AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, February 5, 2025 – 5:30 pm
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 994 8849 4618# No participant code. Just press #.**

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

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

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

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
2	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Bob Rebitzer, Board Chair	Possible Motion	**5:30 pm**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
4	**PUBLIC COMMUNICATION** a. **Oral Comments** *This opportunity is provided for people to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. **Written Public Comments** *Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Bob Rebitzer, Board Chair	Information	**5:30 pm**
5	**QUALITY FOCUSED REVIEW** - Receive FY25 Q2 STEEEP Dashboard - Focused Review: Journey to Zero Preventable Harm	Carol Somersille, MD Quality Committee Chair Shreyas Mallur, MD CQO	Discussion	**5:30 – 5:55**
6	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**5:55 – 5:56**
7	**STRATEGIC PLAN IMPLEMENTATION – Q2 FY25 METRICS** *Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs.*	Dan Woods, CEO AJ Reall, VP Strategy	Information	**5:56 – 6:11**
8	**QUARTERLY FINANCE AND STRATEGIC MARKET SHARE UPDATE** *Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs.*	Carlos Bohorquez, CFO	Discussion	**6:11 – 6:35**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
9	**VERBAL FINANCE COMMITTEE UPDATE ON STRATEGIC PROJECT** *Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs.*	Don Watters, Finance Committee Chair Carlos Bohorquez, CFO	Information	**6:35 – 6:45**
10	**PHYSICIAN SERVICES AGREEMENTS** - OB Hospital Services Renewal Agreement *Health and Safety Code Section 32106(b) – for a report and discussion involving healthcare facility trade secrets.*	Mark Adams, MD, CMO	Discussion	**6:45 – 6:55**
11	**APPROVE CREDENTIALING AND PRIVILEGING REPORT** *Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*:	Mark Adams, MD, CMO	**Motion Required**	**6:55 – 7:00**
12	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS** - Minutes of the Closed Session of the ECHB Meeting (12/11/2024) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Bob Rebitzer, Board Chair	**Motion Required**	**7:00 – 7:02**
13	**EXECUTIVE SESSION** *Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management*	Bob Rebitzer, Board Chair	Discussion	**7:02 – 7:12**
14	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**7:12 – 7:13**
15	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Gabe Fernandez, Governance Services Coordinator	Information	**7:13 – 7:14**
16	**APPROVE PHYSICIAN SERVICES AGREEMENTS** - OB Hospital Services Renewal Agreement	Bob Rebitzer, Board Chair	**Motion Required**	**7:14 – 7:17**
17	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (12/11/24) b. Approve Core Values Update as Reviewed and Recommended for Approval by Executive Leadership c. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee d. Receive Period 5 Financials e. Receive Period 6 Financials f. Receive FY25 ECHB Pacing Plan g. Receive FY25 ECHB Follow Up Items	Bob Rebitzer, Board Chair	**Motion Required**	**7:17 – 7:20**
18	**CEO REPORT**	Dan Woods, Chief Executive Officer	Information	**7:20 – 7:25**
19	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:25 – 7:30**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
20	**ADJOURNMENT** **POLICIES APPENDIX**	Bob Rebitzer, Board Chair	**Motion Required**	**7:30**

NEXT MEETINGS: March 12, 2025; April 16, 2025 (Board Retreat); May 14, 2025; June 18, 2025

El Camino Health

El Camino Health Board of Directors
Hospital Board Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, Chief Quality Officer
Date: February 5, 2025
Subject: STEEEP Dashboard through December 2024

Purpose:

To update the Hospital on quality, safety, and experience measure performance through December 2024 (unless otherwise noted). This memo will describe the performance of the STEEEP 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 16 (2.67 cases per month) (Goal: </= 27 infections FY 2025 or less than 2.25 cases/month) Hospital Acquired C=Diff infections in Q2 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 have measures described above in place which we believe will impact this rate)

2. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 6 CAUTI in Q1 FY2025 with a goal to have less than ten for the fiscal year. Q2 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. We are also looking at spreading best practices across the organization)

3. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for the end of Q1 FY2025 year to date (0.16) 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 (4.33) 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 Q3/Q4 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 (83.2) to target of 80%. (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 through Q2 (71%) 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 (9.5%) 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 through Q2 FY25 (0.97) 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 through Q2 FY2025 (1.07) 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 October of 2024 (25.4%) is unfavorable to target of 23.9%.The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: 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 (1.06) 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).** Performance through Q2 2025 (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 (11%) 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 will be on track to meet this metric since a new Epic tool for screening was implemented. The latest month screening rate was 74%)

2. **Voyce Interpretation Minutes Used:** FY 2025 performance (335,532 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 FY25 YTD (80.9) 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. **2. Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** FY 2025 YTD (82.2) 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 (78.8) through Q2 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 (81.6) to target of (83.4). We continue to perform in the top decile in the Bay Area and 87% nationally.

Attachment(s):

1. STEEEP Dashboard through December of 2024.

El Camino Health Quality Board: FYTD25 STEEEP

El Camino Health

Show Filter

Date: 1/1/2024 12/31/2024

Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator		Last 12 Months Trend
	FY 24Q3	FY 24Q4	FY 25Q1	FY 25Q2	FY24	FYTD25			Trend Chart Period: 1/1/2024 to 12/31/2024
Safe Care									
C-Diff Clostridioides Difficile Infection	7	3	6	10	28	**16**	🔴	<= 27 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	1	1	3	3	11	**6**	🟢	<=10 cases	Lower is Better
CLABSI (Central Line-Associated Bloodstream Infection)	2	0	0	1	3	**1**	🟢	<=5 cases	Lower is Better
SSI (Surgical Site Infection)	11	9	15	11	38	**26**	🔴	<=30 cases	Lower is Better
Hand Hygiene Audit Compliance (Leapfrog measure)	87.2%	87.3%	85.3%	81.5%	84.1%	**83.2%**	🟢	>=80%	Higher is Better
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	81.4%	81.0%	74.0%	69.4%	77.7%	**71.7%**	🔴	>=84.0%	Higher is Better
Effective									
Readmission (Based on Vizient Risk Model)	10.3%	10.1%	9.3%	9.7%	9.8%	**9.5%**	🟢	<=9.8%	Lower is Better
Hospital Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.14	1.25	0.87	1.06	1.16	**0.97**	🟢	<= 1.0	Lower is Better
Sepsis Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.43	1.36	1.06	1.10	1.35	**1.07**	🔴	<=1.0	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure)	23.0%	26.7%	24.2%	29.1%	24.7%	**25.4%**	🔴	<=23.9%	Lower is Better
Efficient									
Avg Length of Stay (ALOS) (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.07	1.07	1.06	1.07	1.07	**1.06**	🔴	1.02	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	155	155	151	152	155.8	**151.3**	🟢	<=160	Lower is Better
Equitable									
Social Driver of Health (SDOH) Screening Rate	2.1%	2.5%	4.0%	21.0%	2.1%	**11.1%**	🔴	50%	Higher is Better
Voyce Interpretation Minutes Used	53,231	59,672	57,925	53,919	617,023	**335,532**	⚪	TBD	
Patient-Centered									
Inpatient Hospital: Likelihood to Recommend Press Ganey	79.9	83.4	80.7	81.5	81.9	**80.9**	🔴	81.9	Higher is Better
ED: Likelihood to Recommend Press Ganey	74.3	75.6	78.9	78.3	75.6	**78.8**	🟢	77.2	Higher is Better
MCH - INPATIENT Press Ganey	83.2	81.4	82.8	80.5	82.0	**82.2**	🟢	82.0	Higher is Better

El Camino Health

El Camino Health Board of Directors
Hospital Board Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, Chief Quality Officer
Date: February 5, 2025
Subject: Quality Deep Dive Topic: Eliminating Preventable Harm at El Camino Health

Purpose:

To provide an overview of El Camino Health's ongoing efforts to enhance patient and workforce safety through the **Safety First/Mission Zero** initiative. The presentation will highlight key progress, challenges, and next steps in our commitment to eliminating preventable harm.

Summary:

El Camino Hospital has made significant strides in building a culture of safety, focusing on both patient and workforce well-being. Healthcare-related injuries remain a national challenge, costing an estimated $13 billion annually. To address this, the organization has implemented structured training, proactive reporting mechanisms, and a Just Culture approach to safety event investigations.

Since the launch of Safety First/Mission Zero in 2021, safety reporting has increased by 2.9% year-over-year, reinforcing an environment where staff feel empowered to report and address risks. Key milestones include the successful training of all staff and 99% of physicians, the introduction of the Safety Coach Program, and mandatory HRO training for all new employees. Looking ahead, El Camino Health aims to further strengthen its safety culture by expanding Safety Coaches, fostering psychological safety, and implementing resilient engineering strategies to mitigate risk.

El Camino Health

Journey to Zero: Eliminating Preventable Harm

Shreyas Mallur, MD
Chief Quality Officer
February 5, 2025

Safety Event Classification

Root Cause Analysis

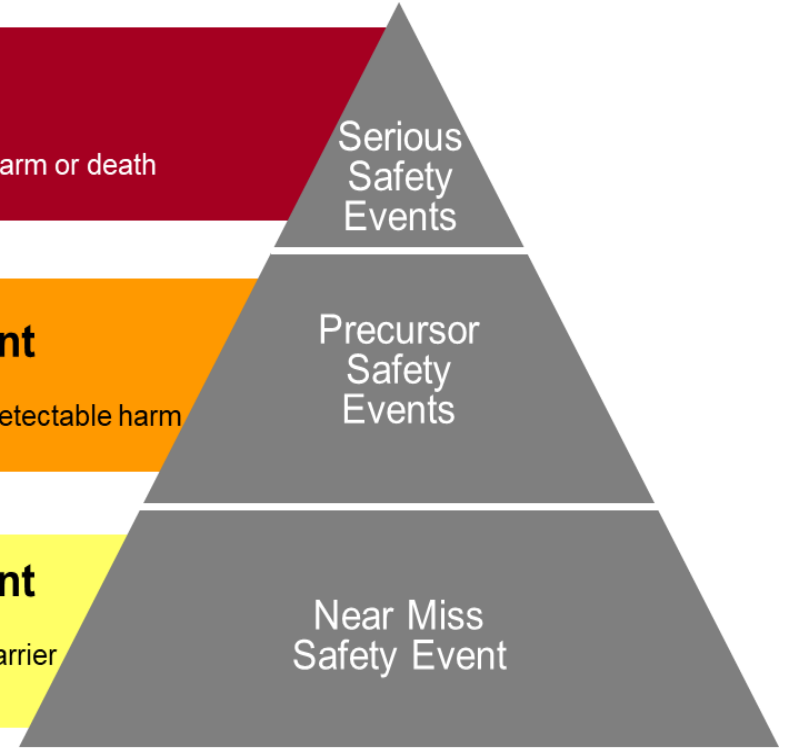
Serious Safety Event
- Reaches the patient
- Results in moderate to severe harm or death

Apparent Cause Analysis

Precursor Safety Event
- Reaches the patient
- Results in minimal harm or no detectable harm

Trending or Apparent Cause Analysis

Near Miss Safety Event
- Does not reach the patient
- Error is caught by a detection barrier
- or by chance



All Events: Common Cause Analysis

FMEA before new process

El Camino Health®

Examples of SSE, PSE and NME

- Serious Safety Event: Retained instrument during surgery necessitating return to the Hospital and repeat surgery.
- Precursor Safety Event: CT scan performed on the wrong patient resulting in unnecessary radiation exposure to patient.
- Near Miss Event: CT scan order on the wrong patient caught by the technologist prior to performing the scan. Error caught before reaching the patient.

El Camino Health Safety First/Mission Zero

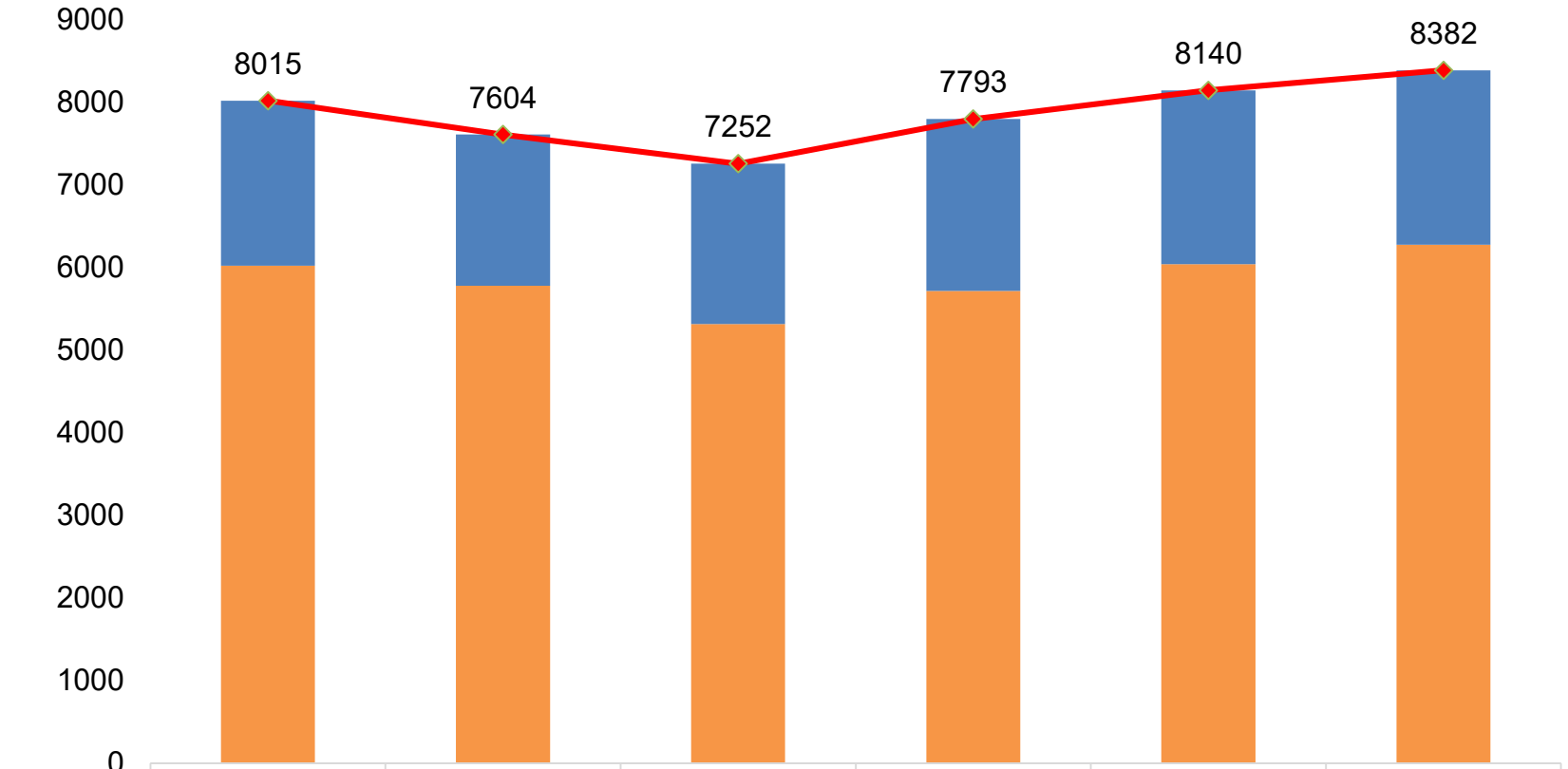
- **July 2021**: Launched Safety First/Mission Zero
- **August 2021-June 2022**: Assessment phase
- **July 2022**: Launched training for Staff and Physicians
- **December 2022**: Completed 100 % Staff and 99 % Physician training
- **July 2023**: Launched Safety Coach Program
- **Current**: All new staff and physicians required to take HRO training prior to start

Sustainment and Improvement: Future State

- Safety 2.0: Engineer systems where as much as possible goes right.
- Resilient Engineering : Adapt to unanticipated and inevitable change.
- Psychological Safety: Empower staff to report events without fear of negative consequences or judgement.
- Fair and Just culture model for all safety event investigations.
- Expand Safety Coaches on Units.
- Continue to share lessons learned
- Continue HeRO Recognition Program

Event Report Volume at ECH

Overall: 2.9% increased reporting from FY 2023. Increased reporting helps identify Safety events and promotes a culture of safety



	FY19	FY20	FY21	FY22	FY23	FY24
LG	1998	1830	1940	2079	2102	2107
MV	6017	5774	5312	5714	6038	6273
Total	8015	7604	7252	7793	8140	8382

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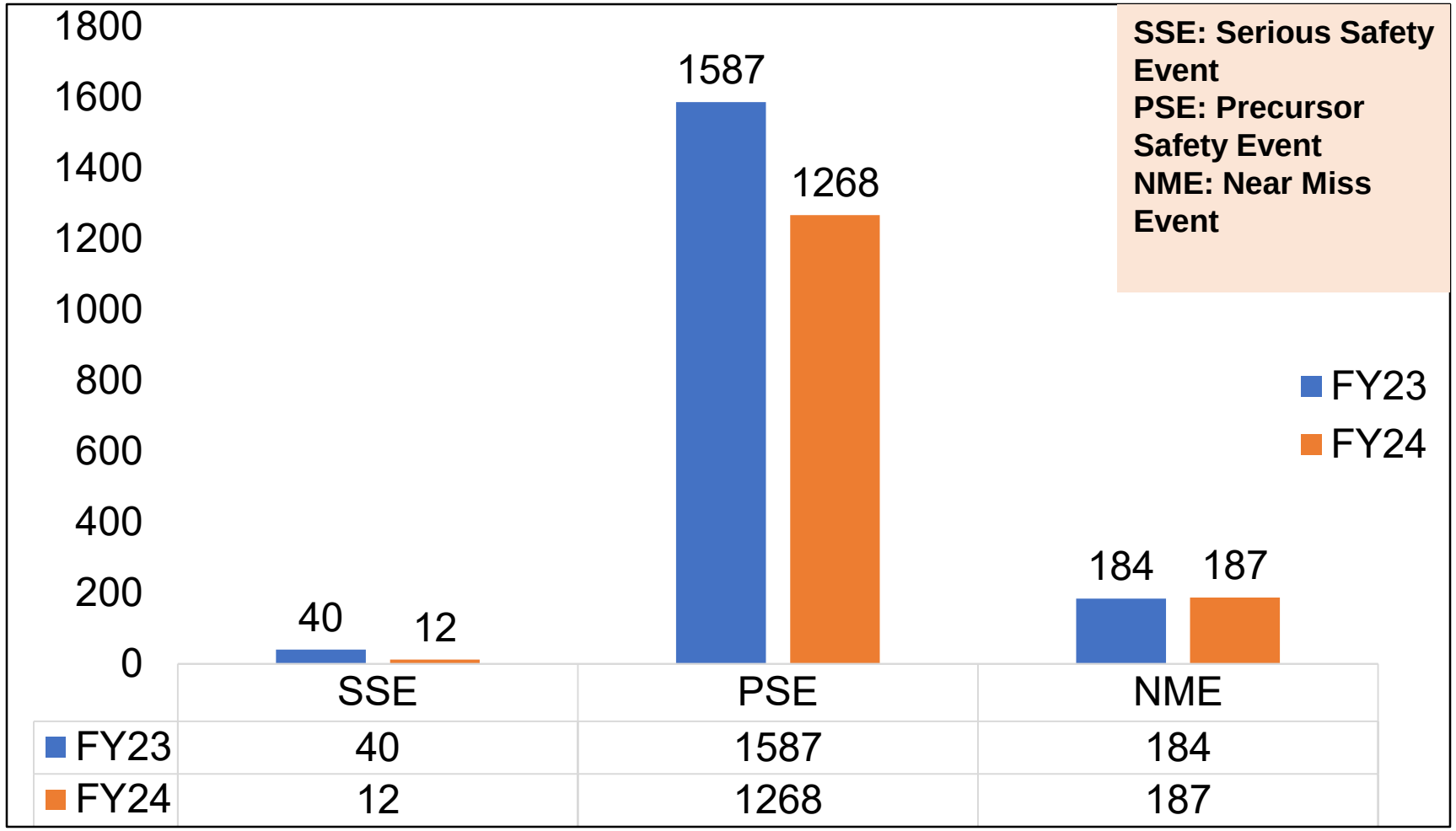
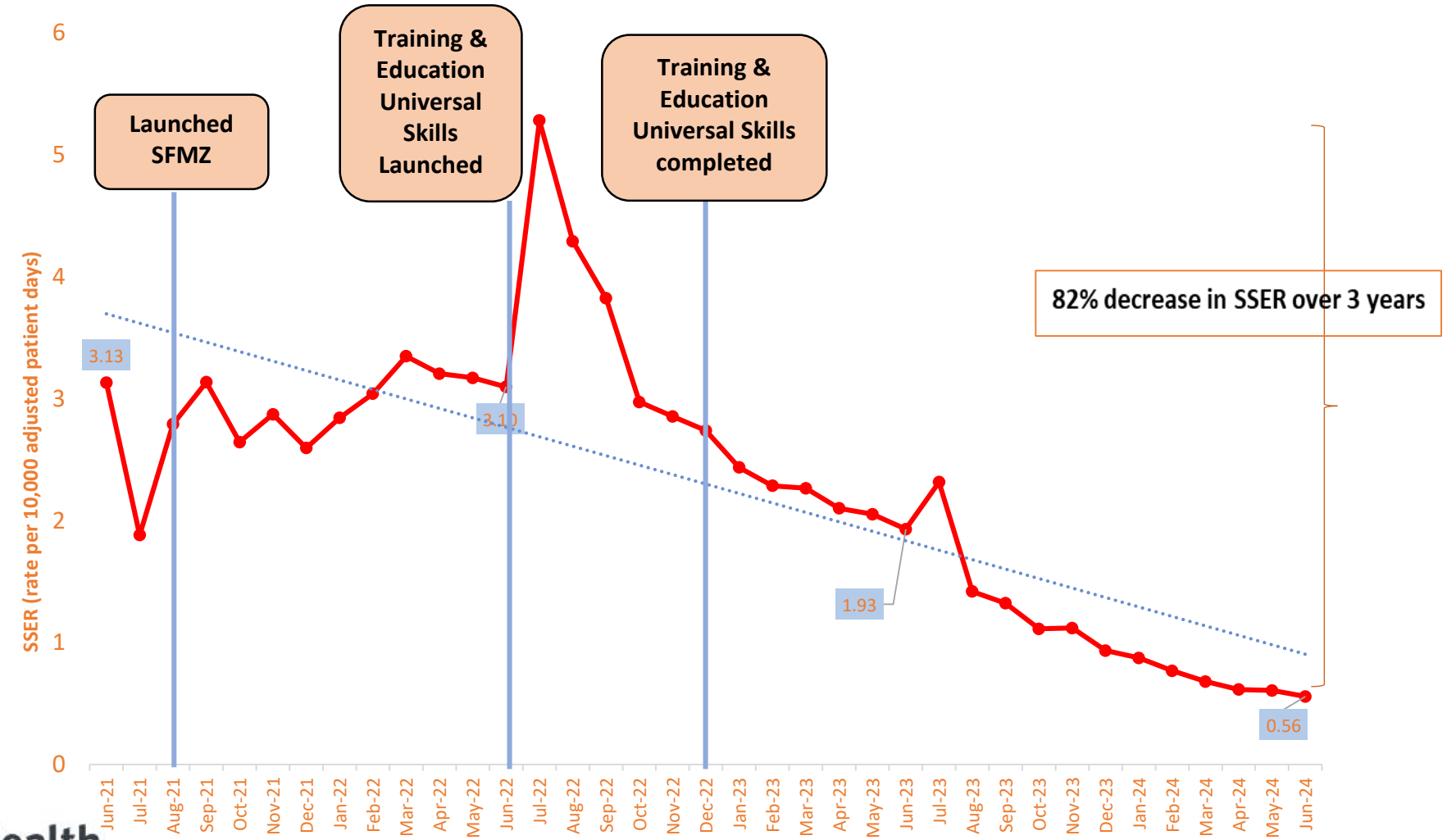
Total SSE, PSE, NME FY23 vs FY24



	SSE	PSE	NME
FY23	40	1587	184
FY24	12	1268	187

Making it Stick

Serious Safety Event Rate (per 10,000 patient days) 2021 – 2024



El Camino Health

Appendix

Safety Is Foundational
…For Our Patients AND Our Workforce

151,200	303,900	183,200	8 of 100	$13 B
Ambulatory workers injured or job acquired illness each year	Hospital workers injured or job acquired illness on job each year	Hospital workers cannot perform their jobs each year	Hospital workers injured or job acquired illness on job each year	Total costs of healthcare illness and injury each year

What is Culture of Safety ?

- Recognize the complex nature of healthcare
- Encourage safety event reporting
- Seek feedback across ranks & disciplines
- Practice blame free environment – coach, mentor, accountability & responsibility

El Camino Health

Swiss Cheese Model of Adverse Events

Reason's Swiss Cheese Model Credits: The Wiley Online Library

El Camino Health

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

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

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

Board Members Absent
None

Staff Present
Dan Woods, CEO
Mark Adams, MD, CMO
Carlos Bohorquez, CFO
Omar Chughtai, CGO
Shahab Dadjou, President, ECHMN
Deanna Dudley, CHRO
Theresa Fuentes, CLO
Ken King, CASO
Mark Klein, CC&MO
Tracey Lewis Taylor, COO
Deb Muro, CIO
Robert Quinn, MD, President, ECHMN
Cheryl Reinking, CNO
Diane Wigglesworth, VP, Compliance
Andreu Reall, VP of Strategy
Jon Cowan, Executive Director, Government Relations and Community Partnerships**

Staff Present (cont.)
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology
Paul Hasbrook, Sr. Director of Supply Chain and Expense Management
Abigail Robles, Manager, Strategic Sourcing – Supply Chain
Manny Hernandez, Manager Supply Chain
Sokphanna Keo, Supervisor Supply Chain
Paul Mares, Supervisor Supply Chain

***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 5:41 p.m. by Chair Bob Rebitzer. Roll call was taken, and a quorum was present. Director Somersille was remote via teleconference. In his opening remarks Chair Rebitzer congratulated Directors Julia Miller, Dr. Carol Somersille, and John Zoglin on their recent re-election to the El Camino Healthcare District Board, acknowledged the new president of the medical network, Dr. Rob Quinn, and thanked the staff for the festive atmosphere.	***The meeting was called to order at 5:41 p.m.***
2. AB-2449 – REMOTE PARTICIPATION	Director Somersille was remote under Just Cause for board travel. Director Chen was remote later in the meeting under Just Cause due to childcare.	
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 and no written correspondence was received.	
5. ECHB SPOTLIGHT RECOGNITION – Purchasing and Supply Chain Departments **Resolution 2024-03**	The Board recogniized the the extraordinary accomplishments made by the purchasing and supply chain teams during the IV solutions shortage caused by hurricanes on the east coast. The team was praised for their quick and decisive actions and the Board voted unanimously to formally recognize their hard work. Mr. Hasbrook, Ms. Robles, Mr. Hernandez, Mr. Keo, and Mr. Mares were present to received the formal recognition.	***Resolution 2024-03 Approved***

	Motion: Approve Resolution 2024-03 recognizing Purchasing and Supply Chain departments. **Movant**: Miller **Second**: Watters **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	
6. FORMATION OF ECHB BYLAWS REVIEW AD HOC COMMITTEE: Resolution 2024-04	Chair Rebitzer asked for approval of Resolution 2024-04 estabishing an ad hoc committee for the review of the ECHB bylaws with Director Watters as Chair of the Bylaws Review Ad Hoc Committee and Directors Miller and Zoglin serving as members of the Bylaws Review Ad Hoc Commiteee. **Motion**: Approve Resolution 2024-04 establishing the Bylaws Review Ad Hoc Committee **Movant**: Chen **Second**: Po **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Resolution 2024-04 Approved***
7. CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Director Zoglin asked for item (a) Hospital Board Open Session Minutes (11/20/2024) to be removed. **Motion:** To approve the consent calendar minus item (a) Hospital Board Open Session Minutes (11/20/2024) **Movant**: Watters **Second**: Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None Director Zoglin asked that the open session minutes be amended to include action item for budget review process to be discussed in February. **Motion:** To approve the consent calendar item (a) Hospital Board Open Session Minutes (11/20/2024) amended with action item to have budget review process added to February agenda. **Movant**: Zoglin **Second**: Miller **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer,	***Consent calendar items b, c, and d were approved.*** *b. Report for Environment of Care* *c. Conflict of Interest Policy* *d. Policies as Reviewed and Recommended by Medical Executive Committee* ***Hospital Board Open Session Minutes (11/20/2024) approved with changes.***

	Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	
8. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 5:58 p.m. **Movant**: Doiguchi **Second**: Po **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Recessed to closed session at 5:58 p.m.***
9. AGENDA ITEM 15: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:46 p.m., and Agenda Items 8-14 were addressed in the closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report and Closed Session Minutes were approved by a unanimous vote of all Directors present and the approval of up to $23.5 million in additional funding to complete the Women's Hospital Expansion Project as reviewed and recommended by the Finance Committee on December 5, 2024 was approved by a majority with Director Miller abstaining.	***Reconvened Open Session at 7:46 p.m.***
10. AGENDA ITEM 16: APPROVE PHYSICIAN SERVICE AGREEMENTS	**Motion:** To approve Enterprise Gastroenterology ED and Inpatient Call Panel Services agreement. **Movant**: Po **Second**: Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None **Motion:** To approve Enterprise Neurodiagnostic Coverage Services agreement. **Movant**: Po **Second**: Watters **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Physician Agreements approved.***

11. AGENDA ITEM 19: ADJOURNMENT	**Motion:** To adjourn at 7:49 p.m. **Movant**: Fung **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 Health Board of Directors
Board Meeting Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, Chief Quality Officer
Date: February 5, 2025
Subject: Addition to Core Values

Purpose:

To approve the addition of the following statement to our core values: "Safety: We put safety first in each decision and process, to achieve our mission of zero harm for our patients, visitors, and team members." This revision has been reviewed and recommended by Executive Leadership.

Summary:

We are actively working on the attestations required for submission to the Centers for Medicare & Medicaid Services ("CMS") in connection with the new patient safety structural requirements for hospitals participating in the Hospital Inpatient Quality Reporting program.

One of the required attestations states: "Our hospital senior governing board prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation."

El Camino Health's core values statement is listed on our website. These values were initially developed by management and integrated into a strategic framework that the board approved in 2018.

While safety is always a priority and embedded in everything we do, it was not specifically called out in the core values statement. As such, executive leadership proposes to add the below language in red to ECH's core values statement. Upon consideration and approval by the board, this addition will support ECH's attestation to CMS that the "governing board prioritizes safety as a core value."

https://www.elcaminohealth.org/about-us/our-mission

Our Core Values

- **Quality. We pursue excellence to deliver evidence based care in partnership with our patients and families.**
- **Safety. We put safety first in each decision and process, to achieve our mission of zero harm for our patients, visitors, and team members.**
- **Compassion. We care for each individual uniquely with kindness, respect and empathy.**
- **Community. We partner with local organizations, volunteers and a philanthropic community to provide healthcare services across all stages of life.**
- **Collaboration. We partner for the best interests of our patients, their families and our community using a team approach.**
- **Stewardship. We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.**

- **Innovation. We embrace solutions and forward thinking approaches that lead to better health.**
- **Accountability. We take responsibility for the impact our actions have on the community and each other.**

Department	Document Name	Origination	Last Reviewed	Revised?	Doc Type	Committee
New Business						
	A17c1. Removed for further internal review. Not included in board packet					
Quality	A17c2.Quality Improvement & Patient Safety Plan (QIPS)	5-2018	6-12-24	Revised	Plan	• PESC • Quality Council • ePolicy • MEC • Quality Committee • Board
Patient Accounts	A17c3. Financial Assistance (Discounted Charity Care, Eligibility Procedures, Review Process)	4-2000	4-13-22	Revised	Policy	• CFO • ePolicy • Board
Peri-Operative Svcs	A17c4. Perioperative Services - Los Gatos (Outpatient Surgery/Short Stay Unit, Post Anesthesia Care Unit, Operating Room & Central Sterile Processing Department)	10-2015	11-10-21	Revised	Scope of Svc	• UPC | Staff Meeting • Dept of Surgery • ePolicy • MEC • Board
Quality	A17c5. Patient Blood Management Patient-Centered Quality Plan	2-2024	2-7-24	Revised	Plan	• Transfusion Safety • ePolicy • MEC • Board
MHAS	A17c6. Scope of Service – Mental Health & Addiction Services	12-2019	12-11-2019	Revised	Scope of Svc	• Med Dir • ePolicy • MEC • Board
Environment of Care	A17c7. Environment of Care Medical Equipment Management Plan	4-2018	6-12-24	Revised	Plan	• Central Safety • PESC • ePolicy • MEC • Board
Lactation	A17c8. Scope of Service: Lactation Services – Enterprise	3-2015	8-12-20	Revised	Scope of Svc	• UPC | Staff Meeting • MCH Exec • ePolicy • MEC • Board
Emergency Mgmt	A17c9. Emergency Operations Plan	3-2018	12-6-23	Revise	Plan	• Emergency Mgmt • ePolicy

						• MEC • Board
4B	A17c10. 4B Medical Surgical Oncology - Mountain View	3-2012	2-12-20	Revised	Scope of Svc	• Med Dir • ePolicy • MEC • Board
Nursing	A17c11. Scope of Practice for Nursing Services	5-1995	12-8-21	None	Scope of Svc	• ePolicy • MEC • Board
Patient Access	A17c12. Scope of Service - Patient Access Department	9-2018	N/A	Revised	Scope of Svc	• Med Dir • ePolicy • MEC • Board
Dialysis	A17c13. Enterprise-wide Inpatient Dialysis: Scope of Services	6-2009	3-13-24	Revised	Scope of Svc	• ePolicy • MEC • Board
Utility Management	A17c14. Environment of Care Utility Management Plan	2-2018	12-9-20	Revised	Plan	• Central Safety • PESC • ePolicy • MEC • Board
Rehabilitation Svcs	A17c15. Scope of Service: Rehabilitation Services	3-2012	6-14-23	Revised	Scope of Svc	• Med Dir • Med Dept Exec • ePolicy • MEC • Board
MCH	A17c16. Neonatal Screening for Critical Congenital Heart Disease (CCHD) Using Pulse Oximetry	2-2013	N/A	Revised	Policy	• UPC | Staff Meeting • Peds Dept • MCH Exec • ePolicy • MEC • Board
Medical Staff	A17c17. Ongoing Professional Practice Evaluation (OPPE) A17c18. Medical Staff Services - Credentialing Quality Process Improvement	11-2008 1-2023	12-8-21 N/A	None None	Policy Plan	#1: • Med Staff Leadership • ePolicy • MEC > Board #2: • IDPC • Credentialing

						• ePolicy • MEC • Board
Imaging Services	A17c19. Radiation Safety - Radiation Protection Program A17c20. Scope of Service - Imaging Services	7-2014 2-2017	6-14-23 10-9-24	None Revised	Policy Scope of Svc	#1: • Radiation Safety • ePolicy • MEC • Board #2: • Med Dir • ePolicy • MEC • Board
Environmental Svcs	A17c21. Environment of Care - Hazardous Materials Management Plan A17c22. Scope of Service Environmental Services	2-2018 12-2006	N/A 9-22-21	Revised Revised	Plan Scope of Svc	#1: • Hazardous Material Group • Central Safety • PESC • ePolicy • MEC • Board #2: • ePolicy • MEC • Board
-HVI -Wound Care	A17c23. Scope of Service - Norma Melchor Heart & Vascular Institute A17c24. Scope of Service - Wound Care Center	8-2015 9-2017	2-10-21 2-7-24	Revised Revised	Scope of Svc Scope of Svc	• Med Dir • ePolicy • MEC • Board
Environment of Care	A17c25. Environment of Care Safe Environment Management Plan A17c26. Environment of Care Security Management Plan	2-2018 2-2018	N/A 10-9-24	Revised Revised	Plan Plan	• Central Safety • PESC • ePolicy • MEC • Borad
O/P Oncology	A17c27. Radiation Oncology Department Scope of Service A17c28. Scope of Service - Cancer Center Clinic A17c29. Scope of Service Infusion Center - Mountain View	7-2014 8-2015 5-2009	6-14-23 5-20-20 9-9-20	None Revised Revised	Policy Scope of Svc Scope of Svc	#1: • Radiation Safety • ePolicy • MEC • Board #2-3: • Med Dir • ePolicy • MEC • Board

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: February 5, 2025
Subject: Financials: FY2025 – Period 5 (November 2024) - Consent Calendar

Purpose:

To provide the Board an update on financial results for FY2025 Period 5 (November 2024).

Executive Summary – Period 5 (November 2024):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 310 is 7 / 2.2% favorable to budget and 2 / 0.5% higher than the same period last year.
- **Adjusted Discharges:** 3,630 are (93) / (2.5%) unfavorable to budget and (9) / (0.3)% lower than the same period last year.
- **Emergency Room Visits:** 6,273 are (259) / (4.0%) unfavorable to budget and (59) / (0.9%) lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 12,292 are 507 / 4.3% favorable to budget and 919 / 8.1% higher than the same period last fiscal year.

Financial performance for Period 5 was favorable to budget. This is attributed to stable patient volumes, strong net patient revenue and favorable management of variable expenses across the enterprise.

Total Operating Revenue ($):	$139.3M is $4.5M / 3.4% favorable to budget and $13.3M / 10.6% higher than the same period last fiscal year.
Operating EBIDA ($):	$24.7M is $5.1M / 26.2% favorable to budget and $3.2M / 15.1% higher than the same period last fiscal year.
Net Income ($):	$35.9M is $19.3M / 116.5% favorable to budget and $4.2M / 13.4% higher than the same period last fiscal year.
Operating Margin (%):	11.7% (actual) vs. 8.2% (budget)
Operating EBIDA Margin (%):	17.7% (actual) vs. 14.5% (budget)
Net Days in A/R (days):	56.8 days are unfavorable to budget by 2.8 days / 5.2% and 3.0 days / 5.6% higher than the same period last year.

Recommendation:

- Recommend receipt of FY2025 – Period 5 & YTD financials

List of Attachments:

- Financial Report: FY2025 Period 5

El Camino Health

Summary of Financial Operations

Fiscal Year 2025 – Period 5

7/1/2024 to 11/30/2024

Operational / Financial Results: Period 5 – November 2024 (as of 11/30/2024)

($ 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	310	303	7	2.2%	309	2	0.5%	---	---	---	---
	Adjusted Discharges	3,630	3,723	(93)	(2.5%)	3,639	(9)	(0.3%)	---	---	---	---
	OP Visits / OP Procedural Cases	12,292	11,785	507	4.3%	11,373	919	8.1%	---	---	---	---
	Percent Government (%)	59.7%	58.3%	1.4%	2.4%	57.8%	1.8%	3.2%	---	---	---	---
	Gross Charges ($)	588,489	569,400	19,089	3.4%	527,171	61,317	11.6%	---	---	---	---
Operations	Cost Per CMI AD	19,057	20,032	(975)	(4.9%)	18,592	465	2.5%	---	---	---	---
	Net Days in A/R	56.8	54.0	2.8	5.2%	53.8	3.0	5.6%	48.1	49.7	47.5	
Financial Performance	Net Patient Revenue ($)	134,047	128,147	5,900	4.6%	120,981	13,066	10.8%	297,558	564,735	---	
	Total Operating Revenue ($)	139,339	134,815	4,524	3.4%	126,030	13,309	10.6%	389,498	610,593	268,739	
	Operating Margin ($)	**16,264**	**11,074**	**5,190**	46.9%	**13,090**	**3,174**	24.3%	**7,400**	**11,601**	**8,331**	
	Operating EBIDA ($)	**24,659**	**19,536**	**5,123**	26.2%	**21,428**	**3,231**	15.1%	**26,400**	**39,689**	**22,574**	
	Net Income ($)	35,930	16,598	19,332	116.5%	31,691	4,238	13.4%	19,085	20,150	15,049	
	Operating Margin (%)	**11.7%**	**8.2%**	**3.5%**	42.1%	**10.4%**	**1.3%**	12.4%	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**17.7%**	**14.5%**	**3.2%**	22.1%	**17.0%**	**0.7%**	4.1%	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	265	275	(10)	(3.6%)	257	8	3.2%	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.

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

El Camino Health

Operational / Financial Results: YTD FY2025 (as of 11/30/2024)

($ 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	305	305	(0)	(0.1%)	305	(0)	(0.0%)	---	---	---	---
	Adjusted Discharges	18,341	18,393	(52)	(0.3%)	18,381	(40)	(0.2%)	---	---	---	---
	OP Visits / OP Procedural Cases	62,961	58,488	4,473	7.6%	56,260	6,701	11.9%	---	---	---	---
	Percent Government (%)	58.2%	58.3%	(0.1%)	(0.2%)	58.5%	(0.3%)	(0.5%)	---	---	---	---
	Gross Charges ($)	2,955,301	2,832,541	122,760	4.3%	2,600,868	354,433	13.6%	---	---	---	---
Operations	Cost Per CMI AD	19,940	20,032	(92)	(0.5%)	18,449	1,491	8.1%	---	---	---	---
	Net Days in A/R	56.8	54.0	2.8	5.2%	53.8	3.0	5.6%	48.1	48.1	47.5	
Financial Performance	Net Patient Revenue ($)	666,574	649,780	16,795	2.6%	599,860	66,714	11.1%	1,487,791	2,823,673	---	
	Total Operating Revenue ($)	694,620	677,352	17,268	2.5%	626,149	68,471	10.9%	1,947,490	3,052,964	3,224,864	
	Operating Margin ($)	**60,668**	**53,716**	**6,952**	12.9%	**55,958**	**4,710**	8.4%	**37,002**	**58,006**	**99,971**	
	Operating EBIDA ($)	**102,615**	**97,027**	**5,588**	5.8%	**97,241**	**5,374**	5.5%	**132,002**	**198,443**	**270,889**	
	Net Income ($)	138,476	79,080	59,396	75.1%	54,634	83,842	153.5%	95,427	174,019	180,592	
	Operating Margin (%)	**8.7%**	**7.9%**	**0.8%**	10.1%	**8.9%**	**(0.2%)**	(2.3%)	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**14.8%**	**14.3%**	**0.4%**	3.1%	**15.5%**	**(0.8%)**	(4.9%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	265	275	(10)	(3.6%)	257	8	3.2%	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.

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

El Camino Health

Consolidated Balance Sheet (as of 11/30/2024)

($000s)

ASSETS		Audited
CURRENT ASSETS	**November 30, 2024**	**June 30, 2024**
Cash	225,614	202,980
Short Term Investments	87,918	100,316
Patient Accounts Receivable, net	252,536	211,960
Other Accounts and Notes Receivable	19,976	25,065
Intercompany Receivables	18,298	17,770
Inventories and Prepaids	58,779	55,556
Total Current Assets	**663,121**	**613,647**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	25,855	23,309
Plant & Equipment Fund	542,017	503,081
Women's Hospital Expansion	44,386	31,740
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	17,573	17,561
Workers Compensation Reserve Fund	12,811	12,811
Postretirement Health/Life Reserve Fund	23,009	22,737
PTO Liability Fund	40,726	37,646
Malpractice Reserve Fund	1,713	1,713
Catastrophic Reserves Fund	43,852	33,030
Total Board Designated Assets	**962,636**	**894,322**
FUNDS HELD BY TRUSTEE	**18**	**18**
LONG TERM INVESTMENTS	**697,373**	**665,759**
CHARITABLE GIFT ANNUITY INVESTMENTS	**1,174**	**965**
INVESTMENTS IN AFFILIATES	**36,599**	**36,663**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,023,334	2,016,992
Less: Accumulated Depreciation	(909,334)	(874,767)
Construction in Progress	201,390	173,449
Property, Plant & Equipment - Net	**1,315,390**	**1,315,675**
DEFERRED OUTFLOWS	46,587	41,550
RESTRICTED ASSETS	34,706	32,166
OTHER ASSETS	191,940	195,447
TOTAL ASSETS	**3,949,545**	**3,796,213**

LIABILITIES AND FUND BALANCE		Audited
CURRENT LIABILITIES	**November 30, 2024**	**June 30, 2024**
Accounts Payable	61,495	71,017
Salaries and Related Liabilities	45,841	35,693
Accrued PTO	41,775	38,634
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	12,470	13,419
Intercompany Payables	14,358	13,907
Malpractice Reserves	1,830	1,830
Bonds Payable - Current	10,820	10,820
Bond Interest Payable	6,138	7,673
Other Liabilities	14,472	12,261
Total Current Liabilities	**211,499**	**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)	28,717	27,707
Bond Payable	439,416	441,105
Total Long Term Liabilities	**503,953**	**504,360**
DEFERRED REVENUE-UNRESTRICTED	**527**	**1,038**
DEFERRED INFLOW OF RESOURCES	**84,484**	**92,261**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,873,135	2,731,120
Minority Interest	(1,159)	(1,114)
Board Designated	224,384	216,378
Restricted	52,722	44,616
Total Fund Bal & Capital Accts	**3,149,082**	**2,991,001**
TOTAL LIABILITIES AND FUND BALANCE	**3,949,545**	**3,796,213**

El Camino Health

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: February 5, 2025
Subject: Financials: FY2025 – Period 6 & YTD (as of 12/31/2024) - Consent Calendar

Purpose:

To provide the Board an update on financial results for FY2025 Period 6 (December 2024) & YTD.

Executive Summary – Period 6 (December 2024):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 322 is 4 / 1.3% favorable to budget and 24 / 8.1% higher than the same period last year.
- **Adjusted Discharges:** 3,898 are 11 / 0.3% unfavorable to budget and 343 / 9.7% higher than the same period last year.
- **Emergency Room Visits:** 7,626 are 126 / 1.7 favorable to budget and 278 / 3.5 lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 12,583 are 1,418 / 12.7% favorable to budget and 1,633 / 14.9% higher than the same period last fiscal year.

Financial performance for Period 6 was favorable to budget. This is attributed to strong surgical, NICU and Emergency Room volumes and disciplined variable expense management.

Total Operating Revenue ($):	$148.1M is $8.4M / 6.0% favorable to budget and $17.2M / 13.1% higher than the same period last fiscal year.
Operating EBIDA ($):	$31.9M is $10.5M / 48.9% favorable to budget and $5.5M / 20.6% higher than the same period last fiscal year.
Net Income ($):	$18.1M is $0.5M / 2.4% unfavorable to budget and $51.1M / 73.8% lower than the same period last fiscal year.
Operating Margin (%):	16.0% (actual) vs. 9.4% (budget)
Operating EBIDA Margin (%):	21.5% (actual) vs. 15.3% (budget)
Net Days in A/R (days):	50.2 days are favorable to budget by 3.8 days / 7.1% and 4.0 days / 7.4% lower than the same period last year. There was a reduction of 6.6 days from period 5.

Executive Summary – YTD FY2025 (as of 12/31/2024):

With the exception of outpatient visits / procedures and surgeries, year-over-year patient activity is consistent with last fiscal year.

- **Average Daily Census:** 308 is 1 / 0.2% favorable to budget and 4 / 1.3% higher than the same period last year.
- **Adjusted Discharges:** 22,239 are 62 / 0.3% unfavorable to budget and 303 / 1.4% higher than the same period last year.

- **Emergency Room Visits:** 40,058 are 289 / 0.7% unfavorable to budget and 341 / 0.8% lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 75,731 are 5,878 / 8.4% favorable to budget and 8,321 / 12.4% higher than the same period last fiscal year.

Total Operating Revenue ($):	$842.7M is $25.6M / 3.1% favorable to budget and $85.7M / 11.3% higher than the same period last fiscal year.
Operating EBIDA ($):	$134.5M is $16.1M / 13.6% favorable to budget and $10.8M / 8.8% higher than the same period last fiscal year.
Net Income ($):	$156.6M is $58.9M / 60.3% favorable to budget and $32.8M / 26.5% higher than the same period last fiscal year. Favorable net income is attributed to stable financial performance and unrealized gains on investment portfolio.
Operating Margin (%):	10.0% (actual) vs. 8.2% (budget)
Operating EBIDA Margin (%):	16.0% (actual) vs. 14.5% (budget)

Recommendation:

- Recommend receipt of FY2025 – Period 6 & YTD financials

List of Attachments:

- Financial Report: FY2025 Period 6

El Camino Health

Summary of Financial Operations

Fiscal Year 2025 – Period 6

7/1/2024 to 12/31/2024

Operational / Financial Results: Period 6 – December 2024 (as of 12/31/2024)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Year over Year change	YoY % Change	Moody's 'Aa3'	S&P 'AA'	Fitch 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	322	318	4	1.3%	298	24	8.1%	---	---	---	---
	Adjusted Discharges	3,898	3,908	(11)	(0.3%)	3,554	343	9.7%	---	---	---	---
	OP Visits / OP Procedural Cases	12,583	11,165	1,418	12.7%	10,950	1,633	14.9%	---	---	---	---
	Percent Government (%)	59.1%	59.0%	0.1%	0.2%	56.4%	2.7%	4.9%	---	---	---	---
	Gross Charges ($)	633,620	600,830	32,790	5.5%	515,757	117,863	22.9%	---	---	---	---
Operations	Cost Per CMI AD	18,138	20,032	(1,895)	(9.5%)	17,774	363	2.0%	---	---	---	---
	Net Days in A/R	50.2	54.0	(3.8)	(7.1%)	54.2	(4.0)	(7.4%)	48.1	49.7	47.5	
Financial Performance	Net Patient Revenue ($)	142,459	133,104	9,354	7.0%	125,939	16,519	13.1%	297,558	564,735	---	
	Total Operating Revenue ($)	148,075	139,716	8,359	6.0%	130,894	17,181	13.1%	389,498	610,593	268,739	
	Operating Margin ($)	**23,626**	**13,074**	**10,553**	80.7%	**18,040**	**5,586**	31.0%	**7,400**	**11,601**	**8,331**	
	Operating EBIDA ($)	**31,897**	**21,429**	**10,469**	48.9%	**26,447**	**5,450**	20.6%	**26,400**	**39,689**	**22,574**	
	Net Income ($)	18,144	18,598	(453)	(2.4%)	69,197	(51,052)	(73.8%)	19,085	20,150	15,049	
	Operating Margin (%)	**16.0%**	**9.4%**	**6.6%**	70.5%	**13.8%**	**2.2%**	15.8%	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**21.5%**	**15.3%**	**6.2%**	40.5%	**20.2%**	**1.3%**	6.6%	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	276	275	1	0.3%	268	7	2.8%	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 12/31/2024)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Year over Year change	YoY % Change	Moody's 'Aa3'	S&P 'AA'	Fitch 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	308	307	1	0.2%	304	4	1.3%	---	---	---	---
	Adjusted Discharges	22,239	22,301	(62)	(0.3%)	21,935	303	1.4%	---	---	---	---
	OP Visits / OP Procedural Cases	75,531	69,653	5,878	8.4%	67,210	8,321	12.4%	---	---	---	---
	Percent Government (%)	58.4%	58.5%	(0.1%)	(0.1%)	58.2%	0.2%	0.4%	---	---	---	---
	Gross Charges ($)	3,588,921	3,433,372	155,550	4.5%	3,116,625	472,296	15.2%	---	---	---	---
Operations	Cost Per CMI AD	19,619	20,032	(413)	(2.1%)	18,332	1,287	7.0%	---	---	---	---
	Net Days in A/R	50.2	54.0	(3.8)	(7.1%)	54.2	(4.0)	(7.4%)	48.1	48.1	47.5	
Financial Performance	Net Patient Revenue ($)	809,033	782,884	26,149	3.3%	725,799	83,234	11.5%	1,785,350	3,388,408	---	
	Total Operating Revenue ($)	842,695	817,068	25,627	3.1%	757,043	85,652	11.3%	2,336,989	3,663,557	3,224,864	
	Operating Margin ($)	**84,295**	**66,790**	**17,505**	26.2%	**73,998**	**10,296**	13.9%	**44,403**	**69,608**	**99,971**	
	Operating EBIDA ($)	**134,512**	**118,456**	**16,057**	13.6%	**123,688**	**10,824**	8.8%	**158,402**	**238,131**	**270,889**	
	Net Income ($)	156,621	97,677	58,943	60.3%	123,831	32,790	26.5%	114,512	208,823	180,592	
	Operating Margin (%)	**10.0%**	**8.2%**	**1.8%**	22.4%	**9.8%**	**0.2%**	2.3%	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**16.0%**	**14.5%**	**1.5%**	10.1%	**16.3%**	**(0.4%)**	(2.3%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	276	275	1	0.3%	268	7	2.8%	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%

Consolidated Balance Sheet (as of 12/31/2024)

($000s)

ASSETS		Audited
CURRENT ASSETS	**December 31, 2024**	**June 30, 2024**
Cash	272,820	202,980
Short Term Investments	86,020	100,316
Patient Accounts Receivable, net	230,662	211,960
Other Accounts and Notes Receivable	25,258	25,065
Intercompany Receivables	18,184	17,770
Inventories and Prepaids	53,487	55,556
Total Current Assets	**686,430**	**613,647**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	25,469	23,309
Plant & Equipment Fund	540,748	503,081
Women's Hospital Expansion	44,603	31,740
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	18,337	17,561
Workers Compensation Reserve Fund	12,811	12,811
Postretirement Health/Life Reserve Fund	23,009	22,737
PTO Liability Fund	40,726	37,646
Malpractice Reserve Fund	1,713	1,713
Catastrophic Reserves Fund	39,953	33,030
Total Board Designated Assets	**958,062**	**894,322**
FUNDS HELD BY TRUSTEE	**18**	**18**
LONG TERM INVESTMENTS	**695,005**	**665,759**
CHARITABLE GIFT ANNUITY INVESTMENTS	**1,127**	**965**
INVESTMENTS IN AFFILIATES	**47,216**	**36,663**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,030,841	2,016,992
Less: Accumulated Depreciation	(916,145)	(874,767)
Construction in Progress	207,176	173,449
Property, Plant & Equipment - Net	**1,321,873**	**1,315,675**
DEFERRED OUTFLOWS	47,091	41,550
RESTRICTED ASSETS	34,608	32,166
OTHER ASSETS	203,987	195,447
TOTAL ASSETS	**3,995,416**	**3,796,213**

LIABILITIES AND FUND BALANCE		Audited
CURRENT LIABILITIES	**December 31, 2024**	**June 30, 2024**
Accounts Payable	63,243	71,017
Salaries and Related Liabilities	52,934	35,693
Accrued PTO	41,755	38,634
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	11,650	13,419
Intercompany Payables	14,166	13,907
Malpractice Reserves	1,830	1,830
Bonds Payable - Current	10,820	10,820
Bond Interest Payable	7,673	7,673
Other Liabilities	15,446	12,261
Total Current Liabilities	**221,816**	**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)	30,536	27,707
Bond Payable	438,966	441,105
Total Long Term Liabilities	**505,322**	**504,360**
DEFERRED REVENUE-UNRESTRICTED	**1,054**	**1,038**
DEFERRED INFLOW OF RESOURCES	**99,431**	**92,261**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,891,677	2,731,120
Minority Interest	(1,159)	(1,114)
Board Designated	224,278	216,378
Restricted	52,997	44,616
Total Fund Bal & Capital Accts	**3,167,793**	**2,991,001**
TOTAL LIABILITIES AND FUND BALANCE	**3,995,416**	**3,796,213**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD
FY2025 PACING PLAN / MASTER CALENDAR

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
APPROVALS AND CONSENT CALENDAR												
Board Minutes		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Committee Reports and Recommendations		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Community Benefit Plan												✓
Credentialing and Privileges Report		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Physician Agreements		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Policies		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
FINANCE												
Audited Financial Report				✓								
Budget (Preview)											✓	
Budget Approval												✓
Period Financials (Consent)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Quarterly Financials (Focus)					✓			✓			✓	
PHYSICIANS AND MEDICAL NETWORK												
ECHMN Report			✓						✓		✓	
Medical Staff Report			✓		✓				✓			✓
QUALITY												
Quality STEEEP Dashboard		✓			✓			✓			✓	
Quality Committee Report			✓						✓			✓
STRATEGY												
Strategic Plan Metrics		✓	✓									
Strategic Plan Update						✓		✓			✓	
Strategy Deep Dive (Retreat)										✓		
Strategic Goals Approval												✓
EXECUTIVE PERFORMANCE												
CEO Self-Assessment (Year in Review)		✓										
CEO Assessment (Board Executive Session)			✓									
Organizational Performance Goal Score (Prior Year)				✓								
Executive Base Salaries and Salary Ranges				✓								
CEO Compensation				✓								
COMPLIANCE AND GOVERNANCE												
Annual Compliance Program Report Out					✓							
Enterprise Risk Management											✓	
Board Assessment Results				✓								
Board Officer Elections (*Even Years*)												
Board Calendar												✓
Committee Goals												✓

El Camino Health

FY25 ECHB MEETING OPEN FOLLOW UP ITEMS

Subject	Timing	Action	Status
December 2024 ECHB Meeting			
Strategy Update	Next Report	Dan to provide a strategy update on the IDN concept.	Paced for April meeting.
November 2024 ECHB Meeting			
ECH Governance Structure	Future Meeting	Chief Legal Officer to prepare a memo outlining requirements for board approvals at each level of the organization.	In progress
Financial Report	Future Meeting	Staff to provide overview of budget review process at February meeting.	Paced for February meeting.
FY2025 Organizational Goals	Next Report	Staff to prepare to share the process or revised process with timeline for strategic updates.	Paced for April meeting.
September 2024 ECHB Meeting			
ECHMN Semi-Annual Report	Future Meeting	Supplement Press Ganey LTR data with alternative metrics like marketing polls via social media.	In progress with ECHMN board.
August 2024 ECHB Meeting			
Quality Report	Future Meeting	Review pacing of ECHMN report and Quality Committee report so they can occur at the same time for Board.	1st synced meeting will occur in May 2025. Moved from February due to changes in ECHMN leadership.
Closed Session CEO Report	Future Meeting	Plan a board trip/event down to LG.	In progress Scheduled for February 12, 2025 2:00 – 5:00 p.m. This will be a Joint ECHB-Finance Committee meeting

Updated 01/30/2025

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT I FEBRUARY 5, 2025

Due to the close timing of the January CEO report, presented to the Board on January 10th, and the ECHB Marketing Announcement, shared with the Board both electronically and in person during the week of January 27th, this report is intentionally abbreviated.

HOSPITAL OPERATIONS: **The Joint Commission** came for the full triennial survey on January 22nd and were onsite at both hospitals. The survey focused on Hospital and Behavioral Health Programs for over **265** standards, over **1,403** individual elements of performance, **12** National Patient Safety Goals (NPSG), and over **3,069** Conditions of Participant (CoPs).

- We had **NO** findings on the National Patient Safety Goals.
- They had 53 " findings" or Request for Improvements. For context, we had 50 findings in our previous triennial survey in 2022.
- Most of the findings were in the "Low Limited Category" and related to Life safety/Environment of care issues. The surveyors mentioned that this was not unusual post pandemic for organizations.
- The surveyors were complimentary of the organization and the staff at both campuses and mentioned that if they needed care, they would not hesitate to come to El Camino Health.
- The Joint Commission will revisit the organization in 30-45 days to ensure that the life safety findings have been corrected. (Most of them have already been corrected and the rest will be corrected in the next 2 weeks)

FOUNDATION: In December, El Camino Health Foundation raised $1,581,812 in donations, bringing the total for FY2025 through period 6 to $11,464,246—**149% of the annual goal**.

In January, the Foundation received the first of three pledge payments for the Linda Rice Rodgers Hope to Health Endowment. Linda Rodgers, an early member of Hope to Health (H2H), used her legal expertise to establish the group's policies, enabling members to direct their pooled donations to El Camino Health programs. Since 2006, H2H has granted approximately $800,000 to improve healthcare for women and families.

The endowment will contribute Linda's $1,000 annual dues in perpetuity and fund an annual cancer education program for H2H members, honoring Linda's legacy and commitment to health education, community service, and philanthropy.

CORPORATE HEALTH SERVICES: To expand choice and drive utilization, Concern made coaching accessible to customers in January. Coaching, an alternative to counseling, helps individuals set goals related to health, work-life balance, and stress reduction. To introduce coaching, Concern will host a free live webinar, ***Coaching for Personal and Professional Growth***, in early February.

The **Chinese Health Initiative** (CHI) launched ***A Guide to Emotional Well-Being for the Chinese Community***, a bilingual resource addressing culturally competent mental health support. Additionally, CHI expanded community engagement through participation in the City of Mountain View's Lunar New Year event and the Sunnyvale Community Services Senior Wellness Fair.

The **South Asian Heart Center** engaged 203 new and returning participants in screenings, education, and coaching programs for heart disease and diabetes prevention, completing 382 consultations and coaching sessions. For the first half of fiscal 2025, the center engaged **1,182 unique participants** and completed **3,305 service encounters**.

AUXILIARY: The Auxiliary donated **3,026 volunteer hours** for the month of December.

Status **Pending** PolicyStat ID **16872459**

Origination	05/2018	Owner	Michael Coston: Director Quality and Public Reporting
Last Approved	N/A		
Effective	Upon Approval	Area	Quality
Last Revised	11/2024	Document Types	Plan
Next Review	1 year after approval		

Quality Improvement & Patient Safety Plan (QIPS)

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

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

The ECH Medical Staff includes over 1100 active, telemedicine, provisional and consultant, ~~328~~353 affiliate physicians, and 116 independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

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

El CAMINO HEALTH VISION

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

El CAMINO HOSPITAL VALUES

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

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

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

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

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

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

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

DEFINITIONS:

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

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

SERVICES/PROGRAMS

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

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

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

Section I Quality Improvement Plan

PURPOSE

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

OBJECTIVES

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

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

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

Governing Board

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

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

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

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

Medical Executive Committee (MEC)

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

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

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

Medical Staff Departments and Divisions

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

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

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

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

Leadership and Support

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

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

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

Medical Staff, Employees, and Contracted Services

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

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is chaired by the ~~past chief of staff~~delegated Medical Staff Leader, ~~their designee,~~ and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY ~~2023 is~~2025 includes the reduction of ~~the Hospital Acquired Conditions (HAC) Index~~C.difficile and CAUTI infections, and increased Hand Hygiene audits. Quality Council receives a monthly report on the progress of the Quality Teams that work to address this goal. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY ~~23~~25 Quality Council report schedule.

Quality Services Department

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

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

The Quality Services Department is also responsible for:

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

Hospital Services

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

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

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

IMPROVING ORGANIZATIONAL PERFORMANCE

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

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

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

Performance Processes

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

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

B. **Measurement**

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

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

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

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

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

C. **Analysis**

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

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

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

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

Improvement Model and Methodology

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

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

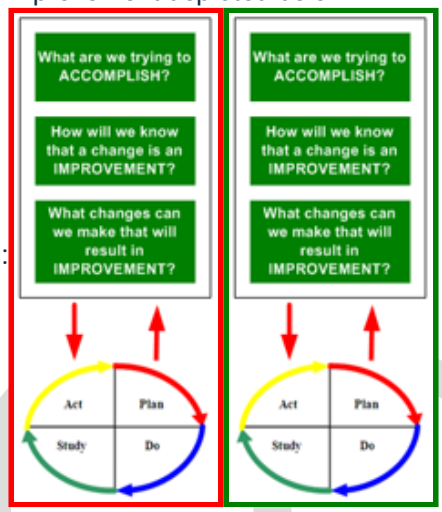
The model has two parts:

A. ***Three fundamental questions, which can be addressed in any order.***

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

B. ***The Plan-Do-Study-Act (PDSA) Cycle***
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.
   Step 1: Plan
   Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
   Step 2: Do
   Try out the test on a small scale. What did we observe that was not a part of our plan?

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



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

1. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
The acronym stands for:
S – Specific
When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
When – You'll get more specific about this question under the "time-bound" section of defining S.M.A.R.T. goals, but you should at least set a time frame.
Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking

business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."
Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.
M – Measurable
What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it's a project that's going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.
A – Achievable
This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don't currently possess those tools/skills, consider what it would take to attain them.
R – Relevant
Relevance refers to focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that's in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn't be relevant.
T – Time-Bound
Anyone can set goals, but if it lacks realistic timing, chances are you're not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it's useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

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

Process Improvement ~~and the El Camino Health Operating System~~

ECH is on a journey of continuous improvement and operational excellence. Process Improvement is a set of

~~concepts,~~ principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. As a High Reliability ~~Organizations~~Organization, we deliver exactly what is needed, at the right time, in the right quantity, without defects, and at the lowest possible cost.

The Process Improvement department has been in existence since 2012~~, and has adopted the use of~~. Our goal is to support a culture of continuous improvement to create problem-solvers at every level and together to make health care better using Lean methodology and ~~principles~~techniques as the foundation ~~for~~of our interventions. We also use tools from Six Sigma, Change Management, and ~~PDCA, to support our transformation in becoming a High Reliability Organization~~PDSA to achieve both incremental and breakthrough improvements. ~~We do this by focusing on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the foundation.~~

The Process Improvement department provides resources to the organization for problem solving, as well as ~~deploying ECHOS,~~deployment of our ~~El Camino Health Operating~~Daily Engagement System. ~~The~~Our dedicated team is comprised of Process Improvement Advisors and Project Managers with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization.

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

The success of Process Improvement is dependent on robust education and training programs. ~~Our PI Academy, a 90-day project based~~We provide focused training ~~program designed to encourage and support all staff to be problem-solvers, is an example of how we engage with front line staff in continuous improvement. We also provide ad hoc training sessions covering~~of Lean/PI tools and methods within improvement projects and workshops throughout the enterprise ~~to assist departments with project completion~~. We also offer specific topic training sessions via PI Talks designed to encourage and support our culture of continuous improvement.

~~The Process Improvement department also has a year-long fellowship program, which has been designed to develop and grow talented, high performing and high potential leaders by providing an accelerated and intensive hands-on learning opportunity with focus on the ECHOS Daily Management and Performance Improvement Systems. Participants leave their current department and join the Performance Improvement team to gain a foundation in core management and improvement system behaviors, methods, and tools to build on their talents. They do this through high-impact assignments that help the organization drive continuous improvement to achieve the highest level outcomes across patient experience, quality, safety, affordability and physician and staff engagement.~~

~~**ECHOS: El Camino Health Operating System**~~

~~The El Camino Health Operating System is the framework in which we manage our business. It is comprised of the processes, methods and tools that we use to run the various functions of our work, and, includes leader behaviors that support our teams. It is the way that we lead and accomplish work at EL Camino Health. Our True North incorporates our mission, vision and values, and is supported by our True North pillars. ECHOS as our foundation, is built on the Lean principles of respect for people and pursuit of~~

~~continuous improvement. These concepts, methods and tools, support our overall Daily Management System.~~

~~The Daily Management System, with our patients as the focus, has three components which define how we:~~

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

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

Quality Improvement Link with Organizational Goals

ECH's Quality Improvement Plan focuses on specific quality measures in ~~three~~two areas: quality & safety, and service ~~and finance~~. See below for the Fiscal Year ~~2024~~2025 Organizational Performance Goals.

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

Quality Improvement & Patient Safety Plan (QIPS)

Pillar	Goal	Measurement Defined			
		FY 23	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.453	1.424	1.410	1.395
Service	Likelihood to Recommend (LTR) – Inpatient	78.5	74.7	76.4	78.1
	LTR – El Camino Health Medical Network	82.7	80.0	81.3	82.6
People	Culture of Safety	3.98	3.95	4.00	4.02
Finance	Operating EBIDA Margin	256.9M	$221M	$233M	$245M

Fiscal Year 2025 Goals

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

Commitment to Patient Experience

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

To deliver upon our goal for exceptional, personalized care, always, ECH established the WeCare service standards. Exceptional patient experience is not a one size fits all – it is a focus on understanding and tailoring care and services to meet patient needs and engage them as a part of the care team. The WeCare service standards highlights the importance of personalizing our interactions to help bridge relationships and establish trust. They are the framework of standards that guide behaviors and communication with our patients, their families and our colleagues. By embedding these service standards across the organization and enterprise, ECH is dedicated to provide a consistent message of compassion and respect through every interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.

SECTION II: Patient Safety Plan

PURPOSE

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

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

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

GUIDING PRINCIPLES

A. We believe that patient safety is at the core of a quality healthcare system.
B. We value the perspectives, experiences and contributions of all staff, medical staff, volunteers, patients, caregivers and the public in their role in patient safety.
C. Patient Safety is a continuous pursuit and is embedded in how we do all of our work.
D. Accountability for patient safety is everyone's business: from the Board of Directors to frontline staff to volunteers.
E. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.

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

OBJECTIVES

A. Deliver high quality safe care for every patient.

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

C. Promote a culture of safety.

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

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

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

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

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

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

J. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions.

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

L. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

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

Governing Board

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

Quality Committee of the Board

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

actions taken to address patient safety, shall be presented to the Quality Committee of the Board

Enterprise Hospital Committees

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

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

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

Patient Safety Department

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

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

- Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure.
- Coordination of ~~an annual~~any requested Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.

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

PATIENT SAFETY PLAN

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

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

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

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

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

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

E. Patient Safety Priorities are based on the following:

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

Patient Safety Initiatives

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

• Infection Prevention and Control Program (including Hand Hygiene and PPE support)	• Radiation Safety Committee
Data from Environmental Safety Issues:	
• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents • Workplace Violence

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

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

Confidentiality

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

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

Annual Evaluation

~~The Chief~~Patient Safety: The Senior Director of Risk Management and Patient Safety shall provide an annual evaluation and presentation of the Patient Safety program to the Patient and Employee Safety Committee and the Quality ~~Officer or the Sr. Director of Quality Services, and the Director of Risk Management and~~

~~Patient Safety shall coordinate the annual evaluation of the Quality and Patient Safety program and written plan for submission to the Enterprise Quality Council, the Medical Executive~~ Committee ~~and the Governing~~of the Board. The annual appraisal shall address ~~both~~the program's effectiveness in preventing harm to patients and visitors, improving patient care~~, patient~~ and safety, ~~and clinical performance,~~ resolving problems, and achieving program objectives. ~~The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program will also be addressed.~~

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

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

Attachments

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY~~24~~25)

Att C Enterprise Quality, Safety and Experience Dashboard FY~~24~~25

Att D Board Quality and Safety Dashboard FY~~24~~25

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicators ~~2023~~

Att G Patient and Employee Safety Dashboard FY~~24~~25

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

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

Attachments

- Att A - Governance Information Flow.pdf
- Att B - Quality Council Reporting Calendar.pdf
- Att C - Enterprise Quality, Safety and Experience Dashboard.pdf

- Att D - STEEEP 10.21.2024 V3.pdf
- Att E - Abbrev Registries List.pdf
- Att F - External Regulatory Compliance Indicator.pdf
- Att G - FY25 Q1 PESC Dashboard (updated).pdf
- Att H - Leader Skills Toolkit.pdf
- Att I - Universal Skills Toolkit.pdf
- Att J - HPI Classification Tools for SEC.pdf
- b64_95ffd793-45d3-4612-978d-dc8c17e63050
- image2.png

Approval Signatures

Step Description	Approver	Date
Quality Committee	Michael Coston: Director Quality and Public Reporting	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2024
Quality Council	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	10/2024
	Michael Coston: Director Quality and Public Reporting [PS]	10/2024

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Owner	Johnna Mohun-Garvey: Director Patient Accounts
Area	Patient Accounts
Document Types	Policy

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

COVERAGE:

Individuals eligible to receive financial assistance, charity care or discounts.

PURPOSE:

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

POLICY STATEMENT:

ECH is committed to providing financial assistance to patients who are unable to pay for medically necessary care based on their individual financial situation. ECH offers this assistance to two classes of financially eligible patients based on income: uninsured patients and those patients with high medical cost. This policy encompasses ECH's charity and discount payment policies required pursuant to Health and Safety Code §§127400-127446.

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

This policy will be posted and distributed consistent with the ECH internal procedure document entitled

"Distribution of Financial Assistance Procedure".

~~REFERENCES:~~

~~Patient Protection and Affordable Care Act of 2010 and Hospital Fair Pricing Policies (Health and Safety Code §§127400-127446, 1339.585; California Code of Regulations, Title 22, sections 70959, 96040-96050)~~

REFERENCE:

- Patient Protection and Affordable Care Act of 2010 and Hospital Fair Pricing Policies (Health and Safety Code §§127400-127446, 1339.585; California Code of Regulations, Title 22, sections 70959, 96040-96050)

DEFINITIONS:

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

~~**Eligible Services:** Financial assistance pursuant to this policy is only available for hospital services provided under the authority of ECH's general acute care license. This includes:~~

- ~~Emergency medical services provided in an emergency room setting~~
- ~~Services for a condition which, in the opinion of the treating physician or other health care professional, would lead to an adverse change in the health status of an individual if not treated promptly~~
- ~~Non-elective services provided in response to life-threatening or health-threatening circumstances~~

~~The following services are excluded as ineligible for the application of Financial Assistance under this policy, except as required by law:~~

- ~~Purchases from ECH retail operations, such as gift shops & cafeteria;~~
- ~~Physician Services that are not billed by Hospital.~~
- ~~Services that are not licensed hospital services are not covered by this policy.~~

~~**Patient's Family:**~~

1. ~~For Persons 18 years of age and older: Patient's spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.~~
2. ~~For Persons under 18 years of age: Patient's parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.~~

~~**Family Income:** Family Income is determined using the following sources of income of a patient and the Patient's Family when computing in accordance with federal poverty guidelines:~~

- ~~Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Disability Income, public assistance, veterans' payments, survivor~~

~~benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;~~

- ~~Non-cash benefits (such as food stamps and housing subsidies), Supplemental, Security Income, veteran disability payments, alimony, workers' compensation, and child support do not count;~~
- ~~Determined on a before-tax basis;~~
- ~~Excludes capital gains or losses; and~~
- ~~Includes the income of Patient's Family members as defined above.~~

~~**Federal poverty level ("FPL"):** The federal poverty level refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.~~

~~**Essential Living Expenses**: Expenses for any of the following: rent, house payment and maintenance, food, household supplies, utilities, telephone, clothing, medical and dental payment, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses~~

- **Eligible Services:** Financial assistance pursuant to this policy is only available for hospital services provided under the authority of ECH's general acute care license. This includes:
  - Emergency medical services provided in an emergency room setting
  - Services for a condition which, in the opinion of the treating physician or other health care professional, would lead to an adverse change in the health status of an individual if not treated promptly
  - Non-elective services provided in response to life-threatening or health-threatening circumstances
    The following services are excluded as ineligible for the application of Financial Assistance under this policy, except as required by law:
  - Purchases from ECH retail operations, such as gift shops & cafeteria;
  - Physician Services that are not billed by Hospital.
  - Services that are not licensed hospital services are not covered by this policy.
- **High Medical Costs**: A patient whose family income does not exceed 400 percent of the Federal Poverty Level, and includes any of the following:
  - Annual out-of-pocket costs incurred by the patient at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months. Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.
  - Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months. Out of pocket-expenses means any expenses for medical care that are not reimbursed by

insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

- **Patient's Family**:
  - For Persons 18 years of age and older: Patient's spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.
  - For Persons under 18 years of age or for a dependent child 18-20 years of age: Patient's parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age, if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.
- **Family Income:** Family Income is determined using recent pay stubs or income tax returns. Other forms of documentation of income are acceptable, but not required. The following sources of income of a patient and the Patient's Family are considered when computing in accordance with federal poverty guidelines:
  - Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Disability Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
  - Non-cash benefits (such as food stamps and housing subsidies), Supplemental, Security Income, veteran disability payments, alimony, workers' compensation, and child support do not count;
  - Determined on a before-tax basis;
  - Excludes capital gains or losses; and
  - Includes the income of Patient's Family members as defined above.
  - Excludes monetary assets.
- **Federal poverty level ("FPL"):** The federal poverty level refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
- **Essential Living Expenses**: Expenses for any of the following: rent, house payment and maintenance, food, household supplies, utilities, telephone, clothing, medical and dental payment, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses

PROCEDURE:

A. **Eligibility for Financial Assistance (Discounted Charity Care)**
ECH offers full charity care to patients ~~whose Family Income is~~who are uninsured or who have High Medical Costs who are at or below 400% of the federal poverty level. Full charity care means the patient liability after the application of any insurance, other health coverage, or third

party assistance will be zero. No account associated with a patient who is determined to be eligible for charity care will be sent to collections, nor will adverse information be reported to a consumer credit reporting agency. The granting of charity care shall be based on an individualized determination of Family Income, and shall not take into account age, gender, race, health status, social or immigrant status, sexual orientation or religious affiliation.

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

- ~~Services provided to Medi-Cal beneficiaries with restricted Medi-Cal (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)~~
- ~~Medi-Cal pending accounts~~
- ~~Medi-Cal or other indigent care program denials~~
- ~~Charges related to days exceeding a length-of-stay limit~~
- ~~Out-of-state Medicaid claims with “no payment"~~
- ~~Line item denials.~~

1. Services provided to Medi-Cal beneficiaries with restricted Medi-Cal (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
2. Medi-Cal pending accounts
3. Medi-Cal or other indigent care program denials
4. Charges related to days exceeding a length-of-stay limit
5. Out-of-state Medicaid claims with "no payment"
6. Line item denials.

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

1. **Application.** Eligibility will be determined in accordance with the following procedures to ensure an individual assessment of Family Income. The application process will require the following information from the patient submitted by e-mail, fax, or mail as specified in the application:

   - ~~Completed signed application and~~
   - ~~Proof of Income Tax return or most recent payroll stub. A patient who does not have an income tax return may submit SSA 1099 to qualify for charity care.~~

   Information obtained pursuant to this application shall not be used for collections activities

a. Completed signed application and

b. Proof of Income Tax return or most recent payroll stub. A patient who does not have an income tax return may submit SSA 1099 to qualify for charity care.
Information obtained pursuant to this application shall not be used for collections activities.

2. **Eligibility**. In determining eligibility, ECH will:

- ~~Document reasonable efforts by ECH to explore appropriate alternative sources of payment and coverage from public and private health insurance or sponsorship, such as Covered California plans, Medicare, or Medi-Cal, and to assist patients to apply for such programs. However, if the patient applies, or has a pending application for another health coverage program at the same time that he or she applies for ECH's charity care, neither application shall preclude eligibility for the other program.~~
- ~~Review the patient's outstanding accounts for any open accounts that may also be eligible for charity care for the approval timeframe.~~

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

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

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

4. **Circumstantial Eligibility**. ECH reserves the discretion to grant circumstantial eligibility based on an objective, good faith determination of financial need, taking into account the individual patient's circumstances, the local cost of living, a patient's income, a patient's family size, and/or the scope and extent of a patient's medical bills, based on reasonable methods to determine financial need. The Chief Executive Officer, the Chief Financial Officer, or his/her/their designees shall be authorized to approve patients for circumstantial eligibility for charity or discounted care, and must ensure documentation of the basis upon which circumstantial eligibility was granted.

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

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

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

D. **Other Provisions**

1. Any contracted emergency department physician or surgeon who provides emergency medical services at ECH is also required by law to provide discounts to

uninsured patients or Patients with High Medical Costs who are at or below 400 percent of the federal poverty level. Patients who receive a bill from a contracted emergency department physician or surgeon should contact that physician's office and request financial assistance. This statement shall not be construed to impose any additional responsibilities upon ECH.

2. ECH shall provide, without discrimination, care for emergency medical conditions to patients regardless of their eligibility under this policy.
3. A patient shall not be denied financial assistance that would be available pursuant to the ECH policy published on the HCAI''s internet website at the time of service.
4. ECH shall maintain all records (including, but not limited to, claims, invoices, bills, litigation, notices, contracts, contact information, debt collections) relating to money owed to the hospital by a patient or a guarantor of the patient for at least 5 years.
5. As required by law, Effective July 1, 2025, ECH contracts creating a medical debt will include the following term: "A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

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

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

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

~~*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.*~~

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

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
CFO	Carlos Bohorquez: CFO	01/2025
Senior Director, Revenue Cycle	Brian Fong: Executive Director Revenue Cycle	12/2024
	Johnna Mohun-Garvey: Director Patient Accounts	12/2024

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Last Approved by Mohun-Garvey, Johnna: Director Patient Accounts on 12/9/2024, 11:48AM EST

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> Johnna Mohun

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> Updated to include regulatory language from Legal Counsel/Theresa Fuentes (required by DHCS for CY2025).

Last Approved by Bohorquez, Carlos: CFO on 1/9/2025, 11:53AM EST

Reviewed and approved

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 1/13/2025, 1:19PM EST

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

SCOPE

The Perioperative Service Line includes the Outpatient Surgery/Short Stay (OPS/SS) Unit, Operating Room (OR), Post Anesthesia Care Unit (PACU). The Outpatient admit area is located on the main floor.

All Outpatient/AM admits procedure patients are admitted through OPS/SS Unit. The Short Stay Unit functions as a ~~PAP (Pre-Admission Program),~~ Pre-Operative Holding Area, Admission Unit, as well as a post operative same day surgery/procedure area.

A nursing manager is responsible for services provided in the service line and reports to the Vice Chief Clinical Operations. An OR Manager is responsible for day-to-day coordination of services in the OR. The PACU/ Manager is responsible for day-to-day coordination of services in this unit. The OPS/SS Clinical Assistant Manager oversees the OPS/SSunit. This individual is responsible for the day-to-day coordination of services. Each Manager/ Assistant contributes to the success of their department by budget control, and providing staffing to accommodate a fluctuating patient population. The Managers/ Assistant Managers report to the Perioperative Services Director.

Outpatient Surgery / Short Stay Unit – Los Gatos

SCOPE

The OPS/SS Unit conducts ~~pre-~~admission ~~and admission~~ services:

- ~~**Pre-Admission Program** – Patients scheduled for surgery are invited to attend the pre-admission program which facilitates early assessment, admission health testing, patient/ family teaching, as well as financial counseling.~~
- **Admission** – Patients to be admitted on the day of surgery/invasive procedure are admitted through the OPS/SS Unit.
- **Post Operative Procedure** – patients on the day of the surgery/invasive procedure are returned to the OPS/SS Unit to complete their recovery and be discharged to home.

STAFFING PLAN

The OPS/SS utilizes RNs to provide direct patient care with the assistance of clinical support personnel (CNAs).

Staffing – Consists of RNs, CNAs, and Administrative Support. Normal business hours are:

Monday – Friday: 0530 hours to 2300 hours

Requirements for Staff – All staff must complete orientation as specified in the Department Specific Orientation Manual, as well as Healthstream Learning Center modules.

Minimum requirements for RNs are: BCLS, AccuCheck, Correct-Site Verification self-study (S-S) module, Surgical Consent S-S module, and age-specific competency.

Minimum requirements for unlicensed clinical support staff are: BCLS, and age-specific competency.

Post Anesthesia Care Unit (PACU) – Los Gatos

SCOPE

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

STAFFING PLAN

PACU utilizes ACLS certified RNs to provide direct patient care with the assistance of clinical support personnel. Clinical support personnel provide direct patient care under the supervision of the RN and provide patient transportation. A ratio of RN/PT is progressive, beginning at 1:1 until airway patency is

stable, and then maintained at 1:2 until the patient is transferred out of the PACU. A charge nurse is assigned daily to make assignments and direct patient care.

Staffing: - Consists of RNs and CNAs.

Normal business hours are:

Monday – Friday: 0700 hours to 2330 hours, on call only 2300 hours to 0700 hours.

Saturday: on call 0700 hours to Monday 0700 hours.

Sunday: on call 0700 hours to Monday 0700 hours.

Requirements for Staff: All staff must complete orientation as specified in the Department Specific Orientation Manual, as well as Healthstream Learning Center modules.

Minimum requirements for RN staff are: ACLS, previous experience in PACU or Critical Care Unit, AccuCheck, Malignant Hyperthermia S-S module, Correct-Site Verification S-S module, Surgical Consent S-S module, and age-specific competency.

Minimum requirements for CNA staff are: BCLS and age-specific competency.

Operating Room – Los Gatos

SCOPE

The Operating Room (OR) consists of eight suites, a center core for sterile instruments, supplies storage and Decontamination Room.

Common procedures include:

Laparoscopic Cholecystectomy

Colon Resection

Lumbar Laminectomy

Major Spinal Fusion with Instrumentation

Hysterectomy/Hysteroscopy

Total Hip and Knee Joint Replacement

Arthroscopy/ACL

Endoscopic Carpal Tunnel

Brachytherapy

Lithotripsy

Urological Procedures

SWT elbow foot

Ophthalmology

Radical Prostatectomy

Laparoscopy Assisted Procedures, e.g.: LAVH, Bowel Resection Laparoscopic and open General, Thoracic and GYN Oncology procedures

Thoracoscopy, Thoracotomy, Bronchoscopy

Robotic Procedures, e.g.: Da Vinci, Makoplasty, Rosa, Mazor, and Omni

STAFFING PLAN

The department staffing consists of RNs, operating room technicians, OR Assistants ORA and business office clerical personnel. There are staff nurses who have responsibility for being a resource to the staff regarding particular surgical specialties. RNs are assigned to coordinate instruments and supplies for the suites. An RN or a business office clerical person may be assigned to the OR front desk to coordinate the daily schedule and facilitate activities in the department, under the direction of the OR Manager.

Every case is assigned two OR staff persons. An RN is always assigned to circulate.

Either an RN or an ST may be assigned to scrub.

If the patient is to receive moderate sedation without the presence of an anesthesiologist, an additional ACLS certified RN is assigned to monitor the patient and administer moderate sedation.

If the laser is used, a laser-trained RN or ST is assigned to the case.

ORA's and EVS personnel assist with room turnover, supply and equipment management, cleaning, transporting patients, and anesthesia cleanup and setup. Staffing in the OR is based on the minimum number of staff required to manage the projected schedule of surgeries.

Staffing: Consists of RNs, ST, ORA's, and Business Office personnel.

Normal business hours:

Monday – Friday – 0645 hours to 2315 hours, on call only 2300 hours to 0700 hours.

Saturday – Sunday – On Call 0700 hours to Monday 0700 hours.

Requirements for Staff: All staff must complete orientation as specified in the Department Specific Orientation Manual, as well as Healthstream Learning Center modules.

Minimum requirements for RNs are: BCLS, age specific competencies, Malignant Hypertension S-S module, Moderate Sedation S-S module, Correct-Site Verification S-S module, Surgical Consent S-S module.

Minimum requirements for STs are: Successful completion of ST training program, BCLS, age specific competencies.

Minimum requirements for ORA's are: BCLS, successful completion of the anesthesia assistant training and ORA Aseptic Technique and Sterile IV System Setup program. A percentage of RNs are ACLS and

CNOR certified.

SURGICAL SERVICES

OBJECTIVES:

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

GOALS:

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

Description of the Operating Room

The Operating Room suite is located on the second floor of the main building of the Hospital. The suite consists of eight operating rooms with support areas for instruments and equipment.

Services using the Operating Room are, ENT, Plastic, Podiatry, Orthopedics, Urology, Ophthalmology, GYN, General, Neurosurgery, Vascular, Thoracic and Oral/Dentistry. Elective surgery is scheduled Monday through Friday from 0730 hours to 1530 hours, according to a block scheduling system. Surgery volume is a mix of both In and Out Patient populations.

The Operating Room provides twenty-four hours nursing care to the patients requiring surgical intervention. The surgical patient is admitted to the hospital either as an outpatient, the same day of surgery (AM admit) as an inpatient, or from the Emergency Department.

The Operating room consists of a mix of RNS, ORTs, and Ancillary Personnel. Activities are performed by the RN, ORT, ORA, and office personnel, all with appropriate training. The unit uses AORN Recommended Standards of Practice and Standards of Care established by the OR and approved by the Hospital administration, Chief of Surgery, and the Hospital Board of Directors. The department uses Title 22 and AORN standards as guidelines for staffing. Staffing levels are based on an acuity system which takes

into account patient acuity, staff skill level, staffing training needs, equipment, OR protocols, infection control and patient safety requirements. The RN performs circulating duties. The RN and/or ORT perform scrub duties. RN assessments and nursing diagnoses are the basis for care planning for the surgical patient in the OR. Performance Improvement programs track data associated with SCIP measures, National Patient Safety Goals and Intradepartmental initiatives for improved patient care outcomes.

Scheduling:

1. **Elective Surgery and Procedures:**
   OR's are scheduled by "Block" designation. Block holders are expected to maintain 70% utilization. Blocks have varying release times depending on the nature of the block assignment. Changes in block allocations are made by the Operating Room Committee based on results of utilization and requests for time.
   Elective surgeries are scheduled through the OR schedulers Monday through Friday between 0730 hours and 1730 hours.
   Special procedures are scheduled according to physician and staff availability i.e., Pain control and Cardioversions.
2. **Urgent Surgery and Procedures:**
   Definition of "Urgent" is: Case must be scheduled within 12-24 hours. Urgent cases are given the first available time slot. The surgeon notifies the OR schedulers or charge nurse when an urgent case arises.
3. **Emergency Surgery and Procedures:**
   OR Definition:
   Case must begin within 1-2 hours. When the surgery schedule does not accommodate an emergency case, the surgeon has the option of pre-empting other cases. The surgeon will accomplish this by communicating with the anesthesiologist and surgeon who will be bumped.
   Staff called in for emergencies will be ready to start case preparation within 30 minutes of notification.
   Physicians notify the OR charge nurse or the Hospital shift supervisor for emergency cases after hours.
   Endoscopy Center Definition:
   Procedure must begin within 1-2 hours. When the Endoscopy schedule does not accommodate an emergency procedure, the physician has the option of pre-empting another procedure. The physician is responsible for notifying the physician he is bumping. If the procedure occurs outside scheduled hours, the call system will be activated.
   Emergency Endoscopy cases are also performed in the Critical Care Unit, the Operating Room and the Emergency Department. The Endoscopy staff is available 24 hours a day for emergencies.
4. ~~**Pre-Admission Program:**~~
   ~~The patient scheduled at least 72 hours before scheduled surgery is invited via phone call to attend the Pre-Admission Program. Those who decline will receive preoperative instructions and preoperative data collection over the phone.~~

STAFFING PATTERNS

Operating Room:

The staffing pattern describes core staffing. Adjustments to core staffing are made the previous day for the planned case schedule. Adjustments are made during the day as changes to the schedule arise and for the evening shift. The OR Director, and OR Manager or their designee makes adjustments.

When immediate increase in staffing is required, staff assigned to rest/meal breaks may be assigned to a case/patient care. At change of shift, staff may be assigned overtime to complete a case in progress.

Excused time off is granted or assigned when staffing exceeds the need. This is done according to department guidelines and is classified as Hospital Convenience "HC" or Daily Cancellation "DC" time off.

The O.R. Manager or designee makes patient care assignments each afternoon for the following day.

Registry and traveler staff is used to supplement staffing when necessary.

Shift reports take place in the morning, afternoon and evening

There are resource nurses for each specialty available within the staffing matrix to support training and learning needs of the staff.

Staffing is supplemented on weekends, holidays and sometimes on evening shift with the on-call and/or case rate on-call staff. Nurses and technicians are scheduled for call only after demonstrating competency in the types of cases usually performed on an urgent or emergent basis. Additional staff may be called to work to provide special skills or additional staff at the discretion of the charge nurse.

The staffing pattern describes the usual number and skill mix required each day. It is based on projected caseload, patient acuity, and the block allocations. It is adjusted when blocks change, a permanent change in case load occurs, as staff training needs are identified, when patient acuity changes or O.R. protocols dictate.

When staff members are scheduled, supervision is assigned to the OR Manager or charge nurse on the day shift and a charge nurse on the evening shift, weekends and holidays. No charge nurse is assigned when the O.R. is covered by call staff only. Weekend/holiday charge nurses have completed all competencies, have at least one year experience in the O.R. and have completed the charge nurse orientation. The Nursing Supervisor for the Hospital is available as a resource for both charge nurses and nurses on call. The charge nurse may be the circulating nurse. The variable is the level of activity in the department and the complexity of the case(s) and availability of other personnel.

A registered nurse is always assigned as circulating nurse. For most cases, two staff members are assigned with an RN to circulate and an ORT to scrub. If a local case will involve moderate sedation and an anesthesiologist will not be present, a third RN will be assigned to exclusively monitor the patient during the procedure. The monitoring RN must be ACLS certified. The second RN may be an RN from the O.R., PACU, or Critical Care Unit. When the Laser is used, a laser trained staff member will be assigned to the laser procedure. When the laser is in "Active" use, the OR personnel needs to stay close to the laser unit to be able to switch the unit back to standby or adjust power as needed.

An OR computer system (Surgical Information System) is utilized to schedule procedures and collect data for Perioperative Services.

The ORA's are assigned to rooms and supports the activities of the O.R. staff and anesthesiologists.

Post Anesthesia Care Unit (PACU):

The staff of PACU consists of RNs for direct patient care and one CNA who supports the nursing staff activities and transports patients. The RNs do not float to other units in the Hospital. (Except designated PACU to OPS/SS RNs)

The RNs are responsible for the care of all patients in PACU. RNs are assigned two beds per shift and the charge nurse assigns patients to the beds based on patient needs and nurse availability. Each nurse is trained to provide care to any patients requiring post anesthesia recovery and is responsible for assigned patients from admission to PACU through discharge from PACU. The charge nurse is not assigned specific beds but acts as a float nurse to assist with patient flow, admissions, discharges, transports and break relief. When the charge nurse leaves the unit, another RN is assigned to direct patient flow. Clinical support staff transports patients, cleans and stocks supplies, assists nursing personnel with lifting and turning of patients, and with some clinical tasks.

Students serve as observers in PACU and any care given in the department is provided **only** under the direct supervision of a staff nurse.

Responsibilities of On-Call Staff Members:

Staff members on-call for emergencies is responsible for maintaining communication with the Hospital. . The department or Nursing supervisor is to be notified each time a change in the communication link is made from pager to phone.

Staff members must be able to arrive at the Hospital within 30 minutes from notification by phone..Patients will be recovered in the CCU when PACU is closed and staffing warrants coverage.

OPERATING ROOM STANDARDS OF CARE

Nursing Process:

The nursing process is applied to the care of patients in the O.R. The circulating RN is responsible to ensure the process is used as the basis for each patient's care.

- **Assessment**
  Assessment begins in the Outpatient Surgery/PreOp Unit for Outpatients or AM admits, and in the nursing unit from which a surgery patient will come. An RN receives the patient and begins the assessment including the verification process to ensure the correct patient with complete and correct identification has informed consent for the anticipated procedure. Data collected by the admitting RNs and physician, test results and other information are reviewed to identify extraordinary needs. The circulating RN reviews the preoperative assessment and verifies the patient's name, birthdate, medical record number, history and physical, consents, patient's

anticipated procedure and boarding pass are consistent. Care is then transferred to the O.R. RN. When Outpatient Surgery/PreO is closed (nights, weekends and holidays), this assessment process is performed by the O.R. RN.

- **Nursing Diagnosis**
  Patients coming to the O.R. have these nursing diagnoses:
  1. Potential for anxiety due to:
     a. Loss of personal control
     b. Knowledge deficit
     c. Unfamiliar setting
  2. Potential for injury due to:
     a. Loss of protective reflexes
     b. Loss of sensation
     c. Immobility
     d. Contact with high energy equipment
  3. Potential for infection due to endogenous and exogenous sources.
  4. Potential for hypothermia due to evaporation, conduction or radiation.
  5. Potential for alteration in comfort due to surgical intervention.

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

8. Experience a caring and supportive environment
9. Maintain patient's rights.
   The initial care plan is either written on the Perioperative Nursing Record or communicated to the O.R. team.

- **Intervention**
  Independent nursing actions may include:
  1. **Adherence to Universal Protocol and Correct Site Verification & Marking (Patient Site Marking occurs outside Surgical Suite. Time Out performed by MD in the Surgical Suite prior to start of procedure.**
  2. Monitoring, proper positioning and security
  3. Skin preparation
  4. Maintaining aseptic field
  5. Safety procedures
  6. Providing information and emotion support
  7. Facilitating communication
  8. Accommodating physical limitations
  9. Pain management
  10. Selection of grounding sites for electrical devices
  11. Performing surgical counts – sponges, needles and instruments
  12. Handling of specimens
- **Evaluation**
  The circulating RN evaluates patient care at the conclusion of each case. The extent of the evaluation depends on the level of consciousness of the patient.
  The skin is assessed for signs of injury. The patient's temperature is recorded in PACU.
  Adverse patient responses are reported either verbally or through the Quality Review Report.

Documentation

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

GOVERNING RULES FOR THE OPERATING ROOM

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

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

Block Schedule:

The operating rooms are scheduled according to "Block Scheduling" designation.

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

Utilization:

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

Start Times:

- Surgery "start time" is defined as **"patient in-room time."**
- For surgeries starting at 7:30am, the anesthesiologist, surgeon and nursing personnel must arrive at a time that allows for all required procedures, processes and documentation to be

completed in order for transport of the patients into the operating rooms to begin at 7:15am. The patient should be in the O.R. suites no later than 7:30am. All lab work, H&P and preoperative requirements must be ordered and completed to avoid delays in patient preparation.

- Physicians are expected to arrive in the O.R. at their scheduled start time unless otherwise notified by the O.R. that their scheduled start time has changed. Surgeons should arrive at the time needed in order for patient preparation to be complete for transport to begin on time.
- When a physician is consistently late for his/her scheduled surgery, the Chair of the O.R. Committee will contact the surgeon to discuss the expectations regarding start times and the implications of continued late arrival. After three warnings, the surgeon will no longer be allowed to schedule in the AM time slots. The surgeon will lose block time privileges and/or 7:30am start time privileges for three months. **Late arrival is defined as 10 minutes.**
- The O.R. will postpone a surgery if the physician is more than 30 minutes late.

Schedule Delays:

- If a scheduled surgery is taking longer than originally scheduled and will be impacting the start time of the following physician, anesthesiologists and O.R. personnel will collaborate to find another room that can accommodate an earlier start time for the delayed surgeon.
- The O.R. will make every attempt to notify a physician at least 30 minutes in advance if a delay in his/her starts time is anticipated.

Urgent/Emergent Add-On Cases:

- In order to expedite the add-on surgery schedule and based on surgeon, room and equipment/ instrumentation availability, add-on cases will be scheduled into any of the staffed rooms during the day and evening shift.
- The "Anesthesia Scheduler" will help expedite the flow of add-on cases as necessary.
- A collaborative effort will be made to accommodate the requested start time for these ad-on cases.
- Any identified issues with start times will be discussed at the O.R. Committee.

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]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Department of Surgery	Patrick Santos: Policy and Procedure Coordinator	11/2024
Department of Surgery	Nancy Billington: Dir Perioperative Svcs	11/2024
Owner | UPC | Staff Meeting	Nancy Billington: Dir Perioperative Svcs	11/2024

History

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Last Approved by Billington, Nancy: Dir Perioperative Svcs on 11/18/2024, 3:26PM EST

Last Approved by Billington, Nancy: Dir Perioperative Svcs on 11/18/2024, 3:27PM EST

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> Notice sent to owner re: Dept of Surgery 11/27.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 11/27/2024, 11:25AM EST

> Dept of Surgery 11/27/24

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 12/30/2024, 1:56PM EST

> ePolicy 12/13/24

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 1/23/2025, 1:33PM EST

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

Per MEC 1/23/25, removed any PAP reference as this is an old program.

Last Approved by Coston, Michael: Director Quality and Public Reporting on 1/24/2025, 11:08AM EST

MEC 1/23/25

Status **Pending** PolicyStat ID **17338610**

Origination	02/2024
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Effective	Upon Approval
Last Revised	01/2025
Next Review	1 year after approval
Owner	Jeong Chae: Patient Blood Management Programs Manager
Area	Quality
Document Types	Plan

Patient Blood Management Patient-Centered Quality Plan

PROGRAM OVERVIEW:

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

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

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

VISION FOR QUALITY:

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

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

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

PRINCIPLES OF PATIENT BLOOD MANAGEMENT:

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

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

B. **Partnering with patients**
The Standard aims to ensure that patients (and surrogates) are engaged in decisions about their care management and, if they chose to receive blood and blood products, they do so appropriately and safely. Information should be provided to patients about optimizing their own blood, PBM strategies and the potential need for blood and blood products, including all treatment options, risks and benefits.

When discussing PBM with patients, it is important to:

1. Ensure that the information is current, and that clinicians have ready access to it.
2. Provide information in a format that is easy to understand and able to be adapted to level of health literacy.
3. Honor an adult patient who has capacity to make medical decisions (or their designated surrogate decision maker) to refuse blood product and review non-blood medical alternatives and treat the patient without using allogeneic blood.

~~ECH's PBM supports clinicians to communicate with patients and surrogates to respect the~~

~~patient's values and preferences along with an appropriate informed consent process.~~

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

PBM PROGRAM IMPLEMENTATION:

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

Transfusion clinical practice guidelines include:

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

~~These guidelines were embedded in the hospital's clinical policy and the Computerized Physician Order Entry (CPOE) system. They are also disseminated throughout various communication channels both verbally and via reports. The chair of the Transfusion Safety Committee (a medical director of PBM) and program manager of PBM visit various physician specialties, groups, departments, and committee meetings to present the new guidelines and their specific outcomes data.~~

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

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

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

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

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

E. **Ongoing Professional Practice Evaluation (OPPE)**
ECH has been able to collect meaningful transfusion-related data, and provide that data to

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

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

G. **Development of a protocol to check Type and Screen prior to elective surgery**
Beginning an elective high blood loss surgery without confirming the availability of a patient's specific blood type is a safety concern. ECH endeavors to ensure that compatible blood is available since about 3% of specimens have a serologic finding that requires further investigation, causing a potential delay. Development of a formal protocol to have blood testing completed (when ordered) prior to potential high blood loss elective surgery may optimize management of blood resources and maximize patient safety.

An internal audit showed that the rate of same-day type and screen (T&S) was high even though this increases the chances of delayed surgery for compatible blood. A small portion of the population had a T&S between one and sixteen days prior to surgery. More than half of the cases had no T&S. For example, out of 371 cases of elective orthopedic surgeries, the percentage of T&S on the same day of surgery was 33.4% (124 cases) and only 14.2% had a T&S done before the surgery day.

To address these concerns, ECH ~~has initiated~~implemented a systematic pre-admission screening protocol. ~~Based~~This initiative based on a review of research articles and clinical guidelines by healthcare organizations, which underscored the value of universal pre-admission T&S ~~enabled~~testing. By identifying patients with positive screens early, hospitals ~~to identify patients with a positive~~can prepare matched blood and reduce potential delays.
A key feature of the protocol is an extended specimen policy, which ensures antibody screen ~~and to prepare matched blood. An extended specimen policy was implemented allowing for antibody screen~~ results ~~to be~~remain valid for up to ~~30~~14 days. ~~PBM~~A nurse-led multidisciplinary team developed an action plan to integrate high-risk procedures into the Pre-admission Services (PAS) team's ~~medical director has communicated~~navigation software. Surgeons identified 354 out of 1,513 procedures as high-risk, which formed the basis for software updates.
With the updated system, pre-admission nurses receive automatic alerts for high-risk procedures, prompting them to schedule laboratory visits for T&S testing prior to surgery. Positive antibody results are promptly shared with surgeons ~~and finalized a list of high~~, facilitating the timely pre-ordering of compatible blood ~~loss elective surgeries~~.

This patient-centered protocol, developed as part of ECH's ~~Pre Admission Services~~Patient Blood Management (~~PAS~~PBM) ~~team will place an order for T&S and other needed~~program, has set comprehensive standards for preoperative ~~tests and call patients to be tested as early as 14 days prior to surgery. This preoperative~~ screening ~~practice will minimize delays in transfusions and ensure sufficient time to correct a~~. By ensuring the availability of compatible blood for high-risk procedures, the protocol maximizes patient~~'s anemia~~ safety and streamlines surgical preparation processes.

H. **Ongoing education**

ECH has been continuously seeking educational outreach to clinical staff to reinforce evidence-based transfusion guidelines and share the department specific analytic data at group meetings. Various communication tools are utilized to provide PBM reminders, such as a letter from the office of the Chief Medical Officer, physician newsletters, displays in physician lounges, pocket-size cards for clinicians regarding guidelines, and poster presentations.

For nursing, PBM modules are incorporated into mandated annual nursing education. The main focus is highlighting the importance of assessing patient's clinical symptoms and hemodynamic instability instead of depending on arbitrary laboratory values. Also, nurses are encouraged to implement restricted diagnostic phlebotomy by minimizing frequency of sampling, utilizing pediatric size blood collection tubes, and utilizing point of care testing for frequently needed chemistry tests such as potassium levels for post-operative cardiac surgery cases.

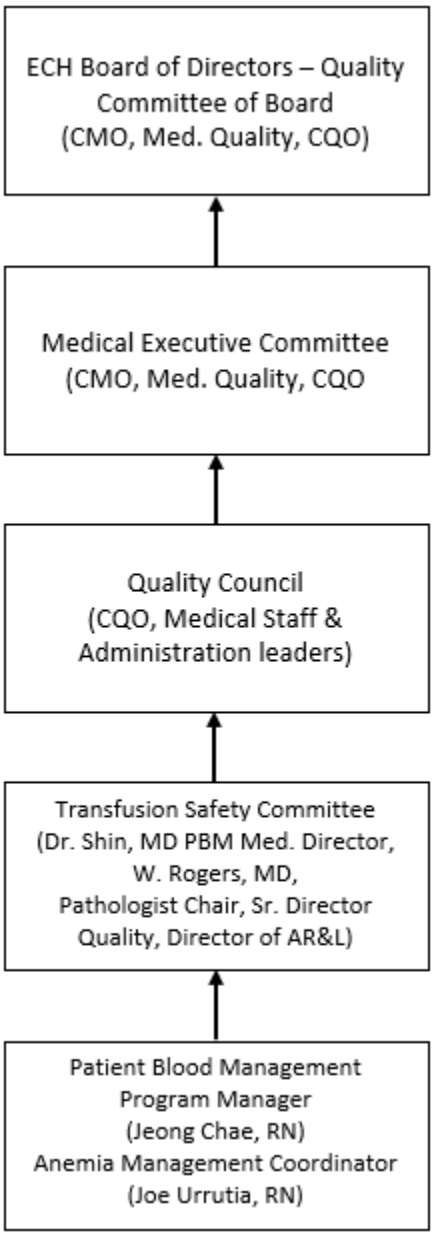
Additionally, ECH hosted a PBM Clinical Conference to introduce the medical staff and other clinicians to the most up to date clinical evidence related to transfusion practice. For example, on May 17, 2018, two PBM leaders from the nation's first two organizations (Johns Hopkins and Georgetown University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

I. **TJC/AABB PBM certification**

The natural next step in our PBM effort is obtaining Joint Commission Certification for our program. The certification process will provide a knowledgeable third party review on our processes and practices. This will ensure that we make continuous quality improvements in PBM. In October ~~2021~~2023, ECH has successfully finished re-certification survey by TJC and AABB and recognized as a certified PBM organization.

~~PROGRAM STRUCTURE AND ACCOUNTABILITY:~~PROGRAM STRUCTURE AND ACCOUNTABILITY:

The overall organizational structure is depicted below.



The Medical Director of PBM provides oversight for the enterprise quality in patient care by promoting system-wide patient blood management function through appropriate and safe fresh blood product administration throughout ECH. This position is a specialist role which provides an effective clinical

function in improving patient outcomes. The position holder influences the practice of nursing, medical/clinicians, laboratory and allied health disciplines in PBM both within and external to the health service. Areas of accountability will include the provision of leadership, clinical standard setting and monitoring, policy development, and change management. This position ensures that all steps necessary to embed PBM as a standard of care in ECH in question are accomplished.

The medical director's responsibilities include:

A. Provides leadership, direction and overall clinical management of the PBM program
B. Chairs a hospital based multidisciplinary Transfusion Safety Committee to advance and embed PBM as a standard of care
C. Responsible for reporting on program performance to the clinical staff, hospital administration
D. Works closely with the PBM program manager regarding the dissemination and creation of PBM throughout the hospital, being a resource and leader
E. Ensures the development of educational programs and resources about PBM for all clinical and non-clinical staff, including orientation for new staff
F. Provides regular reports (eg. quarterly, biannual, annual) regarding program performance to clinical staff, hospital administration
G. Works closely with the Transfusion Medicine Director regarding transfusion usage data, and assures regulatory requirements in the areas pertaining to transfusion and PBM are satisfied
H. Assists in the development and or reorganization of patient flow for the outpatient/inpatient assessment of iron deficiency (with or without anemia) in the perioperative/medical setting
I. Assists in strategies to reduce blood loss (including iatrogenic) for all patients
J. Liaises with other department heads and hospital committees on issues relevant to the PB M program
K. Helps develop a mechanism of action / plan with the executive medical staff; regarding identifying transfusion outliers by specialty and individually, with follow through action in that plan.
L. Ensures the development and communication of best practice guidelines to secure consistent, equitable and quality outcomes are achieved across the Patient Blood Management Program
M. Monitors, analyses and reports on adherence to the best practice guidelines and performance standards
N. Develops, refines and communicates operational plans resulting from treatment protocols and clinical pathways, and regularly reviews PBM policies, procedures and protocols
O. Assists in the development, maintenance and monitoring of data to determine cost reduction and cost avoidance as it relates to transfusion of blood products and anemia care products
P. Monitors and analyses trends for continuous improvement of the Program and proposes
Q. Represents the ECH's PBM Program at relevant conferences, events, boards and committees
R. Ensure enhancement of blood conservation through the utilization of product alternatives by developing and providing education to medical staff and other appropriate clinicians on current technology including (but not limited to): autologous cell salvage, bio-friendly cardiac

bypass circuits, and pharmacologic agents which reduce bleeding and stimulate blood cell production

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

Patient Blood Management Program Manager's responsibilities include:

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

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

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

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

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

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

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

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

I. Works collaboratively with the Laboratory Manager, Technical Specialist and Blood Transfusion staff to provide input to procedures and policies relating to transfusions.

J. Participates as a member of hospital committees requiring Transfusion Medicine input such

as new product evaluation and nursing procedures.

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

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

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

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

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

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

Transfusion safety committee's roles include:

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

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

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

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

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

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

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

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

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

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

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

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

Attachments – Clinical Practice Guidelines and Procedures related to PBM

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

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
Transfusion Safety Committee	Jeong Chae: Patient Blood Management Programs Manager	01/2025
	Jeong Chae: Patient Blood Management Programs Manager	01/2025

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Scope of Service – Mental Health & Addiction Services

Types and Ages of Patients Served

Mental Health and Addiction Services (MHAS) provides psychiatric care and services for adolescent through geriatric patients with mental health and/or chemical dependency needs. Inpatient and outpatient services are offered at the Mountain View campus, while only outpatient services are offered at the Los Gatos campus. The types of patients served are described in the Scope and Complexity of Services Offered section.

Level of Service Provided

The level of services provided are consistent with the needs of patients as determined by the medical staff including the Psychiatric Executive Committee, ECT Committee, and the Department of Psychiatry.

Assessment Methods

MHAS provides patient care and assessment utilizing a multi-disciplinary treatment team. Nursing care is provided by registered nurses (RNs) utilizing the nursing process as described in the El Camino Hospital Standards of Psychiatric Nursing Care. RNs provide direct supervision to licensed vocational nurses (LVNs), licensed psychiatric technicians (LPTs), and other non-licensed caregivers in the provision of direct patient care.

Other members of the multi-disciplinary treatment team include the psychiatrist, primary care physician, advance practice RNs, social workers, marriage and family therapists, psychologists, dieticians, occupational therapists, art therapists, and physical therapists. These individuals provide clinical services and assessments within their defined scope of practice.

The attending medical staff and clinical staff of MHAS participate in performance improvement processes relating to patient care delivery.

Appropriateness, Necessity and Timeliness of Services

The medical directors, attending psychiatrists, clinical director, clinical managers, assistant clinical manager(s), charge nurses, and other staff trained in the intake process assess the appropriateness, necessity, and timeliness of service provided to each individual patient. The services provided by MHAS are addressed in hospital and department-specific policies and procedures.

Staffing

Strategic direction and program growth are managed by a service line director who is supported by a service line operations ~~manager and a community engagement~~ manager.

MHAS is staffed by psychiatric registered nurses, social workers, licensed psychiatric technicians, licensed vocational nurses, psychologists, ~~marriage and family~~Lic. Marriage and Family Therapists, Lic. Clinical Social Worker, occupational therapists, ~~occupational therapists,~~ behavioral health workers, administrative support, assistant clinical manager(s), clinical manager(s), program coordinator, clinical director, and medical directors. All personnel who work on the unit are specially oriented and trained in their work, performing under the supervision of the clinical director, clinical managers, and medical director, MHAS. Staffing is comprised of a combination of fixed and variable staffing depending on census and acuity.

Psychiatric Emergency Services (PES) are provided in the Emergency Department by qualified mental health clinicians, working under the direct supervision of a psychiatrist. Adult Inpatient Psychiatric Care staffs for the provision of PES during hours determined by the hospital to be of highest need. Staff act as consultants for the Emergency Department and other medical staff physicians.

Advance practice registered nurses who work under the direct supervision of a psychiatrist, provide mental health and chemical dependency consultations for patients admitted medically.

Standard of Practice

MHAS is governed by state regulations as outlined in Title 22, The Joint Commission Standards, and the Center for Medicare/Medicaid Services. MHAS meets Lanterman- Petris-Short (LPS) Act requirements as outlined by the Santa Clara Valley Health and Hospital System Mental Health Department, Santa Clara County Mental Health Advocacy Project, and the Santa Clara County LPS Designation Committee.

Scope and Complexity of Services Offered

MHAS consists of the following individual programs and services:

- Psychiatric Emergency Services (PES)

- Consultation Liaison Service
- Adult Inpatient Psychiatric Care
- Psychiatric Partial Hospital (PHP)
- Intensive Outpatient Program (IOP)
- Outpatient Therapy
- Inpatient and Outpatient Electroconvulsive Therapy (ECT)
- Mental Health and Chemical Dependency Consultation Services

MOUNTAIN VIEW CAMPUS:

The community served includes the El Camino Hospital District and all externally referred patients assessed appropriate for acute mental health services at this facility. The continuum of care provided by the MHAS Department of Psychiatry at El Camino Hospital includes:

- Psychiatric Emergency Services (PES)
- Adult Inpatient Psychiatric Care
- Elective Partial Hospital Programs (PHP)
- Intensive Outpatient Programs (IOP)
- Outpatient Therapy

Adult Inpatient Psychiatric Care at El Camino Hospital in Mountain View provides a continuum of mental health care to adult patients requiring acute mental health treatment. These services are provided in the 36-bed, state-of-the-art Taube Pavilion that was designed to provide an optimal therapeutic milieu. The 36 beds are divided among the following patient populations:

- Psychiatric Intensive Care Unit
- Psychiatric Acute Care Unit
- Women's Specialty Care Unit

Outpatient therapy for older adults is provided in Mountain View..

Adolescent programs are limited to IOP DBT-based 8-week program and are located in Mountain View and Los Gatos. Adolescents or children who present with acute psychiatric treatment needs beyond the scope of IOP, will be assessed in the Emergency Department and referred to an appropriate level of care at locations where such care is provided.

ECT services are offered at the Mountain View Campus. Treatments are performed in the Post Anesthesia Care Unit. Patients are admitted to short stay unit pre-treatment and post recovery.

Outpatient Services are offered at 2590 Grant road (PHP/IOP, Outpatient, and Addiction services,), Outpatient Services have a separate outside entrance. Each area includes consultation rooms, program

offices, reception and intake area, group rooms, occupational therapy room, and a snack/kitchen area. The MHAS outpatient programs at 2400 Grant Road are in an office suite with a separate entrance and include a reception waiting area, program offices, and group rooms.

LOS GATOS CAMPUS:

The Los Gatos outpatient programs at 825 Pollard Road Los Gatos are in an office suite with a separate entrance and include a reception and waiting area, program offices, group rooms, consultation rooms, occupational therapy room, and a snack/kitchen area.

The outpatient services provided on the Los Gatos Campus focus on IOP.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Department Medical Director or Director for non-clinical Departments	Digant Dave: Director Behavioral HealthSvcs	12/2024
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Scope of Service – Mental Health & Addiction Services

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Area	Clinical Engineering
Document Types	Plan

Environment of Care Medical Equipment Management Plan

~~COVERAGE:~~COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, accessible and effective Environment of Care (EOC), consistent with its mission, services and applicable governmental mandates. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, employees and visitors. This plan describes a comprehensive facility-wide Medical Equipment Management Plan that describes the process for: The Mountain View and Los Gatos campuses as well as all associated clinics where El Camino patients are cared for. To that end, it is the intent of this plan to describe a comprehensive facilities-wide management system that promotes safe and effective use of medical equipment, the objectives of which include:

- Maintaining a current accurate ~~inventory~~inventory of equipment included in the program
- Ensuring all equipment receives an ~~initial inspection~~ initial inspection prior to use
- Ensuring ~~preventive maintenance~~preventive maintenance is performed pursuant to a risk-based equipment maintenance strategy and schedule
- Providing timely and effective ~~corrective maintenance services~~corrective maintenance services
- ~~Reporting, investigating and resolving~~Reporting, investigating and resolving incidents,

problems and failures involving equipment in a timely and effective fashion

- Assist in the development and/or provide training materials in coordination with Hospital Educator
- Ensuring equipment is ~~cybersecurity~~cybersecurity safe and providing support for medical ~~device integration~~device integration.

SCOPE AND APPLICATION:

This plan applies to select medical equipment, devices and technology and the uses thereof, which are generally included within a designed environment of care management program.

The items, processes, and critical functions addressed in this plan include, but are not limited to the following:

- Program planning/design, implementation, and the measurement of outcomes and performance improvements
- Medical equipment which is purchased, rented, leased, borrowed, cosigned and supplied for evaluation
- Equipment identification, risk assessment, inventory and maintenance
- Equipment Device-related hazard alerts and product recalls
- Equipment involved in incidents that have, or may have, contributed to adverse effect pursuant to the Safe Medical Device Act (SMDA)
- Clinical and technical consultative services relative to medical equipment, such as pre-purchase evaluation, end user training, and equipment life-cycle analysis.
- Oversight of the hemodialysis equipment in collaboration with Chief of Dialysis.

REFERENCES:

- Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC.02.04.01 and EC.02.04.03
- California Code of Regulations, Title 22, sections 70837, 70853
- NFPA 99,2012
- HITRUST
- NIST

AUTHORITY:

In accordance with its bylaws, the Central Safety Committee has the authority to ensure this plan is formulated, appropriately set forth and carried out. The authority and responsibility for program strategic design and operational oversight has been delegated to the Director of Clinical Engineering.

PROGRAM ORGANIZATION AND RESPONSIBILITIES:

A. Executive Management (i.e. the organization's governing body, the facility Leadership Team) provides the program vision, leadership, support and appropriate resources through the development, communication and institutionalizing of pertinent business fundamentals.

B. The Clinical Engineering Department, has been given the responsibility for:

1. Cataloging all medical devices and equipment and determining which devices are deemed critical and to be included in the scheduled maintenance program
2. Maintaining an accurate inventory of all the devices deemed critical
3. Performing initial safety tests and inspections of all medical equipment
4. Inspecting and maintaining equipment that does not meet the criteria to be listed individually in the maintenance program through a series of scheduled environmental inspections and testing
5. Performing and documenting maintenance activities through the design and implementation of the equipment management program, to include coordination of the initial risk assessments
6. Developing written plans and operating procedures
7. Identifying training needs of the maintenance staff
8. Providing technical consultation and assistance with equipment end user training
9. Initial response to, investigation and reporting of incidents for potential Safe Medical Devices Act issues and Sentinel Events

C. Each Department Manager/Director is responsible to develop and manage department specific elements of the equipment management program to include:

1. Ensuring all equipment, regardless of the type or ownership, receives an initial inspection before being introduced into the patient care environment and is functionally tested prior to each use insofar as it is recognized that each use of the device constitutes a functional test.
2. Maintaining the proper use of medical equipment through the development and management of department-specific elements of the equipment management program, including user training, and assessing program effectiveness.
3. Implementation of procedures to address failed devices:
    a. How to respond to equipment failure
    b. How staff should contact Clinical Engineering when equipment repair is required
    c. How to pro-actively identify equipment that is in disrepair or in need of assessment
    d. How to ensure failed equipment is properly tagged and taken out of service

e. Assurance before use the proper maintenance has been performed

D. A multi-disciplinary Central Safety Committee (CSC) ensures that the program remains in alignment with the core values, direction, and goals of the organization by providing leadership, determining priority and assessing the utility and efficacy of changes to the program. The CSC is also the central hub of the applicable Information Collection and Evaluation System (ICES) and acts as a clearinghouse for action items and recommendations, as well as a forum for leveraging issues, and developing program imperatives.

   The CSC meets regularly throughout the year and, as part of the standing agenda, receives and reviews reports and summaries of actions taken, deficiencies, issues and performance improvement relative to equipment management, as well as several other pertinent functions and disciplines.

E. Employees (all those who use equipment, to include contract employees, registry/on-call personnel, etc.) are responsible to participate in equipment training and demonstrate core competencies relative to safe, effective equipment operations (including the performance of routine functional testing of equipment to verify integrity with each use). Employees must ensure their work practices and processes are safe and are in accordance with departmental procedures, training, provisions of this plan, and sound clinical judgment.

RISK ASSESSMENT:

The clinical, informational and physical risks associated with the management of medical equipment are discerned through the following facility-wide processes:

- Risk-based initial & scheduled inspections, testing and maintenance
- Ongoing Equipment Safety Management methods and protocols, including those designed to address operator/user errors and equipment failures
- Incident Report review/evaluation through the applicable Information Collection and Evaluation System and the EM/ISC
- Device-related hazard alerts and product recalls
- Environmental and Hazard Surveillance rounds
- Communications with customers (end users)
- Root Cause Analysis of medical equipment related to significant adverse events
- Information Technology Security

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE:

A. The selection and acquisition of medical equipment is accomplished through local and clinical specialty evaluation committees and through the utilization of medical technology and product line materials. Conformance to pre-established standards, as appropriate, is ensured through the purchasing process.

   1. The risk-based criteria for inclusion in the medical equipment preventive

maintenance (PM) program includes:

2. Equipment function/clinical application (e.g. diagnostic, therapeutic, or monitoring)
3. Physical/clinical risks associated with use and/or failure
4. Maintenance requirements
5. Equipment classification incident history
6. Environment of equipment use (areas of equipment use)
7. Information/Network Security

Clinical Engineering is responsible for establishing appropriate PM schedules based upon the foregoing risk criteria, experience, and ongoing monitoring and evaluation of equipment performance, reliability and use. All medical equipment, regardless of the type of ownership, receives inspection, maintenance and testing at appropriate frequencies using approved methodologies, commensurate with relative risk, criticality and priority.

B. Medical device product recalls and alert notifications are managed through a system involving Clinical Engineering, Facility Services, Materials Management, Safety, Risk and the equipment user departments. As medical equipment alerts, product recalls and manufacturer letters are received, they are researched through the Clinical Engineering department.

When the alert or the recall involves equipment supported by Clinical Engineering, the equipment/product user department and Clinical Engineering check inventory and take action, as prescribed in the notice. Clinical Engineering provides the CSC with relevant data where it is tracked and monitored for follow up on the alert.

C. The investigation and reporting of device-related incidents involving death, serious injury, serious illness, or posing a significant impact on care or an occupational hazard are managed through an ad hoc administrative investigation team (Quality Review Report (QRR). The Team is comprised of individuals who collectively possess the technical, clinical, and operational skill sets necessary to effectively evaluate the surrounding circumstances and determine the need for reporting under the Safe Medical Devices Act (SMDA) requirements.

The SMDA investigation process and ensuing investigative reports are instrumental in discovering user error issues that provide impetus for training improvements. In instances when the governmental criteria are met, the investigation and root cause analysis is documented on the FDA "*MedWatch*" report form, in accordance with the SMDA policy. In addition, the user's department under the direction of Risk Management completes a QRR form. This form is used to document user errors; as well as other equipment use management issues such as cannot duplicate problem, equipment abuse, and unsafe practices.

D. Clinical, information/network security and physical risks relative to the use of equipment are identified and assessed through processes involving periodic performance assessment, user feedback, safety rounds, and incident reporting/review.

E. Education and Training for the end users of equipment (including use, reporting failures, emergency procedures, etc.) is area/department specific and provided through the individual department manager. Educational topics include:

1. Capabilities, limitations and special applications of equipment

2. Basic operations and safety precautions
3. Emergency procedures
4. Skills necessary to perform equipment maintenance
5. Processes for reporting program problems, failures, and user errors.

~~Clinical Engineering will provide technical consultation, as appropriate. Department managers/ Administrators, in concert with the Education Department will verify that each employee possesses the required core competencies relative to the safe and effective use and maintenance of equipment, as required. Education and training for maintainers of equipment (e.g. Clinical Engineering) is provided through the equipment vendors and ongoing technical, educational and professional development programs. An engineer's equipment training is based upon a training needs assessment and coordinated through the Director of Clinical Engineering. Required competencies are established, monitored and documented through the Director of Clinical Engineering.~~

~~Training materials and programs are developed and periodically revised to reflect:~~ **Clinical Engineering will provide technical consultation, as appropriate. Department managers/ Administrators, in concert with the Education Department will verify that each employee possesses the required core competencies relative to the safe and effective use and maintenance of equipment, as required. Education and training for maintainers of equipment (e.g. Clinical Engineering) is provided through the equipment vendors and ongoing technical, educational and professional development programs. An engineer's equipment training is based upon a training needs assessment and coordinated through the Director of Clinical Engineering. Required competencies are established, monitored and documented through the Director of Clinical Engineering.**

Training materials and programs are developed and periodically revised to reflect:

1. Assessment of educational needs
2. Organization-wide experiences
3. New technologies, equipment, and systems
4. Results of risk assessments, environmental rounds, audits, and inspections
5. Changes in pertinent laws, codes, and standards
6. CSC recommendations

F. Procedures are developed by the Clinical Engineering Department in conjunction with the user Departments. They include processes to ensure failed or deficient devices are immediately taken out of service. In these cases, the user enters pertinent information onto a repair tag and Clinical Engineering is notified, without delay. Other aspects included within the user-specific departmental procedures address failure procedures, emergency clinical interventions in the event of critical equipment failure and obtaining emergency back-up equipment and repair services.

PERFORMANCE MEASURE:

FY25 Performance Indicators

~~**FY24 Performance Indicators**~~

This year the performance improvement will focused on Asset Management and ~~Cybersecurity~~Asset Recalls.

- ~~Raise the percentage of the total database completed that is currently at 96.77% to 98%. This will confirm that 98% of all inventoried medical devices received a completed maintenance within the last 12 months.~~
- ~~Reduce open ECRI recall/alerts by 80%. Currently at 331 open ECRI alerts.~~

Enhance the efficiency and accuracy of our DICOM (Digital Imaging and Communications in Medicine) systems across the enterprise. By focusing on these areas, we aim to enhance the overall efficiency, accuracy, and compliance of our DICOM systems, ultimately improving patient care and operational effectiveness. Achieve 80% compliance and accuracy of all modalities (157) data sending, receiving and documented.

Reduce open ECRI recall/alerts to 100% managed. Alerts being managed is defined by each alert/recall has been addressed and closed. Any work orders left opened is only due to the manufacture corrective action plans have not been developed or have the ability to execute to remediate the alert/recall.

PROGRAM EFFECTIVENESS:

The effectiveness of the equipment management program, including the appropriateness of the program design, training, maintaining equipment integrity, issues, and behaviors will be monitored and assessed on an ongoing basis. Relevant reports and concurrent and retrospective data relative to the management of equipment will be garnered and tracked through the applicable Information Collection and Evaluation System (ICES). The CSC will receive periodic reports and give approvals or make recommendations, as indicated. These reports include summaries of monitoring results relative to performance standards, but are not limited to:

- Reports of SMDA issues, investigations, and follow up
- Relevant device/product related hazard alerts/product recalls and follow up
- Reports of equipment related significant events
- Trends or clusters of; cannot duplicate reported equipment problems, user errors, and equipment that cannot be located for scheduled preventive maintenance
- Efficient scheduled and corrective maintenance completion

ANNUAL PROGRAM EVALUATION:

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued effectiveness of program on an annual basis, the

Utility Systems Management Plan/Program is evaluated relative to its ~~objectives, scope, effectiveness and performance.~~ objectives, scope, effectiveness and performance. This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

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

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

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

Medical Equipment Risk Level Assignment Form.doc

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy	Patrick Santos: Policy and Procedure Coordinator	12/2024

Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	11/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	10/2024
	Jeff Hayes: Dir Clinical Engineering IT [PS]	10/2024

History

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> Initiating review for FY25. Per email from Matt Scannell to use word version to upload into system for review.

Last Approved by Hayes, Jeff: Dir Clinical Engineering IT on 10/25/2024, 5:33PM EDT

Last Approved by Scannell, Matthew: Director Safety & Security Services on 10/28/2024, 2:59PM EDT

Last Approved by Madrid, Delfina: Quality Data Analyst on 11/18/2024, 11:29AM EST

> Approved by PESC 11/15/24

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 12/27/2024, 11:11AM EST

> ePolicy 12/13/24

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 12/27/2024, 11:15AM EST

> Minor update to performance measure; draft version received from owner on 12/13/24.

Last Approved by Coston, Michael: Director Quality and Public Reporting on 1/24/2025, 11:04AM EST

> MEC 1/23/25

Status **Pending** PolicyStat ID **16931994**

El Camino Health

Origination	03/2015
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Effective	Upon Approval
Last Revised	01/2025
Next Review	3 years after approval
Owner	Nancy Held: Clinical Mgr
Area	Scopes of Service
Document Types	Scope of Service/ADT

Scope of Service: Lactation Services – Enterprise

Types and Ages of Patient Served

The patient population consists of ~~mothers and babies~~pregnant and birthing patients, infants and their families.

Assessment Methods

Breastfeeding support and education is first evaluated by nursing staff from ~~Mother-baby and~~ labor and Delivery, Maternity, and the Neonatal Intensive Care Unit (NICU). A referral for an inpatient consult from Lactation Services can be made by nurses, doctors or patients when additional resources and experience is needed. Lactation Consultants make assessments, document and develop a plan of care to help primary care nurse and patient.

Out-patient consults are scheduled and seen by Internationally Board Certified Lactation Consultants (IBCLC) after the ~~mother~~birthing patient has been discharged from the hospital.

For patients requiring resources not available through Lactation Services, they will be referred to their ~~physician~~Obstetrical or Pediatric provider, out patient or other resources in the community.

Scope and Complexity of Services Offered

Lactation Services provides breastfeeding support and education resources to inpatients and outpatients. Inpatient and outpatient ~~mothers~~birth patients can be referred to a lactation consultant by nursing, ~~physicians~~Obstetric or Pediatric providers, and patients.

~~Physicians~~Obstetric and Pediatric providers are notified of consultation by fax or by phone if there is an

immediate concern for the baby's needs.

Appropriateness, Necessity and Timeliness of Services

The Department Manager assesses the appropriateness, necessity, and timeliness of service. The appropriateness is addressed in hospital and department specific policies and procedures which are established in coordination with the medical staff and Unit Partnership Council (UPC).

A continuous Performance Improvement process is in place to monitor on-going performance. This process is designed to assess all aspects of care. Patient progress is evaluated by lactation consultants, nursing staff and medical staff, along with patient and family satisfaction.

Staffing

Lactation consulting is provided daily~~, except some holidays,~~ to inpatients. Coverage includes ~~Mother-Baby~~Maternity, NICU, Critical Care Unit (CCU), Pediatrics and other areas in the hospital which need lactation consulting for their patient population. The lactation consultant is ~~availalble~~available to provide outpatient consultations as scheduled and conducts a weekly drop-in, virtual support group.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the lactation consultants, ~~Mother-baby~~Maternity, Labor and Delivery and NICU nurses' assessment, as well as patient input. Lactation Services ~~is~~are designed to meet the needs of the patient, combining inpatient and outpatient care.

Standard of Practice

Outpatient Lactation Services is governed by state regulations as outlined in Title 22. These standards follow recommendations from the Academy of Breastfeeding Medicine (ABM), the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), ~~and~~International Lactation Consultants Association, (ILCA), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the World Health Organization ~~and International Lactation Consultants Association,~~ (~~ILCA~~WHO).

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

Infant Feeding Procedure.pdf

Scope of Service: Lactation Services – Enterprise

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
MCH Executive Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
MCH Executive Committee	Nancy Held: Clinical Mgr	01/2025
UPC | Staff Meeting	Nancy Held: Clinical Mgr	01/2025
UPC | Staff Meeting	Heather Freeman: Executive Director - Women's and Newborn Services	01/2025
MV | LG Manager	Heather Freeman: Executive Director - Women's and Newborn Services [PS]	01/2025
MV | LG Manager	Liliana Bruzzese-Pisegna: Clinical Manager	01/2025

History

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Edited by Held, Nancy: Clinical Mgr on 10/22/2024, 6:27PM EDT

> Changed mother to birthing patient
> included families in patient served
> Changed mother baby to new term "Maternity"
> Removed "except some holidays" under staffing since lactation is available 365 days per year
> Moved ILCA to third standard of practice group since it is one of the most important.
> Attached Infant Feeding procedure since most of what lactation services does is included in that procedure.

Last Approved by Bruzzese-Pisegna, Liliana: Clinical Manager on 10/23/2024, 10:07AM EDT

Last Approved by Freeman, Heather: Executive Director - Women's and Newborn Services on 10/25/

2024, 5:34PM EDT

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Comment by Held, Nancy: Clinical Mgr on 12/5/2024, 3:52PM EST

> Added "s" to providers in 3rd paragraph of assessment

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 12/6/2024, 5:24PM EST

> Pulled Nancy's revision to pending; deleted draft.

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> Added Scope of Service to title

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> Added scope of service to title

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> approved

Last Approved by Freeman, Heather: Executive Director - Women's and Newborn Services on 1/10/2025, 12:55PM EST

Comment by Freeman, Heather: Executive Director - Women's and Newborn Services on 1/10/2025, 12:57PM EST

> Looks good, thank you

Scope of Service: Lactation Services – Enterprise

Last Approved by Freeman, Heather: Executive Director - Women's and Newborn Services on 1/10/2025, 12:57PM EST

Last Approved by Held, Nancy: Clinical Mgr on 1/10/2025, 1:01PM EST

Last Approved by Held, Nancy: Clinical Mgr on 1/10/2025, 1:02PM EST

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> MCH Exec 12/5/24

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> ePolicy 1/10/25

Last Approved by Coston, Michael: Director Quality and Public Reporting on 1/24/2025, 11:17AM EST

> MEC 1/23/25

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Owner	Bryan Plett: Mgr Environmental Hlth&Safety
Area	Emergency Management
Document Types	Plan

Emergency Operations Plan

COVERAGE:

This Emergency Operations Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics as listed below.

Mountain View	Los Gatos
• Main Hospital • Advanced Radiotherapy & CyberKnife Radiosurgery Center (125 South Dr.) • Cedar Pavilion (2660 Grant Road) • Melchor Pavilion (Lab - 1st Floor; Concern, Community Benefits, Chinese Health Initiative, and South Asian Heart Center - 3rd Floor) • Oak Pavilion • Orchard Pavilion (Women's Hospital) • Park Pavilion (excludes YMCA) • Sobrato Pavilion (Ground, 1st, 2nd and ECH-occupied offices on other floors) • Taube Pavilion (MHAS Services) • Willow Pavilion	• Main Hospital • Cancer/Infusion Center • Rehabilitation Center (355 Dardanelli Ln.) • PPI (555 Knowles Dr., Suite 100) • OATS/Aspire (825 Pollard Rd.) • Men's Clinic (825 Pollard Rd.)

PURPOSE:

This Emergency Operations Plan at El Camino Health describes how the organization ensures effective response to disasters or emergencies affecting the safe operation of the hospital. The Emergency Management Committee implements processes for developing, implementing and monitoring the Plan.

STATEMENT:

The El Camino Health Emergency Operations Plan is an “All Hazards” approach to the facilitation and coordination of incidents and emergencies that directly affect the hospital or have been determined to have a high likelihood of affecting hospital operations. The plan directly addresses the following six (6) critical areas identified by The Joint Commission:

A. Communications (EM.12.02.01)
B. Staffing (EM.12.02.03)
C. Patient Clinical and Support Activities (EM.12.02.05)
D. Safety and security (EM.12.02.07)
E. Resources and assets (EM.12.02.09)
F. Utilities (EM.12.02.11)

El Camino Health is prepared to respond to single emergencies that can temporarily affect demand for services, along with multiple emergencies (that can occur concurrently or sequentially) that adversely impact patient safety and the ability to provide care, treatment, and services for an extended length of time.

Necessary policies and procedures have been adopted to ensure the hospital adequately addresses response efforts in each of the following four (4) phases of the Emergency Management program:

A. Mitigation
B. Preparedness
C. Response
D. Recovery

These current plans and procedures are exercised and reviewed to determine and measure functional capability. The Emergency Operations Plan complies with the National Incident Management System (NIMS) components.

RESPONSIBILITIES:

A. Leadership

The hospital's leaders are involved in the planning activities and the development of the Emergency Operations Plan. The administrators and department heads are represented in the Emergency Management Committee. Executive sponsors of the program include the Chief Administrative Services Officer and the Chief Medical Officer.

B. Emergency Management Program

The Manager of Environmental Health and Safety and Emergency Management provides overall support to the hospital's preparedness efforts, including developing needed procedures, coordinating production or revision of the Emergency Operations Plan, planning and executing training and exercises, and coordinating the critiquing of the events and preparing the After Action Reports (AAR).

C. The Emergency Management Committee

The Emergency Management Committee is a group of multidisciplinary hospital representatives. The committee meets regularly and includes representatives from senior leadership, nursing services, medical staff, pharmacy services, infection prevention and control, facilities engineering, security, and information technology.

The chairperson sets each meeting's agenda and facilitates the committee's work to achieve an annually established set of objectives. Subcommittees or task groups are appointed to accomplish identified projects or to plan training and exercises. Minutes of each meeting are published and available for review by hospital.

D. Hospital Incident Command System

The hospital utilizes the Hospital Incident Command System (HICS) to manage and direct hospital operations during incidents that could impact hospital operations. Information on HICS and its utilization are available in the Emergency Management Policies and Procedures located online (Electronic Policy Database: Emergency Management)

PLANNING

A. Hazard Vulnerability Analysis

Hazard Vulnerability Assessments (HVAs) are conducted annually at each hospital campus to identify the potential emergencies that could affect the ability of the organization to provide normal services. This assessment identifies the likelihood of those events occurring and the consequences of those events. The assessment provides a realistic understanding of the vulnerabilities and helps focus the resources and planning efforts.

The HVA's of other area hospitals and health-care agencies are shared and summarized to help develop a list of priorities on a county-wide basis. This summary is updated annually.

B. Community Involvement

A strong relationship has been established between other hospitals and agencies within Santa Clara County. The combined group meets regularly to share information and resources and to work together to identify and meet the needs and vulnerabilities of each facility.

C. Mitigation & Preparedness

Specific emergency response plans have been established to address needs based on priorities from the HVA. Each plan addresses the four phases of emergency management

activities:

1. Mitigation: Activities designed to reduce the risk of and potential damage due to an emergency (i.e., the installation of stand-by or redundant equipment, training).
2. Preparedness: Activities that organize and mobilize essential resources (i.e., plan-writing, employee education, preparation with outside agencies, acquiring and maintaining critical supplies).
3. Response: Activities the hospital undertakes to respond to disruptive events. The actions are designed with strategies and actions to be activated during the emergency (i.e., control, warnings, and evacuations).
4. Recovery: Activities the hospital undertakes to return the facility to complete business operations. Short-term actions assess damage and return vital life-support operations to minimum operating standards. The long-term focus should be on returning all hospital operations back to normal or an improved state of affairs.

D. Hospital Command Center

El Camino Health responds to incidents and/or emergencies by activating the Hospital Command Center (HCC) in accordance with the Hospital Incident Command System (HICS) and the National Incident Management System (NIMS). The incident command structure is flexible and scalable in order to respond to varying types and degrees of emergencies or disaster incidents. The El Camino Health Incident Command Staff includes an Incident Commander, Medical / Technical Specialists, Safety Officer, Public Information Officer, and Liaison Officer as dictated by the complexity of a given incident. A representative from Environmental Health and Safety / Emergency Management shall serve as the Hospital Command Center (HCC) Manager.

The Incident Commander shall determine incident specific objectives in the addition to the following standing objectives:

Protect Life
Protect the Facilities, Critical Utilities, and Network Infrastructure
Continue Mission Critical Operations

The Hospital Command Center (HCC) will be established according to procedures designated in HICS and NIMS. See the following documents for additional information:

- Hospital Command Center (HCC)
- HICS Chart (See attachment)
- HICS Roles Information Guide (See attachment)

E. Inventory & Monitoring of Assets & Resources

The resources and assets that are available on-site and/or elsewhere to respond to an emergency are maintained and inventoried. This includes, but is not limited to the following assets and resources:

- Food

- Fuel
- Medical supplies
- Medications
- Personal protective equipment (PPE)
- Water

The current equipment inventory can be found in the ***Emergency Supply and Equipment Plan***

The organization will establish a threshold for resource quantities that trigger a resupply actions. These levels will be the Par Levels, a quantity at a midpoint between extremes on a scale of normal availability.

Emergency Operations Plans

A. Response

A response procedure to an emergency can include the following:

- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the hospital to new patients
- Staged evacuation
- Total evacuation.
- HICS shall be activated as outlined in: Activation and Termination of Hospital Incident Command System -HICS
- Staff respond to the emergency as outlined in: Code Triage

B. Sustainability

A process has been developed for determining the sustainability of the organization during an emergency. The end-point in planning for sustaining an emergency is 96-hours without the support of the local community. The planning on sustainability is coordinated with the Emergency Management Committee and the appropriate departments. The organization will continually monitor the availability and consumption rate of resources and assets to determine the length of time the organization can provide services. When necessary, the organization will adjust the consumption of the resources to extend the sustainability period. When it is determined the organization cannot provide services at an acceptable level of services, safety, and protection, a partial or total evacuation will be considered.

C. Recovery Procedures

The return to normal operations from an emergency will utilize the procedures outlined in

Activation and Termination of Hospital Incident Command System (HICS).

D. Incident Levels and Phases

1. **Emergency Response Level 1:** Potential Emergency - An unusual event or potential emergency affecting a single department of a single building area. The situation is an isolated incident. Life safety is not threatened and patients are not adversely affected.
2. **Emergency Response Level 2:** Localized Emergency - An emergency situation affecting multiple departments or buildings. Patients may be affected and life safety may be threatened.
3. **Emergency Response Level 3:** Major Disaster – A major disaster affecting buildings, utilities and patient care. Life safety may be threatened. Code Triage is in effect. Multiple Casualty Incident (MCI) patients are arriving at the hospital Emergency Department at a time when buildings and utilities are damaged or disrupted and personnel are affected.

An "All Clear" may be called while the recovery efforts continue until the hospital is back to normal operations.

Details on the levels of incidents and phases are outlined in Activation and Termination of HICS.

E. Alternate Care Site

In a major emergency situation, there is a possibility that the buildings or spaces in which patient care is normally provided will be rendered unusable. In this event, an alternate care site will be designated as a location on the facility grounds or within the community. More information on the selection of Alternate Care Sites is available in ~~Emergency Management - Hospital Surge Capacity Plan – Alternate Care Sites~~Emergency Management - Hospital Surge Capacity Plan – Alternate Care Sites.

- 1135 Waiver
  When the President declares an emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency, the Secretary may temporarily waive certain EMTALA sanctions during the emergency period. The hospital may request the waiver after implementing a disaster protocol. Refer to procedure HICS - Alternate Care Sites - Requesting 1135 Waiver for details.

Communication Management

A. Internal Communication & Staff Notification

1. Staff shall be notified of an incident utilizing overhead pages through the Fire Alarm System (FAS) or through other methods as outlined in EM - Internal Communications Plan. This plan also includes back-up communications systems within the hospital.

B. Notification & Communication with External Authorities

When an emergency plan is initiated, the appropriate external authorities and community

resources will be notified. Contact information can be found in: ***HICS - Communication with Hospitals, City, County and State***.

C. Communication with Patients & Family

1. A Family Assistance Center (FAC) may be established to coordinate the needs and information to family ~~support center may be established to coordinate the needs and information to family~~ members of patients, to coordinate the information on the location of patients, and to provide critical incident stress debriefings.
2. These activities will be managed by the Logistics Section with the Support Branch and the Family Unit Leader.
3. There will be direct communication with the Patient Tracking Manager for tracking patients.
4. If the emergency contact family member is not present with the patient, they will be contacted with the location of the patient once they are moved or evacuated.
5. Additional information on communications with family in the event of a patient discharge or transfer is available in Patient Discharge - Transfer Plan.

D. Communication with Media

1. The Public Information Officer (PIO) is responsible for interacting with media and public information.
    a. For internal events, the PIO will develop communications to staff and community with the authorization of the Incident Commander in the HCC.
    b. If the event is external to the hospital, the county Joint Information Center (JIC) will coordinate with the PIO to develop a unified message.

E. Communication with Suppliers

A list of suppliers, including vendors, contractors, and consultants that can provide specific services before, during, and after an emergency event is available in the Command Center. The list will be maintained by the individual that normally interacts with the purveyor. Where appropriate, Memoranda of Understandings (MOUs) are developed as needed to help facilitate services during the time of a community event.

F. Communication with other health care organizations

1. A working relationship has been established with other health care organizations within Santa Clara County. A Memorandum of Understanding (MOU) is in place to share resources as needed and available.
2. Key information to share with the other health care organizations includes:
    a. Command systems & other command center information
    b. Names & roles of command center system
    c. Resources & assets to be potentially shared
    d. Process for the dissemination of patient & deceased individual names for tracking purposes
    e. Communication with third parties

3. Inter-agency communications is maintained through several channels:
    - Telephone
    - 2-Way Command Radio
    - EM-Resources – on-line hospital status reporting in real-time
    - Amateur Radio - volunteer radio operator system
4. Patient information that must be shared with the other healthcare organizations, local or state health departments, or other law enforcement authorities on the whereabouts on patients during an emergency will be transmitted in accordance with applicable laws and regulations.

G. Alternate Care Site Communications

The Command Center will maintain communications with the Alternate Care Site (ACS). Once an ACS has been established, the site will initiate contact with the HCC and may establish an Alternate Care Command Center (ACCC).

RESOURCE & ASSET MANAGEMENT

A. Obtaining & Replenishing Medical, Non-Medical & Medication Supplies

The amounts, locations and processes for obtaining and replenishing medical and non-medical pharmaceutical supplies, are evaluated to determine how many hours the facility can sustain before replenishing. The inventory of resources and assets is the starting point of par levels.

Mutual Aid Agreements have been developed to expedite receipt of items when needed. The MOU Agreements references the agreement with the other health care organizations on response of assets.

B. Monitoring Resources and Assets

During the emergency, the Logistics Chief will monitor the overall quantities of assets and resources. This information will be communicated to the HCC and to those in the community.

SECURITY & SAFETY MANAGEMENT

A. Security

El Camino Health has a Security Plan for Code Triage or Disaster. The plan describes the roles that internal security will have in the event of an emergency and how the hospital will coordinate security activities with outside law enforcement.

The Director of Safety and Security shall have primary responsibility for security during emergencies and shall participate in the Hospital Incident Command System / Hospital Command Center whenever it is activated in support of a security related incident.

B. Access & Egress Control

The facility "lock down" procedures will be implemented when deemed appropriate by the Incident Commander (IC) to provide the proper control of access and egress to the facility.

C. Traffic Control

The Incident Commander will initiate a Traffic Control Plan to manage the movement of personnel, vehicles, and patients both inside and on the grounds of the facility if deemed appropriate.

1. Security staff will assist in the movement of vehicles, including cars, and emergency and commercial vehicles, on the grounds.
2. When appropriate, local law enforcement will be contacted for assistance in the management of traffic on the grounds of facility.

D. Managing Hazardous Waste

The hazardous waste generated after decontamination and during isolation procedures, including biological, chemical, and radioactive waste will be stored in the appropriate location and with sufficient security. This would also include the waste that would accumulate during an emergency, but not removed because of vendor issues. A list of alternate vendors will be maintained.

E. Biological, Radiological & Chemical Isolation & Decontamination

For contagious patients in need of isolation, consult the Infection Control guidelines located in the Infection Control Manual for isolation and standard precautions. For contaminated patients, Decontamination Procedures would be implemented.

STAFF MANAGEMENT

A. Staffing Plan

El Camino Health maintains a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge.

1. Bringing in Staff / Managing Staff and Volunteers During an Emergency

   El Camino Health maintains a staffing plan (Disaster Staffing Needs: Off Duty Employees, Volunteers and Physician Staffing) and (Independent Contractor / Outside Labor Plan) to ensure there is adequate staff to care for patients during an emergency or disaster event. The plan specifically addresses the emergency or disaster situations which require additional off duty staff to be called in to assist with hospital operations as well as the use of external staffing agencies.

2. Granting Disaster Privileges to Volunteer Physicians and Other Licensed Practitioners

   El Camino Health maintains a plan for Privileging Licensed Independent

Practitioners During Disaster Events. In addition to the Privileging Licensed Independent Practitioners During Disaster Events plan, the hospital has a HICS – Volunteer Credentialing Plan. These plans ensure that physicians and allied health practitioners that do not possess medical staff or practice privileges, may be accepted to work at El Camino Hospital during a disaster, when Code Triage has been activated.

3. Hospital Command Center Staffing

   When the Hospital Command Center is activated, the HICS Chart and Job Action Sheets are used to assure critical task positions are filled first. As other staff members become available, they are assigned to the most critical jobs remaining.

   If staff is not available for handling critical tasks defined by the Job Actions Sheets, staff will be drawn from the appropriate departments. If no staff is available, staff will be drawn from the labor pool.

   As staff is called in, they will replace personnel on tasks they are better qualified to perform. If questions arise, the Section Leaders will determine who will perform the task. The tasks are evaluated frequently to assure the most appropriate staff members available are being used, burnout or incident stress problems are identified, and staff members in these jobs are rotated as soon as possible.

B. Managing Staff Support Activities

During activations of the Emergency Operation Plan (EOP), the following accommodations are authorized:

1. Where necessary because of conditions, the hospital will accommodate staff that need to sleep, eat, and/or other services in order to be at the hospital to provide needed services.
2. The Logistics Chief with the Service Branch Staff Food and Water Leader will handle the needs of staff during the emergency. The Logistics Chief is authorized to modify the normal use of hospital space and to work with local hotels and motels to provide accommodations for staff. Meal service for staff is authorized where approved by the Logistics Chief.
3. Preparation is made for incident stress debriefings. These areas will be staffed by Concern, the hospitals EAP and/or staff from community mental health services, clergy, and others trained in incident stress debriefing.
4. Communication with staff family members will also be arranged through the Staff Family Support Leader.

C. Managing Staff Family Support Activities

During activations of the EOP, the IC will determine if various accommodations may be made for staff's families to assist staff availability for providing their services.

D. Training and Identification of Staff

1. Training: The staff identified in the critical areas will receive the appropriate training in HICS and NIMS prior to an event.
2. Identification:
    a. HICS identification apparel is issued to the appropriate roles in the HICS.
    b. Employees will wear their hospital identification badges at all times during the emergency.
    c. Additional identification will be distributed, as needed to all serving in specific roles during the emergency.

MANAGING UTILITIES

During an emergency, alternate means will be provided for essential utility systems as identified in the plan. These utility systems are identified as well as alternate means for providing the services. The organization will assess the requirements needed to support these systems such as fuel, water, and supplies for a period of time identified. This assessment includes the requirements for 96 hours without community support.

The alternative utility systems and supplies networks shall include, but not be limited to the following:

- Emergency power supply system
- Water supplies for consumption and essential care activities
- Water supplies for equipment and sanitary usage
- Fuel supplies for building operations, generators, and essential transportation services
- Medical gas systems
- Ventilation systems, Vacuum systems and Steam
- Other essential utilities

Refer to ~~Utility Systems - Equipment Inventory~~Utility Systems - Equipment Inventory and Utilities Systems or Equipment Failure Response for more information

MANAGING PATIENT CLINICAL & SUPPORT ACTIVITIES

A. Clinical Activities

Clinical activities for the treatment of patients during an emergency include triage, scheduling, assessment, treatment, and discharge. Whenever possible, the routine policies for patient services will be utilized.

B. Evacuation Activities

An evacuation of the hospital for a situation which renders the facility no longer capable of providing the necessary support for patient care, treatment and services, will be directed by the IC. The evacuation will be handled in cooperation with local police, fire departments and

county EMS agency.

C. Vulnerable Patients

The policy on the clinical services includes providing for treatment of special patients during an emergency includes pediatrics, geriatrics, and disabled. This may also include patients with serious chronic conditions such as mental health or addiction.

D. Personal Hygiene and Sanitation Requirements

The HCC will determine appropriate alternatives for personal hygiene. This can include baby wipes, personal wipes, or alcohol-based rubs. Family members can also assist in cleaning the patient during an event. If toilets are inoperable, bags in toilet, bucket brigade, other appropriate alternatives can be used.

E. Mental Health Services

During an emergency, mental health services will be provided to the patients when deemed necessary. Mental Health and Addiction Services (MHAS) will track these patients receiving these services during the emergency.

F. Mortuary Services

In the event of deceased patients, the local medical examiner will be contacted for the appropriate clearance and procedures.

G. Patient Tracking: Internal & External

Patients will be tracked using current policies of the department. This includes discharge or patient transfer. That information will be given to the Patient Tracking Manager who will track all the patients within the facility during disaster. The form to use for patient tracking will be the *HICS* 254 – Disaster Victim Patient Tracking Form. Staff shall follow internal procedures for tracking patients and notifying patient families.

If patients are evacuated, the following HICS forms should be utilized:

- ~~*HICS* 260 – Patient Evacuation Tracking Form~~*HICS* 260 – Patient Evacuation Tracking Form, for individual patients.
- ~~HICS 255 – Master Patient Evacuation Tracking Form~~HICS 255 – Master Patient Evacuation Tracking Form should be used to gain a master copy of all those that were evacuated.

DISASTER PRIVILEGES

A. Volunteer Licensed Independent Practitioners (LIP)

Disaster privileges may be granted to volunteer licensed independent practitioners (LIP) when the EOP has been activated and the hospital is unable to meet immediate patient needs.

The Medical Staffing Office is responsible for granting disaster privileges to volunteer LIP and will distinguish volunteer LIP from other LIP's. Refer to Policy/Procedure: ~~Medical Staff-~~

~~Privileging Licensed Independent Practitioners During Disaster Events.~~Medical Staff Services Department Credentialing and Privileging Procedure

B. Other Licensed Volunteers (non-LIP)

Disaster responsibilities may be assigned to volunteers that are licensed, certified and/or registered in a skilled healthcare position when the EOP has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

The hospital identifies the individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not a LIP and will distinguish volunteer practitioners who are not LIP's from its staff. The hospital will oversee the performance of volunteer practitioners who are not LIPs who are assigned disaster responsibilities by direct observation, mentoring, or medical record review. Refer to ***HICS - Volunteer Credentialing***.

EMERGENCY RESPONSE PLANS

Emergency Plans for the incident types listed below can be found in the Emergency Management section of the Safety Tab on the Toolbox.

- ~~Closed Point of Dispensing (POD)~~Closed Point of Dispensing (POD)
  - This plan coordinates the hospital planning and response actions during a public health emergency requiring medical countermeasures given to a group of people at risk of exposure to a disease in accordance with public health guidelines or recommendations.
- ~~Earthquake~~Earthquake
  - This plan is to ensure safety of patients, staff and visitors in the event of a major earthquake
- ~~Hospital Evacuation / Shelter in Place~~Hospital Evacuation / Shelter in Place
  - This plan provides a framework for sheltering-in-place and evacuation when hazardous conditions develop to the degree that the facility and/or first responders must take action to protect patients, visitors and staff.
- ~~Hospital Surge~~Hospital Surge
  - This plan is intended to assist the hospital in thinking through critical issues related to healthcare surge in emergency situations
- Mass Casualty Incident
  - This plan provides a strategic framework designed to ensure that El Camino Health can effectively manage a large-scale emergency that overwealms the health system's resources, personnel, and/or supplies as a result of the sudden influx of casualties
- ~~Mass Fatality~~Mass Fatality
  - This plan is designed to outline the management and disposition of large numbers of human remains as a result of a natural disaster, epidemic, pandemic or other

catastrophic event

- ~~Pandemic~~Pandemic
    - This plan is intended to protect employees, physicians, volunteers, patients, contractors, and visitors minimizing exposure to a pandemic influenza event
- Post-Disaster Business Continuity Plan
    - This plan ensures the continuity of mission essential services after a wide range of emergencies and incidents.

Additional plans and procedures are available through Facilities, Nutrition Services and Material Management.

PLAN EVALUATION AND PERFORMANCE IMPROVEMENT

A. The following events will be reviewed and critiqued to determine the effectiveness of the Emergency Management Plans.
    1. Planned exercises
    2. Actual events impacting or having the potential to impact hospital operations.

B. Assessment is conducted through the analysis of the information and reports that create an overall critique of the disaster event or exercise to determine:
    1. If plans and job actions are appropriately designed.
    2. The level of performance of systems and individuals.
    3. The level of improvement from prior events.
    4. The effectiveness of redesigned plans and job actions.

C. Opportunities for improvement are continuously evaluated and implemented through the Emergency Management Committee.

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

HICS Chart.pdf

HICS Roles Information Guide.pdf

Emergency Operations Plan

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
Emergency Management Committee	Bryan Plett: Mgr Environmental Hlth&Safety	01/2025
	Bryan Plett: Mgr Environmental Hlth&Safety	01/2025

History

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> "Family Support Center" changed to "Family Assistance Center" Broken links repaired or removed Mass Casualty Incident added to list of response plans

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Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 1/6/2025, 3:09PM EST

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> Approved by Emergency mgmt cmte via email 1/6/25, per phone call from Bryan Plett.

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> ePolicy 1/10/25

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> MEC 1/23/25

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El Camino Health

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Owner	Shara Poppe: Clinical Manager
Area	Scopes of Service
Document Types	Scope of Service/ADT

4B Medical Surgical Oncology - Mountain View

Types and Ages of Patients Served

Medical Surgical Oncology Nursing Services, provides care to patients ranging in age from young adult to geriatric. The unit provides services to medical, surgical and oncology patients who meet departmental admission, discharge and transfer criteria, including the short stay (outpatient) medical surgical oncology patient.

Assessment Methods

Nursing care is provided by a registered nurse utilizing the nursing process. Registered nurses provide direct supervision to LVNs and clinical support caregivers in the provision of patient care. Reassessment is performed after interventions as part of the evaluation process.

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

Scope and Complexity of Services Offered

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

Appropriateness, Necessity and Timeliness of Services

The Clinical Manager, Assistant Clinical Nurse Manager and shift charge nurses assess the appropriateness, necessity and timeliness of service. The appropriateness of services is addressed in hospital and department specific policies and procedures and the department's Admission, discharge and transfer criteria are established in collaboration with the medical staff.

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

Staffing/Skill Mix

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

Level of Service Provided

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

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

Standard of Practice

Medical Surgical Oncology Nursing Services is governed by State regulations as outlined in Title 22 and Joint Commission on Accreditation of Healthcare Organizations standards, and adhere to the recommendations from the American College of Surgeons, the Commission on Cancer and the Oncology Nursing Society. Additional practices are described in the Patient Care Policies and Procedures, departmental 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.

4B Medical Surgical Oncology - Mountain View

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Department Medical Director or Director for non-clinical Departments	Shara Poppe: Clinical Manager	11/2024
	Shara Poppe: Clinical Manager	11/2024

History

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Edited by Poppe, Shara: Clinical Manager on 11/18/2024, 3:26PM EST

> Changes: Multidisciplinary rounds "once w week" to "weekdays."
> Changed acuity scoring name from "Nursing Intensity Measurements" (NIMs) to "Nursing Workload Scoring System." Attached the ECH Nursing Workload Scoring Rules 2-2-23.pdf

Last Approved by Poppe, Shara: Clinical Manager on 11/18/2024, 3:26PM EST

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> Approved

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Owner	Cheryl Reinking: Chief Nursing Officer
Area	Scopes of Service
Document Types	Scope of Service/ADT

Scope of Practice for Nursing Services

COVERAGE:

All Patient Care Services Employees

PURPOSE:

The Nursing Practice Act (www.rn.ca.gov - Section 2725) defines the practice of nursing as "those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill." The RN -considered competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nurse process.

The Standards of Competent Performance delineated in Section 1443.5 of the California Code of Regulations require the RN to directly observe and assess the patient, "through interpretation of information of information obtained from the client and others including the health team." RNs provide an ongoing patient assessments and document findings in the patient's medical record. The assessment is to be performed and documented each shift and upon receipt of the patient when he/she is transferred to another patient care area.

STATEMENT:

This policy governs the official role of the Registered Nurse practicing at El Camino Hospital.

PROCEDURE:

RN independently initiates and performs complex thinking strategies in all phases of the nursing process. This includes the ability to formulate a patient specific set of diagnoses when there is uncertain, inconsistent, unique and conflicting patient information.

The RN plays the predominate role in the timely communication of the patients response or lack of response to treatment to others, including physicians.

The RN is responsible/accountable to see actual and potential patient needs/health problems are addressed and get recorded on the plan of care.

The following will be performed only the RN:

- performance of a **comprehensive** assessment
- validation of the assessment data;
- formulation of individualized Plans of Care including problem statement, goal, interventions and progress

Delegation of duties occurs between licensed individuals. The responsibility for the patient(s) accompanies delegation. Acceptance of delegation must occur. Delegation must occur within the individual's scope of practice. RNs ensure delegate has appropriate education, skills, experience and documented competency before delegating a task.

Assignment of duties occurs when tasks are assigned to an unlicensed person by a licensed individual.

Evidence that the RN has advocated for the patient includes:

- Clarification of physician orders & comprehensive plan of care
- Ensure informed consent for treatment
- Appropriate/timely discharge planning
- Ensure safe, timely delivery of all aspects of care
- Recognize/record quality variance reporting of actual or "near misses"
- Monitor & follow-up on patient response to treatment regimen
- Ensure patient care assignments for self & others are appropriate and supervised properly

"Standardized procedures" authorize performance of a medical function by an RN. They are developed through collaboration among administrators and health professional including physicians and nurses and are approved through the Interdisciplinary Practice Committee, Patient Care Management Council, the Medical Executive Committee and the Board of Directors

Interim Permittee

The practice of nursing by a nurse with an interim permit is under the supervision of a registered nurse and is restricted to nursing processes and procedures taught in the nurse's basic course work. Excluded from the practice of nurses are those procedures requiring special validation such as arterial blood gas draws, chemotherapy, and CAPD.

Clinical Supervision

The practice of nursing by unlicensed (assistive) personnel is defined in performance standards. They assume responsibilities and perform acts consistent with their education and training, as assigned by the RN, LVN and as allowed by policy, protocols, procedures and guidelines. The responsibility for the assignment always remains with the licensed person. The registered nurse ultimately decides the appropriateness of assignment of tasks for his/her care team.

As defined by the California Board of Registered Nursing, "unlicensed assistive personnel (UAP)" refers to those health care workers who are not licensed to perform nursing tasks and to those health care workers who may be trained and certified but not licensed. UAP are utilized in the delivery of patient care. Effective supervision of these members of the care team is based on the RN's ability to assess real or potential harm associated with patient care procedures and to determine which tasks may be performed by the UAP. Factors which must be considered are patient safety, the competency of the unlicensed person to perform the task, the number and acuity of patients, the number and complexity of tasks, and the number of staff that the RN is supervising.

The direct care RN will independently make decisions regarding the assignment of tasks, based on individual nursing judgments. Tasks requiring a substantial amount of scientific knowledge and technical skill will not be assigned to the UAP. Tasks that are assigned should meet **all** of the following criteria:

- be considered routine care for the patient;
- pose little potential hazard for the patient;
- involve little or no modification from one client situation to another;
- be performed with a predictable outcome;
- not inherently involve ongoing assessments, interpretations, or decision-making which could not be logically separated from the procedure itself.

UAP can perform procedures that require clean technique. They cannot perform any procedures that require aseptic technique. LVNs are licensed and can perform a number of tasks requiring aseptic technique. UAP can collect data, but cannot assess or interpret the data. UAP and LVNs can monitor patients. Only the RN can manage the patient. Management is defined as the assessment, planning, and prioritization of interventions.

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Approval Signatures

Step Description	Approver	Date

Scope of Practice for Nursing Services

Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
	Cheryl Reinking: Chief Nursing Officer	01/2025

History

Sent for re-approval by Reinking, Cheryl: Chief Nursing Officer on 1/7/2025, 10:19AM EST

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> this policy has no revisions and is ready for approval.

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El Camino Health

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Owner	Karla Romero: Director, Patient Access & Financial Counseling S
Area	Patient Access
Document Types	Scope of Service

Scope of Service - Patient Access Department

Types and Ages of Patients Served

The Patient Access department is a division of Patient Financial Services. The Patient Access Department typically serves as the first point of contact for patients entering the hospital. We ~~provide comprehensive registration service to~~facilitate a smooth and efficient patient intake process while ensuring data accuracy, regulatory compliance, and a positive experience for the patient. Patient Access serves patients of all ages in our ~~outpatients as well as our inpatients. Patient Access serves patients of all ages in our~~ community.

Assessment Methods

Patient Access interviews and collects patient financial, clinical and demographic information in order to produce a clean claim and update the medical and financial records while ensuring that the patient understands the need and reason for the information being gathered.

Scope and Complexity of Services Offered

Services provided by the Patient Access department include, but are not limited to:

- ~~Schegistrars~~Patient Service Representatives/Registrars register outpatients by conducting patient interviews to collect required registration and clinical information.
- Admits patients, confirms/updates required registration and clinical information, prepares all paperwork and obtains signatures on appropriate forms.
- Assists in the Direct Admit process of patients by contacting the Assistant Hospital ~~Supervisor~~Manager (AHM) or Patient Flow Coordinator when applicable.

- Schedules outpatient visits for designated departments.
- Provides pre-registration for scheduled outpatients and scheduled admissions.
- ~~Obtains~~Verify pre-authorization for scheduled admissions and high dollar scheduled outpatient procedures.
- Interprets and applies payor contract terms. Reviews patient liability on pre-admits and on urgent/emergent admissions while patient is in-house and obtains payment if appropriate or starts the Financial Assistance process and/or refers patients to appropriate outside agency for assistance.
- Works closely with Care Coordination regarding in-house patients to keep them updated on the patient's insurance or the lack thereof.
- Upon request, ~~gives~~provides patients with estimates ~~of prices by quoting a "price range" for all patients~~.
- Manages the daily productivity and work flow of ~~all~~corresponding registration sites ~~by rounding on staff and patients~~.
- Helps support the IT department by testing and training related to new and existing system updates and applications.
- ~~Provides technical support in the area of report writing, system and report documentation, menu and screen design.~~
- Audits registrations for accuracy and error rates in order to provide statistical basis on which to develop ongoing performance standards.
- Works closely with Patient Accounts to provide a supportive team atmosphere in an effort to successfully meet goals related to the revenue cycle at El Camino Hospital.
- Provides interpretation and translation services to all non-English speaking patients through the "Language Line Services" phone.

Appropriateness, Necessity and Timeliness of Services

Patient Access works closely with the Assistant Hospital ~~Supervisor~~Manager who assesses our patient's clinical needs.

The Patient Access department provides scheduling, pre-registration services for scheduled outpatients as well as scheduled admissions. This allows ~~our patients to bypass~~ us ~~on the day of their service and report directly to their destination~~to capture required registration elements for the patient record. In the Emergency Department, our patient registration process begins with an "Arrival" allowing the clinicians the ability to access a patient's ~~registration process begins with a "quick registration" allowing the clinicians the ability to access a patient's~~ record to assess their patient.

Staffing

The Patient Access department is staffed twenty-four hours a day, seven days a week. Types of staff providing services include ~~schegistrars~~Patient Access Representatives/Registrars, ~~registrars~~Financial Counselors, ~~financial counselors~~Supervisors, ~~supervisors and a manager~~Manager and Director.

Levels of Service Provided

The Patient Access department provides services under hospital and departmental policy and procedure guidelines.

Standards of Practice

Where applicable, the Patient Access department is governed by the state and federal guidelines and Department of Health Services and Joint Commission on Accreditation of Healthcare Organizations requirements.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Department Medical Director or Director for non-clinical Departments	Karla Romero: Director, Patient Access & Financial Counseling S	11/2024
	Karla Romero: Director, Patient Access & Financial Counseling S	11/2024

History

Edited by Romero, Karla: Director, Patient Access & Financial Counseling S on 11/14/2024, 12:56PM EST

> Updated roles and verbiage to reflect current state.

Scope of Service - Patient Access Department

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Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 11/14/2024, 1:26PM EST

> Updated area and doc type

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> Included 'Scope of Service' in title, per ePolicy recommendation.

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El Camino Health

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Owner	Martin Rozario: Director Patient Care Resources
Area	Dialysis
Document Types	Scope of Service/ADT

Enterprise-wide Inpatient Dialysis: Scope of Services

Scope and Complexity of Services Offered

The Inpatient Dialysis ~~Service~~department provides hemodialysis, hemofiltration, apheresis, and continuous ambulatory peritoneal dialysis (CAPD) at El Camino ~~Hospital~~Health. ~~All services are available 24 hours daily.~~

Scope of Services Includes

~~The Inpatient Dialysis Service provides~~ Hemodialysis, Hemofiltration, and Continuous Ambulatory Peritoneal Dialysis (CAPD).

Types and Ages of Clients Served

The Inpatient Dialysis ~~Services~~department provides care to adult and geriatric patients admitted in the inpatient, acute care setting with acute renal failure, and end-stage renal disease (ESRD). ~~This care is provided in the inpatient acute care setting.~~

Assessment Methods

The diagnostic and therapeutic dialysis services provided to patients are assessed by an interdisciplinary team (IDT), including the physician, nurse, ~~patient care technician,~~ and chief technician. A comprehensive patient assessment is completed upon admission. Ongoing response to dialysis treatment is assessed at each treatment.

Appropriateness, Necessity and Timeliness of

Services

All services are available across the enterprise 24 hours daily.

Staffing/Skill Mix

~~A~~The Director ~~of~~& Clinical Manager of Patient Care Resources oversees Inpatient Dialysis ~~Patient Care oversees El Camino Inpatient Dialysis Service~~department in conjunction with a Medical Director. The Medical Director for ~~the El Camino~~ Inpatient Dialysis ~~Service~~services is responsible for the inpatient program. ~~There~~The Chief Dialysis Technician is ~~a chief technician~~ responsible for plant and technical operations for the inpatient program. The staffing ratio is one-to-one (1:1) for accurately ill or unstable patients.

~~In the inpatient service, the staffing ration is one-to-one for accurately ill or unstable patients.~~

Level of Service Provided

The levels of service provided by the Inpatient Dialysis ~~Service~~department are consistent with the diagnostic and therapeutic needs of the patient as determined by the IDT.

Inpatient Dialysis services are designed to meet patient needs by accurately performing and interpreting diagnostic and therapeutic procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which the Inpatient Dialysis ~~Service~~department meets patient needs.

Standards of Practice

The Inpatient Dialysis ~~Service~~department is governed by state regulations as outlines in Title 22 and federal regulations as outlined in the Federal Register, Department of Health, Education and Welfare as related to ESRD facilities. The department also follows guidelines set forth by the TransPacific Renal Network #17, the Renal Physicians' Association (RPA), the American Nephrology Nurses Association (ANNA), the National Association of Nephrology Technicians (NANT), the National Kidney Foundation (NKF), the Council of Renal Social Workers, the Council of Renal ~~Dieticians~~Dietitians, and the American Association of Medical Instrumentation (AAMI). Standard of practice are described in department policies, procedures, and protocol.

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

Enterprise-wide Inpatient Dialysis: Scope of Services

Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
Department Medical Director or Director for non-clinical Departments	Martin Rozario: Director Patient Care Resources	12/2024
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Last Approved	N/A	Area	Utility Management
Effective	Upon Approval	Document Types	Plan
Last Revised	12/2024		
Next Review	1 year after approval		

Environment of Care Utility Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

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

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

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

~~A. Goals:~~

~~Based on areas of improvement noted in the FY-20 Annual Evaluation, the performance improvement indicators for FY-21 will be:~~

1. ~~Staff can describe the proper way to store oxygen cylinders as well as the amount per smoke compartment~~
2. ~~Staff can describe who has the authorization to turn off medical gas controls.~~

~~B. Objectives:~~
~~Specific objectives of the FY-21 Utility Management Plan include the following:~~

1. ~~Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new Sobrato and Taube buildings.~~
2. ~~Continue to monitor and ensure contractor access controls to sensitive Engineering areas.~~
3. ~~Develop a periodic equipment replacement or renovation plan for both Mountain View and Los Gatos.~~

A. **Goals:**

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

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

B. **Objectives:**

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

1. Complete the remote critical power monitoring management system to see the power distribution of emergency power and the remote control of automatic transfer switches.
2. Engineering will revise the elevator entrapment policy to include elevator locations, contact numbers to call into the elevator and which elevators are programmed to be operational during a PG&E power outage.
3. Maintain critical electrical systems through inspection and scheduled maintenance.
4. Evaluate and manage Utility compliance with NFPA and Joint Commission compliance.
5. Evaluate the water management plan for clarification on how water is distributed to specialty services i.e Dialysis and facility emergency water supply distribution.

SCOPE AND APPLICATION:

A. This plan applies to utility systems, components and the uses thereof, for the purposes of providing:

- ~~Environmental control/comfort ventilation~~
- ~~Mechanical ventilation for the purposes of infection/exposure control~~

- ~~Life support~~
- ~~Support to the diagnostic and therapeutic environments~~
- ~~Communication systems~~
- ~~Support to other critical processes and equipment~~

1. Environmental control/comfort ventilation
2. Mechanical ventilation for the purposes of infection/exposure control
3. Life support
4. Support to the diagnostic and therapeutic environments
5. Communication systems
6. Support to other critical processes and equipment

B. The items, processes and critical functions addressed in this plan include, but are not limited to the following:

- ~~Heating, Ventilation and Air Conditioning (HVAC);~~
- ~~Electrical distribution and emergency power;~~
- ~~Vertical transport;~~
- ~~Domestic Water and plumbing;~~
- ~~Boiler/steam;~~
- ~~Medical gases (Oxygen, Medical Air, Nitrous Oxide, Nitrogen, Vacuum); and~~
- ~~Communications (Phones, Nurse Call systems, Public Address).~~

1. Heating, Ventilation and Air Conditioning (HVAC);
2. Electrical distribution and emergency power;
3. Vertical transport;
4. Domestic Water and plumbing;
5. Boiler/steam;
6. Medical gases (Oxygen, Medical Air, Nitrous Oxide, Nitrogen, Vacuum); and
7. Communications (Phones, Nurse Call systems, Public Address).

REFERENCES:

1. ~~Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC .02.05.01, .02.05.03, .02.05.05, .02.05.07, .02.05.09, (lighting and ventilation), .02.06.01~~
2. ~~California Code of Regulations, Title 22, Sections 70837, 70841, 70849, 70851, 70853, 70855;~~
3. ~~California Code of Regulations, Title 24 (UMC), Sections 330, 412, 413;~~
4. ~~California Code of Regulations, Title 8, Sections 5141, 5142, 5143, and 5154.~~

- Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC .02.05.01, .02.05.03, .02.05.05, .02.05.07, .02.05.09, (lighting and ventilation), .02.06.01

- California Code of Regulations, Title 22, Sections 70837, 70841, 70849, 70851, 70853, 70855;
- California Code of Regulations, Title 24 (UMC), Sections 330, 412, 413;
- California Code of Regulations, Title 8, Sections 5141, 5142, 5143, and 5154.

AUTHORITY:

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

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

PROGRAM ORGANIZATION AND RESPONSIBILITIES:

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

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

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

- ~~Coordination of the initial and ongoing risk assessments~~
- ~~Development of written plans and operating procedures~~
- ~~Identifying training needs~~
- ~~Providing technical consultation and assistance with utilities end users, and emergency response training~~
- ~~Planning for and organizing initial response to utility failures~~
- ~~Investigation and reporting of related incidents and significant events~~
- ~~Evaluating overall program efficacy and performance~~

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2. Development of written plans and operating procedures
3. Identifying training needs
4. Providing technical consultation and assistance with utilities end users, and emergency response training
5. Planning for and organizing initial response to utility failures

6. Investigation and reporting of related incidents and significant events
7. Evaluating overall program efficacy and performance

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

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

D. **Central Safety Committee**

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

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

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

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

E. **Employees**

Employees are responsible for participating in utilities training and demonstrating core competencies relative to safe, effective utility systems operations pertinent to their department. Employees must ensure their work practices, operations, and behaviors are safe, and in accordance with departmental procedures, the provisions of this plan, sound infection control principles, hygiene practices and clinical judgment.

Applicable employees are also responsible for knowing the locations of the shut off apparatus for critical utility system components, the proper use, capabilities and limitations of utility systems, and procedures for failures and outages.

RISK ASSESSMENT:

The risks associated with the management of Utility Systems are assessed and controlled through the following facility-wide processes:

- Ongoing Utilities management/Quality Control methods and protocols, including those

designed to address user errors and system failures;

- Incident Report review/evaluation through the ~~incident reporting system and the~~Quality Review Report (QRR) and Central Safety Committee;
- Identifying and mapping the layout of utility systems, and taking inventory of operating components, relative to their impact on critical systems and potential risks associated with system failure;
- Dust Control risk assessments through Infection Control
- Monitoring of ILSM and Methods of Procedures (MOP'S) during construction projects and planned utility shutdowns.
- Environmental rounds and hazard surveillance surveys;
- Communications with end users of utility systems; and
- Results of education and training skills assessments.

The profile of potential physical risks with respect to utilities management includes, patient impact/ adverse outcomes, occupational hazards (electrical, mechanical, etc.), and compromised system function/integrity.

Risks are evaluated and controlled through the review of risk management/incident reports, examination and analysis of pertinent data through the ~~incident reporting system~~QRR, and the response to and correction of utility failures, systemic issues and user errors.

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE:

The following describes the implementation of El Camino Hospitals utility management program:

A. The establishment of criteria for identifying, evaluating and taking inventory of critical operating components for inclusion in the utility management system. The basic criteria for designating systems that will be included in the management program are established through collaborative efforts between both Mountain View and Los Gatos campuses. This process begins with the identification of systems that are involved with sustaining a safe, homogenous environment within the facility. These criteria also address utility systems with impact on

- ~~Life safety systems;~~
- ~~Infection Control systems;~~
- ~~Environmental support systems;~~
- ~~Equipment support systems; and~~
- ~~Communication systems~~

1. Life safety systems;
2. Infection Control systems;
3. Environmental support systems;
4. Equipment support systems; and

5. Communication systems

Specific systems addressed in this maintenance plan include:

- ~~HVAC systems (e.g. comfort ventilation, general dilution and local exhaust ventilation, temperature and relative humidity, air balance and pressure relationships, Indoor Environmental Quality (IEQ))~~
- ~~Medical vacuum, air, oxygen, nitrogen and nitrous oxide~~
- ~~Electrical distribution~~
- ~~Emergency Power/UPS~~
- ~~Boiler/steam systems~~
- ~~Water distribution~~
- ~~Waste water, drains and vents~~
- ~~Nurse Call~~
- ~~Overhead page~~
- ~~Vertical lifts~~

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2. Medical vacuum, air, oxygen, nitrogen and nitrous oxide
3. Electrical distribution
4. Emergency Power/UPS
5. Boiler/steam systems
6. Water distribution
7. Waste water, drains and vents
8. Nurse Call
9. Overhead page
10. Vertical lifts

B. Inspection, testing and maintaining critical operating components falls under the purview of the Engineering Department. For utility components that meet the above criteria, an equipment file form is completed. Each component included in the program is assigned a unique identification number. From there, it is included within scheduled preventive maintenance and testing activities, as indicated. Specific written procedures (instruction sets) are designed for utility inspection, testing and maintenance (**EC.02.05.01, .02.05.03**)

1. All critical components of the facility's Piped Medical Gas system are inspected, maintained and tested through the engineering department. The general and routine inspection and maintenance of medical gas systems include:
    - ~~Visual inspections performed daily to monitor medical gas levels by~~

~~Engineering. Engineers log and respond to any system alarms;~~

- ~~Signaling panels and area alarm devices, inspected periodically by Engineering;~~
- ~~Valves, pressure switches connectors and end-user service outlets, inspection by Engineering;~~
- ~~Cross connection testing, purity testing and pressure testing will be coordinated through Engineering whenever the system is modified, repaired or otherwise breached, or at least annually (***22 CCR 70849***). Testing will be conducted in accordance with NFPA 99, section 4-5.~~

a. Visual inspections performed daily to monitor medical gas levels by Engineering. Engineers log and respond to any system alarms;

b. Signaling panels and area alarm devices, inspected periodically by Engineering;

c. Valves, pressure switches connectors and end-user service outlets, inspection by Engineering;

d. Cross connection testing, purity testing and pressure testing will be coordinated through Engineering whenever the system is modified, repaired or otherwise breached, or at least annually (***22 CCR 70849***). Testing will be conducted in accordance with NFPA 99, section 4-5.

2. As part of the internal system to periodically verify the reliability of the Emergency Power Supply System (EPSS), monthly tests of the emergency generators and transfer switches for 30 continuous minutes are conducted under load by Engineering once per month. Each month, each generator will be exercised for at least 30 continuous minutes under a dynamic load that is at least 30% of the nameplate rating. If this requirement cannot be met, the following conditions shall be implemented (See below). (***EC.02.05.01)***
    a. As an additional proactive measure to better ensure adequate exercising of the engines and to ensure the requirements for wet stacking are met: A "load bank" test will be performed to test each generator with a graduated process of supplemental loads, in accordance with the Joint Commission standard annually on any engine not under a load of 30% or more during each monthly test. Every 36 months a four hour load bank test will be performed per the prescribed requirements.
    b. These generator tests are documented and any discovered problem of deficiency is promptly addressed, reported through the safety function, as needed and tracked where applicable to overall system performance metrics.(***EC.02.05.01)***
3. The Engineering Department implements procedures to effectively reduce the risk of organizational-acquired illnesses through the control of biological agents in water sources. (~~such~~Such as cooling towers) and other aerosolized water systems as indicated. ~~Refer to **Reducing Environment-Acquired Illnesses** for more information.~~ (***EC.02.05.01)***

This aspect of the utilities program is fashioned after applicable portions of existing standards for the environmental control of *Legionella*. Effective *Legionella* control measures will also impact the colonization and proliferation of other water borne pathogens.

4. Mechanical ventilation systems designed for optimal control of airborne contaminants are maintained through Engineering.
5. General air balancing and verification are conducted by Facilities Engineering. Engineering ensures the maintenance and verification of specific air pressure relationships and air exchange ratios, through routine systems maintenance and corrective actions. These specified conditions will be maintained to meet established standards for
    a. Negative pressure isolation rooms
    b. Positive pressure rooms
    c. Atmospheric isolation relative to preventing the transmission of TB
    d. Required pressure relationships for certain health facility areas

Additionally Engineering periodically ensures the verification and efficacy of:

- ~~Negative pressure isolation rooms~~
- ~~Positive pressure rooms~~
- ~~Atmospheric isolation relative to preventing the transmission of TB~~
- ~~Required pressure relationships for certain health facility areas~~

~~Additionally, Engineering periodically ensures the verification and efficacy of:~~

- ~~Dilution air ventilation to limit the concentration of potential airborne contaminants~~
- ~~Air flow patterns within a room (such as laminar flow in the OR)~~
- ~~Proper Air flow direction (such as "clean" to "soiled" in Central Processing)~~
- ~~Filters~~

a. Dilution air ventilation to limit the concentration of potential airborne contaminants
b. Air flow patterns within a room (such as laminar flow in the OR)
c. Proper Air flow direction (such as "clean" to "soiled" in Central Processing)
d. Filters

C. The Engineering Department has developed a Building Maintenance Program to address routine maintenance and inspection of site utility systems. In accordance with this program, Preventive Maintenance/Inspection schedules and instruction sets, P.M. completion rates,

system reliability and functionality is ensured and relative risks controlled through routine preventive maintenance, testing and the identification and correction of deficiencies. (**EC.02.05.01**)

D. Mapping the Layout of Utility Systems and Labeling Controls - A complete set of current mechanical drawings of utility systems are maintained in the Engineering Department, to help ensure system reliability, reduce failures and provide for effective response. The Engineers ensure system controls are consistently marked throughout the facility to ensure appropriate recognition for partial or complete emergency shutdown. Examples include valve tags, labeling of shut-off valves, numbering air handlers, distribution/disconnect panels and mechanical equipment, marking of overhead pipes, etc. (***EC.02.05.01)***

E. Utility system problems, failures and user errors are investigated through Engineering. Each event as well as the corrective actions implemented is documented and reviewed by the Chief Engineer. From this process, training needs, significant events, true leveraging issues and information pertinent to the department's given performance dimensions are collected and communicated to the Central Safety Committee, as needed. (***EC.02.05.01)***

F. Education and Training for end users of utilities is provided through the individual department manager.

Training programs address the following:

- ~~System capabilities, limitations and applications;~~
- ~~Emergency procedures in the event of failure;~~
- ~~Information needed to perform assigned maintenance duties;~~
- ~~Location and instructions for emergency shut-off controls;~~
- ~~Processes for reporting problems, failures or errors~~

~~Technical consultative support is provided through the Engineering Department.~~

1. System capabilities, limitations and applications;
2. Emergency procedures in the event of failure;
3. Information needed to perform assigned maintenance duties;
4. Location and instructions for emergency shut-off controls;
5. Processes for reporting problems, failures or errors

Technical consultative support is provided through the Engineering Department.

PERFORMANCE:

The standards and metrics by which Utility Management performance will be measured are based upon organizational experiences, customer expectations/satisfaction, regulatory requirements, discerned risks, Central Safety Committee and Quality Committee recommendations, and/or observed work practices and behaviors.

A. **Performance Standard**

Based on opportunities for improvement identified in the FY-~~20~~24 EOC Annual Evaluation the FY-~~21~~25 Performance Improvement Indicators are as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Utility Systems	~~Staff can describe the proper way to store oxygen cylinders as well as the amount per smoke compartment~~Staff can describe where their emergency power (red) outlets are located.	Engineering & Department Managers	> 90%
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%

B. **Process and Frequency of Measurement**

Progress for this project will be reported out quarterly at the Central Safety Committee. Data will be collected during Hazard Surveillance rounds and Engineering Life Safety rounds.

PROGRAM EFFECTIVENESS:

The effectiveness of the utility management program includes the appropriateness of the program design, training, maintaining systems integrity, failures, emergency generator testing and performance and other pertinent issues will be monitored and assessed on an ongoing basis.

Relevant incident reports, failures and concurrent and retrospective data relative to the management of Utility Systems will be gathered and tracked through Engineering and the Central Safety Committee. The Central Safety Committee will receive periodic reports and give approvals or make recommendations, as indicated. Substance of reports includes, but is not limited to:

- Summaries of monitoring results relative to established Utility Systems Management performance dimensions and standards, including emergency power system performance levels and preventative maintenance; and
- Reports of system failures or sentinel events, issues, investigation and follow-up.

ANNUAL PROGRAM EVALUATION:

On an annual basis, the Utility Systems Management Plan/Program is evaluated relative to its ***objectives, scope, effectiveness and performance*.** This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

- The continued appropriateness and relevance of program objectives, as well as whether or not these objectives were met.
- The Scope of the program, relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- The extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given scope and objectives. This

analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.

- The performance dimensions, to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

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

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	11/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	10/2024
	John Thompson: Chief Engineer	09/2024

History

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> Updated goals and objectives for FY2022

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> The previous owner's account (*Nick Stoliar: Chief Engineer*) was deactivated, so all of their responsibilities were transferred to *John Thompson: Chief Engineer*.

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> Approve

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> Starting approval process.

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> Per email from Matt Scannell to use revised word version; uploaded to system.

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Owner	Kris Wittman: Dir Rehabilitation Svcs
Area	Scopes of Service
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Scope of Service: Rehabilitation Services

Type and Ages of Patients Served

Rehabilitation Services serves young adult, adult and geriatric in-patients and out-patients. Neonates and pediatric patients up to two years of age are treated in our Neonatal Intensive Care Unit (NICU) by an El Camino Hospital (ECH) provider.

Assessment Methods

Therapeutic ~~exercises/activities and modalities~~interventions are provided to patients after assessment by licensed/registered physical, occupational and speech therapists, as appropriate per departmental policies and procedures, who monitor patients' responses to therapy. All ~~therapeutic activities~~interventions follow an established plan of care documented in the evaluation or re-evaluation of the patient's status.

Scope and Complexity of Services Offered

Rehabilitation Services provides comprehensive specialty rehabilitation services for El Camino Hospital including inpatient and outpatient care. These services include Occupational Therapy (OT), Physical Therapy (PT), and Speech and Language Pathology (SLP). The inpatient services cover all areas of the hospital. The highest volumes of patients seen are orthopedic patients including joint replacements; neurosurgical patients; neurological patients (especially post CVA); and medical/surgical/oncology patients. Neonatal patients are also regularly treated. Pediatric and psychiatric patients are occasionally treated

The outpatient clinics at Mountain View and Los Gatos provide Occupational Therapy, Physical Therapy,

and Speech and Language Pathology. All clinical areas of the patient population are served. The highest volume seen are orthopedic patients, especially those with lumbar and cervical injuries and joint replacements; industrial injuries; neurological patients, especially those post-CVA; general medicine patients; arthritis patients; post-surgical patients; those with oncology related sequelae; and those with cumulative trauma.

All specialty services are provided by skilled and licensed/certified professionals. Services are provided on a referral basis only. All staff works actively to promote and support the mission, vision, and values of El Camino Hospital.

Rehabilitation Services Provides:

PT	Back care training, gait training/ambulation, transfer training, manual therapy, therapeutic exercise programs, neuromuscular re-education, vestibular assessment with appropriate treatment or referral pelvic floor interventions, prosthetic training, modalities, neonatal massage therapy, neonatal feeding, neonatal voice therapy, and developmental interventions & programs as appropriate.
OT	Evaluation and treatment of daily living, social, educational, play/leisure skills, work adjustment, sensorimotor evaluation and therapy, self-management, therapeutic adaptations, preventive techniques, cognitive evaluation and therapy, UE evaluation and treatment, neuromuscular re-education, vestibular assessment with appropriate treatment or referral splinting and therapeutic activities, neonatal massage therapy, neonatal feeding, assisting the radiologist with videofluoroscopic examination for swallowing, neonatal voice therapy and developmental interventions & programs as appropriate.
ST	Evaluation and treatment of speech and language disorders or dysphagia evaluation and treatment, including Vital Stimulation, evaluations and treatment of cognition impairments, assisting the radiologist with videofluoroscopic examinations, performing fiberoptic endoscopic evaluation of swallowing neonatal massage therapy, neonatal feeding, neonatal voice therapy, and developmental interventions & programs as appropriate.

Appropriateness, Necessity and Timeliness of Services

Rehabilitation Services assesses the appropriateness and necessity of therapeutic ~~exercises/ activities and modalities~~interventions by evaluating the patient's clinical history and current condition for pertinence to the therapy ordered. Criteria for the termination of rehabilitation services are described in the departmental policies and procedures.

The timeliness of services is addressed in departmental policies and procedures that describe the hours of operation, criteria for prioritization of patients/treatments, as well as performance of routine procedures.

Staffing/Staff Mix

Rehabilitation Services hours of service for in-patient rehab therapy are daily, 8:30 a.m. to 5:00 p.m.;

regular NICU days of service are Monday-Friday. Diminished staffing levels are scheduled during weekends and holidays.

IN-PATIENT	El Camino Hospital **Mountain View** (main building) 2500 Grant Road Mountain View, CA 94039-7025 Mail Stop: 4A 4AREH Phone: (650) 940-7269
	El Camino Hospital **Los Gatos** 815 Pollard Mail Stop: LGH117 Los Gatos. CA 95032 Hours: Sunday - Saturday, 8:30 a.m. - 5:00 p.m. Legal holidays, except as listed: 8:30 am – 5:00 pm

Outpatient rehabilitation services are provided Monday through Friday, 8:00 a.m. to 5:00 p.m. with the exception of all legal holidays, or by special appointment.

OUT-PATIENT	**Mountain View** Park Pavilion Building, 2nd Floor 2400 Grant Road Mountain View, CA 94040-4378 Mail Stop: PAR 210 Phone: (650) 940-7285 Fax: (650) 965-2992
	Los Gatos 555 Knowles Drive, Suite 100 M/S: KNO101 Los Gatos. CA 95032 Phone: (408) 866-4059 Fax: (408) 871-2347 Hours: Monday - Friday, 8:00 a.m. - 5:00 p.m. Closed on legal holidays

The types of staff providing care and services include licensed/registered physical therapists, occupational therapists, and speech ~~therapists~~ language pathologists; licensed/registered physical therapy assistants and occupational therapy assistants; therapy aides and front desk staff.

Levels of Service Provided

The levels of services provided by the department are consistent with the therapeutic needs of the patients as determined by the medical staff.

Services are designed to meet patient needs by accurately performing procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which Rehabilitation Services meet patient needs.

Standards of Practice

Rehabilitation Services ~~is governed by~~adhere to written Medicare guidelines and requirements for skilled intervention; adheres to state regulations ~~as~~ outlined in Title 22, Physical Therapy Practice Act, Occupational Therapy Practice Act, and Speech-Language Pathologists and Audiologists Practice Act; and follows the guidelines set forth by the Ethical Codes of Conduct and Standards / Scopes of Practice of the American Occupational Therapy ~~Practice Act. The department also follows guidelines set forth by the American Occupational Therapy~~ Association, American Physical Therapy Association, and the American Speech~~,~~ -Language-Hearing ~~and Language~~ Association. Additional ~~practices~~Practices are described in ~~department~~Department policies and procedures ~~(see below):~~.

A. Physical Therapy:

Physical Therapy assists in the prevention, correction or alleviation of pain, disability or deformity caused by injury or disease. Neonatal therapy implements neuroprotective strategies to minimize infant physiologic stress and maximize infant growth and development. Physical Therapy provides, but is not limited to, the following services:

1. Functional evaluations and goal setting.
2. Medical (including oncology), neurological and orthopedic rehabilitation.
3. Therapeutic exercise, including strengthening, flexibility training, and developmental interventions.
4. Modalities: traction, moist heat, ~~cold~~paraffin, cryotherapy, electrotherapy, and ultrasound.
5. Manual therapy: myofascial release, manual lymph drainage, peripheral and spinal joint mobilization, soft tissue mobilization, manual traction, and neonatal touch and massage.
6. Gait, transfer training, and neonatal 4-handed care for positioning.
7. ~~LE Prosthetic training.~~Lower extremity prosthetic training.
8. Use of exercise equipment.
9. Balance training, coordination training, and neonatal neuromuscular reeducation.
10. Patient, family and caregiver education and training.
11. Ergonomic assessments, injury prevention training, and neonatal positioning programs to preserve musculoskeletal integrity.
12. Advancement of physical therapy rehabilitation programs
13. Aquatic therapy.
14. Evaluation and treatment of pelvic floor dysfunction
15. Neonatal feeding

16. ~~Neonatal feeding~~Evaluation and treatment of vestibular dysfunction

    Advanced Practice Physical Therapy: Additional and separate current certification is required for any Physical Therapist performing procedures involving Electromyography or Electroneuromyography.

B. Occupational Therapy:

Occupational Therapy provides for goal-directed, purposeful activity to aid in the development of adaptive skills and performance capacities by individuals of all ages who have physical disabilities and related psychological impairment(s). Such therapy is designed to maximize independence, prevent further disability, and maintain health. Neonatal therapy implements neuroprotective strategies to minimize infant physiologic stress and maximize infant growth and development. Occupational Therapy provides, but is not limited to, the following services:

1. Functional evaluations and goal setting.
2. Medical (including oncology), neurological, orthopedic, and developmental interventions for rehabilitation.
3. Sensorimotor, cognitive and perceptual evaluation and rehabilitation; neonatal touch and massage.
4. Balance and coordination training; neonatal neuromuscular reeducation, neonatal positioning programs to preserve musculoskeletal integrity..
5. Energy conservation training.
6. Bed mobility and transfer training; neonatal 4-handed care for positioning.
7. Wheelchair fitting and mobility training.
8. Activities of daily living (ADL) training.
9. Instrumental activities of daily living (IADLs) including pre-driving assessments
10. Advancement of Occupational Therapy rehabilitation programs.
11. Feeding training.
12. Patient, family and caregiver education and training.
13. Recommendations for static and dynamic splinting.
14. Therapeutic exercises.
15. Evaluation and treatment of vestibular dysfunction.

C. Advanced Practice Occupational Therapy: Additional and separate current certification is required for any Occupational Therapist treating patients in the areas of:

1. Hand Therapy – including, but not limited to, fabrication of static and dynamic splints, manual peripheral joint mobilization, soft tissue mobilization, UE prosthetic training
2. Use of physical agent modalities
3. Swallowing Assessment, Evaluation or Intervention including video fluoroscopic swallow studies.

D. Speech and Language Pathology:

Speech and Language Pathology services include screening, assessing and interpreting disorders of speech and language, oral-pharyngeal function, and cognitive/communicative disorders. Neonatal therapy implements neuroprotective strategies to minimize infant physiologic stress and maximize infant growth and development. Speech and Language Pathology provides, but is not limited to, the following services:

1. Diagnostic speech and language evaluation and goal setting.
2. Medical (including oncology), neurological, orthopedic, and developmental interventions for rehabilitation.
3. Instrumentation: Videofluoroscopy and Fiberoptic Endoscopic Evaluation of Swallow (FEES).
4. Cognitive evaluation and treatment.
5. Prosthetic assessment and training.
6. Dysphagia evaluation and treatment.
7. Advancement of Speech Therapy rehabilitation programs.
8. Patient, family and caregiver training.
9. Assessment and interventions for neonates including: developmental interventions, neonatal touch and massage, neonatal 4-handed care for positioning, neonatal neuromuscular reeducation, neonatal feeding, and neonatal positioning programs to preserve musculoskeletal integrity.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
Medicine Department Executive Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024

Scope of Service: Rehabilitation Services

Medicine Department Executive Committee	Kris Wittman: Dir Rehabilitation Svcs	09/2024
Medical Director	Kris Wittman: Dir Rehabilitation Svcs	09/2024
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Scope of Service: Rehabilitation Services

MEC 1/23/25

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Origination	02/2013	Owner	Melinda Porter: CNS/NP
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Last Revised	11/2024		
Next Review	2 years after approval		

Neonatal Screening for Critical Congenital Heart Disease (CCHD) Using Pulse Oximetry

COVERAGE:

All Maternal Child Health Staff

PURPOSE:

A. Babies with a critical congenital heart defect (CCHD) are at significant risk for death or disability if their condition is not diagnosed soon after birth.

B. CCHDs can potentially be detected using pulse oximetry screening, which is a test to determine the amount of oxygen in the blood and pulse rate.

POLICY STATEMENT:

It is the policy of El Camino Hospital to ensure patient safety. All babies in the Mother Baby Unit (MBU) and Neonatal Intensive Care Unit (NICU) will have a CCHD screening done before discharge, except babies who have been evaluated by a diagnostic echocardiogram.

REFERENCES:

- CDC (2024). Clinical Screening and Diagnosis for Critical Congenital Heart Defects | Congenital Heart Defects (CHDs) | CDC Accessed 11/18/24. https://www.cdc.gov/heart-defects/hcp/screening/index.html
- State of California - Health and Human Services Agency, Department of Health Care Services. (2014, reviewed 2024 no updates). Guidelines for Critical Congenital Heart Disease Screening

Services. https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl040314.pdf

- ~~Knapp, AA, Metterville, DR, Kemper, AR, Prosser, L, Perrin, JM. (2010) Evidence review: Critical congenital cyanotic heart disease. Prepared for the Maternal and Child Health Bureau, Health Resources and Services Administration.~~
- ~~Kemper AR, Mahle WT, Martin GR, Cooley WC, Kumar P, Morrow WR, Kelm K, Pearson GD, Glidewell J, Grosse SD, Lloyd-Puryear M, Howell RR. (2011). Strategies for Implementing Screening for Critical Congenital Heart Disease. Pediatrics; 128:e1-e8.~~

PROCEDURE:

A. Gather Equipment:
    1. Portable Pulse Oximetry Monitor
    2. Infant Pulse Oximetry Sensor
    3. ~~Alcohol wipes~~
    4. Instruction sheet for parents: "When Babies are Screened" (See Attachment A)

B. Place sensor on infant's right hand/wrist, followed by right foot and obtain readings. Ascertain readings are accurate by observing pulse wave form and correlating pulse rate if necessary. If infant is active or fussy, wait until infant calms to obtain readings.

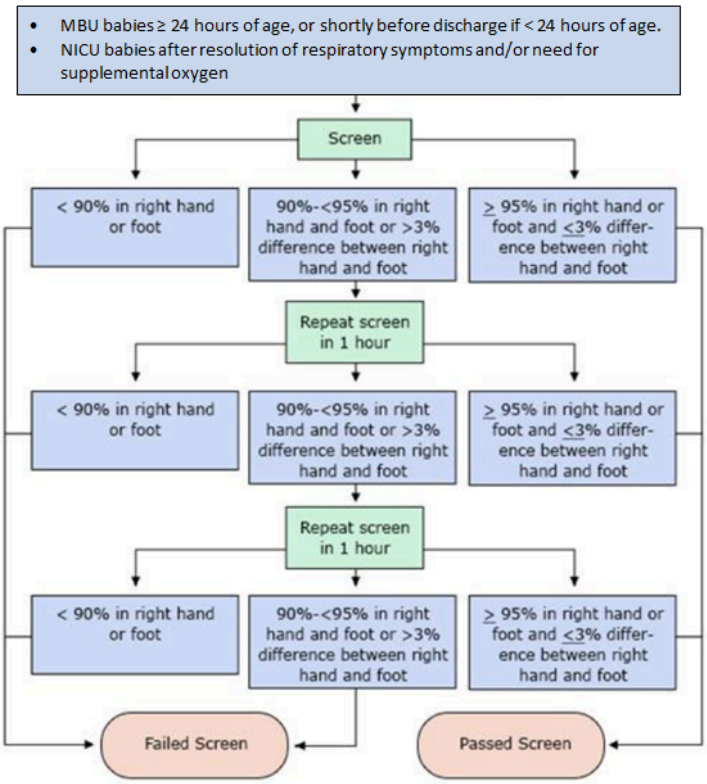
C. For passed screen: (see chart below) record results of testing on patient in Electronic Health Record (EHR) and indicate that testing is complete.

D. For failed screen: document result (less than 90% in right hand or foot) and notify infant's pediatrician for additional treatment. Record results of testing on patient in EHR.

E. For equivocal screen: document result and repeat testing (see chart) in one hour intervals, two times, to determine if result is negative or positive result. If positive notify infant's pediatrician for additional treatment. Record results of testing on patient in EHR.

F. Once testing and documentation complete; inform parents of result, remove infant sensor, clean and return pulse oximetry monitor to designated holding area and return sensor to recycling area. Wash hands.

Neonatal Screening for Critical Congenital Heart Disease (CCHD) Using Pulse Oximetry



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Attachments

A: Instruction Sheet for Parents

Image 1

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025

ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
MCH Executive Committee	Melinda Porter: CNS/NP	12/2024
Pediatric Department	Melinda Porter: CNS/NP	12/2024
UPC | Staff Meeting	Melinda Porter: CNS/NP	12/2024
	Melinda Porter: CNS/NP	12/2024

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Neonatal Screening for Critical Congenital Heart Disease (CCHD) Using Pulse Oximetry

MEC 1/23/25

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Owner	Raquel Barnett: Sr. Director Medical Staff Services
Area	Medical Staff
Document Types	Policy

Ongoing Professional Practice Evaluation (OPPE)

COVERAGE:

All members of the medical staff and allied health practitioners.

PURPOSE:

To define the process for ongoing professional practice evaluation (OPPE) of medical staff members and allied health practitioners at El Camino Health. The primary goal of OPPE is to identify professional practice trends that impact the quality and safety of patient care and to ensure current clinical competence of medical staff members and allied health practitioners as part of El Camino Health's commitment to quality.

POLICY STATEMENT:

Ongoing Professional Practice Evaluation (OPPE) is conducted on an ongoing basis and will include review of performance data for all practitioners with clinical privileges at ECH. This process includes concurrent and/or retrospective review of an individual practitioner's performance of clinical professional activities by Department Chair and/or their designee through the procedures outlined in this policy.

The Medical Staff Services Department manages, compiles, and evaluates OPPE data in coordination with Department Chairs and designees.

DEFINITIONS:

1. **Practitioner**: The word Practitioner used throughout this policy means both licensed independent

practitioner and allied health practitioner.

2. **OPPE:** Ongoing Professional Practice Evaluation (OPPE) monitors and evaluates professional practice trends that impact on quality of care and patient safety for medical staff members and allied health practitioners under medical staff supervision. Ongoing professional practice evaluation differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual practitioner's performance rather than appraising the quality of care rendered by a group of professionals or a system. The evaluation is based upon generally recognized standards of care and multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data per El Camino Hospital Medical Staff Bylaws and Rules and Regulations, and other relevant criteria as reasonably determined by the hospital's Medical Staff. Through this process, practitioners receive feedback for clinical improvement or confirmation of clinical achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

3. **FPPE:** Focused Professional Practice Evaluation (FPPE) establishes and confirms an individual practitioner's privilege-specific competency at the time when he/she requests new privileges, either at initial appointment or as a current member of the medical staff or allied health practitioner staff, and is also used to evaluate and monitor a practitioner's ability to provide safe, high quality care. FPPE is a time-limited period or process in which a designated number of procedures, admissions, or consults, etc., are reviewed, during which the Medical Staff evaluates and determines a practitioner's professional competence.

4. **OPPE Indicators:** Specialty-specific data, both quantitative and qualitative, that has been approved by the medical staff as an evaluation tool for competent and quality care of patients. OPPE includes but is not limited to evaluation of patient care, medical clinical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and system-based practice.

5. **Quantitative Data:** Quantitative data reflects a certain quantity, amount, or range and is generally expressed as a unit of measure in quantities such as measurements, counts, percentage compliant, ratios, thresholds, intervals, time frames, etc.

6. **Qualitative Data:** Qualitative data reflects data that approximates and charaterizes' and is often non-numerical in nature. This type of data may be collected through methods of observations, discussions with other individuals, chart review, monitoring of diagnostic and treatment techniques, etc.

7. **Triggers/thresholds:** OPPE indicator thresholds/triggers are established by the medical staff and indicate the need for performance monitoring. Triggers can be single incidents or evidence of a clinical practice trend.

8. **Designee:** A Vice Chair or appointed Medical Director of a medical specialty or a person identified by the Chief of Staff.

REFERENCES:

1. Comprehensive Accreditation Manual for Hospitals, Medical Staff Chapter.
2. FPPE/OPPE Booster Pak - The Joint Commission,

3. Ongoing Professional Practice Evaluation (OPPE) - Understanding the Requirements, The Joint Commission
4. National Practitioner Data Bank (NPDB) Guidebook

PROCEDURE:

A. Ongoing Professional Practice Evaluation review will be conducted every eight (8) months and applies to any privilege granted to be exercised in the hospital

B. The Medical Executive Committee (MEC) will establish criteria for OPPE in consultation with Department Chairs and Medical Directors. All practitioners will be part of this ongoing evaluation.

C. Department Chair or designee will be responsible for:

1. Establishing criteria for the specialty that will be included in the ongoing evaluation.
2. Review, investigate, and address any concerns regarding the information in each department practitioner's OPPE report. The Department Chair, or designee will sign off each report within sixty (60) days.
3. The Department Chair may recommend the following but not limited to:
    a. Continue privileges – Practitioner is performing well or within desired expectations
    b. Targeted chart review - Concerns exist
    c. Trend for next OPPE cycle - Concerns exist
    d. FPPE Recommended - Concerns exist
    e. Recommend limit or revoke privileges - Significant concerns exist (Physician has the right to appeal as per Article 8 of the Bylaws)

D. Upon review of relevant information, the Department Chair in coordination with the Credentials Committee and/or the Department Executive Committee may do any of the following: chart review, track and trend, FPPE, recommend limitation or revocation of privileges to the Medical Executive Committee and Board of Directors.

E. The Credentials Committee will be responsible for:

1. Review and either accept or revise recommendations
2. Any changes to OPPE recommendations are communicated to the Department Chair and the practitioner.

F. Medical Staff Executive Committee (MEC) will be responsible for:

1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.

G. Board of Directors will be responsible for:

1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.

H. OPPE Data:

1. The Medical Staff Services Department manages, compiles, and evaluates OPPE data in coordination with Department Chairs and designees.
2. The Professional Practice Evaluation Manager will review OPPE Indicators with Department Chairs and designees at least annually.
3. All documentation related to FPPE and OPPE will be stored in the practitioner's confidential electronic file which is stored in MD-Staff/MD-Stat database.
4. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Medical Staff Leadership Committee	Raquel Barnett: Sr. Director Medical Staff Services	11/2024
	Raquel Barnett: Sr. Director Medical Staff Services	11/2024

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Ongoing Professional Practice Evaluation (OPPE)

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Owner	Raquel Barnett: Sr. Director Medical Staff Services
Area	Medical Staff
Document Types	Plan

Medical Staff Services - Credentialing Quality Process Improvement

PURPOSE:

El Camino Hospital (ECH) Medical Staff Services Credentialing Quality Improvement Process describes the internal quality improvement framework utilized to continuously improve the credentialing process.

CREDENTIALING QUALITY IMPROVEMENT PROGRAM STRUCTURE:

A. The scope of activities covered by the Medical Staff Services Credentialing Quality Improvement Program (Program) include but are not limited to the following:
    1. Data integrity
    2. Timeliness of practitioner onboarding
    3. Credential file audit process (prior to Department Chair, Interdisciplinary Practice Committee, Credentials Committee, Medical Executive Committee review and recommendation)

B. Medical Staff Services maintains credentialing data and documents in a secure electronic and paperless environment which is the system of truth across health system. The goals and objectives of the Program for each quality indicator, A.1-3 are as follows:
    1. Ongoing oversight of credentialing related data to ensure accuracy of practitioner data internally and to downstream systems (e.g. Epic, Find a Doc, Pharmacy).
    2. Timely practitioner onboarding includes an initial application turn-around time within

120 days of receipt of a completed application. The objective is to support specialty and patient needs across the health system.

3. Credential file audit is to ensure all required elements are obtained as defined by ECH, California State, and Regulatory bodies (e.g. TJC, NCQA, CDPH, CMS). The objective is to ensure file completeness and regulatory compliance prior to a credentialing decision.

C. Performance Assessment for the Program indicators and analysis is defined as follows:

1. Credentialing data is evaluated on an ongoing basis using routine reports from the credentialing database (e.g. practitioners by alarm, reappointment, temporary privileges, expirables).
2. Credentialing Quality Improvement Dashboard
    a. Applicant Preapplication Turn Around Time
    b. Preapplication Received to Application Sent
    c. Onboarding Turn Around Time
    d. Monthly Application Volume
    e. FPPE Status
    f. Expirables
    g. Denials
3. Credentials file audit is the systematic review of credentials files undergoing initial credentialing, recredentialing, return from leave of absence, change of practitioner status and/or privileges mid-cycle, temporary/expedited privileges. The analysis is conducted by Medical Staff Services Department leadership and is defined in the Medical Staff Services Department Credential and Privileging Procedure, credentialing system controls, virtual committee process, and checklists.
    a. 100% of credentials files are screened for completeness and accuracy prior to review and recommendation by committees

D. Process for resolving client complaints

1. Complaint is received from client and reviewed within 30 days of receipt.
2. Investigate and review by appropriate personnel for additional information and/or follow-up (as needed).
3. Appropriate action plan is developed and implemented within 30 days in accordance with client.
4. Action plan is monitored for ongoing compliance.
5. Track and trend as appropriate.

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Medical Staff Services - Credentialing Quality Process Improvement

Approval Signatures

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Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
Credentialing Committee	Raquel Barnett: Sr. Director Medical Staff Services	01/2025
IDPC	Raquel Barnett: Sr. Director Medical Staff Services	12/2024
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Medical Staff Services - Credentialing Quality Process Improvement

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Radiation Safety - Radiation Protection Program

COVERAGE:

All El Camino Hospital staff, medical staff, and volunteers

PURPOSE:

To provide standards for proper radiation protection at El Camino Hospital

POLICY STATEMENT:

This policy describes the ECH Radiation Protection Program, the reporting structure and program oversight. It is the hospital guidance document for occupational and public radiation safety/exposure.

DEFINITIONS:

- ALARA: an acronym for "as low as (is) reasonably achievable," which means making every reasonable effort to maintain **exposures** to **ionizing radiation** as far below the dose limits as practical.
- RSO: Radiation Safety Officer
- RSC: Radiation Safety Committee
- RPP: Radiation Protection Plan
- RPA: Radiation Protection Apparel

REFERENCES:

- American College of Radiology – Radiation Safety
- California Department of Public Health- Radiologic Health Branch
- California State Bill 1237
- Title 17, the California Code of Regulations, Title 10, Code of Federal Regulations, Part 20
- NCRP Recommendations for Ending Routine Gonadal Shielding During Abdominal and Pelvic Radiography
- RSO Delegation of Authority: http://policies.elcaminohospital.org/dotNet/documents/?docid=9828https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8243IR1.pdf

PROCEDURE:

A. **Program Structure and Oversight**

1. **Radiation Safety Officer (RSO) -** The RSO is qualified by the California Department of Health Services, Radiologic Health Branch (CDPH) and is responsible for the Radiation Protection Program (RPP.)
    a. The duties and responsibilities of the RSO and governance of the RSO and organization are addressed in the Delegation of Authority document.
    b. The RSO is responsible to report annually the activities of the RPP to the hospital medical staff.
2. **Radiation Safety Committee-** The Radiation Safety committee reports to the Hospital Safety Committee and meets quarterly. A quorum for any meeting is three of the four core members.
    a. Membership
        1. Core Members of the RSC are:
            i. RSO
            ii. The Chairman
            iii. A representative from hospital administration
            iv. A representative from nursing administration
        2. Represented members are required from each department that utilizes ionizing radiation and may include members of the Medical Staff.
        3. Appointment to the RSC is made through recommendation and approval by the RSO.
    b. Radiation Safety Committee has the following responsibilities:
        1. To review proposals for diagnostic and therapeutic uses of radionuclides.

2. To review regulations for the use, transport, storage and disposal of radioactive materials.
3. In concert with the RSO, analyze technical data regarding the use of ionizing radiation for the ECH Enterprise, and make recommendations to ensure best institutional safety practices, and review regulatory requirements for compliance.
4. To review rules and guidelines for nursing and other individuals who are in contact with patients receiving therapeutic amounts of unsealed radionuclides; rules relating to the discharge of such patients; and rules to protect personnel involved when such patients undergo procedures or autopsy.
5. To assure the provision of radiation safety training suitable to the needs of the hospital.
6. Annual review of equipment records to ensure physics surveys are within limits.
7. Review the Radiation Protection Plan annually.
8. Review quarterly Quality Control records from all areas where radiation is used.
9. Maintains policies on the following topics for guidance.
    i. Radiation Protection
    ii. Inspection and maintenance of Radiation Protective Apparel (RPA)
    iii. Dosimetry monitoring
    iv. CT radiation dose documentation
    v. Declared pregnant radiation workers
    vi. Pregnancy screening and patient management
    vii. Portable radiography guidelines
    viii. Fluoroscopy exposure regulatory guidance
    ix. Radiation exposure events; wrong patient or body part imaged
    x. Radionuclide delivery and storage
    xi. Radioactive spills and emergencies
    xii. Radiopharmaceuticals safety
    xiii. Radioactive waste management
10. Annual review of RPA inspection report.

c. Radiation Areas

1. A current copy of department form RH-2364 (notice to employees) is posted. Title 17 is available on-line.

2. All radiation areas are identified as hazardous via the posting of a radiation sign or placard.
3. Emergency procedures applicable to working with sources of radiation are available.

d. Occupational Exposure

1. The hospital will issue a dosimeter to any individual whose anticipated dose is expected to exceed 10% of the annual dose limit while at the facility.
2. Dosimeters must be worn appropriately by all radiation workers at all times, if likely to receive 5mSv per year according to the Nuclear Regulatory Commission.
3. Dosimeter reports are reviewed by the RSO monthly and reported quarterly to the RSC. Reports are available for review by radiation workers on-line at www.myldr.com
4. At no time will a dosimeter be exposed to radiation unless worn by the individual to whom it is issued. Any infraction of this rule may result in the loss of that person's privilege to work with radioactive material and/or ionizing radiation. Flagrant violations of this policy may result in discipline up to and including termination.

3. **Radiation Safety of Pregnant Radiation Workers**
Radiation workers may declare their pregnancy in writing to the Radiation Safety Officer. Upon declaration, the Radiation Safety Officer or designee will order a fetal dosimeter, provide a spare as needed, and provide specific precautions and policies relating to radiation safety during their pregnancy. If the pregnancy is not declared, the individual is not considered to be pregnant. See policy **Declared Pregnant Radiation Worker**

4. **Education**

a. It is an El Camino Hospital requirement that all staff working in a radiation environment be provided with radiation safety training as part of their orientation prior to assumption of duties.

b. All staff members meet continuing education in radiation safety through current licensure and/or HealthStream.

5. **Investigational Levels for ALARA:**

a. El Camino Hospital has established investigational levels for occupational doses in conjunction with 10 CFR 20.1201 significantly lower than the annual Nuclear Regulatory Commission ALARA levels. Individuals exceeding ALARA exposure limits will receive notification from Landauer, reviewed by the RSO. The RSO conducts an investigation and maintains records of all occurrences and findings. Should any worker exceed NRC limits, an immediate review by the RSO and RSC will occur. A report of the investigation, any actions taken, and a copy of the individual's exposure

records will be presented to the RSC at its first meeting following completion of the investigation.

b. Licensees Investigational Level Thresholds- All Sub-accounts

Badge Exposure Diagnostic Radiology Nuclear Medicine Radiation Oncology Interventional Cardiology Fluoroscopy Supervisor	**Monthly**	**Quarterly**	**Yearly**	**% NRC**
DDE/TEDE	>125 mrem	>375 mrem	>1500 mrem	30%
LDE	>375 mrem	>1125 mrem	>4500 mrem	30%
SDE	>1250 mrem	>3750 mrem	> 15000 mrem	30%
Ring	>750 mrem	>2250 mrem	> 9000 mrem	18%

c. The Committee will review each dose in comparison with those of others performing similar tasks as an index of ALARA program quality and will record the review in the Committee minutes.

6. **Reestablishment of Investigational Levels**:
   a. In cases where a worker's, or a group of workers' doses, need to exceed an investigation level, a new, higher investigational level may be established for that individual or group on the basis that it is consistent with good ALARA practices.
   b. Justification for new investigational levels will be documented.
   c. The RSC will review the justification, and must approve or disapprove all revisions of investigational levels.

B. **Public (patient) Safety Radiation Exposure -** It is the policy of El Camino Hospital to keep the radiation exposure to all patients at the lowest possible levels.
   1. No imaging study will be performed without a valid physician order and corresponding requisition from a licensed medical practitioner.
   2. Technique charts and modality protocols are available to assist technologist in maintaining ALARA while still producing diagnostic quality images for interpretation.
   3. The Technologist will use ALARA based principles, optimize technical factors for image acquisition, and maintain best practices in order to reduce patient dose while maintaining diagnostic image quality.
      a. The technologist will use lead or lead equivalent shielding during radiographic procedures where shield placement is appropriate and aligned with minimizing patient radiation exposure. Gonadal and fetal

shielding should not be used during abdominal and pelvic radiography when it could interfere with the automatic exposure control or obscure the anatomy of interest.

b. All female patients of child-bearing age will be screened for pregnancy.

c. Student Radiologic Technologists work under the direct supervision of a licensed radiographer until they receive competency. For the studies they have received competency on, they may work under indirect supervision.

4. During the use of portable fluoroscopy (C-arms), the technologist will delineate the area of radiation exposure or risk during the procedure unless otherwise directed or changed by the supervising physician.
5. Relatives of the patient or other healthcare workers wearing protective apparel may hold the patient in position if other methods fail. Technologists are to hold patients only in an emergency.
6. Any event where a patient is unnecessarily or incorrectly exposed to ionizing radiation will be reviewed, e.g. wrong patient, wrong body part.

C. **Pediatric Patients**

1. In an effort to reduce patient radiation dose, all pediatric patients should have proper techniques and immobilization devices used while undergoing imaging procedures.
2. When performing CT Scans on pediatric patients, the technologist should significantly reduce technique by using appropriate pediatric protocol.

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]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
Radiation Safety	Joni Ballin: Service Line Project Coordinator	12/2024
	Aletha Fulgham: Dir Diagnostic Imaging Svcs	11/2024

History

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Origination	02/2017	Owner	Aletha Fulgham: Dir Diagnostic Imaging Svcs
Last Approved	N/A	Area	Imaging Services
Effective	Upon Approval	Document Types	Scope of Service
Last Revised	12/2024		
Next Review	3 years after approval		

Scope of Service - Imaging Services

Scope:

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

Patient Types

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

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

Services Offered

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

General Diagnostic Radiography
Magnetic Resonance Imaging (MRI)
Nuclear Medicine
Ultrasound

Mammography
Fluoroscopy
Computerized Tomography (CT)
PET/CT
Vascular Imaging
Interventional Radiology

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

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

Nuclear Medicine-Specifics

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

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

Interventional Radiology

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

Staffing Guidelines for Operating Room Coverage

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

From Monday through Friday, three (3) radiologic technologists are scheduled to provide imaging

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

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

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

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

Appropriateness, Necessity and Timeliness of Services

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

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

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

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

Interpreting Physicians

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

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

Scope of Service - Imaging Services

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

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

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

Mammography Reports:

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

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

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

Modality Protocols:

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

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

Staffing/Skill Mix and Requirements

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

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

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

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

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

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

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

Radiation Safety Officer (RSO) AND Radiation Safety Committee:

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

Clinical Engineering (Imaging Services Equipment):

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

Standards of Practice

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

Security Considerations

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

Hours of Operation

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

Scope of Service - Imaging Services

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

Scope of Service - Imaging Services

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

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]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2025
Department Medical Director or Director for non-clinical Departments	Aletha Fulgham: Dir Diagnostic Imaging Svcs	12/2024
	Aletha Fulgham: Dir Diagnostic Imaging Svcs	12/2024

History

Scope of Service - Imaging Services

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Last Revised	10/2024
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Owner	Lorna Koep: Director Environmental Svcs
Area	Hazardous Materials Management
Document Types	Plan

Environment of Care - Hazardous Materials Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino ~~Health~~Hospital is committed to providing a safe, accessible and effective Environment of Care, consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, visitors, employees and staff. The intent of this plan is to protect human health and the environment from risks related to hazardous materials and waste by identifying materials that need special handling and implementing processes to minimize the risk of unsafe use and improper disposal of hazardous materials.

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

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

   1. ~~Staff can describe the process for accessing a Safety data sheet (> 95%)~~

2. ~~Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes. (> 95%)~~

the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)

1. Measurement of success :> 95%.

B. Staff can describe the process for accessing a safety data sheet.

1. Measurement of Success: >95%.

C. Objectives~~:~~

Specific objectives of the FY-~~2022~~25 Hazardous Materials and Waste Management Plan include the following:

1. All employees will have access to ~~Safety Data Sheets (SDS) on line~~policy stat to reference policies as needed.
2. ~~Ongoing training for staff on the new NIOSH 800 regulations.~~All employees will have access to Safety Data Sheets (SDS) online.
3. ~~Updated~~Follow up with appropriate leaders to complete the Code Orange spill response reporting form.
4. Refresher and initial decontamination training will be offered to staff at least ~~one time~~once in FY ~~2022~~25.
5. Initial and annual ~~HAZWOPER~~Hazwoper training will be offered to identified individuals in FY ~~2022~~25.
6. Develop, educate and implement the ~~Handling of Hazardous Drugs (USP 800) plan~~Code Orange Policy in FY ~~2022~~25.
7. Review, revise and educate staff on the changes to the hospital container waste guide based on opportunities for improvement identified during the hazardous waste inspections with the county
8. Spill response training will be offered to staff who respond to spills and code orange events ~~(e.g., EVS, Engineering, Lab etc.).~~to designated departments
9. ~~Surveillance and education for appropriate usage of~~Further, implement & monitor the controlled substances non-retrievable waste container ~~(CSRX)~~ program in FY ~~2022~~25.
10. Conduct internal audit of regular trash to monitor adherence to proper segregation per hospital waste container guide.

SCOPE AND APPLICATION:

The Hazardous Materials and Waste Management Plan apply to patients, employees, and visitors at all areas of El Camino ~~Health~~ Hospital. This plan applies to all operations, processes, activities and departments involved in the selection, procurement, handling, storage and disposal of hazardous materials. For the purposes of this plan, the term ~~"~~"hazardous materials~~"~~" may apply to the following:

- Hazardous substances (as listed and defined under CERCLA , 40 CFR 300),
- Hazardous Materials (as addressed in the OSHA Hazard Communication Standard & Director's list 8 CCR 339),
- Designated wastes under the federal and state regulations,
- Listed carcinogens and reproductive hazards, under 22 CCR 12000 (Prop. 65),
- Compressed gases,
- Chemotherapeutic agents (CYTOTOXIC),
- Radioactive materials, ~~refer to "Nuclear Medicine - Radioactive Spills Procedure"~~
- Potentially infectious materials (as defined in the Blood borne Pathogen Standard) and Medical wastes (as defined in the Medical Waste Management Act),
- Pesticides (Title 3, Division 6, Health & Safety Code, Section 25500),
- Universal Waste (batteries, fluorescent light bulbs), or
- Any other material which the user or Administering Agency has reasonable basis to classify as harmful to living organisms or the environment.

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

- Program planning/design, implementation, the measurement of outcomes and performance improvement;
- Risk Assessments; Identification, analysis and control of risks;
- Reporting and investigating including incidents, accidents and failures;
- Occupational health and safety;
- Control of exposures to potentially harmful conditions/industrial hygiene;
- Orientation, education and training;
- Environmental maintenance, testing and inspection;
- Examining and addressing safety issues

The hazardous materials and waste management plan and associated policies, procedures and programs are instituted by the Central Safety Committee through a multi-disciplinary approach which integrates the efforts of key functional areas, including but not limited to EVS, Infection Control (IC Committee), Engineering, Laboratory, Nursing, and Security

REFERENCES:

1. ~~Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC.02.02.01~~
2. ~~Code of Federal Regulations, Title 29, Sections 1910.101-106, 120, 1000, 1030, 1200, 1450;~~
3. ~~Code of Federal Regulations, Title 40, Section 261 et seq.;~~
4. ~~California Code of Regulations, Title 8, Sections 3203, 4650, 5076, 5144, 5155, 5191, 5193, 5194;~~

5. ~~Title 22, Sections 66261 et seq., 12000;~~
6. ~~Title 17, Section 30100;~~
7. ~~Title 3, Section 6145 et seq., 6600 et seq.;~~
8. ~~California Health and Safety Code, Sections 117600 et seq.;~~
9. ~~NFPA 30.~~

- Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC.02.02.01
- Code of Federal Regulations, Title 29, Sections 1910.101-106, 120, 1000, 1030, 1200, 1450;
- Code of Federal Regulations, Title 40, Section 261 et seq.;
- California Code of Regulations, Title 8, Sections 3203, 4650, 5076, 5144, 5155, 5191, 5193, 5194;
- Title 22, Sections 66261 et seq., 12000;
- Title 17, Section 30100;
- Title 3, Section 6145 et seq., 6600 et seq.;
- California Health and Safety Code, Sections 117600 et seq.;
- NFPA 30.

AUTHORITY

The El Camino ~~Health~~Hospital Leadership Team provides vision, leadership, support, and appropriate resources to the program. In accordance with its bylaws, the El Camino ~~Health~~Hospital leadership has given the Central Safety Committee the authority to ensure that this plan is developed and implemented. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the Hazardous Materials and Waste Work Group.

PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. ~~**Clinical Laboratory:**~~Clinical Laboratory: Hazardous material and waste management in the Pathology and Clinical Laboratories, and the implementation of the Chemical Hygiene Plan, is the responsibility of the Laboratory Director/Manager.

B. ~~**Radiation Safety Committee:**~~Radiation Safety Committee: Radioactive materials and waste management is the responsibility of the site Radiation Safety Officer and the Radiation Safety Committee.

C. ~~**Hazardous Materials and Waste Management Workgroup:** The~~ Hazardous Materials and Waste Management Workgroup: The Hazardous Materials and Waste Management Workgroups or designee in collaboration with the Central Safety Committee is responsible for the overall management of the hazardous materials and waste program. These include:

   - ~~Coordinating the initial assessment of risks,~~
   - ~~Program design,~~

- ~~Developing the facility's written plan and program objectives for each year,~~
- ~~Establishing, monitoring and assessing Performance Improvement dimensions~~
- ~~Identifying training needs,~~
- ~~Regulatory tracking/interpretation,~~
- ~~Assistance with departmental implementation,~~
- ~~Initial response investigation and reporting of significant events, and~~
- ~~Program evaluations.~~

1. Coordinating the initial assessment of risks,
2. Program design,
3. Developing the facility's written plan and program objectives for each year,
4. Establishing, monitoring and assessing Performance Improvement dimensions
5. Identifying training needs,
6. Regulatory tracking/interpretation,
7. Assistance with departmental implementation,
8. Initial response investigation and reporting of significant events, and
9. Program evaluations.

D. ~~**Central Safety Committee (CSC):**~~Central Safety Committee (CSC): The CSC, as part of the standing agenda, receives and reviews reports and summaries of actions taken related to Hazardous Materials and Waste Management. The Committee also identifies and analyzes issues and seeks there timely resolution. Agenda items include~~:~~

- ~~Issues requiring action, recommendations or approval,~~
- ~~Issues requiring monitoring/periodic or ongoing review,~~
- ~~Needs that are multi-disciplinary in nature,~~
- ~~Regulatory updates, and~~
- ~~Performance Data review.~~

:

1. Issues requiring action, recommendations or approval,
2. Issues requiring monitoring/periodic or ongoing review,
3. Needs that are multi-disciplinary in nature,
4. Regulatory updates, and
5. Performance Data review.

RISK ASSESSMENT:

Risks associated with the management of hazardous materials and wastes are typically identified and assessed through facility-wide processes, such as routine safety rounds , product inventory

management, the facility''s Safety Trends reports, Central Safety Committee review, and ~~the incident reporting application~~i-safe evaluations. The risk profile with respect to hazardous wastes includes, but is not limited to: risk of occupational and occupant exposures; fires and chemical reactions; releases; nosocomial infections; and legal exposures.

Key factors driving the level of relative risk include the likelihood of an unwanted event coupled with the magnitude of the consequences. These factors are typically associated with the volume of chemical substances, constituents, inherent physical or chemical properties, concentration and handling practices, as well as invasive procedures involving blood or other potentially infectious materials and waste handling. Identified high risk areas to which additional resources and attention are directed are listed below.

- Clinical Laboratories and the Pathology ~~department~~Department
- The Operating Room
- Sterile Processing department
- Material Management
- Facility Engineering
- Pharmacies
- Environmental Services (EVS)
- Gastroenterology (GI)
- Oncology/Hematology
- Radiology
- High volume patient care areas

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

The plan provides processes for the following.

A. The facility developed and maintains an inventory that identifies hazardous materials and waste used, stored, and generated using criteria consistent with applicable laws and regulations as follows:

- ~~A Hazardous Materials Business Plan is kept current in accordance with local and state regulations and ordinances.~~
- ~~The facility's policy and procedure requires each department to update a department chemical inventory.~~

1. A Hazardous Materials Business Plan is kept current in accordance with local and state regulations and ordinances.
2. The facility's policy and procedure requires each department to update a department chemical inventory.

B. Selection, handling, and use of hazardous materials and waste: Products and substances

containing chemical constituents deemed to be hazardous will be identified, evaluated and listed by recognizable names within department-specific inventories. Department managers (in conjunction with the EH&S Manager) will evaluate waste streams to ensure waste materials from all processes, procedures and operations are correctly characterized and classified, per regulatory criteria. Department programs include waste minimization components, such as procurement and inventory control. For each hazardous material used and handled, the department manager will provide a corresponding Safety Data Sheet (SDS). These documents will remain readily available to employees at all times and should form the basis for department-specific training and written procedures for proper handling, storage, safe use and spill procedures. Containers of hazardous substances are labeled in accordance with applicable regulations with appropriate hazard communication and expiration dates.

C. The facility monitors use and disposal of hazardous gases and vapors including, but not limited to:

- ~~Formaldehyde~~
- ~~Various compressed gas cylinders, including oxygen, medical air, nitrous oxide and nitrogen.~~

1. Formaldehyde
2. Various compressed gas cylinders, including oxygen, medical air, nitrous oxide and nitrogen.

D. Hazardous Materials and waste emergency procedures address the following:

- ~~Incidental and major spills: Emergency procedures and materials are implemented that provide preventative, precautionary measures, response procedures, and appropriate personal protective equipment (PPE). The EH&S Manager participates with department managers in the development and implementation of emergency procedures.~~
- ~~Small, relatively innocuous hazardous material spills: These spills are addressed by the individual causing or discovering the spill or appropriately trained staff. The containment materials will be used for proper spill cleanup.~~
- ~~Large spills: These spills will be handled by contracted vendor and/or emergency response agency personnel. In the event of a release or exposure involving radioactive materials, the Radiation Safety Officer will immediately be notified and will coordinate the response.~~
- ~~Clean-up procedures: Department managers will ensure that appropriate spill procedures and spill control materials are readily available for use within close proximity of where hazardous substances are stored, used or handled. Additionally, facilities engineering maintains a chemical spill cart to supplement existing spill materials and PPE.~~
- ~~Personal protective equipment: Department managers will ensure that appropriate personal protective equipment (PPE) is readily available for use within close proximity of where hazardous substances are stored, used or handled. Exposure management equipment, materials, suppression systems, alarm systems and other features of the hazardous materials and waste management program are inspected and maintained primarily through Facilities Services, in concert with the EH&S~~

~~Manager. Examples include, but are not limited to:~~

- ~~Mechanical ventilation~~
- ~~Administrative controls~~
- ~~Personal Protective Equipment (PPE)~~
- ~~Periodic exposure monitoring for operations that involve the handling of solvents, reagents, fixatives and other chemicals that may produce fugitive emissions, volatilize or otherwise off-gas into occupied spaces and/or work areas.~~ ~~**(See PM records and monitoring records).**~~

- ~~Personnel monitoring, system assessments, local exhaust ventilation/scavenger units and alarm systems for the control of waste anesthetic gases (including nitrous oxide).~~
- ~~Reporting and investigation of hazardous materials incidents:~~

~~The EH&S Manager will ensure all releases and exposure incidents are duly investigated and reported to the Central Safety Committee and appropriate agencies.~~

1. Incidental and major spills: Emergency procedures and materials are implemented that provide preventative, precautionary measures, response procedures, and appropriate personal protective equipment (PPE). The EH&S Manager participates with department managers in the development and implementation of emergency procedures.
2. Small, relatively innocuous hazardous material spills: These spills are addressed by the individual causing or discovering the spill or appropriately trained staff. The containment materials will be used for proper spill cleanup.
3. Large spills: These spills will be handled by contracted vendor and/or emergency response agency personnel. In the event of a release or exposure involving radioactive materials, the Radiation Safety Officer will immediately be notified and will coordinate the response.
4. Clean-up procedures: Department managers will ensure that appropriate spill procedures and spill control materials are readily available for use within close proximity of where hazardous substances are stored, used or handled. Additionally, facilities engineering maintains a chemical spill cart to supplement existing spill materials and PPE.
5. Personal protective equipment: Department managers will ensure that appropriate personal protective equipment (PPE) is readily available for use within close proximity of where hazardous substances are stored, used or handled. Exposure management equipment, materials, suppression systems, alarm systems and other features of the hazardous materials and waste management program are inspected and maintained primarily through Facilities Services, in concert with the EH&S Manager. Examples include, but are not limited to:
    a. Mechanical ventilation
    b. Administrative controls

c. Personal Protective Equipment (PPE)

d. Periodic exposure monitoring for operations that involve the handling of solvents, reagents, fixatives and other chemicals that may produce fugitive emissions, volatilize or otherwise off-gas into occupied spaces and/or work areas. **(See PM records and monitoring records).**

6. Personnel monitoring, system assessments, local exhaust ventilation/scavenger units and alarm systems for the control of waste anesthetic gases (including nitrous oxide).

7. Reporting and investigation of hazardous materials incidents:

   The EH&S Manager will ensure all releases and exposure incidents are duly investigated and reported to the Central Safety Committee and appropriate agencies.

E. Documentation is maintained that includes required permits and licenses in Facility Services

F. As prescribed by governmental standards, hazardous waste is manifested for transport to a permitted, licensed treatment, storage and disposal facility (TSDF), by a licensed contracted hazardous waste hauler in accordance with applicable regulations (See Manifests).

G. Hazardous materials and waste are properly labeled in accordance with pertinent laws and regulations i.e. DOT shipping requirements, NFPA Placards, Title 22, etc.

H. Hazardous materials and waste storage and processing areas are separated from other areas of the facility as follows:

- Where hazardous materials or wastes are stored, physical barriers separate incompatible materials. Applied release prevention measures include diversionary structures, bins, tubs, berms, secondary containment, etc. Hazardous materials are used and stored under adequate general ventilation or local exhaust ventilation.
- Hazardous wastes are collected and accumulated on site in a main accumulation area and in satellite accumulation areas near the point of generation. These accumulation areas are provided with structural features, containers, signage, equipment, and supplies conducive to occupational safety, spill prevention and control, and environmental protection **(Hazardous waste storage area inspection check list).**
- Bio-hazardous waste is contained within rigid, leak resistant, labeled containers; accumulated on-site within secured and designated areas. Sharps waste is transported by a licensed hauler and incinerated by a permitted facility. Regulated medical (bio-hazardous and sharps) waste is segregated from solid municipal wastes at the point of generation.

I. Education and Training:

   All employees attend General Hospital Orientation at the time of hire and annual training where general information and education regarding the management of hazardous materials and wastes is provided. Departments will also conduct training that is specific to processes, materials; precautions and relative risk associated with job function and work practices, to

include:

1. Elements of the written programs, interpretation of labeling and hazard warning systems, specific SDS information (physical and health hazards, precautions), proper storage, waste Management, emergency procedures and incident reporting (including spills, releases and exposures);
2. Department manager(s) will verify that each employee possesses the required core competencies relative to the safe and effective use of products and substances deemed hazardous;
3. Technical consultative support is provided through the Safety and Security Services Department, as requested;
4. The education department and each department manager will periodically revisit their training materials and modify, adjust and improve, as indicated, to reflect:
    - ~~Organizational experiences and learning~~
    - ~~Results of risk assessments, hazard surveillance rounds, audits, inspections~~
    - ~~Changes in pertinent regulations, codes or standards~~
    - ~~Recommendations from the Central Safety Committee or the Safety and Security Services Department~~

    a. Organizational experiences and learning
    b. Results of risk assessments, hazard surveillance rounds, audits, inspections
    c. Changes in pertinent regulations, codes or standards
    d. Recommendations from the Central Safety Committee or the Safety and Security Services Department

PERFORMANCE:

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Integrated Safety Committee recommendations.

A. Intent and Requirement: To monitor, assess and improve staff knowledge, skills and competencies with respect to hazardous materials and waste.

B. The FY-~~2022~~2025 Performance Improvement Indicators are as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
~~Hazardous Materials Management~~**Hazardous Materials Management**	Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes) ~~minutes~~	Safety	>95%
~~Hazardous Materials~~	Staff can describe the process for	Safety	>95%

~~Management~~**Hazardous Materials Management**	accessing a ~~Safety~~safety data sheet.		

C. Process and Frequency of Measurement

Data will be collected through safety rounds.

PROGRAM EFFECTIVENESS:

The Central Safety Committee evaluates the effectiveness of the program, including the appropriateness of design, outcomes of implementation; training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action(s) taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the hazardous materials and waste program to include: hazardous surveillance results; inspections by regulatory agencies; spills, releases or other emergencies; management of the hazardous waste accumulation area; occupational exposures to hazardous materials; and hazardous materials and waste reduction efforts.

ANNUAL PROGRAM EVALUATION:

On an annual basis, the Hazardous Materials and Waste program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Integrated Safety Committee and the Safety Officer.

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

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

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.

Environment of Care - Hazardous Materials Management Plan

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Patient and Employee Safety	Delfina Madrid: Quality Data Analyst	11/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	10/2024
Hazardous Materials Work Group	Lorna Koep: Director Environmental Svcs	03/2023
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> Changed program goals and objectives. updated performance indicators for FY23

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Environment of Care - Hazardous Materials Management Plan

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> Per email from Matt Scannell to use updated word version.

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> Approved by PESC 11/15/24

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Last Approved	N/A	Area	Environmental Services
Effective	Upon Approval	Document Types	Scope of Service
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Next Review	3 years after approval		

Scope of Service Environmental Services

Types and Ages of Patients/Clients Served

The Environmental Services Department serves El Camino Health inpatients/residents, outpatients, visitors and hospital personnel of all ages.

Assessment Methods

The primary purpose of the Environmental Service Department is to maintain a clean, aseptic, and aesthetically attractive hospital for the comfort and protection of patients/residents, visitors and hospital personnel. These goals are continuously assessed by Infection/Environment of Care team rounds, department performance improvement (PI), nursing rounds, and administrative rounds.

Scope and Complexity of Services Offered

The Environmental Services staff consists of environmental services, laundry services, and unit support personnel qualified to perform the services as outlined by the department. The following is an outline of the duties and responsibilities of the Environmental Services Department.

Environmental/Unit Support/ Laundry Services	**Additional Unit Support Services**
Patient/ room cleaning	Vocera operation
Discharge patient/ room cleaning	Patient/~~resident~~Non -Patient transport
UV Light disinfection cleaning	Morgue transport
Non-patient area cleaning	iCare/EPIC use for discharge room cleaning and patient and non-patient transport

Carpet care/cleaning	24 Hour availability of patient food
Sanitize hallway floors	Laboratory - Blood Bank units, and designated specimens
Restroom cleaning	~~Maternal Child Health late tray deliveries~~
Wall washing	
Care of equipment	
Stripping and refinishing	
Housekeeping safety	
Window/glass cleaning	
Curtain/Cubical cleaning	
Bed making	
Cleaning of Central Supply	
Medical Office Building	
Pest control	
Infection control	
Hand and glove washing	
Nursery cleaning	
Cleaning of Labor and Delivery	
Cleaning of ~~Surgery~~Procedural areas	
Regular waste disposal	
Recycling waste disposal Confidential Waste disposal	
Medical waste disposal	
Linen distribution	

Appropriateness, Necessity, and Timeliness of Services

Please refer to the standard policy and procedures manual for detailed information for timeliness of services, hours of operation, how to contact the department for immediate service, special projects, audio visual equipment, and outside services i.e. pest control, window cleaning.

Staffing

The Environmental Services Department is staffed 24 hours a day, seven days a week with environmental services and unit support employees, and eight hours a day, seven days a week with linen services.

Level of Service Provided

The level of service provided is consistent with patient/residents needs and the needs of all the hospital departments and the medical office building. Performance improvement and quality control activities are in place to measure and access the degree to which the department meets patient/resident and hospital department needs.

Standards of Practice

The Environmental Services Department is governed by state regulations, such as Title 22, Joint Commission on Accreditation of Healthcare Organizations standards, and the American Society of Environmental Services.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Department Medical Director or Director for non-clinical Departments	Lorna Koep: Director Environmental Svcs	11/2024
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> no major changes to the policies, aside from grammatical and wording adjustments for clarity and consistency.

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Owner	Manvir Nijjar: Director Heart & Vascular Institute
Area	Scopes of Service
Document Types	Scope of Service/ADT

Scope of Service - Norma Melchor Heart & Vascular Institute

Types and Ages of Patients Served

The Norma Melchor Heart & Vascular Institute (HVI) is a cardiovascular service line at El Camino Hospital. The HVI is an oversight body that provides comprehensive services to adults with cardiovascular disease. Services focus on the coordination and treatment throughout the trajectory of care for cardiovascular patients. Types of patients served are described in the scope and complexity of services offered section.

Assessment Methods

Patient assessment and care is provided by multiple professionals including interventional cardiologists, cardiologists, cardiothoracic surgeons, advanced nurse practitioners, registered nurses, care coordinators, social workers, nutritionists, cardiac rehabilitation, pharmacists and other healthcare professionals, as appropriate and according to the scope and dictates of their professional practice.

Scope and Complexity of Services Offered

The HVI is located at 2500 Grant Road, First Floor, Mountain View, California.
Routine operating hours will be posted within the facility.

HVI provides services in the following clinical sub-programs:

- Acute Coronary Syndrome & Chest Pain Center
- Heart Failure

- Electrophysiology
- Vascular - Interventional and Surgical
- Cardiac and Pulmonary Wellness Center
- Cardiothoracic Surgery & Transcatheter Valve Repair / Replacement

The following services are provided:

- Develop and revise administrative policies and procedures related to clinical sub-programs.
- Develop and enhance clinical sub-programs to promote high quality and safe patient care for cardiovascular patients.
- Facilitate CME Education Program for ongoing physician and staff education.
- Monitor quality and outcomes metrics to guide performance/quality improvement projects.
- Utilize registry data, quality, and outcomes metrics to advise and guide departments for performance improvement initiatives.
- Respond to cardiovascular quality related incidents, investigate and/or report potential patient safety and quality issues for review.
- Manage cardiovascular service line related accreditations:
    - Chest Pain Center with PCI by Society of Cardiovascular Patient Care
    - STEMI Receiving Center by the Santa Clara County Emergency Medical Services
    - Intersocietal Commission for the Accreditation of Echocardiography Labs
- Chair and participate in clinical sub-program meetings and committees
- Evaluate strategic, business development of new clinical sub-programs and recommend strategies for service line growth.
- Recommend evidence based cardiovascular patient care to affected departments related to the service line and implement via standardized order sets.
- Develop community outreach programs for prevention, continuity of care, and increased awareness of cardiovascular issues.

Appropriateness, Necessity and Timeliness of Services

The HVI Physicians, advanced practice nurses, and physician assistants assess the appropriateness, necessity and timeliness of service, according to department specific guidelines and ECH policies and procedures.

The HVI Clinical Data Specialists collect and report quality metrics to appropriate committees and councils.

Staffing/Staff Mix

Each sub-program is overseen by a medical director, advanced practice nurse, ~~quality manager,~~ and clinical systems specialist.

Each sub-program medical director reports to the medical director of the HVI.

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

- Medical Staff Office
- Quality Department
- Marketing
- Information Systems and Information Technology
- Purchasing and Finance
- Health Information Management Systems

Requirements for Staff

- All staff must complete hospital and department specific orientation.
- Safety/Emergency policies and procedures are reviewed annually by all staff.
- All Clinical Staff will be licensed/certified according to El Camino Hospital Policies and Procedures.

Level of Service Provided

The HVI Service Line provides services under hospital and departmental policy and procedure guidelines.

Standards of Practice

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

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

Scope of Service - Norma Melchor Heart & Vascular Institute

MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Department Medical Director or Director for non-clinical Departments	Manvir Nijjar: Director Heart & Vascular Institute	11/2024
	Manvir Nijjar: Director Heart & Vascular Institute	11/2024

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> eliminated quality manager from the staffing structure as this role does not exist

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Area	Scopes of Service
Document Types	Scope of Service/ADT

Scope of Service - Wound Care Center

A. **Types and Ages of Patient Served**

The Wound Care Center (WCC) is an outpatient department of El Camino Hospital (ECH). The WCC provides comprehensive and coordinated wound care to outpatient adults eighteen years of age and older. WCC focuses on the assessment and treatment of adults with the goal of optimizing complex wound healing in adults of all ages. Types of patients served are described in the scope and complexity of services offered below.

B. **Assessment Methods**

Patient assessment and care is provided by physicians, Wound Ostomy Certified Nurses (WOCNs) registered nurses and licensed vocational nurses as appropriate and according to their scope of practice. The Clinical Manager (RN) provide direct supervision to the registered nurses, licensed vocational nurse, and medical assistant in the provision of patient care.

C. **Scope and Complexity of Services Offered**

The WCC is located at 2660 Grant Road, Suite F, Mountain View, California. The WCC operating hours are Monday - Friday from 8 am to 4:30 pm. WCC facility is not open on weekends or holidays recognized by El Camino Hospital. Physicians are not available after the WCC operating hours and patients are instructed to contact their primary MD if needed during those hours or to go to the Emergency Room if in need of urgent attention

The WCC has exam rooms for clinical examinations and moderate to complex procedures. Each room is equipped with the necessary supplies with sharps and topical medications secured in the rooms in a locked medication cart.

- Dirty instruments are ~~removed from the exam~~treated with a surfactant-based cleaner,

PreKlenz, at the point of care. The instruments are then taken to the dirty utility room ~~after the patient visit and sprayed with enzymatic cleaner in the dirty utility room~~ and placed in the red bin for collection.

- Topical medications are labeled with the date opened and date to be discarded
- The WCC will follow the pharmacy policy multidose medications, by discarding at 28 days

A. The WCC clinical schedule and patient records are maintained in an electronic health record by trained staff.

The following services are provided:

- Comprehensive wound assessment for etiology and characterization of wounds
- Appropriate tissue debridement as indicated
- Application of suction devices, compression devices/dressings or therapeutic tissue substitutes when indicated
- Product samples are not allowed in the WCC
- Prescribing of oral medications, topical treatments and dressing protocols and referral for diagnostic testing and procedures when appropriate

Patient care is given as directed and prescribed by the physician. The medical staff working in the WCC will have hospital privileges on file in the ECH Medical Staff Office. Staff communicates specific patient needs and coordinates treatment and plan of care with referring and consultative physicians. Services and treatments provided according to department specific procedures and guidelines and ECH policies and procedures.

B. **Staffing/Staff Mix**

A Clinical Manager (RN) oversees the clinical operations of the Wound Care Center and reports to the Department Director and the Medical Directors. Physicians provide direct care and assessment with the assistance of the WOCN and/or LVN. WCC staffing will be determined by patient volume and patient needs.

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

C. **Requirements for Staff**

- All staff must complete specific orientation.
- The Health Stream safety series as well as Safety/Emergency policies and procedures are reviewed annually by all staff.
- Specific competencies related to wound care are included in the required Health Stream modules
- All clinical staff members are required to be Basic Life Support certified.
- All clinical staff will be licensed according to ECH policies and procedures and by the State of California.

D. **Level of Service Provided**

The level of service is consistent with ambulatory wound care and treatment. The WCC is designed to advocate for and support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a caring and enduring partnership between the care team, patients and the patient's family.

E. **Standards of Practice**

WCC is governed by state regulations as outlined in Title 22, the Center for Medicare/Medicaid Services, and The Joint Commission.

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Approval Signatures

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Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
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Department Medical Director or Director for non-clinical Departments	Manvir Nijjar: Director Heart & Vascular Institute	11/2024
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> updated the cleaner used for dirty instruments and aligned verbiage/process to JC requirements.

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Scope of Service - Wound Care Center

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Area	Environment of Care
Document Types	Plan

Environment of Care Safe Environment Management Plan

COVERAGE:

This Safe Environment Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics. It covers all employees, contractors, volunteers, students, registry personnel and anyone working under the facility's auspices.

PROGRAM OBJECTIVES AND SCOPE:

El Camino Hospital and associated Outpatient Clinics are committed to providing a safe, accessible and effective Environment of Care (EOC), consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, employees and visitors. This plan describes a comprehensive facility-wide Safe Environment Management Plan that describes the process for:

A. ~~Identification and minimization of safety risks~~**Identification and minimization of safety risks**
B. ~~Maintenance of a safe environment~~**Maintenance of a safe environment**

Based on areas of improvement noted in the FY-~~20~~24 Annual Evaluation, ~~patient fall prevention/ assistance continues to be the most common, and rising cause of injury accounting for 35% of those reported in~~the primary FY~~20. The primary FY-21~~ 25 performance improvement project for Safety Management involves continuing revision of the initiatives to reduce work-related injuries to further focus on Staff Safety Management Systems. In particular, the focus is on ~~improving~~implementing strategies and process improvements to decrease our work -related ~~injury/illness resulting from assisted patient falls~~injuries related to BloodBorne Pathogen Exposures (BBPE).

~~A. Objectives:~~

~~Specific objectives of the FY-21 Safe Environment Management Plan include the following:~~

1. ~~The Patient- and Employee- Fall Prevention Committees continue to partner to identify opportunities for prevention. An after fall huddle/report is under consideration; training and provision of gait belts is being evaluated; sit/stand/walk aids encouraged; and 3 low frame beds are now available for fall risk patients.~~
2. ~~Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving communication is being strategized to promote equipment use and fall prevention.~~
3. ~~Deploy new Accident Injury & Exposure Report (AIER) utilizing the RLDatix system.~~

OBJECTIVE:

Specific objectives of the FY-25 Safe Environment Management Plan include the following:

A. **Reduce BloodBorne Pathogen Exposure OSHA Recordable employee injuries by 10% from FY-24 baseline.**

REFERENCES:

~~A. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .02.01.03, .02.06.01, Code of Federal Regulations, Title 29, Sections 1910 et seq., 1910.1450~~

~~B. California Code of Regulations, Title 8, Sections 3203 et seq., 5191;~~

~~C. California Code of Regulations, Title 22 70837, 70739.~~

- **Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .02.01.03, .02.06.01, Code of Federal Regulations, Title 29, Sections 1910 et seq., 1910.1450**
- **California Code of Regulations, Title 8, Sections 3203 et seq., 5191;**
- **California Code of Regulations, Title 22 70837, 70739.**

AUTHORITY:

In accordance with its bylaws, the El Camino Hospital Leadership has given Employee Wellness and Health Services (EWHS) and the Central Safety Committee (CSC) the authority to ensure that the plan is formulated appropriately and carried out effectively. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the EH&S Manager and the Safety and Security Director in collaboration with EWHS. EH&S Manager and the Safety and Security Director in concert with EWHS and the Central Safety Committee has oversight over the Workplace Safety Program, which includes reducing injuries and workers compensation claims.

PROGRAM ORGANIZATION AND RESPONSIBILITIES:

A. **El Camino Hospital Leadership Team**

The hospital leadership team provides the program vision, leadership, support and appropriate resources to ensure environmental health and safety.

B. **Environmental, Health and Safety Manager and Safety and Security Director** collaborate to compile reports submitted to the Central Safety Committee,

C. **Hospital Safety Officer: Ken King**

- ~~Has the authority to intervene whenever conditions pose an immediate threat to life or health, or property damage.~~
- ~~Is appointed by the hospital CEO.~~
- ~~Provides to the Executive Committee annual summary reports, Issues identified by the CSC, and policies and procedures as applicable for Executive Committee review.~~

1. Has the authority to intervene whenever conditions pose an immediate threat to life or health, or property damage.
2. Is appointed by the hospital CEO.
3. Provides to the Executive Committee annual summary reports, Issues identified by the CSC, and policies and procedures as applicable for Executive Committee review.

D. **Central Safety Committee (CSC)**

The CSC ensures that the safe environment program remains in alignment with the organization's core values, goals and social purpose by providing direction, determining priorities, and assessing/approving program changes. The Central Safety Committee provides a forum for and ensures the timely resolution of action items, issues, and risks. This committee also addresses recommendations, grants approvals, leverages issues, and develops program imperatives. The charter of the CSC is to:

- ~~Develop strategic goals and annual performance targets relative to the environment of the Hospital~~
- ~~Carry out analysis and seek resolution of Environment of Care Management issues,~~
- ~~Prioritize goals and resources,~~
- ~~Ensure coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, and~~
- ~~Establish and approve infrastructures to support Performance Improvement techniques.~~

1. Develop strategic goals and annual performance targets relative to the environment of the Hospital
2. Carry out analysis and seek resolution of Environment of Care Management issues,

3. Prioritize goals and resources,
4. Ensure coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, and
5. Establish and approve infrastructures to support Performance Improvement techniques.

E. **Department Managers**

Department Managers are responsible for the provision of a safe working environment for staff, patients, and visitors through full implementation of established EOC programs. This responsibility can include the identification of occupational risks, staff training, the development and management of specific safety policies and procedures, and injury investigation.

F. **Employees**

All employees are responsible to participate in safety training, as required, as well as to demonstrate core competencies in the given subject matter. Employees must ensure their behaviors, work practices and operations are safe, responsible and in alignment with facility and departmental procedures, applicable training and the provisions of this plan.

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE:

Implementation of the safety plan is contingent upon the incorporation of safety principles into the culture and routine clinical and business practices at all levels of the organization. Another imperative of successful program implementation is the integration of cross-functional management systems and processes that relate to the environment provided for members, employees and visitors, as well as aspects of public health and environmental protection. These program components and processes are coordinated through the Safety Officer and processes are monitored through the Central Safety Committee. They include:

A. Supervision of all grounds and equipment through the implementation of the Safe Environment Program, Fire Prevention Program, Security Management Program, Hazardous Materials and Wastes Program, Medical Equipment Management Program and Utilities Management Program and an ongoing Hazardous Surveillance Rounds process.

B. Risk Assessments, which proactively evaluate the impact of building, grounds, equipment occupants and internal physical systems on patients and public safety, are accomplished primarily through the use of Hazard Surveillance Rounds.

C. The Central Safety Committee, whose make-up includes Administration, Clinical Services, Operation Support Services, Physicians and other appropriate organizational representatives, examines safety issues, including failures, exposures, personal injury and hazards.

D. Incidents ~~ofstaff~~of staff, patient and/or visitor injuries and incidents, attributed to environmental conditions or safety hazards are reported and investigated through Risk Management and EH&S departments and reported to the Central Safety Committee.

E. Occupational injury, illness and exposure data is monitored and tracked on an ongoing basis these include the following:

- ~~Historical Workers' Compensation data.~~
- ~~Injury frequencies by type~~
- ~~Injuries by department~~
- ~~OSHA "recordable" injuries~~
- ~~Ergonomic/Repetitive Motion Injuries~~

1. Historical Workers' Compensation data.
2. Injury frequencies by type
3. Injuries by department
4. OSHA "recordable" injuries
5. Slips/Trips/Falls related injuries
6. Patient Handling related injuries

F. Effective, ongoing surveillance, inspection and testing of operational safety elements and components of the environment is achieved through the use of Safety Rounds coordinated by the EH&S Manager, supply and equipment recalls and alerts (shared by ~~Materiel~~Material Management and Clinical Engineering) and preventive maintenance surveys conducted by engineering. Hazard Surveillance Rounds are conducted at least semi-annually in areas where patients are served and annually in other areas.

G. Product safety recalls - Recall notices are sent from the vendor, Clinical Technology or Material Management Departments. Notices are forwarded to department managers for follow up and resolution. Documentation is kept by departments and reported to the Central Safety Committee monthly by Clinical Technology or Materials Management.

H. Patient safety is evaluated through hazard surveillance, utilities and equipment preventative maintenance, and incident reports.

I. Safety Educational Programs are implemented through the development, review, and evaluation of education programs designed to promote health, safety and environmental regulatory compliance.

1. All employees at the time of hire are required to attend General Hospital Orientation. This includes information presented by EH&S personnel, where general information and education regarding the environment of care and safety are provided.
2. At the department level, training is specific to processes, materials, precautions and work practices/behaviors relative to the individual job functions and risks (can include roles during safety inspection, accident/incident reporting, notification and recall processes, preventative maintenance and correct use of equipment). Department managers will verify that each employee possesses the required core competencies with respect to safety and the environment of care. Technical consultative support is provided through EH&S.
3. Human Resources, EH&S and department managers will periodically revisit their training materials and modify, adjust and improve as indicated, to reflect:

- ~~The results of education and training needs assessments as determined through employee interview and written test/quiz scores and determinations made by the Central Safety Committee.~~
- ~~Organizational experiences and learning, including relevant performance indicator results reported and discussed by the Central Safety Committee.~~
- ~~Results of risk assessments, environmental hazard surveillance rounds, audits, inspections and environmental and industrial hygiene monitoring.~~
- ~~Injury/illness trends.~~
- ~~Changes in applicable laws, regulations, codes or standards.~~
- ~~Integrated Safety Committee or EH&S manager recommendations.~~
- ~~Continuing education in Environment of Care areas will be conducted at least annually utilizing the on line safety fair, or presentations by manager or technical expert.~~

a. The results of education and training needs assessments as determined through employee interview and written test/quiz scores and determinations made by the Central Safety Committee.

b. Organizational experiences and learning, including relevant performance indicator results reported and discussed by the Central Safety Committee.

c. Results of risk assessments, environmental hazard surveillance rounds, audits, inspections and environmental and industrial hygiene monitoring.

d. Injury/illness trends.

e. Changes in applicable laws, regulations, codes or standards.

f. Integrated Safety Committee or EH&S manager recommendations.

g. Continuing education in Environment of Care areas will be conducted at least annually utilizing the on line safety fair, or presentations by manager or technical expert.

J. The mandatory training and education program provides required EOC elements, to include Safe Environment, Fire Prevention, Secure Environment, Medical Equipment, Utility Management, Hazardous Materials & Waste Management, Emergency Management, and Infection Control.

K. Department specific safety plans are used to detail the specific hazards, safety precautions, and emergency plans for that area.

L. Management of Hazardous Materials and Waste is conducted in a manner that controls risks of harm as well as ensures compliance with applicable legal requirements. Program implementation will include employee training, identification and inventory of the hazardous materials and the identification and management of hazardous waste streams.

M. Identifying and addressing significant concerns pertaining to the management of equipment, utilities and facility grounds.

N. The establishment of an effective Emergency Management program which is written using a multi-hazard functional planning approach and is based on the nationally recognized "Hospital

Incident Command System" model. Semi- annual exercises are conducted to test program effectiveness.

O. No Smoking Policy: El Camino Hospital has a facility-wide no-smoking policy. No smoking is allowed on the campus property. Smoking cessation education, information, and options are provided to patients who smoke. Security, along with the entire medical center staff monitors compliance with this smoking policy.

P. Other Environmental Considerations:

1. The hospital will plan, develop and maintain an environment that is safe, supports healing assists in achieving positive patient outcomes and consistently meets patients' needs.
2. Facility Services, with Administration, EH&S, and Infection Prevention will ensure planning for remodels, renovations, alterations, modifications and new facilities takes into consideration appropriate space, equipment, privacy, utility systems, etc.
    a. Design criteria for size configurations, equipment, utilities and life safety systems will include:
        - ~~Office of Statewide Health Planning and Development (OSHPD) permitting protocols~~
        - ~~Uniform Building Code- 24 CCR, section 420A et seq~~
        - ~~AIA Guidelines for Design and Construction of Health Care Facilities~~
        - ~~Life Safety Code- NFPA 101~~
        - ~~Standards, specifications and criteria referenced by health care community or industry consensus~~

        i. Office of Statewide Health Planning and Development (OSHPD) permitting protocols
        ii. Uniform Building Code- 24 CCR, section 420A et seq
        iii. AIA Guidelines for Design and Construction of Health Care Facilities
        iv. Life Safety Code- NFPA 101
        v. Standards, specifications and criteria referenced by health care community or industry consensus

    b. Appropriateness of Space, Furnishings, and Equipment:

    ~~Facilities Services will work with Nursing and Administration to make certain the design of remodeled areas and new spaces and the maintenance of existing areas are comfortable, safe, and aesthetically pleasing.~~
    ~~Engineering maintains utilities and services to ensure the mechanical ventilation system provides acceptable levels of temperatures, relative humidity and removal of odors. Adequate space is provided within patient rooms for personal property, clothing and grooming articles.~~

i. Facilities Services will work with Nursing and Administration to make certain the design of remodeled areas and new spaces and the maintenance of existing areas are comfortable, safe, and aesthetically pleasing.

ii. Engineering maintains utilities and services to ensure the mechanical ventilation system provides acceptable levels of temperatures, relative humidity and removal of odors. Adequate space is provided within patient rooms for personal property, clothing and grooming articles.

iii. Appropriate Privacy and Confidentiality

Facilities Services and clinical staff will ensure appropriate confidentiality, auditory and visual privacy. Efforts to accomplish this include:

- Space & equipment arrangement
- Privacy curtains and partitions
- Assisting patients (when appropriate) to don gowns while preserving patient privacy and dignity
- Access to telephones for private conversations (where clinically appropriate). Reasonable accommodations will be given to physically challenged patients
- White boards should only display patient information for staff members (no diagnostic, patient condition, disposition or other sensitive/personal information)
- Staff will respect the rights of patients and refrain from conversations involving medical condition, diagnoses, prognoses or any other personal information in open/public areas.
- Confidential patient documentation that is no longer needed will be managed in a secure and appropriate manner from the point of generation to final disposition.

c. ~~Appropriate Privacy and Confidentiality~~

~~Facilities Services and clinical staff will ensure appropriate confidentiality, auditory and visual privacy. Efforts to accomplish this include:~~

- ~~Space & equipment arrangement~~
- ~~Privacy curtains and partitions~~
- ~~Assisting patients (when appropriate) to don gowns while preserving patient privacy and dignity~~
- ~~Access to telephones for private conversations (where clinically appropriate). Reasonable accommodations will be given to~~

~~physically challenged patients~~

- ~~White boards should only display patient information for staff members (no diagnostic, patient condition, disposition or other sensitive/personal information)~~
- ~~Staff will respect the rights of patients and refrain from conversations involving medical condition, diagnoses, prognoses or any other personal information in open/public areas.~~
- ~~Confidential patient documentation that is no longer needed will be managed in a secure and appropriate manner from the point of generation to final disposition.~~

PROGRAM PERFORMANCE

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Central Safety Committee recommendations.

A. Intent and Requirement

To monitor, assess and improve staff knowledge, skills and competencies with respect to their roles and responsibilities to the Safe Environment Management Plan.

B. Performance Standard

The FY-~~21~~25 Performance Improvement ~~Indicators are~~Indicator is:

~~EOC Area~~	~~Indicator~~	~~Responsible Dept./Function~~	~~Target~~
~~Safety~~	~~Reduce employee injuries related to assisted patient falls.~~	~~EWHS / Fall Committee~~	~~Reduce injuries related to assisted patient falls by 25%.~~
~~Safety~~	~~Deploy new AIER injury reporting system under RLDatix~~	~~EWHS~~	~~We expect this implementation will increase end user satisfaction. Increase injury investigation completion within 3 days after the injury by 10%.~~

EOC Area	**Indicator**	**Responsible Dept./Function**	**Target**
Safety	**Reduce Blood-Borne Pathogen Exposure OSHA Recordable employee injuries 10% over FY24**	EWHS /EH&S	10% reduction over FY 24

C. Frequency of Measurement and Process

All injury data is collected through ~~Accident Injury and Exposure Reports (AIER~~Enterprise Health incident reports). Incidents will be reviewed by the applicable committee as appropriate for corrective actions and then reported to the Central Safety committee monthly.

EVALUATION OF PROGRAM EFFECTIVENESS:

Through the Safety Trends report and the Central Safety Committee, the effectiveness of the program, including the appropriateness of design, outcomes of implementation, training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the safety program to include: hazardous surveillance reports, occupational illness/injury investigation reports, staff educational surveys, security incidents, medical device incidents, fire drills, and disaster exercises

ANNUAL PERFORMANCE EVALUATION:

On an annual basis, the safe environment program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Safety Officer and approved by the Central Safety Committee.

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

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

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]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	11/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	10/2024
	Matthew Scannell: Director Safety & Security Services	06/2023

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Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 6/28/2023, 2:21PM EDT

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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.

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Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 12/27/2024, 11:30AM EST

> ePolicy 12/13/24

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Status **Pending** PolicyStat ID **16951386**

Origination	02/2018	Owner	Matthew Scannell: Director Safety & Security Services
Last Approved	N/A	Area	Security Management
Effective	Upon Approval	Document Types	Plan
Last Revised	10/2024		
Next Review	1 year after approval		

Environment of Care Security Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

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

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

A. ~~Goals -~~**Goals:**

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

1. 3 % reduction in the number of reportable workplace violence incidents over FY 2024.
2. 5 % reduction in the number of Code Greys over FY 2024

3. Security Officer response time to panic alarm less than 2 minutes.

B. ~~Objectives~~**Objectives:**

Specific objectives of the FY 2025 Secure Management Plan include the following:

1. ~~Specific objectives of the FY 2025 Secure Management Plan include the following:~~ Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess and control security risks, vulnerabilities, protect sensitive areas, and to track access control.
2. Complete the El Camino Health active shooter video.
3. Train all MHAS and ED staff on the Non Violent Crisit Intervention Mental Health program.
4. Continue to enhance the work with nursing to identify and proactively plan for potential Code Gray patients.
5. Use the Code Gray security reports to improve response with a focus of ensuring the safety of the staff and patients during these events.
6. Further, implement the Workplace Violence Plan to reduce workplace violence incidents.
7. Ensure timely and effective responses to security emergencies. Less than three minutes response time
8. Ensure quality and effective responses to service requests.
9. Report and investigate incidents of theft, vehicle accidents, threats, and property damage.
10. Ensure all users of the infant security system in the Women's hospital are trained on how to use the system.
11. Periodically inspect and test all security systems, devices, and equipment.
12. Promote security awareness and education on a quarterly basis.
13. Enforce various medical center rules and policies.
14. Establish and implement critical program elements to include measures to safeguard people, equipment, supplies, and medications and to control traffic in and around the Medical Center and the outlying medical offices.
15. Enforce our visitor ID program in various locations across both campuses.
16. Review and revise as needed post orders for security staff in the Taube, Sobrato and Orchard buildings.

SCOPE AND APPLICATION:

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

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

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

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

REFERENCES:

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

AUTHORITY:

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

PROGRAM ORGANIZATION AND RESPONSIBILITIES:

A. **Security Director:**

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

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

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

C. **Security Department:**

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

D. **Central Safety Committee (CSC):**

The CSC, comprised of clinical, administrative, operations support services, and labor representatives and other appropriate organizational representatives, ensures the Security management program remains in alignment with the core values and goals of the organization by providing direction, strategic goals, determining priority and assessing the need for change. The committee also ensures coordination, communication and appropriate integration of

performance improvement, strategic planning and injury prevention activities, including those of existing committees, sub-committees and organizational units and establishes and /or approves infrastructures to support Performance Improvement techniques.

E. **Department Managers:**

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

F. **Employees:**

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

RISK ASSESSMENT:

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

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

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

Handling areas, Laboratory, Nutritional Services, Nuclear Medicine, Hazardous Waste Storage area, and Medical Gas Storage areas.

PROGRAM EFFECTIVENESS:

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

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

PERFORMANCE:

EOC Area	Indicator	Responsible Dept./Function	Target
Security	3 % reduction in the number of reportable workplace violence incidents over FY 2024.	Security/WPV Committee	3 % decrease from FY 2024
Security	5 % reduction in the number of Code Greys over FY 2024	Security	5 % decrease from FY 2024
Security	Security Officer response time to panic alarm less than 2 minutes.	Security	Less than 2 minutes for each panic button activation.

ANNUAL PROGRAM EVALUATION:

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

- ~~The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.~~**The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.**
- ~~The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant policy and procedures, technology, and practices that add value and elements conducive to continuous regulatory compliance.~~**The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant policy and procedures, technology, and practices that add value and elements conducive to continuous regulatory compliance.**
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meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.

- ~~The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.~~**The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.**

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

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy	Patrick Santos: Policy and Procedure Coordinator	12/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	11/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	10/2024
	Matthew Scannell: Director Safety & Security Services	10/2024

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Environment of Care Security Management Plan

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> Per email from Matt Scannell to use revised word version; uploaded into system.

Last Approved by Scannell, Matthew: Director Safety & Security Services on 10/28/2024, 2:59PM EDT

Last Approved by Scannell, Matthew: Director Safety & Security Services on 10/28/2024, 2:59PM EDT

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Last Revised	12/2024
Next Review	3 years after approval
Owner	Gail Dammert: Clinical Director Outpatient Oncology
Area	Scopes of Service
Document Types	Scope of Service/ADT

Radiation Oncology Department Scope of Service

Types and Ages of Patients Treated

Radiation Oncology serves in-patients and outpatients **ranging from young adults to geriatrics, including emergency patients**. ***~~Remove underlined text: ranging from young adults to geriatrics, including emergency patients~~***.

Assessment Methods

Assessment and evaluation of service are identified by physical examination and appropriate diagnostic studies at initial consultation. In addition, patient's response to treatment is assessed at each follow-up visit following a course of radiation therapy. The Medical Director, his Physician Associates, and/or the Register Nurses (RNs) are responsible for clinical data collection, and medical assessment documentation. Quality assurance documentation and patient teaching is performed on an on-going basis, via Peer Review Sessions or Weekly Chart Rounds.

Scope and Complexity of Services Offered

Inpatient and outpatient treatments are performed in the same facility and with the same level of care. The Radiation Oncology Department provides treatment with external beam radiation, High-Dose Rate (HDR) ***~~Remove underlined text~~*** **~~and Low-Dose Rate (LDR)~~**and Low-Dose Rate (LDR) brachytherapy, ~~intracavitary~~radioisotope therapy, and Stereotactic Radiosurgery.

Appropriateness, Necessity and Timeliness of Services

Following initial diagnosis and work-up by the primary care physician, surgeon, or medical oncologist, the appropriate referral is made to Radiation Oncology. During the initial consultation, an assessment and evaluation of each patient's diagnostic studies are made. Appropriate treatment, if indicated, is discussed with the patient and their family members. Therapy is initiated in a timely manner, with a focus on ~~minimizing discomfort~~optimizing patient outcomes.

Staffing and Skill Mix

All therapeutic procedures are performed by or under the supervision of Radiation Oncologists who are board certified or eligible, and are members of the medical staff at El Camino Health. Radiation Therapists (RT) are licensed by the American Registry of Radiological Technologists (ARRT), and must be a graduate of an accredited radiation therapy program. Therapists must be licensed by the State of California, and possess their ACR license to administer radiation therapy treatments. They will be certified in Cardio Pulmonary Resuscitation (CPR). A Registered Nurse (RN) certified in BLS is available full time Monday through Friday to provide support and assistance to the Radiation Oncologist for all radiation oncology procedures. A Medical Assistant (MA) certified in CPR to provide support and assistance to the RN and Radiation Oncologist. Knowledge of chemotherapy drugs side effects and response in relation to radiation therapy is preferred. Assistance will be provided for all new patients, as well as follow-up patients. This will include emotional support, clinically assessing physical needs, and providing comfort measures.

Levels of Service Provided

Primary service hours are from 7:30 am to 4:30 p.m., Monday through Friday. Services are provided on weekends and holidays, on an emergent basis. Services are designed to meet patient needs by accurately and professionally evaluating the appropriate treatment in a timely manner. Performance improvement and quality control activities are in place to assess the degree to which radiation oncology services meet these needs. Radiation Oncology is designated as a 911 facility. For emergency medical service, 911 will be called for evaluation, treatment and transportation to the emergency room. Urgent care/emergent care assessment or treatment is not provided in this setting.

Standards of Practice and the Radiation Safety Officer

The Department of Radiation Oncology is governed by state regulations as outlined in Title 17 and Title 22. The department also follows guidelines set forth by the American College of Radiology and standards established by the Joint Commission on Accreditation of Healthcare Organizations. The Radiation Safety Officer or R.S.O. is a qualified candidate who is appointed by the Radiation Safety Committee and approved by the C.E.O. and the State of California. When he/she is not available, the radiologist "on-call", is designated as the Alternate Radiation Safety Officer. Additional practices are

described in department policy and procedure. ~~This manual is maintained within the department.~~

Medical Physicist and Dosimetry Services

A qualified medical physicist performs quality control procedures on all equipment used for treatment, including the simulator used to localize the intended treatment site. The physicist also provides dosimetry support, including weekly chart checks, quality assurance supervision, as well as all other medical physics support. Treatment planning computer systems are utilized to assist the physicist and/or dosimetrists in generating isodose therapy plans or calculations, as prescribed by the Radiation Oncologist.

Radiation Monitoring and the Radiation Safety Committee

An accurate record of all occupational radiation received by personnel, working in departments where radiation may be an occupational risk, is maintained. Both the medical physicist and the Radiation Safety Officer review the monthly occupational dosimetry reports. The Radiation Safety Committee, where the appropriate action is discussed and delineated, also reviews any exposure exceeding standard limits. El Camino Hospital is committed to an ALARA program, or "As Low As Reasonably Achievable" dose limits set forth by the State of California.

Cross References:

- Radiation Safety - Personnel and Medical Staff Monitoring and Dosimetry
- Radiation Safety - Radiation Protection Program

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2024

Radiation Oncology Department Scope of Service

Department Medical Director or Director for non-clinical Departments	Gail Dammert: Clinical Director Outpatient Oncology	11/2024
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> ePolicy 12/16/24 recommendation to remove last statement under standards of practice "manual in dept." Also to include cross-references to radiation safety documents.

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Scope of Service - Cancer Center Clinic

Types and Ages of Patient Served

The Cancer Center (CC) is an outpatient department of El Camino Hospital. The CC provides comprehensive and coordinated care to outpatient adults with an Oncology/Hematology diagnosis. Services focus on the coordination and treatment throughout the trajectory of care for an Oncology or Hematology diagnosis. Types of patients served are described in the scope and complexity of services offered section.

Assessment Methods

Patient assessment and care is provided by multiple professionals including physicians, nurse practitioner, registered nurses, social workers, nutritionists, and other ~~healthcare~~health care professionals, as appropriate and according to the scope and dictates of their professional practice.

Scope and Complexity of Services Offered

The Mountain View Cancer Center is located at 2505 Hospital Drive, First Floor, Mountain View, California. The CC facility is equipped to provide service for the anticipated ~~healthcare~~health care needs of the population served. Routine operating hours for the CC will be posted within the facility. Physicians will be available after CC operating hours as per the physician call schedule. The CC facility is not open on weekends or holidays recognized by El Camino Hospital.

The Los Gatos Cancer Center is located at 815 Pollard Ave., Los Gatos, California. The CC facility is equipped to provide service for the anticipated ~~healthcare~~health care needs of the population served. Routine operating hours for the CC will be posted within the facility. Physicians will be available after CC

operating hours as per the physician call schedule. The CC facility is not open on weekends or holidays recognized by El Camino Hospital.

The following services are provided: Oncology/Hematology disease management, treatment, episodic care for symptom management, nutritional assessments and education, social & psychological evaluations and counseling, and care coordination. Services and treatments provided according to department specific procedures and guidelines and ECH policies and procedures.

Care is given as directed and prescribed by the physician and care team. The medical staff working in the Cancer Center will have hospital privileges on file. Staff communicates patient needs, in addition to coordinating treatments and a plan of care with all ancillary departments and referring physicians.

Appropriateness, Necessity and Timeliness of Services

The CC Physicians, NP, and/or Clinical Manager assess the appropriateness, necessity and timeliness of service, according to department specific guidelines and ECH policies and procedures.

Staffing/Staff Mix

A Clinical Manager oversees the clinical operations of the Cancer Center and reports to the ~~Practice~~Clinical Director ~~and the Director of Medical Surgical Nursing~~. CC staffing will be determined by patient volume and patient needs.

Physicians and care team members provide direct patient care and assessment with the assistance of a ~~certified~~Certified Medical Assistant. The medical assistant~~. The medical assistant~~ performs the technical aspects of patient care within a defined scope of practice upon authorization and supervision of a physician.

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

Nurse Practitioner
Registered Nurse(s)
Community Outreach Coordinator
Licensed Social Worker
Registered Dietician

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

Requirements for Staff

- All staff must complete hospital and department specific orientation.
- Safety/Emergency policies and procedures are reviewed annually by all staff.

- All staff members are required to be BLS certified.
- All Clinical Staff will be licensed/certified according to El Camino Hospital Policies and Procedures.
- ~~MAs~~CMAs must have completed a training program and be currently certified/registered by an agency approved by the Medical Board of California.

Level of Service Provided

The level of service is consistent with ambulatory health care and treatment. The department is designed to advocate and support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a caring and enduring partnership between the care team, patients, and the patient's family.

Patient's progress is evaluated by the physician and members of the care team, as well as by the patient and family.

Standards of Practice

The Cancer Center is governed by state regulations as outlined in Title 22, standards established by The Joint Commission, and the Center for Medicare/Medicaid Services.

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Approval Signatures

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Scope of Service - Cancer Center Clinic

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Scope of Service Infusion Center - Mountain View

Types and Ages of Patient Served

The Infusion Center (IFC) serves individuals 18 years and older in the outpatient setting upon referral by their physician, and under the supervision of one of the Cancer Center Hematologists/Oncologists.

Assessment Methods

Nursing care is provided by ONS/ONCC Chemotherapy and ~~Biotherapy trained and certified~~Immunotherapy Certified Registered Nurses (RNs) utilizing the nursing process and the Oncology Nursing Society (ONS) Chemotherapy Administration Safety Standards. The Registered Nurses provide direct supervision to the Certified Medical Assistants (~~MAs~~CMAs) or Certified Nursing Assistant (CNA)in the provision of patient care.

Scope and Complexity of Services Offered

The Infusion Center is located in the Cancer Center at 2505 Hospital Drive, First Floor. Routine operating hours for the IFC are Monday through Friday, 8:30am to 6:30pm. Services are not available on weekends or holidays recognized by El Camino Hospital. The infusion center has 16 treatment chairs and two treatment gurneys in addition to an injection chair. Patients provide for and arrange their own transportation to and from the Infusion Center.

The following treatments are provided: chemotherapy ~~and~~, immunotherapy, biotherapy ~~infusion~~infusions; blood product transfusions, i.e., packed red cells, platelets, fresh frozen plasma, and albumin; hydration; electrolyte replacement; supportive therapies for patients undergoing chemotherapy; IVIG; iron infusions; bi-phosphonate infusions; central line management; therapeutic phlebotomies among majority

administered. Treatments requiring cardiac monitoring are not provided.

Care is given as directed and prescribed by the ~~physician~~MD/NP (Provider and Nurse Practitioner). Staff communicate specific patient needs and coordinate treatment and plan of care with all ancillary departments. A licensed ~~provider~~MD/NP with privileges at El Camino Hospital is on campus immediately available while patients are present in Infusion Center.

Additional services include (formal) patient education relating to individualized ~~chemotherapy~~ treatments and evaluating and providing resources within El Camino Hospital (i.e., wound care by WOCN and nutritional services) as well as the community (American Cancer Society, support groups, IV infusion companies, home health and hospice services).

Appropriateness, Necessity and Timeliness of Services

The Clinical Manager, ~~Nursing Unit Coordinator and~~ Charge nurse assess the appropriateness, necessity and timeliness of service. Concerns are addressed with Clinical Director for final decision if needed. The appropriateness of services is addressed in **Patient Care Services Policies and Services** which are established in collaboration with the medical staff.

Staffing/Staff Mix

A Clinical Manager oversees the broader operations of the Infusion Center and reports to Clinical Director/Nursing Administration. The ~~Nursing Unit Coordinator~~Charge RN oversees the day-to-day operations of the Infusion Center, is responsible for making sure there is adequate staffing for the unit, and reports to the Clinical Manager. A Charge nurse is assigned to each work day. The Charge nurse coordinates shift activities and ensures safe and efficient flow on the unit. A Registered Nurse (RN) with current ONS/ONCC Chemotherapy/~~Biotherapy~~Immunotherapy Certified provider card and chemotherapy administration competencies provide direct care with the assistance of a ~~medical assistant~~Certified Medical Assistant (MA) or Certified Nursing Assistant (CNA). Two RNs are present when any patient is on site. Staffing increases as volume increases.

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

Other El Camino Hospital clinical and support staff routinely providing services to patients in this area include:

- Laboratory technicians
- Clinical Pharmacists
- Clinical Oncology Dietitian
- ~~Oncology Coordinators~~Clinic Nurses
- Survivorship Program
- Genetic Counseling

- Massage Therapist (off site)
- Palliative Care
- Social Workers
- Wound Nurse (off site)
- Community Outreach Coordinator
- Spiritual Care Volunteers
- Cancer Center Volunteers
- Musician(s)

Requirements for Staff

- All staff is required to complete hospital-wide as well as unit-specific orientation. Competencies are completed annually, and staffs' Professional Profiles are maintained and kept on the unit.
- The Heath Stream safety series as well as Safety/Emergency are reviewed every year by all staff..
- All staff members are required to be ~~BCLS~~BLS certified.
- RNs must have a current California RN license, current ONS/ONCC Chemotherapy/~~Biotherapy~~Immunotherapy Certified provider card and current chemotherapy administration experience.
- All nurses in the infusion Center are encouraged to become certified as an Oncology Certified Nurse (OCN) within the first year of employment or when reach required hours by ONS to sit for exam.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the medical staff. The department provides medical care as prescribed by the medical staff while observing practices and procedures of the hospital. In addition to the hospital practices, guidelines are further defined by the use of the **Emergency Care of the Patient in the Cancer Center and Outpatient Infusion** standardized procedure. The Infusion Center is designated as a 911 facility. For emergency medical service, 911 will be called for evaluation, treatment and transportation to the emergency room. All emergent care provided until the arrival of EMS will follow the applicable standardized procedures outlined in: **Treatment of Adult Anaphylaxis** and **Chemotherapy Adverse Reaction Management-Hypersensitivity and Extravasation.**

A performance improvement process is in place to identify opportunities for improvement in patient care processes. These processes are measured for compliance on an on-going basis. Patient's progress is evaluated by physician(s), nurses, members of other health disciplines as well as by the patient and family.

~~A performance improvement process is in place to identify opportunities for improvement in patient care processes. These processes are measured for compliance on an on-going basis. Patient's progress is evaluated by physician(s), nurses, members of other health disciplines as well as by the patient and~~

~~family.~~

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Standards of Practice

The Infusion Center is governed by state regulations as outlined in Title 22 and standards established by the TJC. Additional practices are described in the Patient Care Services Policies and Procedures and Clinical Practice Standards.

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Scope of Service Infusion Center - Mountain View

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