AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, October 9, 2024 – 5:30 pm
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 985 0409 9563# No participant code. Just press #.**

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

Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

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

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
2	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Bob Rebitzer, Board Chair	Possible Motion	**5:30 pm**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
4	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Bob Rebitzer, Board Chair	Information	**5:30 pm**
5	**BOARD ASSESSMENT RESULTS**	Dan Woods, CEO George Anderson, Spencer Stuart	Discussion	**5:30 – 5:50**
6	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	Motion Required	**5:50 – 5:51**
7	**FY2024 AUDITED FINANCIAL REPORT** *Gov't Code Section 54957(b) Report regarding personnel performance – Senior Management*	Carlos Bohorquez, Chief Financial Officer Joelle Pulver, Moss Adams	Discussion	**5:51 – 6:01**
8	**APPROVE CREDENTIALING AND PRIVILEGING REPORT** *Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*:	Mark Adams, MD, CMO	Motion Required	**6:01 – 6:05**

9	**EXECUTIVE COMPENSATION ITEMS** **a. FY2024 ORGANIZATION PERFORMANCE INCENTIVE PLAN SCORE** **b. EXECUTIVE COMPENSATION COMMITTEE REPORT** *Gov't Code Section 54957) Report regarding personnel performance – Senior Management.*	Dan Woods, Chief Executive Officer Deanna Dudley, Chief Human Resources Officer	Discussion	**6:05 – 6:35**
10	**EXECUTIVE PERFORMANCE REVIEW SESSION** **a. FY2024 CEO PERFORMANCE INCENTIVE INDIVIDUAL SCORE** **b. FY2025 CEO BASE SALARY AND RANGE** *Gov't Code Section 54957 Report regarding personnel performance – Chief Executive Officer*	Bob Rebitzer, Board Chair Bob Miller, Executive Compensation Committee Chair Rob Kirkpatrick, Mercer	Discussion	**6:35– 7:10**
	BREAK *(Chair to confirm final numbers from Agenda Item 10 and share with staff for accuracy in motions to follow)*			**7:10 – 7:12**
11	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS** - Minutes of the Closed Session of the ECHB Meeting (08/14/2024) - Minutes of the Closed Session of the ECHB Meeting (09/11/2024) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Bob Rebitzer, Board Chair	Motion Required	**7:12 – 7:13**
12	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	Motion Required	**7:13 – 7:14**
13	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	**7:14 – 7:15**
14	**APPROVE FY2024 AUDITED FINANCIAL REPORT**	Bob Rebitzer, Board Chair	Motion Required	**7:15 – 7:17**
15	**APPROVE FY2024 ORGANIZATION PERFORMANCE INCENTIVE PLAN SCORE** Approved Document Appended	Bob Rebitzer, Board Chair	Motion Required	**7:17 – 7:19**
16	**REPORT OF RECOMMENDATION FOR FY2024 CEO PERFORMANCE INCENTIVE PLAN PAYOUT** - Approve FY2024 CEO Performance Incentive Plan Payout Approved Document Appended	Bob Rebitzer, Board Chair	Motion Required	**7:19 – 7:21**
17	**REPORT OF RECOMMENDATION FOR FY2025 CEO BASE SALARY** - Approve FY2025 CEO Base Salary	Bob Rebitzer, Board Chair	Motion Required	**7:21 – 7:23**
18	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (09/11/2024) b. Receive Period 2 Financials c. Approve Policies, Plans and Scopes of Service as Reviewed and Recommended for	Bob Rebitzer, Board Chair	Motion Required	**7:23 – 7:25**

	Approval by the Medical Executive Committee			
19	**CEO REPORT**	Dan Woods, Chief Executive Officer	Information	**7:25 – 7:30**
20	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:30 – 7:40**
21	**ADJOURNMENT** **APPENDIX**	Bob Rebitzer, Board Chair	Motion Required	**7:40**

NEXT MEETINGS: November 20, 2024; December 11, 2024; February 5, 2024; March 12, 2025; April 16, 2025; May 14, 2025; June 18, 2025

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: George Anderson, Spencer Stuart
Date: October 9, 2024
Subject: Board Assessment Results

Purpose:

Review the results of the Board Governance Assessment conducted by Spencer Stuart, an outside consulting firm, that was presented to the Board of Directors and Advisory Committees.

Summary:

The Hospital Board of Directors utilized the services of an independent consulting firm to conduct an assessment to promote optimal processes and practices for the board and committees.

The El Camino Health Board Assessment Survey, conducted by Spencer Stuart, evaluated the effectiveness of the El Camino Health Board. All ten Board members participated, providing feedback on various aspects of Board and Committee operations. The survey identified strengths in Board meetings, particularly the management of discussions by the Chair, and the Board's ability to express views openly. However, areas needing improvement included committee effectiveness and the Board's role in overseeing financial performance and community healthcare needs.

The survey also compared the 2024 results to those from 2022, highlighting both progress and areas where further improvement is required. Key findings include the need for a stronger pipeline for new Board candidates, more effective strategic planning processes, and enhanced conflict of interest resolution mechanisms. Detailed open responses provided insights into potential improvements in strategic discussions, committee roles, and Board member engagement

SpencerStuart presented the detailed responses to the Governance Committee and the Committee will work on recommendations from that discussion and today’s discussion to form an action plan for the Hospital Board.

List of Attachments:

1. Board Assessment Results

SpencerStuart

El Camino Health

El Camino Health Board Survey

October 9, 2024

Prepared for El Camino Health

Board and Committee Review Process

- Spencer Stuart was engaged by the Board and Chief Executive Officer of El Camino Health to assist with a survey-based review of the Board's effectiveness.

- The online survey was open from August 12 – 23, 2024. All Board Members (10) completed the survey. The survey results and open-response comments are presented on an unattributed basis in this report.
  - Please note: all questions about the Board as a whole have an "n" of 10.

- Participants were asked to answer a series of questions on a 4-point Likert scale, where a rating of "1" indicates strong disagreement and a rating of "4" indicates strong agreement. Participants were also given the option to respond "N/A," indicating "no opportunity to observe."

- Comments in the Open Response sections may have been edited for clarity or to protect the identity of the authors. Certain comments have been redacted or modified if they referenced individuals in directly identifiable way.

- This report will be reviewed by the full Board at its October 9, 2024 meeting.

2024 Survey Findings

Summary: Highest and Lowest Rated Areas

The highest and lowest rated items by the Board about the Board as a collective. Scores were given on a 1-4 scale, from "Strongly Disagree" to "Strongly Agree." A 4.0 rating is the average highest score possible. A 1.0 rating is the lowest.

Highest Rated	Avg. Score	Lowest Rated	Avg. Score
Board Meetings: The Board Chair effectively manages board dialogue, ensures all voices are heard, guides discussion towards closure and decision, and manages time effectively.	3.7	**Committee Effectiveness:** Board Members are organized properly into appropriate committees based on background and expertise of each member.	2.9
Board Culture and Dynamics: Board Members are comfortable expressing their views openly and productively during Board Meetings, and with Board leadership and management when necessary.	3.6	**Execution of Oversight Responsibilities:** On an annual basis, the Board effectively deliberates on and approves appropriate performance goals.	2.9
Execution of Oversight Responsibilities: The Board effectively assesses the organization's financial performance in relation to its goals.	3.6	**Execution of Oversight Responsibilities:** The Board frequently evaluates the organization's performance in relation to community healthcare needs.	2.9
Board Meetings: Board meetings cover appropriate topics and areas of board oversight.	3.5	**Execution of Oversight Responsibilities:** The Board has an effective mechanism in place for resolving potential conflicts of interest.	3.0
Board Meetings: Board Members receive meeting notices, written agendas, minutes and other materials well in advance of meetings with appropriate time to review and prepare for meetings.	3.5	**Board Skills, Experiences, and Attributes:** The Board actively cultivates new candidates to form a pipeline of potential candidates who are qualified based on defined, competency-based criteria.	3.0
Board Role: The expectations for Board service are clearly articulated and well understood by Board Members.	3.5	**Board Culture and Dynamics:** Board Members possess strong communication skills, knowing when to listen and when to speak up.	3.0
Board Role: The time commitment Board Members are asked to make is reasonable and appropriate for fulfilling our duties.	3.5	**Board Skills, Experiences, and Attributes:** The Board is composed of members with optimal subject matter expertise and appropriate competencies.	3.1
Relationship with Management: On an annual basis, the Board effectively assesses the performance of the Chief Executive Officer.	3.5	**Relationship with Management:** Management provides high quality board materials, with the appropriate level of detail, to enable the Board to effectively carry out its oversight responsibilities.	3.1
Relationship with Management: The Board has an effective working relationship with the Chief Executive Officer and leadership team.	3.5		
Execution of Oversight Responsibilities: The Board has established procedures to effectively oversee quality.	3.5		

Note: Reported scores here are for the Board as a collective and do not include the "Self-Reflection" questions. See page 28 for those averages.

Summary: Areas of Most Agreement

Committee Effectiveness: The current committee structure and operating procedures are effective.

Execution of Board's Oversight Responsibilities: The organization's strategic planning processes are effective, and the Board provides appropriate input into the strategic planning process, taking into account all key stakeholders.

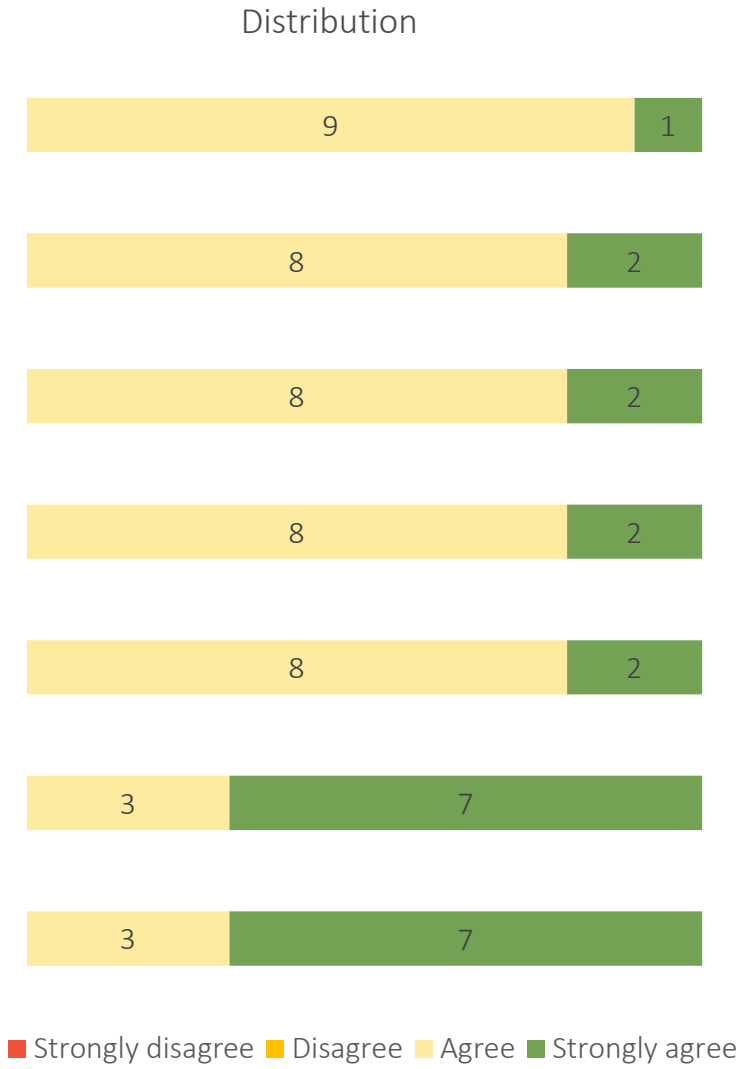
Relationship with Management: The Board and management exhibit mutual trust and respect and foster transparency in the working relationship.

Committee Effectiveness: The Committees have strong leadership.

Committee Effectiveness: Committee agendas are prepared and circulated timely and contain all pertinent information, minutes are taken accurately, and informational and logistical support are provided by management and outside advisors.

Board Meetings: The Board Chair effectively manages board dialogue, ensures all voices are heard, guides discussion towards closure and decision, and manages time effectively.

Self-Reflection: I prepare for and actively participate in Board Meetings as well as other activities expected of me as a Board Member.



Summary: Areas of Least Agreement

Execution of Board's Oversight Responsibilities: The Board frequently evaluates the organization's performance in relation to community healthcare needs.

Board Skills, Experiences, and Attributes: The Board actively cultivates new candidates to form a pipeline of potential candidates who are qualified based on defined, competency-based criteria.

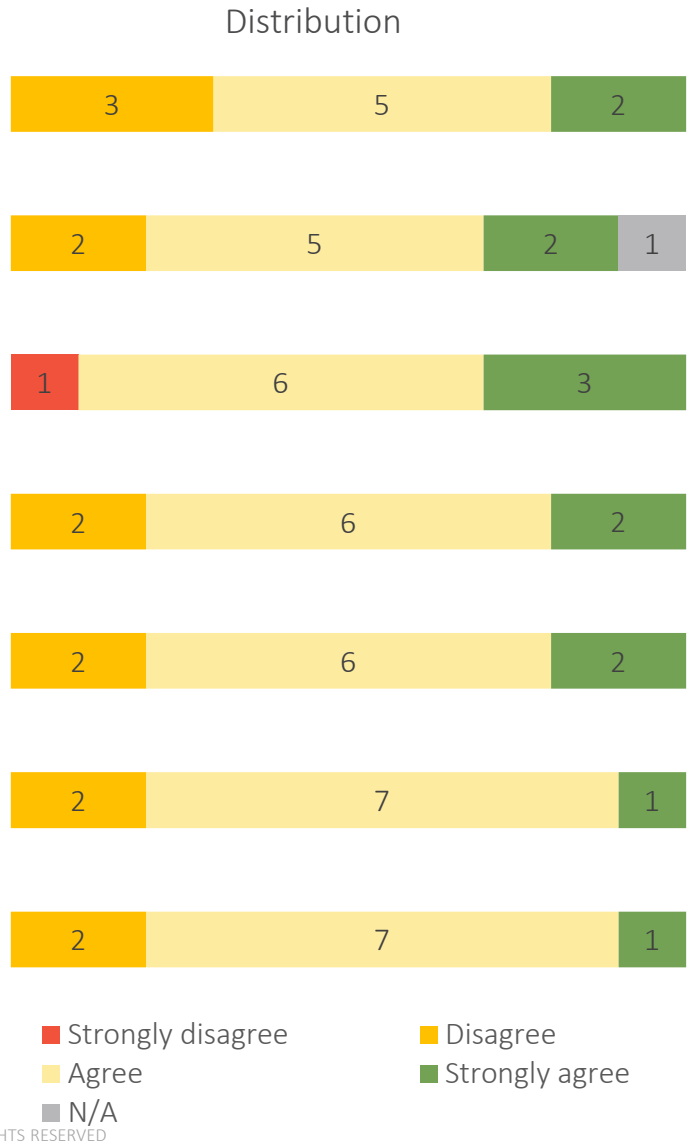
Relationship with Management: Management provides high quality board materials, with the appropriate level of detail, to enable the Board to effectively carry out its oversight responsibilities.

Execution of Board's Oversight Responsibilities: The Board has an effective mechanism in place for resolving potential conflicts of interest.

Self-Reflection: As a Board Member, my expertise and experience are being fully leveraged.

Execution of Board's Oversight Responsibilities: On an annual basis, the Board effectively deliberates on and approves appropriate performance goals.

Committee Effectiveness: Board Members are organized properly into appropriate committees based on background and expertise of each member.



2024 Results By District vs. Hospital only Board Members

Summary: Highest Rated Areas

Highest Rated	Avg. Score	Distribution
Board Meetings: The Board Chair effectively manages board dialogue, ensures all voices are heard, guides discussion towards closure and decision, and manages time effectively.	3.7	District board members: 3 Agree, 2 Strongly Agree Hospital board members: 5 Strongly Agree
Board Culture and Dynamics: Board Members are comfortable expressing their views openly and productively during Board Meetings, and with Board leadership and management when necessary.	3.6	District board members: 2 Agree, 3 Strongly Agree Hospital board members: 2 Agree, 3 Strongly Agree
Execution of Oversight Responsibilities: The Board effectively assesses the organization's financial performance in relation to its goals.	3.6	District board members: 2 Agree, 3 Strongly Agree Hospital board members: 2 Agree, 3 Strongly Agree
Board Meetings: Board meetings cover appropriate topics and areas of board oversight.	3.5	District board members: 3 Agree, 2 Strongly Agree Hospital board members: 2 Agree, 3 Strongly Agree
Board Meetings: Board Members receive meeting notices, written agendas, minutes and other materials well in advance of meetings with appropriate time to review and prepare for meetings.	3.5	District board members: 4 Agree, 1 Strongly Agree Hospital board members: 1 Agree, 4 Strongly Agree
Board Role: The expectations for Board service are clearly articulated and well understood by Board Members.	3.5	District board members: 2 Agree, 3 Strongly Agree Hospital board members: 3 Agree, 2 Strongly Agree
Board Role: The time commitment Board Members are asked to make is reasonable and appropriate for fulfilling our duties.	3.5	District board members: 2 Agree, 3 Strongly Agree Hospital board members: 3 Agree, 2 Strongly Agree
Relationship with Management: On an annual basis, the Board effectively assesses the performance of the Chief Executive Officer.	3.5	District board members: 3 Agree, 2 Strongly Agree Hospital board members: 2 Agree, 3 Strongly Agree
Relationship with Management: The Board has an effective working relationship with the Chief Executive Officer and leadership team.	3.5	District board members: 3 Agree, 2 Strongly Agree Hospital board members: 2 Agree, 3 Strongly Agree
Execution of Oversight Responsibilities: The Board has established procedures to effectively oversee quality.	3.5	District board members: 3 Agree, 2 Strongly Agree Hospital board members: 2 Agree, 3 Strongly Agree

Summary: Lowest Rated Areas

Lowest Rated	Avg. Score	Distribution
Committee Effectiveness: Board Members are organized properly into appropriate committees based on background and expertise of each member.	2.9	District board members: 2 Disagree, 3 Agree Hospital board members: 4 Agree, 1 Strongly Agree
Execution of Oversight Responsibilities: On an annual basis, the Board effectively deliberates on and approves appropriate performance goals.	2.9	District board members: 2 Disagree, 3 Agree Hospital board members: 4 Agree, 1 Strongly Agree
Execution of Oversight Responsibilities: The Board frequently evaluates the organization's performance in relation to community healthcare needs.	2.9	District board members: 2 Disagree, 2 Agree, 1 Strongly Agree Hospital board members: 1 Disagree, 3 Agree, 1 Strongly Agree
Execution of Oversight Responsibilities: The Board has an effective mechanism in place for resolving potential conflicts of interest.	3.0	District board members: 1 Disagree, 4 Agree Hospital board members: 1 Disagree, 2 Agree, 2 Strongly Agree
Board Skills, Experiences, and Attributes: The Board actively cultivates new candidates to form a pipeline of potential candidates who are qualified based on defined, competency-based criteria.	3.0	District board members: 1 Disagree, 3 Agree, 1 Strongly Agree Hospital board members: 1 Unknown, 1 Disagree, 2 Agree, 1 Strongly Agree
Board Culture and Dynamics: Board Members possess strong communication skills, knowing when to listen and when to speak up.	3.0	District board members: 4 Agree, 1 Strongly Agree Hospital board members: 1 Disagree, 4 Agree
Board Skills, Experiences, and Attributes: The Board is composed of members with optimal subject matter expertise and appropriate competencies.	3.1	District board members: 4 Agree, 1 Strongly Agree Hospital board members: 1 Disagree, 3 Agree, 1 Strongly Agree
Relationship with Management: Management provides high quality board materials, with the appropriate level of detail, to enable the Board to effectively carry out its oversight responsibilities.	3.1	District board members: 1 Strongly Disagree, 4 Agree Hospital board members: 2 Agree, 3 Strongly Agree

2024 Results Compared to 2022 Results

2024 Compared to 2022 Highest Rated

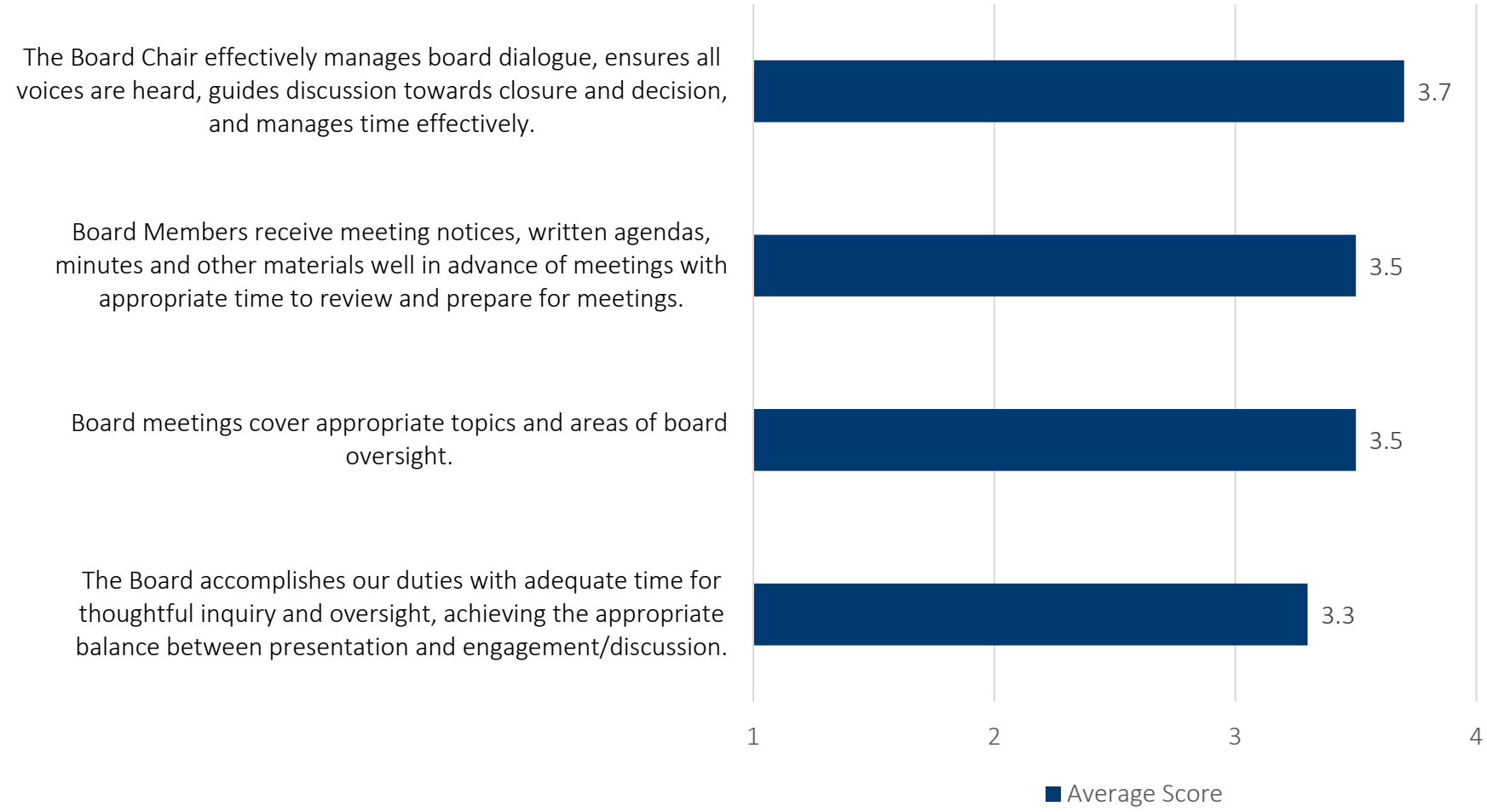
Highest Rated	'24 Avg. Score	'22 Avg. Score	
Board Meetings: The Board Chair effectively manages board dialogue, ensures all voices are heard, guides discussion towards closure and decision, and manages time effectively.	3.7	3.3	⬆
Board Culture and Dynamics: Board Members are comfortable expressing their views openly and productively during Board Meetings, and with Board leadership and management when necessary.	3.6	3.2	⬆
Execution of Oversight Responsibilities: The Board effectively assesses the organization's financial performance in relation to its goals.	3.6	3.5	
Board Meetings: Board meetings cover appropriate topics and areas of board oversight.	3.5	3.3 (slightly differently worded)	
Board Meetings: Board Members receive meeting notices, written agendas, minutes and other materials well in advance of meetings with appropriate time to review and prepare for meetings.	3.5	3.6	
Board Role: The expectations for Board service are clearly articulated and well understood by Board Members.	3.5	3.3	⬆
Board Role: The time commitment Board Members are asked to make is reasonable and appropriate for fulfilling our duties.	3.5	3.1	⬆
Relationship with Management: On an annual basis, the Board effectively assesses the performance of the Chief Executive Officer.	3.5	3.4	
Relationship with Management: The Board has an effective working relationship with the Chief Executive Officer and leadership team.	3.5	3.8	⬇
Execution of Oversight Responsibilities: The Board has established procedures to effectively oversee quality.	3.5	3.3	

2024 Compared to 2022 Lowest Rated

Lowest Rated	'24 Avg. Score	'22 Avg. Score
Committee Effectiveness: Board Members are organized properly into appropriate committees based on background and expertise of each member.	2.9	3.0
Execution of Oversight Responsibilities: On an annual basis, the Board effectively deliberates on and approves appropriate performance goals.	2.9	3.1
Execution of Oversight Responsibilities: The Board frequently evaluates the organization's performance in relation to community healthcare needs.	2.9	2.7
Execution of Oversight Responsibilities: The Board has an effective mechanism in place for resolving potential conflicts of interest.	3.0	3.4
Board Skills, Experiences, and Attributes: The Board actively cultivates new candidates to form a pipeline of potential candidates who are qualified based on defined, competency-based criteria.	3.0	2.4, different question; asked about committees too
Board Culture and Dynamics: Board Members possess strong communication skills, knowing when to listen and when to speak up.	3.0	3.0
Board Skills, Experiences, and Attributes: The Board is composed of members with optimal subject matter expertise and appropriate competencies.	3.1	3.0
Relationship with Management: Management provides high quality board materials, with the appropriate level of detail, to enable the Board to effectively carry out its oversight responsibilities.	3.1	3.1
Committee Effectiveness: The current committee structure and operating procedures are effective.	3.1	Did not ask overall (asked for each committee)

Survey Question Averages and Open Response Comments

Board Meetings



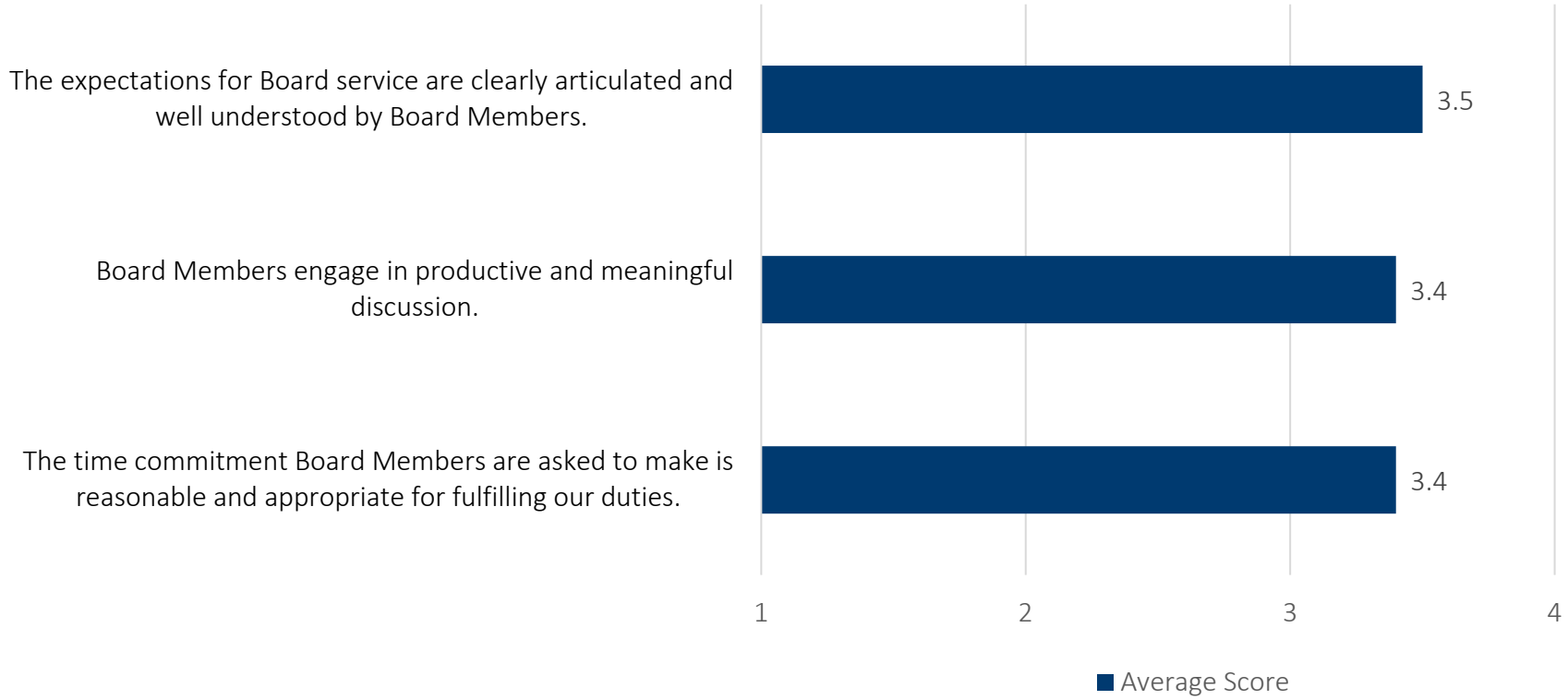
Board Meetings

Prompt	Open Response
What topics would you like to see covered in future Board meetings?	• LG replacement in context of strategic framework and value proposition. • Emphasis on strategy, communication, collaboration, community engagement, personnel, and resource management. • We have done a good job limiting the time we spend on pro forma information presentations. We need to continue to create more opportunities for strategic discussions. • How emerging healthcare policies will affect our healthcare system regarding quality assessment and reimbursements. • Ways to capture progress on goals and strategic plan. • The Board is responsible for the quality and performance of all employees and the Medical Staff. Aside from the credentialing report, it has no systematic mechanism to ensure that the clinical judgment, processes and outcomes are up to date and continuously being reviewed or improved. It needs to ensure that processes and outcomes are appropriately reviewed, and care is optimized with no inappropriate variations in practice. • Top 4 Strategic Lines of Business deep dive - review of budget in time to provide strategic discussion, e.g., should we invest more in certain strategic areas?

Board Meetings

Prompt	Open Response
Additional comments on Board Meetings?	• Would like reduced presentation time. Suggestion: ask presenter to give "2-minute overview" of topic (to get everyone "tuned in" before asking if anyone has questions). • It often seems that ending on time is more important than fully discussing complex topics. Extraneous, rambling discussions need to be curtailed, but there are occasions that fruitful, productive matters which would benefit from fuller explorative discussion are cut short in order to follow the agenda schedule, which is arbitrarily set. There are times brief comments are all that is appropriate, but there are times when freer explorative ideas are necessary and desirable. • Could be flexible on agenda item discussions vs. cutting off to meet listed agenda time. • I believe the pendulum has swung too far and that we are not scheduling enough time in meetings for full discussion of strategic issues. • Streamlined and adequate summary without duplication of nonessential materials and information. • I think we need to continue to work to reduce the number of Board Meetings and to pitch the reports to the governance, not the managerial, level. • Well run. Excellent Chair. • Bob is amazing at summarizing the conversation and directing the conversation.

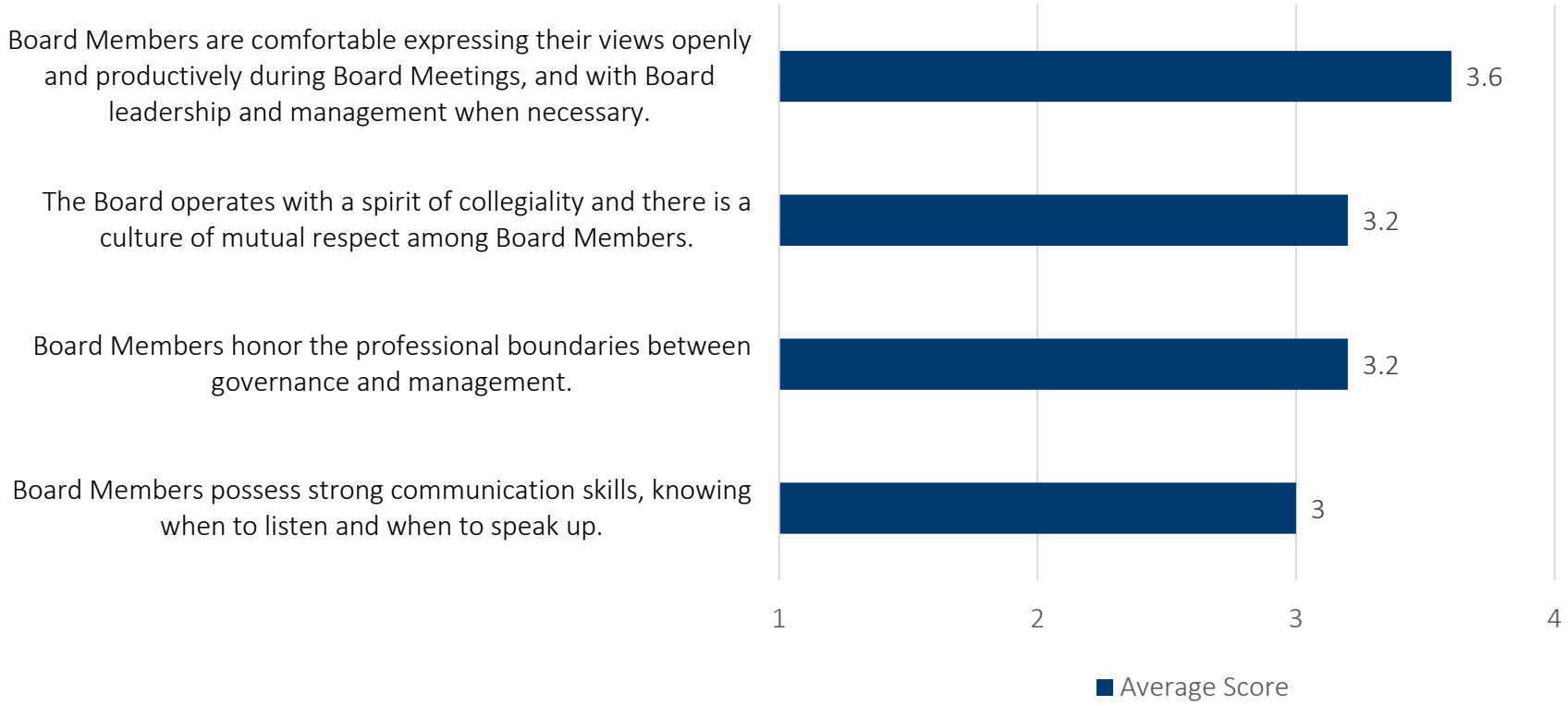
Board Role



Board Role

Prompt	Open Response
Additional comments regarding the Board's role?	• Discussions are sometimes repetitive and irrelevant, especially among certain members of the Board. • Our job as a Board is to hold management accountable for their performance and to help management make El Camino a great organization. Although we are improving, too often, the Board asks questions as if our role is to be a "watchdog." Watchdogs look for the bad things management may be up to, which can lead to negative or accusing questions. We need to continue our evolution to a focus on accountability - which seeks to understand the issues critically - and support, which emphasizes problem-solving rather than "gotcha" moments. • Board Members contribute at different levels with time.

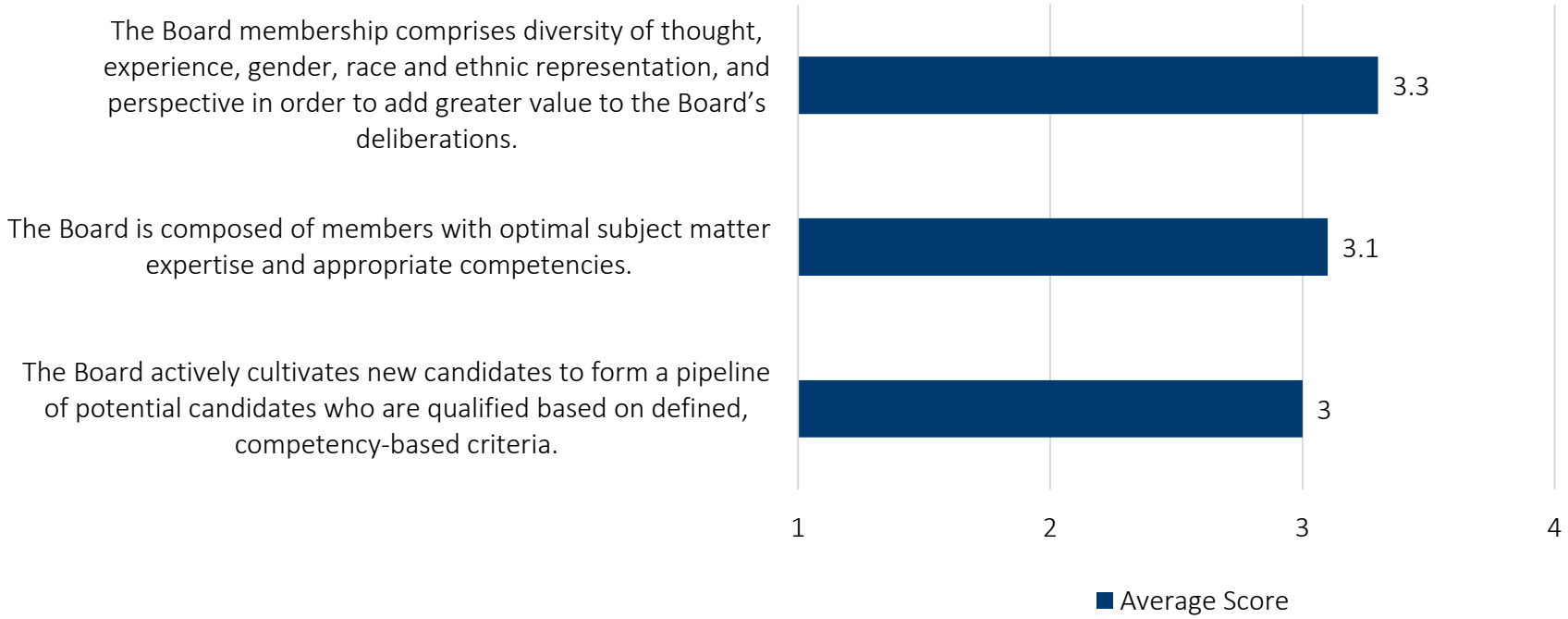
Board Culture and Dynamics



Board Culture and Dynamics

Prompt	Open Response
Additional comments regarding the Board's culture and working dynamics?	• Sometimes one or two members take us down the "rabbit hole" from the governance to management level. • At certain times, members may not be clearcut on the boundaries of governance and management. • We have come a long way towards developing a culture of collegiality and respect among Board Members. We need to improve our ability to communicate on difficult issues with management in the same spirit of collegiality and respect. • The spirit of collegiality and mutual respect among Board Members could be improved. • The management team is less quick to recite the same old tired complaint of claiming the Board is "overstepping into the management role" as a defense mechanism when disagreements occur. This has led to more collaboration and thoughtful discussion. • There are a couple people who do not consistently meet the standards expected and this behavior should be recognized in diminution of responsibilities at ECH Board level.

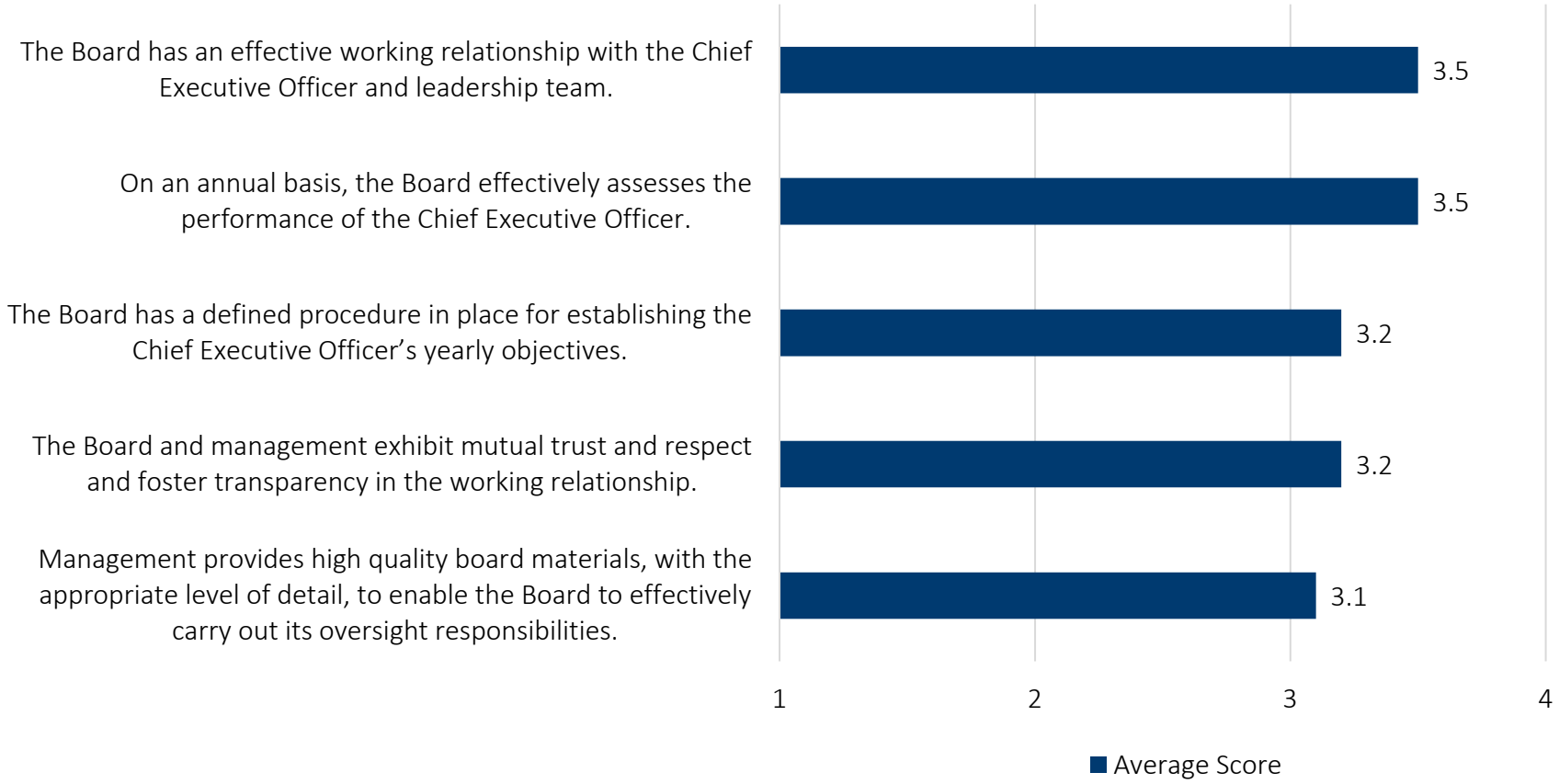
Board Skills, Experiences, and Attributes



Board Skills, Experiences, and Attributes

Prompt	Open Response
Additional comments regarding Board skills, experiences, and attributes?	• Now beginning to see Committee Members as a "farm team" to source Board candidates. • We need to do a better job of cultivating Committee Members into future Board Members. • None of the appointed Board Members are women. Our healthcare district has a large Hispanic base. None of our Board Members are Hispanic. • I disagree with the premise that race and ethnic representation are more important than socio-economic representation. The Board membership comprises diversity of thought, experience, gender, race and ethnic representation, and perspective in order to add greater value to the Board's deliberations. • Skills and experiences are different and contribute to the whole; sometimes these differences are not acknowledged and contribute to some dysfunction.

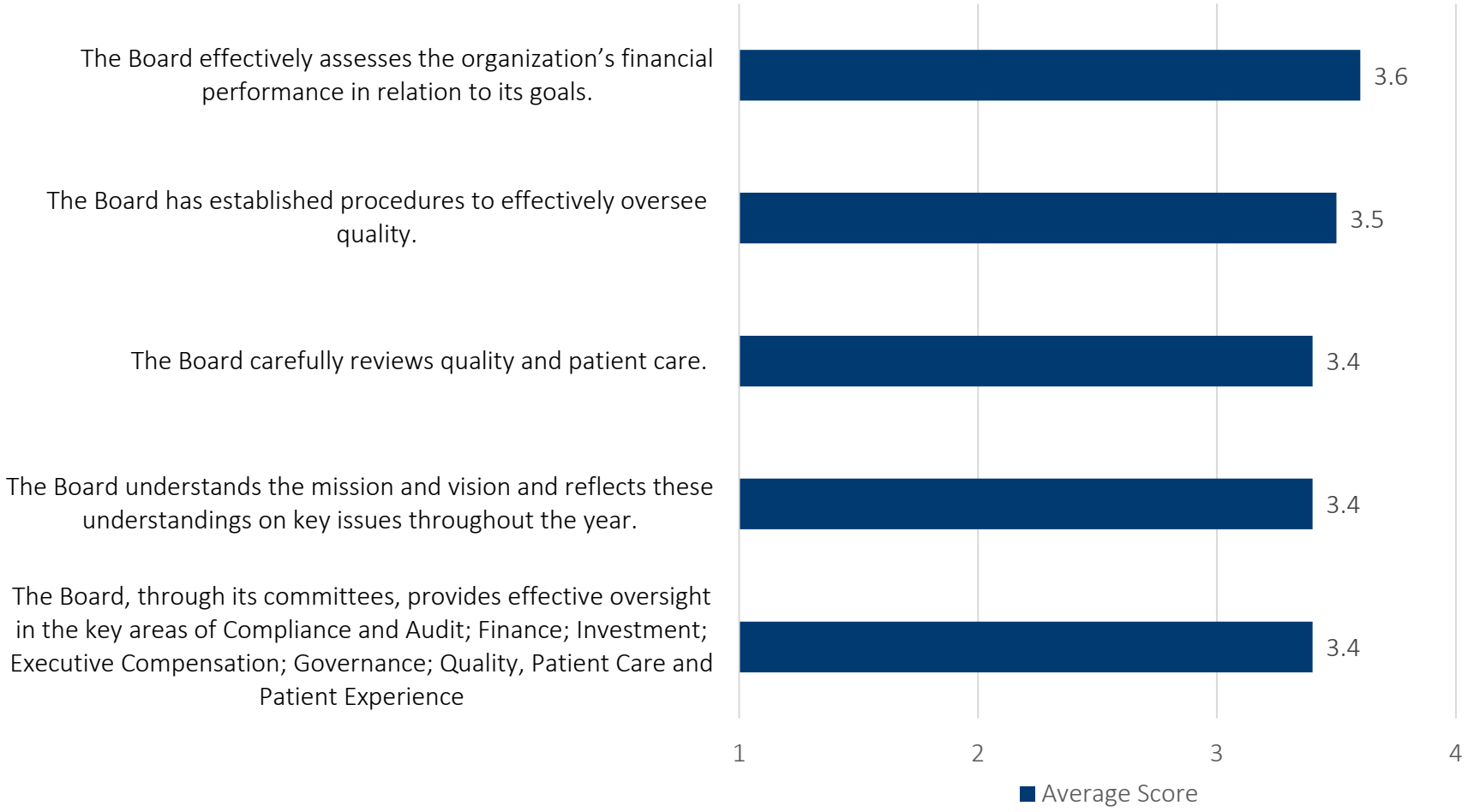
Relationship with Management



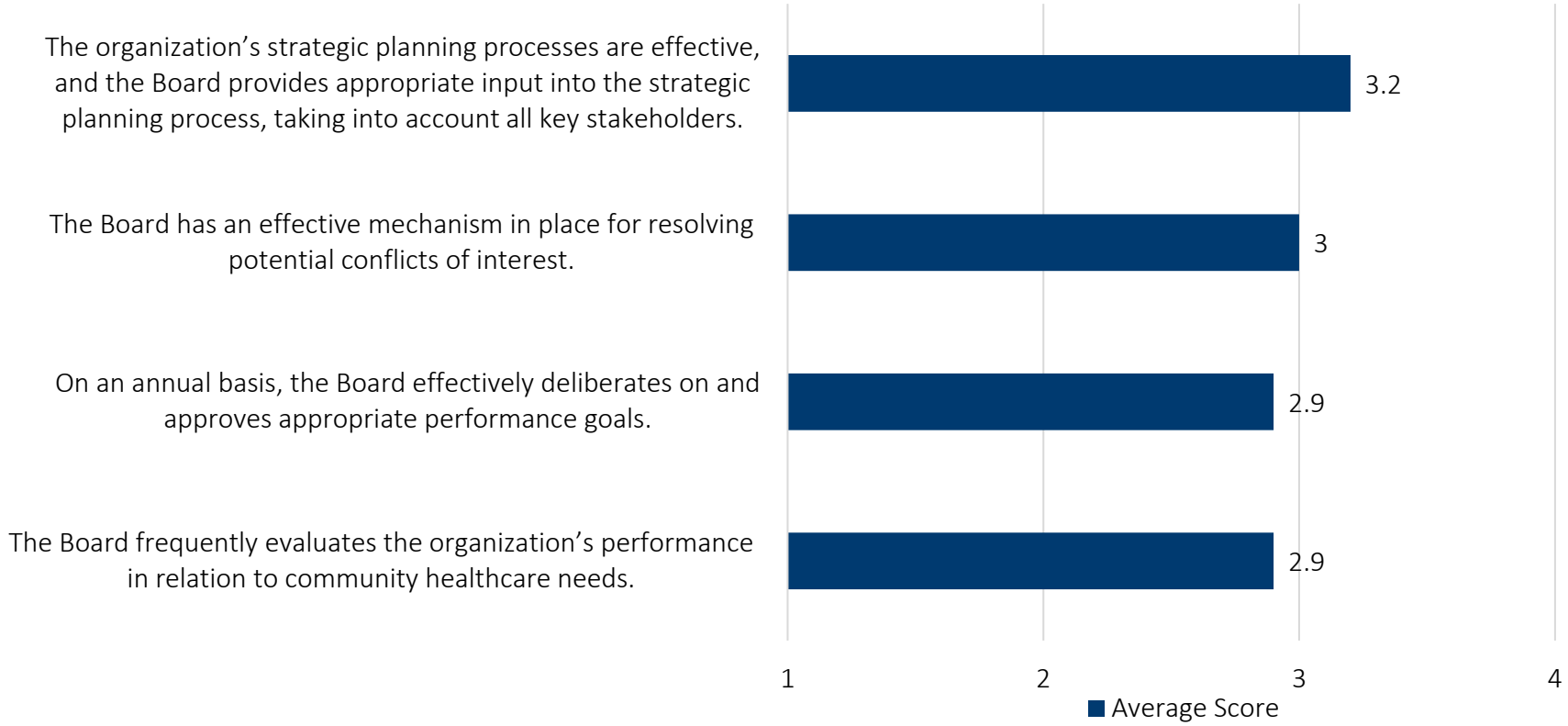
Relationship with Management

Prompt	Open Response
Additional comments regarding the relationship with management?	• There is good and mutual respect between the Board and the management team. • There is progressively less defensive posturing and claiming the Board is overstepping into management when constructive oversight by Board Members challenges management's decisions. This has been extremely helpful in advancing our goals. • When a Board Member questions almost everything, management can become frustrated and other Board Members can feel uncomfortable. • Although we are getting better every year, Board materials are still too lengthy and often pitched at the managerial rather than the governance level. Administrative support for the Board is uneven. Materials often contain small errors and sometimes documents do not make it into Board packets. To-do items and next steps that emerge from Board Meetings are incompletely documented and sometimes are dropped. • Errors on Board materials have increased.

Execution of Board's Oversight Responsibilities



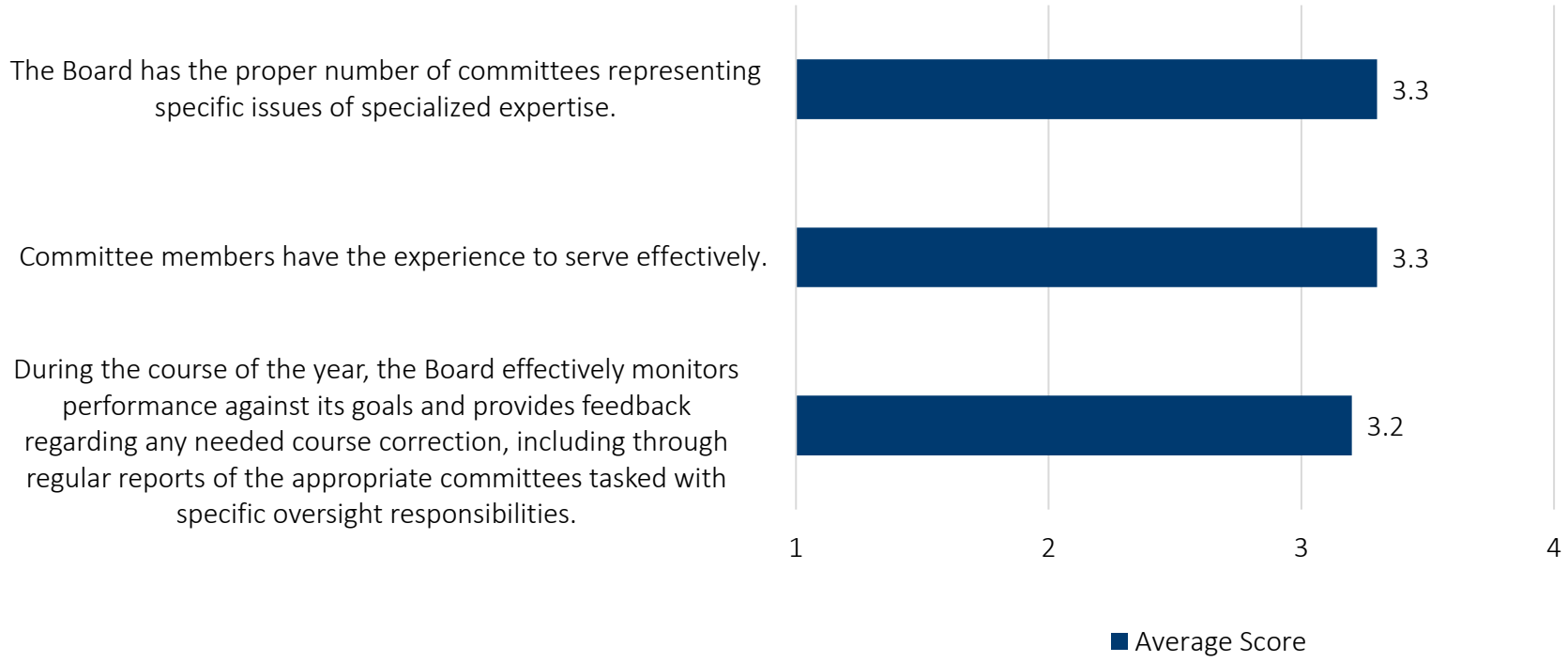
Execution of Board's Oversight Responsibilities, continued



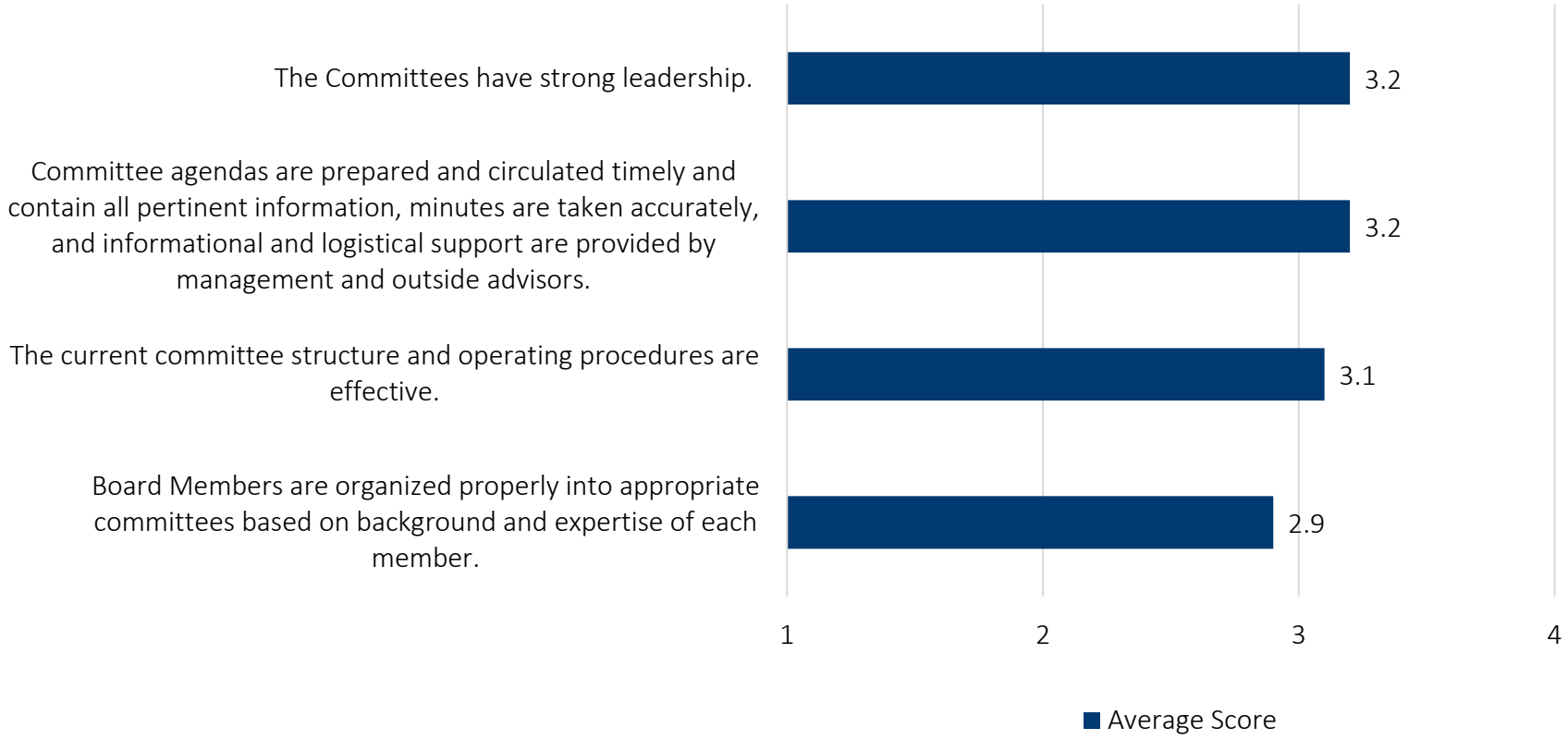
Execution of Board's Oversight Responsibilities

Prompt	Open Response
Additional comments regarding the execution of the Board's oversight responsibilities?	• There seems to be a need for fresh and innovative input to the strategic planning process. It does appear stale and unchanged over the last several years. Community engagement and partnership can be improved and should be encouraged. There has been a long delay in the hiring of key personnel executives. • Need to allow time for board members to "soak in the hot tub" with management before asking for approval of what management has already "figured out." All involved might change their individual perspectives - and align on "the best course of action." • I don't believe we have had active discussions that should lead to annual updating and iteration of organizational strategic goals. • I think Board Members need education about what constitutes conflicts of interest. We have some philosophical differences about how to balance quantitative goals with context and strategic judgement. These difference arise each year and we can do more to bridge the differences. Our ability to make assessments of our quality as a system, rather than as a hospital, is improving, but more work is needed. Our assessment of patient experience is too narrowly focused. I think we need a balanced patient experience scorecard much as we have a quality scorecard. • The Board should refer conflict of interest issues for ruling by the appropriate government agencies before bringing the issues in a biased manner to ill-informed Board Members. The CLO should be counseled accordingly. • Process needs to be fluid and sometimes no time to update. • I'm honestly not really sure what the community healthcare needs are, so that's why I disagreed.

Committee Effectiveness



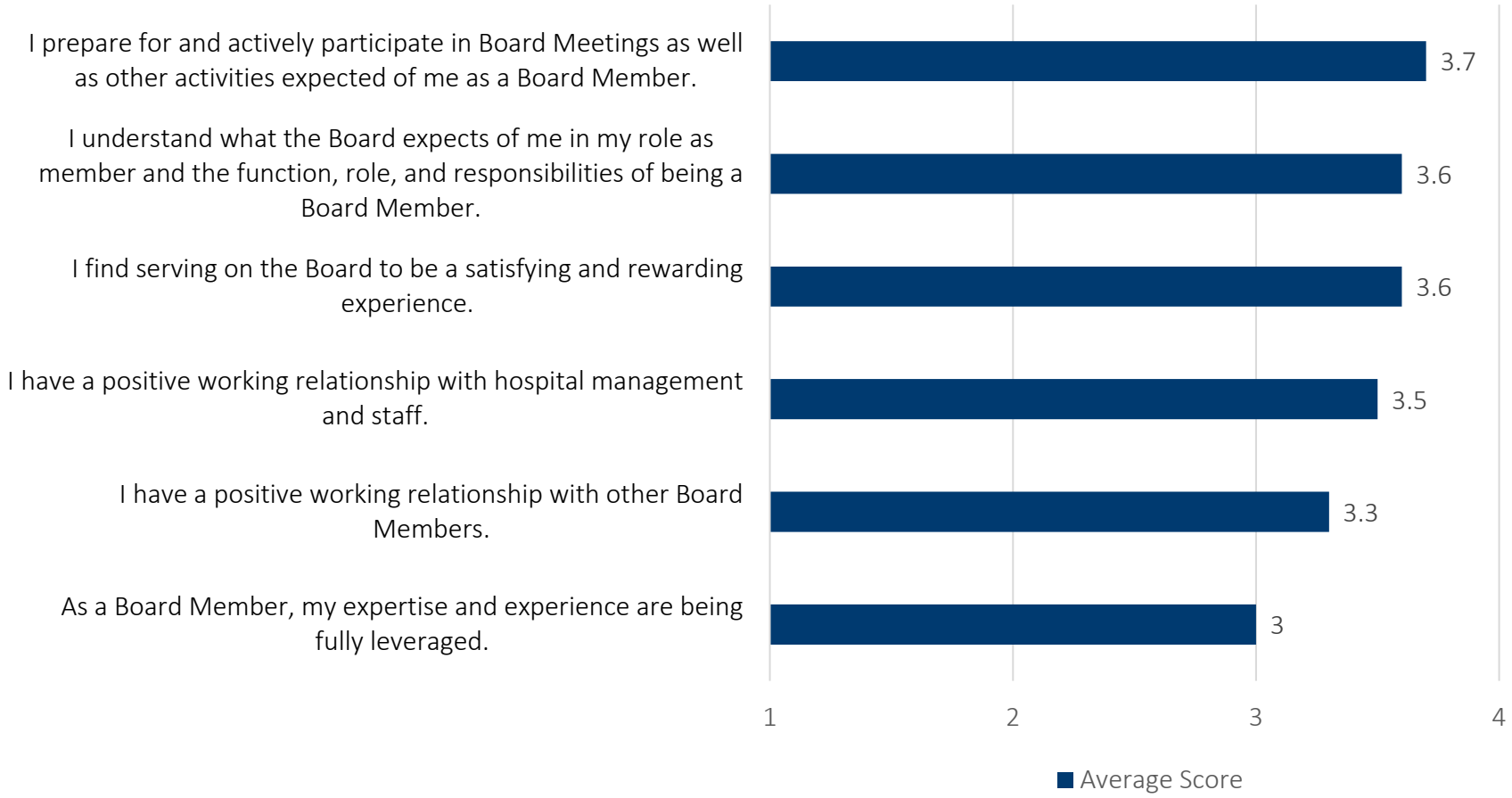
Committee Effectiveness, continued



Committee Effectiveness

Prompt	Open Response
Additional comments regarding committee effectiveness?	• I think we need to assess our Committees to ensure that they represent the diversity of the community we serve. Not all Committees have a Vice Chair role. We need such a role in each Committee to ensure continuity and to develop future leaders. • Big fan of more community board members being the Chair, on the other hand, I'm not sure why we need an Investment Committee and not fold that into Finance. • Materials are not always timely. Committee meeting time/invites/minutes are not always available to all Board Members for review/interest. • Without a formal strategic planning committee structure, critical strategic issues might not get thoroughly vetted before arriving on the board's "lap" for approval. • Board Members could be rotated among Committees more regularly. Appears some are assigned to avoid conflict with executives that are to be held accountable. I am concerned that Committees, including their ability to largely self-recruit members, could become too stove piped, particularly with reduced x-committee engagement/meetings. I believe at least one, if not two per year should be required.

Self-Reflection on Your Contributions to the Board



Additional Reflection on the Performance of the Board

Prompt	Open Response
1. Please provide any additional comments on the effectiveness of the Board over the last year. 2. Looking to the future, what should be the goals of the Board over the next two years; what do we want to accomplish as a Board separate from the goals of the organization? (E.g., expanded Board education programs; changes; enhanced communication; better use of Board Meeting time; other potential areas of responsibility and oversight?). 3. Do you have other input about the Board that has not been addressed in this survey?	• As companies grow, Boards should reevaluate themselves to be sure they still have all the right skill sets to help in the growth process. • The Current Chair has totally changed the dynamics of the board discussions for the better. Absolutely OUTSTANDING leadership!!! • 1. Suggest instead of general statements on this feedback, please focus on specific actions or decisions made by the Board. 2. Balance praise and critique - allow us to highlight what's working well and introduce ideas for improvement. For example, how we can introduce communication to the community. 3. We need to have smart metrics to link performance to outcomes, both on the success of the programs, services, not just on the financial profits. 4. Need to allow the Board Members and service administrator to self-reflect on the success of the programs. 5. The feedback of this exercise should be action-oriented - such as developing partnerships with local health organizations. A summary of points and scores are of limited value. • Excellent Board Chair. Effective Board. Efficient Board. Recommend more thorough discussion regarding strategic planning for the Los Gatos campus. Recommend more discussion on coordination of care between outpatient and inpatient services. • Some Board Members are lacking in the effort of congeniality to others. With improvement, creates better productivity, outcomes and results. • [Comment regarding board members who are in leadership positions should] “discipline inappropriate behavior in the boardroom.” • I'm probably quite useful talking about IT and roadmaps there, but I don't think we spend a lot of time talking about it in the organization.

SpencerStuart

Appendix: Distribution of All Responses

Board Meetings

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Board Chair effectively manages board dialogue, ensures all voices are heard, guides discussion towards closure and decision, and manages time effectively.				3	7	3.7
Board Members receive meeting notices, written agendas, minutes and other materials well in advance of meetings with appropriate time to review and prepare for meetings.				5	5	3.5
Board meetings cover appropriate topics and areas of board oversight.				5	5	3.5
The Board accomplishes our duties with adequate time for thoughtful inquiry and oversight, achieving the appropriate balance between presentation and engagement/discussion.			1	5	4	3.3

Board Role

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The expectations for Board service are clearly articulated and well understood by Board Members.				5	5	3.5
The time commitment Board Members are asked to make is reasonable and appropriate for fulfilling our duties.				5	5	3.5
Board Members engage in productive and meaningful discussion.				6	4	3.4

Board Culture and Dynamics

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
Board Members are comfortable expressing their views openly and productively during Board Meetings, and with Board leadership and management when necessary.				4	6	3.6
The Board operates with a spirit of collegiality and there is a culture of mutual respect among Board Members.			1	6	3	3.2
Board Members honor the professional boundaries between governance and management.	1			7	2	3.2
Board Members possess strong communication skills, knowing when to listen and when to speak up.			1	8	1	3.0

Board Skills, Experiences, and Attributes

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Board membership comprises diversity of thought, experience, gender, race and ethnic representation, and perspective in order to add greater value to the Board's deliberations.	1		1	4	4	3.3
The Board is composed of members with optimal subject matter expertise and appropriate competencies.			1	7	2	3.1
The Board actively cultivates new candidates to form a pipeline of potential candidates who are qualified based on defined, competency-based criteria.	1		2	5	2	3.0

Relationship with Management

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
On an annual basis, the Board effectively assesses the performance of the Chief Executive Officer.				5	5	3.5
The Board has an effective working relationship with the Chief Executive Officer and leadership team.				5	5	3.5
The Board has a defined procedure in place for establishing the Chief Executive Officer's yearly objectives.			1	6	3	3.2
The Board and management exhibit mutual trust and respect and foster transparency in the working relationship.				8	2	3.2
Management provides high quality board materials, with the appropriate level of detail, to enable the Board to effectively carry out its oversight responsibilities.		1		6	3	3.1

Execution of Board's Oversight Responsibilities

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Board effectively assesses the organization's financial performance in relation to its goals.				4	6	3.6
The Board has established procedures to effectively oversee quality.				5	5	3.5
The Board carefully reviews quality and patient care.				6	4	3.4
The Board understands the mission and vision and reflects these understandings on key issues throughout the year.				6	4	3.4
The Board, through its committees, provides effective oversight in the key areas of Compliance and Audit; Finance; Investment; Executive Compensation; Governance; Quality, Patient Care and Patient Experience				6	4	3.4

Execution of Board's Oversight Responsibilities, continued

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The organization's strategic planning processes are effective, and the Board provides appropriate input into the strategic planning process, taking into account all key stakeholders.				8	2	3.2
The Board has an effective mechanism in place for resolving potential conflicts of interest.			2	6	2	3.0
The Board frequently evaluates the organization's performance in relation to community healthcare needs.			3	5	2	2.9
On an annual basis, the Board effectively deliberates on and approves appropriate performance goals.			2	7	1	2.9

Committee Effectiveness

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
The Board has the proper number of committees representing specific issues of specialized expertise.				7	3	3.3
Committee Members have the experience to serve effectively.				7	3	3.3
The Committees have strong leadership.				8	2	3.2
During the course of the year, the Board effectively monitors performance against its goals and provides feedback regarding any needed course correction, including through regular reports of the appropriate committees tasked with specific oversight responsibilities.			1	6	3	3.2

Committee Effectiveness, continued

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
Committee agendas are prepared and circulated timely and contain all pertinent information, minutes are taken accurately, and informational and logistical support are provided by management and outside advisors.				8	2	3.2
The current committee structure and operating procedures are effective.				9	1	3.1
Board Members are organized properly into appropriate committees based on background and expertise of each member.			2	7	1	2.9

Self-Reflection on Your Contributions to the Board

Question	Distribution of Scores					
	N/A / Unknown	Strong Disagree "1"	Disagree "2"	Agree "3"	Strongly Agree "4"	**Average Score**
I prepare for and actively participate in Board Meetings as well as other activities expected of me as a Board Member.				3	7	3.7
I understand what the Board expects of me in my role as a member and the function, role, and responsibilities of being a Board Member.				4	6	3.6
I find serving on the Board to be a satisfying and rewarding experience.				4	6	3.6
I have a positive working relationship with hospital management and staff.				5	5	3.5
I have a positive working relationship with other Board Members.				7	3	3.3
As a Board Member, my expertise and experience are being fully leveraged.			2	6	2	3.0

SpencerStuart

APPROVED BY ECHB

FY 24 Organizational Performance Incentive Score

FY-2024 PRELIMINARY ORGANIZATION SCORE *Subject to Modification Pending Finalization of EBIDA Margin per Annual Audit*

True North Pillar	Weight	OBJECTIVES/OUTCOMES	Benchmark		Measurement Defined			Measurement Period	Results	Score	Weighted Score
			Internal Benchmarks	External Benchmark	Minimum	Target	Stretch				
Threshold		Maintain positive EBIDA Margin	FY2022: 21.1% FY2023: 17.8% FY2024(B): 15.1%	Moody's: Median for 'Aa3': 8.7% S&P Median for 'AA': 11.0%	≥ 12.08% Operating EBIDA $187.2 million (80% of budget)			FY2024	**Met threshold (108.4% of budget)**		N/A
Quality and Safety	**25%**	**HAC Index**	FY2023 HAC 2.0 Baseline = **1.453**	Benchmarked through CMS and Leapfrog metrics	2% Improvement from FY2023 baseline **1.213**	3% Improvement from FY2023 baseline **1.201**	4% Improvement from FY2023 baseline **1.188**	FY2024	**0.985**	**150.0%**	**37.5%**
Service	**25% (Hospital)**	**Likelihood to Recommend (LTR) - Inpatient**	FY2023: **78.5**	Press Ganey	74.7 (76th percentile)	76.4 (80th percentile)	78.1 (84th percentile)	FY2024	81.9 (86th percentile)	**150.0%**	**37.5%**
People	**25% (Managers)**	**Culture of Safety Engagement Score**	FY2023: **3.98**	2023 National Average = 3.95	3.95	4.00	4.02	FY2024	**4.05***	**150.0%**	**37.5%**
Finance	**25%**	**Operating EBIDA**	FY2023: $256.9M	Moody's: Median for 'Aa3': 8.7% S&P Median for 'AA': 11.0%	$221.0M	$233.0M	$245.0M	FY2024	**252.5M**	**150.0%**	**37.5%**
								PROPOSED ORGANIZATION SCORE:			**150.0%**

** No %ile data available*

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, September 11, 2024

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

Board Members Present
Bob Rebitzer, Chair
Jack Po, MD, Ph.D., Vice-Chair
John Zoglin, Secretary/Treasurer
Wayne Doiguchi
Julia E. Miller
Carol A. Somersille, MD
George O. Ting, MD
Don Watters

Board Members Absent
Lanhee Chen, JD, PhD
Peter Fung, MD

Others Present
Dan Woods, CEO
Mark Adams, **MD**, CMO
Carlos Bohorquez, CFO
Omar Chughtai, CGO**
Shahab Dadjou, President, ECHMN
Theresa Fuentes, CLO
Mark Klein, CC&MO
Tracey Lewis Taylor, COO
Shreyas Mallur, **MD**, CQO
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO

Others Present (cont.)
Steve Xanthopoulos, MD, MV Chief of Staff
Shahram Gholami, MD, LG Chief of Staff
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology

***via teleconference*

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:33 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. Directors Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, and Zoglin were present constituting a quorum. Directors Chen and Fung were absent.	***The meeting was called to order at 5:33 p.m.***
2. AB-2449 – REMOTE PARTICIPATION	No AB-2449 requests were received by the members of the Board.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board if any member had a conflict of interest with any items on the agenda. No conflicts were noted.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board. No members of the public were present.	
5. RECEIVE VERBAL MEDICAL STAFF REPORT	Dr. Xanthopoulos provided a verbal report. He acknowledged the previous chief's contributions and highlighted the importance of hospital-based specialties, including anesthesia, pathology, and radiology. He expressed gratitude for the board's support of these specialties and emphasized the need to continue monitoring their development. He stressed the importance of physician recruitment and retention, especially in hospital-based specialties. A key focus is on physician wellness, with an existing Wellness Committee that is expected to expand. Dr. Gholami was also present and agreed with what Dr. Xanthopoulos had summarized for the board.	

6. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 5:40 p.m. **Movant**: Miller **Second**: Po **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Recessed to closed session at 5:40 p.m.***
7. AGENDA ITEM 15: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:47 p.m., and Agenda Items 7-14 were addressed in the closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report was approved by a unanimous vote of all Directors present (Directors Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin).	***Reconvened Open Session at 7:47 p.m.***
8. AGENDA ITEM 16: JOINT VENTURE FOR PROJECT DEVELOPMENT OF REHABILITATION HOSPITAL	**Motion:** To approve the ECHB Resolution 2024-05. **Movant**: Miller **Second**: Po **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***ECHB Resolution 2024-05 was approved.***
9. AGENDA ITEM 17: CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Director Miller asked for item (b) to be removed and moved to closed session at the next meeting. **Motion:** To approve the consent calendar minus item (b). **Movant**: Po **Second**: Doiguchi **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None **Motion:** To move item (b) Closed Session Minutes to the closed session of the next meeting. **Movant**: Po **Second**: Doiguchi **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Action: Consent Calendar items (a) and (c) were approved.*** *Prior Open Minutes, Investment Advisory Firm Update* ***Action: Item (b) Closed Session Minutes will be moved to the closed session of the next board meeting.***

10. AGENDA ITEM 18: CEO REPORT	Mr. Woods provided the CEO report acknowledging El Camino Health was recognized in the 2024 list of Healthiest Employers in Northern California. Mr. Woods shared that, in July, the El Camino Health Foundation secured ~$5.1M in donations, which is 68% of the $7.7M goal for FY25 and the establishment of the Pauline and Ken Nist Critical Care Endowment deriving from the gift from Pauline Nist, in memory of her husband Ken. Mr. Woods announced that El Camino Health has entered an agreement with San Jose State University as the Official Healthcare Partner of San Jose State Athletics. Mr. Woods shared that the Hospital Auxiliary donated 3,601 volunteer hours for the month of July.	
11. AGENDA ITEM 19: BOARD ANNOUNCEMENTS	Director Miller noted that it was Hispanic Heritage Month and asked the Board to observe a moment of silence in recognition of the lives lost on September 11th, 23 years ago.	
12. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 7:53 p.m. **Movant**: Po **Second**: Ting **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Meeting adjourned at 7:53 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: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: Tracy Fowler, Director, Governance Services
Reviewed by Legal: Theresa Fuentes, Chief Legal Officer

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Carlos A. Bohorquez, Chief Financial Officer
Date: October 9, 2024
Subject: Financials: FY2025 - Period 2 (as of 08/31/2024) – Consent Calendar

Purpose:

To provide the Board an update on financial results for FY2025 Period 2 (August 2024).

Executive Summary – Period 2 (August 2024):

With the exception of outpatient visits / procedures, patient activity / volume shows a small YOY decrease.

- **Average Daily Census:** 295 which is 15 / 5.0% unfavorable to budget and 4 / 1.3% lower than the same period last year.
- **Adjusted Discharges:** 3,704 which are 85 / 2.2% unfavorable to budget and 117 / 3.1% lower than the same period last year.
- **Emergency Room Visits:** 6,638 which are 212 / 3.1% unfavorable to budget and 415 / 5.9% lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 12,522 which are 244 / 2.0% favorable to budget and 741 / 6.3% higher than the same period last fiscal year.

Financial performance for Period 2 was consistent with budget. This is attributed revenue improvement initiatives and negotiated managed care increases.

Total Operating Revenue ($):	$139.1M is favorable to budget by $1.1M / 0.8% and $10.0M / 7.8% higher than the same period last fiscal year.
Operating EBIDA ($):	$20.0M is consistent with budget and inline with the same period last fiscal year.
Net Income ($):	$37.4M is favorable to budget by $20.9M / 125.8% and $39.9M / 1654.6% higher than the same period last fiscal year.
Operating Margin (%):	8.2% (actual) vs. 8.0% (budget)
Operating EBIDA Margin (%):	14.3% (actual) vs. 14.4% (budget)
Net Days in A/R (days):	54.3 days are unfavorable to budget by 0.3 days / 0.5% and 4.1 days / 7.1% better than the same period last year.

Recommendation:

- Board receive FY2025 – Period 2 financials

List of Attachments:

- Period 2 FY2025 Financial Report

El Camino Health

Summary of Financial Operations

Fiscal Year 2025 – Period 2

7/1/2024 to 08/31/2024

Please Note: Period 2 / YTD results are pending review & approval by the Finance Committee

Operational / Financial Results: Period 2 – August 2024 (as of 08/31/2024)

($ 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	295	311	(15)	(5.0%)	299	(4)	(1.3%)	---	---	---	---
	Adjusted Discharges	3,704	3,789	(85)	(2.2%)	3,821	(117)	(3.1%)	---	---	---	---
	OP Visits / OP Procedural Cases	12,522	12,278	244	2.0%	11,781	741	6.3%	---	---	---	---
	Percent Government (%)	58.8%	58.4%	0.4%	0.7%	58.1%	0.7%	1.2%	---	---	---	---
	Gross Charges ($)	598,024	588,509	9,516	1.6%	541,360	56,664	10.5%	---	---	---	---
Operations	Cost Per CMI AD	20,304	20,032	271	1.4%	18,358	1,946	10.6%	---	---	---	---
	Net Days in A/R	54.3	54.0	0.3	0.5%	58.4	(4.1)	(7.1%)	48.1	49.7	47.5	
Financial Performance	Net Patient Revenue ($)	133,648	132,755	893	0.7%	123,779	9,869	8.0%	297,558	564,735	---	
	Total Operating Revenue ($)	139,079	137,991	1,088	0.8%	129,039	10,041	7.8%	389,498	610,593	268,739	
	Operating Margin ($)	**11,396**	**11,061**	**335**	3.0%	**11,634**	**(238)**	(2.0%)	**7,400**	**11,601**	**8,331**	
	Operating EBIDA ($)	**19,834**	**19,850**	**(16)**	(0.1%)	**19,843**	**(9)**	(0.0%)	**26,400**	**39,689**	**22,574**	
	Net Income ($)	37,446	16,585	20,862	125.8%	(2,409)	39,855	1654.6%	19,085	20,150	15,049	
	Operating Margin (%)	**8.2%**	**8.0%**	**0.2%**	2.2%	**9.0%**	**(0.8%)**	(9.1%)	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**14.3%**	**14.4%**	**(0.1%)**	(0.9%)	**15.4%**	**(1.1%)**	(7.3%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	279	275	4	1.4%	253	26	10.1%	258	304	311	

Moody's Medians: Not-for-profit and public healthcare annual report; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
Fitch Ratings: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; July 2024. Dollar amounts have been adjusted to reflect monthly averages.

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

El Camino Health

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

Operational / Financial Results: YTD FY2025 (as of 08/31/2024)

($ 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	291	305	(13)	(4.4%)	302	(11)	(3.6%)	---	---	---	---
	Adjusted Discharges	7,247	7,326	(79)	(1.1%)	7,288	(41)	(0.6%)	---	---	---	---
	OP Visits / OP Procedural Cases	24,695	23,165	1,530	6.6%	22,242	2,453	11.0%	---	---	---	---
	Percent Government (%)	58.2%	58.3%	(0.1%)	(0.1%)	58.9%	(0.7%)	(1.3%)	---	---	---	---
	Gross Charges ($)	1,159,922	1,126,622	33,300	3.0%	1,024,445	135,477	13.2%	---	---	---	---
Operations	Cost Per CMI AD	20,387	20,032	354	1.8%	18,671	1,716	9.2%	---	---	---	---
	Net Days in A/R	54.3	54.0	0.3	0.5%	58.4	(4.1)	(7.1%)	48.1	48.1	47.5	
Financial Performance	Net Patient Revenue ($)	262,124	259,947	2,177	0.8%	236,074	26,051	11.0%	595,117	1,129,469	---	
	Total Operating Revenue ($)	273,091	270,426	2,665	1.0%	246,754	26,337	10.7%	778,996	1,221,186	3,224,864	
	Operating Margin ($)	**21,753**	**20,206**	**1,546**	7.7%	**20,455**	**1,297**	6.3%	**14,801**	**23,203**	**99,971**	
	Operating EBIDA ($)	**38,638**	**37,809**	**829**	2.2%	**36,921**	**1,717**	4.7%	**52,801**	**79,377**	**270,889**	
	Net Income ($)	68,201	29,299	38,903	132.8%	25,896	42,305	163.4%	38,171	69,608	180,592	
	Operating Margin (%)	**8.0%**	**7.5%**	**0.5%**	6.6%	**8.3%**	**(0.3%)**	(3.9%)	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**14.1%**	**14.0%**	**0.2%**	1.2%	**15.0%**	**(0.8%)**	(5.4%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	279	275	4	1.4%	253	26	10.1%	258	304	311	

Moody's Medians: Not-for-profit and public healthcare annual report; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
Fitch Ratings: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; July 2024. Dollar amounts have been adjusted to reflect monthly averages.

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

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

Consolidated Balance Sheet (as of 08/31/2024)

($000s)

ASSETS		Unaudited
CURRENT ASSETS	**August 31, 2024**	**June 30, 2024**
Cash	229,246	202,980
Short Term Investments	101,410	100,316
Patient Accounts Receivable, net	224,081	211,960
Other Accounts and Notes Receivable	26,775	25,065
Intercompany Receivables	19,221	17,770
Inventories and Prepaids	50,625	55,556
Total Current Assets	**651,358**	**613,647**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	24,316	23,309
Plant & Equipment Fund	503,266	503,081
Women's Hospital Expansion	43,577	31,740
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	17,731	17,561
Workers Compensation Reserve Fund	13,871	12,811
Postretirement Health/Life Reserve Fund	22,918	22,737
PTO Liability Fund	37,646	37,646
Malpractice Reserve Fund	1,730	1,713
Catastrophic Reserves Fund	34,023	33,030
Total Board Designated Assets	**909,771**	**894,322**
FUNDS HELD BY TRUSTEE	**18**	**18**
LONG TERM INVESTMENTS	**708,935**	**665,759**
CHARITABLE GIFT ANNUITY INVESTMENTS	**997**	**965**
INVESTMENTS IN AFFILIATES	**35,856**	**36,663**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,019,945	2,016,992
Less: Accumulated Depreciation	(889,091)	(874,767)
Construction in Progress	183,882	173,449
Property, Plant & Equipment - Net	**1,314,735**	**1,315,675**
DEFERRED OUTFLOWS	46,737	41,550
RESTRICTED ASSETS	32,032	32,166
OTHER ASSETS	194,447	195,447
TOTAL ASSETS	**3,894,886**	**3,796,213**

LIABILITIES AND FUND BALANCE		Unaudited
CURRENT LIABILITIES	**August 31, 2024**	**June 30, 2024**
Accounts Payable	65,058	71,017
Salaries and Related Liabilities	50,287	35,693
Accrued PTO	39,754	38,634
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	13,365	13,419
Intercompany Payables	15,204	13,907
Malpractice Reserves	1,830	1,830
Bonds Payable - Current	6,898	10,820
Bond Interest Payable	1,535	7,673
Other Liabilities	15,630	12,261
Total Current Liabilities	**211,860**	**207,554**
LONG TERM LIABILITIES		
Post Retirement Benefits	22,918	22,737
Worker's Comp Reserve	12,811	12,811
Other L/T Obligation (Asbestos)	30,036	27,707
Bond Payable	443,713	441,105
Total Long Term Liabilities	**509,479**	**504,360**
DEFERRED REVENUE-UNRESTRICTED	**1,798**	**1,038**
DEFERRED INFLOW OF RESOURCES	**92,970**	**92,261**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,805,471	2,731,120
Minority Interest	(1,159)	(1,114)
Board Designated	224,667	216,378
Restricted	49,800	44,616
Total Fund Bal & Capital Accts	**3,078,779**	**2,991,001**
TOTAL LIABILITIES AND FUND BALANCE	**3,894,886**	**3,796,213**

El Camino Health

El Camino Health

BOARD OF DIRECTORS
Documents for Review
October 9, 2024

Department	Document Name	Revised?	Doc Type	Notes	Committee Approvals
New Business					
Administration	A18c1. Legal Holds Policy	New	Policy	1. None	• ePolicy • Board > Publish
Administration	A18c2. Post Disaster Business Continuity Plan	None	Plan	1. None	• Central Safety • ePolicy • MEC • Board > Publish
Environment of Care	A18c3. Environment of Care Performance Improvement Planning Procedure	Revised	Plan	1. Updated Procedure section	• Central Safety • PESC • ePolicy • MEC • Board > Publish
Advanced Care and Diagnostic Center	A18c4. Scope of Service – Advance Care and Diagnostic Center	None	Scope of Svc	1. None	• Med Dir • ePolicy • MEC • Board > Publish
Imaging Services	A18c5. Scope of Service – Imaging Services	Revised	Scope of Svc	1. Updated Sections: Appropriateness, Necessity and Timeliness of Services; Interpreting Physicians; Staffing/Skill Mix and Requirements; Hours of Operations	• Dept Med Dir • ePolicy • MEC • Board > Publish
Emergency Department	A18c6. Scope of Service Emergency Department – Mountain View	Revised	Scope of Svc	1. Updated Sections: Scop and Complexity of Services Offered; Appropriateness, Necessity and Timeliness of Service; Assessment Methods and Level of Services Provided; Staffing/Skill Mix; Standards of Practice	• Dept Med Dir • Med Dept Exec • ePolicy • MEC • Board > Publish
Infection Prevention	A18c7. FY2024 Infection Control Plan	Revised	Plan	1. Updated Sections: Updated all FY23 reference to FY24; Santa Clara County Geographic Location and Demographics subsections; Community TB Profile 2021; Seasonal Influenza Activity;	• Infection Prevention Committee • Med Dept Exec • ePolicy • MEC

				Threats facing Santa Clara County; Procedure; Reference	• Board > Publish
Security Management	A18c8. Environment of Care Security Management Plan	None	Plan	1. None	• Central Safety • PESC • ePolicy • MEC • Board > Publish
Security Management	A18c9. Security Services Scope of Services	None	Scope of Svc	1. None	• ePolicy • MEC • Board > Publish
Corporate Compliance	A18c10. Corporate Compliance Scope of Service	Revised	Scope of Svc	1. Minor update	• ePolicy • MEC • Board > Publish
Quality	A18c11. Policy & Procedure Formulation, Approval & Distribution (Policy on Policies)	Revised	Policy	1. Updated Procedure section	• ePolicy • Leadership Council • MEC • Board > Publish
Patient Experience	A18c12. Administration: Visitors Policy	Revised	Policy	1. Updated Procedure section	• ePolicy • MEC • Board > Publish
Employee Wellness	A18c13. COVID-19 Vaccine Plan	Revised	Plan	1. Updated Procedure section	• Infection Prevention Committee • Med Dept Exec • ePolicy • MEC • Board > Publish

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EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT I OCTOBER 9, 2024

FINANCE:

- **FY2025 Period 2 – August 2024**
  - **Total Operating Revenue**: $139.1M
    - $1.1M / 0.8% vs. Budget
    - $10.0M / 7.8% higher than the same period last year
  - **Operating EBIDA**: $20.0M
    - ($0.2M) / (0.1%) vs. Budget
    - $0.0 / 0.0% same as the same period last year
  - **Net Income**: $37.4M
    - $20.9M / 125.6% vs. Budget
    - $39.9M / $1654.6% higher than the same period last year

INFORMATION SERVICES: **Artificial Intelligence (AI) generated in-basket patient response messages** went live in 5 departments within ECHMN, improving efficiency. Studies have shown patients prefer the AI generated responses due to improved message quality and increased empathic message tone. ECH is in the **top 30th percentile** of healthcare organizations in a recent **cybersecurity industry benchmark** report related to the effectiveness of website browser security, a common vector for cybersecurity attacks. **Getwell**, the patient room entertainment and clinical platform on patient room TV's, is now integrated with the ECH dietary system, CBORD Nutrition, to provide interactive meal order capabilities to improve patient satisfaction and efficiency

FOUNDATION: In August, El Camino Health Foundation secured $655,286 in donations. This brings total funds raised through **Period 2 to $5.9M, which is 77% of the $7.7M goal for FY2025**. Our engagement with Huron|GG+A Global Philanthropy remains strong and starting Fall, **three leadership briefings** will be held with current and prospective major donors to share our progress and receive feedback

MARKETING + COMMUNICATION:

Since mid-July launch through August, the "Strong" brand awareness campaign has reached nearly **6M impressions** on various media outlets, with digital display advertising reaching over 20M impressions. Our top performing post for the period (8/16-9/15) was a LinkedIn video announcing **El Camino Health as the Official Healthcare Partner of San Jose State Athletics**

CORPORATE HEALTH: Concern has created **2024 Election Stress Campaign** to help employees navigate stress and difficult conversations at work via tip sheets and webinars. In October, The Chinese Health Initiative will host its annual in-person Chinese-Speaking Physician Network Appreciation Dinner with physicians from various specialties attending

GOVERNMENT RELATIONS + COMMUNITY PARTNERSHIPS: A special **reception for Congresswoman Anna Eshoo** was held at our Mountain View campus to pay tribute and to honor her years of service in Congress. With over 125 people attending, ECH thanked Congresswoman Eshoo for her decades of fearless advocacy to ensure that all Americans have access to high-quality healthcare services. El Camino Health and the City of Mountain View held a ribbon cutting ceremony to officially commemorate the completion of the **Cuesta Park Fitness Court**. El Camino Health's Community Benefit Program made **a $150,000 donation** to support the project

AUXILIARY: The Auxiliary donated **967 volunteer hours** for the month of August

A18a. DRAFT 2024-09-11 ECHB Minutes (Open)

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, September 11, 2024

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

Board Members Present
Bob Rebitzer, Chair
Jack Po, MD, Ph.D., Vice-Chair
John Zoglin, Secretary/Treasurer
Wayne Doiguchi
Julia E. Miller
Carol A. Somersille, MD
George O. Ting, MD
Don Watters

Board Members Absent
Lanhee Chen, JD, PhD
Peter Fung, MD

Others Present
Dan Woods, CEO
Mark Adams, **MD**, CMO
Carlos Bohorquez, CFO
Omar Chughtai, CGO**
Shahab Dadjou, President, ECHMN
Theresa Fuentes, CLO
Mark Klein, CC&MO
Tracey Lewis Taylor, COO
Shreyas Mallur, **MD**, CQO
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO

Others Present (cont.)
Steve Xanthopoulos, MD, MV Chief of Staff
Shahram Gholami, MD, LG Chief of Staff
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology

***via teleconference*

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:33 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. Directors Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, and Zoglin were present constituting a quorum. Directors Chen and Fung were absent.	***The meeting was called to order at 5:33 p.m.***
2. AB-2449 – REMOTE PARTICIPATION	No AB-2449 requests were received by the members of the Board.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board if any member had a conflict of interest with any items on the agenda. No conflicts were noted.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board. No members of the public were present.	
5. RECEIVE VERBAL MEDICAL STAFF REPORT	Dr. Xanthopoulos provided a verbal report. He acknowledged the previous chief's contributions and highlighted the importance of hospital-based specialties, including anesthesia, pathology, and radiology. He expressed gratitude for the board's support of these specialties and emphasized the need to continue monitoring their development. He stressed the importance of physician recruitment and retention, especially in hospital-based specialties. A key focus is on physician wellness, with an existing Wellness Committee that is expected to expand. Dr. Gholami was also present and agreed with what Dr. Xanthopoulos had summarized for the board.	

6. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 5:40 p.m. **Movant**: Miller **Second**: Po **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Recessed to closed session at 5:40 p.m.***
7. AGENDA ITEM 15: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:47 p.m., and Agenda Items 7-14 were addressed in the closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report was approved by a unanimous vote of all Directors present (Directors Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin).	***Reconvened Open Session at 7:47 p.m.***
8. AGENDA ITEM 16: JOINT VENTURE FOR PROJECT DEVELOPMENT OF REHABILITATION HOSPITAL	**Motion:** To approve the ECHB Resolution 2024-05. **Movant**: Miller **Second**: Po **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***ECHB Resolution 2024-05 was approved.***
9. AGENDA ITEM 17: CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Director Miller asked for item (b) to be removed and moved to closed session at the next meeting. **Motion:** To approve the consent calendar minus item (b). **Movant**: Po **Second**: Doiguchi **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None **Motion:** To move item (b) Closed Session Minutes to the closed session of the next meeting. **Movant**: Po **Second**: Doiguchi **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Action: Consent Calendar items (a) and (c) were approved.*** *Prior Open Minutes, Investment Advisory Firm Update* ***Action: Item (b) Closed Session Minutes will be moved to the closed session of the next board meeting.***

10. AGENDA ITEM 18: CEO REPORT	Mr. Woods provided the CEO report acknowledging El Camino Health was recognized in the 2024 list of Healthiest Employers in Northern California. Mr. Woods shared that, in July, the El Camino Health Foundation secured ~$5.1M in donations, which is 68% of the $7.7M goal for FY25 and the establishment of the Pauline and Ken Nist Critical Care Endowment deriving from the gift from Pauline Nist, in memory of her husband Ken. Mr. Woods announced that El Camino Health has entered an agreement with San Jose State University as the Official Healthcare Partner of San Jose State Athletics. Mr. Woods shared that the Hospital Auxiliary donated 3,601 volunteer hours for the month of July.	
11. AGENDA ITEM 19: BOARD ANNOUNCEMENTS	Director Miller noted that it was Hispanic Heritage Month and asked the Board to observe a moment of silence in recognition of the lives lost on September 11th, 23 years ago.	
12. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 7:53 p.m. **Movant**: Po **Second**: Ting **Ayes**: Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Meeting adjourned at 7:53 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: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: Tracy Fowler, Director, Governance Services
Reviewed by Legal: Theresa Fuentes, Chief Legal Officer

A18c1. Legal Holds Policy-History

Status **Pending** PolicyStat ID **16569235**

El Camino Health

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

Owner	Priya Shah: Associate Chief Legal Officer
Area	Administration
Document Types	Policy

Legal Holds Policy

COVERAGE:

This policy applies to all employees, vendors, and agents operating on behalf of El Camino Health.

PURPOSE:

The purpose of this Policy is to establish the necessary actions for the preservation of records, information, and data when there is an actual or reasonable anticipation of litigation, an audit, or an investigation or when a subpoena, claim, or discovery request is received (collectively “Legal Matters”).

This Policy addresses the operational steps and communication process to issue a Legal Hold notice for Legal Matters so that relevant ECH records, information, and data, whether paper-based or electronic, will be appropriately preserved during the extent of the Legal Hold.

POLICY STATEMENT:

It is the policy of ECH to preserve records, information, and data that are or will potentially be utilized in Legal Matters. It is furthermore the policy of ECH that is has the duty to preserve relevant records and information under a Legal Hold notice and suspend any normal destruction practices when there is a Legal Matter

In the event that a Legal Matter is received by ECH, ECH Legal Counsel (Legal Counsel), shall determine if a Legal Hold is required and, if so, the Legal Department will issue a Legal Hold notice. The Legal Hold notice shall remain in place until Legal Counsel advises that the duty to preserve the relevant records, information, and data no longer exists.

For guidance in carrying out the requirements of ECH Legal Hold process, please refer to the Procedure below.

DEFINITIONS:

A. Legal Hold – Also known as a litigation hold, a Legal Hold is a notice issued to all affected personnel communicating their legal obligation to preserve potentially relevant evidence that may be needed during the course of legal proceedings. This may be in the form of physical or electronically stored information.

REFERENCES:

PROCEDURE:

A. Legal Counsel identifies a potential "triggering" event and advises the identified individuals that a "duty to preserve" records and information exists. A potential "triggering" event can be:
    1. The receipt of a lawsuit, subpoena, discovery notice, etc.
    2. Verbal or written threat of litigation
    3. Knowledge of related investigations or litigation, and/or
    4. Reasonable anticipation of litigation or audit
    5. Alternatively, if a potential "triggering" event comes to the attention of another ECH employee prior to Legal Counsel, then such employee shall inform Legal Counsel (e.g., an internal administrative issue), then:
        a. Legal Counsel to determine whether a "duty to preserve" records and information exists.
        b. If it is determined that a "triggering" event necessitates a Legal Hold notice be issued, proceed to Step 2.

B. Determine scope of Litigation Hold
    1. Working with Legal Counsel, the Compliance Officer, and IT shall define which types of records and information are relevant to the Litigation Hold (i.e., need to be preserved)
    2. Identify ECH staff who may be in possession of relevant records and information or may have knowledge of the "triggering" event

C. Issue Legal Hold notice – Legal Department will send an email notice to all ECH staff affected by the Legal Hold. Attached to the email will be the ECH "Legal Hold Notice Form" for the specific Legal Hold (see Appendix A: Legal Hold Notice Form). Other or additional forms of communication will be used if required (e.g., formal letter, fax, etc.).
    1. Legal will send a copy of such notice to the Manager of Cyber Security Operations, with CC CISO and/or Deputy CISO ("Cyber") and other applicable parties.

D. Preservation of Records and Information

1. As required by the notice, Cyber will coordinate the placement of holds on required data (e.g. e-mail inboxes).
2. Cyber, in consultation with Legal Counsel, shall work with ECH staff, to determine the format and location of records and information to be preserved under the Legal Hold.
3. Cyber shall work with the ECH staff, IT, Operations, Risk, HR, and HIM Departments, and any other ECH departments and staff and/or outside vendors and contractors to ensure the preservation of records and information per the Legal Hold requirements.

E. Review of Legal Hold

1. It is necessary for the Legal Hold to be reviewed periodically, not to exceed 1 year, since the original Legal Hold issuance or last review.
2. If the Legal Hold review results in the release of the Legal Hold, proceed to Step 7.
3. If the Legal Hold review does not result in the Legal Hold being released, the Legal Hold shall remain in effect until a Release of Legal Hold is issued pursuant to Section 6.

F. Release of Legal Hold

1. Legal Counsel reviews Legal Hold circumstances to determine if the "duty to preserve" no longer exists (refer to Step 5).
2. The Legal Counsel will send email notice to all ECH staff affected by the Legal Hold notice currently or in the past. Attached to the email will be the ECH "Legal Hold Release Form" for the specific Legal Hold (see Appendix B: Legal Hold Release Form). i. Other or additional forms of communication will be used if required (e.g., formal letter, fax, etc.)
3. Cyber shall resume the application of routine retention to records that have not met their retention period. Cyber shall implement, at the appropriate time, the disposition process for any records that have met their retention period.
4. IT shall identify any data and/or backup tapes that can be deleted or destroyed per the normal retention process. Upon consultation with Cyber, IT shall delete and/or destroy the necessary data and backup tapes.

G. Compliance: If non-compliance with the Legal Hold notice is identified, the non-compliance incident should be:

1. Reported to the Legal Counsel,
2. Addressed by appropriate corrective actions and/or training, and
3. Properly documented (including any remedial steps).

H. Documentation: Proper documentation of the Legal Hold process is maintained by the Legal Department in ECH official records repository. Documentation may include:

1. The date of the Legal Hold issuance and by whom;
2. The initial scope of information and locations/systems involved;

3. Subsequent scope changes as new data is identified;
4. Original Legal Hold notice sent;
5. Legal Hold notice reminders sent;
6. Legal Hold notices sent to ECH staff added after the initial notice;
7. Confirmations of compliance (if applicable):
8. Handling of exceptions (if applicable);
9. Release of Legal Hold notice; and
10. Any additional documentation pertinent to issuing, managing, and releasing the Legal Hold.

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

Appendix A Legal Hold Notice Form.docx

Appendix B Legal Hold Release Form.docx

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
	Priya Shah: Associate Chief Legal Officer	09/2024

History

Created by Shah, Priya: Associate Chief Legal Officer on 9/11/2024, 3:45PM EDT

Last Approved by Shah, Priya: Associate Chief Legal Officer on 9/11/2024, 3:45PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 9/11/2024, 4:05PM

EDT

> Updated approval workflow and document type.

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 9/12/2024, 12:58PM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 9/16/2024, 12:12PM EDT

> ePolicy 9/13/24

A18c2. Post Disaster Business Continuity Plan-History

Status **Pending** PolicyStat ID **16085994**

Origination	09/2021
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2021
Next Review	3 years after approval
Owner	Matthew Scannell: Director Safety & Security Services
Area	Administration
Document Types	Plan

Post Disaster Business Continuity Plan

I. COVERAGE:

This Business Continuity Plan (BCP) is a strategic framework that applies to the operations and functions at all El Camino Health facilities, including the Mountain View and Los Gatos campuses and outpatient clinics. The BCP is intended to be activated after emergency conditions are stabilized and emergency response procedures have been implemented. The BCP provides a framework within El Camino Health's management structure to support the organization's leadership in making decisions to ensure the continued delivery of mission-critical services.

II. PURPOSE:

This Business Continuity Plan reflects the policy of El Camino Health to recognize the important role business continuity planning serves in ensuring the continuity of mission essential services after a wide range of emergencies and incidents. This plan builds upon the foundation of the robust emergency management environment at El Camino Health.

III. STATEMENT:

It is the policy of El Camino Health to maintain service delivery or restore services as rapidly as possible following an incident that disrupts those services. As soon as the safety of patients, visitors, and staff has been assured, the organization will give priority to providing or ensuring patient access to health care.

Business continuity planning is an integral aspect of emergency management and must be carried out, not only in response to, but proactively in preparation for potential business continuity disruptions.

Although preparing for major disasters or emergencies is important, it is equally important to prepare for emergencies that are less severe but more frequent. For example, in an average year, El Camino Health may likely be more affected by severe storms, fires, flooding, power outages, seasonal flu absenteeism or technological interruptions than a major disaster or terrorist incident. While risks and threats vary for each department, it is clear that the more prepared the organization is as a whole, the more effective its operational capability will be to maintain delivery of essential functions and services.

This policy describes the principles and processes required to develop and maintain robust business continuity arrangements for El Camino Health. Business Continuity Management will be driven by senior management who will ensure that risks that pose a threat to normal service delivery are identified and planned for. During a disruption, the short-term focus is the maintenance of critical functions whilst also forward planning to recover and resume business as usual as quickly as possible.

IV. RESPONSIBILITIES:

The hospital's leaders are involved in the planning activities and the development of the Business Continuity Plan.

- The Chief Operations Officer holds overall authority for the business continuity plan and will coordinate with various other key personnel to oversee implementation, maintenance, evaluation and revisions of the plan.
- The Emergency Management Committee is a group of multidisciplinary hospital representatives, including leadership, clinical and non-clinical representatives from key departments. The work of the Emergency Management Committee is the foundation upon which this BCP is built, and is responsible for keeping executive leadership updated on the activities and outputs upon which this BCP depends.
- Departmental leadership is responsible for participating in updates and training exercises.

V. CONTINUITY PLANNING:

Assumptions

This BCP is based on the following assumptions and considerations:

- The BCP is intended to be a dynamic tool that can be used in the aftermath of emergencies, disasters, and other disruptive events to guide efficient and effective decision-making as well as a proactive planning tool to drive risk mitigation efforts.
- Leadership has identified and prioritized the mission essential services of El Camino Health. From this information, more detailed plans and operational procedures can be developed through a regular program of personnel training, plan testing, and maintenance.
- Emergencies occurring within the hospital (internally), or within the community (externally), may affect the organization's ability to provide optimal care, treatment, and/or service.
- El Camino Health has an Emergency Operations Plan (EOP), which uses the Hospital

Incident Command System (HICS) as the management structure for command and control of an incident. The EOP includes references to this plan as part of making the transition period from incident response into recovery, before normal operations are able to fully resume.

Inputs

Emergency Management Planning

El Camino Health's Emergency Operations Plan (EOP) guides the organization in response to an emergency/disaster situation or a mass casualty incident. Continuity planning augments existing EOPs in order to strengthen the organization's resiliency in response to a range of events impacting operations.

Ongoing Updates

- El Camino Health currently conducts bi-annual emergency disaster drills. As part of the exercise, testing of the BCP by each department will be included in the objectives.

Regional Health Care System

Strong relationships have been established by El Camino Health between other hospitals and agencies within Santa Clara County. These regional partnerships includes sharing information and resources and opportunities to collaborate with each other in order to better identify and meet the needs of the regional health care ecosystem.

Hazard Vulnerability Analysis

El Camino Health conducts annual Hazard Vulnerability Assessments (HVAs) at each hospital campus in order to identify potential emergencies that could affect the ability of the organization to provide normal services. This assessment identifies the likelihood of those events occurring and the consequences of those events. Leadership reviews the results of the HVAs as part of the continuity planning process.

VI. CONTINUATION OF OPERATIONS

In the wake of a disruptive incident, decisions regarding the continuity of operations at El Camino Health are typically based on the following priorities:

- Incident response and stabilization
- Life-saving actions
- Property preservation
- Administration and financial business

Essential Functions of El Camino Health

The essential functions of the organization are fundamentally as follows:

Mission Essential Functions	
Provision of Patient Care	Building Safety Personnel Safety Health Care Providers and Staff Imaging/Laboratory Medication Management Furniture, Fixtures and Equipment Food, Drugs and Supplies
Direct Support for Health Care Service Delivery	IT & Communications Systems Security Environmental Services Sterile Processing
Indirect Support for Health Care Service Delivery	Human Resources Support Legal, Risk and Compliance Revenue Cycle Procurement Accounting and Payroll Marketing and Public Relations Health Information Management Administrative Support

Decision-Making Considerations

General assumptions include:

- Emergencies and threatened emergencies will differ in priority and impact.
- Structural integrity of facilities must be assessed/evaluated if compromised.
- The loss of equipment, supplies, and personnel must be assessed/evaluated.
- Mutual aid with other regional health care providers located outside the area affected by the emergency or threat will be available as necessary to help provide Essential Functions.

Recovery Strategies

Each department leader is responsible for developing and planning their department's individual recovery strategies and resources to support the identified essential services. These plans should include considerations necessary for the support and the provision of care, including:

- Facilities;
- Workforce; and
- Equipment and Supplies.

At a minimum, these plans should be reviewed and updated on an annual basis and as needed.

Assessment of Community/Facility Critical Infrastructure

El Camino Health depends upon critical infrastructure – including power, water, and sanitation capabilities – in order to support patient care environments for the provision of health care.

In the event of a disruptive event, El Camino Health's facilities team will assess the extent of disruption/loss/damage of facility critical infrastructure, including:

- Electrical System
- Water System
- Ventilation
- Fire Protection System
- Fuel Sources
- Medical Gas & Vacuum Systems
- Communication Infrastructure

El Camino Health will prioritize restoration efforts to meet the operational goals of its health care service delivery.

Workforce – Adjustments and Recovery

El Camino Health must be able deploy a credentialed health workforce to provide patient care to support healthcare service delivery in all environments.

Absenteeism after a disaster may increase due to:

- Personal injury/illness or incapacitation of staff or family members.
- Inaccessibility of clinical locations.
- Employees under home quarantine or isolation as a result of state-ordered curfew.
- Employees caring for children dismissed from schools.
- Employees self-quarantining out of safety concerns.

In the event of a disruptive event, as necessary El Camino Health will:

- Identify medical and nonmedical staffing shortages;
- Define resource requirements to recall additional staff incrementally to assist in

continuity operations;

- Coordinate with contracted staffing agencies to increase availability of critical medical staff;
- Integrate credentialed, licensed, independent practitioners into continuity medical operations;
- Coordinate with volunteer groups to supplement medical & non-medical personnel; and
- Disseminate reports of staffing shortages to local incident management & state health authorities.

VII. ORDER OF SUCCESSION

El Camino Health has established and maintains Orders of Succession for key positions in the event leadership is incapable of performing authorized duties. The designation as a successor enables that individual to serve in the same position as the principal in the event of that principal's death, incapacity, or resignation.

All persons (by position) listed will have full, unlimited authority to operate in the position they are assuming to the fullest extent possible until such person is relieved by the next highest-ranking individual.

Business Operations Succession Plan		
Key Position	**Successor 1**	**Successor 2**
Chief Executive Officer	Chief Operations Officer	Chief Financial Officer
Chief Operating Officer	Chief Nursing Officer	Chief Administrative Services Officer
Chief Medical Officer	Associate Medical Officer (MV)	Associate Medical Officer (LG)
Chief Financial Officer	Controller	Director of Finance
Chief Nursing Officer	Senior Nursing Director	Nursing Director
Chief Administrative Services Officer	Director of Facilities	Manager of Facilities
Chief Information Officer	Director of Technical Services	Director of Administration (IT)

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	06/2024
	Matthew Scannell: Director Safety & Security Services	06/2024

History

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> Approved

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> MEC 8/22/24

A18c3. Environment of Care Performance Improvement Planning Procedure-History

Status **Pending** PolicyStat ID **13281685**

Origination	03/1997	Owner	Matthew Scannell: Director Safety & Security Services
Last Approved	N/A	Area	Environment of Care
Effective	Upon Approval	Document Types	Procedure
Last Revised	08/2024		
Next Review	3 years after approval		

Environment of Care Performance Improvement Planning Procedure

COVERAGE:

El Camino Hospital employees, medical staff, and volunteers

PURPOSE:

To assess the effectiveness of the management plans that shape the Safety Program, to assess the effectiveness of the goals and objectives and to improve the Environment of Care.

STATEMENT:

The objectives, scope, performance, and effectiveness of the Safety Program will be evaluated annually.

PROCEDURE:

A. Design (Plan as follows):

1. Measurable performance standards are developed by the work group for each key component of the Safety Program for Managing the Environment of Care. These performance indicators are determined through review and analysis of aggregate data provided to the Central Safety Committee and as required by accreditation and federal, state and local regulations. Specifically, written reports are presented to the Board of Directors, CEO and Department Directors that outline safety issues, activities and trends including areas of improvement.
2. Monthly and quarterly review of indicators and performance criteria from each of the

key components of the safety program are reported through the safety trends report. Critical incidents, variances, or sentinel events for each area are identified.

3. Review of each key component work group's report of problems, identified needs, recommendations, actions taken and effectiveness of action taken by Central Safety Committee members.
4. Annual evaluation of each of the Safety Program's key components through review and analysis of performance criteria and key indicators.

B. Measurement:

1. Performance measurement of the Safety Program for Managing the Environment of Care is based on the safety trend indicators outlined below.
2. The Safety Indicators are provided to and reviewed by the Central Safety Committee at least quarterly.

a. SAFETY MANAGEMENT

1. Employee Safety

- Total Injury/Illness Reports
- OSHA Recordable Injury/Illness
  - Lost Time
  - No Lost Time
- Repetitive Motion Injury (RMI) – Computer, keyboard, mouse
- Repetitive Motion Injury (RMI) – Non-Computer
- Patient Handling Injuries
- Trip/Slip/Fall (all incidents reported)
- Staff Assaults by Patients

2. Infection Control

- Blood & Body Fluid Exposures
  - Percutaneous
  - Skin/Mucus Membrane Contact
- TB Conversion Rate

b. SECURITY MANAGEMENT

- Code Gray Incidents
  - Composite Code Gray Score
- All Security Incidents Codes
  - Code Red
  - Code Blue

- Code Gray
- Code Silver
- Code Active Shooter
- Code Pink
- Code Purple
- Code Orange
- Code Yellow
- Code Green
- Code Triage

c. HAZARDOUS MATERIAL MANAGEMENT
   - Reportable Hazardous Material Incidents
   - Recordable Hazardous Material Incidents
   - Waste Water Discharge Violations

d. FIRE SAFETY MANAGEMENT
   - Fire Incidents - Actual
   - Fire Alarm Events
   - Fire Watches
   - Fire Drills Completed/Scheduled
     - Fire Drill Corrective Actions, Assigned/Completed
   - ILSM Tracking

e. MEDICAL EQUIPMENT MANAGEMENT
   - Reports to FDA
   - PM Completion Rate
   - ECH (Clinical Engineering)
     - Laboratory
     - Dialysis
     - Radiology
   - Product & Equipment Recalls

f. UTILITIES MANAGEMENT
   - Utility Reportable Incidents
   - PM Completion Rate
   - Generator Test
   - Egress Lighting Monthly/Annual Test

C. Assessment:

- Assessment is conducted through the analysis of aggregate data and of critical or sentinel incidents/events from quarterly reports and safety trends reports to determine:
    a. If functions and processes are well-designed
    b. The level of performance of designated functions and processes
    c. The level of improvement in functions and processes
    d. The actions necessary to improve functions and processes
    e. The effectiveness of the actions taken
    f. When applicable, statistical methods are utilized, and comparisons are made with best practices, industry benchmarks, previous experience or targets.

D. Improvement:

1. Opportunities for improvement are continuously evaluated and implemented. The plan is reviewed annually and improved based on system priorities and changes in customer requirements.
2. The Central Safety Committee targets priorities for improvements in safety program processes and outcomes.
3. Each Environment of Care Work Group assesses its program and recommends redesign for improvements.
4. Improvements are targeted for areas that most strongly affect the cost and quality of the environment of care, and are consistent with the mission, vision, values and strategic objectives of the hospital.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2024

Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	04/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	04/2024

History

Draft saved by Weirauch, Steve: Mgr Environmental Hlth&Safety on 12/8/2020, 11:27AM EST

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> The previous owner's account (*Daniel Peck: Mgr Environmental Hlth&Safety*) was deactivated, so all of their responsibilities were transferred to *Matthew Scannell: Director Safety & Security Services*.

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> Updated Procedure B (2-b) per ePolicy recommendation.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 7/16/2024, 1:33PM EDT

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> Updated code incident w/ cross reference hyperlinks.

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> MEC 8/22/24

A18c4. Scope of Service - Advanced Care and Diagnostic Center-History

Status **Pending** PolicyStat ID **16140962**

Origination	02/2020
Last Approved	N/A
Effective	Upon Approval
Last Revised	02/2020
Next Review	3 years after approval
Owner	Shabnaz Taherkhani: Manager Service Line Ops
Area	Scopes of Service
Document Types	Scope of Service/ADT

Scope of Service - Advanced Care and Diagnostic Center

Scope

The Advanced Care and Diagnostic Center Scope of Service is provided by ECH to ensure that all patients treated will receive high quality care in an expedient and professional manner. Performance standards and quality initiatives are in place to measure outcomes and meet patient and clinician needs. Patient reports and exam records can be accessed upon request and are stored indefinitely as part of the patient's Electronic Health Record (EHR). The center provides comprehensive and coordinated care to outpatient adults, eighteen years of age and older. The Advanced Care and Diagnostic Center focuses on risk factor assessment and treatment of patients through consultation and care plans. Patients will be consulted by a licensed clinician, either a Physician or Nurse Practitioner (NP). In addition to consultation services, the center has diagnostic services to support EEG, EKG, and Echocardiography.

Patient Types

Consultation and diagnostic exams are performed on outpatient patients. Patient age groups served are adults 18 years and older.

Diagnostic studies are performed upon receipt of a written or electronic request from a physician or licensed independent practitioner.

Scope and Complexity of Services Offered

The Advanced Care and Diagnostic Center is located at 2500 Grant Road, Sobrato Center, Suite 1F, Mountain View, California. The Center's operating hours are Monday – Friday from 8am to 5pm. The Center is not open on weekends or holidays recognized by El Camino Hospital. Physicians are not

available after the Center's operating hours and patients are instructed to contact their primary MD if needed during those hours or to go to the Emergency Room if in need of urgent attention.

The Advanced Care and Diagnostic Center has exam rooms for clinical examinations (no procedures are performed). The clinical schedule and patient records are maintained in an electronic health record by trained staff.

The following services are provided:

- Patient education
- Prescribing oral medications
- Referral for diagnostic testing and procedures when appropriate

Diagnostic Modalities provided at the center are:

- Echocardiography
- ECG
- EEG

ECG, EEG, Echocardiography Specifics

Muscles in the heart carry electrical charges which change as the heart beats. These changes are recorded as an Electrocardiogram. The terms EKG and ECG are synonymous and are often used interchangeably, though ECG is the newer and preferred term.

EEGs record brain-wave activity through electrodes attached to the scalp and transcribes electrical activity in the brain.

Echocardiography utilizes ultrasound waves to visualize the functional or non-functional movements of the heart.

Services Available:

- Routine Outpatient ECGs
- Routine Outpatient EEGs
- Routine Outpatient Transthoracic Echocardiography

Patient care is given as directed and prescribed by the Physician or Nurse Practitioner. The medical staff working in the Advanced Care and Diagnostic Center will have hospital privileges on file in the El Camino Hospital Medical Staff Office. Staff communicates specific patient needs and coordinates treatment and plan of care with referring and consultative physicians. Services provided according to ECH policies and procedures.

Staffing/Skill Mix

A Clinical Manager (RN) oversees the clinical operations of the Advanced Care and Diagnostic Center. Physicians and a Nurse Practitioner provide direct care and assessment.

The Service Line Manager of Neurosciences oversees the Diagnostic Services Operations. The Manager

is supported by the Clinical Manager, Director of HVI, and Director of Neurosciences. The daily work of each modality is organized by the Charge Technologist in each modality and/or shift.

The competency of the staff is evaluated through observation and performance and skills competency validation. Staff education and training is provided to assist in the achievement of performance standards.

Requirements for Staff

- All staff must complete specific orientation
- All staff must review annual Healthstream safety series as well as Safety/Emergency policies and procedures for ECH
- All clinical staff members are required to be Basic Life Support certified.
- All clinical staff will be licensed according to ECH policies and procedures and by the State of California.

Level of Service Provide

The level of service is consistent with ambulatory outpatient clinic. The Advanced Care and Diagnostic Center is designed to advocate for preventive health and treatment of various cardiac/neurovascular diseases, and to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a caring and enduring partnership between the care team, patients and the patient's family.

Standards of Practice

The Advanced Care and Diagnostic Center is governed by state regulations as outlined in Title 22, the Center for Medicare/Medicaid Services.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024

ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2024
Department Medical Director or Director for non-clinical Departments	Shabnaz Taherkhani: Manager Service Line Ops	07/2024
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History

Comment by Hanley, Jeanne: Policy and Procedure Coordinator on 11/5/2019, 1:41PM EST

> Please review for Friday's ePolicy meeting

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> MEC 8/22/24

A18c5. Scope of Service - Imaging Services-History-Changes

Status **Pending** PolicyStat ID **16348174**

Origination	02/2017
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2024
Next Review	3 years after approval

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

Scope of Service - Imaging Services

Scope:

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

Patient Types

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

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

Services Offered

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

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

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

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

Nuclear Medicine-Specifics

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

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

Interventional Radiology

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

Staffing Guidelines for Operating Room Coverage

At least two (2) radiologic technologists are scheduled to cover the operating room Monday through Friday until 4:30pm at the Mountain View campus, 3:30pm at the Los Gatos campus. After these times and on weekends, the department utilizes the OR call schedule for surgery cases. The surgery department will work very closely with the diagnostic charge tech or modality operations manager during the scheduling of exams that require radiological support.

Appropriateness, Necessity and Timeliness of Services

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

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

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

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

~~Radiologists~~

Interpreting Physicians

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

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

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

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

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

~~Mammography~~**Mammography Reports:**

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

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

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

date.

Modality Protocols:

All modality protocols are established based on current standards of practice and other key criteria, which include clinical indication, contrast administration, age, patient size and body habitus. In addition to these key criteria, CT Protocols include the expected radiation dose range.

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

Staffing/Skill Mix and Requirements

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

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

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

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

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

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

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

make recommendations regarding radiation exposure factors, ACR quality guidelines, and quality analysis.

Radiation Safety Officer (RSO) AND Radiation Safety Committee:

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

Clinical Engineering (Imaging Services Equipment):

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

Standards of Practice

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

Security Considerations

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

Hours of Operation

Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On–Call Services	
Diagnostic Imaging	24/7	**Mountain View Campus** M - F: 7am - 7pm Sat: 8a - 4p	None	OR Cases or Influx of Patients	
		Los Gatos Campus M - F: 7am - 7pm			
Computed Tomography	24/7	**Mountain View Campus** M - F: ~~8~~7am to ~~7~~10pm Sat: 8:30am - ~~11am~~4:30pm	None	N/A	
		Los Gatos Campus M - F: 7:30am - ~~7~~10:30pm Sat: 8:30am - 12pm			

Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On–Call Services				
Ultrasound	24/7	**Mountain View Campus** M – F: 8am -~~3~~ 4:30pm	**Mountain View Campus** None	Stat US in order of priority: 1. Suspected Ruptured AAA, aortic aneurysm 2. Scrotal US: torsion, pain 3. Pelvic US: ectopic, ruptured ectopic, torsion, bleeding in pregnancy				
		Los Gatos Campus M - F: 8am - ~~6:30~~10pm *excludes holidays	**Los Gatos Campus** Sa/Su: 7am - 12am					
Magnetic Resonance Imaging	24/7	**Mountain View Campus** M - F: 8am - ~~5~~7:30pm S: 8am - 4:30pm	**Mountain View Campus** None	*MV & LG ED physicians triage and prioritize requests. Stat MRI in order of priority:* 1. *R/O cord compression* 2. *Stroke/Bleed* 3. *Compression fracture spine* 4. *Appendicitis in pregnant patients* 5. *Others as they come on first come first serve*				
		Los Gatos Campus M - F: ~~8~~7am - 10:30~~am - 7~~pm	**Los Gatos Campus** Sa/Su: 10a - 6p					
Mammography	N/A	**Mountain View Campus** M - F: 7:30am - 4:30pm	N/A	*N/A*				
		Los Gatos Campus ~~M - F~~Select Fridays: 8am - ~~7:00~~3pm						
~~**Nuclear Medicine**~~	**Nuclear Medicine**	M - F: 7am - 3:30pm	**Mountain View Campus**	~~M - F: 8am - 3:30pm~~	~~Sa/ Su:~~	~~*GI Bleed*~~	Sa/ Su:	*GI Bleed*

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

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]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Department Medical Director or Director for non-clinical Departments	Aletha Fulgham: Dir Diagnostic Imaging Svcs	08/2024
	Aletha Fulgham: Dir Diagnostic Imaging Svcs	08/2024

History

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> Minor changes to verbiage and operating hours.

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> Updating Area to Imaging Services

A18c6. Scope of Service Emergency Department-Mountain View-History-Changes

Status **Pending** PolicyStat ID **15944917**

Origination	11/2018	Owner	Rita Thomas: Dir Interventional Services
Last Approved	N/A	Area	Emergency Department
Effective	Upon Approval	Document Types	Scope of Service
Last Revised	09/2024		
Next Review	3 years after approval		

Scope of Service Emergency Department- Mountain View

Ages and Population Served:

Emergency Services provides care for individuals of all ages across a multi-cultural and diverse socio-economic population. Care is offered for physical or emotional alterations in health that is episodic and usually acute.

Scope and Complexity of Services Offered:

ECH Emergency Department (ED) is a non-trauma designated Level II basic emergency medical service. The scope of emergency practice encompasses assessment, diagnosis, treatment and evaluation of progress. Reassessment is an integral part of the ongoing patient evaluation process. Service includes the care of patients of every age who present with a broad spectrum of disease or injury. Resolution of problems may require minimal care, advanced life support measures, patient and family education and appropriate referral. The patient can expect to have ~~his/her~~their physical and psychosocial needs addressed.

The spectrum of services includes ~~care for~~:

- ~~Critically ill or injured infant, pediatric, child and adult population~~
- General pediatric designation (the ability to care for and stabilize critically ill or injured infant, children and adolescents population prior to transfer to a comprehensive pediatric receiving facility).
- Caring for critically ill or injured adults.
- ~~Urgent~~Treatment of medical needs requiring intervention or pain management
- ~~Minor injuries; Minor injuries in the Fast Track Service (MV)~~Treatment of minor injuries

- Treatment ~~for the~~of injured ~~worker~~employees/workers compensation cases
- Crisis intervention provided by the ED, and Social Services in consultation with the psychiatric services team at ECH-MV staff for patients with psychiatric disorders ~~or problems~~
- Patients seeking help ~~for~~with drug and alcohol addiction; evaluation, admission for detoxification, or referral by a Social Services counselor to an appropriate program
- ~~Obstetric~~Peri-natal patients presenting with problems related to pregnancy ~~(16 weeks gestation or greater, are referred to Labor & Delivery).~~
    - Medical Screening Exam (MSE) is to be preformed on all patients presenting to the ED
    - 16 weeks gestation or greater, are referred to Labor & Delivery

The department provides medical care as prescribed by the medical staff while observing practices and procedures of the hospital. In addition to the hospital practices, guidelines are further defined by the ~~use of the~~ Emergency Services Policies and Procedures, Standards of Patient Care and Collaborative Practice Guidelines, and the Clinical Practice Standards.

Appropriateness, Necessity and Timeliness of Service:

~~Ambulatory~~All patients ~~will~~ receive care based on the Emergency Severity Index (ESI), Five Level Triage priority system after assessment by the Registered Nurse (RN) at triage. Following ~~brief~~ triage, a Medical Screening Examination (MSE) is performed by a Physician ~~or~~, Physician Assistant (PA), or Nurse Practitioner (~~MV~~NP). Further assessment and treatment is provided by the primary care nurse (RN) in collaboration with the physician or PA/NP. In the event of a disaster, refer to Mass Causality Incident (~~MV~~MCI) ~~on admission to the department~~policy. ~~Patients arriving by ambulance will receive the same ratings based on assessment of the nurse. physician or PA (MV) on admission to the department. The Emergency Services Clinical Manager, Medical Director and charge nurses will assess the appropriateness, necessity and timeliness of the service.~~

Assessment Methods and Level of Service Provided:

The Emergency Department uses a multi-disciplinary team approach for patient assessment and treatment. ~~Initial assessment will occur in the~~All patients are triaged to determine the severity of illness or injury. El Camino Hospital utilizes a five level urgency category triage ~~area for ambulatory patients and in the department for patients arriving by ambulance~~system as defined below. ~~All patients are triaged to determine the severity of illness or injury by the RN,Physician, or PA (MV). El Camino Hospital utilizes a five level urgency category triage system as defined below:~~

~~**LEVEL 1:** Immediate care required patient unstable; life or limb-threatening illness or injury present, emergent condition~~

- ~~Nurse ratio requirement: 2:1 or 1:1 (RN to patient)~~
- ~~Assessment/Reassessment: continuous~~

- ~~Examples: Cardiac arrest, seizures, major trauma, severe respiratory distress, major burn, unconscious, patient chemical exposure requiring decontamination~~

~~**LEVEL 2:** Immediate Care required patient stable; potentially life-threatening~~

- ~~Nurse ratio requirement: 1:1 or 1:2 (RN to patient)~~
- ~~Assessment/Reassessment: every 30 minutes x 4 times; then every 60 minutes until patient leaves Emergency Department.~~
- ~~Examples: Chest Pain, respiratory distress, severe pain, surgical abdomen, fever with hypotension, severe hypertension, stroke alert, trauma with possible C-spine injury, minor burns, open fractures, anaphylaxis, uncontrolled bleeding,~~

~~**LEVEL 3:** Delayed care patient stable; non-life threatening illness or injury but condition presents danger if not treated within two hours, condition urgent~~

- ~~Nurse ratio requirement: 1:4 (RN to patient)~~
- ~~Assessment/Reassessment: upon arrival, every 60 minutesx2; then every two hours until patient leaves Emergency Department.~~
- ~~Examples: moderate pain, closed fracture, drug ingestions longer than 3 hours and asymptomatic, crisis intervention~~

~~**LEVEL 4:** Fast Track (MV), Routine care required, condition minor, not expected to worsen over the next two hours assessment and discharge instructions provided by MD.~~

- ~~Nurse ratio requirement: 1:4 (RN to patient)~~
- ~~Reassessment: provided by PMD or on scheduled return visit~~
- ~~Examples: minor suture, rash, abrasion, minor flu symptoms, eye irritation, simple sore throat, simple ear pain, uncomplicated flu-like symptoms~~

~~**LEVEL 5:** Fast Track (MV), Routine care, condition minor, assessment and discharge instructions provided by MD.~~

- ~~Nurse ratio requirement: 1:4 (RN to patient)~~
- ~~Reassessment: not necessary or referral to PMD~~
- ~~Examples: prescription refills, suture removals~~

~~All patients receive a Medical Screening Examination (MSE) by a licensed provider. The MSE is performed bya physician, or PA (MV).. The Physician plan of care is initiated by a RN for all patients in triage Levels 1-3, utilizing Collaborative Practice Guidelines in conjunction with the physician. Physicians, PAs (MV), or RNs provide direct supervision to the Emergency Department Technicians (MV). Nursing staff monitor and evaluate the patient's progress toward expected outcomes. Reassessment of the patient is an integral part of the ongoing patient evaluation processes.~~

*Attachment A_ ESI Defined Resources

ESI LEVEL 1: **Immediate life-saving intervention is required**

- Appropriate nurse to patient ratios will be maintained dependent on patient stability

- Assessment and reassessment is based on patient condition.

ESI LEVEL 2: High risk situation that could lead to deterioration

- Appropriate nurse to patient ratios will be maintained dependent on patient stability
- Assessment and reassessment is based on patient condition.

ESI LEVEL 3: Resource driven acuity requiring two or more ESI defined resources

- Appropriate nurse to patient ratios will be maintained dependent on patient stability
- Assessment and reassessment is based on patient condition.

ESI LEVEL 4: Resource driven acuity requiring one ESI defined resource

- Appropriate nurse to patient ratios will be maintained dependent on patient stability
- Reassessment may not be necessary. Patient may be referred to primary MD for a return

ESI LEVEL 5: Resource driven acuity requiring no ESI defined resource

- Appropriate nurse to patient ratios will be maintained dependent on patient stability
- Patients waiting in the waiting room for extended periods of time should be reassessed based on the patients condition and acuity.

Staffing/Skill Mix:

The Emergency ~~Services~~Department is staffed ~~24 hours a day, seven days a week~~at all times by physicians, PAs ~~(MV)~~, NPs, RNs, Emergency Technicians ~~(MV)~~, and administrative support staff. All ~~Emergency Services~~ED RNs are certified in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). The nursing staff's competency ~~of the nursing staff~~ is evaluated through observation of performance and skill competency. Staff education and training is provided to achieve a standard of performance that reflects an acceptable level of expertise and understanding of ongoing changes in practice.

~~Nurses assigned to~~Charge and triage ~~and charge~~ nurse ~~responsibilities~~ have additional training required to function in these roles. ~~ED Technicians (MV) function within their scope of practice under the direction of the RNs.~~

ED Technicians (MV) support the medical and nursing care. All technicians ~~have had previous experience in ED care or as a corpsmen, emergency medical technician, paramedic, or~~are certified ~~nursing assistant. All technicians are certified~~ in Basic Life Support (BLS) and validated annually in basic competencies as outlined by the Emergency Nurses Association, *"Guidelines for Emergency Department Technicians"*.

Behavioral Health Worker (BHW) provides services to support patients in the treatment environment, primarily focused on the provision of safety. The BHW maintains constant observation and conducts safety checks on mental health and addiction services patients patients under the direction of the RN.

Staffing is based on ~~a core staff required to cover~~covering all ~~the~~ nursing care areas ~~of care~~in the department. This is outlined in the Emergency ~~Services~~Department Unit Description and Organization.

The number of staff and the skill mix varies by the time of day. Core staffing is based on data analysis of patient arrival times and history of the overall patient visit levels and trends. ~~Further~~Appropriate, ~~staffing is consistent with the California Assemble Bill 384 requiring a minimum Emergency Department staffing core of 1 Nurse to every four patients (1:4 ratio)~~safe nurse to patient ratios will be maintained. The number of staff and the skill mix varies by the time of day and triage acuity of the patient~~:~~.

- ~~Level 1 Immediate = 1:1 or RN staffing~~
- ~~Level 2 Immediate = 1:1 or 1:2 RN staffing~~
- ~~Level 3 Delayed = 1: 3 or 1:4 RN staffing~~
- ~~Level 4 Minor = 1:4 RN staffing~~
- ~~Level 5 Minor = 1:4 RN staffing~~

~~Staffing adjustment is made based on the nursing intensity of the patient population and changes in the patient visits.~~

~~Standards of Practice:~~

Standards of Practice:

The Emergency Department is governed by state regulations as outlined in Title 22, and by the Center for Medicare and Medicaid (CMS), and federal regulations such as the Emergency Medical Treatment and Active Labor Act (EMTALA). We also adhere to the standards established by The Joint Commission (TJC). Additional practices are described in the Patient Care Policy Manual, Administrative Policies and Procedures, the Environment of Care Safety Standards, Clinical Practice Standards and the Emergency Department Standards of Patient Care and Collaborative Practice Guidelines.

In addition, the Emergency Services at EL Camino ~~Hospital~~Health endorses the philosophy of the Emergency Nurses Association Standards of Practice that states: "Emergency nursing practice is systematic and includes nursing process, nursing diagnosis, decision making, analytic and scientific thinking and inquiry. Professional behaviors inherent in emergency nursing practice are acquisition and application of a specialized body of knowledge and skills, accountability and responsibility, communication, autonomy, and collaborative relationships with others."

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

Attachments

Attachment A_ ESI Defined Resources.docx

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Medicine Department Executive Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Medicine Department Executive Committee	Rita Thomas: Dir Interventional Services [PS]	09/2024
Medical Director	Rita Thomas: Dir Interventional Services [PS]	09/2024
	Rita Thomas: Dir Interventional Services	09/2024

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> Updates throughout policy

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> Updating Area to ED

A18c7. FY2024 Infection Control Plan-History

Status **Pending** PolicyStat ID **16161351**

Origination	01/1996
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2024
Next Review	1 year after approval

Owner	Catherine Nalesnik: Director Infection Prevention
Area	Infection Prevention
Document Types	Plan

FY2024 Infection Control Plan

COVERAGE:

All El Camino Hospital staff

PURPOSE:

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

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

STATEMENT:

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

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

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

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

El Camino Hospitals: Mountain View and Los Gatos

Geographic location, patient volume and services provided: (FY2019 data):

- Hospital geographic location – 2 hospital campuses in a large urban areas
- MV beds: 274 General Acute Care
- LG beds: 143 General Acute Care
- Patient volume: greater than 18,000 discharges per year
- Enterprise admissions: FY23 31,084 (FY2022 31,415)
- Enterprise Patient Days: FY23 105,388 (FY2022 104,347)
- Patient population served: multicultural
- Hospital clinical focus – emergency services, maternal child services, cancer services, Adult & neonatal critical care services, diagnostic services, medical/surgical services, cardiac services, cyber knife & radiosurgery center, acute rehab center, behavioral health services and out-patient services

Santa Clara County Geographic Location and Demographics:

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

With 1.9 million residents, Santa Clara County is the sixth most populated of California's 58 counties and the most populous in the Bay Area. More than one-third (37%) of county residents are foreign-born. The largest percentage of foreign-born residents were born in Mexico (21%), followed by Vietnam (15%), India (13%), the Philippines (9%), and China (8%), excluding Hong Kong and Taiwan.

Santa Clara County encompasses 1,312 square miles and runs the entire length of the Valley from north to south, ringed by the rolling hills of the Diablo Range on the east, and the Santa Cruz Mountains on the west. Nearly 92% of the population lives in suburban areas

The local industry of the County of Santa Clara is dominated by the technology sector.
The County has three main interstate highways; 280, 680, and 880, one U.S. Route (101), and the following CA State Routes; 9, 17, 82, 85, 87, 130, and 237.

Airports include: Norman Y. Mineta International Airport, Moffett Federal Airfield, and three County airports: Reid Hillview, Palo Alto, and South County.

Mountain View Demographics:

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

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

Los Gatos Demographics:

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

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

Santa Clara County Community Health Status Assessment:

https://www.sccgov.org/sites/phd/collab/chip/Documents/cha-chip/cha-chip.pdf

(Data: 2015-2020 Partners for Health Santa Clara County)

Access to Care	87% of adults have health insurance
Chronic Disease	8% of adults have diabetes. Heart disease: 22% of the death among county residents.
Overweight and Obesity	Over 50% of adults and over 25% of adolescents in the county are overweight or obese
HIV/ AIDS	Over 4,500 adults in Santa Clara County are living with HIV
Tobacco use	1 in 10 adults and 1 in 12 adolescents in the county smoke cigarettes

TB Risk Assessment: *(retrieved from Santa Clara County TB Control Report; based on CY 2022)*

California Overview

- California reported 1843 new TB cases in 2022 compared to 1750 cases in 2021.
- California's annual TB incidence was 4.7 cases per 100,000 persons, which is nearly double the national incidence rate of 2.5.
- More than 2 million Californians (6% of the population) have Latent TB Infection (LTBI) which can progress to active TB without diagnosis and treatment.
- Among California's TB cases, an estimated 3% were imported from outside of the United States, 11% resulted from recent transmission and 86% were due to reactivation of latent tuberculosis infection (LTBI) to active TB..

COMMUNITY TB PROFILE 2021

www.SCCPHD.ORG

- Santa Clara County (SCC) has the third highest number of cases among all jurisdictions in California, after Imperial and San Francisco counties.
- SCC had 141 cases of tuberculosis (TB) disease in 2022, which increased compared with 2021 (133 TB cases).
- This represents a case rate of 7.5 per 100,000 residents

El Camino TB Profile CY 2022 : Medium Risk Facility

- 20 total cases: 13 In-patients and 7 Out-patients which is unchanged from 20 cases in 2021.
- Designated as a "Medium Risk Facility" for TB based on the community rate of infection.
- El Camino Hospital and their Infectious Disease Specialists are considered the 2nd largest provider of TB care in Santa Clara County next to the SCC TB Clinic.

Seasonal Influenza Activity

Infection Prevention and Control: Seasonal Influenza Procedure

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

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

Threats facing Santa Clara County:

- **COVID-19 (SARS Co-V-2 virus) Worldwide Pandemic** Santa Clara County (SCC) experienced a

significant impact of the SARS Co-V-2 virus circulation. On March 16, 2020 The Health Officer of the County of Santa Clara issued a "Shelter in Place" mandate. Goal of the mandate was to ensure that the maximum number of people isolated in their place of residence to slow the spread of COVID-19. In 2023, COVID-19 transmission mitigation efforts were continued by SCC Public Health Department including mandates for mandatory masking at times and social distancing.

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

PROCEDURE:

A. **Goals**

1. Maintain Enterprise hospital acquired Central Line Associated Bloodstream Infections (CLABSI) at or below National Healthcare Safety Network (NHSN) Standardized Infection Ratio (SIR) SIR < 0.50.
2. Maintain Enterprise hospital acquired Catheter Associated Urinary Tract Infection (CAUTI) at or below NHSN SIR ≤ 0.75.
3. Maintain Enterprise hospital acquired Clostridium difficile (C.diff) infections at or below NHSN SIR ≤ 0.70
4. Maintain hospital acquired Pacemaker Surgical Site Infections (SSI) at or below NHSN SIR <1.00
5. Maintain hospital acquired Total Knee SSI at or below NHSN SIR <1.00.
6. Maintain hospital acquired Total Hip SSI at or below NHSN SIR <1.00.
7. Maintain hospital acquired Laminectomy SSI at or below NHSN SIR <1.00.
8. Maintain hospital acquired Spinal fusion /Re-fusion SSI at or below NHSN SIR < 1.00.

9. Maintain Enterprise hospital acquired Methicillin Resistant Staphylococcus aureus (MRSA) infection rate to ≤ 0.90 /10,000 patient days.
10. Maintain Enterprise MRSA screening compliance rate to 92% or more.
Maintain Enterprise hospital onset Multi- Drug Resistant Organisms (MDRO) infection rate to ≤ 0.50 / 10,000 patient days.
11. Maintain hand hygiene compliance at ≥ 80%.
12. Maintain reporting compliance with regulatory and accrediting agencies
13. Maintain compliance with Infection Control Risk Assessment (ICRA) for all new construction projects
14. Maintain compliance with Seasonal Influenza Procedure

B. **Objectives**

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

a. Report all required data monthly to Center for Disease Control (CDC) NHSN data base
b. Report mandated disease conditions, non-Covid-19 (86 possible) to SCC PHD
c. Report all suspected or active Tuberculosis cases to the Santa Clara County TB Control
d. Report unusual infectious disease occurrences to CDPH and CDC

4. Educate staff on hand hygiene standards and measure compliance outcomes
    a. Upon hire, educate all staff on how to correctly perform hand hygiene (HH)
    b. During isolation rounding by IP staff, observe compliance with hand hygiene and provide immediate feedback to staff with non-compliance.
    c. Track monthly HH compliance with the HAI committee and strategize on performance improvement activities.
    d. Review monthly hand hygiene compliance data from the clinical nursing units dashboard.

5. Perform Infection Control Risk Assessments (ICRA) for all hospital construction activities
    a. Conduct a risk assessment for all new construction projects and sign permit
    b. Perform daily rounding on all construction sites for compliance to ICRA permit standards
    c. Conduct ICRA permit for construction projects for unexpected water intrusion and mold issues

6. Attend the following hospital committee meetings to represent IC
    a. HAI (Hospital Acquired Infection) Committee
    b. Critical Care Committee
    c. Antimicrobial Stewardship
    d. Emergency Management
    e. Patient Care Value Analysis
    f. Clinical Microbiology Lab, Pharmacy and Infection Prevention (MIPP)
    g. Central Safety
    h. E-policy
    i. Safety Event Classification Team (SEC)
    j. Patient Employee and Safety Committee
    k. Hospital Surge Planning
    l. Non-Ventilator Hospital Acquired Pneumonia (nvHAP)
    m. Enhanced Recovery after Surgery (ERAS)

7. Provide Infection Prevention and Control Education to the following:
    a. General Hospital Orientation
    b. Physician Orientation
    c. Ancillary Staff and any hospital department in-service as requested
    d. Environmental Services Department (EVS) yearly update
    e. Health Stream: annual Infection Prevention and Control Standards
8. Initiate the Seasonal Influenza Procedure in August (prior to flu season)
    a. Meet with required departments to verify readiness for flu season
    b. Track daily numbers of influenza hospital admissions and deaths
    c. Monitor trends of influenza on the local, state and national level
    d. Institute visitor restrictions if widespread flu is present in the community
9. Perform Monthly Infection Control/ Quality tracers
    a. Attend monthly safety rounds at Mountain View and Los Gatos
    b. Educate staff on areas on infection control non-compliance
    c. Report outcomes to the Infection Control Committee Meeting

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

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

5. The Infection Prevention and Control Department shall develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.
6. The committee minutes shall be reviewed by the Medical Executive Committee.

D. **Scope of Services**

1. The infection control program is divided into functional groups of routine activities that address the integrated facets of surveillance and prevention of infections, monitoring and evaluation, epidemiological investigation, risk reduction, consultation and education.
2. Hospital Onset Infection Surveillance and Prevention
    a. For the purpose of surveillance, hospital onset infections shall be clinically active infections occurring in hospitalized patients in whom the infection was not present or incubating at the time of admission.
    b. Infections with endogenous organisms of the patient and those organisms transmitted either by healthcare workers or indirectly by a contaminated environment shall be included.
    c. Strict criteria shall be used for assessment in regard to targeted hospital onset infections. Not all hospital onset infections in the hospital shall be counted and presented for statistical analysis. The type of data collection to be used and analyzed shall be determined by the Infection Control Committee (ICC) based upon the annual Risk Assessment.
    d. The criteria written by the Center for Disease Control and Prevention (CDC) shall be used when calculating infection rates for statistical analysis.

E. **General Surveillance Activities**

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

F. **Data Collection Methods**

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

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

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

H. **Reporting to Outside Agencies**

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

I. **Education**

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

J. **Liaison**

1. Provide ongoing expert advice and consultation as appropriate to other departments including but not limited to Microbiology Laboratory, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
2. Coordinate Infection Control activities with other departments or units including but not limited to Dialysis Services, Patient Care Services, Microbiology Laboratory, Pathology, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
3. Function as a liaison to the Santa Clara Public Health Department and other agencies.
4. Function as a liaison to Infection Control Programs at other hospitals and long-term care facilities.

K. **Policy Formation**

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

L. **Quality Improvement**

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

M. **Environmental Conditions**

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

N. **Reporting Mechanisms**

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

REFERENCES:

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

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

Attachments

FY23 Annual Report-FY23 Evaluation of the Infection Prevention Plan.pdf

FY24 IC Risk Assessment.pdf

Approval Signatures

Step Description	Approver	Date

Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Medicine Department Executive Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Medicine Department Executive Committee	Catherine Nalesnik: Director Infection Prevention	07/2024
Infection Prevention Committee	Delfina Madrid: Quality Data Analyst	07/2024
	Catherine Nalesnik: Director Infection Prevention	07/2024

History

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> Med Dept Exec 8/8/24

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> ePolicy 9/13/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 9/30/2024, 10:57AM EDT

> MEC 9/26/24

A18c8. Environment of Care Security Management Plan-History

Status **Pending** PolicyStat ID **13790857**

Origination	02/2018	Owner	Matthew Scannell: Director Safety & Security Services
Last Approved	N/A	Area	Security Management
Effective	Upon Approval	Document Types	Plan
Last Revised	02/2022		
Next Review	1 year after approval		

Environment of Care Security Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

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

To that end, it is the overall intent of this plan to establish the framework, organization and processes for the development, implementation, maintenance and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology and physical barriers.

A. Goals:
Based on areas of improvement noted in the FY 2021 Annual Evaluation, the performance improvement indicators for FY 2022 will be:

1. 10 % reduction in the number of reportable workplace violence incidents over FY 2021.
2. Reduce the number of reported thefts on campus by 10% over FY 21 totals

3. Security Officer (non recordable) Injury rate of <5% per 100 employees for FY 22.

B. Objectives:

Specific objectives of the FY 2022 Security Management Plan include the following:

- Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess and control security risks, vulnerabilities, protect sensitive areas, and to track access control.
- Work with nursing to identify and proactively plan for potential Code Gray patients.
- Use the Code Gray critiques to improve response with a focus of ensuring the safety of the staff and patients during these events.
- Further implement the Prevention of Workplace Violence Plan to reduce workplace violence incidents.
- Ensure timely and effective responses to security emergencies. Less than three minutes response time
- Ensure quality and effective responses to service requests.
- Report and investigate incidents of theft, vehicle accidents, threats, and property damage.
- Review the current infant abduction prevention system in the women's hospital for comparison to newer technology.
- Periodically inspect and test all security systems, devices and equipment.
- Promote security awareness and education.
- Enforce various medical center rules and policies.
- Establish and implement critical program elements to include measures to safeguard people, equipment, supplies, and medications and to control traffic in and around the Medical Center and the outlying medical offices.
- Enforce visitor ID program in various locations across both campuses.
- Review and revise as needed post orders for security staff in the Taube and Sabroto buildings.
- Replace DVR's with NVR's to improve security camera retention and quality.
- Train all security staff on CPR.
- Replace the visitor management system from an excel and word application to an actual management system (Omnigo).
- Secure funding for an outside vendor to conduct a MV security risk assessment.

SCOPE AND APPLICATION:

The Security Management Plan comprises standards applicable to address and facilitate the protection, welfare, safety and security of the environment. Included is a full range of protective services for all persons, property and assets at the Medical Center and outlying facilities. It requires compliance with all policies and procedures from all staff members, physicians and contractors employed by El Camino

Health and associated outpatient clinics. It provides for quality customer service for all members, patients, visitors and staff, along with the protection of property and assets.

The scope of the plan addresses all elements required to provide a safe and secure environment in which care is delivered, as well as to ensure safety in the workplace. Key aspects include:

- Further develop a comprehensive patrol plan for the Medical Center and the outlying medical offices
- Sustain Nonviolent Crisis Intervention training for all security officers
- Improve/enhance Emergency Department physical and technological security
- Program planning/design, implementation and the measurement of outcomes and performance improvement.
- Risk assessments, identification, analysis, and control of risks.
- Reporting and investigating including incidents, accidents and failures.
- Orientation, education and training of staff and officers.
- Use and maintenance of equipment, such as lights, locks and barriers, C-cure 9000 systems and alarms.
- Traffic control and the security of sensitive areas.
- Evaluate the effectiveness of the infant monitoring systems.
- Upgrade the C-Cure 9000 system to increase functionally of systems including the use of cameras.

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .04.01.0, .04.01.03, .04.01.05
2. California Code of Regulations, Title 8, Sections 8 CCR 3203 et seq.
3. California Code of Regulations, Title 22, Sections 22 CCR 70738
4. Health & Safety Code, Section 1257.7, 1257.8

AUTHORITY

El Camino Health Leadership team provides the program, vision, leadership, support and appropriate resources, which are embodied within and conveyed through the development and institutionalizing of business fundamentals relative to Security.

PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. **Security Director:**

   1. Responsible for the overall management of the security program including program design, implementation and assessment, identification and control of risks, staff

educational needs, and consultation and assistance.

2. Has the authority to intervene whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or the facility.
3. Provides support and direction to the Security Account Manager and Security Management Program by participating in the development and approval of policies and procedures, reviewing and performing security risk assessments and ensuring the appropriate resources are available to permit the completion of the objectives and goals related to the Security Management Plan.
4. Makes recommendations to the Central Safety Committee concerning the implementation of new procedures and operations, as well as installation of new systems.
5. Communicate actions taken secondary to significant security incidents or performance issues to Security Workgroup and the Central Safety Committee.

B. **Security Account Manager (AM):**

1. Provides security personnel and site management of security operations, compiling relevant information from incident reports and security service date to form the basis for quarterly reports submitted to the Central Safety Committee, functional oversight and responsibility for the day to day operations of the Security department and the implementation of the program.
2. Assures employees receive all security related training, report situations involving threats or the perception of an unsafe work place to the Security Work Group, assures employees follow security instructions for their areas, and contacts the Director of Security with all security related issues.

C. **Security Department:**

1. Works in collaboration with the Mountain View Police Department. Law Enforcement provides the El Camino Health campuses with periodic patrols and a prompt response when needed.
2. Periodically inspect and test all security systems, devices, and equipment.

D. **Central Safety Committee (CSC):**
The CSC, comprised of clinical, administrative, operations support services, and labor representatives and other appropriate organizational representatives, ensures the Security management program remains in alignment with the core values and goals of the organization by providing direction, strategic goals, determining priority and assessing the need for change. The committee also ensures coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, including those of existing committees, sub-committees and organizational units and establishes and /or approves infrastructures to support Performance Improvement techniques.

E. **Department Managers:**
The Department Managers are responsible for the provision of a safe and secure working environment for their staff and patients, suitable provisions for the care of patients, through full implementation of established Environment of Care programs to include identification of security risks, staff education, developing and implementing department specific security

policies and procedures, incident reporting and suitable provisions for the protection of patients and their belongings.

F. **Employees**
Employees are responsible to follow security polices and guidelines of personal protection and report any/all security incidents, risks and threats to the Security Department. For the purpose of this plan, employees include contract employees, volunteers, students, registry personnel and anyone working under the facility's auspices. Employee's Security responsibilities include wearing their identification badges at all times and reporting any suspicious persons or activities in their area.

RISK ASSESSMENT

Security risks, potential vulnerabilities and sensitive areas are identified and assessed through ongoing facility-wide processes and coordinated through the Security Director and Security Account Manager. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics and physical systems. Considerations include:

- Routine Environmental Rounds (i.e. safety inspections).
- Root cause analysis of significant events.
- Electronic event reports (iSAFE)
- Sentinel Event Alerts produced by the Joint Commission.
- Security Patrols.
- Information Collection and Evaluation System (ICES) - Committee review of pertinent data/ information, incident reports, evaluations and risk assessments.
- Community crime statistical data or review.
- Facility crime, incident and property loss statistics (Perspective)-
- Risk of elopement (such as clinically indicated restraints, medical holds and the need for stand-by services)

The profile for potential risks gives rise to an integrated, proactive approach to risk control and measures to safeguard people and assets. Secondary to the risk assessment(s) performed, identified security "Sensitive Areas" include, but are not limited to; Emergency Department, Newborn Areas, Pediatrics, Pharmacies, Psychiatry, Mechanical Rooms, Main Computer/Information Technology areas, Cash Handling areas, Laboratory, Nutritional Services, Nuclear Medicine, Hazardous Waste Storage area, and Medical Gas Storage areas.

PROGRAM EFFECTIVENESS

The Security workgroup and the CSC monitor the effectiveness of the Security Program, including the appropriateness of design, outcomes of implementation; training and materials are monitored and assessed on an ongoing basis. Relative documents, reports of action taken, as well as concurrent and retrospective data is tracked and monitored relative to success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the security program.

PERFORMANCE

EoC Area	Indicator	Responsible Dept./Function	Target
Security	10% reduction in the number of reportable workplace violence incidents over FY 2021.	Security	10% Decrease from FY 2021 statistics
Security	Security Officer (non recordable) Injury rate of <5% per 100 employees for FY 22.	Security	< 5% per 100 employees
Security	Reduce the number of reported thefts on both campuses by 10% over FY 2021 totals	Security	10% Decrease from FY 2021 statistics

ANNUAL PROGRAM EVALUATION

On an annual basis, the Security Management Program is evaluated relative to its objectives, scope, effectiveness and performance. This evaluation process is coordinated with the Security Director and the onsite Security Manager and reported to the CSC

- The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.
- The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant policy and procedures, technology, and practices that add value and elements conducive to continuous regulatory compliance.
- The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

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Approval Signatures

Step Description	Approver	Date

Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy	Patrick Santos: Policy and Procedure Coordinator	09/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	07/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	07/2024
	Matthew Scannell: Director Safety & Security Services	06/2023

History

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> Updating Area to Security Mgmt.

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> Minor update

A18c9. Security Services Scope of Service-History

Status **Pending** PolicyStat ID **16085992**

Origination	03/2016	Owner	Matthew Scannell: Director Safety & Security Services
Last Approved	N/A	Area	Security Management
Effective	Upon Approval	Document Types	Scope of Service
Last Revised	03/2021		
Next Review	3 years after approval		

Security Services Scope of Service

Types and Ages of Clients Served

Security Services provides support and services to clients of all ages. Individuals served include physicians, staff, contractors, students, volunteers, patients, visitors and members of the public.

Assessment Methods

Security Services activities and performance are presented to and evaluated by the Security Work Group which reports to the Central Safety Committee.

Scope and Complexity of Services Offered

Security Services priority function is that of ensuring a safe environment for all individuals who enter the El Camino Hospital (ECH) campus through monitoring, implementation of security measures, and reporting of incidents with appropriate action taken to resolve issues and minimize risk. Services include but are not limited to: active security patrols, asset protection, lost and found, safe storage of patient belongings, parking lot escorts, directional assistance, emergency response, risk assessments, investigations, personal safety and prevention information and incident reporting.

Appropriateness, Necessity and Timeliness of Services

Director, Security Services, in collaboration with other departmental managers, staff, and the Security Work Group, assesses the appropriateness, necessity and timeliness of service. The appropriateness of service is addressed in departmental policies and procedures.

Staffing/Skill Mix at Mountain View Campus & Los Gatos

Security Services is staffed 24 hours/day, seven days a week. Staffing includes a department Director, Security Services and onsite contract security officers. Contract security officers receive Basic Officer Training orientation to ECH, ECH policies and procedures and Management of Assaultive Behavior Training. Contract Service Provider also performs monthly training for the security officers.

Level of Service Provided

The level of security service is consistent with the needs of the hospital, geographical area, and industry standards. Services are provided under hospital policy and procedural guidelines.

Standards of Practice

Security Services adheres to applicable state and federal regulations including but not limited to standards established by the Joint Commission on Accreditation of Healthcare Organizations as well as hospital and departmental policy and procedures.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Department Medical Director or Director for non-clinical Departments	Matthew Scannell: Director Safety & Security Services	07/2024
	Matthew Scannell: Director Safety & Security Services	07/2024

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A18c10. Corporate Compliance Scope of Service-History-Changes

Status **Pending** PolicyStat ID **16318188**

El Camino Health

Origination	10/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2024
Next Review	3 years after approval

Owner	Diane Wigglesworth: VP, Compliance and Privacy Officer
Area	Corporate Compliance
Document Types	Scope of Service

Corporate Compliance Scope of Service

Types and Ages of Clients Served

The Corporate Compliance Department provides services to El Camino Hospital management, staff, physicians, patients, and members of the hospital community.

Scope and Complexity of Services Offered

The Corporate Compliance Department provides services, analyses, and audits to enhance El Camino Hospital's Corporate Compliance program in the areas of billing and coding, patient privacy and IT security, enterprise risk management, organizational governance, financial reporting, business ethics and compliance. Functions provided include, but are not limited to:

- Developing and revising administrative policies and procedures related to scope areas.
- Developing and enhancing compliance program infrastructure or controls to promote prevention and detection of non compliance within the organization.
- Conducting education and training related to scope areas.
- Conducting internal audits for high risk areas, providing follow-up to affected areas, and supporting corrective action based on results.
- Monitoring high-risk areas and recommending corrective action based on results.
- Responding to the Corporate Compliance hotline. Investigating all concerns, complaints or potential issues resulting from hotline calls or directly reported that may result in compliance risk to the hospital.
- Chairing and participating in related committees, including Board Compliance and Audit Committee, IT Security, Privacy and Compliance Decision ~~Committee, Clinical Research~~

~~Committee, and Revenue Integrity~~ Committee.

- Evaluating strategic, business development, and other organizational proposals for potential compliance issues. Recommending strategies to mitigate compliance or enterprise risk.
- Recommending to affected departments, Human Resources, Administration, and other affected areas appropriate corrective action due to compliance violations.

Staffing

The staff providing services includes managers of compliance and privacy, internal auditor, compliance analyst , and ~~a Director of Corporate Compliance who also serves as~~ El Camino Hospital's Compliance/ Privacy Officer.

Level of Service Provided

The Corporate Compliance department provides services under hospital and departmental policy and procedure guidelines.

Standard of Practice

Where applicable, the Compliance department is governed by state and federal regulations, including the state Department of Health Services, Department of Health and Human Services, the Office of Inspector General, the Office of Civil Rights, and Joint Commission on Accreditation of Healthcare Organizations requirements.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Department Medical Director or Director for non-clinical Departments	Diane Wigglesworth: VP, Compliance and Privacy Officer	07/2024

Diane Wigglesworth: VP, Compliance and Privacy Officer	07/2024

History

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Last Approved by Wigglesworth, Diane: VP, Compliance and Privacy Officer on 7/30/2024, 3:10PM EDT

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Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 9/5/2024, 2:16PM EDT

> ePolicy 8/9/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 9/30/2024, 10:45AM EDT

> MEC 9/26/24

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 9/30/2024, 11:11AM EDT

> Updating Area to Corporate Compliance

A18c11. Policy & Procedure Formulation- Approval & Distribution -Policy on Policies-History-Changes

Status Pending PolicyStat ID 15346389

Origination	06/1998	Owner	Diane Wigglesworth: VP, Compliance and Privacy Officer
Last Approved	N/A		
Effective	Upon Approval	Area	Quality
Last Revised	09/2024	Document Types	Policy
Next Review	3 years after approval		

Policy & Procedure Formulation, Approval & Distribution (Policy on Policies)

COVERAGE:

All El Camino Hospital Staff, Medical Staff

PURPOSE:

It is the policy of El Camino Hospital to monitor and control the development, review, revision, modification, approval, and distribution of policies, procedure, plans, protocols, and standardized procedures.

STATEMENT:

~~A. It is the policy of El Camino Hospital to provide a process for the development and implementation of policies and other related documents.~~

~~B. All policies and other documents as defined below must be developed with the review and input of all affected policy owners, approved by leadership of the organization and routinely reviewed. This review must be minimally every three years unless required more frequently as defined by Title 22 or other regulatory bodies, when there is accreditation or regulatory changes, or when operations or patient care practices change.~~

~~C. The Board of Directors shall approve policies, plans and scopes of services as outlined in the Administrative policy-Board of Director Approval of Hospital Policies.~~

~~D. ECH reserves the right to change or eliminate policies and other documents as defined below as needed to comply with regulatory changes or changes in practice. ECH will be responsible for communicating any such actions to the policy owner.~~

- It is the policy of El Camino Hospital to provide a process for the development and implementation of policies and other related documents.
- All policies and other documents as defined below must be developed with the review and input of all affected policy owners, approved by leadership of the organization and routinely reviewed. This review must be minimally every three years unless required more frequently as defined by Title 22 or

other regulatory bodies, when there is accreditation or regulatory changes, or when operations or patient care practices change.

- The Board of Directors shall approve policies, plans and scopes of services as outlined in the Administrative policy-Board of Director Approval of Hospital Policies.
- ECH reserves the right to change or eliminate policies and other documents as defined below as needed to comply with regulatory changes or changes in practice. ECH will be responsible for communicating any such actions to the policy owner.

DEFINITIONS:

- **Policy**: A policy is defined as a brief written statement of intent or principle that determines actions or decisions. Generally, a policy is based on law, regulations, accreditation standards, or leadership decisions.
- **Plan:** A single document that provides detailed description of provision of particular program or scope of service, often required by regulation. Ex. Disaster Plan, Pandemic Plan, Plan for Provision of Care Procedure**.**
- **Procedure**: A step-by-step written outline detailing how something is to be accomplished. Procedures answer the "what" and "How do I do it" questions. Ex: Chemotherapy, Administration of.
- **Protocol***:* Defines care and management of a patient care issue as outlined in the protocol document. A medical staff member must order the activation of a specific protocol. Subsequent orders of the protocol may be entered by the licensed staff into EHR. There must be an order set in Epic (Example "Pharmacy to Manage TPN" or "Wound/Ostomy Evaluate and Treat Protocol")
- **Clinical Guideline**: Guidelines describe the hospital approved care approach for a given diagnosis or condition. Guidelines must be evidenced based and are often listed in evidence based databases. Includes a prescriptive, detailed definition of what is to be implemented using precise, sequential steps. Examples include: Care of the Bariatric Patient.
- **Standardized Procedure**. The legal mechanism for nurses and nurse practitioners to perform specific functions which would otherwise be considered the practice of medicine. Standardized procedures are developed collaboratively by nursing, medical staff, and administration at the hospital. By approval of standardized procedures, Medical Staff authorize specific tasks to be performed by specific nurses in specific circumstances for the care of the patient.
- **Scope of Service**: A document that describes the provision of service of a particular program or department of the hospital.

PROCEDURE:

A. **Document Development and Format**

1. Documents should be written by the individuals most closely related to the issues with input by persons who have special expertise on the subject matter.
2. Documents should reflect what is considered to be the professional standard of care and match practice. There must be a realistic expectation that compliance with the document can be met.
3. Documents, as defined above, should be concise, and words and phrases not universally understood should be defined.
4. All documents except those designated in Section 6 below will be developed and revised in the template available on the toolbox under the policy/procedure tab in the policy software application, and contain the following elements:.
    a. Purpose section: a clear and concise purpose to educate readers on what the

policy/procedure entails.

b. Statement section

c. Definitions

d. Procedure: This section contains a clear and concise step-by-step methodology to be followed for compliance with the purpose and statement.

e. Approval Box: The approvals section will list any committees that are required to approve the policy and the date(s) when they approved it. This section will also list the Board of Directors and the date when it approved the policy. The minutes of these various groups will reflect approval of the policy. Only the most recent date will be reflected in the box.

5. For nursing, respiratory care, and physical therapy procedures, ECH uses ~~Lippincott Clinical Procedures~~EBSCO Dynamic Health which can be accessed directly from PolicyStat and from the Toolbox.
6. The ePolicy Committee is composed of internal stakeholders from various departments who review and approve all policies, procedures, protocols, plans and practice guidelines before distribution of documents to the Board and/or MEC.
7. The following departments have obtained approval from the ePolicy Committee to maintain department specific procedures in their department systems and be responsible for applicable reviews according to regulatory guidelines. Any other department requesting to use a separate system other than PolicyStat must obtain approval from the ePolicy Committee.
    a. Laboratory and Pathology procedures that only affect internal lab/pathology procedures will be maintained in Q Pulse.
    b. Imaging Radiation Dosing protocols will be maintained by the Imaging Department.
    c. ~~HITRUST/HIPAA procedures will be maintained internally by Information Security department.~~

B. **Approval Matrix for ECH Manuals**

1. Documents which involve accreditation, state and federal statutory requirements shall be reviewed by the Director of Accreditation and/or Risk Management.
2. Documents which involve compliance with HIPAA and privacy concerns shall be reviewed with the Privacy Officer.
3. In addition to the approval matrix below, nursing related documents require approval as follows:
    a. All applicable unit based practice councils and Patient Care Leadership committees
    b. For broad based changes enterprise changes to nursing practice, Central Partnership Council approval is required.
    c. For approval of standardized procedures, Interdisciplinary Practice Committee is required.
4. Medical Staff collaboration and approval through the appropriate medical staff department, committee ~~or~~, medical director or designee is required for those that need approval before presenting to the ePolicy ~~Committee and to the Medical Executive~~ Committee. and to the Medical Executive Committee (see chart below).
5. Any policies, procedures, or protocols that will apply to a Mountain View and Los Gatos location must have approval from department managers and medical staff committees from each campus before the policy is sent through the final approval processes.

6. Department documents shall be approved by the department manager or designee, and apply to only one department. Approval shall be by department leadership along in accordance with the matrix below.

	~~Administrative~~Admin	Clinical/ Patient Care Services	Emergency/ Disaster Management	~~Human Resources~~HR	Infection Prevention	Support (Non Cli ~~Departm~~
~~Department/ VP Approval~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~
Central Safety Committee			X			
Infection Control Committee ** Any document relating to cleaning, prevention of infection across the organization		** Any document relating to cleaning, prevention of infection across the organization			X	** Any d relating t preventi infection organiza
Pharmacy and Therapeutics ** Any document concerning administration of medication		**Any document concerning administration of medication			** Any document concerning administration of medication	
Medical Staff Departments of Medicine, Surgery or Maternal Child Health for any document affecting the department's patient population. Departmental approval is all that is required if no other department is affected.		X			X	
ePolicy Committee	X	X	X	X	X	X

Medical Executive Committee **Review required for any document relating to care of patient that involves multiple departments/ specialization and or infection prevention.		X			X	
Board of Directors (only policies/ scope of services/ plans)						

C. **Distribution:**

1. Documents defined in this policy will be available on the hospital network to all staff, physicians and volunteers.
2. ~~A copy of the organization's policies will be stored on a USB device that will be maintained in the hospital supervisor office at each campus.~~

D. **Policy, Procedure, Protocol Maintenance:**

1. The original electronic ~~copy of~~ current hospital-wide policies and procedures will be centralized ~~on the hospital network file directory (ToolBox)~~in PolicyStat. The Quality Department will also maintain backup copies of all active policies and procedure in their department share drive.
2. To meet legal requirements, all documents in the policy software application that have been deleted or revised will be archived for a minimum of seven years.
3. Maternal Child Health documents in the policy software application will be retained for 25 years.

E. **Document Updates in the policy software application**

1. All El Camino Hospital staff covered by policies, procedures, or protocols will have "Read Only" access to currently approved documents through the hospital network via the policy software application.
2. New policies or updates made to documents must be made in the policy software application accessed through the Toolbox.
3. If an approved document is a new version of an existing document, the previous version is automatically archived when the new version is published
4. Once approved by the Board and/or MEC, the Policy and Procedure Specialist will be notified and will make the final approval via the policy software application and publish the document.

ATTACHMENT:

- Standard Grid for Policies and Procedure Process

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

Standard Grid for Policies and Procedure Process

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
Leadership Council	Diane Wigglesworth: VP, Compliance and Privacy Officer [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	06/2024
	Diane Wigglesworth: Compliance and Privacy Officer	06/2024

History

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 2/29/2024, 4:30PM EST

Edited by Santos, Patrick: Policy and Procedure Coordinator on 2/29/2024, 4:32PM EST

> Ready for review

Last Approved by Wigglesworth, Diane: VP, Compliance and Privacy Officer on 6/4/2024, 10:22AM EDT

> Recommend approval of these initial edits since the policy is currently overdue.

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 6/17/2024, 2:16PM EDT

> Per ePolicy to remove Lippincott and update to EBSCO Dynamic Health.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 6/17/2024, 3:24PM EDT

> ePolicy 6/14/24

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 9/3/2024, 3:09PM EDT

Last Approved by Wigglesworth, Diane: VP, Compliance and Privacy Officer on 9/3/2024, 3:24PM EDT

> Leadership Council 8/20/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 9/30/2024, 10:44AM EDT

> MEC 9/26/24

A18c12. Administrative- Visitors Policy-History-Changes

Status **Pending** PolicyStat ID **16457524**

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

Administrative: Visitors Policy

COVERAGE:

All El Camino Hospital staff

PURPOSE:

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

DEFINITIONS:

- 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.
- 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:

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 officer 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
MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024

	Christine Cunningham: Chief Experience and Performance Improvement Offic	08/2024

History

Draft saved by Patel, Ketul: Manager Privacy on 8/22/2024, 6:11PM EDT

Edited by Patel, Ketul: Manager Privacy on 8/22/2024, 6:12PM EDT

> Item J added related to police and body camera.

Draft saved by Patel, Ketul: Manager Privacy on 8/22/2024, 6:13PM EDT

Edited by Patel, Ketul: Manager Privacy on 8/22/2024, 6:14PM EDT

> Item J only

Last Approved by Cunningham, Christine: Chief Experience and Performance Improvement Offic on 8/22/2024, 6:15PM EDT

> approved

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 9/16/2024, 12:09PM EDT

> ePolicy 9/13/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 9/30/2024, 10:43AM EDT

> MEC 9/26/24

A18c13. COVID-19 Vaccine Plan-History-Changes

Status **Pending** PolicyStat ID **15268573**

Origination	09/2021	Owner	Michael Rea: Mgr Emp Wellness & Health Svcs
Last Approved	N/A	Area	Employee Wellness & Health
Effective	Upon Approval	Document Types	Plan
Last Revised	09/2024		
Next Review	3 years after approval		

COVID-19 Vaccine Plan

COVERAGE:

This plan applies to El Camino Hospital employees, physicians, contractors, volunteers, observers and students. If there is a conflict between the Hospital plan and the applicable MOU, the applicable MOU will prevail.

PURPOSE:

El Camino Hospital has an obligation to provide a safe environment of care and is genuinely concerned about the safety of all, patients, visitors, employees, physicians, contractors, volunteers, observers and students. COVID-19 (SARS-CoV-2) is a contagious respiratory illness caused by the SARS-CoV-2 virus. COVID-19 can cause mild to severe illness, and at times can lead to death. It is thought that COVID-19 mortality rate is substantially higher (possible 10 times more) than that of most strains of flu. As of the date of the approval of this policy, the FDA, under the emergency use act (EUA), has approved three COVID-19 vaccines. All vaccines have been found to be both safe and effective in reducing the risk of COVID-19, and health-care related transmission.

REFERENCES:

- Health Order Requiring Use of Face Masks in Patient Care Areas of Healthcare Delivery Facilities During Designated Winter Respiratory Virus Period; Rescission of Prior Health Orders, Santa Clara County Department of Public Health, Effective April 4, 2023. (sccgov.org))
- Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, https://www.federalregister.gov/documents/2021/11/05/2021-23831/medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-vaccination

- Center for Disease Control (CDC) Vaccines for COVID-19 5/23/2021 https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html

PROCEDURE:

A. This plan is intended to maximize vaccination against COVID-19 among all ECH healthcare workers and to comply with the State of California and Santa Clara County Public Health Department COVID-19 guidance regarding COVID-19 vaccination, testing and mandated masking of healthcare workers.

B. COVID-19 vaccination is a condition of hire and retention for all employees. All employees, physicians, contractors, volunteers, observers and students must be fully vaccinated (except in unusual and specific circumstances as described in Procedure D) as communicated by EWHS.

C. ~~An individual is considered up to date with vaccines after receipt of one dose of the Pfizer or Moderna bivalent vaccine, regardless if or what prior vaccine doses were received; or who has had 2 doses of Novavax; or a booster dose of Novavax following a single Johnson & Johnson vaccine dose or a series of 2 monovalent Moderna or Pfizer-BioNTech doses.~~ An individual is considered fully vaccinated after receiving the second dose in a two dose COVID-19 vaccine or after receiving a single dose COVID-19 vaccine.

D. Exemption requests will be considered under the following circumstances:
    1. Medical/religious contraindications to vaccination including:
        a. Persons with written documentation by a healthcare provider of a medical contraindication to the COVID-19 vaccine (See addendum COVID-19 Exemption Request Form), including whether all or a specific vaccine are contraindicated.
        b. Written documentation of a qualifying religious exception (See addendum COVID-19 Vaccine Exemption Request Form).

E. The COVID-19 Vaccine Plan includes the following features:
    1. When additional vaccination recommendations are published by Santa Clara County Public Health (SCCPH), El Camino Hospital will inform staff about the following:
        a. Requirement(s) for vaccination
        b. Dates when COVID-19 vaccine(s) are available
        c. Vaccine(s) will be provided at no out of pocket expense to the employee
        d. Procedure for receiving the vaccination
        e. Procedure for submitting written documentation of vaccine obtained outside ECH, EWHS
        f. Procedure for declining
        g. Consequences for non-compliance with this plan
    2. If vaccine shortages occur or if SCCPH, CDPH, and/or the CDC recommendations are altered, all or part of this plan may be modified, suspended, or revoked.
    3. Staff will be educated on the following (this education may occur either at the time of the vaccination activity, or at the time of hire or as part of ongoing training and

education, or any combination thereof):

a. Benefits of COVID-19 vaccine
b. Potential health consequences of COVID-19 illness for themselves and patients
c. Epidemiology and modes of transmission, diagnosis, and non-vaccine infection control strategies (such as the use of appropriate precautions & respiratory hygiene).

4. Visual cues for ID badges may be used to permit monitoring compliance with the above requirements.
5. All staff are responsible for compliance with this Plan.
6. Staff supervisors, managers and directors (as applicable to worker) are responsible for the enforcement of this Plan.

RESPONSIBILITIES

A. **COVID-19 Vaccine All ECH Staff:**

1. Receive the COVID-19 vaccine(s) provided by ECH and coordinated by EWHS
2. Or complete and submit a COVID-19 Exemption Request Form to EWHS stating the reason for the exemption request as described in the section above (see attached COVID-19 Exemption Review Process)
3. Or provide current written proof of receipt of required COVID-19 vaccine(s) if not given by EWHS or designee including the date and type of vaccination received
4. Comply with Santa Clara Health Department mandate to wear a mask regardless of vaccination during the designated Winter Respiratory Virus Period and/or at any other time as mandated by SCCHD or CDPH
5. Not report to work if experiencing any COVID-19 symptoms and call the EWHS Flu/ COVID Hotline (650-988-7808)

B. **COVID-19 Testing**

1. All staff are encouraged to test for COVID-19 whenever they experience symptoms of COVID-19 and/or when they know they have been or may have been exposed.
2. Unvaccinated Staff may be required to test for COVID-19 more frequently based on Santa Clara County Health Department mandates.

C. **Universal Masking**

1. Regardless of COVID-19 vaccination status, all healthcare workers in every healthcare setting shall adhere to standard precautions during the care of patients in order to prevent disease transmission.
2. Masking is required in patient care areas during the Winter Respiratory Virus Period as designated annually by the Santa Clara County Department of Public Health and/ or at any time deemed necessary by Santa Clara County Department of Public Health and/or the California Department of Public Health.

D. **Compliance**

1. Non-compliance with any part of this plan may lead to disciplinary action including suspension and up to termination. Non-compliance with health requirements may result in disciplinary action that will affect employee's incentive payout (bonus).

E. **Reporting**

1. Employee Wellness & Health Services (EWHS)
    a. Review and approve documentation of acceptable medical contraindications
    b. Forward religious exemptions requests to Human Resources for review and approval
    c. Coordinate COVID-19 vaccination distribution and tracking to departments for department-based COVID-19 vaccination of employees
    d. Maintain electronic records for staff that have received or declined COVID-19 vaccination
    e. Notify Managers and Supervisors regarding COVID-19 vaccination status of employees in their respective departments
    f. Report required COVID-19 vaccination data to government agencies as required
    g. Provide information to Human Resources regarding those employees who are not in compliance with this policy
    h. Review employee COVID-19 vaccination rates

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

COVID-19 Vaccine Exemption Request Form

COVID-19 Vaccines Exemption Review Process (6-21-24)

Approval Signatures

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

MEC	Michael Coston: Director Quality and Public Reporting [PS]	09/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Medicine Department Executive Committee	Patrick Santos: Policy and Procedure Coordinator	09/2024
Medicine Department Executive Committee	Michael Rea: Mgr Emp Wellness & Health Svcs	04/2024
Infection Prevention Committee	Delfina Madrid: Quality Data Analyst	04/2024
HR Leaders and CHRO	Tamara Stafford: Dir Talent Development & EWHS	03/2024
HR Leaders and CHRO	Michael Rea: Mgr Emp Wellness & Health Svcs	02/2024

History

Draft saved by Rea, Michael: Mgr Emp Wellness & Health Svcs on 2/19/2024, 11:11AM EST

Comment by Rea, Michael: Mgr Emp Wellness & Health Svcs on 2/19/2024, 11:12AM EST

> Changed "up to date" to "fully vaccinated" removing specific examples using "after receiving second dose in a two dose COVID-19 vaccine or after receiving a single dose COVID-19 vaccine" to align with current practice and that new COVID vaccine is not required.

Edited by Rea, Michael: Mgr Emp Wellness & Health Svcs on 2/19/2024, 11:13AM EST

> Changed "up to date" to "fully vaccinated" removing specific examples using "after receiving second dose in a two dose COVID-19 vaccine or after receiving a single dose COVID-19 vaccine" to align with current practice and that new COVID vaccine is not required.

Last Approved by Rea, Michael: Mgr Emp Wellness & Health Svcs on 2/19/2024, 11:13AM EST

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Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 3/21/2024, 7:53PM EDT

> Reviewed by HR Leadership Team, March 20, 2024

Last Approved by Madrid, Delfina: Quality Data Analyst on 4/29/2024, 1:19PM EDT

> Approved by ICC 4/22/24

Last Approved by Rea, Michael: Mgr Emp Wellness & Health Svcs on 4/29/2024, 1:22PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 4/29/2024, 6:06PM EDT

> Pulled formatting correction from draft version.

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 4/29/2024, 6:07PM EDT

Draft discarded by Santos, Patrick: Policy and Procedure Coordinator on 4/29/2024, 6:07PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 4/29/2024, 6:08PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 6/21/2024, 6:30PM EDT

> Uploaded updated COVID 19 Exemption Review Process, per email from owner.

Comment by Santos, Patrick: Policy and Procedure Coordinator on 9/4/2024, 1:52PM EDT

> Note: Per Medicine Dept Exec Cmte that this plan doesn't need to go to them. However, this needs to be discussed at ePolicy before change can be made.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 9/4/2024, 1:52PM EDT

> Med Dept Exec 8/8/24

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 9/13/2024, 6:15PM EDT

> Per email from owner (cc'd Dr. Shin) to change annual review to 3-year cycle.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 9/16/2024, 1:31PM EDT

> ePolicy 9/13/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 9/30/2024, 10:41AM EDT

> MEC 9/26/24