AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, November 20, 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: 916 7360 5235# No participant code. Just press #.**

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

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

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

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
2	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Bob Rebitzer, Board Chair	Possible Motion	**5:30 pm**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
4	**PUBLIC COMMUNICATION** a. **Oral Comments** *This opportunity is provided for people to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. **Written Public Comments** *Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.* - Written comment from Karen Lemes received November 17, 2024	Bob Rebitzer, Board Chair	Information	**5:30 pm**
5	**RECEIVE VERBAL MEDICAL STAFF REPORT**	Steven Xanthopoulos, MD, Chief of Staff, Mountain View Shahram Gholami, MD, Chief of Staff, Los Gatos	Information	**5:30 – 5:40**
6	**QUALITY FOCUSED REVIEW** - FY2025 Q1 STEEEP Update - Deep Dive: HAI Review	Carol Somersille, MD Quality Committee Chair Shreyas Mallur, MD Chief Quality Officer	Discussion	**5:40 – 6:00**
7	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	Motion Required	**6:00 – 6:01**

8	**ECH GOVERNANCE STRUCTURE AND IMPLICATIONS FOR GROWTH** Video shared with Board separately *Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs*	Bob Rebitzer, Chair Jack Po, Vice Chair Theresa Fuentes, CLO	Discussion	**6:01 – 6:31**
9	**FY2025 ORGANIZATIONAL GOALS UPDATE** - Organizational Goals, Metrics, and Methodology *Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs*	Dan Woods, CEO A.J. Reall, VP, Strategy	Discussion	**6:32 – 6:52**
10	**FY2025 Q1 FINANCIALS – QUARTERLY STRATEGIC UPDATE** *Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs*	Carlos Bohorquez, CFO	Information	**6:53 – 7:03**
11	**ANNUAL CORPORATE COMPLIANCE SUMMARY FY24** *Gov't Code Section 54956.9(d) – conference with legal counsel – pending or threatened litigation*	Diane Wigglesworth, VP, Compliance Theresa Fuentes, Chief Legal Officer	Information	**7:04 – 7:10**
12	**APPROVE CREDENTIALING AND PRIVILEGING REPORT** *Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*:	Shreyas Mallur, MD, CQO	Motion Required	**7:11 – 7:15**
13	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS** - Minutes of the Closed Session of the ECHB Meeting (10/09/2024) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Bob Rebitzer, Board Chair	Motion Required	**7:16 – 7:17**
14	**EXECUTIVE SESSION** *Report involving Gov't Code Section 54957 for discussion and report on personnel performance matters – Senior Management*	Bob Rebitzer, Board Chair	Discussion	**7:18 – 7:23**
15	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	Motion Required	**7:24 – 7:25**
16	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	**7:26 – 7:27**
17	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (10/09/2024) b. Receive Period 3 Financials c. Approve Policies, Plans and Scopes of Service as Reviewed and Recommended for Approval by the Medical Executive Committee	Bob Rebitzer, Board Chair	Motion Required	**7:28 – 7:30**
18	**CEO REPORT**	Dan Woods, Chief Executive Officer	Information	**7:31 – 7:35**

19	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:36 – 7:39**
20	**ADJOURNMENT** **APPENDIX**	Bob Rebitzer, Board Chair	Motion Required	**7:40**

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

- Written comment from Karen Lemes received November 17, 2024

From: **Karen Lemes** <karenlemes@earthlink.net>
Date: Sun, Nov 17, 2024 at 4:00 PM
Subject: RFK JR appointment is a danger to our nation's health
To: <julia@juliamiller.net>

Dear Julia,

Would you help me to circulate the following Letter to the Editor to the El Camino Hospital Board Members before their November 20 board meeting? I hope and urge that the board write a similar letter to the San Jose Mercury and to appropriate elected national officials, such as our Congressmembers and Senators.

Letter to the Editor,

I remember the day 73 years ago when our doctor came to examine my brother who could not move his legs. It was the summer of a polio epidemic. In spite of our not being allowed the summer pleasures of swimming or playing with other children, my brother now had polio, the doctor told my parents. My Dad drove my brother to the Sister Kenny hospital in Minneapolis. After months in their trailblazing treatment center, including his 8th birthday party, my brother was sent home. After months of my mother coaching him in exercises to help him regain use of his legs, he returned to school.

Those of us who have lived through polio epidemics, measles, and mumps are so grateful for vaccines to prevent our grandchildren from experiencing these debilitating diseases. Robert F. Kennedy, Jr. , vaccine opponent , is a danger to our nation's health.

Karen Lemes, 27271 Moody Road, Los Altos Hills. 650-400-3246

El Camino Health

El Camino Health Board of Directors
Board Meeting Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, Chief Quality Officer
Date: November 20, 2024
Subject: STEEEP Dashboard through September 2024

Purpose:

To update the El Camino Hospital Board of Directors on quality, safety, and experience measure performance through September 2024 (unless otherwise noted). This memo will describe the performance of the STEEEP Quality Dashboard.

Summary:

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

Assessment:

A. Safe Care

1. **C. Difficile Infection:** There have been 6 (2 cases per month) (Goal: </= 27 infections FY 2025 or less than 2.25 cases/month) Hospital Acquired C=Diff infections in Q1 FY2025. Areas of focus to decrease C. Diff are three-fold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program has been implemented. Third, a robust antibiotic stewardship program is in place. (Timeline for improvement: We are on track to meet the goal)

2. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been three CAUTI in Q1 FY2025 with a goal to have less than ten for the fiscal year. Q1 FY25 we are at (1.00) versus a target of (0.83/month).Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team rounds on every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. (Timeline for improvement: We are close to target and we will be reinforcing following existing processes)

3. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for the end of Q1 FY2025 year to date (0.0) is favorable to target (0.42 cases per month). Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management of hemodyalsis catheters. (Timeline for improvement: We are on track to meet target)

4. **Surgical Site Infection**. The number of cases/month of surgical site infections for Q1 FY2025 (4.67) is unfavorable to target (2.5). Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. A taskforce including SPD, OR staff, physicians has been instituted to reinforce best practices, enforce normothermia, timing of preoperative antibiotics and clean closure tray utilization in the OR and perioperative areas. (Timeline for improvement: We anticipate that our SSI rate will go down by Q2/Q3 of FY 2025. This is a major focus for the organization, and we have devoted significant resources to understand and implement any changes needed)

5. **Hand Hygiene Combined Compliance rate:** Performance for Q1 FY2025 is favorable (85.3) to target of 85%. (Timeline for improvement: We are on track to meet this target).

6. **Hand Hygiene % of Departments Meeting Audit Compliance target:** Performance for Q1 FY2025 is favorable (100%) to target of 80% of units.

B. Timely

1. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance for Q1 (74%) is unfavorable to target (84%). The root cause of the delays relates to multiple factors, primary being radiology staffing issues experienced by the contracted vendor. In addition, there have been issues with the transfer of images and interface with our system which are being worked on. The vendor is hiring more radiologists to their team to expedite reading of images. (Timeline for improvement: Realistically, we anticipate improvement in the Turnaround times by Q3 2025)

C. Effective

1. **30 Day Readmission Observed Rate:** Performance through Q1 FY2025 (8.3%) is favorable to target (</=9.8%). El Camino Health remains committed to ensuring timely follow-up care for patients under primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital. In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital. (Timeline for improvement: We are on track to achieve target for FY 2025)

2. **Risk Adjusted Mortality Index.** Performance for Q1 FY25 (0.88) is favorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. Though we are on track for this metric, we will be closely monitoring this since the system changes introduced in documentation integrity, reduction in clinical variation and institution of earlier hospice and GIP are just in the initial phases of implementation. (Timeline for improvement: We are on track to achieve this target for FY 2025)

3. **Sepsis Mortality Index.** Performance for Q1 FY2025 (1.06) is unfavorable to target (1.00). Patients often arrive in the ED in Septic Shock. We are working to increase Social Work and/or Palliative Care support in the ED for goals of care discussions. Pursue hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change internally was that the sepsis coordinators provide concurrent sepsis bundle compliance to ED physicians and staff in the real time. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program. (Timeline for improvement: The GIP program is planned for go-Live in Q2/Q3 of FY25. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation. This alone, Palliative care consult" increases the expected risk of mortality 6-fold)

4. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV)**. FY25 performance through August of 2024 (21.7) is unfavorable to target of 23.9%.The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: We are on track with this metric, however, we are closely watching this to ensure that the improvement is sustainable)

D. Efficient

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD is (1.07) is unfavorable to target of (1.02). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams are optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place.
    - Within Epic a centralized care plan was created that pulls together important information about the patients care plan. This tool increased efficiency and allows the care team to obtain pertinent information in a timely way. Additionally, interdisciplinary team members can track internal and external delays which will offer insight into the primary reasons for delays in patient throughput.
    - Since the initiation of Multidisciplinary rounds (MDR) in December 2023, there have been significant improvements in LOS within the pilot program for patients who stay in nursing unit 2C. The data indicates a noteworthy decrease of -1.1 days in LOS (as of 04/24/2024) for these patients. Given the successful demonstration, the MDR process was expanded to the nursing unit on 3C. In addition, the plan is to roll out the MDR process to 3 additional units in Q1 2025.
    - We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4 patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements. (Timeline for improvement: We anticipate improvement due to the changes implemented by Q3 of 2025)

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY25 Q1 performance (151 minutes) is favorable to the target of < 160 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

E. Equitable

1. **Social Drivers of Health Screening rate:** FY 25 performance YTD is (4%) is unfavorable to target of 50%. This is a new measure and steps taken to improve our screening rate includes creating a new tool for staff to document required elements of the metric. Our team including care coordinators, nurses and informatics teams are working to implement this tool in the next few months. (We expect significant improvement in this metric by Q3 2025 once the new tool is deployed and adopted)

2. **Voyce Interpretation Minutes Used:** FY 2025 performance (173,776 minutes). We are in the process of establishing a target for this metric. This is the first year that we are using this metric, hence there is no benchmark either locally or nationally. We believe that this metric is an important proxy for communication with patients who do not have English as their primary language.

F. Patient Centered

1. **Inpatient HCAHPS Likelihood to Recommend**. For the month of March (83.4) and FY25 (80.7) performance is unfavorable to target of 81.9. We are continuing to focus on our Key Drivers of Nurse Communication, Hourly Rounding, and Responsiveness. We continue to upgrade our RN call system on both campuses leading to better responsiveness. (Timeline for improvement: We should see improvement in this metric in Q2/Q3 2025)

2. **Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** FY 2025 YTD (82.8.4) is favorable to target of 82.0. We continue to perform in the top decile in the Bay Area and 87% nationally. Our new facility in Mountain View has rave reviews from our patients and families.

3. **ED Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** The overall ED top box score exceeded target (78.9) Q1 FY2025 is favorable to target of (77.2)

4. **El Camino Health Medical Network: Likelihood to Recommend Care Provider Top Box Rating of "Yes, Definitely likely to Recommend".** Performance for Q1 FY2025 is unfavorable (80.9) to target of (83.4). We continue to perform in the top decile in the Bay Area and 87% nationally. Our new facility in Mountain View has rave reviews from our patients and families.

Attachments:

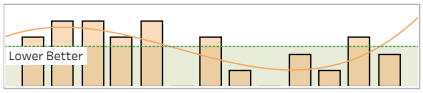
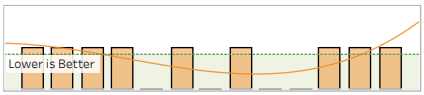
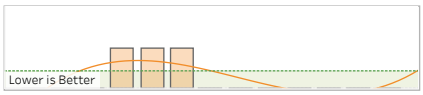
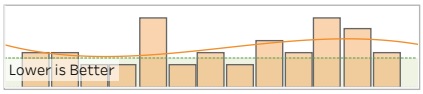
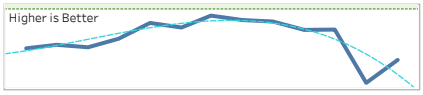
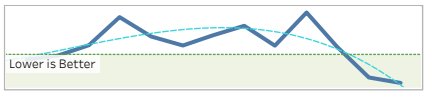
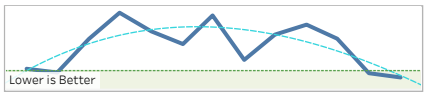
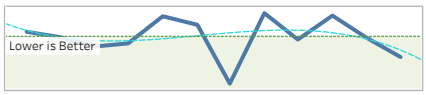
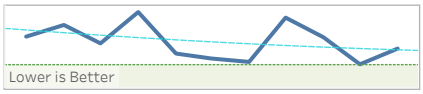
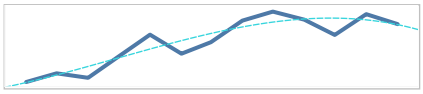
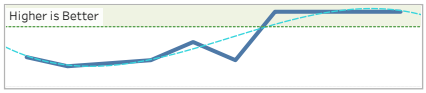
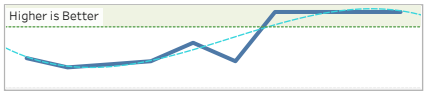
1. STEEEP Dashboard through September of 2024.

El Camino Health Quality Board: FYTD25 STEEEP

El Camino Health

Show Filter

Date: 10/1/2023 09/30/2024

Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator		Last 12 Months Trend
Safe Care	FY 24Q2	FY 24Q3	FY 24Q4	FY 25Q1	FY24	FYTD25			
C-Diff Clostridioides Difficile Infection Count	11	7	3	6	28	**6**	🟢	<= 27 cases	
CAUTI Catheter-Associated Urinary Tract Infection Count	3	1	1	3	11	**3**	🟢	<=10 cases	
CLABSI Central Line-Associated Bloodstream Infection Count	1	2	0	0	3	**0**	🟢	<=5 cases	
SSI Surgical Site Infection Count	7	11	9	14	38	**14**	🔴	<=30 cases	
Hand Hygiene Compliance (Entry and Exit Combined Rate)	76.5%	87.2%	87.3%	85.3%	84.1%	**85.3%**	🟢	>=80%	
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	76.9%	81.4%	81.0%	74.0%	77.7%	**74.0%**	🔴	>=84.0%	
Effective									
Readmission (Based on Vizient Risk Model) ***Includes data up to Aug 2024 Only*	8.9%	9.6%	9.3%	8.3%	9.8%	**8.3%**	🟢	<=9.8%	
Hospital Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.15	1.14	1.25	0.88	1.16	**0.88**	🟢	<= 1.0	
Sepsis Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.33	1.43	1.36	1.07	1.35	**1.06**	🔴	<=1.0	
NTSV Cesarean Section (CMS PC-02 Measure) ***Includes data up to Aug 2024 Only*	22.7%	23.0%	26.8%	21.7%	24.7%	**21.7%**	🟢	<= 23.9%	
Efficient									
Avg Length of Stay (ALOS) (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.08	1.07	1.07	1.06	1.07	**1.06**	🔴	<= 1.02	
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	156	155	155	151	155.8	**151.0**	🟢	<=160	
Equitable									
Social Driver of Health (SDOH) Screening Rate	2.2%	2.1%	2.5%	4.0%	2.1%	**4.0%**	🔴	50%	
Voyce Interpretation Minutes Used	46,915	53,231	59,672	57,925	617,023	**173,776**	⚪	TBD	
Patient-Centered									
Inpatient Hospital: Likelihood to Recommend Press Ganey	80.3	79.9	83.4	80.7	80.12	**80.7**	🔴	81.9	
ED: Likelihood to Recommend Press Ganey	74.5	74.3	75.6	78.9	75.0	**78.9**	🟢	77.2	
MCH - INPATIENT Press Ganey	83.7	83.2	81.4	82.8	75.00	**82.8**	🟢	82.0	

El Camino Health

El Camino Health Board of Directors
Board Meeting Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, Chief Quality Officer
Date: November 20, 2024
Subject: Quality Deep Dive Topic: Reducing Hospital Acquired Infections at El Camino Health

Purpose:

Review the current state of Hospital Acquired Infections at El Camino Health and performance improvement initiatives to decrease the HAI rate.

Summary:

Based on latest data, this is a summary of the current state of HAIs at El Camino Health.

- Overall HAI rates at El Camino Health had increased during the pandemic in line with national trends.
- HAIs have started to trend down at El Camino Health due to very specific, targeted efforts by our teams
- Though we are doing better than National and State averages in measures, there is room for improvement compared to the best performing health systems in the country for CAUTI and C.Diff

Attachments:

1. Presentation: Hospital Acquired Infection Data and Performance Analysis.

El Camino Health®

SAFEGUARDING PATIENTS' HEALTH

ECH's Initiatives to Reduce Healthcare Associated Infections (HAIs)

Shreyas Mallur, MD
Chief Quality Officer

November 20, 2024

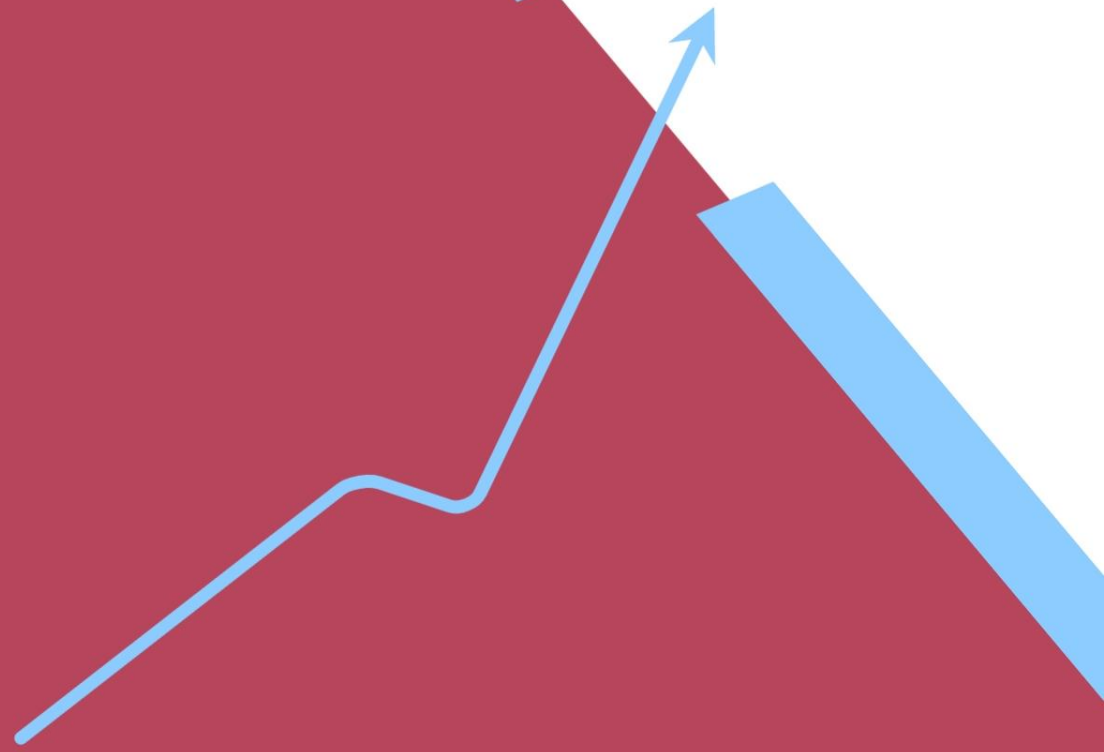
El Camino Health®

"THERE ARE SOME PATIENTS WHOM WE CANNOT HELP, BUT THERE ARE NONE WE CANNOT HARM"

- Arthur Bloomfield, MD 1933

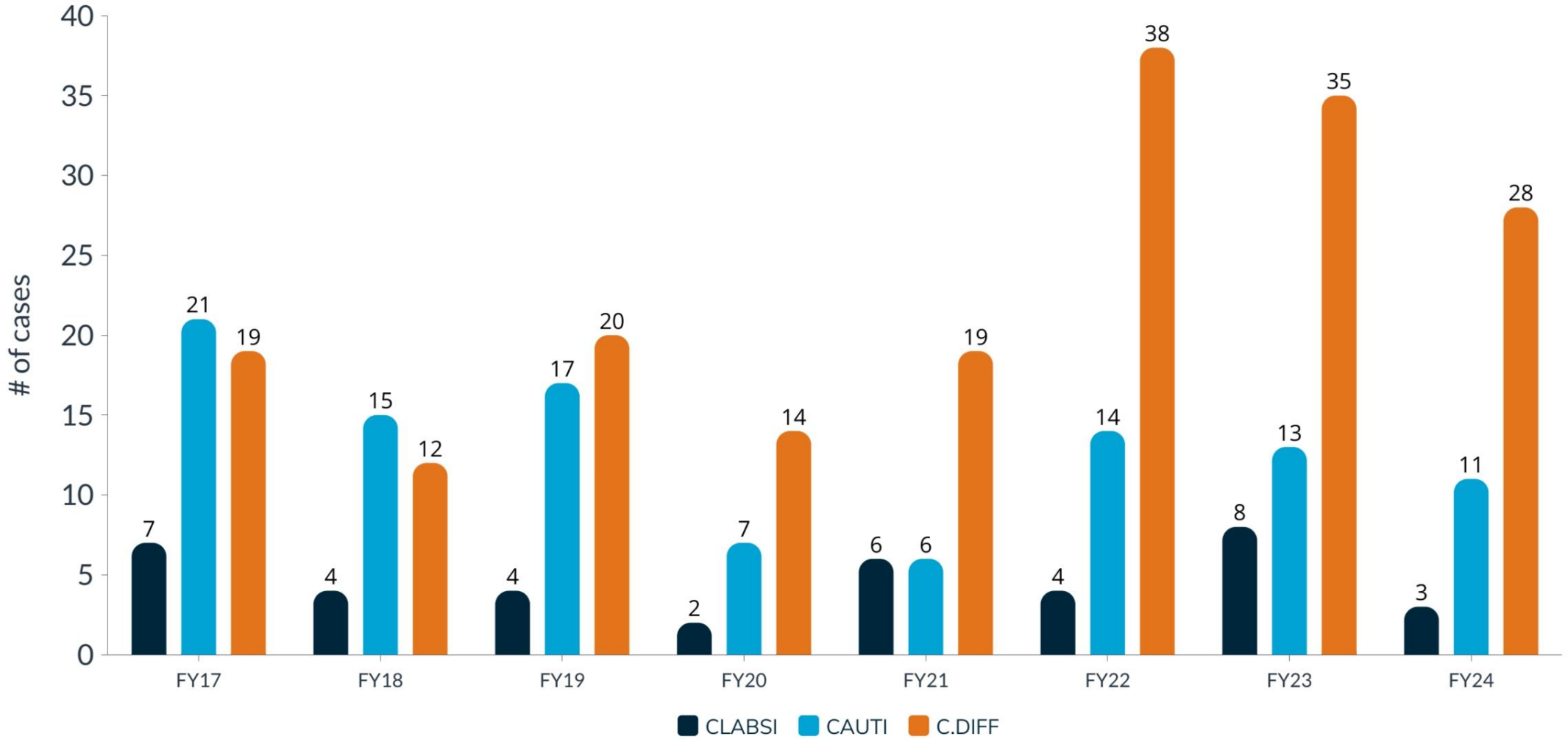
BY THE NUMBERS:

1.7	99K	$33B
# of HAIs/Year Nationally	# of Avoidable Deaths	Healthcare Dollars



HAIs TREND

El Camino Health: FY 2017-2024



STANDARDIZED INFECTION RATIO (SIR)

A score that shows how well we are doing in preventing infections, based on National Averages

$$SIR = \frac{\text{Actual Infections}}{\text{Predicted Infections}}$$

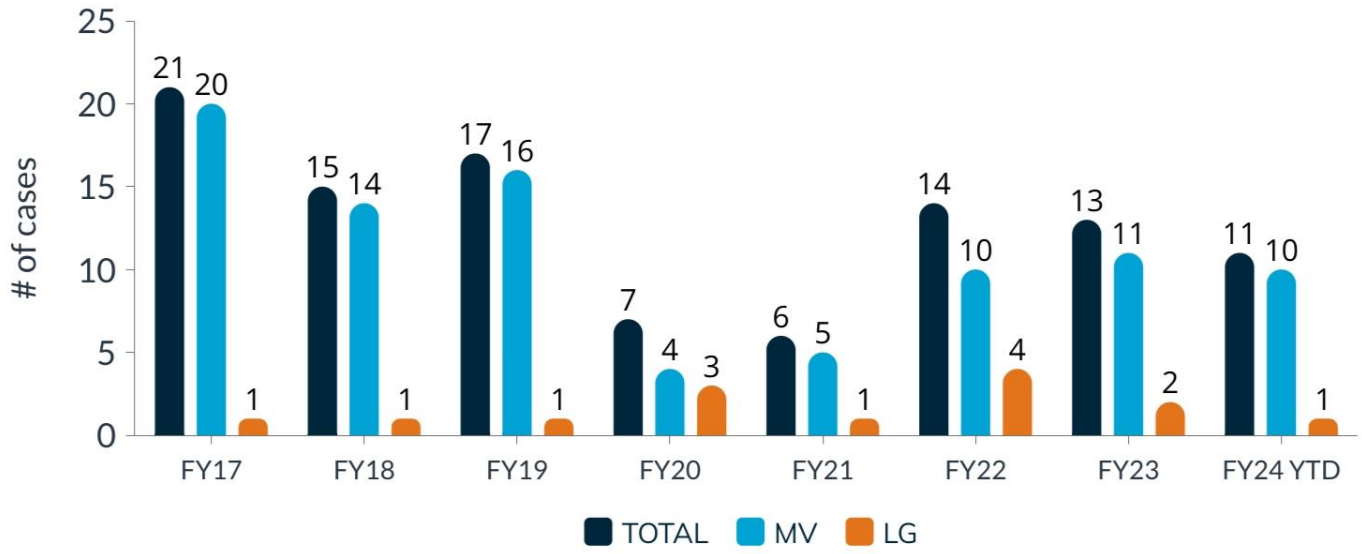
SIR < 1	SIR= 1	SIR > 1
Fewer infections than predicted	**Average**	**More** infections than predicted

CAUTI

Measures to Decrease CAUTI

- Don't put a Foley in
- Using alternatives
- Insertion techniques
- Maintenance
- Removal
- Process and structure to achieve and maintain
- Daily justification check
- Designated nurse champions on unit
- External catheters
- Daily rounding
- Urine culture: use appropriate technique

FY 2017-2024 Trend



National SIR	California SIR
CY 2020 - **0.75**	CY 2020 - **0.89**
CY 2021- **0.79**	CY 2021- **0.88**
CY 2022 - **0.69**	CY 2022 - **0.79**

El Camino Health SIR

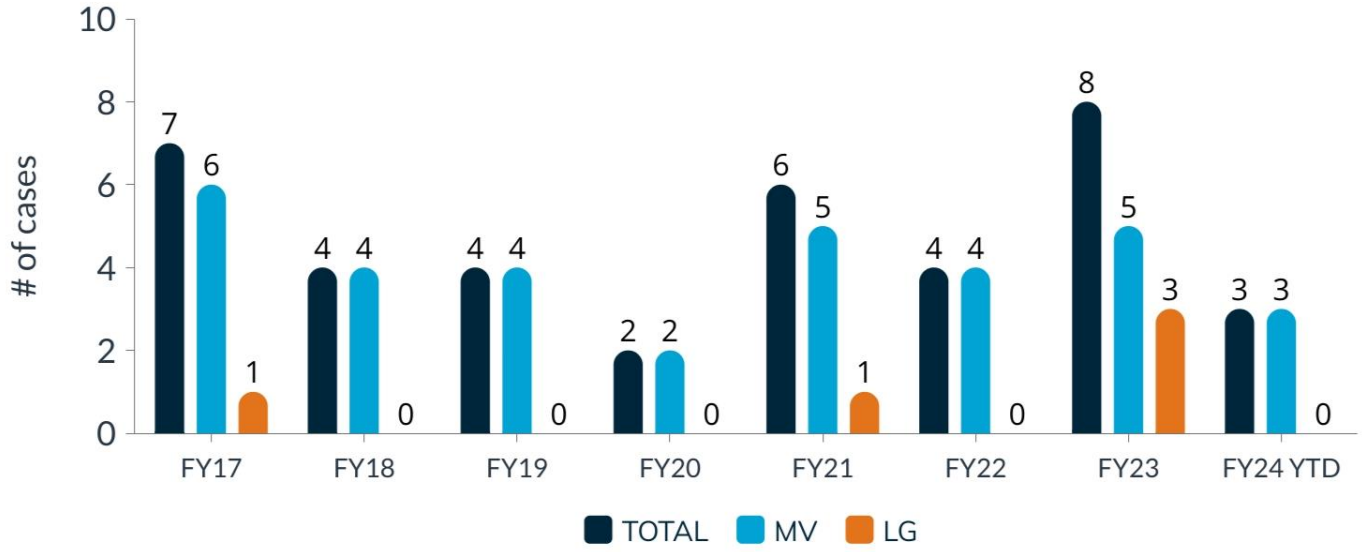
Enterprise	MV	LG
FY20 - **0.53**	FY20 - **0.50**	FY20 - **0.68**
FY21- **0.46**	FY21- **0.54**	FY21- **0.0**
FY22 - **1.27**	FY22 - **1.2**	FY22 - **1.6**
FY23 - **0.91**	FY23 - **1.1**	FY23 - **0.0**
FY24 - **0.98**	FY24 - **1.1**	FY24 - **0.46**

CLABSI

Measures to Decrease CLABSI

- Insertion: Use bundles, aseptic technique
- Maintenance of catheters: Dressing changes
- Daily review of line necessity
- Removal of catheters
- Special circumstances: NICU and hemodialysis catheters

FY 2017-2024 Trend



National SIR	California SIR
CY 2020 - **0.86**	CY 2020 - **0.86**
CY 2021- **0.92**	CY 2021- **0.91**
CY 2022 - **0.84**	CY 2022 - **0.84**

El Camino Health SIR

Enterprise	MV	LG
FY20 - **0.2**	FY20 - **0.2**	FY20 - **0.0**
FY21- **0.36**	FY21- **0.29**	FY21- **0.83**
FY22 - **0.36**	FY22 - **0.38**	FY22 - **0.0**
FY23 - **0.62**	FY23 - **0.46**	FY23 - **1.4**
FY24 - **0.24**	FY24 - **0.27**	FY24 - **0.0**

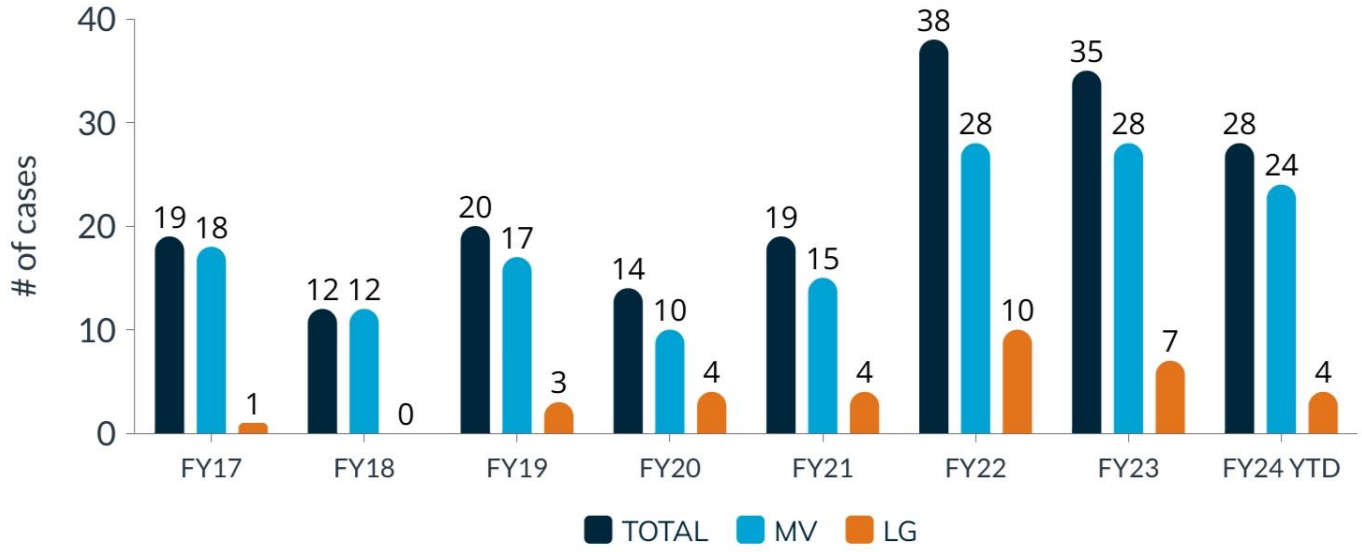
C.DIFFICILE

El Camino Health®

Measures to Decrease C.DIFFICILE

- Surveillance: Testing high risk patients (i.e., SNFs)
- Early testing: Patients with diarrhea on admission or the first three days
- Hand hygiene and contact precautions
- Environmental cleaning and disinfection: C.Diff spores can stay on surfaces for months
- Antibiotic Stewardship Program: Reduce the use of antibiotics and discontinue antibiotics when not required

FY 2017-2024 Trend



National SIR

CY 2020 - **0.50**
CY 2021- **0.52**
CY 2022 - **0.48**

California SIR

CY 2020 - **0.55**
CY 2021- **0.55**
CY 2022 - **0.52**

El Camino Health SIR

Enterprise	MV	LG
FY20 - **0.38**	FY20 - **0.33**	FY20 - **0.83**
FY21- **0.32**	FY21- **0.31**	FY21- **0.35**
FY22 - **0.61**	FY22 - **0.52**	FY22 - **1.6**
FY23 - **0.50**	FY23 - **0.46**	FY23 - **0.79**
FY24 - **0.43**	FY24 - **0.40**	FY24 - **0.6**

LEAPFROG - FALL 2024

As "Straight A" hospitals, El Camino Health hospitals earned an "A" in at least 5 consecutive cycles - An uncommon feat that makes our facilities true standouts

QUESTIONS

El Camino Health®

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, October 9, 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
Lanhee Chen, JD, PhD
Wayne Doiguchi
Peter Fung, MD
Julia E. Miller
Carol A. Somersille, MD
George O. Ting, MD
Don Watters

Others Present
Dan Woods, CEO
Mark Adams, **MD**, CMO
Carlos Bohorquez, CFO
Omar Chughtai, CGO**
Theresa Fuentes, CLO
Mark Klein, CC&MO**
Andreu Reall, VP of Strategy**

Others Present (cont.)
Bob Miller, Executive Compensation Committee Chair
Ed Braxton, Director, Total Rewards
Rob Kirkpatrick, Mercer**
Tracy Fowler, Director, Governance Services
Brian Richards, Information Technology

Board Members Absent
None

***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. All Directors were present constituting a quorum.	***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. BOARD ASSESSMENT RESULTS	The assessment results from the August surveys were discussed with George Anderson from SpencerStuart providing insights. Discussion opened with a focus on areas such as committee effectiveness and overall board performance. Directors commented on the challenges of benchmarking the survey data due to its uniqueness and questioned the significance of small numerical changes in scores. The board proposed improvements to the feedback process, including anonymous comments and qualitative, interview-based feedback for deeper insights. Concerns were raised about committee assignments, particularly for District members, and the need for a more formal approach to matching members to committees based on expertise. Specific areas for improvement, such as community engagement and committee effectiveness, were highlighted. Mr. Anderson concluded by calling attention to the board's strong performance in open communication and board meetings. The discussion emphasized both celebrating the board's successes and continuing to improve its governance practices moving forward.	

6. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 6:01 p.m. **Movant**: Ting **Second**: Watters **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Recessed to closed session at 6:01 p.m.***
7. AGENDA ITEM 13: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:28 p.m., and Agenda Items 7-11 were addressed in the closed session. Ms. Fowler reported that during the closed session, the Credentialing and Privileges Report and Closed Session Minutes were approved by a unanimous vote of all Directors present.	***Reconvened Open Session at 7:28 p.m.***
8. AGENDA ITEM 14: FY2024 AUDITED FINANCIAL REPORT	**Motion:** To approve the FY2024 Consolidated Financial, 403(b) Retirement Plan and Cash Balance Plan Audit Reports. **Movant**: Watters **Second**: Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***FY2024 Audited Financial Report was approved.***
9. AGENDA ITEM 15: APPROVE FY2024 ORGANIZATION PERFORMANCE INCENTIVE PLAN SCORE	**Motion:** To approve an organizational score of 150% subject to the finalization for the external audit approved at this meeting. **Movant**: Somersille **Second**: Ting **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***FY2024 Organization Performance Incentive Plan Score was approved at 150%.*** ***Action:*** *Staff to provide FY2024 results to public packet on the ECH website.*
10. AGENDA ITEM 16: REPORT OF RECOMMENDATION FOR FY2024 CEO PERFORMANCE INCENTIVE PLAN PAYOUT	**Motion:** To approve payment of the FY2024 CEO Individual Incentive Plan consistent with the organizational score of 150%. **Movant**: Watters **Second**: Miller **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None	***FY2024 CEO Individual Incentive Plan payment was approved at 150%.***

	Absent: None **Recused**: None	
11. AGENDA ITEM 17: REPORT OF RECOMMENDATION FOR FY2025 CEO BASE SALARY	**Motion:** To approve the proposed FY25 salary for the CEO as follows: "The fixed cash compensation for the Chief Executive Officer consists of an annual base salary of $1.500 million dollars plus the continuing fixed allowance of 7% of base salary, for a total of $1.605 million dollars. The salary range for the CEO position is $1.275 million minimum to a maximum of $1.915 million with a midpoint of $1.595 million." **Movant**: Po **Second**: Miller **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***The FY2025 CEO base salary and salary range were approved as moved.***
12. AGENDA ITEM 18: 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 (c) to be removed. **Motion:** To approve the consent calendar minus item (c). **Movant**: Miller **Second**: Chen **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None **Motion:** To approve item (c) Policies, Plans and Scopes of Service as Reviewed and Recommended for Approval by the Medical Executive Committee with recommended changes to be part of future reports. **Movant**: Miller **Second**: Po **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Consent Calendar item (a) was approved.*** *Prior Open Minutes,* ***Item (c) Policies, Plans and Scopes of Services was approved.*** ***Action:*** *Staff to add column to show date last reviewed by the board. Staff to have name of policy on each page of the document for clarity in reviewing.*
13. AGENDA ITEM 19:	Mr. Woods provided the CEO report summarizing key	***Action****: Staff to*

CEO REPORT	organizational updates. He noted the continued strong revenue and overall performance. He shared a cybersecurity industry benchmark where El Camino ranked in the top 30th percentile of secure healthcare organizations. He also shared that the Foundation was reported to be on track with fundraising efforts, having raised $5.9 million out of a $7.7 million annual goal by period 2. Mr. Woods shared some community engagement events that were well received – a special reception for Congresswoman Anna Eshoo and a ribbon cutting ceremony commemorating the completion of the Cuesta Park Fitness Court. He concluded his comments with a reminder about flu season and the availability of COVID and flu vaccines.	*share flu clinic information with the Board.* *Staff to share a list of ECH clinics and facilities with the Board.*
14. AGENDA ITEM 20: BOARD ANNOUNCEMENTS	There were no announcements from the Board.	
15. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 7:49 p.m. **Movant**: Miller **Second**: Po **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Meeting adjourned at 7:49 p.m.***

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

_____

John Zoglin, Secretary/Treasurer

Prepared by: 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: November 20, 2024
Subject: Financials: FY2025 – Period 3 & YTD (as of 09/30/2024) - Consent Calendar

Purpose:

To provide the Board an update on financial results for FY2025 Period 3 (September 2024) & YTD.

Executive Summary – Period 3 (September 2024):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 315 is 6 / 1.9% favorable to budget and 8 / 2.7% higher than the same period last year.
- **Adjusted Discharges:** 3,610 are 31 / (0.8%) unfavorable to budget and 64 / 1.7% lower than the same period last year.
- **Emergency Room Visits:** 6,486 are (15) / (0.2%) unfavorable to budget and 51 / (0.1%) lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 11,835 are 399 / 3.5% favorable to budget and 825 / 7.5% higher than the same period last fiscal year.

Financial performance for Period 3 was unfavorable to budget. This is attributed higher than budgeted Medi-Cal payor mix and increase in benefit expenses associated with employee and dependent coverage.

Total Operating Revenue ($):	$134.7M is $0.7M / 0.5% favorable to budget and $14.0M / 11.8% higher than the same period last fiscal year.
Operating EBIDA ($):	$17.5M is $1.5M / 8.1% unfavorable to budget and $0.4M / 2.1% higher than the same period last fiscal year.
Net Income ($):	$33.6M is $17.7M / 111.7% favorable to budget and $49.2M / 315.7% higher than the same period last fiscal year.
Operating Margin (%):	6.8% (actual) vs. 7.7% (budget)
Operating EBIDA Margin (%):	13.0% (actual) vs. 14.2% (budget)
Net Days in A/R (days):	54.5 days are unfavorable to budget by 0.5 days / 0.9% and 4.1 days / 7.1% better than the same period last year.

Executive Summary – YTD FY2025 (as of 9/30/2024):

With the exception of outpatient visits / procedures and surgeries, year-over-year patient activity is flat.

- **Average Daily Census:** 299 is 7 / 2.3% unfavorable to budget and 5 / 1.6% lower than the same period last year.
- **Adjusted Discharges:** 10,857 are 110 / 1.0% unfavorable to budget and 105 / 1.0% lower than the same period last year.
- **Emergency Room Visits:** 19,514 are 250 / 1.3% unfavorable to budget and 118 / 1.0% lower than the same period last fiscal year.

- **Outpatient Visits / Procedures:** 36,550 are 1,949 / 5.6% favorable to budget and 3,298 / 9.9% higher than the same period last fiscal year.

Total Operating Revenue ($):	$407.8M is $3.3M / 0.8% favorable to budget and $40.3M / 11.0% higher than the same period last fiscal year.
Operating EBIDA ($):	$56.2M is $0.7M / 1.2% unfavorable to budget and $2.1M / 3.9% higher than the same period last fiscal year.
Net Income ($):	$101.8M is $56.6M / 125.4% favorable to budget and $91.5M / 887.2% higher than the same period last fiscal year. Favorable net income is attributed stable financial performance and unrealized gains on investment portfolio.
Operating Margin (%):	7.6% (actual) vs. 8.0% (budget)
Operating EBIDA Margin (%):	13.8% (actual) vs. 14.1% (budget)

Recommendation:

- Board approval of FY2025 – Period 3 & YTD financials

List of Attachments:

- Financial Report: FY2025 Period 3

Suggested Board Discussion Questions:

- None

El Camino Health

Summary of Financial Operations

Fiscal Year 2025 – Period 3

7/1/2024 to 09/30/2024

Please Note: Period 3 / YTD results are pending review & approval by the Finance Committee

Operational / Financial Results: Period 3 – September 2024 (as of 09/30/2024)

($ 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	315	309	6	1.9%	307	8	2.7%	---	---	---	---
	Adjusted Discharges	3,610	3,641	(31)	(0.8%)	3,675	(64)	(1.7%)	---	---	---	---
	OP Visits / OP Procedural Cases	11,835	11,436	399	3.5%	11,010	825	7.5%	---	---	---	---
	Percent Government (%)	58.1%	59.0%	(0.9%)	(1.6%)	58.9%	(0.8%)	(1.3%)	---	---	---	---
	Gross Charges ($)	580,421	562,322	18,099	3.2%	515,816	64,604	12.5%	---	---	---	---
Operations	Cost Per CMI AD	19,813	20,032	(220)	(1.1%)	18,001	1,811	10.1%	---	---	---	---
	Net Days in A/R	54.5	54.0	0.5	0.9%	58.6	(4.1)	(7.1%)	48.1	49.7	47.5	
Financial Performance	Net Patient Revenue ($)	128,662	128,795	(133)	(0.1%)	116,006	12,656	10.9%	297,558	564,735	---	
	Total Operating Revenue ($)	134,683	134,014	669	0.5%	120,719	13,964	11.6%	389,498	610,593	268,739	
	Operating Margin ($)	**9,177**	**10,351**	**(1,174)**	(11.3%)	**8,897**	**279**	3.1%	**7,400**	**11,601**	**8,331**	
	Operating EBIDA ($)	**17,536**	**19,071**	**(1,536)**	(8.1%)	**17,167**	**368**	2.1%	**26,400**	**39,689**	**22,574**	
	Net Income ($)	33,607	15,875	17,732	111.7%	(15,583)	49,190	315.7%	19,085	20,150	15,049	
	Operating Margin (%)	**6.8%**	**7.7%**	**(0.9%)**	(11.8%)	**7.4%**	**(0.6%)**	(7.6%)	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**13.0%**	**14.2%**	**(1.2%)**	(8.5%)	**14.2%**	**(1.2%)**	(8.4%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	280	275	5	1.8%	255	25	10.0%	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 09/30/2024)

($ 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	299	306	(7)	(2.3%)	304	(5)	(1.5%)	---	---	---	---
	Adjusted Discharges	10,857	10,967	(110)	(1.0%)	10,963	(105)	(1.0%)	---	---	---	---
	OP Visits / OP Procedural Cases	36,550	34,601	1,949	5.6%	33,252	3,298	9.9%	---	---	---	---
	Percent Government (%)	58.2%	58.5%	(0.3%)	(0.6%)	58.9%	(0.8%)	(1.3%)	---	---	---	---
	Gross Charges ($)	1,740,343	1,688,944	51,399	3.0%	1,540,261	200,081	13.0%	---	---	---	---
Operations	Cost Per CMI AD	20,188	20,032	156	0.8%	18,445	1,743	9.5%	---	---	---	---
	Net Days in A/R	54.5	54.0	0.5	0.9%	58.6	(4.1)	(7.1%)	48.1	48.1	47.5	
Financial Performance	Net Patient Revenue ($)	390,787	388,742	2,045	0.5%	352,080	38,707	11.0%	892,675	1,694,204	---	
	Total Operating Revenue ($)	407,774	404,440	3,334	0.8%	367,473	40,301	11.0%	1,168,494	1,831,779	3,224,864	
	Operating Margin ($)	**30,929**	**30,557**	**372**	1.2%	**29,353**	**1,577**	5.4%	**22,201**	**34,804**	**99,971**	
	Operating EBIDA ($)	**56,174**	**56,881**	**(706)**	(1.2%)	**54,089**	**2,086**	3.9%	**79,201**	**119,066**	**270,889**	
	Net Income ($)	101,808	45,173	56,635	125.4%	10,313	91,495	887.2%	57,256	104,411	180,592	
	Operating Margin (%)	**7.6%**	**7.6%**	**0.0%**	0.4%	**8.0%**	**(0.4%)**	(5.0%)	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**13.8%**	**14.1%**	**(0.3%)**	(2.0%)	**14.7%**	**(0.9%)**	(6.4%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	280	275	5	1.8%	255	25	10.0%	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.
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Notes: DCOH total includes cash, short-term and long-term investments.
OP Visits / Procedural Cases includes Covid Vaccinations / Testing.

El Camino Health

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

Consolidated Balance Sheet (as of 09/30/2024)

($000s)

ASSETS		Unaudited
CURRENT ASSETS	**September 30, 2024**	**June 30, 2024**
Cash	248,435	202,980
Short Term Investments	91,822	100,316
Patient Accounts Receivable, net	231,396	211,960
Other Accounts and Notes Receivable	19,569	25,065
Intercompany Receivables	17,640	17,770
Inventories and Prepaids	49,331	55,556
Total Current Assets	**658,193**	**613,647**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	24,841	23,309
Plant & Equipment Fund	524,966	503,081
Women's Hospital Expansion	43,797	31,740
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	17,572	17,561
Workers Compensation Reserve Fund	14,471	12,811
Postretirement Health/Life Reserve Fund	23,009	22,737
PTO Liability Fund	37,646	37,646
Malpractice Reserve Fund	1,713	1,713
Catastrophic Reserves Fund	36,408	33,030
Total Board Designated Assets	**935,116**	**894,322**
FUNDS HELD BY TRUSTEE	**18**	**18**
LONG TERM INVESTMENTS	**715,437**	**665,759**
CHARITABLE GIFT ANNUITY INVESTMENTS	**987**	**965**
INVESTMENTS IN AFFILIATES	**37,448**	**36,663**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,020,500	2,016,992
Less: Accumulated Depreciation	(895,600)	(874,767)
Construction in Progress	187,236	173,449
Property, Plant & Equipment - Net	**1,312,136**	**1,315,675**
DEFERRED OUTFLOWS	46,687	41,550
RESTRICTED ASSETS	32,177	32,166
OTHER ASSETS	188,903	195,447
TOTAL ASSETS	**3,927,102**	**3,796,213**

LIABILITIES AND FUND BALANCE		Unaudited
CURRENT LIABILITIES	**September 30, 2024**	**June 30, 2024**
Accounts Payable	63,015	71,017
Salaries and Related Liabilities	64,108	35,693
Accrued PTO	40,349	38,634
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	13,679	13,419
Intercompany Payables	13,735	13,907
Malpractice Reserves	1,830	1,830
Bonds Payable - Current	10,820	10,820
Bond Interest Payable	3,069	7,673
Other Liabilities	14,654	12,261
Total Current Liabilities	**227,560**	**207,554**
LONG TERM LIABILITIES		
Post Retirement Benefits	23,009	22,737
Worker's Comp Reserve	12,811	12,811
Other L/T Obligation (Asbestos)	28,687	27,707
Bond Payable	439,980	441,105
Total Long Term Liabilities	**504,487**	**504,360**
DEFERRED REVENUE-UNRESTRICTED	**1,162**	**1,038**
DEFERRED INFLOW OF RESOURCES	**84,484**	**92,261**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,836,144	2,731,120
Minority Interest	(1,159)	(1,114)
Board Designated	224,536	216,378
Restricted	49,890	44,616
Total Fund Bal & Capital Accts	**3,109,410**	**2,991,001**
TOTAL LIABILITIES AND FUND BALANCE	**3,927,102**	**3,796,213**

El Camino Health

Department	Document Name	Origination	Last Reviewed	Revised?	Doc Type	Committee
New Business						
Sleep Center	17c1. Scope of Service – Sleep Center Los Gatos	3-2015	3-14-24	Revised	Scope of Svc	• Med Dir • ePolicy • MEC • Board > Publish
Security Mgmt	17c2. Workplace Violence Prevention Plan	5-2018	6-8-22	Revised	Plan	• Central Safety • PESC • ePolicy • MEC • Board > Publish
Medical Staff	17c3. Focused Professional Practice Evaluation (FPPE)	11-2008	N/A	Revised	Policy	• IDPC • Credentialing Cmte • ePolicy • MEC • Board > Publish
Information Security	17c4. Artificial Intelligence Policy	6-2024	6-12-24	Revised	Policy	• CISO | CIO • ePolicy • MEC • Board > Publish
HIM	17c5. HIPAA Restricting Use or Disclosure of Protected Health Information	4-2003	9-22-21	Revised	Policy	• HIM Leadership • ePolicy • MEC • Board > Publish
Foundation	17c6. Third-Party Fundraising Events Policy	N/A	N/A	New	Policy	• Finance Cmte • Executive Cmte • Foundation Board • ePolicy • Board > Publish

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT I NOVEMBER 20, 2024

FINANCE:

- **Period 3 – September 2024**
  - **Total Operating Revenue: $134.7M**
    - $0.7M / 0.5% vs. Budget
    - $14.0M / 11.6% higher than the same period last year
  - **Operating EBIDA: $17.5M**
    - ($1.5M) / (8.1%) vs. Budget
    - $0.4M / 0.2% higher as the same period last year
  - **Net Income: $33.6M**
    - $17.7M / 111.7% vs. Budget
    - $49.2M / 315.7% higher than the same period last year

NURSING: A group of El Camino Health nurses, as well as nurse leaders, attended the ANCC Magnet conference in New Orleans with 14,000 other nurses from around the world. Several ECH nurses presented best practices through poster presentation and a podium presentation

INFORMATION SERVICES: **Imprivata Fairwarning** is now live, providing improved automated privacy auditing and monitoring of access to patient information in the EMR. As of September 30, patients can now access their medical records through MyChart (myCare) in Spanish, with more than 1,100 myCare sessions in Spanish completed. ECHMN My Chart patient activation has increased to 77%, placing them in the Top 10th percentile of Epic customers

FOUNDATION: In September, El Camino Health Foundation secured $122,812 in donations. This brings **total funds raised through period 3 to $6,025,289, which is 78% of the $7,700,000 goal for FY2025**. The Foundation held the 28th Annual El Camino Heritage Golf Tournament at Palo Alto Hills Golf & Country Club and raised $110,100, which will benefit the new emotional support program that is being developed by the Cancer Center and Scrivner Center for Mental Health & Addiction Services

MARKETING + COMMUNICATION: **Emergency Department (ED)** launched Search Engine Marketing (SEM) campaigns for our Mountain View and Los Gatos locations to increase visibility and drive patient visits. The Fall 2024 Town Halls drew **a record 1,100 El Camino Health attendees** — representing approximately a quarter of our employee population. In addition to a highly informative presentation on **cybersecurity threats and best practices in the healthcare space**, two notable videos debuted at the Town Halls, our **FY24 accomplishments report** and our **Performance Pillar & True North Goals educational campaign**

CORPORATE HEALTH: Concern **successfully completed the triannual department of managed healthcare financial audit with no deficiencies**. This success was due to a strong collaboration between the finance team and Concern

HEALTHCARE ANCHOR NETWORK (HAN): The HAN catalyzes health systems to leverage their hiring, purchasing, and other key assets **to build inclusive local economies to address inequities in community conditions that create poor health**. This is a place-based and people-centric approach to local economic development aimed at enhancing El Camino's local social impact through inclusivity. As a member of HAN, El Camino Health compares ourselves against the HAN network for hiring and procurement

Human Resources

One of the benchmark measures focuses on our employees' financial well-being by assessing the percentage of employees paid at or above the local living wage. We have received HAN's newest report published in September and El Camino Health ranks #4 out of 46 nationwide institutions with 93.5% (median = 75.9%) of our employees paid at or above the local living wage. The 46 institutions represented in this report encompass approximately 1.1 million employees

Another measure reported by HAN is that El Camino Health ranks #5 out of 51 organizations applicable to employee retention with a 90.3% retention rate (employed both on the first and last days of the fiscal year). The median retention rate is 85.4% per the report

Additionally, in 2024, El Camino has supported HAN's focus by hosting internships for high school and college students in the following departments: Integrated Care, Nursing Administration in Los Gatos, Pharmacy, Operating Room, Human Resources, Health Equity, Foundation, Quality – Clinical Analytics, and Information Systems. During their internships, these students completed projects, forged connections with their departments and fellow interns, and participated in peer check-ins. They had the opportunity to showcase their accomplishments by presenting their projects to hospital managers and their peers

Supply Chain

In parallel with this effort, our Supply Chain team has increased sourcing for both supplies and professional services from qualified diverse suppliers. This includes minority owned, women owned, veteran owned business. In many cases this is in combination with pursuing cost reduction and superior performance. Before this effort began, our qualified spend in these areas was less than $5M. In 2023 our diverse spend increased to $12M, representing a 20% increase over 2022. In 2024, this number is on pace to be well over $15M, with additional growth of more than 30%. Based on the latest HAN report, this puts El Camino Health 5th out of 44 health systems in percentage of spend going to certified diverse suppliers

GROWTH: El Camino Health's 6th Annual Maternal Mental Health Symposium had over 1,680 participants from over 31 states and 33 countries. The symposium included participation from the U.S. Surgeon General Office, 5 patients and the Kelley Family

AUXILIARY: The Auxiliary donated **3,519 volunteer hours** for the month of September

A17c1. Scope of Service - Sleep Center Los Gatos

Status **Pending** PolicyStat ID **16789153**

Origination	03/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2024
Next Review	3 years after approval
Owner	Merlynn Tan: Physician Service Line Operations Specialist
Area	Sleep Center
Document Types	Scope of Service

Scope of Service - Sleep Center Los Gatos

Types and Ages of Patients Served

The Sleep Center serves outpatients ~~2~~5 years and older. It is not necessary that the referring physician have privileges at El Camino Hospital for the patient to receive services.

Assessment Methods

Sleep studies are provided by a licensed, technologist who adheres to the ethical and practice guidelines of the Board of Registered Polysomnographic Technologists. An El Camino Hospital privileged physician provides oversight to the sleep study in the provision of patient care.

Phone calls from patients with additional questions or concerns following a sleep study will be addressed by the sleep center staff or physician. The sleep center staff will address the questions or concerns and make referrals as necessary. General patient care is through the ~~Director of~~Assistant Chief Nursing Officer.

Scope and Complexity of Services Offered

The Sleep Center is located at El Camino Hospital Los Gatos. Routine operating hours for the sleep center scheduling are Monday through Friday, 8:30am to 5:00pm. Services are not available on holidays recognized by El Camino Hospital. Sleep studies are conducted from 8:30pm to 7:00am Monday through Saturday. The sleep center has 2 sleep rooms and one control room. Patients provide for and arrange their own transportation to and from the sleep center. The sleep center schedule is maintained by the sleep coordinator. Sleep technologists are health professionals with specialized education, training and experience in sleep studies.

Appropriateness, Necessity and Timeliness of Services

The physician conducting the consultation with the patient will assess whether or not the patient needs a sleep study. The medical director makes the final decision for the appropriateness of a patient's ability to participate in a sleep study.

Criteria for Exclusion

The following criteria provide guidance for patients that would be excluded from participating in a sleep study at El Camino Hospital.

- Patients less than 5 years of age
- Non ambulatory patients
- Patients with intravenous lines in place
- Patients with severe dementia

Staffing/Staff Mix

An Executive Director, Medical Director and ~~Nurse Director~~Assistant Chief Nursing Officer oversees the operations of the Sleep Center. Sleep technologist will conduct the sleep study with general oversight by the patient care director and medical director. Staffing may increase as volume increases.

The competency of the staff is evaluated through observation of performance and skills competency validation by both the El Camino medical director and chief technologist.

Requirements for Staff

- All staff will follow all applicable hospital policies and procedures.
- All staff will be required to participate in the HeathStream safety series.
- Hospital orientation
- Safety/Emergency binders are reviewed annually by all staff.

All sleep technologists on staff are required to be board certified or board eligible by the board of registered polysomnographic technologists as a registered polysomnographic technologist.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the sleep technologist, and supervising physician. The department is designed to meet the level of care needs of the patient. Additional practices are described in department policy and procedure. This manual is maintained within the department and posted online.

A performance improvement process will be developed by medical director to identify opportunities for improvement in patient care. Patients and referring physicians may be contacted by El Camino Hospital

to assess their satisfaction with its Sleep Center program.

Standards of Practice

Sleep technologists are credentialed by the Board of Registered Polysomnographic Technologists. The sleep center service at the El Camino hospital complies with the laws and standards established by these two bodies. Additional practices are described in the Patient Care Services Policies and Procedures and Clinical Practice Standards.

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]	10/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2024
Department Medical Director or Director for non-clinical Departments	Merlynn Tan: Projects Coordinator	09/2024
	Merlynn Tan: Projects Coordinator	09/2024

History

Draft saved by Tan, Merlynn: Physician Service Line Operations Specialist on 9/26/2024, 1:12PM EDT

Edited by Tan, Merlynn: Physician Service Line Operations Specialist on 9/26/2024, 1:14PM EDT

> changed age from 2 to 5

Last Approved by Tan, Merlynn: Physician Service Line Operations Specialist on 9/26/2024, 1:14PM EDT

Last Approved by Tan, Merlynn: Physician Service Line Operations Specialist on 9/26/2024, 1:14PM EDT

Effective date schedule changed by Tan, Merlynn: Physician Service Line Operations Specialist on 9/26/2024, 1:17PM EDT

> Effective date delay removed. Policy scheduled to become active immediately upon final approval.

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 10/14/2024, 10:05AM EDT

> Per ePolicy recommendation, to update Director of Nursing to Assistant Chief Nursing Officer.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/15/2024, 12:27PM EDT

> ePolicy 10/11/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 10/24/2024, 1:07PM EDT

> MEC 10/24/24

A17c2. Workplace Violence Prevention Plan

Status **Pending** PolicyStat ID **13790859**

Origination	05/2018
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2024
Next Review	1 year after approval
Owner	Matthew Scannell: Director Safety & Security Services
Area	Security Management
Document Types	Plan

Workplace Violence Prevention Plan

COVERAGE:

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

PURPOSE:

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

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

PLAN STATEMENT:

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

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

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

DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

REFERENCES:

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

SCOPE:

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

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

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

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

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

ECH PLAN:

A. ~~Plan Owner(s)~~

~~1. At El Camino Hospital, the responsibility for implementing the Workplace Violence Prevention Plan (Plan) lies with the Hospital Safety Officer.~~

Plan Owner(s)

1. At El Camino Hospital, the responsibility for implementing the Workplace Violence Prevention Plan (Plan) lies with the Hospital Safety Officer.

2. Oversight of Plan and Workplace Violence Prevention Plan. The Behavioral Expectations and Workplace Violence Prevention Steering Committee is tasked with overseeing and enhancing the workplace violence prevention plan by reporting on progress, removing barriers, attaining necessary resources, and ensuring compliance with regulatory requirements. Additionally, the committee will evaluate pilot measures and monitor the effectiveness of implemented strategies to promote a safe and respectful workplace environment.

B. Engaging Employees and their Representative's

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

C. Coordination with External Employers for Supplemental Workers

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

D. Adherence to Retaliation Policy

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

E. Compliance

1. El Camino Hospital has established procedures to ensure that both supervisory and

non-supervisory employees comply with the plan. The ECH Policy Security Management- Prevention of Workplace Violence sets expectations for compliance. **Managers will work with Human Resources and/or Labor Relations if the policies are not followed**.

F. Communication

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

d. The following should be considered when determining the appropriate communication:
    i. Identify the party(ies) providing the communication
    ii. the urgency of the situation
    iii. the recipients of the communication
    iv. The mode of transmission (overhead page, email, nurse shift exchanges, group text, etc.)
    v. How an employee can report a violent incident, threat or concern
        - The preferred notification process for all workplace violence incidents is through the following reports:
            - ~~**Accident, Injury or Exposure Report** (AIER): Report of any injuries or assaults to Employee Wellness and Health. This should be completed as soon as possible by the employee of their supervisor.~~
            - ~~**Code Gray Critique Form:** This form is completed after each code gray incident. Forms are available under the Safety tab on the Toolbox~~
            - **Incident Reporting (Enterprise Health Employee Portal)**: The incident reporting system for hospital and medical staff to report clinical or safety related concerns. This may include information about workplace violence events..
            - **Security Incident Reports:** Security incident reports are generated for all security responses. If the report notes a workplace violent incident, it may be used to log the incident by the team as noted below.

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

    vi. Cal/OSHA Reporting Hospital Reporting Requirements for Incidents Occurring in Hospitals
        - Any incident involving physical violence against an employee will be reported regardless of whether this resulted in an injury to the employee or not.
            - If there are any questions of whether the incident should be reported, the *Workplace*

Violence Incident Reporting Team will review the incident and make a determination.

- The designated person will then complete the internal WPV Reporting Log and the Cal-OSHA Workplace Violence Incident Online Report on the OSHA website.

G. Training

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

1. Awareness/Basic training:

   Training for employees and supplemental workers is required initially when the Plan is first established and when an employee is newly hired or newly assigned to perform duties for which training is required. Refresher training will be required whenever there is a change to the Plan or operations impacting the potential for workplace violence. Employees will be given the opportunity to submit questions and receive a response within 24 hours.

2. High Risk Training

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

H. Environmental Risk Assessment

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

1. Department and area managers will participate in completing area assessments with staff to determine and list high and general risk areas.

   a. ***Workplace Violence Department Risk Assessment***

      This tool is to recognize and consider historical hazards ~~and risks (minimally – past 12 months), as well as current hazards~~ and risks, as well as current hazards and risks, confronting staff. It is to be used to engage and solicit participation from department/service-line staff and representatives in order to develop, implement and review the workplace violence Plan, as well as gain greater insight and obtain solutions and/or alternatives for making the workplace a safer environment.

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

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

1. Procedures are being developed to identify and evaluate patient-specific physical and mental risk factors, including;
    a. Patient's mental status and conditions that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively or aggressively.
    b. Patient's treatment and medication status, type, and dosage as it is known.
    c. Patient's history of violence, as it is known.
    d. Patient's disruptive or threatening behavior.
2. Department and services subject to higher behavioral risks may include the Emergency Department, Behavioral Health, and other high risks departments. Typical characteristics of patients and/or family members displaying threatening or disruptive behavior within these higher risk departments include:
    a. Emotionally charged over injury or injury of loved one
    b. Perceived delay in treatment
    c. History of aggressive behavior or violence
    d. Substance abuse
    e. Feels victimized blames others
    f. Emotionally depressed
    g. Behaving belligerently using harassing or abusive language and
    h. Unfavorable medical diagnosis

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

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

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

1. El Camino Hospital has developed the following procedures to correct workplace violence hazards in a timely manner. Risks identified during the environmental risk assessment, reported to managers or found as a result of a workplace violence incident must be addressed within the following time-frames:
    a. Imminent hazards – Employees must be protected immediately.
    b. Serious hazards – must be corrected within 7 days of discovery.

    NOTE: Interim measures may be taken to abate the imminent or serious hazard while completing the permanent corrective action plan.
2. Corrective Action shall include Enhanced Engineering and Work Practice Controls

    Engineering controls and Work Practice Controls are used to eliminate or minimize employee exposure to the identified workplace hazards. Remedial measures to protect employees from imminent hazards shall be taken immediately. Remediation activity (Engineering and Work Practice Controls) will be planned and implemented within 7-days following discovery of a serious hazard. If remediation cannot be completed during the specified time-frame, interim measures to abate imminent or seriousness of the hazard may be taken while completing permanent control measures. Enhanced Engineering and Work Practice Controls shall include, but not limited to:
        a. Engineering Control considerations
            i. Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.
            ii. Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.
            iii. Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1 or Type 2 violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.

b. Work Practice Control considerations

~~a. Minimizing, removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2* violence are reasonably anticipated to be present.~~

~~b. Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.~~

~~c. Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.~~

~~d. Establishing an effective response plan for actual or potential workplace violence incidents emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm.~~

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

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

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

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

i. Minimizing, removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2* violence are reasonably anticipated to be present.

ii. Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.

iii. Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.

iv. Establishing an effective response plan for actual or potential workplace violence incidents emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm.

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

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

K. ~~Incident Response and investigation~~

1. ~~El Camino Hospital has procedures for post incident response and investigation based on the below language.~~
    a. ~~Providing immediate medical care or first aid to all employees affected by the incident.~~
    b. ~~Identifying all employees involved in the incident.~~
    c. ~~Providing trauma counseling via Employee Assistance Program (EAP)[2].~~
    d. ~~Conducting a post incident debriefing as soon as possible after the incident with all employees, supervisors and security involved.~~
    e. ~~Reviewing any patient-specific risk factors and risk reduction measures that were specified for that patient.~~
    f. ~~Reviewing whether appropriate corrective measures were effectively implemented.~~
    g. ~~Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause and where any measure would have prevented the injury.~~

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

L. ~~Annual Review~~

1. ~~The Plan must be reviewed annually, in conjunction with employees, regarding their respective work areas, services, operations as related to prevention of workplace violence. this includes:~~
    a. ~~Staffing, staffing patterns, patient classification systems~~

~~b. Sufficiency of security systems, including alarms, emergency response, and security personnel availability~~

~~c. Job design, equipment and facilities~~

~~d. Security risks associated with specific areas and times of day~~

~~e. A review of the violent incident log~~

~~2. The annual review will take place via the Workplace Violence Prevention Committee and reported to the Central Safety Committee. Results of the annual review will be used to revise the Plan.~~

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

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

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

C. Incident Response and investigation

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

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

b. Identifying all employees involved in the incident.

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

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

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

f. Reviewing whether appropriate corrective measures were effectively implemented.

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

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

D. Annual Review

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

NOTE:

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

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

Attachments

- Workplace Violence Prevention (WPV) Risk Assessment Checklist

Approval Signatures

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

MEC	Michael Coston: Director Quality and Public Reporting [PS]	10/2024
ePolicy	Patrick Santos: Policy and Procedure Coordinator	10/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	08/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	08/2024
	Matthew Scannell: Director Safety & Security Services	08/2024

History

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> 1.Removed all references to Code Grey Critique forms.
> 2.Grammar corrections

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> Per email from Michael Rea, AIER is no longer accessible. ECH will no be using the new Incident Report through the Enterprise Health Employee Portal.

Draft saved by Scannell, Matthew: Director Safety & Security Services on 8/15/2024, 11:26AM EDT

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> • Employees working in locations isolated from other employees (including employees engaging in patient contact activities) because of being assigned to work alone or in remote locations, during night or early morning hours, or where an assailant could prevent entry into the work area by responders or other employees; • Lack of effective escape routes; • Storage of high-value items, currency, or pharmaceuticals. Added this to the policy per the internal workplace violence audit

Last Approved by Scannell, Matthew: Director Safety & Security Services on 8/15/2024, 11:28AM EDT

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> Approved

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> ePolicy 10/14/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 10/24/2024, 1:07PM EDT

> MEC 10/24/24

A17c3. Focused Professional Practice Evaluation -FPPE

Status **Pending** PolicyStat ID **16314768**

Origination	11/2008	Owner	Raquel Barnett: Sr. Director Medical Staff Services
Last Approved	N/A	Area	Medical Staff
Effective	Upon Approval	Document Types	Policy
Last Revised	09/2024		
Next Review	3 years after approval		

Focused Professional Practice Evaluation (FPPE)

COVERAGE:

All members of the medical staff and allied health practitioners with clinical privileges at El Camino Hospital

PURPOSE:

To define the process for focused professional practice evaluation (FPPE) of medical staff members and allied health practitioners at El Camino Hospital. The primary goal is to use FPPE as a tool to assess practitioners' professional performance and ensure competence as part of El Camino Hospital's commitment to quality.

POLICY STATEMENT:

FPPE is conducted to assist the medical staff in assessing current clinical competence of medical staff members and allied health practitioners at El Camino Hospital under the following circumstances:

- Upon the granting of new privileges for initial applicants
- Upon the granting of new, additional privileges for current medical staff members and allied health practitioners
- When questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care
- For renewal of privileges performed so infrequently that assessment of current competence is not feasible

REFERENCES:

1. ~~Comprehensive Accreditation Manual for Hospitals, The Joint Commission, July 1, 2019~~
2. ~~Update the FPPE Toolbox – HCPro, Inc, 2015~~
3. ~~Briefings on Credentialing – September 2008, Vol. 17, No. 9~~

- The Joint Commission, Medical Staff Standard: MS.08.01.01

DEFINITIONS:

1. **Practitioner**- The word Practitioner used throughout this policy means both licensed independent practitioner and allied health practitioner.
2. **Focused Professional Practice Evaluation (FPPE**): The establishment and confirmation of an individual practitioner's current competency at the time when he/she requests new privileges, either at initial appointment or as a current member of the medical staff; and, is also used to evaluate and monitor concerns based on a medical disciplinary cause or reason which are raised through the Ongoing Professional Practice Evaluation (OPPE) or other processes. These activities include, but are not limited to, what is typically called proctoring or focused review, depending on the nature of the circumstances.
3. **Ongoing Professional Practice Evaluation (OPPE):** The routine, ongoing monitoring and evaluation of competency for medical staff members and allied health clinicians under medical staff supervision, as defined by the six Joint Commission/ACGME general competencies.
4. Six General Competencies (basis for FPPE and OPPE)

- **Patient Care**: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life
- **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others
- **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care
- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams
- **Professionalism**: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society
- **Systems-Based Practice**: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare

PROCEDURE:

A. FPPE Methods and Data Sources:

1. A combination of the following methods may be used to determine a practitioner's competency:
    a. Prospective evaluation: Presentation of cases with planned treatment outlined for the proctor's treatment concurrence, review of case documentation for treatment concurrence, or completion of a written or oral examination or case simulation.
    b. Concurrent ~~proctoring~~FPPE: Direct observation of the procedure being performed or medical management either through observation of practitioner interactions with patients and staff members or review of clinical history and physical and review of treatment orders during the patient's hospital stay.
    c. Retrospective evaluation: Review of the case record after care has been completed. May also involve discussions with personnel directly involved in the care of the patient.
    d. External evaluation: Evaluation by an external proctor brought in may be used in situations where a proctor is unavailable (for example, when no one on the medical staff or allied health staff holds the privileges under review; or when practitioners on the medical staff with those privileges are determined to have a conflict of interest regarding the practitioner under review). Utilization of an outside proctor must be recommended by the Credentials Committee and approved by the Medical Executive Committee (MEC).
2. FPPE sources of data may include:
    a. Direct observation of practitioner
    b. Discussion with other individuals involved in the care of each patient (e.g. consulting physician, assistants in surgery, nursing or administrative personnel)
    c. Detailed medical record/chart review
    d. Review of OPPE (rate and rule data) and review of malpractice claims
    e. Monitoring of clinical practice patterns (audits by non-medical staff personnel for important clinical functions
    f. Incident reports
    g. Finding of cases identified for review by medical staff peer review committees
    h. Patient satisfaction data

B. The FPPE Period

1. All practitioners granted clinical privileges shall complete a period of FPPE ~~and~~

~~undergo proctoring~~. Members of the medical staff are placed into the Provisional Staff Category until satisfactory completion of the FPPE requirements.

2. The FPPE period begins when the practitioner is granted the initial privileges or new additional privileges and will conclude when the prescribed number of cases has been evaluated to meet the FPPE plan to determine competence.
3. FPPE should be completed within 12 months; however, may be extended for a maximum of an additional 12 months by the Department ~~Chief~~Chair with approval by the Credentials Committee. FPPE may be extended when there is insufficient data due to lack of clinical activity during the initial period of if concerns are raised that require further evaluation.
4. If at the end of the extension(s), there is still insufficient activity, the practitioner may be deemed to have voluntarily resigned the privileges. In such circumstances, the practitioner has no right to a hearing pursuant to Medical Staff Bylaws.

C. Development of the FPPE Plan for Each Practitioner

1. The Department ~~Chief~~Chair (~~or Division Chief~~ or designee) shall be responsible for overseeing the evaluation process for all applicants or staff members assigned to his/her department or division.
2. Each medical staff ~~department chief~~Department Chair (or ~~one of the department officers, if designated by the chief~~designee) shall be responsible for establishing minimum criteria in developing an FPPE plan ~~and selecting proctors~~.
3. The Interdisciplinary Practice Committee Chair (or designee) shall be responsible for establishing minimum criteria in developing an FPPE plan ~~and selecting proctors~~ of allied health practitioners.
4. Proctors must be Active or Consulting members of the medical staff in good standing, ideally in the same specialty or department and must have unrestricted privileges to perform the same privileges or procedures ~~to be observed~~.
5. The Department ~~Chief~~Chair will report any significant concerns to the Practitioner's Excellence Committee (PEC), MEC and Credentials Committee as indicated when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care.
    a. If the results of an OPPE indicate a potential significant issue with physician performance, the Department ~~Chief~~Chair will refer the matter to the PEC or MEC who may initiate a FPPE to determine whether there is problem with current competency of the physician for either specific privileges or for more global dimensions of performance
    b. When focused review is required, the ~~Practitioner Excellence Committee~~PEC, or the ~~Medical Executive Committee~~MEC may refer the case to the appropriate reviewer or committee who will ~~refer the case to the appropriate reviewer or committee who will~~ conduct the focused review. Focused review findings, conclusions and recommendations to improve practitioner performance will be communicated as appropriate so that action can be taken as needed.

D. FPPE Procedure (Initially granted privileges, new additional privileges, recredentialing when volume is insufficient to determine competency)

1. The Department ~~Chief~~Chair will review the information gathered in the credentials file in order to determine the approach and extent of FPPE needed.
2. The Department ~~Chief~~Chair will recommend a practitioner-specific FPPE plan to the Credentials Committee with his/her recommendation for privileges. The plan will include types of cases/procedures to be evaluated, number of cases, the evaluation methods, time frame and proctor requirements.
3. The Credentials Committee has the responsibility for reviewing and approving FPPE plans for initial applicants, newly added privileges, and FPPE when insufficient performance of a privilege to determine competency has occurred and forwarding recommendations to the MEC.
4. The MEC will forward recommendations of the Department Chief and Credentials Committee to the Governing Board with the credentialing and privileging recommendations.
5. Upon approval and granting of the initial privileges, additional privileges or recredentialing with FPPE for insufficient volume, ~~the~~ Medical Staff Services (MSS) shall send a letter to the practitioner ~~and proctor~~ informing them of the FPPE plan ~~and containing the contact information, and a copy of this policy and attachments~~.
6. ~~The MSSD~~MSS shall provide the practitioner ~~and proctor~~ with copies of the privileges granted.
7. ~~The MSSD~~MSS shall place copies of all documentation in the quality section of the credentials database.
8. At least monthly, ~~the MSSD~~MSS shall provide a status report to the Credentials Committee of FPPE activity for ~~all~~ practitioners' completing FPPE and requesting extension of FPPE.
9. Responsibilities of the Proctored Practitioner:
    a. The practitioner must provide the necessary cases to the proctor for review in a timely manner; if applicable, must obtain agreement from the proctor to attend and observe the procedure and/or the practitioner must provide the proctor with access to all information regarding the patient's clinical history and care, pertinent physical findings, lab and x-ray results; the course of treatment or management including a copy of the H&P, operative reports, consultations, and discharge summaries.
    b. The practitioner shall notify the proctor of each case in which care is to be evaluated and, when concurrent ~~proctoring~~FPPE is required, do so in sufficient time to enable the proctor to conduct.
    c. ~~For surgical or invasive procedures where concurrent proctoring is required, the practitioner must secure agreement from the patient for the proctor to attend and observe the procedure.~~
    d. ~~The practitioner has the option of requesting from the Chief of Service, a change of proctor if disagreements with the current proctor may adversely~~

~~affect his/her ability to complete the proctorship timely and satisfactorily.~~

e. Inform the proctor of any unusual incidents associated with his/her patients.

f. It is the responsibility of the practitioner to ensure documentation of the satisfactory completion of his/her ~~proctorship~~FPPE, including the completion and delivery of ~~proctorship~~FPPE forms to ~~the MSSD~~MSS.

g. If the summary ~~proctor report~~FPPE form is not completed and submitted to ~~the MSSD~~MSS when due, or if the practitioner fails to complete the FPPE requirements prior to the expiration of the proctoring ~~requirements prior to the expiration of the proctoring~~ period, the additional or new privileges that are the subject of proctoring shall be deemed to be voluntarily relinquished by the practitioner and the practitioner shall immediately stop performing these privileges.

10. Responsibilities of the Proctor:

a. The proctor shall evaluate the care of the practitioner per the established FPPE plan. The proctor's role is to review and observe cases, not supervise or consult except when evaluating allied health practitioners.

b. Proctors should be available for the start of the procedure and will monitor those portions of the medical care rendered by the practitioner that are sufficient to be able to judge the quality of care provided in relationship to the privilege(s) requested.

c. The performance of a specific procedure shall be reviewed, or in the situation that the privilege encompasses cognitive care, then the relative components of the patients chart must also be reviewed for that aspect of care.

d. Proctors will ensure the confidentiality of the ~~proctoring~~FPPE results and forms. The proctor will deliver the completed proctoring form(s) to ~~the Department Chief or MSSD~~MSS.

e. If at any time during the ~~proctoring~~FPPE period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor should promptly notify the respective Department ~~Chief~~Chair.

I. One of the following may be recommended:

- The Department ~~Chief~~Chair will intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for the patient
- The Department ~~Chief of~~Chair or designee will review the case for possible peer review at the next department meeting.
- Additional or revised ~~proctoring~~FPPE requirements may be imposed upon the practitioner until the proctor

can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored.

II. If during the initial period ~~of proctoring~~ofFPPE the proctor feels there may be imminent danger to the health and safety of any individual, the continuation of the privilege(s) requested and proctoring are subject to being discontinued by the Department Chair or Chief ~~or Chief~~ of Staff.

III. All members of the medical staff with relevant privileges, within each department, are expected as part of medical staff membership to serve as proctors when asked to do so.

IV. In addition to specialty and privilege specific issues, ~~proctoring~~FPPE also will address the general competencies.

11. FPPE Results and Recommendations:
    a. ~~The MSSD~~MSS will provide ~~the proctor~~completed FPPE forms to the Department ~~Chief~~Chair or designee for review.
    b. The Department ~~Chief~~Chair will provide the Credentials Committee with a recommendation as to whether the practitioner has satisfactorily completed the FPPE plan, is in need of further evaluation, or care is unacceptable.
    c. The Credentials Committee based upon the Department ~~Chief'~~Chair's recommendation will forward its recommendation to the MEC for one of the following:
        i. conclusion of the FPPE period, and advancement from the provisional staff category
        ii. an additional period of time or number of cases for FPPE; or
        iii. modification of some of the requested clinical privileges.
    d. If there is a recommendation ~~of~~from the MEC to terminate the practitioner's clinical privileges due to concerns about behavior or clinical competence, the practitioner shall be entitled to the hearing and appeal process outlined in the medical staff bylaws.
12. Liability of proctor: A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the medical staff. The proctor shall receive no compensation directly or indirectly from any patient for this service, and he or she shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor, or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner.
13. Completion of ~~proctorship~~FPPE: At the end of the ~~proctoring~~FPPE period, the ~~department chief or his/her~~Department Chair or designee shall determine one or

more of the following:

a. Whether a sufficient number of cases done at El Camino Hospital have been presented for review to properly evaluate the clinical privileges requested.

b. If a sufficient number of cases have not been presented for review, whether the ~~proctoring~~FPPE period or provisional appointment should be extended.

c. For provisional appointees, make a recommendation for permanent membership and continued clinical privileges as requested, recommend an additionalFPPE period or continued provisional staff status not to exceed an additional ~~proctoring period or continued provisional staff status not to exceed an additional~~ year, or not recommend permanent membership and continued clinical privileges as requested.

d. For new or additional privileges, make a recommendation to independently perform the requested privileges, recommend an additional ~~proctoring~~FPPE period, or not recommend continued clinical privileges as requested.

14. FPPE For Physician Performance Issues:

a. FPPE shall be conducted when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care that have been identified through the peer review process, ongoing feedback reports, or pursuant to the corrective action plan. Any such issues identified by a Department or Division must be reported to the ~~Professional~~Practitioner Excellence Committee (PEC);

15. Thresholds for FPPE

a. If the results of an OPPE indicate a potential significant issue with physician performance, the MEC or PEC may initiate a FPPE to determine whether there is problem with current competency of the physician for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or data from rule or rate indicators. When focused review is required, the Practitioner Excellence Committee, or the Medical Executive Committee will refer the case to the appropriate reviewer or committee who will conduct the focused review. Focused review findings, conclusions and recommendations to improve practitioner performance will be communicated as appropriate so that action can be taken as needed.

b. Triggers can be single events or evidence of practice trends that may initiate this process and include but are not limited to:

i. infection rates

ii. sentinel events

iii. patient complaints, and other events that are not sentinel

iv. small number of admissions or procedures over an extended

period of time that raise the concern of continued competence

v. a growing number of longer lengths of stay than other practioners

vi. returns to surgery

vii. frequent or repeat readmission suggesting possibly poor or inadequate initial management/treatment

viii. patterns of unnecessary diagnostic testing/treatments

ix. failure to follow approved ~~clincal~~clinical practice guidelines (This may or may not indicate care problems, but why is there a variance?)

c. The determination to assign a period of FPPE should be based on the practitioner's current clinical competence, practice behavior, and ability to perform the privileges at issue. Other existing privileges in good standing should not be affected by this decision.

d. The terms, methods, ~~and~~ duration, and oversight of the evaluation period shall be determined by Department or Division Chief, ~~Department or Division Executive~~or the Practitioner Excellence Committee~~, or the Professional Excellence Committee~~ (PEC). ~~FPPEs shall be subject to ongoing review by the (PEC)~~

e. ~~Follow the FPPE on the Department Executive Committee agenda and the PEC Tracking Tool until the FPPE has been completed – report completion to MEC and the Governing Board.~~

16. ~~Statutory Authority~~

~~a. This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and Appropriate State Codes…… All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities.~~

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]	10/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2024
Credentialing Committee	Raquel Barnett: Sr. Director Medical Staff Services	10/2024
IDPC	Raquel Barnett: Sr. Director Medical Staff Services	10/2024
	Raquel Barnett: Sr. Director Medical Staff Services	09/2024

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> Updating to correct approval workflow. Confirmed w/ Ryan Nhan.

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> ePolicy 10/14/24

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> MEC 10/24/24

A17c4. Artificial Intelligence Policy

Status **Pending** PolicyStat ID **16700461**

Origination	06/2024	Owner	Melissa Flitsch: Cybersecurity Risk & Compliance Manager
Last Approved	N/A	Area	Information Security
Effective	Upon Approval	Document Types	Policy
Last Revised	10/2024		
Next Review	3 years after approval		

Artificial Intelligence Policy

COVERAGE:

This policy applies to all workforce members, medical staff and affiliated parties working with or on behalf of El Camino Hospital (ECH). For purposes of this policy, workforce members include ~~El Camino Hospital~~ECH staff, contingent workers and contractors. It governs all interactions and communication with ~~generative~~ Artificial Intelligence (AI) technologies, including but not limited to ChatGPT and similar conversational AI systems.

PURPOSE:

With the increasing popularity and prevalence of ~~generative~~ Artificial Intelligence (AI) technologies, such as OpenAI's ChatGPT and Epic's drafting of clinical notes, it has become necessary to outline the proper use of such tools while working at ~~El Camino Hospital~~ECH. ~~Generative~~While ECH remains committed to adopting new technologies that aid our mission, we also understand the risks and limitations of AI ~~refers to technology capable of generating human-like content~~, ~~including text~~especially generative AI, ~~images and audio~~and must ensure its safe and responsible use.

~~While we remain committed to adopting new technologies to aid our mission, we also understand the risks and limitations of generative AI and must ensure its safe and responsible use.~~

~~There are, however, risks in using generative AI, including discriminatory bias, uncertainty about who owns the AI-created content, and security/privacy concerns with inputting proprietary organizational information or sensitive information about an employee, patient, vendor, etc. Additionally, the accuracy of AI-created content cannot be relied upon, as the information may be outdated, misleading or — in some cases — fabricated.~~

POLICY STATEMENT:

~~Generative~~ AI ~~technologies~~ must be used safely and responsibly to protect patients, employees, vendors and ~~El Camino Hospital~~ECH from harm. This policy, as well as supporting practices and procedures, will align to the NIST Artificial Intelligence Risk Management Framework.

DEFINITIONS:

- **Artificial Intelligence (AI):** Computer systems able to perform tasks that normally require human intelligence.
- **Bias:** In the context of AI models, unwanted or unintended discrimination in predictions or recommendations.
- **Generative AI:** A subset of AI that involves models and algorithms capable of generating new, previously unseen outputs based on the data it has been trained on.
- **Protected Health Information (PHI):** Any individually identifiable personal health information created, stored, transmitted or received by ~~El Camino Hospital~~ECH or its business associates.

GUIDING PRINCIPLES

The use of ~~generative~~ AI technologies at ~~El Camino Hospital~~ECH will be guided by the following principles:

- **Ensure Safe Patient Interaction:** ~~Generative~~ AI systems shall not provide medical advice to patients unless the outputs are strictly controlled and thoroughly vetted by both industry experts and the relevant regulatory bodies. The distinct risk of AI hallucinations and biases in healthcare necessitates medical professionals, who are trained and experienced, to supervise interactions. Medical professionals are essential in ensuring the accuracy and reliability of the advice given, recognizing the limitations of AI, and preventing potential harm to patients.
- **Safeguard Privacy and Security:** The confidentiality and integrity of all personally identifiable information shall remain paramount. Given the emergence of potentially insecure AI services, adherence to established healthcare standards and regulatory guidelines is required. Implementing rigorous privacy protocols and security provisions is vital to uphold trust and protect the interests of our community.
- **Adhere to Evidence-Based Medicine:** Misinformation and biases are prevalent, even in reputable sources across the internet. ~~Generative~~ AI in healthcare must be anchored in evidence-based medicine, relying on trusted, scientific sources to inform its knowledge base. A stringent, proactive approach is essential to mitigate the risk of circulating harmful and inaccurate data points, improving the accuracy, reliability and safety of the AI-generated outputs.
- **Commit to Transparency and Prudence:** ~~Generative~~ AI systems have a potential for errors — even when utilized by trained medical professionals. Given the inherent intricacies of ~~generative~~ AI, it is essential to provide clarity regarding its limitations. Medical professionals must monitor AI outputs with a critical eye and exercise due diligence to discern potential inaccuracies, avoid biases and safeguard patient well-being.

PROCEDURE:

A. **Governance of ~~Generative~~ AI Technologies**

1. The ~~Generative~~ AI Steering Committee will maintain an Approved Application Roster, listing approved ~~generative~~ AI technologies along with the limitations and requirements for their use.
2. Approval is required for all new ~~generative~~ AI technologies, even those that are not cloud-based.
    a. Any workforce member seeking to use a new ~~generative~~ AI technology must complete the ~~Generative~~ AI Intake Form in ServiceNow. The ~~Generative~~ AI Intake Form assists the ~~Generative~~ AI Taskforce in reviewing the proposed use case, including the establishment of any requirements and restrictions. It also helps identify productive follow-up questions.
    b. The ~~Generative~~ AI Application Review Taskforce will review the submitted ~~Generative~~ AI Intake Form. The Taskforce may send clarifying and/or follow-up questions to the requester via email. Alternatively, the Taskforce may schedule a meeting with the requester to discuss clarifying and/or follow-up questions.
    c. The ~~Generative~~ AI Application Review Taskforce will strive to provide its recommendation to the ~~Generative~~ AI Steering Committee within five (5) business days of receiving the ~~Generative~~ AI Intake Form.
    d. The ~~Generative~~ AI Steering Committee will review the recommendation of the ~~Generative~~ AI Application Review Taskforce. Following its review, the ~~Generative~~ AI Steering Committee will deliver its decision to the requester:
        i. Approval. If the request is approved, the requester will receive an email with the approval and any restrictions or necessary accommodations.
        ii. Denial. If the request is denied, the requester will receive an email with reasons for the denial.
        iii. Deferment. If the request is deferred, the requester will receive an email with additional steps required for approval. This could include additional requirements such as submitting the request through Conga or completing a Security Risk Assessment (SRA).
3. Confidential, PHI or proprietary information must not be entered into generative AI technologies unless that application and information type is permitted in the Approved Application Roster.
4. All third parties that provide generative AI chatbot services to ~~El Camino Hospital~~ECH must have a HIPAA Business Associate Agreement (BAA) in effect before use. This includes all use, even if PHI is not intended to be entered into the service.

B. **Use of Approved ~~Generative~~ AI Technologies**

1. Users of approved applications must receive sufficient training to understand the

capabilities and limitations of ~~generative~~ AI in the healthcare context, as well as being made aware of resources to report biases, inaccuracies or anomalies.

2. Users of approved applications must review AI-generated content for biases, inaccuracies or anomalies before relying on it for work purposes, including clinical care. If a reliable source cannot verify factual information generated by the AI, that information must not be used for work purposes. The ultimate responsibility for AI-generated content and decisions regarding its use rests with the user.
3. As generative AI may produce content that could be considered plagiarized from its knowledge base, including copyrighted works, no text generated or partially generated from generative AI will be eligible to have an ~~El Camino Hospital~~ECH copyright, trademark or patent at this time.
4. Users of approved applications must adhere to applicable standards and requirements. For example, use of the ~~El Camino Hospital~~ECH AI Copilot must follow Microsoft's Responsible AI Principles.
5. When creating documentation, users of approved applications must be aware of, and comply with, the latest conventions and standards for citing and disclosing the use of generative AI in the creation of that documentation.
6. Use of approved applications must comply with all relevant ~~El Camino Hospital~~ECH policies, including but not limited to those related to conduct and anti-discrimination, intellectual property and acceptable use. For instance, generative AI must not be used to create content that is inappropriate, discriminatory or otherwise harmful to others or the organization.

COMPLIANCE:

Violations of this policy must be reported to the Chief Information Security Officer or the Compliance Officer. Alternatively, violations may be reported anonymously as outlined in *Compliance Hotline* procedure, available in PolicyStat.

AUDITING:

At any time, the Chief Information Security Officer or the Compliance Officer may authorize the audit of the ECH environment, including its systems and services, for compliance with this policy.

REFERENCES:

~~National Institute of Standards and Technology (2023) *Artificial Intelligence Risk Management Framework (AI RMF 1.0).* https://doi.org/10.6028/NIST.AI.100-1~~

- National Institute of Standards and Technology (2023) *Artificial Intelligence Risk Management Framework (AI RMF 1.0).* https://doi.org/10.6028/NIST.AI.100-1
- Artificial Intelligence (AI) Governance and Use

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]	10/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2024
InfoSec - CISO, Technical Services Director, CIO	Joshua Spencer: Interim Asst VP – Chief Information Security	09/2024
	Melissa Flitsch: Cybersecurity Risk & Compliance Manager	09/2024

History

Comment by Flitsch, Melissa: Cybersecurity Risk & Compliance Manager on 2/13/2024, 1:52PM EST

> Corrected one title in the Compliance and Auditing sections, changing "Chief Compliance Officer" to "Compliance Officer" per Diane Wigglesworth.

Draft saved by Flitsch, Melissa: Cybersecurity Risk & Compliance Manager on 8/6/2024, 12:40PM EDT

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> Broadened "generative AI" to "AI" where appropriate; some other text edits for consistency and clarity.

Last Approved by Flitsch, Melissa: Cybersecurity Risk & Compliance Manager on 9/18/2024, 2:11PM EDT

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> Removed highlighting.

Last Approved by Flitsch, Melissa: Cybersecurity Risk & Compliance Manager on 9/24/2024, 10:48AM EDT

Last Approved by Spencer, Joshua: Interim Asst VP – Chief Information Security on 9/24/2024, 11:24AM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/15/2024, 1:09PM EDT

> ePolicy 10/14/24

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 10/18/2024, 8:42PM EDT

> Updated reference section, per owner request.

Last Approved by Coston, Michael: Director Quality and Public Reporting on 10/24/2024, 11:45AM EDT

> MEC 10/24/24

A17c5. HIPAA Restricting Use or Disclosure of Protected Health Information

Status **Pending** PolicyStat ID **16778687**

Origination	04/2003	Owner	Kristina Underhill: Manager HIM Ops
Last Approved	N/A	Area	HIM
Effective	Upon Approval	Document Types	Policy
Last Revised	09/2024		
Next Review	3 years after approval		

HIPAA Restricting Use or Disclosure of Protected Health Information

COVERAGE:

All El Camino Hospital staff

PURPOSE:

Patients will be provided the right to request restriction of certain uses and disclosures of their protected health information that is contained within the designated record set. This may include restriction on the information released to family and friends. While the law does not require the hospital to comply with the patient's request, El Camino Hospital will consider each request.

STATEMENT:

It is the policy of El Camino Hospital to comply with all mandatory reporting requirements for health insurance portability and accountability act (HIPAA).

DEFINITIONS:

The definitions below are in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1. **Designated Record Set:** Medical records, behavioral health records (including psychiatric, alcohol and drug treatment records), and billing records about an individual patient maintained by the hospital and used to make decisions in the process of ~~healthcare~~health care delivery.

Medical records created by another provider filed with records of El Camino Hospital are included. Peer review, quality assurance, and information created and maintained for business purposes of the hospital not used to make decisions about an individual patient in the process of ~~healthcare~~health care delivery are ***not*** considered part of the designated record set and are not subject to inspection or correction by the patient or legal representative.

2. **Health Care Operations:** Any of the following activities:
    - Internal performance improvement activities, excluding research
    - Reviewing the competence or qualifications of health care professionals
    - Underwriting, premium rating, and other activities related to health insurance contracting
    - Medical review, legal services, and auditing
    - Business planning and development
    - Business management and general administrative activities
3. **Individually Identifiable Health Information:** Information that identifies an individual (or could reasonably be used to identify an individual) that:
    - Is created or received by ECH;
    - Relates to the past, present, or future physical or mental health or condition of an individual;
    - Relates to the provision of health care to an individual;
    - Relates to the past, present, or future payment for the provision of health care to an individual.

    This includes demographic information (such as name, address, date of birth, sex, and race) collected from an individual.
4. **Payment:** Activities undertaken to obtain or provide reimbursement for health care services, including:
    - Billing, claims management, and collection activities;
    - Review of health care services for medical necessity, coverage, appropriateness, or charge justification
    - Utilization review activities
5. **Protected Health Information:** Individually identifiable health information that is transmitted or maintained by electronic or any other medium.
6. **Treatment:** Provision, coordination, or management of health care and related services by one or more health care providers, including:
    - Management of care by a provider with a third party;
    - Consultation between health care providers relating to a patient;
    - Referral of a patient from one provider to another

PROCEDURE:

A. **Policy for restriction of use or disclosure of protected health information:**

1. **Legal Requirement**
   Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have the right to request restrictions on use or disclosure of their protected health information, but covered entities (including hospitals) are not required to agree to those restrictions. El Camino Hospital will consider each request for restriction and agree to those that it can reasonably accommodate.
2. **Allowable restrictions**
   A patient may request restrictions on use or disclosure of protected health information in a designated record set at El Camino Hospital. Such restrictions may include withholding of information from family or friends. A determination to restrict uses or disclosures must be made very carefully to ensure the request can be met.
3. **Request in Writing**
   All requests for restrictions must be in writing, using the form Request to restrict use or disclosure of Protected Health Information or submitting an eRequest via their patient portal.
4. **Employees permitted to approve special requests for restriction**

   Requests for restrictions must be addressed by the Privacy Officer, or designee. No other member of the workforce may agree to such a request unless specifically authorized by the Privacy Officer.
5. **Providing the restriction**
   The Privacy Officer must ensure that the request can be met and that the designated record set is flagged per hospital procedure. The hospital may inform others of the existence of a restriction, when appropriate, so long as it does not result in the disclosure of the restricted information. A patients request to restrict disclosure cannot be applied towards protect health information released prior to the date of the request.
6. **Denial of request**
   If the Privacy Officer determines that the hospital is not able to meet the request and provide the level of restriction requested by the patient, he/she must notify the patient of the denial in writing.
7. **Required documentation and retention**
   The hospital must document the request and response and file the following information with the patient's medical record:
   - The designated record sets that are subject to restriction;
   - The titles of the persons responsible for receiving and processing requests for access by individuals; and
   - All correspondence and associated documentation related to the patient's request.
   - All documentation related to the request will be retained in accordance

with the hospital's policy on "Record Retention and Destruction."

8. **Terminating a restriction**
   The hospital may terminate its agreement to a restriction, if:
   - The individual agrees to or requests the termination in writing;
   - The individual orally agrees to the termination and such agreement is documented; or
   - The hospital informs the individual that it is terminating its agreement to a restriction, except that such termination is only effective with respect to protected health information created or received after it has so informed the individual.

9. **Medical emergencies**
   An agreed-upon restriction may only be broken in a medical emergency. If restricted information is given to another provider for use in emergency treatment, the other provider must be asked not to further use or disclose the information.

10. An agreement for restriction does not prevent uses or disclosures made for the following purposes:
    - Inclusion in the facility directory
    - For certain public health activities
    - For reporting abuse, neglect, domestic violence or other crimes
    - For health agency oversight activities or law enforcement investigations
    - For judicial or administrative proceedings
    - For identifying deceased persons to coroners and medical examiners or determining a cause of death
    - For organ procurement
    - For certain research activities
    - For worker's compensation programs
    - For uses or disclosures otherwise required by law

B. **Procedure for restriction of use or disclosure of protected health information:**

1. The hospital must permit a patient to request restrictions on the use and disclosure of protected health information as contained in the designated record set. Requests for restriction must be presented in writing.
2. The written request must be presented to the Privacy Officer, or designee, immediately. The Privacy Officer, or designee, are the only members of the workforce who may agree to any restriction.
3. The right to request restrictions and the process for making the request are outlined in the Notice of Privacy Practices.
4. The hospital is not required to act immediately and will investigate its ability to meet the request prior to agreeing to any restriction.

5. The patient's request and letter notifying the patient of the Privacy Officer's decision will be filed with the medical record.
6. If restriction is granted, appropriate FYI flag alerts and chart advisories will be added to the patients medical record.

REFERENCES:

Consent Manual, California Health Care Association, 2019

Title 45, Code of Federal Regulations, Parts 160 and 164

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]	10/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2024
HIM Leadership	Kristina Underhill: Manager HIM Ops	09/2024
	Kristina Underhill: Manager HIM Ops	09/2024

History

Draft saved by Underhill, Kristina: Manager HIM Ops on 9/24/2024, 8:33PM EDT

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> @Patel, Ketul: Manager Privacy - please review and approve

Edited by Underhill, Kristina: Manager HIM Ops on 9/24/2024, 8:34PM EDT

> Minor - added additional information regarding adding chart advisories if restriction is approved

Last Approved by Underhill, Kristina: Manager HIM Ops on 9/24/2024, 8:34PM EDT

Last Approved by Underhill, Kristina: Manager HIM Ops on 9/24/2024, 8:35PM EDT

> Waiting for Ketul Patel to approve as well

Comment by Patel, Ketul: Manager Privacy on 9/25/2024, 1:58PM EDT

> @Underhill, Kristina: Manager HIM Ops- no changes, ok to proceed.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/15/2024, 1:10PM EDT

> ePolicy 10/14/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 10/24/2024, 11:42AM EDT

> MEC 10/24/24

A17c6. Third-Party Fundraising Events Policy

Status **Pending** PolicyStat ID **16833783**

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

Third-Party Fundraising Events Policy

COVERAGE:

All El Camino Health, El Camino Health Foundation Staff and Third-Party Event Sponsors or Leaders.

PURPOSE:

The purpose of this policy is to enhance the success of Third-Party fundraising events, while avoiding conflicts with El Camino Health Foundation's donors, corporate sponsors, or other previously planned events. This policy is intended only as a guide. Flexibility within this policy is permitted in situations where it is considered by the President of El Camino Health Foundation to be appropriate and in the best interests of the organization.

PROCEDURE:

A. ECHF's policies, procedures and programs must be consistent with the mission and programs of ECH and ECHF. Except as specifically described, the provisions of this policy shall be binding on ECH, ECHF, Third-Party Event Sponsors or Leaders.

B. The following guidelines have been created to ensure that:

1. Third-Party event sponsors and ECHF understand and agree, in advance and in writing, on their respective roles in the planning and conduct of the event.
2. Third-Party events complement and support ECH and ECHF mission, image, and core values.
3. Third-Party events do not require material support from the ECHF Board or staff.
4. Third-Party events are financially viable in relation to expense to income projections.

5. The distribution of the funds raised during the Third-Party event reflects both the intent of the donors and the stated objectives of ECHF.
6. ECHF endorses the purpose of the Third-Party event using our brand, name, and fund-raising purpose.

C. PERMISSIONS

1. All Third-Party fundraising events for ECHF require written permission from ECHF and at least three months' notice in advance. Public announcements or event promotion should not be made until written approval has been received. Permission is ultimately granted by the President of El Camino Health Foundation and may include consultation with leaders at the El Camino Health organization, including but not limited to the office of the CEO, Risk Management, and Marketing & Communications.

D. EVENT PROMOTION

1. Advertising and event promotion is the sole responsibility of the event organizer.
    a. ECHF must review all promotional materials (including press releases, public service announcements, posters, tickets, brochures, invitations, etc.) before they are used.
    b. ECHF logo is a registered trademark and cannot legally be reproduced without written permission.
    c. ECHF can, at its sole discretion, promote the event, when appropriate, through:
        i. ECHF website (with a link to the event's/organization's website).
        ii. ECHF newsletter.
        iii. ECHF cannot solicit sponsors and does not provide any donor or client contact information.
2. In order to support ECHF's stewardship practices, a list of potential sponsorship contacts (including all potential in-kind donors) must be provided to ECHF prior to any solicitations. This allows ECHF the opportunity to identify those donors who have been previously or will be approached by ECHF to support another fundraising effort.
3. Promotional materials must clearly state the specific percentage or amount of the proceeds being donated to ECHF and must properly characterize the use for which the donations will be made. Suggested text: *"Proceeds benefit El Camino Health Foundation."*

E. FINANCIAL GUIDELINES

1. All Third-Party events must diligently comply with all IRS regulations and fundraising best practices. The organizer will be solely responsible for all event costs and expenses incurred.
    a. Event expenses should not exceed forty percent (40%) of the total amount raised, excluding in-kind donations. The event organizer will provide a

completed budget for review and approval as part of the "Event Proposal Form." Flexibility within this policy is permitted in situations where it is considered by the President of El Camino Health Foundation to be appropriate and in the best interests of the organization.

b. ECHF cannot provide our 501(C)3 tax identification number or accept and acknowledge individual donations for the event except for checks written directly to El Camino Health Foundation which are separate from event fees.

c. Donors to the Third-Party event must be notified of what percentage of money raised was donated to ECHF post event and that their gifts are not tax deductible unless the Third-Party event organizer is a 501(c)3.

d. The organization or group conducting the event is responsible for payment of all expenses.

e. ECHF sales tax-exemption (on purchases) cannot be extended to any event or fundraising effort.

f. Proceeds are to be sent within 60 days after the last day of the event in the form of a check made payable to El Camino Health Foundation to:

El Camino Health Foundation
Dept. No. 05868
PO Box 885868
Los Angeles, CA 90088-5868

F. LIABILITY AND LICENSES

1. The organizer will be solely responsible for providing proof of appropriate liability, property and general insurance coverage and all licenses that may be required.

    a. If circumstances warrant, ECHF may at any time through any of its leadership, officers, or legal staff direct the event organizer to cancel the event or withdraw any ECH or ECHF affiliation with the event.

    b. The event organizers agree to indemnify and hold harmless ECHF, ECH, all its affiliates and all its leadership, officers, and employees from any and all claims and liabilities in any way related to the event.

    c. ECHF must receive written notice of any material changes planned for the event.

G. WHAT ECHF CAN DO TO HELP YOU

1. Once the "Event Proposal Form" has been approved, ECHF staff can:

    a. Offer event planning expertise and advice.

    b. Acknowledge direct contributions to ECHF. Note: These contributions will be added to the event donation total but cannot be used to offset event expenses.

    c. Assist in the designation of the event proceeds.

    d. Provide a letter of support to validate the authenticity of the event and its

organizers.

e. Provide limited existing materials for your event such as brochures and return envelopes.

H. **WHAT ECHF CANNOT DO TO HELP YOU**

1. Provide on-site staff or volunteer support at your event (except as mutually agreed upon during event approval).
2. Provide insurance coverage.
3. Provide funding or reimbursement for expenses (except as mutually agreed upon during event approval).
4. Solicit sponsorship revenue for your fundraising activities (except as mutually agreed upon during event approval).
5. Provide celebrities or professional athletes for your event.
6. Provide publicity: newspaper, radio, TV coverage, etc. (except as mutually agreed upon during event approval).
7. Provide mailing lists of contributors, employees, volunteers or vendors (except as mutually agreed upon during event approval).
8. Provide hospital or system letterhead, place event fliers, posters or distribute other promotional material throughout ECH, or guarantee attendance of staff, care givers or patients at the event (except as mutually agreed upon during event approval).

   ** Note Please also understand the volume of requests exceeds available staff who are able to attend or assist with events. Please call ECHF as early as possible to discuss your plans.

I. **THINGS TO CONSIDER**

1. Complete and sign the event proposal form at least three months prior to the event.
2. Establish goals that are realistic and measurable.
3. Identify your audience.
4. Plan a budget. Identify sources of income and all expenses.
5. Ensure that all promotional and publicity materials are approved by ECHF.
6. Until written permission is received, the names “El Camino Health” and “El Camino Health Foundation” cannot be used for any purpose and contributions cannot be solicited.

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

Event Proposal Form (5-9-24)

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy	Patrick Santos: Policy and Procedure Coordinator	10/2024
Foundation Board	Dakota Atley: Dir Foundation Operations	10/2024
Executive Committee	Dakota Atley: Dir Foundation Operations	10/2024
Finance Committee	Dakota Atley: Dir Foundation Operations	10/2024
	Dakota Atley: Dir Foundation Operations	10/2024

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Created by Atley, Dakota: Dir Foundation Operations on 10/4/2024, 12:08PM EDT

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> Finance Committee approved 8/26/2024
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> Foundation Board approved 8/28/2024

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> Foundation Board approved 8/28/2024

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> Finance Committee approved 8/26/2024

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ePolicy 10/14/24