Results shall be directly sent to the ordering practitioner unless otherwise requested by the ordering practitioner. As required in California Health and Safety Code 123148(f)(1)-(4), the health care professional is required to discuss the results with the patient prior to electronic medical record auto releasing. Results will be released to the patient seven (7) days after results are finalized. The electronic medical record will release routinely processed tissues including but not limited to skin biopsies, pap smear tests, products of conception, and bone marrow aspirations for morphological evaluation, even if they reveal a malignancy.
d. Practitioners who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order or refer patients for all outpatient services provided by El Camino Hospital except for chemotherapy orders.

Verbal or telephone orders must be signed/authenticated, dated and timed by the author within 48 hours. Faxed or electronic signatures may be used to authenticate a verbal or telephone order. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice. Verbal or telephone orders should be limited to those situations in which it is impossible for the prescriber to enter it into a computer.

In the case of an incorrect order, the practitioner must document in the medical information system or on the Unsigned Orders Summary, that the order was entered incorrectly.

5. A Record of Newborn must be completed for each normal newborn. The Admission Examination must be completed within twenty-four (24) hours of birth by the attending physician.

6. Medical Screening Exams (as defined under the Emergency Medical Treatment and Labor Act) shall be performed and documented in the Emergency Department and Labor and Delivery. Medical Screening Exams shall be performed by a credentialed MD, DO, certified nurse midwife, Emergency Department physician assistants under appropriate supervision and within scope of practice, or, in the case of a patient presenting with pregnancy and/or signs and symptoms of labor, RNs who have demonstrated current competence (per hospital policy) in assessing the laboring patient.

7. A discharge summary is required on all stays over forty-eight (48) hours, except for uncomplicated obstetrical cases and normal newborns. Discharge summaries are also required for patients who are transferred to another acute care facility or who die within forty-eight (48) hours, and shall be written or dictated at the time of discharge, transfer or death.

   A discharge summary should briefly recapitulate the reason for hospitalization, the significant findings, the procedures performed, and treatment rendered, the condition of the patient on discharge, medications, and any specific instructions given to the patient and/or family regarding follow-up care.

   For stays less than forty-eight (48) hours, a final progress note may be completed in lieu of a discharge summary unless the patient is transferred or dies. If a discharge summary is not required, the following information must be included in the final progress note: diagnosis, condition of the patient, diet, activity, medications, and follow-up instructions (if not covered with a pre-printed form).

8. Discharge instructions are required on all hospital stays, including short-stay and cancelled surgeries. Discharge instructions must include the following elements: 1) Discharge medication reconciliation; 2) discharge diet; 3) follow-up appointments; 4) activity level; 5) signs/symptoms to watch for.

9. In the event of a death, a discharge summary should be added to the record which the physician must authenticate. The final summary should indicate the reason for admission, the findings, course in the hospital including significant conditions (present on admission and comfort care), and immediate cause of death.

10. When a necropsy is performed, the provisional anatomic diagnosis should be recorded on the medical record within seventy-two (72) hours and a final completed report shall become a part of the record.

11. The records of discharged patients will be completed within 14 days following discharge.

12. All forms designed to become a part of the medical record must be approved by the Medical Records Committee and by the Medical Staff Executive Committee.

13. Procedures for making changes or amendments to record entries:

    a. Any individual who discovers an error or omission of his or her own shall immediately upon discovery correct it and do so in accordance with the procedures in this section.
    b. Simple corrections may be made during the actual writing of a record entry and shall be lined through (not obliterated), initialed and dated/timed.
    c. Errors or omissions discovered at a later time shall be corrected by a separate entry to the appropriate portion of the record. The original entry shall be lined out (not obliterated).

14. Physician Review of Medical Records
    A physician may request to review a chart only when he/she is actively involved in that patient's care or if reviewing the case for official peer review or quality assessment purposes. Any abuse of this privilege may result in disciplinary action.

15. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
    This Act, as implemented by the HIPAA Privacy Regulation (42 CFR Parts 160 and 164) requires that El Camino Hospital implement policies and procedures to protect the privacy and security of "protected health information" and to afford patients certain rights with regard to their information. "Protected health information" includes any health-related information that identifies or could be used to identify an individual, including patient medical and billing records. HIPAA applies both to the Hospital and to the members of the Medical Staff
    a. El Camino Hospital has adopted privacy practices for the use and disclosure of patient information within the Hospital. These privacy practices are summarized in the Hospital's Notice of Privacy Practices, which is furnished to patients and posted at the Hospital's facilities.
    b. The Notice of Privacy Practices applies to all patient health information created or received in the course of providing health care or conducting business operations at any hospital operated location. The Notice is given jointly on behalf of the Hospital and the members of the Medical Staff. It does not, however, apply to patient health information at other locations, such as a Medical Staff member's private office.
    c. Each member of the Medical Staff shall abide by the terms of the Notice of Privacy Practices and with the Hospital's policies and procedures for health information privacy and security, as amended from time to time. Medical Staff members must adopt their own notice of privacy practices at their private offices as necessary to comply with the Privacy Regulations.

**C. REMOVAL OF ORIGINAL RECORDS FROM THE HOSPITAL**

Original records may be removed from the Hospital's custody only pursuant to court order, subpoena or statute, with exception of x-rays and other images, tracings, recordings and clinical and anatomical pathological materials which are sought for purposes of continuing care of the patient.

**D. AUTOPSIES**

Every member of the Medical Staff shall try to secure permission for autopsy when appropriate. No autopsy shall be performed without the written consent of the appropriate party. All autopsies shall be performed by the hospital pathologist(s) or by a physician to whom he may delegate the duty. In all cases where any doubt exists regarding the legal status of death, the coroner shall be notified and request for an autopsy made. (Indications for autopsy are found in the Pathology Department Policy "Autopsies for QA – Indications for Autopsy".)

**E. CONSULTATIONS**

Consultation(s) shall be obtained by all Medical Staff members whenever the patient appears to be developing unexpected complications or untoward results which threaten life or serious harm, either from the failure of the patient to appropriately respond to the therapy being given and/or substantial medical uncertainty in diagnosis and management.

The Consultant shall document the fact the fact that all available, pertinent past medical records were examined.

**F. MANDATORY CONSULTATIONS**

Mandatory consultation(s); in specific, urgent or critical clinical conditions; may be imposed at the discretion of a Medical Staff officer, department or division chief or their designees with concurrence of a Medical Staff officer. Mandatory consultations may be imposed on any staff member in a specific urgent clinical management problem and/or as an overall continuing requirement in all similar types of clinical management cases.

Mandatory consultations may be imposed by departments or division guidelines for all staff members or classes of members in specific clinical conditions, subject to approval of the Medical Staff Executive Committee.

The consultant in a specific urgent or critical situation may or may not be a staff member, but must be a practitioner with acknowledged expertise. Temporary privileges, if necessary, may be granted at the discretion of an appropriate Department Chief, Chief of Staff, and Hospital Administration and are subject to Sections 6.5-l and 14.2 of the Bylaws.

The imposition of mandatory consultation requirements on a member in a specific, urgent or critical clinical condition, or such imposition on all members or a class of members, does not constitute a reduction in privileges. Mandatory consultation requirements constitute a reduction in privileges of a member when the requirement is imposed on the individual member and as a continuing requirement in all similar cases.

Patients who have attempted suicide prior to or during their hospitalization, or who have suicidal ideation identified following hospitalization, must be evaluated for suicidal risk prior to discharge. Such evaluation is to be done by a psychiatrist or by a member of the Behavioral Health Services staff who must then review the case with a psychiatrist prior to discharge.

If an inpatient is on an involuntary psychiatric hold (i.e. 5150 or 5152); then a psychiatrist must evaluate the patient directly prior to such a hold being released.

**G. PATIENT COVERAGE**

Each staff member is responsible to respond to an emergency involving a member's patient or have a substitute staff member respond. In case of failure to respond, the Medical Staff officers or department executive officers of the appropriate department or service shall have the authority to request emergency services from any staff member. When a staff member findsa substitute for coverage of his practice that substitute physician must be a member in good standing of the El Camino Hospital Medical Staff with similar scope of privileges and will assume all duties of the primary physician.

**H. HOSPITAL SERVICES**

Outpatient diagnostic or therapeutic services may be performed only on request of a Medical Staff member with clinical privileges or practitioners who by training, practice, and California licensure would otherwise qualify for Medical Staff membership or if approved by the Medical Staff Executive Committee.

**I. PROCEDURE FOR CREATION OF NEW MEDICAL STAFF DEPARTMENTS**

Existing services or divisions of the Medical Staff may be considered for provisional department status if:

1. This is mandated by Joint Commission or Hospital Board of Directors, and
2. A majority of the members of the considered service or division approve, and
3. The considered service or division has at least 15 Medical Staff members.

Procedure for obtaining provisional department status:
Following approval by a majority of its members, a written request shall be forwarded to the Medical Staff Executive Committee. If the Medical Staff Executive Committee grants provisional departmental status, it shall be bound to review the performance of this provisional department after one year. At this review, the Executive Committee may grant full department status or mandate an additional six-month provisional period. If an additional six-month provisional period is mandated, the Medical Staff Executive Committee will again review the performance of this provisional department at the end of this time and will either grant full department status or will return it to its prior division or service level.

Responsibilities of a provisional Medical Staff department shall include:

1. The establishment of regular meetings at the frequency of not less than quarterly, which must be attended by not less than 50% of its members
2. The maintenance of minutes that reflect concurrent review of appropriateness of care provided by its members consistent with the Quality Assessment program of the Medical Staff
3. The review and recertification of its members' privileges in accord with established guidelines
4. The development of departmental guidelines which are to be submitted to the Medical Staff Executive Committee within three months
5. The development of member privileging criteria which are also to be submitted for approval to the Medical Staff Executive Committee within three months

The Chief and Vice-Chief may sit on the Medical Staff Executive Committee during the provisional period, but may not vote until the department has been granted full status.

**J. FEES**

An applicant to the Medical Staff shall be required to pay $300 as a processing fee.

**K. RESIDENTS**

1. Nature of Affiliation: Residents engaged in patient care at El Camino Hospital must be post-doctoral trainees (residents or fellows) in training programs of approved teaching institutions which have a contract with El Camino Hospital. Residents must be licensed by the Medical Board of California. They may be authorized to perform clinical duties consistent with their training program, and as outlined in the contract between El Camino Hospital and the residency program and the Medical Staff Guidelines for Supervision of Residents (Medical Staff Policy/Procedure, Section 9). The contracting teaching institution must provide professional liability insurance for residents to cover the performance of all clinical duties at El Camino Hospital. The Medical Staff Executive Committee and Board of Directors shall approve the residency contract. Authorization to perform clinical duties will cease at the completion of an individual physician's rotation or under the terms of the contract. Residents are required to comply in all respects with the Medical Staff Bylaws and

   Rules and Regulations, departmental or service rules and regulations as well as applicable policies and procedures.

   Residents do not enjoy the due process rights afforded Medical Staff members. Moreover, the Medical Staff retains the right to require the immediate suspension or withdrawal of any resident if such action is deemed warranted in order to protect patients or other individuals.

2. Supervision: All clinical care provided by residents shall be under the supervision of a member of the Medical Staff. Guidelines for supervision can be found in the ECH Medical Staff Policies and Procedures, Section 9. All policies related to supervision of residents shall be approved by the Medical Staff Executive Committee.

   1. Authorized Activities: A resident may make entries in the patient's medical record as delineated in the Medical Staff Guidelines (Medical Staff Policy/Procedure, Section 9). The extent to which the resident may otherwise participate in patient care services and make entries in the medical record shall be determined by the Supervising Physician and Training Program and shall be consistent with the applicable Guidelines.

**L. ALLIED HEALTH PROFESSIONALS**

Allied Health Professionals ("AHPs") are covered in the Medical Staff policy regarding these practitioners.

**M. DEA Certification Waiver**

Exemption may be granted upon written attestation of the physician that the physician will not prescribe controlled substances in the hospital. The Department Chief and Medical Staff Executive Committee need to concur that a DEA is not required based on the physician's attestation.

**Appendix I**

## *A.* BREAST STEERING LEADERSHIP COMMITTEE

1. COMPOSITION
Composition of the Breast Steering Leadership Committee are approved members of the Commission on Cancer (CoC) Committee who have current specialty board certification in their area of specialty who treat breast patients, have current medical licensure and active medical staff appointments.

Non physician committee members hold appropriate breast program relationships and accountability as outlined in the applicable National Accreditation Program for Breast Cancer (NAPBC) standards. Physician members are medical staff in Medical and Radiation Oncology, Pathology, Breast Imaging Radiology, and Palliative Care.

Non physician members may include research staff, physical therapy, tumor registry, social work, nursing, hospital administration, nurse practitioners, physician assistants, and patient survivors.

2. DUTIES
The committee is the governing body of the breast center and is chaired by Breast Program Leader or Medical Director. This multidisciplinary committee contributes to:
(a) The policies and procedures of the breast center
(b) Dissemination of information
(c) Active assessment of treatment
(d) Goal setting
(e) Planning, initiating, and determining quality standards and projects and research goals, all following national guidelines of NAPBC and CoC under the direction of the American College of Surgeons.

3. MEETINGS
Meetings will follow national guidelines as established by NAPBC and CoC and will meet quarterly following established CoC quarterly meetings.

## *B.* CANCER CARE COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The Committee shall consist of at least one Board certified physician representative, from Surgery, Gyn Oncology, Medical Oncology, Radiation Oncology, Radiology and Pathology, and all other representatives as required by the current American College of Surgeons/Commission on Cancer Standards.

2. DUTIES
The Committee shall:
(a) Develop and evaluate annual goals and objectives for clinical, educational and programmatic activities related to cancer;
(b) Promote a coordinated, multi-disciplinary approach to patient management;
(c) Coordinate educational and consultative cancer conferences to cover all major sites and related issues;
(d) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes;

(e) Promote clinical research;
(f) Supervise the Cancer Registry and ensure accurate and timely abstracting, staging and follow-up reporting;
(g) Perform quality control of registry data;
(h) Encourage data usage and regular reporting;
(i) Uphold medical ethical standards; and
(j) Annually provide a summary quality management report to the Medical Staff Executive Committee.

3. MEETINGS
The committee shall meet at least quarterly and will submit an annual report to the **Quality Council**.

### *C.* CREDENTIALS COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The committee shall be multi-disciplinary consisting of voting and non-voting members. Voting members will be 9-13 active members of the Medical Staff with representation from the departments of Medicine, Surgery and Maternal Child Health and includes the Chair of the Committee and the Chair of IDPC. Non-voting members will include the Chief Medical Officer and Medical Staff Office representative. The voting members will be appointed by the Enterprise Chief of Staff on the recommendations of the Credential Committee Chair and the Department Chairs and to be approved by the Medical Executive Committee. The Chair of the Committee will be appointed by the Enterprise Chief of Staff and approved by the MEC for a 1 year term with unlimited extensions as long as the Chair is eligible and extension is approved by the MEC. Chair will be ex-officio and without voting rights at the Medical Executive Committee. The voting members cannot be department Chairs or Vice-Chairs or members of the Medical Executive Committee.

2. DUTIES (including but not limited to the following:)
(a) Review of initial applications for membership to the Medical Staff or Allied Health status
(b) Review of reapplications for membership to the Medical Staff or Allied Health status
(c) Review of request for privileges at time of initial application and reapplication or at the request of the Medical Staff member.

3. MEETINGS
Monthly or at the discretion of the Chair of the Committee.

### *D.* CRITICAL CARE COMMITTEE – *MV Campus*

1. COMPOSITION
The Committee will consist of physician and non-physician members. Physician members include representatives from the Medical Staff as well as pulmonologists, intensivists and anesthesia critical care. Non-physician members include Nursing Director of ICU/ED, Director of Infection Prevention, Director of Respiratory Services and Nursing representatives from the ICU. The Chair of the Committee will be the Medical Director of the ICU, appointed by the Chief Medical Officer in consultation with the Enterprise Chief of Staff and approved by the Medical Executive Committee for a period of 1 year with unlimited extensions as long as the Chair is eligible and approved by the MEC.

2. DUTIES
(a) Establish guidelines for care of patients on the critical care units.
(b) Perform ongoing review of patient care on the critical care units.
(c) Participate in evaluation and selection of equipment purchases.
(d) Review cases referred from other medical/staff committees as requested.

3. MEETINGS
Monthly or at the discretion of the Chair.

### *E.* HEART AND VASCULAR INSTITUTE (HVI) COMMITTEE - *Enterprise*

1. COMPOSITION
Committee members will include physicians involved in the diagnosis and treatment of cardiovascular and peripheral vascular disease including cardiologists, interventional cardiologists, vascular surgeons, cardiothoracic surgeons, interventional radiologists, interventional neuroradiologists, and interventional nephrologists. Nonvoting members may include support staff from the Cardiac Catheterization Laboratory, Angiography and Interventional Radiology Services, Non-invasive Imaging and Surgery. Physician or patient care related issues of the HVI Committee will be addressed by the Physician Excellence Committee and/or Leadership Council with MEC oversight. The Chair will be an active member of the Medical Staff in good standing appointed by the Chief Medical Officer for a term of 1 year with unlimited extensions as long as the Chair is eligible and approved by the MEC.

2. DUTIES
(a) Conduct multidisciplinary review of coronary and peripheral vascular intervention procedures performed at El Camino Hospital.
(b) Develop recommendations and/or criteria for clinical privileges for percutaneous endovascular procedures.

(c) Develop protocols for a registry of cases performed at El Camino to include indications and outcomes statistics to ensure consistent quality of care
(d) Promote teaching and education amongst the healthcare professionals involved in the evaluation, combined percutaneous-surgical diagnostic and therapeutic endovascular procedures.
(e) Review selected cases identified via medical staff approved criteria and refer cases for secondary peer review to the appropriate department executive committee.

3. MEETINGS
The committee shall meet as often as necessary, but at least quarterly and will submit an annual report to the Quality Council.

***F.*** **CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE – *Enterprise Committee***

1. COMPOSITION
The continuing medical education/library committee shall be composed of physician members and other health professionals of the Medical Staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The Chair and the members will be appointed per Article 11.1-2 of the Bylaws.

2. DUTIES
The continuing medical education/library committee shall perform the following duties:
(a) Plan, implement, coordinate and promote educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital for the Medical Staff. This includes:
    1. Identifying the educational needs of the Medical Staff;
    2. Formulating clear statements of objectives for each program;
    3. Assessing the effectiveness of each program;
    4. Choosing appropriate teaching methods and knowledgeable faculty for each program; and
    5. Documenting staff attendance at each program.

(b) Assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
(c) Establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
(d) Maintain close liaison with other hospital Medical Staff and department committees concerned with patient care.
(e) Make recommendations to the Medical Staff Executive committee regarding library needs of the Medical Staff.
(f) Advise administration of the financial needs of the continuing medical education program.

3. MEETINGS
At least quarterly. It shall maintain minutes of the program planning discussions and report to the Leadership Council and Medical Executive Committee.

***G.*** **INFECTION CONTROL COMMITTEE –** ***Enterprise Committee***

1. COMPOSITION

The Infection Control Committee shall be a multi-disciplinary committee of physician and non-physician members. The physician members including Chair will be appointed per Article 11.1-2 of the Bylaws with representation from the departments of Medicine, Surgery and Maternal Child Health. Non-physician members will include Director of Infection Prevention, and representation but not limited to nursing, microbiology and pathology divisions, pharmacy, facility and environmental services, sterile processing, central services, operating room and Employee Health.

2. DUTIES

The Infection Control Committee shall:

(a) Develop a hospital-wide infection program and maintain surveillance over the program.

(b) Develop a system for reporting, identifying and analyzing the incidence and cause of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.

(c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques. Such techniques shall be defined in written policies and procedures.

(d) Develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.

(e) Act upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, the departments, and other Medical Staff and Hospital committees.

3. MEETINGS

The Committee and subcommittees (if any) shall meet at least quarterly. It shall maintain a record of its proceedings and shall submit quarterly reports to the Quality Council and Critical Care Committee.

***H.*** **INTERDISCIPLINARY PRACTICE COMMITTEE –** ***Enterprise Committee***

1. COMPOSITION

The Committee shall be multi-disciplinary consisting of active members of the Medical Staff, Chief Nursing Officer, Chief Medical Officer or designee, registered nurses and allied health practitioners. The Chair of the Committee and he physician members will be appointed per Article 11.1-2 of the Bylaws. Physician members to include department or division chairs or their designees that employ Allied Health professionals. The Chair of the IDPC will be a member of the Credentials Committee.

(a) The committee shall be responsible for appointment and reappointment of all allied health practitioners in approved categories.

(b) The committee shall review quality assessment issues pertaining to allied health practitioners at the time of reappointment as needed.

2. DUTIES

(a) The Committee shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:

1. Provision for securing recommendations from Medical Staff members in the medical specialty or clinical field of practice under review, and from persons in the appropriate non-medical category who practice in the clinical field or specialty under review.
2. Methodology for the approval of standardized procedures in accordance with Section 2725 of the Business and Professions Code, which requires affirmative approval of the procedures by the Administrator/ Chief Executive Officer or his/her designee, a majority of the physician members, and a majority of the registered nurse members after consultation has been obtained from medical and nursing staff members practicing in the medical and nursing specialties under review.
3. Provision for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the Medical Staff for medical services in the Hospital.
4. Provision for securing approval for each recommendation of the Committee from the Medical Staff Executive Committee and, if so approved, the Board of Directors.

(b) Registered Nurses: The Committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in the Hospital. These policies and procedures will be administered by the Committee, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.

(c) Standardized Procedures for Registered Nurses: The Committee shall be responsible for:

1. Identifying the functions and/or procedures which required the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the Hospital, and initiating the preparations of such standardized procedures in accordance with this Section.
2. The review and approval of such standardized procedures covering practice by registered nurses in the Hospital.
3. Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee or by delegation to the Director of Patient Care Services.

(d) Each standardized procedure approved by the Committee shall:

1. Be in writing and set forth the date it was approved by the Committee.
2. Specify the standardized procedures which registered nurses are authorized to perform and under what circumstances.
3. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular

standardized procedure.

4. Specify any experience, training or special education requirements for performance of the standardized procedures.
5. Establish a method of initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedures.
6. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedures.
7. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedures; for example, if the standardized procedure is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.
8. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
9. State any limitation on settings or departments within the Hospital where the standardized procedure may be performed.
10. Specify any special requirements for procedures relating to patient record keeping.
11. Provide for periodic review of the standardized procedure.

3. MEETINGS
As necessary. The Committee will report to the Credentials Committee with oversight by Leadership Council and Medical Executive Committee.

## *I.* INSTITUTIONAL REVIEW BOARD – *Enterprise Committee*

1. COMPOSITION
The Institutional Review Board ("IRB") shall be composed in a manner which meets the requirement of the federal Health and Human Services ("HHS") and Food and Drug Administration ("FDA") regulations for the protection of human subjects. The IRB shall have at least five (5) members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted in the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members' backgrounds, including consideration of the racial and cultural backgrounds of members and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to processing the professional competence necessary to review specific research activities, the IRB shall be able to ascertain the accessibility of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB shall, therefore, include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a vulnerable category of subjects, including but not limited to subjects covered by specific regulations, the IRB shall include one or more individuals who are primarily concerned with the welfare of these subjects.

The IRB may not consist entirely of men or entirely of women, or entirely of members of one profession. It shall include at least one (1) member whose primary concerns are in nonscientific areas (for example: lawyers, ethicists, members of the clergy), and at least one (1) member who is not otherwise affiliated with the institution or part of the immediate family of a person who is affiliated with the institution. No member may participate in the IRB's

initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB. The Chair will be a member of the Medical Staff appointed by the Chief Medical Officer (CMO) for a term of 1 year with unlimited extensions as long as the Chair is eligible and approved by the Medical Executive Committee. Administrative and financial responsibilities of the IRB will be the responsibility of the CMO or designee.

2. DUTIES

(a) The IRB must adopt and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, including procedures for:

1. Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and to the institution.
2. Determining which projects require review more often than annually, which projects need verification from sources other than the investigators, and that no material changes have occurred since previous IRB review.
3. Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject.
4. Assuring prompt reporting to the IRB of unanticipated problems involving risks to subject or others.
5. For research subject to HHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.
6. Assuring timely reporting to the appropriate institutional officials of any serious or continuing noncompliance by investigators with the requirements and determinations of the IRB. For research subject to the HHS and FDA regulations, these reports must also be made to HHS, or to the FDA, as appropriate.

(b) Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one (1) member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth Paragraph (c) below. In order for the research to be approved it must meet the criteria set forth in California law and federal regulations and it must receive the approval of a majority of those members present at the meeting. Research which is approved by the IRB may be subject to further appropriate review and approval or disapproval by officials of the institution, but such review is not required. However, those officials may not approve any research subject to the California law and/or federal regulations referenced herein if it has not been approved by an IRB.

(c) The Institutional Review Board shall:

1. Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by HHS, FDA, or California law and regulations.

   Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The

   IRB may require that information, in addition to that specifically mentioned

in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.

2. Require documentation of informed consent or waive documentation in accordance with the provisions of applicable law or regulations.
3. Notify the investigator in writing of its decision to approve or disapprove a proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.
4. Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research.
5. Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and appropriate regulatory authorities.

3. MEETINGS
At least quarterly or as deemed necessary by the Chair.

### *J.* JOINT CONFERENCE COMMITTEE – *Enterprise Committee*

1. COMPOSITION
Chief Executive Officer or designee, Chiefs of Staff, Vice Chiefs of Staff, Immediate Past Chiefs of Staff, Board of Directors' representative, Medical Director of Quality Assessment/Utilization Management, Chief Nursing Officer, Senior Director of Quality and Patient Safety.

2. DUTIES
The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and Medical Staff policy, practice and planning, conflict resolution, and the Medical Staff Executive Committee or the Board of Directors may refer a forum for interaction between the Board of Directors and the Medical Staff on such matters as. The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

3. MEETINGS:
As needed.

### *K.* MEDICAL ETHICS COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The Committee will be multi-disciplinary with representation from the Medical Staff, community, nursing, clergy and administration. The Chair of the Committee and the members will be appointed as per Article 11.1-2 of the Bylaws. Members of the administration including

but not limited to hospital legal counsel, Risk management and CMO or designee will be ex-

officio without voting rights. Members on this committee having voting rights should not be professionally involved in the care of the patient whose case is being reviewed. No member will serve on this Committee if there can be a potential conflict of interest that may affect the quality of care of the patient while discharging their duties as a member of the Committee. Members of Medical Executive Committee, Credentials, Physician Excellence are excluded from serving on this Committee. They may serve as ex-officio members without voting rights when called upon to serve as reviewers. The Chair will report directly to the Leadership Council and to Medical Executive Committee.

2. DUTIES

(a) Provide counsel to physicians, hospital staff, and administration in the understanding, delineations and clarification of medical ethical dilemmas.
(b) Provide regular educational activities on medical ethical dilemmas to the institution.
(c) Assist in the development of ethical guidelines where appropriate.
(d) Submit recommendations to the department executive committee or Medical Staff Executive Committee as appropriate.

3. MEETINGS

As needed and no less than annually.

### *L.* MEDICAL STANDARDS FOR INFORMATION TECHNOLOGY (MSIT) COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The MSIT Committee shall be chaired by an appointee of the Chief Medical Officer. Physician members will be appointed per Article 11.1-2 of the Bylaws and representative**s** from nursing, the Health Information Management Department, Administration, and Information Systems.

2. DUTIES

The duties of the MSIT shall include:

(a) Review and evaluation of the electronic medical record, or a representative sample, to determine whether they: 1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and 2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital;
(b) Review and make recommendations for Medical Staff and hospital policies, rules and regulations relating to the electronic medical record, including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement;
(c) Provide liaison with hospital administration and Health Information personnel in the employ of the hospital on matters relating to practices involving the electronic medical record;
(d) Incorporate Medical Staff input into information systems planning and decisions, such as internet, intranet, email, software applications, and Medical Information Systems (MIS) development, maintenance and upgrade, and other clinical data systems;
(e) Review the hospital-wide Information Management Plan on an annual basis and recommend additions or revisions as may be warranted based upon clinical needs assessment;
(f) Review the Medical Staff clinical data collections applications and recommend changes or upgrades as may be warranted.

3. MEETINGS
Will meet at the discretion of the chair and report annually to the Medical Staff Executive Committee.

***M.*** Enterprise Patient Safety Committee (aka Patient and Employee Safety Committee PESC)~~**PERFORMANCE IMPROVEMENT (PI)/SAFETY COMMITTEE** –~~ ***Enterprise Committee)***

1. COMPOSITION
The Enterprise Patient Safety Committee shall be composed of the Chief Nursing Officer, Chief Medical Officer, Chief Quality Officer or designee, and representation from Patient Safety, physician members of the medical staff, hospital department leadership, Quality, Infection Prevention, and Risk Management staff.
~~The Performance Improvement/Safety Committee shall be composed of the Chief Nursing Officer, Chief Medical Officer, Chief Quality Officer or designee, and representation from Patient Safety, Physician members of the Medical Staff, Nurse Managers, Infection Control Practitioner, Manager of QI/PI, Safety Management Specialist, and the Risk Manager.~~

2. CHAIRS
The committee will be co-chaired by the Chief Nursing Officer and ~~one of the physician members (to be determined by the Chief of Staff).~~the Senior Director for Patient Safety and Risk Management.

3. DUTIES INCLUDE BUT ARE NOT LIMITED TO:
(a) ~~Oversee PI/Safety Teams~~Oversight of patient safety activities
(b) ~~Assess goals and monitor performance of the PI/Safety Teams~~Ensuring that patient safety teams have adequate resources
(c) ~~Ensure PI/Safety Teams have adequate resources~~Identifying gaps in hospital safety and performance and setting targets for patient safety improvement
(d) ~~Identify gaps in hospital safety and performance – set targets for improvement~~Additional duties delineated in Patient Safety Plan

4. MEETINGS
The committee shall meet at least quarterly~~, or at the discretion of the chairs.~~ and shall have the following subcommittees. Additional subcommittees shall be designated in the PESC charter. The PESC shall make periodic reports to the Quality Council of its activities.

(a) Patient Safety Oversight Committee-membership includes but is not limited to Chiefs of Staff or designee and senior hospital leadership. Duties are identified in the hospital's Patient Safety Plan.
(b) Cause Analysis Oversight Committee- Chaired by Chief Medical Officer. Duties are identified in the hospital's Patient Safety Plan.

***N.*** **PERINATAL COMMITTEE** – ***Enterprise Committee***

1. COMPOSITION
This committee will be multi-disciplinary and at least composed of representatives from Pediatrics, OB/GYN, Neonatology, Anesthesia, Care Coordinator and Chief Nursing Officer. The Chair and the members will be appointed per Article 11.1-2 of the Bylaws.

2. DUTIES
(a) Review the ongoing care of patients in Labor and Delivery, NICU, Maternity, and the

**Formatted:** Normal, Indent: Left: 0.6", No bullets or numbering

**Formatted:** Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.86" + Indent at: 1.11"

Nursery.

(b) Establish guidelines for the care of patients in Labor and Delivery, NICU, Maternity, and Nursery.

(c) Submit recommendations/concerns to Maternal-Child Health Department Executive Committee as appropriate.

3. MEETINGS

Monthly, or at the discretion of the Chair. The peer review activities will be monitored by the Physician Excellence Committee.

## *O.* PHARMACY AND THERAPEUTICS COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Pharmacy and Therapeutics Committee is a multi-disciplinary committee consisting of members of the Medical Staff, Nursing, Pharmacy and Administration. The Chair of the Committee and the physician members will be appointed as per Article 11.1-2 of the Bylaws in Consultation with the Chief Medical Officer.

2. DUTIES

The Pharmacy and Therapeutics Committee shall:

(a) Assist in the formulation of broad professional policies regarding the procurement, evaluation, selection, storage, distribution, dispensing, use, safety procedures, administration and all other matters relating to drugs and diagnostic testing materials in the Hospital.

(b) Advise the Medical Staff and the Hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs and review all significant untoward drug reactions.

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(d) Develop and review periodically a formulary or drug list for use in the Hospital.

(e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(f) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(g) Perform an annual review of all Standing Orders.

(h) Perform such other duties as assigned by the Chief of Staff or the Medical Staff Executive Committee.

3. MEETINGS

At least quarterly and at the discretion of the Chair.

## *P.* QUALITY COUNCIL – *Enterprise Committee*

1. COMPOSITION

The Quality Council is a committee of the Medical Staff and hospital that provides oversight of quality improvement activities across the Enterprise. The Medical Staff representation includes the Chairs of the Enterprise Medical Staff Departments (Medicine, Surgery, Maternal Child Health), Medical Service Line Directors as deemed appropriate by the Enterprise Chief of Staff, and Directors of Anesthesiology, Radiology and Emergency Medicine or their designee. Hospital representation will include the Associate Chief Medical Officer, Chief

Quality Officer or designee, Chief Nursing Officer or designee, Nursing Director (Critical Care/ED, Maternal Child Health, Medical/Surgical/Oncology Services), and Director of Medical Staff Information Technology.

2. CHAIRS

The Committee will be co-chaired by Chief Medical Officer and an active member of the Medical Staff appointed by the Enterprise Chief of Staff per Article 11.1-2 of the Bylaws. Chair will be ex-officio and without voting rights at the Medical Executive Committee.

3. DUTIES
(a) Set overall direction for QI activities at El Camino Hospital
(b) Align medical staff and hospital QI activities
(c) Align service line development and hospital growth initiatives with medical staff and hospital QI activities
(d) Continually review committees and reporting structures to ensure collaboration and teamwork with regard to QI activities.

4. MEETINGS
The committee shall meet quarterly, or at the discretion of the Chairs. The Chair will report to Medical Executive Committee.

***Q.*** **RADIATION SAFETY COMMITTEE -** ***Enterprise Committee***

1. COMPOSITION

The Committee will be Chaired by the Radiation Safety Officer (RSO) from the Division of Radiology and appointed by the Chief Medical Officer in consultation with the Enterprise Chief of Staff with approval by the Medical Executive Committee. Members from the Department of Medicine, Surgery and Maternal Child Health will be represented. Non- physician will include representatives from the administration, nuclear medicine and nursing.

2. DUTIES
(a) Establish radiation safety guidelines for staff and patients at El Camino Hospital.
(b) Review ongoing activities relative to radiation safety.
(c) Review proposals for diagnostic and therapeutic uses of unsealed radio nuclides.
(d) Review regulations for the use, transport, storage and disposal of radioactive materials used in Nuclear medicine
(e) Recommend remedial action when there is a failure to observe protection recommendations, rules and regulations.

3. MEETINGS
Meets every 3 months and as deemed necessary by the Chair.

***R.*** **TRANSFUSION AND TISSUE REVIEW COMMITTEE –** ***Enterprise Committee***

1. COMPOSITION
The Transfusion and Tissue Review Committee is a multidisciplinary committee The Committee is Co-Chaired by the Medical Director of the Transfusion Service (from the

Department of Pathology) and an active member of the Medical Staff appointed by the Enterprise Chief of Staff for a period of 1 year with unlimited extensions and approved by the MEC. The other members will include representation from the Department of Medicine, Surgery and Maternal Child Health, Chief Quality Officer or designee, Director if Accreditation/Public Reporting, Director of Laboratory and Pathology Services, Lab Manager from Los Gatos, Blood Bank Manager and Transfusion Safety Officer and other members as deemed necessary by the Chairs.

2. DUTIES
The duties of the transfusion committee shall include:

(a) Monitor the safety and utilization of transfusion of blood and blood products
(b) Provide data on blood utilization to Medical Staff members and hospital leadership
(c) Provide education on the safe and efficacious use of blood products
(d) The committee will also perform tissue review function through the Department of Pathology which includes review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis. The Medical Staff Executive Committee may describe a system by which the tissue review function shall be coordinated with departmental surgical case review.

3. MEETINGS
At least quarterly and at the discretion of the Chair.

***S.*** **UTILIZATION REVIEW COMMITTEE** – ***Enterprise Committee***

1. COMPOSITION
The utilization review committee shall consist of a sufficient number of members to afford fair representation. The committee will include at least 2 members of the Medical Staff. Members on this committee should have no financial interest in the hospital and should not be professionally involved in the care of the patient whose case is being reviewed. No member will serve on this committee if there can be a potential conflict of interest that may affect the quality of care of the patient while discharging their duties as a member of the committee. The Chair of the committee and its members will be selected by the Chief Medical Officer or designee in consultation with the Enterprise Chief of Staff for a 1-year term with unlimited extensions and to be approved by the MEC on a yearly basis. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate.

2. DUTIES
The duties of the utilization review committee shall include:

(a) Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Staff Executive committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety; all peer to peer for "level of care denials" will be done by the Utilization Management medical director or designee. Attending physician can do peer to peer if requested by the Utilization Management medical director. This applies to all payors.
(b) Establishing a utilization review plan which shall be approved by the Medical Staff Executive Committee; and

(c) Obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

3. MEETINGS

The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a quarterly report of its activities and recommendations to the Medical Executive Committee.

This Page is Intentionally Left Blank

This Page is Intentionally Left Blank

El Camino Health

# POLICIES FOR BOARD APPROVAL
# MAY 13, 2026

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| Risk Mgmt & Patient Safety | **FY2026 Patient Safety Plan** | 9-1-25 | 3-18-26 | Major | Plan | • CDPH rejected initial version; revised plan submitted was approved.<br>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 Safety First/Mission Zero high-reliability framework, regulatory requirements, and strategic priorities supporting the delivery of safe, equitable, and patient-centered care.

**SUMMARY OF CHANGES:**
The FY2026 Patient Safety Plan was revised following California Department of Public Health (CDPH) feedback and approval requirements. Key updates include:

- Clarifies governance structure, committee oversight responsibilities, and reporting relationships supporting enterprise patient safety activities.
- Refines descriptions of the Patient and Employee Safety Committee (PESC), Patient Safety Oversight Committee (PSOC), and Cause Analysis Oversight processes to improve alignment and accountability.
- Expands language regarding high reliability principles, Safety First/Mission Zero initiatives, and workforce safety education programs.
- Enhances reporting, event classification, and analysis processes related to patient safety events, root cause analysis, and system-based improvement activities.
- Adds and clarifies processes addressing health equity, racism, discrimination reporting, and sociodemographic review of patient safety events.
- Updates patient safety priorities, performance indicators, dashboards, and organizational safety initiatives to align with current regulatory, accreditation, and operational requirements.
- Revises confidentiality, annual evaluation, and governance reporting language for consistency with applicable patient safety and quality improvement standards.

No change to the overall purpose of the Patient Safety Program; revisions reflect regulatory alignment, organizational clarification, and CDPH-approved updates to the enterprise patient safety framework.

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| Quality | **FY2026 Quality Improvement Plan** | 5-1-18 | 9-17-25 | Major | Plan | • Extracted all 'Patient Safety Plan' content as a standalone document, due to CDPH req.<br>PESC > Quality Council > ePolicy > MEC > Quality Committee > Board |

**POLICY SUMMARY:**
Establishes El Camino Health's enterprise Quality Improvement Plan, serving as the organization's comprehensive framework for quality assessment, performance improvement, patient safety, and regulatory compliance across all care settings. The plan defines the governance structure, organizational responsibilities, improvement methodologies, and performance monitoring processes used to support safe, effective, equitable, patient-centered, and high-reliability care throughout the health system.

**SUMMARY OF CHANGES:**

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| The FY2026 Quality Improvement Plan was updated to align with current organizational priorities, regulatory requirements, and enterprise quality improvement activities. Key updates include:<br>• Removes standalone Patient Safety Plan content that has been extracted into a separate enterprise Patient Safety Plan document in response to regulatory requirements.<br>• Updates organizational quality goals, dashboards, and performance improvement priorities for FY2026, including focus areas related to infection prevention, pressure injuries, and hand hygiene compliance.<br>• Clarifies governance oversight responsibilities and reporting structures supporting quality improvement, patient safety, and performance monitoring activities.<br>• Enhances descriptions of multidisciplinary quality improvement processes, data reporting, and enterprise quality governance workflows.<br>• Updates quality improvement methodologies, process improvement frameworks, and auditing approaches supporting operational excellence and high reliability initiatives.<br>• Revises language related to patient experience, health equity, regulatory compliance, and continuous performance improvement activities.<br>• Updates annual evaluation, reporting, and accountability language for consistency with current organizational structure and accreditation requirements.<br>No change to the overall purpose of the Quality Improvement Program; revisions reflect regulatory alignment, organizational clarification, annual goal updates, and separation of Patient Safety Plan content into a standalone document. | | | | | | |
| Quality | **Patient Blood Management Patient-Centered Quality Plan** | 2-23-24 | 2-5-25 | Minor | Plan | • Minor update<br>Transfusion Committee > ePolicy > MEC > Board |

**POLICY SUMMARY:**
Establishes El Camino Health's Patient Blood Management (PBM) Patient-Centered Quality Plan, providing the organizational framework, governance structure, and evidence-based practices supporting safe, appropriate, and patient-centered use of blood and blood products across the enterprise. The plan promotes high-quality transfusion practices, blood conservation strategies, regulatory compliance, and multidisciplinary oversight to improve patient outcomes and reduce unnecessary transfusions.

**SUMMARY OF CHANGES:**
The Patient Blood Management Patient-Centered Quality Plan was updated to reflect current operational practices, regulatory standards, and quality improvement initiatives supporting the organization's PBM program. Key updates include:

- Updates organizational and program descriptions related to patient blood management activities and evidence-based transfusion practices.
- Enhances language regarding patient-centered care, informed consent, patient engagement, and blood conservation strategies.
- Clarifies transfusion guidelines, computerized physician order entry (CPOE) decision support processes, provider review workflows, and utilization monitoring activities.
- Expands descriptions of analytic dashboards, physician peer review, Ongoing Professional Practice Evaluation (OPPE), tracer audits, and performance monitoring processes supporting transfusion safety and quality oversight.
- Updates pre-admission screening and type-and-screen protocols supporting surgical safety and blood availability management.
- Revises educational, certification, and continuous improvement language related to Joint Commission and AABB Patient Blood Management certification activities.
- Updates governance structure, accountability responsibilities, committee oversight, and reporting relationships supporting enterprise PBM

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| | activities.<br>• Reflects successful Joint Commission/AABB PBM recertification completed in December 2025.<br>No change to the overall purpose of the Patient Blood Management Program; revisions reflect operational enhancements, updated quality oversight processes, certification updates, and continued alignment with evidence-based transfusion management practices. | | | | | |
| Patient Experience | **Administrative: Visitors Policy** | 8-1-11 | 10-9-24 | Major | Policy | • Major update<br>ePolicy > MEC > Board |
| | **POLICY SUMMARY:**<br>Establishes El Camino Health's enterprise visitor policy, outlining patient visitation rights, support person access, and justified clinical restrictions necessary to maintain patient safety, privacy, security, and hospital operations. The policy supports a welcoming, patient-centered healing environment while ensuring compliance with applicable regulatory and nondiscrimination requirements.<br>**SUMMARY OF CHANGES:**<br>The Administrative: Visitors Policy was revised to support a more patient-centered and flexible visitation approach while clarifying operational, safety, and regulatory expectations. Key updates include:<br>• Updates policy language to reflect an open visitation philosophy welcoming visitors and support persons 24 hours a day, 7 days a week, consistent with patient preferences and clinical needs.<br>• Clarifies patient rights regarding designation of visitors and support persons, including the ability to modify or withdraw consent at any time.<br>• Expands and reorganizes definitions and examples of justified clinical restrictions supporting patient safety, infection prevention, privacy, and operational needs.<br>• Adds new sections addressing visitor health concerns, disruptive or unsafe visitor behavior, and operational or clinical circumstances requiring visitation limitations.<br>• Clarifies nondiscrimination language related to visitation rights and support person access.<br>• Updates guidance regarding support persons for incapacitated patients and newborn visitation requirements within Mental Health and Addiction Services.<br>• Adds language regarding limited law enforcement body camera use in specific circumstances and associated privacy considerations.<br>• Enhances communication expectations requiring visitation restrictions to be explained to patients and support persons whenever possible.<br>No change to the overall purpose of the policy; revisions reflect operational clarification, patient-centered visitation enhancements, and alignment with current safety, privacy, and regulatory requirements. | | | | | |
| Pharmacy | **Multidisciplinary Drug Diversion Surveillance** | 11-12-20 | 9-17-24 | Minor | Policy | • Minor update<br>P&T > ePolicy > MEC > Board |
| | **POLICY SUMMARY:**<br>Establishes El Camino Health's multidisciplinary drug diversion surveillance framework, outlining the governance structure, monitoring processes, investigation protocols, and accountability measures used to prevent, detect, investigate, and report controlled substance diversion activities. The policy supports patient safety, regulatory compliance, secure medication management, and safe controlled substance handling across all stages of the medication use process.<br>**SUMMARY OF CHANGES:** | | | | | |

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| The Multidisciplinary Drug Diversion Surveillance policy was updated to strengthen controlled substance security, diversion prevention activities, and operational response processes. Key updates include:<br>• Clarifies multidisciplinary team (MDT) oversight responsibilities, required membership, meeting frequency, documentation expectations, and escalation workflows related to drug diversion prevention activities.<br>• Enhances surveillance and monitoring processes utilizing diversion detection software, IRIS reporting, automated dispensing cabinet reviews, and controlled substance utilization analytics.<br>• Updates investigation, reconciliation, and reporting processes related to suspected diversion events, unresolved discrepancies, and controlled substance losses or theft.<br>• Expands language addressing chain of custody, medication storage security, anesthesia audits, patient-owned medications, and controlled substance inventory controls.<br>• Clarifies education, competency, and cultural expectations supporting staff awareness, reporting responsibilities, and safe controlled substance management practices.<br>• Adds new operational language requiring immediate pharmacist-in-charge notification and securing instructions upon discovery of unsecured controlled substances during investigations.<br>• Updates references, surveillance technology descriptions, and hardware deterrent strategies supporting diversion prevention and regulatory compliance activities.<br>No change to the overall purpose of the policy; revisions reflect operational enhancements, strengthened surveillance controls, clarified investigation procedures, and continued alignment with federal and state controlled substance management requirements | | | | | | |
| Medical Staff | **Medical Staff Services - Electronic Signatures** | 1-31-23 | N/A | Minor | Policy | • Minor update<br>IDPC > Credentialing > ePolicy > MEC > Board |
| **POLICY SUMMARY:**<br>Establishes guidelines for the use of electronic signatures within Medical Staff Services processes, including communications related to medical staff membership and privileges, allied health practitioner status, peer review activities, and professional practice evaluations. The policy supports secure, legally binding, and operationally efficient electronic approval and attestation processes within a confidential and peer review protected environment.<br>**SUMMARY OF CHANGES:**<br>The Medical Staff Services – Electronic Signatures policy was reviewed and resubmitted for reapproval with no substantive policy changes. Minor administrative updates and formatting revisions were made pursuant to ePolicy review recommendations.<br>No change to the overall purpose, scope, or operational requirements of the policy. | | | | | | |
| Corporate Compliance | **Physician Financial Arrangements – Review and Approval** | 06-2008 | 03-2023 | Major | Policy | • Major update<br>ePolicy > Finance Committee > Board |
| **POLICY SUMMARY:**<br>Establishes El Camino Health's governance, approval, and oversight framework for physician financial arrangements, including medical directorships, consulting agreements, professional services agreements, leases, education/training reimbursement, and physician recruitment arrangements. The policy defines administrative standards, fair market value requirements, contract review and approval processes, compliance safeguards, and Board oversight responsibilities necessary to ensure physician financial relationships comply with Stark Law, Anti-Kickback | | | | | | |

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|

Statute, HIPAA, and other applicable federal and state laws.

**SUMMARY OF CHANGES:**

The Physician Financial Arrangements – Review and Approval Policy was revised to clarify governance oversight, strengthen approval workflows, and align physician contracting requirements across El Camino Health and El Camino Health Medical Network (ECHMN). Key updates include:

· Clarifies enterprise applicability of the policy across El Camino Health and affiliated entities, including ECHMN.
· Updates terminology and references throughout the policy for consistency with current organizational structure and governance terminology.
· Adds and clarifies approval thresholds requiring Finance Committee, Board, or ECHMN Board of Managers review for physician compensation arrangements exceeding specified fair market value benchmarks.
· Expands language regarding fair market value documentation, commercial reasonableness standards, and review requirements for physician compensation arrangements.
· Clarifies executive signature authority and approval responsibilities related to physician contracts, including ECHMN leadership authority and professional services agreements.
· Enhances contract documentation, contract management system, and compliance review requirements for physician financial arrangements and lease agreements.
· Revises Board oversight and annual reporting requirements related to physician financial arrangements, fair market value trends, compensation oversight, and Medical Director performance reporting.
· Updates language regarding Medical Director agreements, physician consulting arrangements, lease agreements, education/training reimbursement, and physician recruitment arrangements to improve operational clarity and regulatory alignment.
· Clarifies compliance safeguards related to Stark Law exceptions, compensation changes, conflict of interest review, suspension of arrangements for compliance concerns, and contract execution requirements prior to commencement of services.
· Adds and clarifies governance requirements specific to El Camino Health Medical Network physician compensation and compensation structure oversight.

No change to the overall purpose of the policy; revisions reflect governance clarification, strengthened oversight and approval processes, regulatory alignment, and operational updates supporting compliant physician financial arrangements.

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<br>-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

# CEO Report – May 13, 2026

## FINANCIAL PERFORMANCE

Financial performance through February (FY2026 Period 8) remains strong, with results exceeding budget and prior year across key metrics. Year-to-date operating EBIDA reached $191.2 million (15.6%), approximately $24 million favorable to budget, while operating margin totaled $123.6 million (10.1%), $26.6 million above budget and $9.7 million higher than the same period last year.

Performance continues to be driven by strong volumes in interventional and outpatient surgical services, along with sustained discipline in labor productivity and expense management. Operating expenses remain favorable to budget, including improved cost performance when adjusted for case mix.

Net margin is $78.7 million higher than the same period last year, reflecting continued operational strength and financial market performance. The organization continues to monitor the ongoing shift toward governmental payors, which remains a key consideration for long-term financial performance.

---

## SERVICE LINES

**Heart & Vascular**

The Norma Melchor Heart & Vascular Institute received national recognition for clinical excellence, earning two distinctions: inclusion in *America's 100 Best Hospitals for Coronary Intervention* by Healthgrades and a 3-star rating (the highest achievement) from the Society of Thoracic Surgeons for its Transcatheter Aortic Valve Replacement (TAVR) program. These recognitions place the program among the top-performing cardiovascular programs nationally and reflect high-quality outcomes in complex cardiac procedures.

---

## INFORMATION SERVICES

El Camino Health was represented in the authorship of ANSI/HSI 2800-2025, the first national standard for AI Governance in Healthcare Operations, reflecting the organization's leadership role in advancing responsible and effective AI practices across the healthcare industry.

Virtual care utilization also continued to expand. In March, El Camino Health completed 1,920 virtual patient visits, representing the highest monthly volume achieved in the past three years. Provider performance remained exceptionally strong, with a 99.4% success rate, reinforcing clinical engagement and reliable patient access across the virtual care platform.

In addition, El Camino Health and Lockheed Martin received an Institute of Electrical and Electronics Engineers Milestone Recognition honoring "Innovation in Health Care Technology for Pioneering the World's First Hospital-Wide Computerized Medical Information System" from 1965–1974. A recognition ceremony will be held on May 14, 2026, at the Mountain View campus.

---

## MARKETING & COMMUNICATIONS

A central pillar of El Camino Health's marketing strategy to drive growth is building a more differentiated brand in the marketplace. This month, the organization launched its new brand strategy, Togethering Heals™, culminating a year-long effort to articulate and amplify what makes El Camino Health

distinctive. Developed through extensive engagement with leaders, employees, and physicians, the strategy is designed to strengthen trust and preference, increase awareness and consideration, and better position El Camino Health for growth in an increasingly competitive environment.

Finally, Mark Klein, chief communications and marketing officer, was recently named to Becker's 2026 list of "Chief Marketing Officers to Know." Mr. Klein is recognized among a distinguished group of national leaders shaping how hospitals and health systems build trust, strengthen their brands, and connect more meaningfully with patients and communities. His leadership continues to strengthen El Camino Health's brand and market presence, deepen trust with the communities El Camino Health serves, and advance the organization's growth and impact across the region.

## RECOGNITION

For the fifth consecutive year, El Camino Health has been named one of the World's Best Hospitals by Newsweek. El Camino Health's Mountain View hospital ranked #97 nationally and #15 in California, reflecting strong performance in clinical quality, patient outcomes, and advanced medical technology.

The annual ranking, developed in partnership with Statista, evaluates hospitals across 32 countries. In the Bay Area, El Camino Health's Mountain View hospital is the highest-ranked community hospital on the list and ranks among the top three hospitals overall.

El Camino Health was also named a Top 5 Finalist for Hospital of the Year at the Lactation Impact Awards by the California Breastfeeding Coalition, recognizing excellence in maternal and infant health and nursing-led, family-centered care.

## GOVERNMENT RELATIONS & COMMUNITY PARTNERSHIPS

El Camino Health partnered with state and community leaders to convene a discussion focused on California's perinatal mental health crisis. The event included participation from First Partner Jennifer Siebel Newsom, Diana Ramos, MD, California's Surgeon General and Dan Woods, and regional clinical and policy leaders. Dr. Nirmaljit Dhami, medical director of inpatient perinatal mental health services, highlighted opportunities to strengthen access, coordination, and continuity of care for women during pregnancy and the postpartum period. Facilitated by the California Perinatal Wellness Alliance, the convening focused on advancing more integrated systems of perinatal behavioral health care across the state. El Camino Health was selected to host the discussion in recognition of its leadership role as one of only five inpatient perinatal psychiatric programs in the nation.

Community partnerships efforts also expanded this month through a new regional strategic sponsorship with the National Fitness Campaign across Santa Clara County. In partnership with Marketing & Communications, the initiative will help fund outdoor fitness courts in local communities, schools, and public spaces to promote accessible physical activity and community wellness. Designed for individuals of all fitness levels, the initiative supports preventive health and aligns with the organization's broader community health strategy.

## CORPORATE HEALTH

The Chinese Health Initiative (CHI) launched a four-month Diabetes Prevention Series in Cantonese, supporting more than 110 participants in improving diet, physical activity, sleep, and stress management. CHI also participated in an upcoming segment on social isolation in the Chinese community for KTSF's *Health Matters*, alongside Dr. Wei Chien Lee, with the episode scheduled to air in June.

The South Asian Heart Center marked its 20th anniversary with a donor appreciation event recognizing two decades of leadership in cardiovascular disease prevention. The Center's impact was further acknowledged by the U.S. House of Representatives, the California State Legislature, and the Santa Clara County Board of Supervisors, highlighting El Camino Health's commitment to community-based prevention and population health.

## FOUNDATION

Total philanthropic support through Period 10 reached $15.2 million, representing 152% of the FY26 fundraising goal of $10.0 million. Annual Giving has raised more than $1.0 million to date, exceeding the FY26 goal by 33% and outperforming the prior fiscal year with two months remaining.

The Foundation also announced the establishment of the Mary & Richard Wallace Medical Director of the Heart & Vascular Institute Endowment, only the second endowment of its kind in El Camino Health history. The endowment honors Dr. Fred St. Goar's leadership and will provide permanent support for physician leadership within the Norma Melchor Heart & Vascular Institute, strengthening the organization's ability to sustain nationally recognized cardiovascular care and recruit future clinical leaders.

Community engagement efforts continue to support philanthropic growth. The Foundation's April direct mail campaign reached more than 312,000 households and highlighted a patient survival story demonstrating the impact of coordinated emergency and critical care services. As of April 30, the campaign had generated more than $61,000 in contributions.

Looking ahead, the Foundation will host its Spring Benefit on June 2, 2026, at the Mountain View Center for the Performing Arts featuring Dr. Atul Gawande.

## AUXILIARY

In March 2026, the El Camino Health Auxiliary contributed 4,445 volunteer hours across the organization, reflecting the continued dedication and service of its 400+ members.

El Camino Health

# POLICIES FOR BOARD APPROVAL
# MAY 13, 2026

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| Risk Mgmt & Patient Safety | **FY2026 Patient Safety Plan** | 9-1-25 | 3-18-26 | Major | Plan | • CDPH rejected initial version; revised plan submitted was approved.<br>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 Safety First/Mission Zero high-reliability framework, regulatory requirements, and strategic priorities supporting the delivery of safe, equitable, and patient-centered care.

**SUMMARY OF CHANGES:**
The FY2026 Patient Safety Plan was revised following California Department of Public Health (CDPH) feedback and approval requirements. Key updates include:

- Clarifies governance structure, committee oversight responsibilities, and reporting relationships supporting enterprise patient safety activities.
- Refines descriptions of the Patient and Employee Safety Committee (PESC), Patient Safety Oversight Committee (PSOC), and Cause Analysis Oversight processes to improve alignment and accountability.
- Expands language regarding high reliability principles, Safety First/Mission Zero initiatives, and workforce safety education programs.
- Enhances reporting, event classification, and analysis processes related to patient safety events, root cause analysis, and system-based improvement activities.
- Adds and clarifies processes addressing health equity, racism, discrimination reporting, and sociodemographic review of patient safety events.
- Updates patient safety priorities, performance indicators, dashboards, and organizational safety initiatives to align with current regulatory, accreditation, and operational requirements.
- Revises confidentiality, annual evaluation, and governance reporting language for consistency with applicable patient safety and quality improvement standards.

No change to the overall purpose of the Patient Safety Program; revisions reflect regulatory alignment, organizational clarification, and CDPH-approved updates to the enterprise patient safety framework.

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| Quality | **FY2026 Quality Improvement Plan** | 5-1-18 | 9-17-25 | Major | Plan | • Extracted all 'Patient Safety Plan' content as a standalone document, due to CDPH req.<br>PESC > Quality Council > ePolicy > MEC > Quality Committee > Board |

**POLICY SUMMARY:**
Establishes El Camino Health's enterprise Quality Improvement Plan, serving as the organization's comprehensive framework for quality assessment, performance improvement, patient safety, and regulatory compliance across all care settings. The plan defines the governance structure, organizational responsibilities, improvement methodologies, and performance monitoring processes used to support safe, effective, equitable, patient-centered, and high-reliability care throughout the health system.

**SUMMARY OF CHANGES:**

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| The FY2026 Quality Improvement Plan was updated to align with current organizational priorities, regulatory requirements, and enterprise quality improvement activities. Key updates include:<br>• Removes standalone Patient Safety Plan content that has been extracted into a separate enterprise Patient Safety Plan document in response to regulatory requirements.<br>• Updates organizational quality goals, dashboards, and performance improvement priorities for FY2026, including focus areas related to infection prevention, pressure injuries, and hand hygiene compliance.<br>• Clarifies governance oversight responsibilities and reporting structures supporting quality improvement, patient safety, and performance monitoring activities.<br>• Enhances descriptions of multidisciplinary quality improvement processes, data reporting, and enterprise quality governance workflows.<br>• Updates quality improvement methodologies, process improvement frameworks, and auditing approaches supporting operational excellence and high reliability initiatives.<br>• Revises language related to patient experience, health equity, regulatory compliance, and continuous performance improvement activities.<br>• Updates annual evaluation, reporting, and accountability language for consistency with current organizational structure and accreditation requirements.<br>No change to the overall purpose of the Quality Improvement Program; revisions reflect regulatory alignment, organizational clarification, annual goal updates, and separation of Patient Safety Plan content into a standalone document. | | | | | | |
| Quality | **Patient Blood Management Patient-Centered Quality Plan** | 2-23-24 | 2-5-25 | Minor | Plan | • Minor update<br>Transfusion Committee > ePolicy > MEC > Board |

**POLICY SUMMARY:**
Establishes El Camino Health's Patient Blood Management (PBM) Patient-Centered Quality Plan, providing the organizational framework, governance structure, and evidence-based practices supporting safe, appropriate, and patient-centered use of blood and blood products across the enterprise. The plan promotes high-quality transfusion practices, blood conservation strategies, regulatory compliance, and multidisciplinary oversight to improve patient outcomes and reduce unnecessary transfusions.

**SUMMARY OF CHANGES:**
The Patient Blood Management Patient-Centered Quality Plan was updated to reflect current operational practices, regulatory standards, and quality improvement initiatives supporting the organization's PBM program. Key updates include:

- Updates organizational and program descriptions related to patient blood management activities and evidence-based transfusion practices.
- Enhances language regarding patient-centered care, informed consent, patient engagement, and blood conservation strategies.
- Clarifies transfusion guidelines, computerized physician order entry (CPOE) decision support processes, provider review workflows, and utilization monitoring activities.
- Expands descriptions of analytic dashboards, physician peer review, Ongoing Professional Practice Evaluation (OPPE), tracer audits, and performance monitoring processes supporting transfusion safety and quality oversight.
- Updates pre-admission screening and type-and-screen protocols supporting surgical safety and blood availability management.
- Revises educational, certification, and continuous improvement language related to Joint Commission and AABB Patient Blood Management certification activities.
- Updates governance structure, accountability responsibilities, committee oversight, and reporting relationships supporting enterprise PBM

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| activities.<br>• Reflects successful Joint Commission/AABB PBM recertification completed in December 2025.<br>No change to the overall purpose of the Patient Blood Management Program; revisions reflect operational enhancements, updated quality oversight processes, certification updates, and continued alignment with evidence-based transfusion management practices. | | | | | | |
| Patient Experience | **Administrative: Visitors Policy** | 8-1-11 | 10-9-24 | Major | Policy | • Major update<br>ePolicy > MEC > Board |
| **POLICY SUMMARY:**<br>Establishes El Camino Health's enterprise visitor policy, outlining patient visitation rights, support person access, and justified clinical restrictions necessary to maintain patient safety, privacy, security, and hospital operations. The policy supports a welcoming, patient-centered healing environment while ensuring compliance with applicable regulatory and nondiscrimination requirements.<br>**SUMMARY OF CHANGES:**<br>The Administrative: Visitors Policy was revised to support a more patient-centered and flexible visitation approach while clarifying operational, safety, and regulatory expectations. Key updates include:<br>• Updates policy language to reflect an open visitation philosophy welcoming visitors and support persons 24 hours a day, 7 days a week, consistent with patient preferences and clinical needs.<br>• Clarifies patient rights regarding designation of visitors and support persons, including the ability to modify or withdraw consent at any time.<br>• Expands and reorganizes definitions and examples of justified clinical restrictions supporting patient safety, infection prevention, privacy, and operational needs.<br>• Adds new sections addressing visitor health concerns, disruptive or unsafe visitor behavior, and operational or clinical circumstances requiring visitation limitations.<br>• Clarifies nondiscrimination language related to visitation rights and support person access.<br>• Updates guidance regarding support persons for incapacitated patients and newborn visitation requirements within Mental Health and Addiction Services.<br>• Adds language regarding limited law enforcement body camera use in specific circumstances and associated privacy considerations.<br>• Enhances communication expectations requiring visitation restrictions to be explained to patients and support persons whenever possible.<br>No change to the overall purpose of the policy; revisions reflect operational clarification, patient-centered visitation enhancements, and alignment with current safety, privacy, and regulatory requirements. | | | | | | |
| Pharmacy | **Multidisciplinary Drug Diversion Surveillance** | 11-12-20 | 9-17-24 | Minor | Policy | • Minor update<br>P&T > ePolicy > MEC > Board |
| **POLICY SUMMARY:**<br>Establishes El Camino Health's multidisciplinary drug diversion surveillance framework, outlining the governance structure, monitoring processes, investigation protocols, and accountability measures used to prevent, detect, investigate, and report controlled substance diversion activities. The policy supports patient safety, regulatory compliance, secure medication management, and safe controlled substance handling across all stages of the medication use process.<br>**SUMMARY OF CHANGES:** | | | | | | |

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|
| The Multidisciplinary Drug Diversion Surveillance policy was updated to strengthen controlled substance security, diversion prevention activities, and operational response processes. Key updates include:<br>• Clarifies multidisciplinary team (MDT) oversight responsibilities, required membership, meeting frequency, documentation expectations, and escalation workflows related to drug diversion prevention activities.<br>• Enhances surveillance and monitoring processes utilizing diversion detection software, IRIS reporting, automated dispensing cabinet reviews, and controlled substance utilization analytics.<br>• Updates investigation, reconciliation, and reporting processes related to suspected diversion events, unresolved discrepancies, and controlled substance losses or theft.<br>• Expands language addressing chain of custody, medication storage security, anesthesia audits, patient-owned medications, and controlled substance inventory controls.<br>• Clarifies education, competency, and cultural expectations supporting staff awareness, reporting responsibilities, and safe controlled substance management practices.<br>• Adds new operational language requiring immediate pharmacist-in-charge notification and securing instructions upon discovery of unsecured controlled substances during investigations.<br>• Updates references, surveillance technology descriptions, and hardware deterrent strategies supporting diversion prevention and regulatory compliance activities.<br>No change to the overall purpose of the policy; revisions reflect operational enhancements, strengthened surveillance controls, clarified investigation procedures, and continued alignment with federal and state controlled substance management requirements | | | | | | |
| Medical Staff | **Medical Staff Services - Electronic Signatures** | 1-31-23 | N/A | Minor | Policy | • Minor update<br>IDPC > Credentialing > ePolicy > MEC > Board |
| **POLICY SUMMARY:**<br>Establishes guidelines for the use of electronic signatures within Medical Staff Services processes, including communications related to medical staff membership and privileges, allied health practitioner status, peer review activities, and professional practice evaluations. The policy supports secure, legally binding, and operationally efficient electronic approval and attestation processes within a confidential and peer review protected environment.<br>**SUMMARY OF CHANGES:**<br>The Medical Staff Services – Electronic Signatures policy was reviewed and resubmitted for reapproval with no substantive policy changes. Minor administrative updates and formatting revisions were made pursuant to ePolicy review recommendations.<br>No change to the overall purpose, scope, or operational requirements of the policy. | | | | | | |
| Corporate Compliance | **Physician Financial Arrangements – Review and Approval** | 06-2008 | 03-2023 | Major | Policy | • Major update<br>ePolicy > Finance Committee > Board |
| **POLICY SUMMARY:**<br>Establishes El Camino Health's governance, approval, and oversight framework for physician financial arrangements, including medical directorships, consulting agreements, professional services agreements, leases, education/training reimbursement, and physician recruitment arrangements. The policy defines administrative standards, fair market value requirements, contract review and approval processes, compliance safeguards, and Board oversight responsibilities necessary to ensure physician financial relationships comply with Stark Law, Anti-Kickback | | | | | | |

| Department | Document Title | Origin Date | Last Reviewed | Status | Type | Document Details \| Approval Workflow |
|---|---|---|---|---|---|---|

Statute, HIPAA, and other applicable federal and state laws.

**SUMMARY OF CHANGES:**

The Physician Financial Arrangements – Review and Approval Policy was revised to clarify governance oversight, strengthen approval workflows, and align physician contracting requirements across El Camino Health and El Camino Health Medical Network (ECHMN). Key updates include:

· Clarifies enterprise applicability of the policy across El Camino Health and affiliated entities, including ECHMN.
· Updates terminology and references throughout the policy for consistency with current organizational structure and governance terminology.
· Adds and clarifies approval thresholds requiring Finance Committee, Board, or ECHMN Board of Managers review for physician compensation arrangements exceeding specified fair market value benchmarks.
· Expands language regarding fair market value documentation, commercial reasonableness standards, and review requirements for physician compensation arrangements.
· Clarifies executive signature authority and approval responsibilities related to physician contracts, including ECHMN leadership authority and professional services agreements.
· Enhances contract documentation, contract management system, and compliance review requirements for physician financial arrangements and lease agreements.
· Revises Board oversight and annual reporting requirements related to physician financial arrangements, fair market value trends, compensation oversight, and Medical Director performance reporting.
· Updates language regarding Medical Director agreements, physician consulting arrangements, lease agreements, education/training reimbursement, and physician recruitment arrangements to improve operational clarity and regulatory alignment.
· Clarifies compliance safeguards related to Stark Law exceptions, compensation changes, conflict of interest review, suspension of arrangements for compliance concerns, and contract execution requirements prior to commencement of services.
· Adds and clarifies governance requirements specific to El Camino Health Medical Network physician compensation and compensation structure oversight.

No change to the overall purpose of the policy; revisions reflect governance clarification, strengthened oversight and approval processes, regulatory alignment, and operational updates supporting compliant physician financial arrangements.

Status **Active** PolicyStat ID **20445639**

| | |
|---|---|
| Origination | 09/2025 |
| Last Approved | 04/2026 |
| Effective | 04/2026 |
| Last Revised | 04/2026 |
| Next Review | 04/2027 |
| 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.~~

# FY2026 Patient Safety Plan

## 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 purpose of this Patient Safety Plan is to **improve the health and safety of patients** and **reduce preventable patient safety events**, as required by California Health & Safety Code §1279.6.

This plan establishes the structures, processes, and responsibilities necessary to comply with California Health & Safety Code §1279.6, including reporting systems, event analysis, committee oversight, and annual review requirements.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.~~

The Patient Safety Plan outlines a comprehensive program that encompasses high reliability principles and the hospital's commitment to achieving zero preventable harm known as the Safety First/Mission Zero program. In addition, the Patient Safety Plan 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~~a core value 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 (Att C universal skills).

C. Promote a culture of safety and high reliability known as the Safety First/Mission Zero program.

D. Build processes that improve our capacity to identify and address patient safety issues using high reliability principles and the Safety First/Mission Zero leader skill toolkit (Att B).

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. See Attachment A for Flow of Patient Safety Information.

## Governing Board

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

administration and the committees noted below.

# Quality Committee of the Board

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

# Enterprise Hospital Committees

The Medical Staff Bylaws and Rules and Regulations describe the composition and duties of the **Enterprise Quality Council** ~~as a~~and the **Enterprise Patient Safety Committee;** two combined hospital and medical staff ~~committee~~committees that ~~oversees~~oversee 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 **Enterprise Patient Safety Committee (aka Patient and Employee Safety Committee(PESC)** has the following duties, and reports to Quality Council monthly. Membership includes physicians, nurses, pharmacists and leaders throughout the organization.

A. Review and approve the patient safety plan annually for each campus, incorporating advancements in patient safety practices.
B. Receive and review reports of patient safety events.
C. Monitors implementation of corrective actions for safety events by receiving reports from the Cause Analysis Oversight Committee defined below.
D. Make recommendations to eliminate future patient safety events by initiating performance improvement related to patient and employee safety concerns based on identified trends and concerns.
E. Receives reports from the following patient safety subcommittees: Medication Safety, Falls,Skin Integrity, Hospital-acquired Infections, Central Safety, and the Grievance Committee.
F. Monitors data and receives reports regarding the hospital's Culture of Safety surveys,

# FY2026 Patient Safety Plan

compliance with National Performance Goals (NPG), Safety/Security concerns, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene program, and Employee Injuries including Workplace Violence.

G. Sets an annual patient and employee safety metrics with quality targets based on any available benchmarks and organizational goals. (See Attachment E: latest FY Patient and Employee Safety Dashboard).

The **Cause Analysis Oversight ~~Steering~~ Committee** is a subcommittee and reports to the ~~Enterprise Patient~~PESC. This committee is responsible for providing oversight and monitoring of the Cause Analysis program described in Safety ~~Oversight Committee (PSOC). This committee is responsible for providing oversight and monitoring of the~~Event Management and Cause Analysis ~~program described in Safety Event Management and Cause Analysis~~ procedure. This group is responsible for ensuring that action plans are implemented for apparent cause and 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.~~

The **Enterprise Patient Safety Oversight Committee (PSOC)** is a subcommittee of PESC and is composed of the Chief of Staff or designees along with hospital senior leadership that meet at least monthly 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. PSOC assists in providing prompt direction to the organization and the medical staff in addressing patient safety concerns.



## 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 staff in the Risk Management Patient Safety Department are trained to conduct analysis of patient safety events including root cause analysis, and includes staff with clinical backgrounds in nursing or other clinical areas who shall have appropriate comptencies to do such analyses. The procedure for conducting the analysis is described in the Safety Event Management and Cause Analysis procedure.

Patient Safety events shall be analyzed at least annually on the following sociodemographic factors: age, race, ethcnity, preferred language spoken, disabilty status, payor, sex, and if provided by the patient, gender identity and sexual orientation and reported to the PESC for identification of any disparities.

# FY2026 Patient Safety Plan

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. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment D) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.
- Coordination of any requested Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.
- Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
- Review National 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 peer coaching program
- 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 Training

A. All staff and medical staff upon hire are provided training on patient safety at new hire orientation/physician on-boarding which includes training on the use of SAFETY skills and behaviors to prevent error (Attachment B).

B. Staff receive annual refreshers and medical staff receive refreshers at time of recredentialing through the hospital's learning information system.

C. Leaders also receive training on leader skills to support Safety First/Mission Zero journey to high reliability (Attachment B) through the manager orientation program.

D. The Board of Directors receive training on patient safety when joining the Board.

## Patient Safety Event Reporting

ECH supports and encourages a culture of safety by promoting reporting of patient safety events as follows.

A. ECH has adopted use of an electronic tool called iSAFE to report patient safety events which

# FY2026 Patient Safety Plan

allows anyone including health care practitioners and staff to submit a report concerning patient safety event to the hospital. Reports can also be submitted anonymously by clicking the appropriate box in the iSAFE system.

B. Training is provided to all workforce members upon hire on reporting concerns using ISAFE 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. Details about how to utilize the ISAFE system are found in the Safety Event Reporting procedure.

C. Patients and visitors may share patient safety concerns by contacting the Patient Experience Department by phone or email, or by informing hospital staff. Staff shall then complete a Feedback ISAFE to enter into the electronic patient safety event reporting system. The Patient Experience Department manages the Feedback reports to ensure timely response and follow-up.

D. ECH supports a strong culture of safety by committing to Fair and Just Culture principles surrounding event reporting which include the following:

1. Non punitive response and zero retaliation for reporting patient safety concerns, near misses and incidents.
2. Information shared through the iSAFE system shall be used for improvement purposes.



## Process for Addressing Reports of Racism and Discrimination Involving Patients

El Camino Hospital adopts the following process to address racism and discrimination involving patients, and their impact on patient health and safety, that includes, but is not limited to:

A. The Health Equity Department and the Risk Management and Patient Safety Department shall monitor sociodemographic disparities in patient safety events and develop interventions to remedy known disparities. The Health Equity Department shall report out on known disparities and improvement efforts to the PESC at least annually.

B. Encouraging staff to report suspected instances of racism and discrimination involving patients. Risk Management and Patient Safety staff shall work with hospital leadership to ensure that an investigation is completed which may need to involve Human Resources or the Medical Staff Office.

## FY26 PATIENT SAFETY ~~PLAN~~PRIORITIES AND INITIATIVES

~~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~~

# FY2026 Patient Safety Plan

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:

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

# FY2026 Patient Safety Plan

A. Each Fiscal Year's 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 and Leapfrog
5. Accreditation and regulatory requirements related to patient safety
6. Fallouts from PESC dashboard.

B. Ongoing 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



| | |
|---|---|
| ~~• Safety First Mission Zero SAFETY skill program~~<br>~~• Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis~~<br>~~• Hand Hygiene Audits~~<br>~~• Monthly Leader and Executive Rounding using 4C SAFETY skill scripts~~<br>~~• New hire and manager Orientation to include SAFETY skill education~~<br>~~• HeRO Recognition and Award Program~~ | |
| **Quality Indicators of Patient Safety:** | |
| • Nurse Sensitive Indicators (Medication Safety, Falls)<br>• Healthcare Associated Infections<br>• Surgical site infections<br>• Surgical Safety Checklist | • Pressure Injuries<br>• Transfusion reactions/ blood/blood product administration<br>• Use of Restraints<br>• Employee Safety |

# FY2026 Patient Safety Plan

| | |
|---|---|
| | • Serious Safety Event Rate<br>• Culture of Safety Survey results |
| **Safety Programs:** | |
| • Central Safety Committee<br>• Emergency Preparedness Committee<br>• Infection Prevention and Control Program (including Hand Hygiene and PPE support) | • Antibiotic Stewardship Program<br>• Radiation Safety Committee |
| **Data from Environmental Safety Issues:** | |
| • Product Recalls<br>• Drug Recalls<br>• Product/equipment malfunction | • Air Quality<br>• Security incidents<br>• 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~~patient safety activities. ~~The Directors/Managers of the organization allocate staff time to participate in performance improvement activities~~Budgetary planning shall include resources for patient safety programs. ~~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 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 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 Patient Safety and Quality Improvement ~~& Patient Safety Program of El Camino Hospital has been designed to comply with all~~Act of 2005 (PSQIA) and when 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.

# FY2026 Patient Safety Plan

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

# ANNUAL EVALUATION

The Senior Director of Risk Management and Patient Safety~~: The Senior Director of Risk Management and~~ shall provide an annual evaluation and presentation of the Patient Safety ~~shall provide an annual evaluation and presentation of~~program to the Patient and Employee Safety ~~program to the Patient and Employee Safety~~ Committee~~,~~ and the Quality committee of the Board, ~~and the Governing Board~~which includes a summary of the reports made to the California Department of Public Health. 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~~safety. 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~~D HPI Safety Event Classification Algorithm

Att E PESC Dashboard FY26

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

## Attachments

- Att A - Governance Information Flow.pdf
- Att B - Safety First Mission Zero Leader Skill Toolkit.pdf
- Att C - Safety First MIssion Zero Universal Skills Toolkit.pdf

# FY2026 Patient Safety Plan

Att D - HPI Safety Event Classification Algorithm.pdf

Att E - PESC Dashboard FY26.pdf

Signed Memorandum - FY2026 Patient Safety Plan (4-27-26).pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Administration | Patrick Santos: Policy and Procedure Coordinator | 04/2026 |
| | Sheetal Shah: Sr Director Risk Management and Patient Safety | 04/2026 |

Status **Active** PolicyStat ID **20462992**

| | |
|---|---|
| Origination | 05/2018 |
| Last Approved | 04/2026 |
| Effective | 04/2026 |
| Last Revised | 04/2026 |
| Next Review | 04/2027 |
| Owner | Michael Coston: Director Quality and Public Reporting |
| Area | Quality |
| Document Types | Plan |

# FY2026 Quality Improvement Plan



## ~~QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN~~

## ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a 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.

## El CAMINO HEALTH VISION

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

# FY2026 Quality Improvement Plan

continuum.

## El CAMINO HOSPITAL VALUES

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

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

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

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

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

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

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

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



## DEFINITIONS:

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

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

## SERVICES/PROGRAMS

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

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

# FY2026 Quality Improvement Plan

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



## ~~Section I Quality Improvement Plan~~

## PURPOSE

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

## OBJECTIVES

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

Staff, Medical Staff, and the Governing Board, as appropriate.

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

# ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT



## Governing Board

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

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

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

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

# Medical Executive Committee (MEC)

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

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

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

# Medical Staff Departments and Divisions

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

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



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

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

# Leadership and Support

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

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

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

# Medical Staff, Employees, and Contracted Services

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



# Enterprise Quality Council

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

# Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and improvement throughout the hospital. While implementation and evaluation of quality improvement activities

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

The Quality Services Department is also responsible for:

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

# Hospital Services

All ECH departments and service lines participate in the Quality Improvement Plan by establishing

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

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

# IMPROVING ORGANIZATIONAL PERFORMANCE

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



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

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

# Performance Processes

A. **Design**
The design of processes is in conjunction with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are

evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

B. **Measurement**

ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and safety. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.

Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

1. Consistent with the organization's mission, vision, goals, objectives, and plans;
2. Meeting the needs of individuals served, staff and others;
3. Clinically sound and current;
4. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
5. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
6. Incorporated into the results of performance improvement activities.
7. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs

   Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:

   a. Establish a performance baseline;
   b. Describe process performance or stability;
   c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
   d. Identify areas for more focused data collection to achieve and sustain improvement.

C. **Analysis**

Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.

a. When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy.

Department Directors shall act in accordance with Human Resources policies regarding employee performance.
b. ECH analyzes undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

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

# Improvement Model and Methodology

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

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



The model has two parts:

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

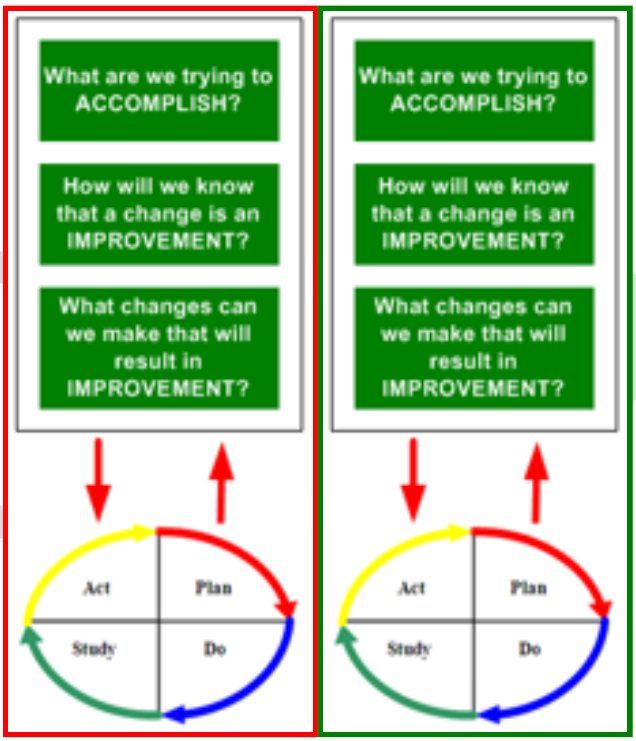
B. **The Plan-Do-Study-Act (PDSA) Cycle**
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.
   1. **Step 1: Plan**
      Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
   2. **Step 2: Do**

# FY2026 Quality Improvement Plan

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

3. **Step 3: Study**
   Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
   Summarize and reflect on what was learned.

4. **Step 4: Act**
   Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous. In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:




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

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

   The acronym stands for:

   **S – Specific**
   When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet

# FY2026 Quality Improvement Plan

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

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

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

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

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

2. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.

# FY2026 Quality Improvement Plan

Measure of Success (MOS) auditing process has specified the following minimums:

a. Sample all cases for a population size of fewer than 30 cases
b. Sample 30 cases for a population size of 30–100 cases
c. Sample 50 cases for a population size of 101–500 cases
d. Sample 70 cases for a population size of more than 500 cases
e. Sample 100 cases for a population greater than 500 cases
   To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

**Process Improvement**

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

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

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

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

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

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

# FY2026 Quality Improvement Plan

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

## Quality Improvement Link with Organizational Goals

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

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

### Fiscal Year 2026 Goals

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

## Commitment to Patient Experience

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

# FY2026 Quality Improvement Plan

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

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

## ~~SECTION II: Patient Safety Plan~~

## ~~PURPOSE~~

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

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

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

## ~~GUIDING PRINCIPLES~~

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

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

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

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

~~E. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and~~

near misses. These reports inform our improvements to care.

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

# OBJECTIVES

A. Deliver high quality safe care for every patient.

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

C. Promote a culture of safety.

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

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

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

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

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

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

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

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

L. Support sharing of knowledge to influence behavioral changes.

# ORGANIZATION AND FUNCTIONS

## Structures that Support Patient Safety

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

## Governing Board

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

## Quality Committee of the Board

The Quality Committee of the Board oversees Patient Safety at the hospital. They review patient safety

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

# Enterprise Hospital Committees

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

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

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

# Risk Management and Patient Safety Department

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

# FY2026 Quality Improvement Plan

- Coordination of any requested Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.
- Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
- Review National Patient Safety Goal (NPSG) and collaborate with Accreditation to conduct gap analyses.
- Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach
- In partnership with 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:

    1. A non-punitive approach and without fear of reprisal, as evidenced by the Fair and Just

# FY2026 Quality Improvement Plan

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<br>• Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis<br>• Hand Hygiene Audits<br>• Monthly Leader and Executive Rounding using 4C SAFETY skill scripts<br>• New hire and manager Orientation to include SAFETY skill education<br>• HeRO Recognition and Award Program | |
| **Quality Indicators of Patient Safety:** | |
| • Nurse Sensitive Indicators (Medication Safety, Falls)<br>• Healthcare Associated Infections<br>• Surgical site infections<br>• Surgical Safety Checklist | • Pressure Injuries<br>• Transfusion reactions/ blood/blood product administration<br>• Use of Restraints<br>• Employee Safety |

# FY2026 Quality Improvement Plan

| | |
|---|---|
| | • ~~Serious Safety Event Rate~~<br>• ~~Culture of Safety Survey results~~ |
| **~~Safety Programs:~~** | |
| • ~~Central Safety Committee~~<br>• ~~Emergency Preparedness Committee~~<br>• ~~Infection Prevention and Control Program (including Hand Hygiene and PPE support)~~ | • ~~Antibiotic Stewardship Program~~<br>• ~~Radiation Safety Committee~~ |
| **~~Data from Environmental Safety Issues:~~** | |
| • ~~Product Recalls~~<br>• ~~Drug Recalls~~<br>• ~~Product/equipment malfunction~~ | • ~~Air Quality~~<br>• ~~Security incidents~~<br>• ~~Workplace Violence~~ |

# ~~QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN~~



## Allocation of Resources

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

## Confidentiality

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

Data, reports, and minutes of the Quality Improvement ~~and Patient Safety~~ Program are the property of ECH. This information is maintained in the Quality, ~~Risk Management and Patient Safety~~ Departments and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. ~~All other requests for information from the program~~

~~shall be in writing stating the purpose and intent of the request, and shall be addressed to the Chief Quality Officer, Sr. Director, Quality Services Department, Director of Risk Management or Patient Safety or the Compliance Officer.~~

# Annual Evaluation

~~Patient Safety: The Senior~~The Chief Quality Officer or the Sr. Director of ~~Risk Management and Patient Safety~~Quality Services, shall ~~provide an~~coordinate the annual evaluation ~~and presentation of the Patient Safety~~of the Quality program ~~to the Patient and Employee Safety~~and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee, the Quality ~~committee~~Committee of the Board, and the Governing Board. The annual appraisal shall address ~~the~~both program's effectiveness in ~~preventing harm to patients and visitors~~improving patient care, ~~improving patient care and safety~~and clinical performance, resolving problems, and achieving program objectives. The annual report of the Quality program will be done at the end of each fiscal year reviewing the organization goals, and enterprise quality dashboard.

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

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

# ATTACHMENTS:

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY26)

Att C Enterprise Quality, Safety and Experience Dashboard (FY25)

Att D Board Quality and Safety Dashboard (FY25)

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicators

~~Att G Patient and Employee Safety Dashboard (FY25 Q4)~~

~~Att H Safety First / Mission Zero Leader Skill Toolkit~~

~~Att I Safety First / Mission Zero Universal Skill Toolkit~~

~~Att J HPI Safety Event Classification Algorithm~~

*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and*

# FY2026 Quality Improvement Plan

*electronic versions of this document, the electronic version prevails.*

## Attachments

- Att A - Quality Governance Flow for QIP.pdf
- Att B - Quality Council Reporting Calendar (FY26)
- Att C - Enterprise Quality, Safety and Experience Dashboard.pdf
- Att D - STEEEP FY26 MOCK (Exclude ED and MCH LTR).pdf
- Att E - Abbrev Registries List.pdf
- Att F - External Regulatory Compliance Indicator.pdf
- b64_124b82d3-50d7-4fd2-9e99-58fa5df26b29
- b64_95ffd793-45d3-4612-978d-dc8c17e63050
- image2.png



## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Administration | Patrick Santos: Policy and Procedure Coordinator | 04/2026 |
| | Michael Coston: Director Quality and Public Reporting | 04/2026 |

Status **Pending** PolicyStat ID **19961656**

El Camino Health

| | |
|---|---|
| Origination | 02/2024 |
| Last Approved | N/A |
| Effective | Upon Approval |
| Last Revised | 02/2026 |
| Next Review | 1 year after approval |

| | |
|---|---|
| Owner | Jeong Chae: Patient Blood Management Programs Manager |
| Area | Quality |
| Document Types | Plan |

# Patient Blood Management Patient-Centered Quality Plan



## PROGRAM OVERVIEW:

El Camino Health (ECH) is a ~~454~~466 bed and nonprofit care organization with hospital campuses in Mountain View, California and Los Gatos, California. Our hospitals have served communities in the South San Francisco Bay Area for over 60 years. ECH is mission-driven to provide the best care to its patients. This quality plan is an effort in extending this care philosophy to the hospital's Patient Blood Management (PBM) program.

There is an increasing awareness of the limited clinical efficacy of blood, an increasing concern regarding its safety, dwindling blood supply and rising costs of blood products. The practice of transfusion medicine now emphasizes the judicious use of transfusion, only when clinically indicated. ECH's patient blood management program is seen as a solution to these problems.

Since July 2014, ECH has been actively involved in a Patient Blood Management (PBM) initiative to promote advancements in transfusion practice. The main areas of implementation included establishing evidence-based transfusion guidelines, reviewing the appropriateness of each transfusion with practitioner feedback, providing ongoing clinical education, creating PBM dashboards, and distributing an analytic blood utilization report. ECH's PBM program has been adopted across medical specialties and we are anticipating a continuous advancement in coming years.

## VISION FOR QUALITY:

The promotion of safe, high quality management and use of blood and blood products is a primary objective of the PBM program. Statements in the Joint Commission (TJC) and the Association for the Advancement of Blood and Biotherapies (AABB)'s PBM standards outline the expectations of healthcare

organizations with regard to the responsible, sustainable and appropriate use of blood and blood products.

ECH's PBM program improves patient outcomes by ensuring that the focus of patient's medical and surgical management is on optimizing and conserving the patient's own blood. PBM sets the standard of ECH's care applied by all clinicians for patients facing a medical or surgical intervention who are at risk of blood loss, bleeding, coagulopathy or may require a blood product as part of their treatment, recognizing that there may be more appropriate ways of using and administering blood and blood products to manage disorders.

# PRINCIPLES OF PATIENT BLOOD MANAGEMENT:

PBM views a patient's own blood as a valuable and unique resource that should be conserved and managed appropriately. This recognizes that for many patients the best and safest blood is their own circulating blood. Appropriate patient management requires a patient's blood (circulatory system) to be considered in the same way as the management of all other body systems.

A. **Reducing inappropriate use**
   Appropriate use of blood products within a blood management framework would mean that red blood cell (RBC) transfusions would be characterized as "appropriate" on the basis of a pre-transfusion hemoglobin, could be rendered unnecessary if a patient's iron deficiency is treated and patients are allowed adequate time to generate their own red cells and hemoglobin in preference to transplanting another person's red blood cells.
   ECH's PBM is a multidisciplinary, evidence-based approach to optimizing the care of patients and represents best practice for transfusion medicine. Appropriate use of blood and blood products should therefore take into account a patient's modifiable risk factors that may reduce the use of transfusion as a treatment option.

B. **Partnering with patients**
   The Standard aims to ensure that patients (and surrogates) are engaged in decisions about their care management and, if they chose to receive blood and blood products, they do so appropriately and safely. Information should be provided to patients about optimizing their own blood, PBM strategies and the potential need for blood and blood products, including all treatment options, risks and benefits.
   When discussing PBM with patients, it is important to:
   1. Ensure that the information is current, and that clinicians have ready access to it.
   2. Provide information in a format that is easy to understand and able to be adapted to level of health literacy.
   3. Honor an adult patient who has capacity to make medical decisions (or their designated surrogate decision maker) to refuse blood product and review non-blood medical alternatives and treat the patient without using allogeneic blood.

ECH's PBM supports clinicians to communicate with patients and surrogates to respect the patient's values and preferences along with an appropriate informed consent process.

# PBM PROGRAM IMPLEMENTATION:

A. **Dissemination of evidence-based transfusion guidelines**
Effective implementation of comprehensive transfusion guidelines is a key element in a successful patient blood management program. These guidelines establish a standard of care within the organization for clinical transfusion decisions. ECH's transfusion guidelines are developed and written by a multidisciplinary group of clinicians based on a review of the literature including national or specialty-specific physician practice guidelines. They are evaluated by the hospital's Transfusion Safety Committee and Medical Executive Committee (MEC) to ensure that the guidelines are followed.
Transfusion clinical practice guidelines include:

1. Hemoglobin level of 7 g/dL or less as a transfusion trigger (except acute massive hemorrhage)
2. Single unit transfusion: One unit of blood can be ordered at a time for stable patients who are not actively bleeding; a second unit may be added after reassessing the patient
3. CPOE will allow single unit of RBC transfusion and block additional RBC transfusion orders for the period of one hour from the time of previous single unit transfusion order entry
4. In order to place more than one unit of RBC, the ordering physician must check at least one of the options from the exclusion criteria
5. Hemoglobin level of 8 g/dL or less as a trigger in cardiovascular disease or a post-operative patient
6. Specific Platelets Guideline by platelet count threshold and clinical indication (Prophylactic use, Peri-procedural use, and Therapeutic Use of Platelets)
These guidelines were embedded in the hospital's clinical policy and the Computerized Physician Order Entry (CPOE) system. They are also disseminated throughout various communication channels both verbally and via reports. The chair of the Transfusion Safety Committee (a medical director of PBM) and program manager of PBM visit various physician specialties, groups, departments, and committee meetings to present the new guidelines and their specific outcomes data.



B. **Provider-specific peer review of transfusions**
Concurrent review of transfusion orders is done by the PBM Program Manager on a daily basis. It has been the most effective tool to evaluate whether hospital transfusion guidelines are being followed by each ordering physician and mid-level clinician. Determination of appropriateness is based on medical condition, evidence-based transfusion guidelines, and adequate and appropriate clinical documentation regarding the decision for transfusion. Each week, collected review cases are sent to the chair of the Transfusion Safety Committee for further review. The results of transfusion review are communicated to the ordering provider and the chief of the service or department. The reviewed cases are entered into the Peer Review data base under the file titled: blood transfusion - outside guidelines. This data is used for education and is also reviewed as a part of the Ongoing Professional Practice Evaluation (OPPE) process.

C. **Computerized Physician Order Entry (CPOE) with clinical decision support**

# Patient Blood Management Patient-Centered Quality Plan

Implementation of the guidelines and assurance that the guidelines are being followed can be accomplished through incorporation of the guidelines into the hospital's blood and blood component ordering process. In our current computer based ordering system, physicians must choose the clinical indication for transfusion from a list and fill out required fields or order detail. The indicated reason for transfusion as part of the ordering process has facilitated transfusion utilization review.

As a part of effective Clinical Decision Support System (CDSS), most recent laboratory values are available in the order set screen. Evidence-based Transfusion guidelines for each category of blood products are available in the order set via hyperlink.

Currently, single unit transfusion is set up as a default for the non-emergent medical patient. Transfusion of a second unit should only be given if the symptoms of anemia have not resolved. This strategy ensures the patient receives the correct response and reduces the risk associate with repeat transfusions. CPOE allows single unit of RBC transfusion and blocks additional RBC transfusion orders for the period of one hour from the time of previous single unit transfusion order entry. In order to place more than one unit of RBC, the ordering physician must check at least one of the options from the exclusion criteria: Patient is actively bleeding and/or patient is in the operating/procedural room. Any other clinical reason for placing more than one unit order must be entered in the transfusion order set.

D. **Patient blood management–related metrics and analytic dashboards**

PBM-related metrics and blood usage are collated and itemized for each clinical specialty to allow identification of potential areas for improvement due to overutilization. These data are analyzed to identify the physician group, department or committee, and individual clinician. Patient blood management related metrics include single unit RBC transfusion episodes, indications for blood product use with mean pre-transfusion levels, and blood product use that falls outside of transfusion guidelines. As a result, a monitoring and feedback system has been established as a standardized format. Next, data analytic software, Tableau, is utilized to generate specialty and physician specific analytic reports. The data is then distributed to key shareholders including heads of the departments and the Medical Director of Quality and Patient Safety on a monthly or quarterly basis.

E. **Ongoing Professional Practice Evaluation (OPPE)**

ECH has been able to collect meaningful transfusion-related data, and provide that data to individual practitioners through OPPEs. In coordination with peer review coordinators, 2 transfusion metrics have been included in the physician OPPE report since October 2017. The practitioner's average transfusion hemoglobin level and the average number of transfused units are compared to other physicians within the same specialty. In addition, the outlier cases that are entered into the clinical effectiveness data base will be added to the OPPE report as an additional metric for the evaluation of transfusion practices. The positive outcome is that most practitioners will make the needed changes when presented with data showing they are not performing to the same level as their peers.

F. **Tracer Audit and Analytic Report on Transfusion Nursing Documentation**

Through tracer audit activity, nurses will be educated and encouraged to closely monitor the patient and document all required fields, including vital signs before, during, and after the transfusion. Unit and individual specific Tableau report will clearly highlight the areas where there is need for greater improvement, including names of nurses who report higher noncompliance rate. The analytic data are disseminated through nursing managers and directors. It is encouraged to share the data with nursing staffs to understand the current

# Patient Blood Management Patient-Centered Quality Plan

status of noncompliance and need of improvement.

G. **Development of a protocol to check Type and Screen prior to elective surgery**
Beginning an elective high blood loss surgery without confirming the availability of a patient's specific blood type is a safety concern. ECH endeavors to ensure that compatible blood is available since about 3% of specimens have a serologic finding that requires further investigation, causing a potential delay. Development of a formal protocol to have blood testing completed (when ordered) prior to potential high blood loss elective surgery may optimize management of blood resources and maximize patient safety.
An internal audit showed that the rate of same-day type and screen (T&S) was high even though this increases the chances of delayed surgery for compatible blood. A small portion of the population had a T&S between one and sixteen days prior to surgery. More than half of the cases had no T&S. For example, out of 371 cases of elective orthopedic surgeries, the percentage of T&S on the same day of surgery was 33.4% (124 cases) and only 14.2% had a T&S done before the surgery day.
To address these concerns, ECH implemented a systematic pre-admission screening protocol. This initiative based on a review of research articles and clinical guidelines by healthcare organizations, which underscored the value of universal pre-admission T&S testing. By identifying patients with positive screens early, hospitals can prepare matched blood and reduce potential delays.
A key feature of the protocol is an extended specimen policy, which ensures antibody screen results remain valid for up to 14 days. A nurse-led multidisciplinary team developed an action plan to integrate high-risk procedures into the Pre-admission Services (PAS) team's navigation software. Surgeons identified 354 out of 1,513 procedures as high-risk, which formed the basis for software updates.
With the updated system, pre-admission nurses receive automatic alerts for high-risk procedures, prompting them to schedule laboratory visits for T&S testing prior to surgery. Positive antibody results are promptly shared with surgeons, facilitating the timely pre-ordering of compatible blood.
This patient-centered protocol, developed as part of ECH's Patient Blood Management (PBM) program, has set comprehensive standards for preoperative screening. By ensuring the availability of compatible blood for high-risk procedures, the protocol maximizes patient safety and streamlines surgical preparation processes.

H. **Ongoing education**
ECH has been continuously seeking educational outreach to clinical staff to reinforce evidence-based transfusion guidelines and share the department specific analytic data at group meetings. Various communication tools are utilized to provide PBM reminders, such as a letter from the office of the Chief Medical Officer, physician newsletters, displays in physician lounges, pocket-size cards for clinicians regarding guidelines, and poster presentations.
For nursing, PBM modules are incorporated into mandated annual nursing education. The main focus is highlighting the importance of assessing patient's clinical symptoms and hemodynamic instability instead of depending on arbitrary laboratory values. Also, nurses are encouraged to implement restricted diagnostic phlebotomy by minimizing frequency of sampling, utilizing pediatric size blood collection tubes, and utilizing point of care testing for frequently needed chemistry tests such as potassium levels for post-operative cardiac surgery cases.
Additionally, ECH hosted a PBM Clinical Conference to introduce the medical staff and other clinicians to the most up to date clinical evidence related to transfusion practice. For example,

on May 17, 2018, two PBM leaders from the nation's first two organizations (Johns Hopkins and Georgetown University Hospitals) – who are recipients of PBM certification from TJC and the AABB, provided excellent presentations for clinicians. They described the recommended indications for blood transfusion according to the latest randomized trials and society guidelines and five specific methods of blood conservation to reduce blood use, enhance patient safety, and reduce cost. During FY 2019, another PBM conference (April 17, 2019) and PBM awareness week (November 5-9, 2018) are planned. Irwin Gross. MD, a nationally recognized speaker and published author in Patient Blood Management and Transfusion Safety provided an education on the topic of care of the surgical patient through effective PBM application. More recent clinical educational event was inviting Aryeh Shander, MD who is the Executive Medical Director of The Institute for Patient Blood Management and Bloodless Medicine and Surgery at Englewood Hospital, and Past -President of the Society for the Advancement of Patient Blood Management in January 2022. He provided a timely education on the topic of pre-operative anemia management and how to improving outcomes in the pre-surgical patient population. These conferences have increased the awareness of PBM as a patient-centric and evidence-based practice.

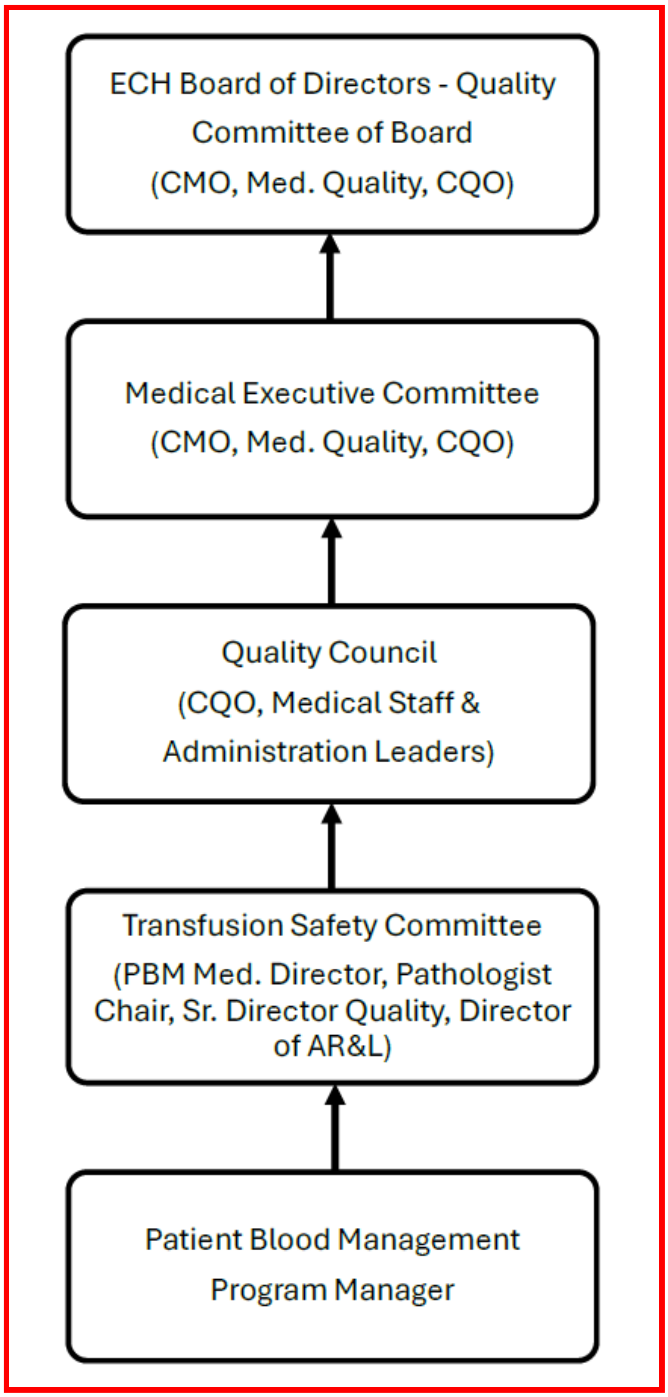
I. **TJC/AABB PBM certification**
The natural next step in our PBM effort is obtaining Joint Commission Certification for our program. The certification process will provide a knowledgeable third party review on our processes and practices. This will ensure that we make continuous quality improvements in PBM. In ~~October2023~~December 2025, ECH has successfully finished re-certification survey by TJC and AABB and recognized as a certified PBM organization.



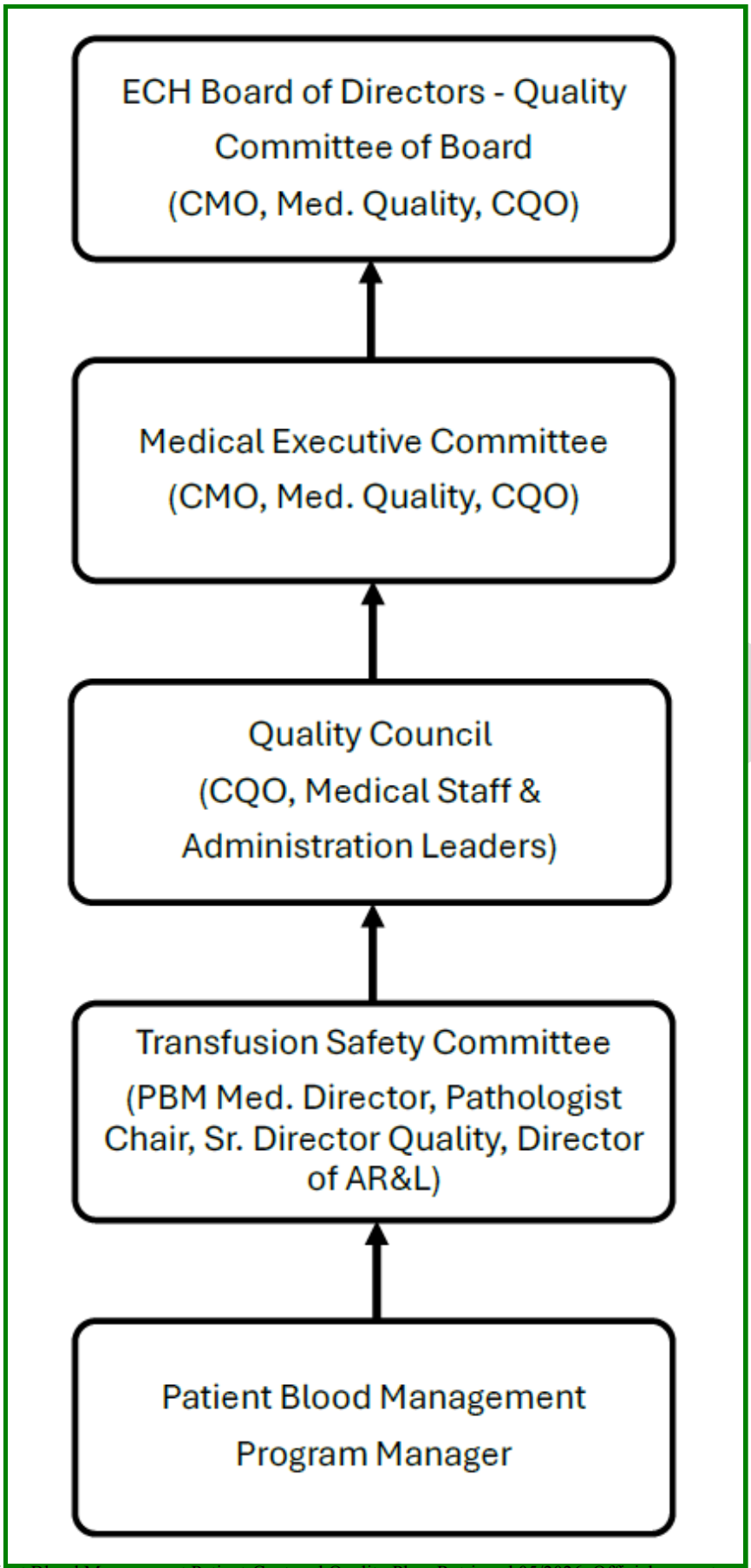
# PROGRAM STRUCTURE AND ACCOUNTABILITY:

The overall organizational structure is depicted below.

# Patient Blood Management Patient-Centered Quality Plan



# Patient Blood Management Patient-Centered Quality Plan



# Patient Blood Management Patient-Centered Quality Plan

**The Medical Director of PBM** provides oversight for the enterprise quality in patient care by promoting system-wide patient blood management function through appropriate and safe fresh blood product administration throughout ECH. This position is a specialist role which provides an effective clinical function in improving patient outcomes. The position holder influences the practice of nursing, medical/ clinicians, laboratory and allied health disciplines in PBM both within and external to the health service. Areas of accountability will include the provision of leadership, clinical standard setting and monitoring, policy development, and change management. This position ensures that all steps necessary to embed PBM as a standard of care in ECH in question are accomplished.

The medical director's responsibilities include:

A. Provides leadership, direction and overall clinical management of the PBM program
B. Chairs a hospital based multidisciplinary Transfusion Safety Committee to advance and embed PBM as a standard of care
C. Responsible for reporting on program performance to the clinical staff, hospital administration
D. Works closely with the PBM program manager regarding the dissemination and creation of PBM throughout the hospital, being a resource and leader
E. Ensures the development of educational programs and resources about PBM for all clinical and non-clinical staff, including orientation for new staff
F. Provides regular reports (eg. quarterly, biannual, annual) regarding program performance to clinical staff, hospital administration
G. Works closely with the Transfusion Medicine Director regarding transfusion usage data, and assures regulatory requirements in the areas pertaining to transfusion and PBM are satisfied
H. Assists in the development and or reorganization of patient flow for the outpatient/inpatient assessment of iron deficiency (with or without anemia) in the perioperative/medical setting
I. Assists in strategies to reduce blood loss (including iatrogenic) for all patients
J. Liaises with other department heads and hospital committees on issues relevant to the PB M program
K. Helps develop a mechanism of action / plan with the executive medical staff; regarding identifying transfusion outliers by specialty and individually, with follow through action in that plan.
L. Ensures the development and communication of best practice guidelines to secure consistent, equitable and quality outcomes are achieved across the Patient Blood Management Program
M. Monitors, analyses and reports on adherence to the best practice guidelines and performance standards
N. Develops, refines and communicates operational plans resulting from treatment protocols and clinical pathways, and regularly reviews PBM policies, procedures and protocols
O. Assists in the development, maintenance and monitoring of data to determine cost reduction and cost avoidance as it relates to transfusion of blood products and anemia care products
P. Monitors and analyses trends for continuous improvement of the Program and proposes
Q. Represents the ECH's PBM Program at relevant conferences, events, boards and committees

# Patient Blood Management Patient-Centered Quality Plan

R. Ensure enhancement of blood conservation through the utilization of product alternatives by developing and providing education to medical staff and other appropriate clinicians on current technology including (but not limited to): autologous cell salvage, bio-friendly cardiac bypass circuits, and pharmacologic agents which reduce bleeding and stimulate blood cell production

**Patient Blood Management Program Manager** acts as the liaison within the hospital environment to ensure that blood management and transfusion related activities are conducted in the safest possible manner, meet or exceed all existing safety and regulatory requirements, and are within established guidelines. The position is responsible for the development and effective coordination of the PBM and processes to assure that all transfusion related activities are conducted in the safest possible manner and meet or exceed all existing safety and regulatory requirements. Patient Blood Management Program Manager collaborates with all levels of clinical and medical personnel to evaluate transfusion management strategies and offer recommendations for improvement. In addition, Patient Blood Management Program Manager assists in establishing policies, protocols and procedures to support PBM and utilizations that meet regulatory standards and guidelines related to evidence-based transfusion medicine practices. Establishes a process to track, audit and analyze key performance metrics and offers recommendations to address areas of concern to improve safety and treatment efficacy, and to reduce costs. Patient Blood Management Program Manager serves as a resource to nurses, medical staff and laboratory staff related to blood management and administration, transfusion related safety issues, and this includes the preparation and presentation of education materials to accomplish this task.



Patient Blood Management Program Manager's responsibilities include:

A. Serves as resource to physicians, nursing and laboratory staff relating to blood utilization and transfusion procedures.

B. Develops and monitors a blood product utilization program to ensure that appropriate products are requested and used and that wastage is minimal.

C. Conducts prospective and retrospective audits on the utilization of blood and blood products and brings utilization issues to the attention of the Quality and Transfusion Service Medical Directors and the Transfusion Safety Committee.

D. Promotes benchmarking and evidence-based practice in the appropriate transfusion of blood, blood products and their alternatives.

E. Responds to concerns and requests for assistance to ensure compliance with established guidelines and policies pertaining to blood component utilization, administration and documentation.

F. Conducts investigations of errors, deviations, and near-miss events that involve blood component administration that occur outside of the laboratory.

G. Reviews and investigates transfusion reactions and reports to the Manager, Medical Director and Transfusion Committee and where appropriate recommends changes to current practices.

H. Leads hospital's Transfusion Committee meetings together with the Transfusion Service Medical Director and PBM Medical Director.

I. Works collaboratively with the Laboratory Manager, Technical Specialist and Blood Transfusion

# Patient Blood Management Patient-Centered Quality Plan

staff to provide input to procedures and policies relating to transfusions.

J. Participates as a member of hospital committees requiring Transfusion Medicine input such as new product evaluation and nursing procedures.

K. Provides education to physicians, clinical laboratory scientists, and nursing personnel on appropriate use of blood, blood products, and blood transfusion devices and other related information.

L. Arranges and facilitates multidisciplinary workgroups as needed to ensure the coordination of blood management services and resources.

M. Maintains professional growth and development in the field of blood management through an ongoing process of formal and informal.

N. Assists with hospital Clinical Quality Outcomes monitoring projects as assigned.

O. Conducts Patient Blood Management audit and provides performance measure reports and analysis to Transfusion Safety Committee. Facilitates pathology review of transfusion service reports.

**Transfusion Safety Committee** is a multidisciplinary group that has the overall responsibility to maintain safe hospital transfusion practice. Its role is pivotal in ensuring appropriate blood utilization and that best practice standards are followed. This committee reports to the Medical Executive Committee of ECH.



Transfusion safety committee's roles include:

A. Developing systems for the implementation of PBM guidelines and standards within the hospital – defining blood transfusion policies

B. Monitor the implementation of evidence-based guidelines in the hospital and take appropriate action to overcome any factors that may be hindering their effective implementation

C. Liaison with blood transfusion services to ensure availability of required blood and blood components

D. Training and assessment for all staff in the hospital that are involved in the blood transfusion process

E. Monitoring the usage of blood and blood components within the hospital and contribute to benchmarking against others

F. Reducing blood component loss due to time expiry and other wastage reasons – linking into clinical areas where clinical wastage is deemed high

G. Monitoring, reporting and investigating transfusion adverse events and near misses and using these experiences to promote learning

H. Ensure a cycle of clinical audits to check transfusion practice and safety and compliance to PBM standards

I. Reduce the number of incidents in which an inappropriate dose of component is given to a patient

J. Disseminating transfusion related information to users including changes to national guidance, audit results and examples of good practice

# Patient Blood Management Patient-Centered Quality Plan

K. Implementing PBM initiatives – reviewing transfusion alternatives and making recommendations of their use

L. Reviewing if recall and other quality manual processes work as intended

**Attachments – Clinical Practice Guidelines and Procedures related to PBM**

- Att A Administration of Blood and Blood Products in the Neonate
- Att B Adult Transfusion Guidelines
- Att C Emergency Blood Release to the NICU
- Att D Management of Patient Receiving Blood and Blood Products
- Att E Management of Patient Who Refuses Blood Products
- Att F Management of the Obstetric Patient Who Refuses Blood Products
- Att G Massive Transfusion & Emergency Release Protocol (MTP)
- Att H Pre Admission Services (PAS) Management of Patient
- Att I Preadmission Procedure for Blood Bank Services

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



## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Tracy Fowler: Director Governance Services | Pending |
| MEC | Michael Coston: Director Quality and Public Reporting [PS] | 03/2026 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 03/2026 |
| Owner \| Transfusion Safety Committee | Jeong Chae: Patient Blood Management Programs Manager | 02/2026 |

## History

**Draft saved by Santos, Patrick: Policy and Procedure Coordinator** on 2/19/2026, 5:32PM EST

**Edited by Santos, Patrick: Policy and Procedure Coordinator** on 2/19/2026, 5:33PM EST

# Patient Blood Management Patient-Centered Quality Plan

> Received revised plan via email from owner; approved at Transfusion Safety Committee 2/19/26.

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 2/19/2026, 5:36PM EST

**Last Approved by Chae, Jeong: Patient Blood Management Programs Manager** on 2/19/2026, 7:12PM EST

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 3/16/2026, 4:11PM EDT

> ePolicy 3/13/26 - Approved

**Last Approved by Coston, Michael: Director Quality and Public Reporting** on 3/26/2026, 2:21PM EDT

> MEC 3/26/26 - Approved

Status **Pending** PolicyStat ID **19911562**

| | | | |
|---|---|---|---|
| Origination | 08/2011 | Owner | Ryan Lockwood: Vice President Patient Experience |
| Last Approved | N/A | Area | Patient Experience |
| Effective | Upon Approval | Document Types | Policy |
| Last Revised | 03/2026 | | |
| Next Review | 3 years after approval | | |

# Administrative: Visitors Policy



## COVERAGE:

All El Camino Hospital staff

## PURPOSE:

The purpose of this policy is to support a welcoming, healing environment by recognizing the important role that family members, friends, and designated support persons play in a patient's care and recovery.

El Camino Health welcomes visitors and support persons 24 hours a day, 7 days a week, consistent with patient preferences and clinical needs. We believe that access to loved ones promotes comfort, healing, emotional wellbeing, and patient centered care.

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

## DEFINITIONS:

- ~~Justified Clinical Restrictions mean any clinically necessary or reasonable restriction or~~

~~limitation imposed by the Hospital on a patient's visitation rights which may be necessary to provide safe care to the patient or other patients, and as necessary in order to conduct hospital operations. These justified clinical restrictions may include, but are not limited to, to the following:~~

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

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



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

# PROCEDURE:

El Camino Health maintains an open visitation philosophy and welcomes visitors 24 hours a day, 7 days a week. Patients have the right to designate who may visit them and may withdraw or modify that consent at any time.

**Circumstances When Visitation May Be Limited or Declined**

While we strive to always maintain open visitation, visitation my be limited, modified, or declined under

# Administrative: Visitors Policy

the following circumstances:

A. The hospital reserves the right to limit the number of visitors, visiting hours, as well as establish minimum age requirements for child (minor) visitors for patients during a designated period based on the clinical needs of the patient, other patients, and or operation of unit.

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

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

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

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

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

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

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

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

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

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

J. Police officers or other law enforcement officers are permitted in limited circumstances to utilize body cameras when engaging with patients as necessary for official responsibilities. Examples include but are not limited to, service of a search and arrest warrants and/or gather suspect or witness statements. To maintain highest standard of privacy, staff can request

# Administrative: Visitors Policy

~~officer deactivate body camera if appropriate. For further clarification or support, contact Security, Compliance, and/or Risk Management department.~~

K. **Visitor Health Concerns**

- When a visitor is exhibiting signs or symptoms of illness
- When a visitor's health status poses a risk of infection to the patient or others
- When infection prevention protocols require temporary limitation

L. **Visitor Behavior**

- When a visitor demonstrates disruptive, aggressive, or unsafe behavior toward patients, other visitors, or staff
- When behavior interferes with the patient's care, safety, privacy, or rest
- When behavior presents a direct risk or threat to the patient, hospital staff, or others in the environment

M. **Clinical or Operational Needs**

- As defined under Justified Clinical Restrictions
- When required to maintain patient safety, privacy, or hospital operations
- During procedures or clinical interventions requiring a controlled environment
- During public health emergencies or regulatory mandates

When visitation must be limited or declined, the reason will be clearly explained to the patient and/or support person whenever possible.

- The hospital reserves the right to limit the number of visitors, as well as establish minimum age requirements for child (minor) visitors for patients during a designated period based on the clinical needs of the patient, other patients, and or operation of the unit.
- Prior to care being provided, patients (or their designated support person) are informed of visitation rights and any potential clinical restrictions. Visitation information is also provided via the hospital's patient guide book which is provided to patients admitted to the hospital and is posted and available in the Visitor's guide in outpatient areas.
- Visitation rights include the right to receive the visitors designated by the patient, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), family member, or a friend, and his/her right to withdraw or deny such consent at any time.
    - If the patient is incapacitated or otherwise unable to communicate his/her wishes and the patient has designated a support person, the hospital is to provide the required notice to this support person and allow that support person to exercise the patient's visitation rights.
    - If the patient is incapacitated as defined above and has not designated a support person in advanced, but a support present asserts that s/he is the patient's support person, the hospital can rely on the assertion.

# Administrative: Visitors Policy

- The hospital prohibits discrimination in visitation based on age, race, color, ethnicity, religion, culture, ancestry, national origin, immigration status, language, physical or mental disability, socioeconomic status, gender, sexual orientation, and gender identity or expression, or educational background.
- The hospital has the right to rescind or restrict the visitation hours and rights based upon the safety and welfare of the patient and the hospital staff, and as necessary in order to conduct normal hospital operations by imposing Justified Clinical Restrictions as defined above. The reasons for the clinical restrictions or limitation must be explained to the patient and family.
- The hospital allows for the presence of support individual of the patient's choice unless the presence infringes on the others' rights, safety, or is medically or therapeutically contraindicated.
- All visitors designated by the patient should enjoy the same visitation privileges as immediate family would enjoy.
- Hospital staff who are involved with managing and controlling visitor access will be trained and informed on these policies.
- Newborn visitor(s) to the Inpatient Mental Health and Addiction Services (MHAS) must be accompanied at all times by a designated support person (must be a responsible adult other than the mom/patient). The designated support person must provide all care for the newborn. If the designated support person needs to leave the patient room or hospital for any reason they must take the newborn visitor(s) when they leave. The newborn visitor(s) is not to be left alone with the mom/patient at any time for any reason.
- Police officers or other law enforcement officers are permitted in limited circumstances to utilize body cameras when engaging with patients as necessary for official responsibilities. Examples include but are not limited to, service of a search and arrest warrants and/or gather suspect or witness statements. To maintain highest standard of privacy, staff can request officers to deactivate body camera if appropriate. For further clarification or support, contact Security, Compliance, and/or Risk Management department.



*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 |

# Administrative: Visitors Policy

| | | |
|---|---|---|
| MEC | Michael Coston: Director Quality and Public Reporting [PS] | 03/2026 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 03/2026 |
| | Ryan Lockwood: Vice President Patient Experience | 02/2026 |

## History

**Draft saved by Lockwood, Ryan: Vice President Patient Experience** on 2/13/2026, 1:35AM EST

**Edited by Lockwood, Ryan: Vice President Patient Experience** on 2/13/2026, 1:41AM EST

> Amended the visitors policy to allow for 24 hours a day, 7 days a week.

**Last Approved by Lockwood, Ryan: Vice President Patient Experience** on 2/13/2026, 1:41AM EST

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 3/16/2026, 4:24PM EDT

> ePolicy 3/13/26 - Approved

**Last Approved by Coston, Michael: Director Quality and Public Reporting** on 3/26/2026, 2:23PM EDT

> MEC 3/26/26 - Approved

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 3/26/2026, 2:52PM EDT

> Per MEC, there is a section that touches on "support present in advance," but is duplicated in the same paragraph. Recommended to remove "but a support present in advance."

Status **Pending** PolicyStat ID **19999877**

| | | | |
|---|---|---|---|
| Origination | 11/2020 | Owner | Jen Huang: Senior Director Pharmacy |
| Last Approved | N/A | Area | Pharmacy |
| Effective | Upon Approval | Document Types | Policy |
| Last Revised | 04/2026 | | |
| Next Review | 3 years after approval | | |

# Multidisciplinary Drug Diversion Surveillance



## COVERAGE:

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

## PURPOSE:

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

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

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

# Multidisciplinary Drug Diversion Surveillance

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

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

## REFERENCES:

- Title 42 § CFR 482.13 Conditions of participation: Patient Rights
- Title 42 § 482.25 Condition of participation: Pharmaceutical services.
- PolicyStat - Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis)
- PolicyStat - Pyxis Anesthesia System
- eCFR ::Title 21 § CFR 1301.76 -- Other security controls for practitioners. accessed 8/8/2025

## PROCEDURE:

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



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

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

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

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

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

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

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

# Multidisciplinary Drug Diversion Surveillance

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

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

H. Surveillance of Controlled Substances Storage:

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

        a. Upon the discovery of an unsecured controlled substance, personnel shall notify the pharmacist-in-charge immediately.

        b. The Pharmacist-in-Charge will issue additional instructions on securing the controlled substance while the investigation is ongoing

    2. Controlled substances administered via Patient-Controlled Analgesia (PCA) pumps and epidural pumps are administered in locked systems.

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

I. Surveillance of Controlled Substances Dispensing:

    1. Override Monitoring: Controlled substances removed utilizing the override functionality are reviewed and reconciled to ensure the existence of a valid corresponding order. (also refer to Policy: PolicyStat ID: 14410726: Use of Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis)

    2. Chain of Custody: Chain-of-custody is utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations of Controlled Substances Administration.

    3. Anesthesia Audit: Assess medication dispensed, medication documented, dose documented, amount wasted, witness signature, Chain of Custody (if appropriate), appropriate variance reporting and follow up if necessary.

J. Surveillance of Controlled Substance Administration Time:

    1. Timely Administration of CS: Ensure the time retrieval from ADC to the administration to the patients meet the policy requirement (within 30 minutes for stat medication and within 60 minutes for routine medication).

    2. Monitoring Patients' Response: Ensure medication administered in compliance with pain scale prescribed.
    Conduct pain assessments per pain assessment policy.

    3. Pain score assessments and documentation to be recorded timely and accurately in iCare.

# Multidisciplinary Drug Diversion Surveillance

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

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

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

1. IRIS report is conducted monthly during the 1st week of the month to review statistical deviations from the previous month.
2. Pharmacy will initiate investigation for all users flagged as red (IRIS score >=4.6)
3. Nursing/anesthesia directors/managers will respond to investigations initiated by the pharmacy, as requested through the Diversion Software program (with analytics and documentation of all activities of the investigation).
    a. For the IRIS investigation checklist and training for nurses or steps to take during their review of high ranked IRIS users to look at the different analytics that made that user high that month.
    b. Pharmacists can provide an objective consistent process to investigate based on all the different analytics.
    c. Require Nurse Managers to have conversations with employees, even if no diversion is suspected, to coach to practice and to document date and time of conversation can be noted in the investigation portfolio under "Nurse Manager reviewed all pertinent reports.
4. If diversion is not suspected, rationale will be documented and investigation closed.
5. If diversion is suspected, the Committee will be notified and activated. Individuals who repeatedly appear as outliers should be reviewed by the multidisciplinary drug diversion prevention committee and a recommended process (e.g., drug test) from the committee for escalation of identified high risk individuals.

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

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

1. Weekly nursing inventory is completed by the unit's Nurse Manager/Supervisor or

# Multidisciplinary Drug Diversion Surveillance

designee. Inventory is completed for all accessed controlled substances. If the unit is closed, notify pharmacy to deactivate access and notify pharmacy for opening. Without deactivation, weekly inventory count is still required on units that are temporarily closed.

2. Monthly CS Inventory Count: CII Safe/ Pharmacy Vault Monthly Inventory, including keys, conducted with two authorized
witness: signature and date of inventory is documented.
3. 90-day CII inventory count conducted per Board of Pharmacy.

O. Investigation and Reporting

1. A drug diversion investigation may be conducted in the following instances:
a. Discovered or suspected diversion based on IRIS reports
b. A significant loss of drug
c. Continued unresolved discrepancies
d. Users identified/observed as having erratic or strange behavior
2. Information Collection, Gathering and sharing: Pharmacy will initiate investigations. Documentation of investigations will be conducted through Software for Controlled Substances Investigation Portfolio. If diversion is suspected, the Human Resources department will be notified and represented by the Director of Pharmacy, the Inpatient Pharmacy Supervisor, Nursing Administration, Anesthesia, Human Resources, and Employee Health. This team will provide consultation for suspected diversion incidents
3. Reporting at the conclusion of investigations
    a. Health care workers suspected of being impaired will be removed from delivering patient care as to prevent further access to drugs and ensure safe care of patients.
    b. Report of significant loss:
    When a significant loss occurs, the Pharmacist in Charge will complete a DEA-106 report there by notifying the DEA as well as the State Board of Pharmacy.
    c. Report of Theft: Theft will be reported to the DEA regardless of a significant loss or not. Based on the regulations, all thefts regardless of volume should be reported to DEA.
    d. Diversion incidences will also be reported to local law enforcement and appropriate State Boards

P. Culture, Education, Competency and Experiences

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

# Multidisciplinary Drug Diversion Surveillance

detecting diversion and often the only way to identify an impaired colleague.

Q. Resources of hardware deterrent for drug diversion prevention and surveillance

1. Current hardware deterrent:
    a. Secured waste containers, badges system for medication room entry for retrievable entry history, IV-to Pole secured CS IV bags/admixtures and secured CS transportation carts are utilized for CS security.
    b. Community drugs take back to limit unnecessary access in community, a secured medication take back kiosk is located at El Camino Health Outpatient Pharmacy for secure disposal of CS for the customers.
2. Next phase in the planning stage: camera video surveillance as deterrent and also to support investigation:
    a. Ensure all stationary ADCs have cameras installed at the appropriate angle to visualize actions being taken at the station, the scope captures return bin activities.
    This does not include ADCs placed in patient care areas (Surgical, ER Trauma, patient rooms…) in compliance with HIPA, Health Insurance Portability & Accountability Act. Within the pharmacy department, ensure all areas of packaging, storage, waste and areas where medications are placed to be checked, or pending delivery are under adequate camera surveillance.
    b. Ensure camera video recorded 24 hours per day and retention is set to 90 days



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

## Attachments

RoadmapSummary.pdf

SoftwareOnePageInstruction.pdf

## Approval Signatures

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

# Multidisciplinary Drug Diversion Surveillance

| | | |
|---|---|---|
| MEC | Michael Coston: Director Quality and Public Reporting [PS] | 04/2026 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 04/2026 |
| P&T | Mojgan Nodoushani: Senior Manager-Clinical Pharmacy | 04/2026 |
| | Jen Huang: Senior Director Pharmacy | 02/2026 |

## History

**Draft saved by Hoang, Ngan: Manager Pharmacy Operations** on 2/25/2026, 1:35PM EST

**Edited by Hoang, Ngan: Manager Pharmacy Operations** on 2/25/2026, 1:38PM EST

> Addition of verbiage:
>
> Upon the discovery of an unsecured controlled substance, personnel shall notify the pharmacist-in-charge immediately.
>
> The Pharmacist-in-Charge will issue additional instructions on securing the controlled substance while the investigation is ongoing

**Last Approved by Huang, Jen: Senior Director Pharmacy** on 2/25/2026, 1:40PM EST

**Last Approved by Nodoushani, Mojgan: Senior Manager-Clinical Pharmacy** on 4/3/2026, 5:42PM EDT

> Approved by P&T on 4/2/2026

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 4/13/2026, 6:05PM EDT

> Per ePolicy recommendation to update last reference; received version from Pharmacy.

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 4/14/2026, 4:10PM EDT

> ePolicy 4/10/26 - Approved

**Last Approved by Coston, Michael: Director Quality and Public Reporting** on 4/23/2026, 4:25PM EDT

> MEC 4/23/26 - Approved

Status **Pending** PolicyStat ID **20193457**

| | | | |
|---|---|---|---|
| Origination | 01/2023 | Owner | Raquel Barnett: Sr. Director Medical Staff Services |
| Last Approved | N/A | Area | Medical Staff |
| Effective | Upon Approval | Document Types | Policy |
| Last Revised | 04/2026 | | |
| Next Review | 3 years after approval | | |

# Medical Staff Services - Electronic Signatures



## COVERAGE:

El Camino Hospital Administration and Medical Staff Leadership ("Leader")

## PURPOSE:

To establish guidelines regarding electronic signatures and streamline the process for communicating to Medical Staff and Allied Health Practitioners regarding matters including but not limited to: medical staff membership/privileges and allied health practitioner status/privileges, Peer Review matters, Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

## STATEMENT:

Medical Staff Services Department ("MSSD") operates within an electronic, confidential, and peer review protected environment. Electronic signature is used by the MSSD as a means of attestation and approval of notification to Medical Staff and Allied Health Practitioners regarding membership, status, and privileges, Peer Review, FPPE, and OPPE.

Electronic signatures are considered legally binding as a means to identify the approval of letters and form contents, confirm content accuracy and completeness as intended by the approver and to ensure e-signature integrity. It is the policy of El Camino Health to accept electronic signatures as defined within this policy for author and/or approver validation of documentation, content accuracy and completeness with all the associated ethical, business, and legal implications.

# Medical Staff Services - Electronic Signatures

## DEFINITIONS:

Practitioner: Medical Staff and Allied Health Practitioners as defined in ECH Medical Staff Bylaws.

## REQUIREMENTS:

Electronic signature is the standard method in the preparation and dissemination of information to El Camino Health practitioners. Communication sent on behalf of a Leader is vetted and approved by the applicable Leader, prior to the electronic signature addition to the document and dissemination to the practitioner.

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

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Tracy Fowler: Director Governance Services | Pending |
| MEC | Michael Coston: Director Quality and Public Reporting [PS] | 04/2026 |
| ePolicy Committee | Patrick Santos: Policy and Procedure Coordinator | 04/2026 |
| Credentialing Committee | Raquel Barnett: Sr. Director Medical Staff Services [FZ] | 03/2026 |
| IDPC | Raquel Barnett: Sr. Director Medical Staff Services [FZ] | 03/2026 |
| | Raquel Barnett: Sr. Director Medical Staff Services [FZ] | 03/2026 |

## History

**Sent for re-approval by Nelmida, Michelle: Data Analyst – Medical Staff Svcs** on 3/20/2026, 1:30PM EDT

> No changes.

# Medical Staff Services - Electronic Signatures

**Last Approved by Barnett, Raquel: Sr. Director Medical Staff Services** on 3/20/2026, 3:58PM EDT

**Last Approved by Barnett, Raquel: Sr. Director Medical Staff Services** on 3/20/2026, 3:58PM EDT

**Last Approved by Barnett, Raquel: Sr. Director Medical Staff Services** on 3/20/2026, 3:59PM EDT

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 4/13/2026, 5:48PM EDT

> Minor update, per ePolicy recommendation.

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 4/14/2026, 4:15PM EDT

> ePolicy 4/10/26 - Approved

**Last Approved by Coston, Michael: Director Quality and Public Reporting** on 4/23/2026, 4:27PM EDT

> MEC 4/23/26 - Approved

# Physician Financial Arrangements - Review and Approval Policy

## COVERAGE:

~~All~~El Camino Health, including El Camino Hospital and its wholly-owned affiliates or entities, and their staff, Contract Personnel, Physicians, employed or contracted Healthcare Providers, and the Governing Board~~.~~

## PURPOSE:

The purpose of this policy is to comply with the Stark law, Anti-Kickback, HIPAA and all other Federal and State Laws.

## POLICY STATEMENT:

This policy implements the overall compliance goals of the Hospital with respect to Physician financial arrangements.

This policy establishes administrative principles and guidelines, Board delegation of authority and oversight, and review processes and approvals that must be followed before ~~the Hospital enters~~El Camino Health ("ECH") enter into a direct or indirect financial arrangement with an individual physician, a physician group, other organizations representing a physician, or a member of immediate family of a physician ("Physician"). Physician financial arrangements that involve any transfer of value, including monetary compensation, are subject to this and the following policies: 1) Signature Authority policy, 2) Reimbursement of Business Expenses policy, and 3) Physician Recruitment policy.

All financial arrangements of any kind involving Physician, including but not limited to, medical director, consulting, on-call arrangements, professional service agreements, education and training, conference reimbursement or real estate leases, will comply with the Stark law, Anti-Kickback, HIPAA and all other Federal and State Laws. All Physician financial arrangements are prohibited except those Physician financial arrangements that are approved and documented as provided in this Policy.

Physician financial arrangements may be entered into only where they are needed and serve the strategic goals (including quality and value) of ~~the Hospital~~ECH. Each Physician financial arrangement must meet or exceed the complex and stringent legal requirements that regulate Physician financial relationships with the Hospital. All Physician financial arrangements between a physician and ~~the Hospital~~El Camino Health must be in writing and meet fair market value, commercial reasonableness and the following requirements as applicable.

## PROCEDURE:

A. Administrative Standards:

When creating or renewing a Physician financial arrangement, the following principles must be followed. This Policy applies to any Physician financial arrangement including, but not limit to: Medical Directorships, ED Call Panels, Professional Services, Panel

Professional Services, Consulting, Lease, Education and Training, Conference Payment, and Physician Recruitment.

1. All Physician Financial Arrangements:

   a. Each Physician financial arrangement (except Physician Lease Contracts) must provide a service that is needed for at least one of the following reasons: 1) it is required by applicable law, 2) required administrative or clinical services or oversight can only be provided by a qualified physician, 3) the administrative services to be provided support an articulated strategic goal of ~~the Hospital~~ECH, such as patient safety, 4) the arrangement must solve, prevent or mitigate an identified operational problem for ~~the Hospital~~ECH.

   b. The terms of the Physician financial arrangement must be fair market value and commercially reasonable and must not take into account the volume or value of any referrals or other business generated between the parties. All of the terms of the Physician financial arrangement must be in a written contract that details the work or activities to be performed and all compensation (of any kind) or the lease terms ("Physician Contracts"). The services contracted for may not exceed those that are reasonable and necessary for the legitimate business purposes of the Physician financial arrangement. If there is more than one Physician Contract with a Physician, the Physician Contracts must cross-reference one another (or be identified on a list of Physician Contracts) and be reviewed for potential overlapping commitments prior to negotiating additional agreements.

      The process for determining Physician compensation for each Physician financial arrangement must be set forth in the Physician Contract file and identified in sufficient detail so that it can be objectively verified as meeting fair market value standards. Any compensation paid to or remuneration received by a Physician shall not vary based on the volume or value of services referred or business otherwise generated by the Physician and must reflect fair market value. All physician financial arrangements must be reviewed and approved by the Chief Medical Officer, Compliance, and Legal. For the Hospital, Compensation cannot exceed the seventy-fifth percentile of fair market value without prior approval from the Finance Committee of the Board of Directors~~. Compensation~~ and compensation cannot exceed the ninetieth percentile without prior approval from the Finance Committee and the Board of Directors. For ECHMN, Compensation cannot exceed seventy-fifth percentile of fair

market value without prior approval from the ECHMN Board of Managers. ~~.~~ All Physician contracts should use local or regional market data, when available, to determine the seventy-fifth percentile of FMV.

In order to support reasonableness of compensation or remuneration, written fair market data must accompany the Physician Contract and show compensation paid by similar situated organizations and/or independent compensation surveys by nationally recognized independent firms.

c. Compensation should not be revised or modified during the first twelve (12) months of any Physician financial arrangement. Exceptions on a case by case basis may be evaluated and approved by Legal and Compliance as long as such modification during the first twelve months adheres to the Stark Law requirements. If the compensation is revised thereafter, it must be evidenced by a written amendment to the Physician Contract, signed by both parties before the increase in compensation takes effect. For example, if the increase in compensation is to take effect on April 1, the amendment must be signed by both parties on or before April 1 and the original Physician Contract must have been effective on or before March 31 of the prior year. The compensation cannot be changed for twelve (12) months after the effective date of such amendment unless an exception is approved by Legal and Compliance and the change adheres to Stark Law requirements. Compensation shall include total combined annual known (e.g., fixed or base salary, bonuses, relocation assistance) and reasonably estimated (e.g., productivity-based) compensation under any Physician Contract.

d. All Physician Contract renewals should ~~-~~ be signed before the expiration of the term of the existing Physician Contract. Exceptions on a case by case basis may be evaluated and approved by Legal and Compliance if the parties are engaged in ongoing negotiations and the exception complies with Stark Law requirements.

e. Physician Contracts must be in writing and executed by the parties before commencement of services. Exceptions on a case by case basis may be evaluated and approved by Legal and Compliance as long as such exception complies with Stark Law requirements. Only the CEO of Hospital or designee or the President of ECHMN or designee ~~by CEO~~ may execute a Physician Contract ~~for the Hospital~~, except

Physicians Contracts that are real estate or equipment leases with Physicians may be signed by the Chief Administrative Services Officer ("CASO"), and IT agreements may be executed by the Chief Information Officer (CIO). Execution of physician contracts by CEO, CMIO, CASO, or CEO designee must comply with the general signature authority and limits established in the Signature Authority policy.

f. Physicians cannot be compensated for work performed, nor may a lease commence, prior to execution by both parties, unless a Stark Law exception applies, and the exception is reviewed and approved by Legal and Compliance.

g. The Physician financial arrangement must not violate the Stark law, the anti-kickback statute (section 1128B(b) of the Act) or any Federal or State law or regulations.

h. The Physician Contract will permit ~~the Hospital~~ECH to suspend performance under the Physician Contract if there is a compliance concern. Concerns about compliance should be directed to Compliance, Legal, or the office of the Chief Medical Officer ("CMO"). Performance under Physician Contracts deemed to not meet the administrative guidelines shall be suspended until the Physician Contract can be remedied.

i. Physician Contracts must contain termination without cause provisions (except for real estate and equipment leases). Physician Contracts which grant an exclusive right to Hospital-based physicians to perform services may not exceed five years. If a Physician Contract is terminated, then the ~~Hospital~~contracting party may not enter into a new financial arrangement with the same Physician covering the same arrangement on different terms within twelve (12) months of the effective date of the terminated Physician Contract.

j. Physicians with potential conflicts of interest must complete a conflict of interest form that must be reviewed by the Compliance Officer prior to entering into a Physician Contract. The conflict must be addressed and referenced in the Physician Contract. A conflict may prevent entry into a Physician Contract.

k. All Physician Contracts must be prepared using the appropriate ~~Hospital~~ contract template prepared by Legal Services. All Physician Contracts must be drafted by personnel designated by Legal Services.

l. All Physician Contracts must comply with the review and documentation process established through the contracts management system, as approved by Legal and Compliance. Physician Lease Contracts must also include a signed "Contract Certification" (Appendix B) and "Lease Contract Review Checklist" (Appendix C) to be reviewed and approved by Legal Services and Compliance.

m. All executed Physician Contracts must be scanned into the contract management system.

n. Payments may not be made to a Physician unless there is adherence with all of the requirements of this Policy.

o. Each Physician Contract shall comply with all applicable laws.

2. Hospital Medical Director Contracts: In addition to the criteria set forth above ~~(D.1)~~ for *All Physician Financial Arrangements*, the following must be met *prior* to creating, renewing or amending a Hospital Medical Directorship:

a. A Medical Directorship may not be intended or used as a means to recruit a Physician to practice at the Hospital.

b. A Medical Directorship must fit within a rational management framework that optimizes coordination of the Medical Director's knowledge and work efforts with Hospital needs and resources. To meet this requirement, the Medical Director must work with, and be accountable to, a supporting Hospital manager-partner who is a Hospital supervisor, manager or executive director who verifies the Medical Director's work and efforts. The Designated Manager shall participate in the negotiation of the Medical Director Contract, including setting duties and goals, and will be familiar with the details of the Medical Director contract. The CMO will evaluate and approve all Medical Director contracts.

c. The number of hours assigned to the Medical Directorship must be appropriate considering the work required. Medical Director contracts are typically a two-year term and upon renewal, an evaluation shall be conducted by the CMO and the Designated Manager to evaluate whether all such services are needed in any new or renewal term, whether new services are needed and if the hours are still reasonable and necessary for the legitimate business purpose of the Medical Directorship arrangement. The proposed services may not duplicate work that is provided to the Hospital by other

Physicians unless the total work under all arrangements is needed.

d. Medical Director Contracts must require Physician completion and submission of a physician time study reports each month in the manner specified in the contract, and each such report must be approved by the Designated Manager and the Compliance Department before any compensation is paid. There must be one or more internal review processes to verify that the Medical Director is performing the expected duties and tasks, of which the required time report is one example. *Please refer to Appendix "D" 'Medical Director Time Report Guidelines' for more detailed guidance on completion of time report.*

e. All Medical Director Contracts providing for total annual compensation of $30,000 or more shall include two (2) annual quality incentive goals that support the Hospital's strategic initiatives, one of which shall be related to an outcome quality metric and the other shall be related to a process metric or milestone for service to patients, unless an exception is approved by the CMO for two (2) process goals. For Medical Director Contracts greater than $100,000 in compensation per year, 20% of the total compensation will be held at risk based on the completion of the quality incentive goals. For Medical Director Contracts between $50,000 to $99,999 per year, 10% of the total compensation will be held at risk based on the completion of the goals. For Medical Director Contracts between $30,000 to $49,999 per year, 5% of the total compensation will be held at risk based on the completion of the goals.

f. Medical Director Contracts must include a Hospital-approved HIPAA Business Associate Agreement.

3. Physician Consulting Contracts:
In addition to the criteria set forth in the *All Physician Financial Arrangements* section ~~(D.1)~~ above, the following criteria must be met *before* creating or renewing a Physician Consulting Contract:

a. Physician Consulting Contracts must require concise deliverables and due dates and require completion of a physician time study report. The deliverables and due dates must be set for the duration of the Physician Consulting Contract before the services begin and the Physician Consulting Contract is signed.

b. The number of hours assigned to the Physician Consulting Contract must be appropriate in light of the work required.

c. Physician Consulting Contracts must include a Hospital-approved HIPAA Business Associate Agreement.

4. Physician Lease Contracts:
In addition to the criteria set forth in the *All Physician Financial Arrangements* section above ~~(D.1),~~ the following criteria must be met *before* creating, amending, or renewing a Physician Lease Contract:

   a. Attached to the final version of a Physician Lease Contract, and prior to execution, must be a completed "Lease Contract Review Checklist" (Appendix C) and an executed "Contract Certification" (Appendix B).

   b. The Physician Lease Contract shall confirm total measurement of the space to be utilized by Physician under the lease.

   c. The Physician Lease Contract must be supported by fair market value documentation from a property appraiser or brokers opinion of value.

   d. Tenant Improvements must be incorporated into the Physician Lease Contract as a Tenant expense.

   e. Physician must not use the space and the Hospital must not make the space available for use prior to the execution of the Physician Lease Contract by both parties.

   f. The Physician Lease Contract shall require that all property taxes are to be paid by the Tenant for Triple Net leases.

   g. Physician Lease Contracts are executed by the CEO or the CASO.

5. Physician Education, Training and Conference Payment Contracts:
In addition to the criteria set forth in the *All Physician Financial Arrangements* section above ~~(D.1)~~ , the following criteria must be met *before* creating a new Education, Training and Conference Reimbursement Contracts and prior to attendance:

   a. Physician Education, Training and Conference Payment Contracts must be created and reimbursed in accordance with Hospital Policy Reimbursement of Business, Education and Travel Expenses.

   b. ~~The Hospital's~~ECH's need for this training to be provided to the Physician shall be documented as part of the approval process.

6. Physician Recruitment Contracts:
In addition to the criteria set forth in the *All Physician Financial*

*Arrangements* section above (D.1), the following criteria must be met *before* creating a new Physician Recruitment Contract:

a. Physician Recruitment Contracts must be created in accordance with the Physician Recruitment Policy Program, and must be consistent with the recruitment plan approved by the Board. ~~.~~

B. Approval of Physician Contracts:

1. Attached to the final version of a Physician Contract *before* ~~CEO~~ execution, must be a completed questionnaire in the contracts management system addressing terms, necessity, and fair market value. Documentation of fair market value must be submitted in the contracts management system. ~~"~~
2. Attached to the final version of a Physician Lease Contract, *prior* to execution by the CEO or the CASO, must be a completed "Lease Contract Review Checklist" (Appendix C) and signed "Contract Certification" (Appendix B).
3. Corporate Compliance and Legal, as needed, will verify the checklist, certification, and documentation accompanying all Physician Contracts (including FMV) prior to execution by the CEO or the CASO. Incomplete or missing checklist and certifications will be returned to the originator for completion.
4. All proposed Physician Contracts lacking the appropriate documentation will be returned to the originator for completion. No services may be performed under the Physician Contract or leases implemented until the Physician Contract is fully executed, or an exception has been granted by Compliance and Legal in accordance with Stark Law requirements.

~~5. CEO Approval: The CEO or the CEO's designee will have authority to execute new, renewal and amended Physician Contracts (up to the authority as stated in the Signature Authority policy) , except as set forth in Section 6) below.~~

~~6. Board Approval: The Board must approve prior to CEO or CEO designee execution of Physician Contracts for the following arrangements:~~

5. ~~All physician financial arrangements, including Professional Services Agreements for the El Camino Health Medical Network that~~

~~a.~~For the Hospital, all physician financial arrangements that exceed 75% of fair market value (regardless of total annual compensation) must be reviewed by the Finance Committee of the Board. ~~All~~Additionally, all physician financial arrangements that exceed 90% of fair market value must also be reviewed and approved by the Board. ~~.~~

~~b.~~1. ~~A memo prepared by the Designated Manager that justifies the Hospital's needs shall be provided to the Finance Committee and/or Board of Directors as necessary for approval as part of the approval documents.~~

6.

~~c.~~The CEO Approval: The CEO or the CEO's designee will have authority to execute new, renewal and amended Physician Contracts for the Hospital (up to the authority as stated in the Signature Authority policy), except that the CEO may execute without Board approval a new, renewal or amended Professional Services Agreement (PSA) with ECHMN~~l Camino Health Medical Associates (ECMA)Network (ECHMN)~~ so long as the total cash compensation to each individual physician is consistent with the approved PSA. ~~employed by ECMAECHMN does not exceed 75% percentile of fair market value or the CEO's signature authority~~.

7. For El Camino Health Medical Network, all physician financial arrangements that exceed 75% of fair market value (regardless of total annual compensation), or which deviate from the approved Compensation Structure-must be reviewed and approved by the El Camino Health Medical Network Board.

8. A memo prepared by the Designated Manager that justifies ~~the Hospital's~~El Camino Health's needs shall be provided to the Finance Committee and/or Board of Directors or Board of Managers as necessary for approval as part of the approval documents.

C. Board Oversight and Internal Review Process for Hospital based arrangements:

During the third quarter of each Hospital fiscal year, management and staff will prepare a summary report for all Hospital based Physician financial arrangements describing: 1) ~~the names of all such arrangements~~Fair Market Value determinations and ~~associated physicians~~trends, 2) ~~the organizational need that justifies each arrangement, 3) the total amounts paid to each physician~~ Overall Budget and Goals ~~/or group for each Physician Contract annually (and in total for duration on of contract term), 4~~3) current and prior year annual financial comparison, ~~,~~and ~~5~~4) any recommendations for changes to the Policy or any procedure.

~~For Medical Directorships, the summary report will also include: 1) the goals set forth for each Medical Directorship, 2) the contracted rate and hours, and 3) assessment of the performance goals of Medical Directors over the past year.~~

The CFO, COO ~~&~~, CLO, and CMO will review the information and prepare recommendations if any regarding specific actions or changes that will be implemented.

The report will then be reviewed by the CEO and presented to the Compliance and Finance committees of the Board of Directors for review ~~and approval~~ no later than the end of the ~~following quarter~~fiscal year.

D. Exceptions:

There are no exceptions to this Policy except as indicated herein.
~~D.~~

E. Review and/or Validate:

The CEO and the Corporate Compliance Officer shall be responsible for reviewing the policy and guidelines as conditions warrant but at a minimum at least annually to assure consistency with Board expectations. The Compliance department will annually monitor organizations adherence to the policy and report to the Board.

F. Policy Enforcement

El Camino ~~Hospital's~~Health's Compliance Officer is responsible for monitoring enforcement of this policy. Any workforce member found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.