El Camino Health

AGENDA
REGULAR MEETING OF T□E
EL CAMINO □OSPITAL □OARD OF DIRECTORS

□ ednesday□Septem□er □□□□□□□ – □:□□ pm
El Camino Hospital □2500 □rant Road Mountain View, CA 94040

PURSUANT TO STATE OF CALIFORNIA E□ECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, El CAMINO HEALTH □ **ILL NOT □E PROVIDING A P□YSICAL LOCATION FOR T□IS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETIN□ VIA TELECONFERENCE AT:

□-□□□-□□□-□□□□□MEETING CODE: □□□ □□□□ □□□□□ No participant code□ □ust press □□

To watch the meeting Livestream, please visit: www.elcaminohealth.org/about-us/leadership/board-meeting-stream
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.

MISSION: To heal, relieve suffering, and advance wellness as your publicly accountable health partner

AGENDA ITEM	PRESENTED □Y		ESTIMATED TIMES
□□ **CALL TO ORDER□ROLL CALL**	Lanhee Chen, Board Chair		□:□□ – □:□□pm
□□ **POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information** □:□□ – □:□□
□□ **PU□LIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.* b. Written Correspondence	Lanhee Chen, Board Chair		**information** □:□□ -□:□□
□□ **□UALITY COMMITTEE REPORT**	Julie □liger, Chair of Quality Committee Dr. Mark Adams, Chief Medical Officer Cheryl Reinking, Chief Nursing Officer		**information** □:□□ – □:□□
□□ **FY□□ PERIOD □FINANCIALS**	Carlos Bohorquez, Chief Financial Officer		**information** □:□□ – □:□□
□□ **AD□OURN TO CLOSED SESSION**	Lanhee Chen, Board Chair	*public comment*	**motion re□uired** □:□□– □:□□
□□ **POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information** □:□□ – □:□□
□□ **CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair		**motion re□uired** □:□□ – □:□□
Approval *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board Meeting (08/18/2021) ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** *Health & Safety Code Section 32155* for a report of the Medical Staff□deliberations concerning reports on Medical Staff quality assurance matters*:* b. Medical Staff Report			

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 □□□□□□□-□□□□ prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

AGENDA ITEM	PRESENTED □Y		ESTIMATED TIMES
Information *Health & Safety Code Section 32155* for a report of the Medical Staff□deliberations concerning reports on Medical Staff quality assurance matters*:* c. Annual FY21 Enterprise Patient Safety Report			
□□ *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: Inpatient Rehabilitation Joint Venture	Dan Woods, Chief Executive Officer		**discussion** □:□□– □:□□
□□□*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: FY21 Strategic Plan Metrics (Final)	Dan Woods, Chief Executive Officer		**discussion** □:□□– □:□□
□□□*Gov't Code Section 54957.6 for discussion and report on personnel matters:* **CEO Report** a. Update b. Pacing Plan	Dan Woods, Chief Executive Officer		**discussion** □:□□– □:□□
□□□ Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: **Executive Session**	Lanhee Chen, Board Chair		**discussion** □:□□– □:□□
□□□**AD□OURN TO OPEN SESSION**	Lanhee Chen, Board Chair		**motion re□uired** □:□□– □:□□
□□□**RECONVENE OPEN SESSION□** **REPORT OUT**	Lanhee Chen, Board Chair		**information** □:□□– □:□□
To report any required disclosures regarding permissible actions taken during Closed Session.			
□□□**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair	*public comment*	**motion re□uired** □:□□– □:□□
Approval a. Minutes of the Open Session of the Joint Hospital & Finance Committee Meeting (05/24/21) b. Minutes of the Open Session of the Hospital Board Meeting (08/18/21) c. Hospital Policy Approvals ***Reviewed and Recommended for Approval by the Finance Committee*** d. Finance Committee Finalists e. FY21 Period 12 Financials f. Mountain View Cathlab Replacement Pro□ect g. Pyxis MedStation Replacement Pro□ect h. Medical Staff Development Plan ***Reviewed and Recommended for Approval by the Medical Executive Committee*** i. Medical Staff Report			
□□□**INPATIENT RE□A□ILITATION □OINT VENTURE**	Dan Woods, Chief Executive Officer	*public comment*	**motion re□uired** □:□□– □:□□
□□□**CEO REPORT**	Dan Woods, Chief Executive Officer		**information** □:□□– □:□□
□□□□**OARD COMMENTS**	Lanhee Chen, Board Chair		**information** □:□□– □:□□
□□□**AD□OURNMENT**	Lanhee Chen, Board Chair	*public comment*	**motion re□uired** □:□□– □:□□**pm**

Upcoming Regular Meetings: October 13, 2021□November 10, 2021□December 8, 2021□February 9, 2022□March 9, 2022□April 13, 2022□May 11, 2022□May 23, 2022 (Joint with Finance Committee)□June 8, 2022

Upcoming Special Meetings - Education□Retreat: October 27, 2021(Joint Board and Committee Education)□February 23, 2021 (Retreat)□April 27, 2022 (Board Education)

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Julie Kliger, Quality Committee Chair
Mark Adams, MD, Chief Medical Officer
Cheryl Reinking, Chief Nursing Officer
Date: September 22, 2021
Subject: Quality, Patient Care and Patient Experience Committee Report

Purpose: To inform the Board of the work of the Quality Committee.

Summary:

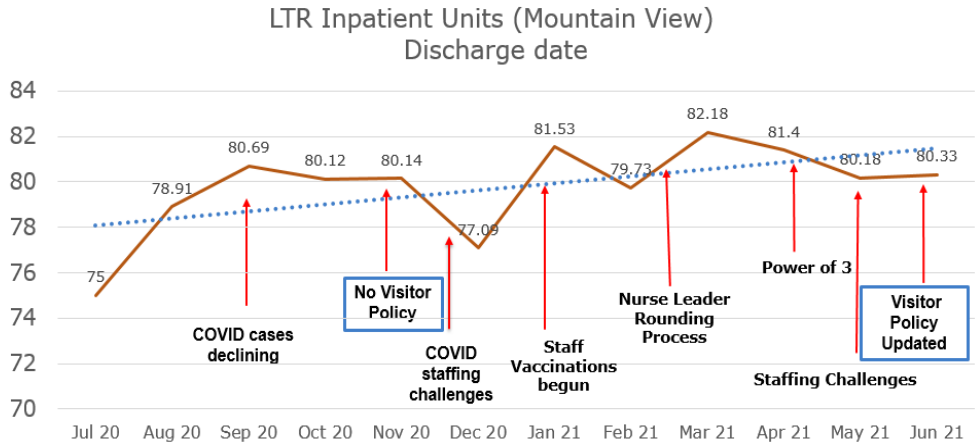
1. The committee chair, Ms. Kliger, facilitated a discussion regarding the committee pacing plan, as proposed in the prior month's meeting. Several additional topics were suggested, including patient access to care, ambulatory care protocols, patient experience, and annual employee engagement survey results emphasizing culture of safety.

2. Cheryl Reinking, CNO, reviewed the most recent patient story, which came from a patient who recently gave birth in our hospital in MV. The patient received an exceptionally positive experience and gave direct feedback to a few of the nurses who, in her words, provided amazing care. The committee prefers to hear negative stories but did appreciate this positive one.

3. Christine Cunningham, executive director of patient experience and performance improvement, provided a comprehensive review of the current status of patient experience and ongoing performance improvement activities directed toward enhancing our results. While we missed our internal aspirational targets, we have been and continue to be well above the national benchmarks, California benchmarks, and all of our bay area competitors. In addition, we have received recognition from Healthgrades for receiving their 2021 outstanding patient experience award, despite significant challenges caused by COVID-19 visitor restrictions and stringent patient screening and monitoring with COVID-19 testing. This is illustrated as follows:

Service - Performance Correlates With Pandemic Related Events

- When LTR performance is viewed by discharge date (rather than received date), declines in performance align with events on the pandemic timeline.



Proven best practices have been implemented at El Camino, including the following:

a. Leader Rounding

b. Discharge Phone calls

c. Nurse Leader Rounding

d. WeCare Service Standards

e. Complaints and Grievance Processing

f. Care Team Coaching

g. Physician Partnership

h. Service Recovery Training

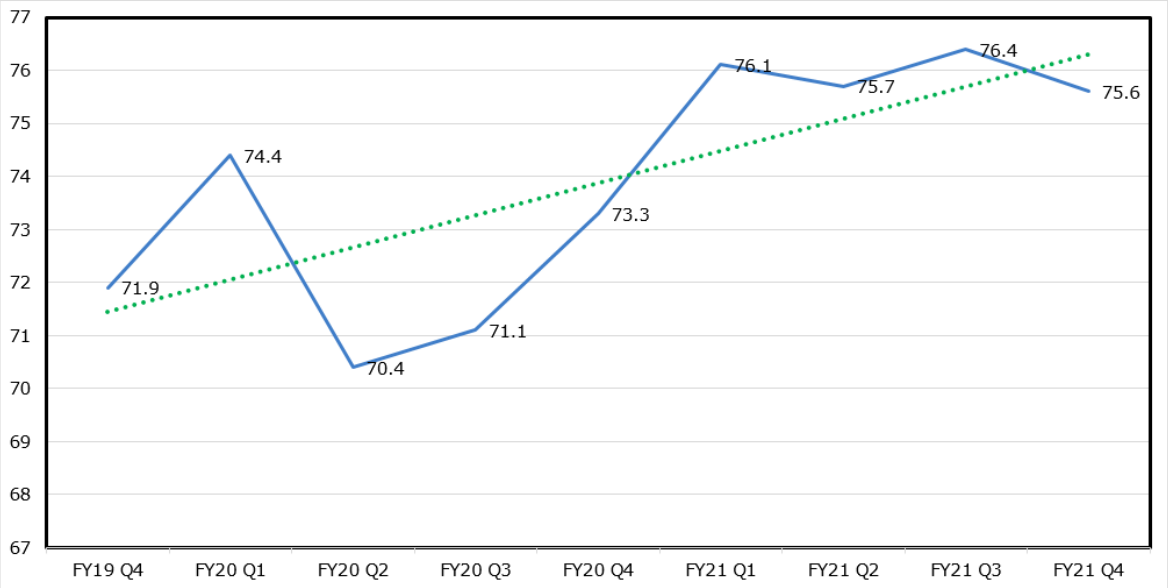
i. Digital Strategy

j. Texting to patients

Based on Press Ganey analysis, new FY22 targets have been established. The new targets will again be very aggressive and aspirational. There was a discussion pertaining to patient experience in the non-hospital-based ambulatory setting at the various ECHMN clinics. There has been steady improvement with a few exceptions.

ECH Medical Network (Clinics)

Net Promoter Score (NPS)



Attachments: none

El Camino Health

Summary of Financial Operations

Fiscal Year 2022 – Period 1

7/1/2021 to 07/31/2021

Executive Summary - Overall Commentary for Period 1

- Strong operating / financial results for Period 1 were attributed to the following:
  - Strong volume / patient activity was attributed to the start of the new OB group at our Mountain View Campus, continued rebound in ER volumes and strong procedural volumes
- Total gross charges, a surrogate for volume, were favorable to budget by $47.9M / 13.4% and $73.1M / 21.9% higher than the same period last year
- Net patient revenue was favorable to budget by $9.0M / 9.7% and $15.9M / 18.5% higher than the same period last year
- Operating expenses were $2.4M / 2.7% unfavorable to budget, which is primarily attributed to higher than expected volume versus budget and significant number of procedural cases performed in July and increase in ED visits
- Operating margin was favorable to budget by $6.2M / 115.4% and $3.4M / 41.5% better than the same period last year
- Operating EBIDA was favorable to budget by $6.3M / 50.6% and $4.0M / 27.1% better than the same period last year
- Unfavorable performance in the investment portfolio of ($4.1M) resulted in Net Income of $7.3M which is $5.7M / 43.6% below budget and $28.4M / 79.4% below the same period last year

Operational / Financial Results: Period 1 – July 2021 (as of 7/31/2021)

($ thousands)

		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians 'A1'	Moody's Medians 'Aa3'	Performance to 'A1' Medians
Activity / Volume	ADC	256	239	17	7.2%	223	32	14.6%	---	---	---
	Total Acute Discharges	1,705	1,598	107	6.7%	1,476	229	15.5%	---	---	---
	Adjusted Discharges	3,428	2,937	491	16.7%	2,843	585	20.6%	---	---	---
	Emergency Room Visits	5,022	4,274	748	17.5%	4,035	987	24.5%	---	---	---
	OP Procedural Cases	12,061	9,873	2,188	22.2%	11,706	355	3.0%	---	---	---
	Gross Charges ($)	406,295	358,298	47,997	13.4%	333,228	73,067	21.9%	---	---	---
Operations	Total FTEs	2,946	2,988	(42)	(1.4%)	2,689	257	9.6%	---	---	---
	Productive Hrs. / APD	28.3	32.9	(4.6)	(13.9%)	31.1	(2.8)	(8.9%)	---	---	---
	Cost Per CMI Adjusted Discharge	15,593	17,952	(2,359)	(13.1%)	16,425	(832)	(5.1%)	---	---	---
	Net Days in A/R	52.2	49.0	3.2	6.5%	44.1	8.0	18.2%	47.7	47.1	
Financial Performance	Net Patient Revenue ($)	101,774	92,754	9,020	9.7%	85,868	15,905	18.5%	106,723	257,000	
	Total Operating Revenue ($)	104,889	96,300	8,589	8.9%	90,535	14,354	15.9%	116,864	314,648	
	Operating Income ($)	**11,498**	**5,339**	**6,159**	115.4%	**8,124**	**3,374**	41.5%	**3,948**	**10,135**	
	Operating EBIDA ($)	**18,793**	**12,475**	**6,318**	50.6%	**14,783**	**4,010**	27.1%	**11,301**	**27,969**	
	Net Income ($)	7,399	13,121	(5,721)	(43.6%)	35,842	(28,443)	(79.4%)	8,219	18,726	
	Operating Margin (%)	**11.0%**	**5.5%**	**5.4%**	97.7%	**9.0%**	**2.0%**	22.2%	**2.9%**	**3.6%**	
	Operating EBIDA (%)	**17.9%**	**13.0%**	**5.0%**	38.3%	**16.3%**	**1.6%**	9.7%	**9.7%**	**8.9%**	
	DCOH (days)	364	325	39	12.0%	341	22	6.6%	254	264	

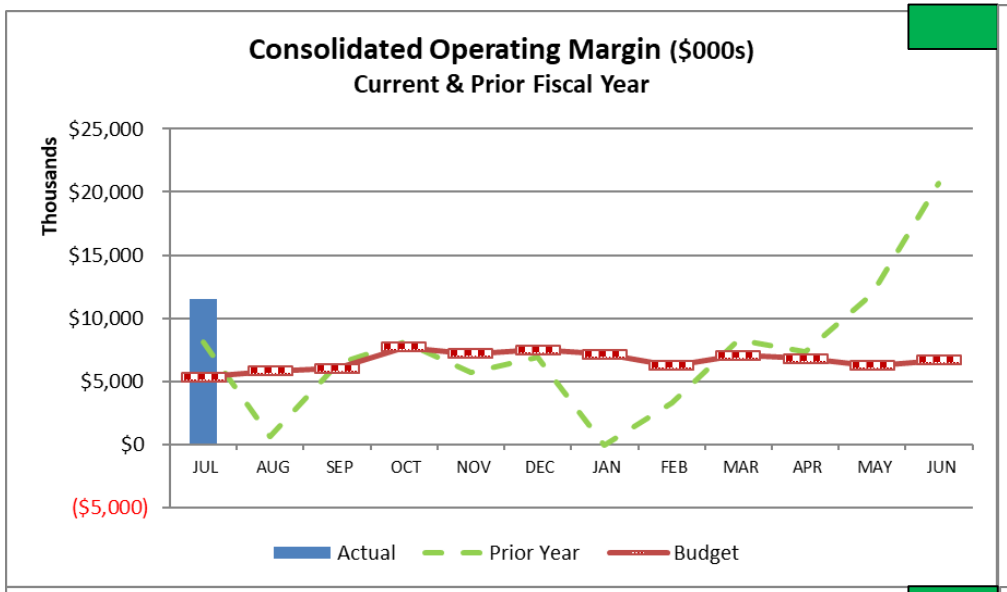
Notes:
1. Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect monthly averages.
2. DCOH total includes cash, short-term and long-term investments.

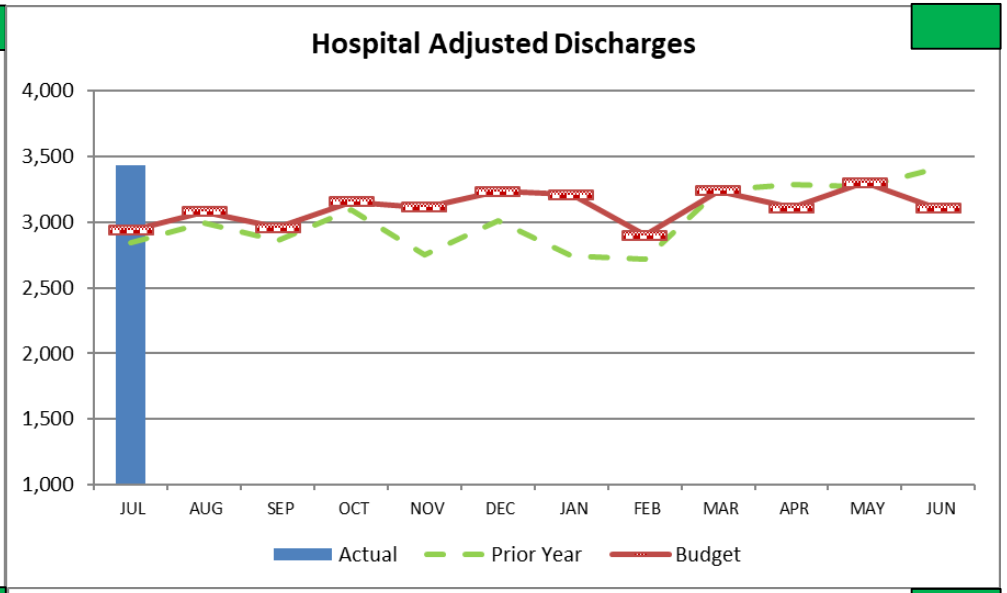
El Camino Health

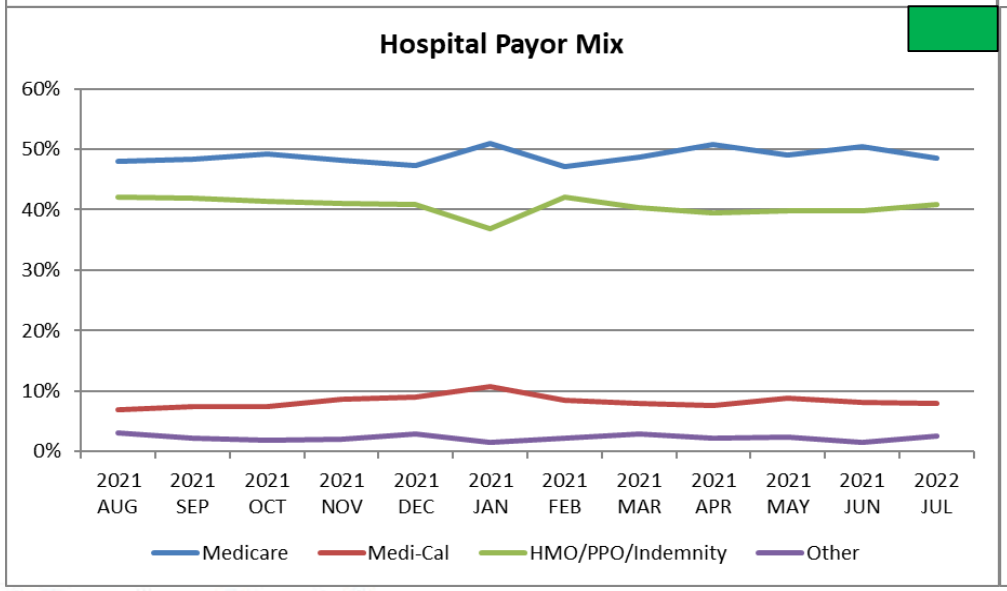
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

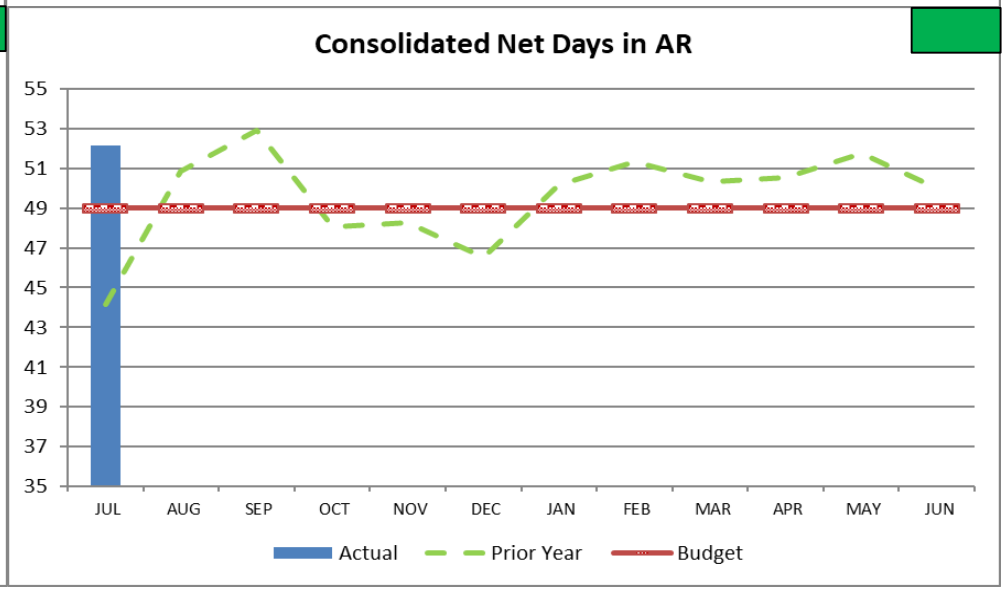
APPENDIX

YTD FY2022 Financial KPIs – Monthly Trends









El Camino Health

Period 1 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 7/31/2021)

($000s)

	Period 1- Month			Period 1- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	12,066	5,340	6,726	12,066	5,340	6,726
Los Gatos	1,997	2,787	(790)	1,997	2,787	(790)
Sub Total - El Camino Hospital, excl. Afflilates	**14,064**	**8,127**	**5,937**	**14,064**	**8,127**	**5,937**
Operating Margin %	**14.1%**	**8.9%**		**14.1%**	**8.9%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**(4,271)**	**7,546**	**(11,818)**	**(4,271)**	**7,546**	**(11,818)**
El Camino Hospital Net Margin	**9,792**	**15,673**	**(5,881)**	**9,792**	**15,673**	**(5,881)**
ECH Net Margin %	**9.8%**	**17.2%**		**9.8%**	**17.2%**	
Concern	316	16	300	316	16	300
ECSC	0	0	0	0	0	0
Foundation	(151)	31	(182)	(151)	31	(182)
El Camino Health Medical Network	(2,558)	(2,600)	42	(2,558)	(2,600)	42
Net Margin Hospital Affiliates	**(2,393)**	**(2,553)**	**160**	**(2,393)**	**(2,553)**	**160**
Total Net Margin Hospital & Affiliates	**7,399**	**13,121**	**(5,721)**	**7,399**	**13,121**	**(5,721)**

Consolidated Balance Sheet (as of 07/31/2021)

($000s)

ASSETS

CURRENT ASSETS	July 31, 2021	UnAudited June 30, 2021
Cash	119,139	151,641
Short Term Investments	279,531	284,262
Patient Accounts Receivable, net	175,510	166,283
Other Accounts and Notes Receivable	2,965	9,540
Intercompany Receivables	13,401	15,116
Inventories and Prepaids	26,195	23,079
Total Current Assets	**616,742**	**649,921**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	21,257	20,932
Plant & Equipment Fund	262,971	258,191
Women's Hospital Expansion	30,401	30,401
Operational Reserve Fund	123,838	123,838
Community Benefit Fund	16,141	18,412
Workers Compensation Reserve Fund	17,002	16,482
Postretirement Health/Life Reserve Fund	30,749	30,658
PTO Liability Fund	32,878	32,498
Malpractice Reserve Fund	1,984	1,977
Catastrophic Reserves Fund	25,061	24,874
Total Board Designated Assets	**562,283**	**558,264**
FUNDS HELD BY TRUSTEE	**8,973**	**5,694**
LONG TERM INVESTMENTS	**602,787**	**603,211**
CHARITABLE GIFT ANNUITY INVESTMENTS	**734**	**728**
INVESTMENTS IN AFFILIATES	**34,346**	**34,170**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,804,877	1,799,463
Less: Accumulated Depreciation	(748,797)	(742,921)
Construction in Progress	94,305	94,236
Property, Plant & Equipment - Net	**1,150,385**	**1,150,778**
DEFERRED OUTFLOWS	21,394	21,444
RESTRICTED ASSETS	29,250	29,332
OTHER ASSETS	86,008	86,764
TOTAL ASSETS	**3,112,901**	**3,140,306**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	July 31, 2021	UnAudited June 30, 2021
Accounts Payable	32,571	39,762
Salaries and Related Liabilities	33,636	50,039
Accrued PTO	33,558	33,197
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	13,021	12,990
Intercompany Payables	12,705	14,704
Malpractice Reserves	1,670	1,670
Bonds Payable - Current	9,430	9,430
Bond Interest Payable	3,282	8,293
Other Liabilities	15,812	16,953
Total Current Liabilities	**157,986**	**189,338**
LONG TERM LIABILITIES		
Post Retirement Benefits	30,749	30,658
Worker's Comp Reserve	17,002	17,002
Other L/T Obligation (Asbestos)	6,176	6,227
Bond Payable	483,661	479,621
Total Long Term Liabilities	**537,587**	**533,509**
DEFERRED REVENUE-UNRESTRICTED	**63,673**	**67,576**
DEFERRED INFLOW OF RESOURCES	**28,009**	**28,009**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,102,967	2,097,010
Board Designated	191,465	193,782
Restricted	31,215	31,082
Total Fund Bal & Capital Accts	**2,325,647**	**2,321,874**
TOTAL LIABILITIES AND FUND BALANCE	**3,112,901**	**3,140,306**

El Camino Health

El Camino Health

Minutes of the Open Session of the
Joint Meeting of the Finance Committee
El Camino Hospital Board of Directors
Monday, May 24, 2021

Pursuant to State of California Executive Order N-29-20 dated March 18, 2020, El Camino Health did not provide a physical location for this meeting. Instead, the public was invited to join the open session meeting via teleconference.

Members Present	Board Members Absent	Members Excused
Hospital Board Members:	one	one
Lanhee Chen, Chair		
Carol Somersille, MD	**via teleconference	
Peter C. Fung, MD**		
Julie Kliger, MPA, BSN**		
Julia E. Miller** ecretary/reas rer		
Jack Po, MD, PhD**		
Bob Rebitzer**		
George O. Ting, MD**		
Don Watters**		
John Zoglin Vice Chair		
Finance Committee Members:		
Joseph Chow**		
Boyd Faust**		
Wayne Doiguchi**		

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	he open session meeting of the oint eeting of the inance Committee and the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 pm y Chair Chen. ver al roll call as ta en. Chair Chen revie ed the logistics for the meeting. ll oard and Committee mem ers ere present e cept for Director Peter ng as a sent and participated via teleconference and videoconference p rs ant to anta Clara County's shelter in place order. A or m as present p rs ant to tate of California E ec tive Orders -25-20 dated arch 12 2020 and -29-20 dated arch 18 2020.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen as ed if any oard mem ers may have a conflict of interest ith any of the items on the agenda. o conflicts ere noted.	
3. PUBLIC COMMUNICATION	Chair Chen as ed if there ere any p lic comm nication no p lic comm nication as reported.	
4. FY2022 OPERATING & CAPITAL BUDGET	*Dan Woods* Chief E ec tive Officer *Carlos Bohorquez* Chief inancial Officer and *Jim Griffith,* Chief Operating Officer presented the 2022 Operating and Capital dget. r. oods egan the disc ssion ith an e ec tive s mmary highlighting that the 2022 dget plan for the coming year and he stated the dget ill p t ECH on a path ay to ard recovery from the impact of the Covid-19 pandemic and achieve strong year-over-year gro th. r. oods and r. ohor e contin ed the disc ssion y presenting the five-year tra ectory of the hospital operations compared to the proposed 2022 dget and highlighted: • he consolidated 2022 dget yields contin ed financial recovery from the Covid-19 pandemic as evident y Operating	

margin of □7□ and Operating E□ID□ margin of 13.7□. □□pport for ECH□ □ for □□2022 is not e□ceeding a total of □33□.

□r. □ohor□□e□stated □e need a sta□le financial tra□ectory from a □ottom-line perspective to maintain local control and governance□s□pport o□r commitment to □□ality f□nd s□fficient capital to meet the strategic needs of the organi□ation□and finish redevelopment pro□ects in □o□ntain Vie□.

□r. □im □riffith contin□ed the disc□ssion □y disc□ssing the □□2022 □□dget vol□me ass□mptions in detail and the □ey e□pense categories: salary□□ages and □enefits□and la□or. □r. □riffith highlighted the follo□ing □ey points:

- □□2022 total □alaries□□ ages□Contract □a□or□and □enefits are increasing 7.1□. □his is primarily attri□□ted to the high cost and shortage of clinical staff. □he organi□ation spends significant reso□rces on e□ternal la□or□O□/ Premi□m pay and recr□itment to ensure that we're adequately staffed and have sufficient resources to meet the needs of o□r comm□nity.
- □ro□p Health Ins□rance premi□ms increased □y 7□ □□hich is offset □y savings from □enefit management initiatives.
- FICA, Pension, and Worker's Compensation are all increasing in proportion to salaries.

□r. □ohor□□e□then presented a s□mmary of the non-la□or s□mmary and highlighted the follo□ing:

- □he impact of Covid on the total □se of s□pplies and cost per □nit has □een significant in □□2021 in most cases the cost of PPE and other s□pplies has increased 2□-4□ from pre-Covid levels. □r. □ohor□□e□stated that as the pandemic eases □e anticipate a grad□al red□ction in the cost per □nit.
- Overall □on-la□or e□pense is decreasing □y □1.1□ □on a per-ad□□sted discharge □asis□primarily driven □y normali□ation of PPE and □a□related s□pply costs d□e to COVID-19 in □□2021.
- □□pplies□□ r. □ohor□□e□stated is the second largest e□pense category. □r. □ohor□□e□highlighted□one contin□ed challenge is pharmace□ticals. He stated □e are loo□ing to address thro□gh an analysis of o□r □PO relationship and it is a contin□ed area of foc□s and concern year over year inflation increase of pharmace□ticals.
- P□rchased services□□ r. □ohor□□e□stated □□2022 □ill incl□de a significant red□ction. □he foc□s □ill □e on less □se of e□ternal vendors□he stated □e are loo□ing into □hat □e can do internally vers□s e□ternally and □e are revie□ing all e□ternal relationships and see if □e have an opport□nity to have competitive □idding as far as o□r services.
- Depreciation and Interest E□pense□□ r. □ohor□□e□stated significant increase in depreciation and interest e□penses starting in □□2021 are associated □ith □o□rato and □a□□e Pavilion.

□r. □ohor□□e□stated □e have done a □al□thro□gh of all □ey ass□mptions that are driving reven□e□e□penses□and vol□me and he stated as □r. □oods and □r. □riffith indicated □e are confident in the tra□ectory that □□2022 □□dget lays o□t□it is contin□ed recovery from the impact of Covid and □e do anticipate that it □ill □e very hard to reach the levels of □□2019. □rom an operating and operating E□ID□ margin standpoint□□e are pro□ecting □□2022 to □e sta□le □ith a contin□ed path to recovery from the pandemic impact. This assumes there isn't a forth or fifth wave which significantly

	increases the n□m□er of Covid patients in o□r hospitals or limits o□r a□ility to f□lly operate o□r proced□ral s□ites. □he estimated s□pport for the Physician □et□or□□as presented and □r. □ohor□□e□stated in □□2020 the s□□sidy from an operating margin standpoint is a little over □40□ □□e pro□ect the ann□ali□ed s□pport for □□2021 to □e □3□□ □hich □o□ld □e □4□ year-over-year improvement. O□r goal is to contin□e to manage the s□pport level □ith an additional improvement of □3□-□5□ over the ne□t 12-18 months. □r. □ohor□□e□ stated there is still a lot of □or□to □e done□and □e have ac□no□ledged it is a □ig n□m□er□□□t it is a strategy that □e strongly □elieve in and the level of s□pport / commitment for o□r physician net□or□is e□□ally strong. □rom a consolidated standpoint□□r. □ohor□□e□stated ro□ghly a□o□t □1.2□ of total operating reven□e□operating margin □7□ □and operating E□ID□ 13.7□. □□2020 Capital Capacity range is at □8□□-□153□ and the remaining capital capacity for □□2022 is a□o□t □79□. □□2022 capital □□dget incl□des □20□ to□ards the replacement/ ac□□isition of clinical□I□□and other e□□ipment to s□pport □□ality□patient satisfaction□ and gro□th thro□gho□t the organi□ation. **Motion**: □o approve the □□2022 Operating and Capital □□dget **Movant:** □ing **Second:** □atters **Ayes:** Chen□□iller□□liger□Po□Re□it□er□□omersille□□ing□□atters□□oglin□ Cho□□Doig□chi□□a□st **Noes:** □one **Abstentions:** □one **Absent:** □□ng **Recused:** □one	
5. AGENDA ITEM 5: ADJOURNMENT	**Motion**: □o ad□o□rn at □:12 pm **Movant:** □iller **Second:** □ing **Ayes:** Chen□□iller□□liger□Po□Re□it□er□□omersille□□ing□□atters□□oglin□ Cho□□Doig□chi□□a□st **Noes:** □one **Abstentions:** □one **Absent:** □□ng **Recused:** □one	***Meeting adjourned at 6:12 pm***

Attest as to the approval of the foregoing minutes by the Finance Committee and the Board of Directors of El Camino Hospital:

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□anhee Chen
Chair□ECH □oard of Directors

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□□lia E. □iller
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□ohn □oglin
Chair□ECH □inance Committee

Prepared □y: □amreen □alehi□E□ec□tive □ssistant II

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, August 18, 2021

Pursuant to State of California Executive Order N-29-20 dated March 18, 2020, El Camino Health did not provide a physical location for this meeting. Instead, the public was invited to join the open session meeting via teleconference.

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair **Peter C. Fung, MD** **Julie Kliger, MPA, BS** **Julia E. Miller,** ecretary/reas rer **Jack Po, MD, Ph.D.** **Bob Rebitzer** **Carol A. Somersille, MD** **Don Watters**** **John Zoglin** Vice Chair	**George O. Ting, MD**	one ****via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	he open session meeting of the oard of Directors of El Camino Hospital the oard as called to order at 5:30 pm y Chair Chen. ver al roll call as ta en. ll oard mem ers ere present at roll call e cl ding Director ing. Chair Chen revie ed the logistics for the meeting. or m as present p rs ant to tate of California E ec tive Orders -25-20 dated arch 12 2020 and -29-20 dated arch 18 2020.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen as ed the oard of Directors for declarations of conflict of interest ith any items on the agenda and none ere reported.	
3. PUBLIC COMMUNICATION	Director Chen invited mem ers of the p lic to address the oard on items not covered on the agenda. eri Roman C at El Camino Health for seven years stated her concern a o t the lac of staffing at El Camino Health. pecifically the ratio among the C staff is 13 patients per 1 C p tting the patients at ris s. Roman f rther stated that she and her team feel stressed and overstretched ith their or load and can no longer attend to the call lights or provide ality care to their patients.	
4. QUALITY COMMITTEE REPORT	Director liger opened the disc ssion y presenting the ality Committee Report incl ding the ality Improvement Patient afety Plan PI for oard approval. Director liger highlighted t o main items for the oard: **1.** ality Committee em ers strive to have meaningf l conversations that add real val e to ECH leaders and management and contin o sly revie the pacing of these items. Over time C has assessed that there ere not eno gh items foc sed on gro th development innovation and advancement of ality e ity and o tcome in patient engagement c rrently paced. Director liger stated the follo ing topics o ld e incl ded in the pacing plan for f t re disc ssions: • Health e ity in care delivery and patient o tcome • ringing for ard the patient voice in a manner that is impactf l and informative and g ide o r policy and program • he need to spend more time to disc ss am latory care metrics o tcomes and governance. **2.** Director liger reported on arterly oard ality Dash oard	

	□□□EEP Dash□oard□and clarified □hen the metrics have more than 2-3 periods in the red□leadership □ill provide an overvie□ of the iss□e □ith a plan of correction for the □oard. Dr. □ar□□dams□C□O□contin□ed the disc□ssion □y revie□ing the red targets and the plan of correction on the □□ality Dash□oard □□□EEP Dash□oard□: • □he dash□oard reports o□t targets□□hat □e aim for□many of them are aspirational□□□t they are not organi□ational goals. • □he organi□ation has set goals tied to an incentive and strategy plan□and the dash□oard does not represent these goals. • □he mortality Inde□is calc□lated □y the o□served divided □y the e□pected □ased on analysis done □y Premier□an organi□ation that □e □se to do o□r data analytics. • Premier has a national □enchmar□□ith over 1000 hospitals that □e compare o□rselves against. Every year□they recalc□late the top-tier performer□s inde□for all inde□es and mortality inde□es. □ hen □e set the targets for □□ 21□the top performers □ere at 0.7□□and these are the top 10-15 top organi□ations across the Co□ntry. ECH □y □3 drifted □p□ending at 0.8□□and the top performers in the Co□ntry their inde□is at 0.90. • ECH is □elo□ the target□reporting at 0.8□□and is reporting red □eca□se of the set target. □hese n□m□ers change as they are not a linear mathematical form□la□and they change year over year. • □epsis □ ortality Inde□□significantly affected □y Covid. □□21 ECH is reporting 1.08□□□t the top performers in the Co□ntry are at 1.05□ ECH is slightly a□ove □□t not very far □p. • Clostridi□m C-diff□Intervention is to contin□e follo□ing hand hygiene protocols and cleaning the rooms □ith □ltraviolet lighting. • □imely category□□ e have contin□o□sly p□t in hard □or□and lean □or□to improve. □□m□ers reported on the dash□oard are a□ove the targets □e have set□they are not e□traordinarily higher□□□t □e have not hit the target in this area□and Covid is a considera□le factor. **Motion:** □o approve the □□ality Committee Report□□hich incl□des the □□ality Improvement Patient □afety Plan □□□PI□ **Movant**: □ atters **Second**: □□ng **Ayes**: Chen□□□ng□□liger□□ iller□Po□Re□it□er□□omersille□□ atters□ □oglin **Noes**: □one **Abstentions**: □one **Absent**: □ing **Recused**: □one	
1. FY21 PERIOD 12 FINANCIALS	Carlos □ohor□□e□□C□O□opened the disc□ssions □y presenting the □□ne 2021 Pre-□□dit financial res□lts and highlighted the follo□ing: • □ r. □ohor□□e□stated □e are pleased □ith the overall res□lts□given the second and third □ave of Covid and □eing o□t of net□or□□□ith □nthem. □rom a vol□me perspective loo□ing at □□ 2021 compared to □□ 2019□□hich □as pre-Covid□the average daily cens□s is higher □y 1.2 □. • □d□□sted discharge is 0.□□ lo□er than □□ 2019□□ r. □ohor□□e□ stated □e are doing □ell □ith a re□o□nd in vol□me e□cept for the ED.	***FY21 Period 12 Financials approved***

	• □trong ED vol□me re□o□nd in □□ne□ED vol□me in □□ne is 21□ higher than the prior 11month average. • □rom an operational metrics standpoint□one item that stands o□t in red is □□Es. □r. □ohor□□e□stated it is red compared to □□dget and yello□ compared to the prior fiscal year. □s vol□me has re□o□nded□ □r. □ohor□□e□said □e have staffed □p for the varia□le departments□□e ac□no□ledge that it is red□□□t this is a □y-prod□ct of the re□o□nd in vol□me. • □rom a □ottom-line standpoint□year-over-year reven□e is □p □y 11.4□ □□ac□to pre-Covid levels. **Motion:** □o approve the Period 12 □inancials **Movant**: □oglin **Second**: □□ng **Ayes**: Chen□□□ng□□liger□□ iller□Po□Re□it□er□□omersille□□ atters□ □oglin **Noes**: □one **Abstentions**: □one **Absent**: □ing **Recused**: □one	
2. GOVERNANCE BEST PRACTICES	Dan □oods□CEO□opened the disc□ssion □y introd□cing □eorge □nderson□ a cons□ltant from □pencer □t□art. □r. □oods provided a □rief overvie□ of the □overnance Committee□s selection of □pencer □t□art as o□r □overnance □ervices Cons□lting □irm □r. □nderson contin□ed the disc□ssion □y providing a high-level overvie□ of the □pcoming □oard Revie□ Pro□ect and ne□t steps.	
3. ADJOURN TO CLOSED SESSION	□o ad□o□rn to closed session at □:34 pm p□rs□ant to *Gov't Code Section 54957.2* for approval of the □in□tes of the Closed □ession of the Hospital □oard □eeting □0□/23/21□p□rs□ant to *Health and Safety Code Section 32155* for a report of the □edical □taff□deli□erations concerning reports on □edical □taff □□ality ass□rance matters: □□ality Committee Report □□edical □taff Credentials and Privileges Report□. **Motion:** to ad□o□rn to closed session at □:34 pm **Movant**: □atters **Second**: □iller **Ayes**: Chen□□□ng□□liger□□ iller□Po□Re□it□er□□omersille□□ atters□ □oglin **Noes**: □one **Abstentions**: □one **Absent**: □ing **Recused**: □one	***Adjourned to closed session at 6:34 pm***
4. AGENDA ITEM 16: RECONVENE OPEN SSSION/ REPORT OUT	Open □ession reconvened at 8:25 pm □y Chair Chen. □genda items 10-15 □ere addressed in the closed session. D□ring the closed session□the □oard approved the □in□tes of the Closed □ession of the Hospital □oard □eeting □0□/23/21□and the □□ality Committee Report□incl□ding the □edical □taff Credentials and Privileges Report□□y a □nanimo□s vote in favor of all mem□ers present and participating in the meeting □Directors Chen□□□ng□□liger□□ iller□Po□ Re□it□er□□omersille□and □atters□Director □ing □as a□sent.	
5. AGENDA ITEM 17:	Chair Chen as□ed if any mem□er of the □oard or the p□□lic □ished to	***Consent***

CONSENT CALENDAR	remove an item from the consent calendar. Director □□ng p□lled item 17g for disc□ssion. **Motion:** □o approve the consent calendar e□cl□ding item 17g. **Movant:** □ iller **Second:** □ atters **Ayes:** Chen□□□ng□□liger□□ iller□Po□Re□it□er□□omersille□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one **Motion:** to approve item 17g □□ edical □taff □yla□s□□ith noted clerical corrections **Movant**: □oglin **Second**: □liger **Ayes**: Chen□□□ng□□liger□□ iller□Po□Re□it□er□□omersille□□ atters□ □oglin **Noes**: □one **Abstentions**: □one **Absent**: □ing **Recused**: □one	***calendar approved***
6. AGENDA ITEM 18: AMENDMENT TO CEO EMPLOYMENT AGREEMENT	Director Chen presented the 3rd □mendment to the CEO Employment □greement changes□as f□rther detailed in the pac□et. **Motion:** □o approve the □mendment to the CEO Employment □greement **Movant**: □ atters **Second**: □ iller **Ayes**: Chen□□□ng□□liger□□ iller□Po□Re□it□er□□omersille□□ atters□ □oglin **Noes**: □one **Abstentions**: □one **Absent**: □ing **Recused**: □one	
7. AGENDA ITEM 19: CEO REPORT	□ r. □ oods presented an □pdate regarding the I-DE□ □Incl□sion-Diversity E□□ity and □elonging□training at a 95□ completion rate for all managers and leadership levels. □o improve patient safety and □□ality□□ r. □ ood stated □e have implemented □arcoding for the □IC□ □nit for trac□ing infant form□la and □reast mil□for □a□ies and o□r moms. □dditionally□□e are □or□ing on red□cing the ris□of dr□g □se □y implementing a C□RE□program. Physicians can access patients imagining □-rays thro□gh their mo□ile. □e□ Path□ays Director search is c□rrently □nder□ay.	
8. AGENDA ITEM 20: BOARD COMMENTS	□one.	

9. AGENDA ITEM 21: ADJOURNMENT	**Motion**: □o ad□o□rn at 8:53 pm. **Movant:** □ iller **Second:** □liger **Ayes:** Chen□□□ng□□liger□□ iller□Po□Re□it□er□□omersille□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □ing **Recused:** □one	***Meeting adjourned at 8:53 pm***

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

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□anhee Chen
Chair□ECH □oard of Directors

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□□lia E. □ iller
□ecretary□ECH □oard of Directors

Prepared □y: □amreen □alehi□E□ec□tive □ssistant □dministrative □ervices

BOARD
September, 2021

Policy Dept.	Policy Name	Type of Change	Type of Document	Notes	Committee Approvals
Risk Management	1. End of Life Option Act Policy	None	Policy		
Imaging Services/Radiation Safety	1. Radiation Safety-Radiation Protection Program 2. Radiation Safety-Declared Pregnant Radiation Worker	Revised Revised	Policy Policy	All Minor changes up for review cycle	Radiation Safety Committee
Education	1. Scope of Service – Clinical Education Department	Revised	Scope of Service	Added Nurse Residency program and removed nursing from students	HR Leadership
Patient Experience	1. Auxiliary Scope of Service	Revised	Scope of Service	Updated services where patient contact is	
Security	1. Post Disaster Business Continuity Plan	New	Plan		
HIM	1. HIPAA Restricting Use or Disclosure of Protected Health Information	Revised	Policy	Updated References	
Emergency Management	1. Pandemic Plan	Revised	Plan	Updated Reference, yearly review	Infection Prevention
Care Coordination	1. Reporting of Domestic Partner Assault 2. Utilization Management Plan	None Revised	Policy Plan	#2Minor changes regarding reporting to appropriate committees	#2Utilization Management
EVS	1. Scope of Service Environmental Services	None	Scope of Service		
Pharmacy	1. MERP Plan	None	Plan	Yearly Review, updated attachment	P&T
EWHS	1. COVID-19 Vaccine Plan	New	Plan		Infection Prevention Committee HR Leaders including CHRO, Dept. of Medicine, both internal and external legal counsel

El Camino Health

Origination:	*05/2016*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*06/2021*
Next Review:	*3 years after approval*
Owner:	*Sheetal Shah: Dir Risk Mgmt & Patient Safety*
Area:	*Patient Care Services*
Document Types:	*Policy*

End of Life Option Act Policy

COVERAGE:

All El Camino Hospital employees and medical staff.

PURPOSE:

To describe and inform El Camino Hospital employees and medical staff as to El Camino Hospital Policy as related to the California End of Life Option Act.

1. The California End of Life Option Act (herein after the Act) allows an adult patient with capacity, who has been diagnosed with a terminal disease with a life expectancy of six months or less, and who meets other requirements, to request a prescription for a drug for the purpose of ending his or her life (aid-in-dying drug) through self-administration of the drug.
2. The purpose of this policy is to describe the requirements and procedures for compliance with the Act and to provide guidelines for responding to patient requests for information about aid-in-dying drugs in accordance with federal and state laws and regulations and The Joint Commission accreditation standards.
3. The requirements outlined in this policy do not preclude or replace other existing policies, including but not limited to Withdrawing or Foregoing Life Sustaining Treatment, Pain Management, Advance Directives /POLST, Resuscitation Status (DNR) or End-of-Life Care.

POLICY STATEMENT:

It is the policy of El Camino Hospital to educate and support patients and providers regarding options available under the Act. However, El Camino Hospital shall not permit ingestion of an aid-in-dying drug as defined in the Act on any El Camino Hospital campus.

1. El Camino Hospital respects both patient and provider choices.
2. All providers practicing in and for El Camino Hospital should respond to any patient s query about the Act with openness and compassion. The goal of El Camino Hospital is to ensure patients are educated thoroughly to make informed decisions about options for and participating in end-of-life care, including Palliative Care and Hospice Care.
3. No patient will be denied other medical care or treatment because of the patient s participation in the Act.
4. El Camino Hospital neither encourages nor discourages participation in the Act provider and patient

participation is entirely voluntary. Only those providers who are willing and desire to participate should do so. Providers who do choose to participate under the Act are reminded that the overall goal is to support the patient's end-of-life wishes, and that participation may not necessarily result in aid-in-dying drugs being prescribed if the patient's needs can be met in other ways (e.g. pain management, hospice or palliative care). Medical staff members shall make an individual decision regarding the degree s/he participates in provision of services permitted under Act.

5. Physicians opting to not be an attending or consulting physician in respect to the Act should facilitate referral to an appropriate participating physician if they are aware of one or to Palliative Care for additional resources.
6. El Camino Hospital shall not permit ingestion of an "aid-in-dying drug" as defined in the End of Life Option Act on any El Camino Hospital campus. Aid in dying drugs cannot be dispensed by a physician in the inpatient setting. However, inquiry and discussion of such a request is permitted during a patient's hospitalization or in the clinic setting. An attending physician may prescribe the aid in dying drug after discharge so long as the requirements of the Act are fulfilled.
7. El Camino Hospital does not accept new patients solely for the purposes of accessing the Act. Eligible individuals should be current ECH patients receiving care for a terminal disease.

DEFINITIONS:

1. **Aid-in-dying drug**: a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his her death due to terminal disease.
2. **Attending physician**: physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.
3. **Consulting physician**: a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.

PROCEDURE:

1. The End of Life Option Act applies only to adults age 18 years or older. All such adult patients may be provided with educational materials regarding end-of-life options to the degree the patient desires and at the patient's request.
2. When a patient makes an inquiry about or requests access to activities under the Act, the patient should be referred to the Palliative Care Department. The Palliative Care Department is able to assist patients in understanding the requirements of the Act, inform them about the process and provide educational material related to the patient's end of life options. This activity will augment, but not substitute for, the obligations of the attending and consulting physicians' roles. If the patient's physician chooses not to participate in the Act, which is his or her right under the law, Palliative Care can assist in the identification of an appropriate resource.
3. Any patient, family member, surrogate decision maker, employee, independent contractor, medical staff, or volunteer may contact Palliative Care for assistance.
4. Support is also available as needed from Spiritual Care Department and the Ethics Committee.
5. Patients who have met all obligations and all criteria as described in the Act, and desire to ingest "aid-in-dying drug" yet cannot be discharged from the hospital for an extenuating circumstance, will be evaluated on a case-by-case basis by a multi-disciplinary team of physicians, nursing, care coordination, Palliative

Care as available, and Risk Management or Legal to develop an acceptable plan of care for the patients/ family.

6. Discussions and care conferences with patients and families regarding the End of Life Option Act are to be documented in the electronic health record (EHR).
7. Risk Management and/or Legal should be contacted prior to an ECH provider providing an ECH patient a prescription for an aid in dying drug in an ECH outpatient clinic to ensure that all appropriate processes have been followed and documentation completed.
8. Risk Management and the Legal Department is available to provide guidance to providers regarding the requirements under the law, and may review records as necessary to ensure all the safeguards of the law have been followed along with appropriate documentation completed.

REFERENCES:

1. California AB□2-15: End of Life Option Act

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

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	06/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	06/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	06/2021
UPC/Staff Meeting	Sheetal Shah: Dir Risk Mgmt & Patient Safety	05/2021
	Sheetal Shah: Dir Risk Mgmt & Patient Safety	05/2021

El Camino Health

Origination:	*09/1993*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*06/2021*
Next Review:	*3 years after approval*
Owner:	*Aletha Fulgham: Assistant Director Imaging Svc*
Area:	*Imaging Services*
Document Types:	*Procedure*

Radiation Safety - Declared Pregnant Radiation □ or□er

~~I□COVERAGE:~~

COVERAGE:

All El Camino Hospital female staff and medical staff who work directly with, or in close proximity to sources of ionizing radiation

~~II□PURPOSE:~~

PURPOSE:

To provide a consistent process for the declaration and monitoring of pregnant radiation workers

~~III□DEFINITIONS:~~

DEFINITIONS:

- □ RSO □Radiation Safety Office
- □ ALARA □As Low as Reasonably Achievable
- □ RPA □Radiation Protection Apparel□does not include gloves, goggles/lead glasses or rolling shields

~~IV□REFERENCES:~~

REFERENCES:

- □ Title 17, the California Code of Regulations
- □ USNRC CFR Title 10, □20.1208
- □ USNRC Regulatory □uide 8.13 appendix reference: □Instruction Concerning Prenatal Radiation Exposure□

~~V PROCEDURE:~~

PROCEDURE:

Exposure of the embryo/fetus to ionizing radiation carries a risk of causing certain adverse health effects such as cancer and developmental abnormalities, especially during the first three months of gestation. In accordance to Nuclear Regulatory Commission (NRC) regulations 10 CFR 20.108 and California Code of Regulations, Title 17, pertaining to declared pregnant radiation workers, the following procedure has been adopted by ECH s Radiation Safety Committee:

All personnel who directly work with, or are in close vicinity of sources of ionizing radiation, will be made aware of the recommendation of the NRC related to the control of radiation exposure received by declared pregnant women. Female employees who are assigned to wear a radiation badge are eligible to declare their pregnancy status. Pregnant workers may also rescind their declaration in writing to the RSO at any time.

A. Declaration of pregnancy is voluntary. It is the responsibility of the employee to inform their supervisor/ manager and the Radiation Safety Officer. Until there is a declaration of pregnancy, the occupational dose limits remain in effect which are higher than the fetal dose limits. The RSO should be informed as early as possible in the pregnancy term in order to assist the employee. The RSO will be available throughout the term of the pregnancy to answer any questions.

B. A radiation worker who decides to declare a pregnancy will complete the Declaration of Pregnancy form or their own written letter. This will be submitted to the Radiation Safety Officer.

C. This declaration will initiate the process by which the Radiation Safety Officer will evaluate the employee s radiation work environment, past exposure history, and potential for future exposure.

D. The employee will be given the opportunity to meet with the RSO to review the U.S. Nuclear Regulatory Commission Regulator uide (8.13) and associated Questions and Answers concerning Prenatal Radiation Exposure The RSO can educate the employee on the contents of 8.13 and advise them ~~related to~~about how to keep radiation exposure ALARA in their specific ob ~~about how to keep radiation exposure ALARA~~.

E. The pregnant employee may continue working in those areas and ob duties where it is unlikely that her external and internal radiation exposures will exceed the total monthly limits to the embryo/fetus, with proper attention to safe radiation practices.

F. A fetal dose monitor will be ~~issued~~ordered as soon as possible upon the receipt of the signed pregnancy declaration form and the employee will be instructed on the appropriate use. A spare fetal dosimeter will be assigned for use until the ordered fetal dosimeter arrives.

. The pregnant employee needs to incorporate the use of appropriate RPA and rolling shields as well as ALARA techniques of time, distance and shielding when using fluoroscopic equipment. Specific assignment questions can be addressed by the employee s manager.

H. The RSO will review the fetal badge monthly and ensure dose to the embryo/fetus remains below 0.5 rem (5 millisievert) during the entire pregnancy.

I. Dose rates for fluoroscopic vascular/interventional areas may be variable and participation in these types of procedures may need to be individually determined. Additional portable shielding and/or a maternity apron may also be considered.

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document, the electronic version prevails.

Attachments

Voluntary Declaration of Pregnancy

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	06/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	06/2021
Radiation Safety	Toni Murphy: Coord Quality & Education	05/2021
	Aletha Fulgham: Assistant Director Imaging Svc	05/2021

El Camino Health

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Area:	*Imaging Services*
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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 **ioni ing 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
- RSO Delegation of Authority: https://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 □ or□ers**

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 ~~the worker with a fetal dosimeter and~~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 □ or□er**

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 con□unction with 10 CFR 20.1201 significantly lower than the annual Nuclear Regulatory Commission

ALARA levels. Individuals exceeding ALARA exposure limits will receive ~~an ALARA Memorandum~~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 ~~Subaccounts~~Sub-accounts

□**adge Exposure** Diagnostic Radiology Nuclear Medicine Radiation Oncology Interventional Cardiology Fluoroscopy Supervisor	**Monthly**	□**uarterly**	**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. **Reesta□lishment 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 □ustification, and must approve or disapprove all revisions of investigational levels.

B. **Pu□lic □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 shield the gonads of all patients when the gonads lie within six centimeters of a properly collimated primary beam, unless the shielding will interfere with diagnosis.

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 ~~of a licensed radiographer~~.

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.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	06/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	06/2021
Radiation Safety	Toni Murphy: Coord Quality & Education	05/2021
	Aletha Fulgham: Assistant Director Imaging Svc	05/2021

El Camino Health

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Scope of Service - Clinical Education Department

Types and Ages of Clients Served

The Clinical Education Department provides services to all El Camino Hospital employees with a focus on Patient Care Services employees..

Scope and Complexity of Services Offered

The Clinical Education Department provides a competency based nursing orientation, training, and administrative support to assess and ensure staff competency and encourage and promote professional growth. Services provided include, but are not limited to:

- Nursing orientation for new employees, contracted and temporary staff.
- Nurse Residency Program
- Clinical support on all shifts for patient care services employees development of critical thinking assessment of performance problems and development of action plans for correction.
- Annual training and review on topics as required by regulatory and accrediting organizations and state and federal law, such as point of care testing.
- Continuing education classes.
- Managing ~~nursing~~student practicum experiences, liaison between school and the enterprise
- Tracking of attendance at on-site continuing education. Assistance with locating, scheduling and registering for the above classes.
- Serving as an educational resource to staff and patients.
- Instructional design
- Consulting with managers and staff to best decide the focus and implementation of education.

Staffing

The staff providing services includes: general clinical educators and unit based clinical educators. A director provides operational oversight. Additional instructors may be contracted as needed.

Level of Service Provided

The Clinical Education Department provides services under hospital policy and procedure guidelines.

Standard of Practice

The Clinical Education Department is governed by state and federal regulations, Department of Health Services and Joint Commission requirements, and national boards of certification for specialty nurses.

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Attachments

No Attachments

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MEC	Catherine Carson: Senior Director Quality [JH]	06/2021
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HR Leaders including CHRO	Tamara Stafford: Dir Talent Development & EWHS	06/2021
Contributor Input	Beth Willy: Director Clinical Education	05/2021
	Beth Willy: Director Clinical Education	05/2021

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Auxiliary Scope of Service

Types and Ages of Patients Served

The Auxiliary serves all age groups within the El Camino Hospital community, which consists of inpatients, outpatients, families, visitors, hospital employees, medical staff, and other volunteers.

Scope and Complexity of Service

We are a volunteer organization ~~of approximately 800 members,~~ with a variety of services, whose mission it is to render volunteer service to El Camino Hospital, its patients, and the community□to grant scholarships in the health professions□and to provide financial support for approved pro□ects.

~~Patient contact is included in the following services:~~
~~Endoscopy~~
~~Early □reeters~~
~~Emergency Department~~
~~Escort~~
~~Information~~
~~Inpatient Rehab (L□)~~
~~Library~~
~~Maternity~~
~~Med/Surg/Ortho Unit(L□)~~
~~Nursery~~
~~PACU (L□)Patient Care Liaisons~~

~~Rehabilitation Care Center (L□)~~
~~Roadrunners~~

~~Shuttle Service~~
~~Surgery Center~~
~~Telecare Service~~
~~Patient Care Liaison~~
~~□etting to □now You Program~~

Patient contact is included in the following services:

- Chairman of the Day
- Endoscopy

- Emergency Department
- Escort
- Hooks and Needs
- Information Desk
- Inpatient Rehab (L□)
- Java Junction
- Health Library
- Maternity
- Med/Surg/Ortho Unit(L□)
- PACU (L□)
- Pinkies
- Rehabilitation Care Center (L□)
- Roadrunners
- Shuttle
- Surgery Center (L□)
- Telecare Service
- Patient Care Liaison
- □etting to □now You Program

Staffing

The Auxiliary is staffed by a Board of Directors, consisting of a President, an Executive Vice President/ President Elect, a Vice President of Senior Membership (MV), a Vice President of Junior Membership (MV & L□), a ~~Vice President of Junior Membership~~Director of Services (MV & L□), a ~~Director of Services (MV & L□), a~~ Secretary, a Treasurer, an Associate Treasurer, a Parliamentarian, past Presidents ad hoc and a paid full-time Coordinator of Services ~~and a paid part-time Secretary~~. The administrative office is additionally staffed by ~~3~~six (6) volunteers.

Level of Service Provided

The determined level of service provided is ~~dependent upon the needs of the staff and the patients, and the qualifications of the volunteers to provide a specific~~determined by the service description for the patient contact area.

Standard of Practice

The Auxiliary adheres to state and federal guidelines provided in Title 22, the Joint Commission on Accreditation of Healthcare Organization, and the California Association of Hospitals and Healthcare Services.

El Camino Hospital Auxiliary □uidelines cover hospital and Auxiliary operational and safety protocols and are used as mandatory orientation for all volunteers.

Hospital volunteers additionally adhere to HR Policy on Hospital Volunteers and all applicable HR policies.

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Attachments

No Attachments

Approval Signatures

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BOD	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
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Department Medical Director or Director for non-clinical Departments	Christine Cunningham: Exec Director Patient Exp & Perf Improvement	06/2021
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Document Types:	*Plan*

Post Disaster □usiness Continuity Plan

I□COVERAGE:

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

II□PURPOSE:

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

III□STATEMENT:

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

Business continuity planning is an integral aspect of emergency management and must be carried out, not only in response to, but proactively in preparation for potential business continuity disruptions. Although preparing for ma□or disasters or emergencies is important, it is equally important to prepare for emergencies that are less severe but more frequent. For example, in an average year, El Camino Health may likely be more affected by severe storms, fires, flooding, power outages, seasonal flu absenteeism or technological interruptions than a ma□or disaster or terrorist incident. While risks and threats vary for each department, it is clear that the more prepared the organization is as a whole, the more effective its operational capability will be to maintain delivery of essential functions and services.

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

IV RESPONSIBILITIES:

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

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

V CONTINUITY PLANNING:

Assumptions

This BCP is based on the following assumptions and considerations:

- The BCP is intended to be a dynamic tool that can be used in the aftermath of emergencies, disasters, and other disruptive events to guide efficient and effective decision-making as well as a proactive planning tool to drive risk mitigation efforts.
- Leadership has identified and prioritized the mission essential services of El Camino Health. From this information, more detailed plans and operational procedures can be developed through a regular program of personnel training, plan testing, and maintenance.
- Emergencies occurring within the hospital (internally), or within the community (externally), may affect the organization's ability to provide optimal care, treatment, and/or service.
- El Camino Health has an Emergency Operations Plan (EOP), which uses the Hospital Incident Command System (HICS) as the management structure for command and control of an incident. The EOP includes references to this plan as part of making the transition period from incident response into recovery, before normal operations are able to fully resume.

Inputs

Emergency Management Planning

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

Ongoing Updates

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

Regional □ealth Care System

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

□a□ard Vulnera□ility Analysis

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

VI□CONTINUATION OF OPERATIONS

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

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

Essential Functions of El Camino □ealth

The essential functions of the organization are fundamentally as follows:

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

	Administrative Support

Decision-Ma□ing Considerations

□eneral assumptions include:

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

Recovery Strategies

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

- □ Facilities□
- □ Workforce□and
- □ Equipment and Supplies.

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

Assessment of Community□Facility Critical Infrastructure

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

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

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

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

□ or□force □Ad□ustments and Recovery

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

Absenteeism after a disaster may increase due to:

- □ Personal in□ury/illness or incapacitation of staff or family members.
- □ Inaccessibility of clinical locations.
- □ Employees under home quarantine or isolation as a result of state-ordered curfew.

- Employees caring for children dismissed from schools.
- Employees self-quarantining out of safety concerns.

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

- Identify medical and nonmedical staffing shortages
- Define resource requirements to recall additional staff incrementally to assist in continuity operations
- Coordinate with contracted staffing agencies to increase availability of critical medical staff
- Integrate credentialed, licensed, independent practitioners into continuity medical operations
- Coordinate with volunteer groups to supplement medical & non-medical personnel and
- Disseminate reports of staffing shortages to local incident management & state health authorities.

VII ORDER OF SUCCESSION

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

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

usiness Operations Succession Plan

ey Position	Successor	Successor
Chief Executive Officer	Chief Operations Officer	Chief Financial Officer
Chief Operating Officer	Chief Nursing Officer	Chief Administrative Services Officer
Chief Medical Officer	Associate Medical Officer (MV)	Associate Medical Officer (L)
Chief Financial Officer	Controller	Director of Finance
Chief Nursing Officer	Senior Nursing Director	Nursing Director
Chief Administrative Services Officer	Director of Facilities	Manager of Facilities
Chief Information Officer	Director of Technical Services	Director of Administration (IT)

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Attachments

No Attachments

Approval Signatures

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Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
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Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety	06/2021
	Matthew Scannell: Director Safety & Security Services	06/2021

El Camino Health

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Area:	*HIM*
Document Types:	*Policy*

□IPAA Restricting Use or Disclosure of Protected □ealth Information

~~I□COVERAGE:~~

COVERAGE:

All El Camino Hospital staff

~~II□PURPOSE:~~

PURPOSE:

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

~~III□STATEMENT:~~

STATEMENT:

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

~~IV□DEFINITIONS:~~

DEFINITIONS:

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

A. **Designated Record Set:** Medical records, behavioral health records (including psychiatric, alcohol and drug treatment records), and billing records about an individual patient maintained by the hospital and used to make decisions in the process of healthcare delivery. Medical records created by another provider filed with records of El Camino Hospital are included. Peer review, quality assurance, and information created and maintained for business purposes of the hospital not used to make decisions

about an individual patient in the process of healthcare delivery are ***not*** considered part of the designated record set and are not subject to inspection or correction by the patient or legal representative.

B. **□ealth Care Operations:** Any of the following activities:
   - Internal performance improvement activities, excluding research
   - Reviewing the competence or qualifications of health care professionals
   - Underwriting, premium rating, and other activities related to health insurance contracting
   - Medical review, legal services, and auditing
   - Business planning and development
   - Business management and general administrative activities

C. **Individually Identifia□le □ealth Information:** Information that identifies an individual (or could reasonably be used to identify an individual) that:
   - Is created or received by ECH;
   - Relates to the past, present, or future physical or mental health or condition of an individual;
   - Relates to the provision of health care to an individual;
   - Relates to the past, present, or future payment for the provision of health care to an individual.

   This includes demographic information (such as name, address, date of birth, sex, and race) collected from an individual.

D. **Payment:** Activities undertaken to obtain or provide reimbursement for health care services, including:
   - Billing, claims management, and collection activities;
   - Review of health care services for medical necessity, coverage, appropriateness, or charge justification
   - Utilization review activities

E. **Protected □ealth Information:** Individually identifiable health information that is transmitted or maintained by electronic or any other medium.

F. **Treatment:** Provision, coordination, or management of health care and related services by one or more health care providers, including:
   - Management of care by a provider with a third party;
   - Consultation between health care providers relating to a patient;
   - Referral of a patient from one provider to another

~~**V□PROCEDURE:**~~

PROCEDURE:

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

1. **Legal Re□uirement**

   Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have the right to request restrictions on use or disclosure of their protected health information, but covered entities (including hospitals) are not required to agree to those restrictions. El Camino Hospital will

consider each request for restriction and agree to those that it can reasonably accommodate.

2. **Allowa□le restrictions**

   A patient may request restrictions on use or disclosure of protected health information in a designated record set at El Camino Hospital. Such restrictions may include withholding of information from family or friends. A determination to restrict uses or disclosures must be made very carefully to ensure the request can be met.

3. **Re□uest in □ riting**

   All requests for restrictions must be in writing, using the form "Request to restrict use or disclosure of Protected Health Information or submitting an eRequest via their patient portal."

4. **Employees permitted to approve special re□uests for restriction**

   Requests for restrictions must be addressed by the Privacy Officer, or designee. No other member of the workforce may agree to such a request unless specifically authorized by the Privacy Officer.

5. **Providing the restriction**

   The Privacy Officer must ensure that the request can be met and that the designated record set is flagged per hospital procedure. The hospital may inform others of the existence of a restriction, when appropriate, so long as it does not result in the disclosure of the restricted information. A patients request to restrict disclosure cannot be applied towards protect health information released prior to the date of the request.

6. **Denial of re□uest**

   If the Privacy Officer determines that the hospital is not able to meet the request and provide the level of restriction requested by the patient, he/she must notify the patient of the denial in writing.

7. **Re□uired documentation and retention**

   The hospital must document the request and response and file the following information with the patient's medical record:

   - The designated record sets that are subject to restriction;
   - The titles of the persons responsible for receiving and processing requests for access by individuals; and
   - All correspondence and associated documentation related to the patient's request.
   - All documentation related to the request will be retained in accordance with the hospital's policy on "Record Retention and Destruction."

8. **Terminating a restriction**

   The hospital may terminate its agreement to a restriction, if:

   - The individual agrees to or requests the termination in writing;
   - The individual orally agrees to the termination and such agreement is documented; or
   - The hospital informs the individual that it is terminating its agreement to a restriction, except that

such termination is only effective with respect to protected health information created or received after it has so informed the individual.

9. **Medical emergencies**

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

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

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

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

REFERENCES:

~~"The California Patient Privacy~~Consent Manual,~~"~~ California ~~Healthcare~~Health Care Association, ~~October 2002, Second Edition.~~2019

Title 45, Code of Federal Regulations, Parts 160 and 164~~, August 14, 2002.~~

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

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	07/2021
HIM Leadership	Kristina Underhill: Manager HIM Ops	06/2021
	Kristina Underhill: Manager HIM Ops	06/2021

El Camino Health

Origination:	*09/2020*
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Owner:	*Steve Weirauch: Mgr Environmental Hlth&Safety*
Area:	*Emergency Management*
Document Types:	*Plan*

Emergency Management - Pandemic Plan

COVERAGE:

All El Camino Health staff, medical staff, and volunteers.

PURPOSE:

This procedure is intended to protect employees, physicians, volunteers, patients, contractors, and visitors minimizing exposure to a pandemic event.

1. The ability of El Camino Health (ECH) to develop a coordinated health care strategy to effectively prepare and provide for pandemic patients is a critical capacity. Because of the nature of viruses and their natural ability to mutate and become more or less of a threat to humans, there remains uncertainty as to when and how a pandemic will evolve, and its effect on local conditions that will influence decision-making within the health care system. ECH must be prepared for the rapid pace and dynamic characteristics of a pandemic virus.
    - El Camino Health should be equipped to care for:
        - A limited number of patients infected with the virus as part of normal operations
        - An overwhelming increase in the number of patients in the event of escalating transmission of pandemic virus.
    - The hospital is committed to:
        - Identifying and isolating all potential patients with the pandemic virus
        - Implementing infection control practices to prevent transmission
        - Providing medical treatment to patients
        - Ensuring rapid and frequent communication within the hospital, with other health care facilities, and with the Santa Clara County Public Health Department (SCCPHD).
2. Planning Assumptions
    1. The number of ill people requiring outpatient medical care and hospitalization will overwhelm the local health care system.
    2. El Camino Health will maximize the medical surge capacity and capability. However, when hospital capacity is exceeded, Care Centers will be needed for patients who can safely be managed outside of the acute care setting; hospitals will be reserved for patients needing the most sophisticated care.

3. The increased health care demands associated with a pandemic virus cannot be managed by health care facilities alone. An effective pandemic response must include cooperative strategies that use a variety of health care entities including hospitals, clinics, long-term care facilities, private practice physicians, and home health care providers.
4. Hospitals and other health care entities will likely experience staffing shortages throughout the pandemic period and into the subsequent recovery period. Under specific emergency conditions, volunteers, retired health care professionals, and trained unlicensed personnel may be used to provide patient care in a variety of health care settings.
5. Current resources for mass fatality care at all levels, including health care facilities, the county morgue and mortuaries, may be inadequate to meet the challenges posed by a pandemic virus.
6. To maximize health care resources and achieve the optimal benefit for the most people, traditional standards of care may need to be altered. “Sufficiency of care,” medical care that may not be of the same quality as that delivered under non-emergency conditions but that is sufficient for need, may be the standard of care during a pandemic.

DEFINITIONS:

A. **Alert Period** – El Camino Health defines the Alert Period as the first confirmed human-to-human transmission of the virus in the United States

B. **Pandemic Period** – El Camino Health defines the Pandemic Period as the first confirmed human-to-human transmission of the virus in the Bay Area.

C. **Pandemic Action Ta□le** – provides a summary of actions and responsibilities during a pandemic event. See: *Pandemic Plan Action Table*.

D. **Pandemic virus**: global outbreak of a new virus. Pandemics happen when new (novel) viruses emerge which are able to infect people easily and spread from person to person in an efficient and sustained way. The virus can spread quickly because most people will not be immune and a vaccine might not be widely available to offer immediate protection.

REFERENCES:

- Centers for Disease Control (CDC) - CDC’s Emergency Communication System – www.cdc.gov
- Santa Clara County Public Health Department (SCCPHD) - http://sccphd.org
- Infection Control – Seasonal Influenza Procedure·
- ~~Emergency Management - COVID-19 Control Plan~~Emergency Management - COVID-19 Control Plan

PROCEDURE:

Decision Ma□ing

A. **Alert Period**

1. Unless directed otherwise by the Santa Clara County Public Health Department (SCCPHD), El Camino Health shall enter the Alert Period as outlined in the subsequent sections of this plan upon notification by the SCCPHD of the first confirmed case of the pandemic in the United States.
2. Upon entering the Alert Period, the hospital shall convene an emergency pandemic task force to review/revise this plan that includes:

a. Use of the Hospital Incident Command System (HICS) at both hospital campuses for a sustained continuity of hospital operations and patient care services:

i. Specific pandemic planning strategies that incorporate current local, state and federal guidance

ii. Triggers for activating the hospital's internal pandemic emergency plan

iii. Assignment of authority and responsibility for aspects of the pandemic plan and response within the facility

iv. Patient triage systems

3. **Pandemic Period**

a. El Camino Health shall implement the Pandemic Period plans outlined in the subsequent sections when the first confirmed case of the pandemic virus upon either the notification of SCCPHD, or the awareness of a sudden surge of patients during the initial phases of the pandemic within the Bay Area.

□ospital Surveillance

- The goal of disease surveillance is to serve as an early warning system to detect an increase in illness in the hospital & community.

A. **Methods**
Monitor illness symptoms in Santa Clara County. The SCCPHD will define the symptoms for the current virus.

1. ECH ED participates in syndromal surveillance. A tally sheet of major symptoms of ED patients is filled out each day and faxed every 8 hours to SCCPHD.
2. ESSENCE is a computer syndromal surveillance system which is available to hospitals for automatic reporting. ECH is not participating in ESSENCE at this time.

B. **Alert Period**

1. SCCPHD may require:
   a. Laboratory confirmed - associated hospitalizations to be placed on the reportable disease list.
   b. Specimens from patients meeting the case definition for suspect infection are sent to the Santa Clara County Public Health Lab (SCCPHL).
2. ECH lab has a procedure in place for safe transport of specimens to SCCPHL.
3. The following procedure for monitoring employee absenteeism will be implemented.
   a. **All** employees calling in sick with symptoms will be required to leave a voice mail message on a designated **FLU LINE**, that will be published by Employee Wellness and Health in addition to following their normal department sick call procedures.
      i. The employee will be asked to provide the following information:
         a. Name
         b. Department where they work
         c. Contact telephone number
         d. Symptoms they are exhibiting

e. Duration of symptoms.

b. The **FLU LINE** will be monitored by the Employee Wellness and Health Services Department on a daily basis Monday through Friday.

c. A tally sheet of the number of sick calls with the specified symptoms will be filled out daily and faxed to the Infection Prevention Department for review and correlation with the Emergency Department data.

C. **Pandemic Period**

1. ECH will provide status reports through the EMResource messaging. Early in this period, case level reporting will be done. As the pandemic spreads, batch reporting will be done. SCCPHD reporting forms are provided in the county plan.

Infection Control

- The goals of infection control are:
  - To limit transmission of the pandemic virus from infected patients to non-infected patients and staff
  - To provide infection control guidance to the hospital on managing pandemic patients.
  - Since a vaccine for the pandemic virus may not be available immediately, and antiviral drugs may be in limited supply, the ability to limit transmission will depend upon the use of appropriate infection control measures

A. **Alert Period**

1. ECH has a respiratory protection program in place for designated clinical staff. Powered Air-Purifying Respirators (PAPRs) are worn by staff when providing care for a patient with a suspect or known airborne transmitted disease.

   a. In the event that the number of PAPRs is insufficient to protect staff, N-95 masks may be used. However, just-in-time fit testing will need to be completed for all staff prior to using the N-95 mask.

2. Central Stores will order additional supplies of PPE to maintain an adequate supply for the average daily census. The estimated minimum quantities are five sets of PPE used per day for each infected patient. See Section 9 for additional information on surge capacity. A procedure for acquiring additional supplies in an emergency will be developed.

3. All staff is educated on the importance of containing respiratory secretions to prevent the transmission of disease during employee orientation. Emphasis is also placed on staff being prepared at home with emergency supplies which include gloves and masks.

4. Respiratory hygiene etiquette signs and masks are available at the main entrances to the hospital

B. **Pandemic Period**

1. Detection of persons entering the hospital with suspect or known pandemic virus.

2. Instruct persons with signs of respiratory illness to use respiratory hygiene etiquette. This includes:

   a. Respiratory hygiene stations with supplies of masks, tissues and gel and posted signs in appropriate languages with instructions to immediately report symptoms of respiratory infections as directed.

   b. Instructions on the proper use and disposal of masks and tissues, and the use of antimicrobial gels after contact with respiratory secretions. Emphasis on covering the nose/mouth with tissues

or with an arm when coughing and sneezing.

c. Spatial separation of persons with respiratory infections in common areas if possible.

3. Entrances to the hospital may be restricted for patients and visitors and a separate, designated entrance for employees.
4. A designated area will be used for daily screening employees for virus symptoms. This will include monitoring temperature and signs & symptoms of the virus.
    a. A designated colored dot will be placed on staff badges once the virus is ruled out. The color of the dots will change every day.
5. Security or other staff will be available to assist with screening at the entrances
6. Visitors will be screened for signs and symptoms of the virus before entry into the hospital. Anyone suspicious for the virus will not be permitted inside the facility.
7. Family members who accompany patients with the pandemic virus are assumed to be exposed and should wear masks.
8. Only visitors who are necessary for the patient's well-being and care shall be allowed in the hospital.
9. Non infected visitors will be instructed on proper use of PPE and hand hygiene before entering and leaving a patient's room.

C. **Management of Infectious Patients**

1. Patient Placement
    a. Limit admission to pandemic virus patients with severe complications who cannot be cared for outside the hospital.
    b. These patients should be placed on airborne precautions for a minimum of 5 days to 14 days from onset of symptoms or as directed by the SCCPHD.
        i. Immuno-compromised patients may be placed on isolation for the duration of their illness.
    c. A pandemic unit shall be established within the hospital. Assess available spaces for patient care and isolation capabilities. This should be done early in the course of a local outbreak.
    d. Personnel assigned to cohorted patient care units should not float to other units. The number of personnel entering this unit should be limited to those necessary for patient care and support.
    e. Health care workers should be vigilant to avoid:
        i. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved):
        ii. Adjusting PPE after contact with infected patient.
        iii. Improper removal of PPE.
        iv. Contaminating environmental surfaces that are not directly related to the patient (door knobs, light switches, etc.)
    f. Health care workers should practice careful hand hygiene.
2. Personal Protective Equipment (PPE)
    a. Respiratory Protection
        i. **Powered Air-Purifying Respirators (PAPR):** Staff taking care of infected patients will wear a PAPR when in close contact with an infected patient whenever possible.

ii. **N-□□ Mas□s:** Should the need for PAPRs exceed the available quantity, N-95 masks may be used. However, just-in-time fit testing of the N-95 masks must be completed by each employee prior to use.

a. Ideally the mask should be worn once and discarded. If in short supply, this may be changed. If patients are in a common area, one mask may be worn for multiple patients over a short period of time.

b. Change masks when they become soiled or contaminated.

c. Do not leave a mask dangling around the neck.

d. After touching or when discarding the mask, perform hand hygiene.

b. Gloves

i. Gloves should be worn for contact with all body fluids including respiratory secretions.

ii. Remove and discard gloves after contact with a patient. Perform hand hygiene.

iii. If gloves are in short supply, priorities for glove use may need to be established.

c. Gowns

i. Wear an isolation gown if soiling of clothes is anticipated. Most patient contact does not require the use of a gown. Procedures that involve close contact with the patient or the generation of aerosols require the use of a gown.

ii. Gowns should be used only once and then properly disposed of and hand hygiene performed. If gowns are in short supply, priorities for their use may need to be established.

d. Goggles or face shields

i. If sprays or splatters of infectious material are likely, goggles or a face shield should be worn.

ii. Eye protection should be properly disposed of and hand hygiene performed.

3. Patient transport

a. Limit patient movement and transport outside the isolation area. Consider having a portable X-ray machine for use with the area.

b. If transport is essential, patient must wear a regular mask and perform hand hygiene before leaving the area.

4. Standard precautions are used for:

a. Disposal of wastes

b. Handling contaminated linen ~~(linen cart kept in room)~~*(linen cart kept in room)*

c. Handling dishes and eating utensils

d. Handling and reprocessing used patient care equipment

e. Environmental cleaning and disinfection

5. Cleaning and disinfection of an occupied room or area

a. Wear gloves according to facility policy and wearing respiratory protection as defined above. Gowns are not necessary for routine cleaning.

b. Keep areas around patient free of unnecessary supplies and equipment

c. Use only approved disinfectants.

d. Pay special attention to frequently touched surfaces.

6. Cleaning and disinfection after discharge or transfer

a. Follow standard precautions

b. Postmortem care-follow standard precautions

7. Employee Health Issues

a. Implement a system to educate personnel about employee health issues related to the pandemic.

b. Screen all personnel for virus symptoms before they come on duty.

c. Personnel who are at high risk for complications of the virus (pregnant women, immuno-compromised persons) should be informed about their medical risk and offered a job away from infectious patients

8. Control of hospital-acquired transmission

a. If limited hospital-acquired transmission is detected, appropriate controls should be implemented. These may include:

i. Co-horting of patients and staff on affected units.

ii. Restriction of new admissions to the affected areas.

iii. Restriction of visitors to affected areas.

b. If wide spread hospital-acquired transmission occurs, these controls:

i. Restrict all nonessential persons.

ii. Stop admissions not related to pandemic and stop elective surgeries.

□ospital Ris□ Communications

A. Information Sources

1. Information regarding a pandemic and the planning for it is available from a variety of sources, including, but not limited to:

a. Centers for Disease Control (CDC) - CDC's Emergency Communication System – http://www.pandemicflu.gov

b. California Department of Health Services - California Health Alert Network (CAHAN)

c. Santa Clara County Public Health Department (SCCPHD) - http://www.sccgov.org/portal/site/phd/

2. To reduce the likelihood of conflicting or confusing messages during Alert and Pandemic periods across the health care system, El Camino Health will coordinate all external media content with the Santa Clara County Public Health Department (SCCPHD) and other area hospitals. The SCCPHD - Public Information Officer (SCCPHD PIO) will take the lead in development of public health and medical risk communication materials for release to the public, business community, schools, and critical infrastructure including health care facilities. The hospital Public Information Officer (PIO) shall maintain a close working relationship with the SCCPHD PIO.

B. **Alert Period**

Upon activation of the Hospital Command Center (HCC) and implementation of Hospital Incident Command System (HICS), the following procedures will be put into place:

1. External Communication to Health Networks
    a. The hospital Public Information Officer (PIO) shall be the single-source contact with the SCCPHD PIO. The hospital PIO shall be assigned by the Incident Commander under the hospitals HICS plan.
    b. The hospital Infection Prevention staff will assist with the tracking of local transmissible respiratory diseases, case definitions, and new epidemiological findings.
2. External Communication to Public
    a. The PIO shall work with the SCCPHD, HCC and Community Relations to create appropriate messages for staff, patients, and the general public.
    b. Possible resources for distributing information could be:
        i. Social Media (Facebook, Twitter, etc.)
        ii. Mass notification system (e.g. Everbridge)
        iii. Recorded Messages on special hot line
        iv. Hospital Website
        v. Printed bulletins
        vi. Radio – KCBS (740 AM)
3. Internal Communication to Staff
    a. Education and training shall be provided to all staff and volunteers. See Section 5 – Education and Training of this plan.
    b. Information and messages for staff and volunteers including updated information on the hospital status, staffing needs, and other pandemic information provided by the SCCPHD shall be distributed using appropriate channels.
    c. The content of the communications shall be determined by:
        i. PIO
        ii. Liaison Officer
        iii. Infection Prevention
        iv. Human Resources
    d. Possible resources for distributing information can include
        - Recorded Messages on special hot line
        - Hospital Website
        - Mass Notification System (e.g. Everbridge)
        - “All ECH” email
        - Vocera broadcasts
        - Printed bulletins
        - FAQ

C. **Pandemic Period**
During the pandemic period, the hospital PIO will:

1. Maintain a single source of contact with SCCPHD PIO, ensuring information is updated, as needed.
2. Maintain internal and external communications as outlined during the Alert Period.

Education And Training

A. Information Sources

1. Offering information and education prior to an event can be addressed by designating a local educational leader who will plan, conduct and execute training and educational opportunities on topics such as:

Topic	Responsible Party	Status/Action
Awareness of global or local transmissible respiratory infectious diseases	▪ Nursing Education Manager ▪ Safety Officer	▪ See Information from SCCPHD ▪ Documentation from CDC ▪ See Infection Control Exposure Control Plan
Identification of infection control practices, isolation, quarantine, and home care as appropriate or needed to respond to a possible pandemic	▪ Infection Prevention	▪ See Information from SCCPHD ▪ See Infection Control Exposure Control Plan
Awareness of comprehensive standard precautions policies incorporating hand and respiratory hygiene protocols to be practiced at all times as a means of general infection control and prevention	▪ Infection Prevention	▪ See Infection Control Exposure Control Plan ▪ Ongoing revisions and updates as necessary
Use of PPE to decrease disease spread and how to assist patients and visitors on PPE use	▪ Infection Prevention ▪ Nursing Education	▪ HealthStream Training ▪ Ongoing

Topic	Responsible Party	Status/Action
	▪ Employee Wellness and Health Services	
Cross-training of Clinical and Non-clinical staff who are not currently direct caregivers to provide care as needed	▪ Nursing Education ▪ Safety Officer	Upon notification of *Alert Status* by SCCPHD ▪ Town Hall Meetings ▪ Additional Training
Education of patients, family members and visitors	▪ Nursing Education ▪ Infection Prevention ▪ Education Director ▪ Community Relations	▪ See information from SCCPHD ▪ Develop an El Camino Health-specific Pandemic memo.

B. Additional Resources from Pandemic Plan (Attachments)

1. Home Isolation Checklists: *SCC Home Isolation Checklist*
2. Website Reference Tool: *Pandemic Reference Tools*
3. Home Preparedness Checklist: *Home Preparedness Information*

Patient Triage

A. Pandemic Triage Supply List

	Quantities	
Item Description	**Mountain View**	**Los Gatos**
Monitors	2	1
PAPR	45	10
N95 Masks	2000	1000
Surgical Masks	2000	1000
Oxygen tanks	4	2
Oxygen Masks	4	2
Antimicrobial Hand Gel	24 bottles	12 bottles
Antimicrobial Wipes	10 containers	5 containers

Medium Gloves	720 boxes	360 boxes
Isolation gowns	450	225
Tympanic Thermometer	2	2
Thermometer covers	1000	500
Emesis Basins	250	125
Signs to explain how to fill out self-history	2 - 4	2 - 4
Tents	2	2
Chairs	4	4
Heaters	4	4
Garbage Cans	2	2
Wheelchairs	2	2
Copies Home Isolation Checklist	100, Copy as needed	100, Copy as needed

[1] The numbers represent estimated supplies for 150 people for 3 days.
[2] The numbers represent estimated supplies for 75 people for 3 days.

Clinical Guidelines

- El Camino Health is utilizing the clinical guidelines as outlined by the SCCPHD Department in the Pandemic Preparedness and Response Plan.
  - Note: Refer to SCCPHD website for current revision

A. **Overview**
Refer to Module V - Clinical Guidelines and Disease Management for a complete description of guidelines for health care providers.

The CDPH “Pandemic Influenza Preparedness and Response Plan” acknowledges, “The management of a pandemic is based primarily on sound clinical assessment and management of individual patients as well as an assessment of locally available resources such as rapid diagnostics, antiviral drugs and vaccines, and hospital beds."

Health care providers play an essential role in detecting an initial case of novel or pandemic virus in a community. Early detection through heightened clinical awareness of disease and swift action for isolation and initiation of treatment can benefit the individual patient and may slow the spread of the virus within the community. Rapid diagnosis and intervention with clinical care can potentially avert severe complications.” (from the California Department of Health Services Pandemic Influenza Preparedness and Response Plan, Draft. Appendix 5, January, 2006.)

B. **Alert Period**

1. Hospital Pandemic Plans should include a defined process for ensuring that clinical guidance received from SCCPHD and California Department of Public Health (CDPH) is shared with clinical staff.
2. SCCPHD has developed “Clinical Algorithm for Case Management- Alert period” (Tool M5-4) (See attachment - SCC Clinical Algorithm (Alert Period)), that should be used by all SCC clinicians in evaluating and diagnosing a novel virus. This includes both clinical criteria and epidemiological

criteria.

C. **Pandemic Period**
SCC Hospitals should implement plans to assure that clinical guidance received from SCCPHD and CDPH are shared with all clinicians (See attachment - SCC Clinical Algorithm (Pandemic Period)).

Vaccines And Antiviral Drugs

- El Camino Health is utilizing the Vaccines and Antiviral Drugs section as outlined by the Santa Clara County Public Health Department in the Pandemic Influenza Preparedness and Response Plan.
  - Note: Refer to SCCPHD website for current revision: http://www.sccgov.org/portal/site/phd/.

A. Overview
Refer to Module V - Clinical Guidelines and Disease Management for a complete description of the use and administration of vaccines and antiviral drugs during a pandemic.

Once the characteristics of a new pandemic virus are identified, the development of a pandemic vaccine will begin. Recognizing that there may be benefits to immunization with a vaccine prepared before the pandemic against ~~an~~a virus of the same subtype, efforts are underway by the federal government to stockpile vaccines for subtypes with pandemic potential. As supplies of these vaccines become available, it is possible that the federal government will recommend that some health care personnel and others critical to a pandemic response will be vaccinated to provide partial protection or immunological priming for a pandemic strain. HHS has not finalized policies for the use of pre-pandemic vaccine. During a pandemic, these recommendations will be updated, taking into account populations that are most at risk.

Antiviral drugs effective against the circulating pandemic strain can be used for treatment and possibly prophylaxis during a pandemic. Decisions regarding whether to prioritize use of antivirals for treatment over prophylaxis, or for prophylaxis over treatment, will be determined, to the extent possible, on the basis of demonstrated efficacy of the antiviral agents against novel and pandemic virus strains.

B. **Alert Period**
SCC hospitals will:

1. Monitor updated HHS information and recommendations on the development, distribution, and use of a vaccine.
2. Work with SCCPHD on plans for distributing vaccine.
3. Provide estimates of the quantities of vaccine needed for hospital staff and patients using SCCPHD criteria.
4. Develop a hospital pandemic vaccination plan.

C. **Pandemic Period**
SCC hospitals will:

1. Follow SCCPHD guidelines for use and administration of antiviral drugs for prophylaxis measures and treatment, if available.
2. Implement the hospital pandemic vaccination plan, as directed by SCCPHD.

Surge Capacity

- Refer to Emergency Management Plan – Hospital Surge Capacity Plan

Mortuary Issues

- Refer to Emergency Management Plan – Mass Fatality Plan

Security □ Facility Access

A. **Alert Period**
Upon notification that the hospital has entered an Alert Period, as defined by the Santa Clara County Public Health Department, the following may be enforced:

1. The Hospital Command Center (HCC) shall be activated.
    a. The HCC shall direct all actions of the hospital, including:
    b. Decisions regarding the temporary closure of the hospital to new admissions and transfers.
    c. Restricting hospital access to employees, patients, and essential visitors only.
        - Essential visitors include family members, care-givers of patients, vendors delivering essential supplies, and those approved by the HCC.
    d. Non-essential visitors will not be allowed access.
2. Security
    Upon notification that the hospital has restricted access Security shall:
    a. Lock all exterior hospital doors. Access will be by card key only.
    b. Contract additional security staff to assist with and enforce lock down of the facility.
    c. Follow directions from the HCC. (See *Emergency Management Security Plan* for more information.)
3. Facilities
    Upon notification that the hospital has restricted access Facilities shall:
    a. Coordinate with the HCC to define and set up a screening area for all patients and visitors to the hospital. Specifics will be determined by the HCC.
    b. This space may be external to the main hospital buildings, such as
        - Large tent – secure an extended rental of a large event-type tent
        - Parking garage
        - Other space deemed appropriate.
    c. This space will require lighting, electrical power, chairs, cots, tables, gurneys, and other equipment requested by the clinical staff.
    d. EVS and general stores will assist with providing and setting up of equipment.
    e. Facilities will arrange for the leasing of equipment, as needed.

B. **Pandemic Period**
Upon notification by the HCC that the hospital has entered a pandemic period the following additional measures will be taken.

1. HCC
    a. Code Triage will be called.

2. Security
    a. Follow the Emergency Security Plan under the direction of the HCC. (Emergency Management - Security Plan)
    b. Card key access to external doors may be disabled.
    c. All hospital entrances shall be secured.
    d. Officers or other staff shall be posted at all entrances.
    e. Security may request additional assistance from the Labor Pool.
    f. Only staff that have been screened by Employee Wellness and Health Services will be allowed entry.
3. Facilities
    a. Facilities will assist in setting up a screening area for all employees.
    b. This entrance will be separate from the patient/visitor screening area.
    c. Any employee must be approved for entry by Employee Wellness and Health Services.

Occupational □ealth

- Novel viruses can often have an explosive impact in the health care setting and preventing transmission is an important concern for the protection of staff and patients and to ensure that El Camino Health can maintain its core functions.

A. **Alert Period**
Upon notification that the hospital has entered an Alert Period, as defined by the Santa Clara County Public Health Department, the following will occur:

1. All staff and extended staff involved in the care of patients should be vaccinated with the most recent seasonal human influenza vaccine.
2. All staff and extended staff who have traveled within the past 10 days (or as specified by SCCPHD) by airplane or from an area considered high-risk by Infection Prevention shall be screened by Employee Wellness and Health Services before reporting to work.
3. All staff and extended staff will need to be vigilant for symptoms of the virus for up to one week, or as specified by the SCCPHD, after their last exposure to an infected patient.
4. All staff and extended staff who become ill should do the following:
    a. Seek medical care but prior to arrival notify their health care provider they may have been exposed to the suspect virus.
    b. Notify Employee Wellness and Health Services
    c. Stay home until 24 hours (or as defined by SCCPHD) after resolution of fever and symptoms unless one of the following applies:
        i. An alternative diagnosis is established that explains the health care worker's illness
        ii. Diagnostic tests are negative for the virus
    d. While at home, ill persons should practice good respiratory and hand hygiene to lower the risk of transmitting the virus to others.

B. **Pandemic Period**

1. All staff and extended staff will be screened for symptoms before they are allowed to enter any ECH facility.
    a. Main Hospital at both Mountain View and Los Gatos: a single entrance will be made available for all Health care workers of main hospital facility to be screened for clearance to work. This includes staff working in the Women's Hospital, Willow, Oak, Cedar, Sobrato, Taube, Melchor and Park Pavilion, Los Gatos Rehab and PPI.
2. Screening criteria will include:
    a. Temperature
    b. Employee Wellness and Health Services symptom review questionnaire (see *EHS Symptom Review Questionnaire*).
3. Each "cleared" staff will be provided with a colored indicator to be worn for the entire shift to signify that they have been met the criteria for being able to report for duty that day.
    a. Health care workers will not be allowed to enter any ECH facility without the appropriate colored wrist band.
    b. The colored indicator (e.g., wrist bands or dots) will be changed daily.
4. Any health care worker who becomes symptomatic while on duty will be required to don a surgical mask and report to EWHS for a medical evaluation.
5. Concern EAP will be available for counseling for any employee of El Camino Health.
6. Rest and meal breaks will be provided through the Labor Pool. This will be coordinated through the HICS Logistics Branch (Employee Health and Well-Being Unit Leader).

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

Pandemic Plan - SCC Home Isolation Checklist.docx
Pandemic Plan - SCC Clinical Algorithm (Pandemic Period).docx
Pandemic Plan - SCC Clinical Algorithm (Alert Period).docx
Pandemic Plan - Pandemic Reference Tools.docx
Pandemic Plan - Home Preparedness Information.docx
Pandemic Plan - Action Table.docx

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	07/2021
Infection Prevention Committee	Jeanne Hanley: Policy and Procedure Coordinator	07/2021

Step Description	Approver	Date
Emergency Management Committee	Steve Weirauch: Mgr Environmental Hlth&Safety	04/2021
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El Camino Health

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Reporting of Domestic Partner Assault

COVERAGE:

All El Camino Hospital staff

PURPOSE:

Pursuant to California Penal Code Section 11160 □ 11163.6: Suspected domestic violence must be reported by phone, and in writing, to local law enforcement when a patient presents to the hospital and a staff member reasonably suspects that the patient has been physically abused by his/her spouse or the equivalent:

Suspected domestic violence must be reported even if the patient does not desire police involvement, and is unwilling to speak to the police.

Physical abuse includes direct beatings, sexual assault, unreasonable physical restraint, and/or prolonged deprivation of food or water

STATEMENT:

El Camino Hospital to complies with all mandatory reporting requirements for Assault, Domestic Partner

PROCEDURE:

A. Mandatory Telephone Report:

1. El Camino Hospital staff members will report any suspected domestic violence to the police in the □urisdiction where the suspected domestic violence occurred. Telephone contact will be made immediately or as soon as practically possible.
2. If a police officer accompanies the suspected domestic violence victim, the hospital staff member should note their name and obtain their badge number. This contact may take place of the mandatory telephone number.

B. Mandatory Written Report:

1. Hospital staff members must complete a written report and send it to the local law enforcement agency within two working days of receiving the information regarding the person.
2. The report shall include:
   a. The in□ured person□s whereabouts,

b. The character and extent of the person□s in□uries,

c. The identity of any person the in□ured person alleges inflicted the wound, other in□ury or assaultive or abusive conduct upon the in□ured person.

C. All staff will follow the Protocol, Domestic Violence Victim, Management of, to ensure the following ob□ectives:

a. Early identification of the patient being abused or at risk of being abused.

b. To offer resource information and options to aid the patient in moving toward prevention of further abuse.

c. The patient will be offered a safe place to stay when discharged from the Emergency Department or hospital.

d. Legal requirements will be met. Documentation will reflect in□uries sustained and patient statements.

e. Patient confidentiality and safety will be maintained. □enerally, no information, including the presence of the patient in the hospital, will be released.

D. Expired Patients:

1. A telephone and written report must be completed and reported to the police for all suspected victims of domestic violence who have expired. The reports must be made regardless of whether the assaultive or abusive conduct contributed to the cause of death.

REFERENCE:

See protocol: Domestic Violence Victim, Management of, in Protocol and Procedure Manual.

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

No Attachments

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ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	07/2021
	□race Benlice: Director Care Coordination [A□]	06/2021

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Utili□ation Management Plan

~~I□COVERAGE:~~

COVERAGE:

All El Camino Hospital Employees and Medical Staff

~~II□POLICY STATEMENT:~~

STATEMENT:

Appropriate, efficient, and effective health care services in the most cost-effective manner will be delivered to all patients using an organized, collaborative, system-wide approach to resource management. Open communication and on-going education on appropriate utilization practices will be consistently provided. The Care Coordination Department will provide a multidisciplinary, collaborative and systematic approach to ~~healthcare~~health care delivery with a focus on continuity of care, clinical quality, customer service, and fiscal value.

~~III□PROCEDURE:~~

~~A□AUT□ORITY AND RESPONSI□ILITY FOR T□E UTILI□ATION REVIE□ PLAN~~

PROCEDURE:

A□AUT□ORITY AND RESPONSI□ILITY FOR T□E UTILI□ATION REVIE□ PLAN

1. Board of Directors - The responsibility for ensuring a comprehensive, organized effective Utilization Management Plan encompassing the continuum of health care ultimately rests with the Board of Directors. The Board delegates authority to ~~the medical staff~~executive and senior leadership for development, implementation and maintenance of the Utilization Review Plan, as delineated in this plan and in applicable policies, procedures and bylaws.
2. Senior Leadership - Senior leadership will facilitate the effective performance of the Utilization Management Plan providing active support and allocating adequate resources to the implementation of the plan.

3. Medical Staff and Hospital Departments - The medical staff and hospital departments will review the results of utilization management activities related to their areas of clinical and support services. Each department will take appropriate action based on the recommendations made by Utilization Management Senior Leadership as part of ongoing performance improvement.
4. Professional Review Committees:
    a. Committee Structure - The Medical Executive Committee has delegated the responsibility for implementation of the Utilization Management Plan to the Utilization Management Committee (UMC).
    b. Composition:
        i. The Utilization Management Committee (UMC) Chair will be recommended by the hospital Chief Medical Officer and approved by the ~~MEC~~board. The members of the UMC will be appointed by the UMC Chair. The UMC will be composed of two (2) or more physicians of the active staff who broadly represent the services of the medical staff. Each appointed member of the committee shall have a vote.
        ii. The committee will be assisted by other professional personnel. Representatives from Administration, Health Information Management, Care Coordination, Quality/Clinical Effectiveness, Pharmacy and Nursing, as well as directors of reporting ancillary departments may attend the committee meetings ~~as non-voting members~~.
        iii. Upon invitation from the Chair, other representatives of the Hospital or Medical Staff may attend meetings. The Physician Advisor and the Care Coordinator (CC) will function as an extension of the UMC. The Chairman or other designated Members of the committee shall serve as the Physician Advisor (PA) if there is not an appointed advisor available, or when hospital appointed ~~Pas~~Physician Advisors are not available.

    (NOTE: A secondary level reviewer is available to consult with physicians and Care Coordinators to establish patient status, i.e., inpatient versus observation.)

    When the UMC makes a recommendation regarding a physician's practice management, the issue will be referred to the appropriate department for further action.
    c. Meetings - The UMC shall meet and report to the Medical Executive Committee and the appropriate members of the quality team quarterly or more frequently as needed as determined by the UMC Chair.
5. Physician Advisor - Physician Advisors serve as a resource to the hospital and medical staff in evaluating the appropriateness of patient admission and continued stays when necessary. Other medical staff committee members will provide specialty consultation as needed. In the absence of designated Physician Advisor, Utilization Management Committee members will serve as Physician Advisor as necessary. Physician Advisors are responsible for:
    a. Determining the medical necessity of hospital admission, hospital continued stay ~~andancillary~~and ancillary services on referred cases.
    b. Contacting the attending physician to obtain additional information regarding the medical necessity of the admission, continued stay and/or service, as necessary.
    c. Discussing patient medical necessity for an admission or continued stay of a referred case with the assigned Care Coordinator
    d. Serving as a resource to the hospital by identifying utilization issues, recommending improvement opportunities and defining educational needs.

A□UTILI□ATION MANAGEMENT PLAN GOALS AND O□□ECTIVES

□□UTILI□ATION MANAGEMENT PLAN GOALS AND O□□ECTIVES

1. Through implementation of an effective Care Coordination Program, the hospital will further its commitment to the community we serve by providing quality health care in a cost effective manner. This program's focus is to:
    a. Establish and maintain an effective, collaborative, Utilization Management Plan across the continuum of care.
    b. Assess the appropriateness of the treatment setting including the medical necessity of patient placement in observation status, hospital inpatient admissions, continued stay, professional services, and identification of opportunities for providing quality care more economically in alternate care settings.
    c. Assess the appropriateness, efficacy and efficiency of the services and resources provided to the patient and to promote the patient's right to actively participate in treatment decisions.
    d. Identify patterns of under-utilization, over-utilization, and inefficient use of resources and recommend and/or initiate actions to improve the use of health care services.
    e. Establish a mechanism for the review of outlier cases based on extended length of stay and/or extraordinarily high costs.
    f. Initiate and/or recommend improvement plans when areas of inappropriate utilization are identified and to evaluate the effectiveness of the improvement plans.
    g. Achieve and maintain compliance with applicable standards and regulations, including contractual agreements with third-party payers and external review entities, when agreements are consistent with professionally recognized standards of care.
    h. Provide concurrent identification of and, where possible, appropriate intervention in issues related to utilization of resources, risk management and quality of care.
    i. Encourage the incorporation of established quality and utilization performance standards in the daily operating plans of each department, committee and service.
    j. Promote continuity of care and services by identifying all patients in need of post hospital care and assuring that they have an appropriate, timely plan for discharge.
    k. Serve as an advocate for appropriate care, treatment, and discharge decisions that are based on recognized standards of care and not solely on the reimbursement determinations of external review entities.
    l. Communicate utilization information and provide education on appropriate utilization of resources in a collaborative, collegial manner to individual practitioners, departments, committees, senior leadership, the Medical Staff, and the Board of Directors.

□□PROGRAM ELEMENTS

C□PROGRAM ELEMENTS

1. Criteria - The effort of the members of the Care Coordination Department is directed toward assessment

of patients and their medical records to determine appropriateness of admission, level of care setting, continued stays, resource utilization and aftercare needs. Such assignments utilize InterQual® Level of Care Criteria and active participation in the care of patients through interaction with physicians and multidisciplinary unit rounds.

2. Types of Review - The review process is applied to all patients regardless of payer source.
   a. Pre-admission Review (when applicable)

      Pre-admission screening is performed by the Care Coordinator (CC) a member of the Care Coordination Department. Medical necessity, ability to meet the needs of the patient, appropriateness of admission, levels of care setting; pre-authorization requirements as well as other utilization and discharge planning issues are assessed if possible. If a problem is identified, the CM contacts the attending physician to obtain the necessary information to justify admission or validate the appropriateness of the admission.

   b. Admission Review and Concurrent Review

      In general, medical record review will be conducted within 24 hours of the patient's admission or on next business day. This review assesses the medical necessity of admission and continued stay, as well as the ability to meet the continued needs of the patient. If the admission is appropriate, reviews will be conducted as needed until the patient is discharged.

   c. Outlier Case Review Meetings

      Outlier Case Review Meetings focus on ~~proactively~~pro-actively identifying any obstacles to discharge and develop a plan to resolve them in a collaborative environment. Cases will be reviewed for various reasons, such as; length of stay, extraordinarily high cost of care, admission and continued stay criteria, level of care, discharge planning options, referrals to ancillary departments, Social Service referrals, medical treatment issues, delays in service, concerns regarding the adequacy of treatment plans, and financial issues regarding un-funded, or under-funded patients.

   d. Escalation Process - Cases that do not meet InterQual® criteria are escalated. The following process will be followed:
      i. The CM determines that InterQual® criteria are not met, i.e.; the patient could safely go to another level of care and/or there is no barrier to discharge other than not having discharge orders.
      ii. The CM initiates a discussion with the Attending Physician to determine if the patient can be discharged or if other clinical information qualifies the stay and/or change in level of care.
      iii. If unable to come to an agreement, the Care Coordinator escalates the case to a Physician Advisor who takes action.
      iv. The Care Coordinator will document all interventions and activity related to escalation in the electronic record.

   e. Denials and Appeals
      i. Denials

         Questionable admissions, continued stays and discharges identified by the Care Coordinators are escalated using the escalation process. The appropriateness of issuing a formal denial is

determined by the Physician Advisor following consultation with the Attending Physician. Specific procedures and standardized letters are used for purposes of notifications of physicians, patients, and payers as required according to the specifications of each review organization or third party payer.

ii. Appeals

Correspondence regarding claims tentatively denied payment by the insurance provider or review organization shall be referred to the Recover Audit and Appeals Coordinator (RAAC).

- A discussion will be held with the attending physician to initiate the appeals process.
- The attending physician will be asked to assist with the appeal process by providing additional information to justify patient hospital stay.
- An appeal letter will be drafted by the RAAC and sent via certified mail~~ed~~ to the insurance carrier.

iii. Trends in denials and appeals status will be reported to the Utilization Management Committee on a *quarterly* bi-monthly basis.

f. Discharge Planning - Discharge planning is an interdisciplinary hospital-wide function which exists to assist physicians, patients and their families in developing and implementing an optimal post-hospital plan of care. The CC is responsible for assessing the patient for discharge potential, developing a discharge plan. The process includes the following:

i. Facilitation of patient discharge as soon as an acute level of care is no longer required.

ii. Ensuring the continuity of quality patient care, patient safety, and the availability of the hospital's resources for other patients requiring admission and the appropriate utilization of resources.

iii. Improving or maintaining the patient's quality of life and health status on an outpatient basis including but not limited to:

- Placement in alternative care facilities
- Referrals to home health care
- Provision for initial contact with appropriate community resources including hospice
- Communication with the patient, patient's family and attending physician which is documented in the medical record

g. Relationship to Quality Improvement Organization (QIO), Recovery Audit Contractor (RAC), Third Party PAYERS and Other Groups

Every reasonable effort will be made to cooperate with the QIO, RAC, fiscal intermediaries, and other groups having interest in assuring appropriate utilization of hospital services. The established principle of patient/physician confidentiality and individual privacy will be consistently upheld and honored. Information and data will be maintained as required to assure compliance with all applicable regulations for payment of claims.

~~C□RESPONSI□ILITIES OF COMMITTEE~~

D□RESPONSI□ILITIES OF COMMITTEE

1. It is the responsibility of the Utilization Management Committee is to review, analyze, report, and where

appropriate, make recommendations to support and improve efficient and optimal patient care. Committee activities are as follows:

a. Evaluation of Utilization Data includes regular review and reports of the following:
   - Admissions
   - Continued stay
   - Professional services
   - Length of stay
   - Denials
   - Medicare 1 day stays
   - Readmission within 30 days/same diagnosis
   - Appropriateness of operative and invasive procedures

b. There will be ad hoc monitoring for Potential Service Outliers, such as:
   - Length of stay
   - Over utilization and underutilization of resources
   - Level of care considerations
   - Extraordinary high cost cases
   - Patient care contracted services
   - Utilization of high cost drug and biological
   - Professional services

c. Recommendations and Communication

   The committee shall evaluate the findings of the above activities and make recommendations as necessary to the appropriate individual/institutional body in order to improve utilization and appropriateness. Members of the medical and administrative staff shall be advised of findings and recommendations that affect clinical practice and function.

~~D□REPORTING AND E□C□ANGE OF INFORMATION~~

E□REPORTING AND E□C□ANGE OF INFORMATION

The Utilization Management Committee will maintain written reports of their findings, actions and recommendations. All information related to improvement activities is confidential and protected by the California Evidence Code 1156; 1157.

~~E□CONFLICT OF INTEREST~~

F□CONFLICT OF INTEREST

Physicians may not participate in the review of any cases in which they have been or anticipate being professionally involved.

~~F□CONFIDENTIALITY~~

G□CONFIDENTIALITY

All data, reports and minutes are confidential and shall be respected as such by all participants in the Utilization Management Plan. All established organizational policies and procedures on confidentiality and release of information have been incorporated into the Utilization Management Plan.

~~G□PLAN EVALUATION□AMENDMENT AND REVISION~~

□□PLAN EVALUATION□AMENDMENT AND REVISION

The UMC will conduct an assessment of the Utilization Management Plan at least annually and, as necessary, revise the written plan. The evaluation will address overall effectiveness of the plan in achieving the goals and objectives.

A copy of any amendment and revision will be properly signed and dated by an authorized representative of the Utilization Management Committee, Senior Leadership, ~~Medical Staff~~ and the Board of Directors.

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

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	08/2021
Utilization Management	Aarya Khanal: Clinical Mgr [JH]	08/2021
	Grace Benlice: Director Care Coordination [AK]	06/2021

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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 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
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	
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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Attachments

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BOD	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
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Department Medical Director or Director for non-clinical Departments	Lorna □oep: Director Environmental Svcs	07/2021
	Lorna □oep: Director Environmental Svcs	07/2021

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MERP - Medication Error Reduction Plan - FY□□□□

Coverage

El Camino Hospital Mountain View & Los □atos

MERP □Medication Error Reduction Plan□ Overview:

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

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

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

1. Evaluate, assess, and include a method to address the 11 elements: prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.
2. Annual review of the plan to assess the effectiveness of the implementation of procedures and systems related to the 11 elements.
3. Modify the plan as warranted when vulnerabilities or deficiencies are noted to achieve the reduction of medication errors.
4. Evaluate and assess ability and progress in implementing information technology requirements and how technology implementation is expected to reduce medication-related errors.
5. Include a system or process to proactively identify actual or potential medication-related errors. The system or process shall include concurrent and retrospective review of clinical care.
6. Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals,

nursing, medical, information technology and administration to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.

7. Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate e.g., ISMP and medication safety publications.

References:

1. SB1875 & HSC 1339.63(g)

O□□ectives:

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

Structure:

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

   1. care staff. Pharmacy and Nursing Leadership coordinate the meetings. The councils make recommendations, advise, and provide guidance and recommendations related to nursing practice and operationalizing initiatives. RN-R□ reviews ISMP newsletters as part of the agenda. RN-R□ is also the approving body for Automated Dispensing Machines (ADM) override requests.
   2. Medication Safety Committee: The members of the committee include representatives of medical staff, pharmacy, nursing, and quality/patient safety and adhoc members. The committee is responsible for the evaluation and implementation of the MERP and reports directly to P&T. The Medication Safety Committee analyzes medication error reports, medication usage, medication shortages and participates in MERP. This is a committee that proposes action plans for process improvement and makes recommendations to P&T.
   3. MERP subcommittee: The members include: Pharmacy, Nursing and other ad hoc members. MERP subcommittee will be directly working on the Medication Error Reduction Plan and will report to Medication Safety. Responsible for monitoring compliance and developing action plans related to 11 MERP elements.
   4. Pharmacy and Therapeutics (P&T) Committee: Medical Staff Committee consisting of Physicians, Chief Nursing Officer (CNO), Senior Director of Quality , pharmacists, dietician, pharmacy informatics staff, nursing leadership and ad hoc members. P&T reviews a summary of medication error/event reports and adverse drug reactions, approves/monitors formulary deletions and additions, reviews recalls/medications in short supply, MERP plan, and approves policies and procedures.

5. Hospital Quality Committee & Patient/Employee Safety Committee: Medication Safety and Pharmacy Department reports medication safety activities to these committees.
6. Medical Executive Committee: Reviews P&T reports, reviews and approves policies and procedures.
7. Pharmacy Department: Review of medication use related to procedures and systems: prescribing, prescription order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use□medication errors.

B. Medication Error Reporting process:

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

C. Communication of Medication Safety Information:

1. Staff and Department Meetings
2. Departmental or organizational newsletters such as Pharmacy Newsletter, and InTouch (nursing newsletter), Pharmacy-Nursing Connection Newsletter
3. Resources provided include computer based drug information programs (e.g., UpToDate, Micromedex/Lexicomp , as well as other available references in the intranet □Tool Box□)
4. Policies and Procedures: Policies and procedures are available online on the hospital's intranet.
5. Director of Pharmacy sends monthly Nursing ISMP and biweekly overall Institute of Safe Medication Practices Acute Care Edition to all pharmacy and nursing staff.
6. External sources of information will be reviewed and shared with staff as appropriate. Examples of sources include but are not limited to the following: FDA Medwatch list serve, California State Board of Pharmacy list serve, The Joint Commission Sentinel Event Alert list serve, the ASHP Patient Safety News list serve, the Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI).

Medication Error Reporting and Monitoring:

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

1. Prescribing
2. Prescription order communications
3. Product labeling
4. Packaging and nomenclature
5. Compounding

6. Dispensing
7. Distribution
8. Administration
9. Education
10. Monitoring
11. Use

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

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

C. Voluntary Non-Punitive Reporting System:

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

Process:

A. Plan Development Process:

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

B. Assessment:

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

C. Requirements for Assessing the Effectiveness of MERP:

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

improvement.

Refer to EC□ detailed Fiscal Year MERP Crosswal□ □Medication Safety 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

MERP FY2021 Annual and FY22 Plan.pdf
MERP Trends and Accomplishments FY2020.pdf

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	08/2021
P & T Committee	Mo□gan Nodoushani: Manager Clinical Pharmacy	08/2021
Medication Safety Committee	Poopak Barirani: Asst Director Pharmacy	07/2021
	Poopak Barirani: Asst Director Pharmacy	07/2021

MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN

El Camino Los Gatos

El Camino Mountain View

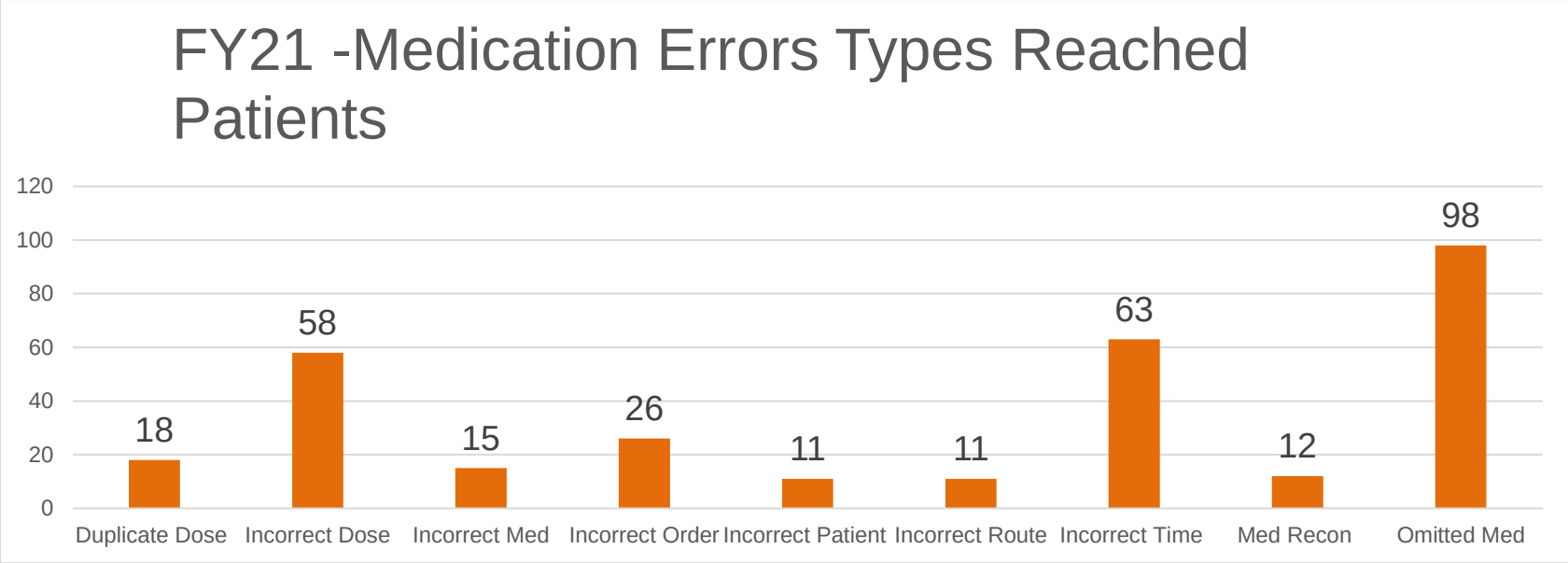
El Camino Health (ECH) includes two not-for-profit acute care hospitals in Los Gatos and Mountain View and urgent care, multi-specialty care and primary care locations across Santa Clara County. ECH aspires to elevate the healthcare experience – beyond healing – for the communities it serves. Through physician partnerships, ECH provides our patients with healthcare options that fit their lifestyle. Urgent care, primary care and specialty care services are provided at 11 locations across Santa Clara County.

MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN

I. Medication Errors & MERP 11 elements trends: A total of 532 medication errors were reported during FY2021 via incident reporting system (iSAFE). There were 328 errors that had reached patients. (FY20 – 361). Med Safety team has investigated all medication errors reported and categorized events into medication error types and MERP 11 categories. 328 errors contributed to 62% of the total errors that reached patients (FY20 = 82%). The top 3 error types as follows:

1. Omitted medication dose = 29%
2. Incorrect time = 19%
3. Incorrect dose= 18%

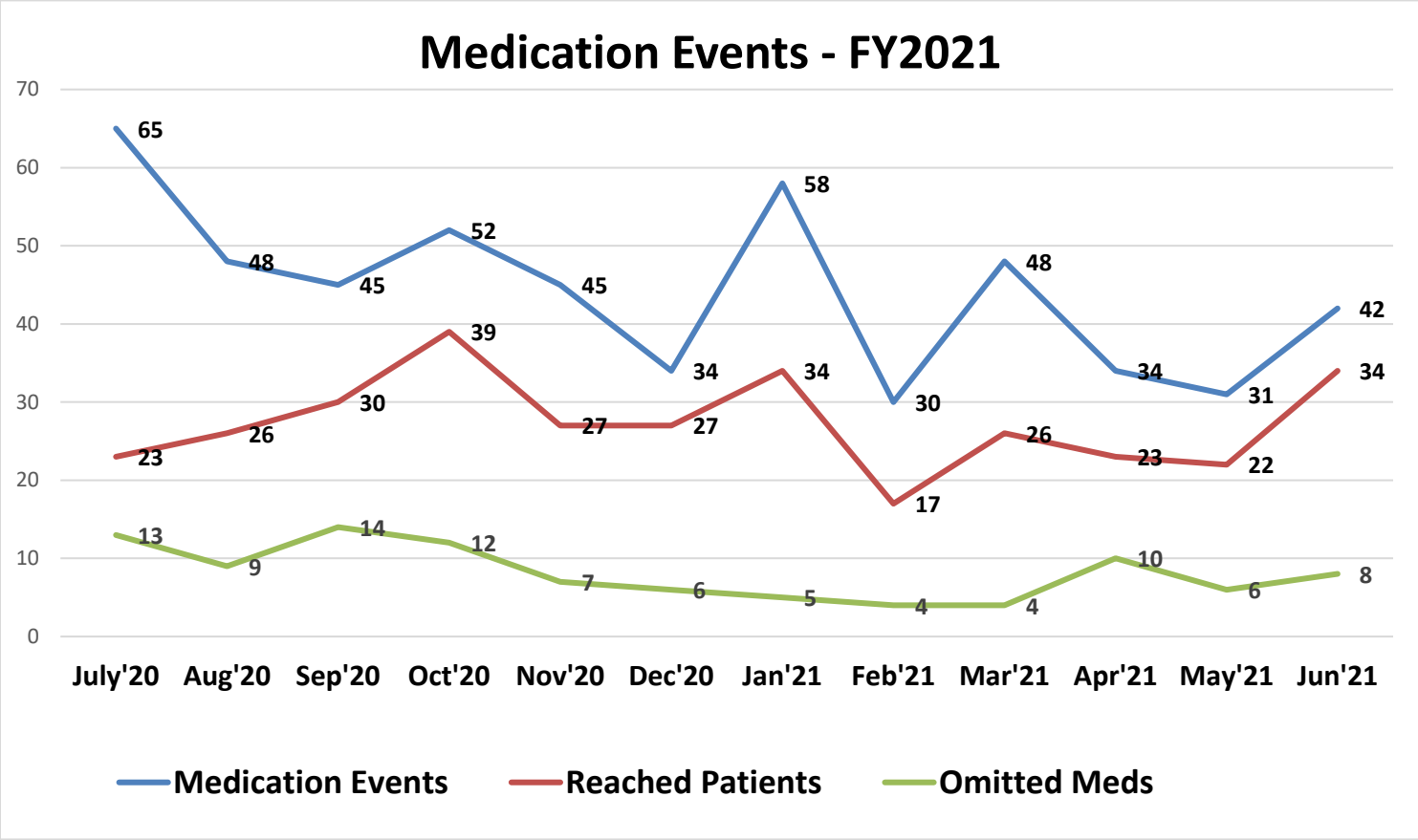
Total number of med errors = 532



Note 1: The delineation of incorrect rate was also trended, started 2021. Transition of incident reporting system (from MCCM to iSAFE) occurred in August 1st week of 2020.

MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN

Note 2: Total med errors reached patients = 328 YTD, FY21 Goal <332; Omitted Medications = 98 YTD, FY21 Goal <117.



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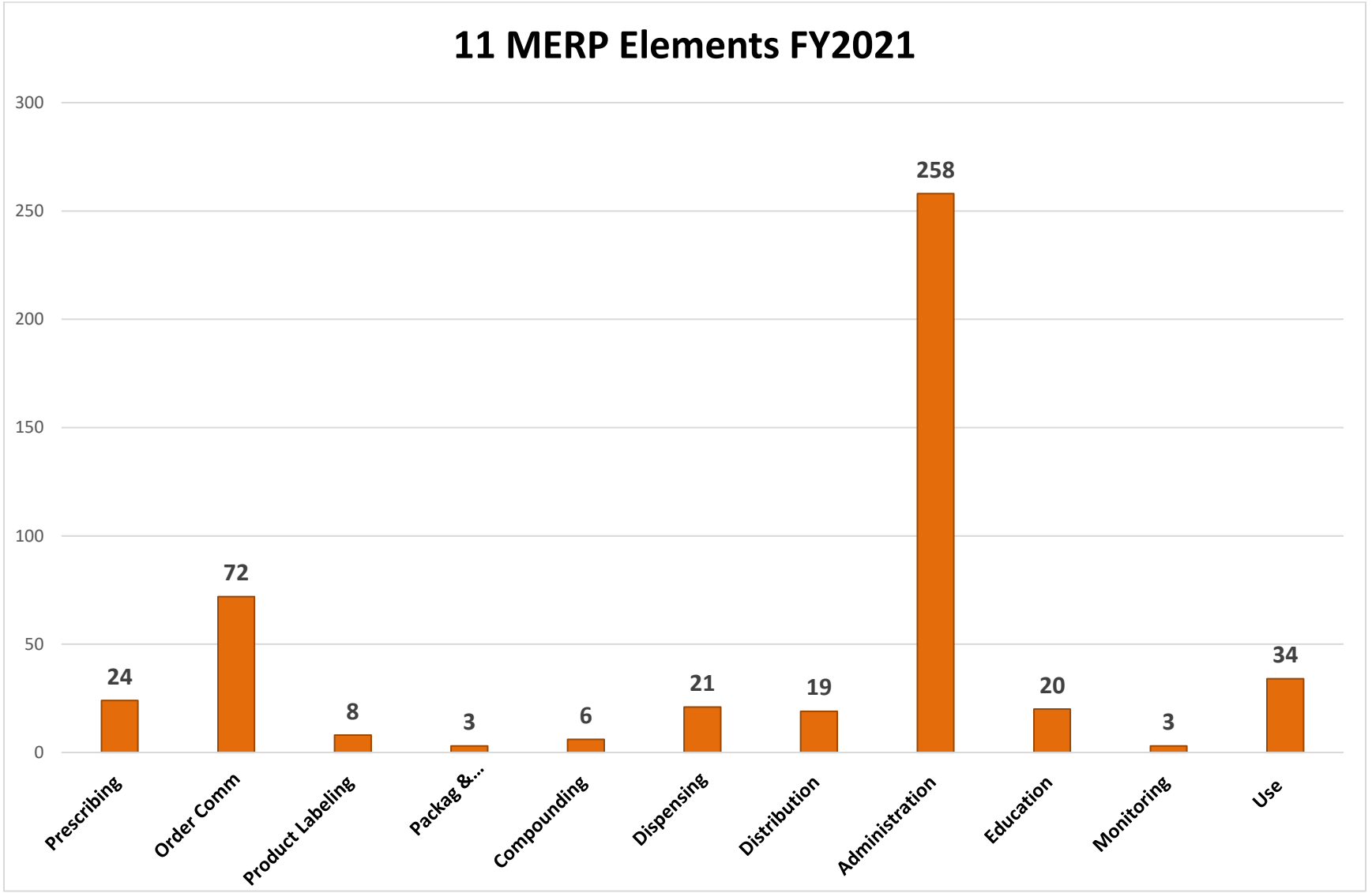
MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN



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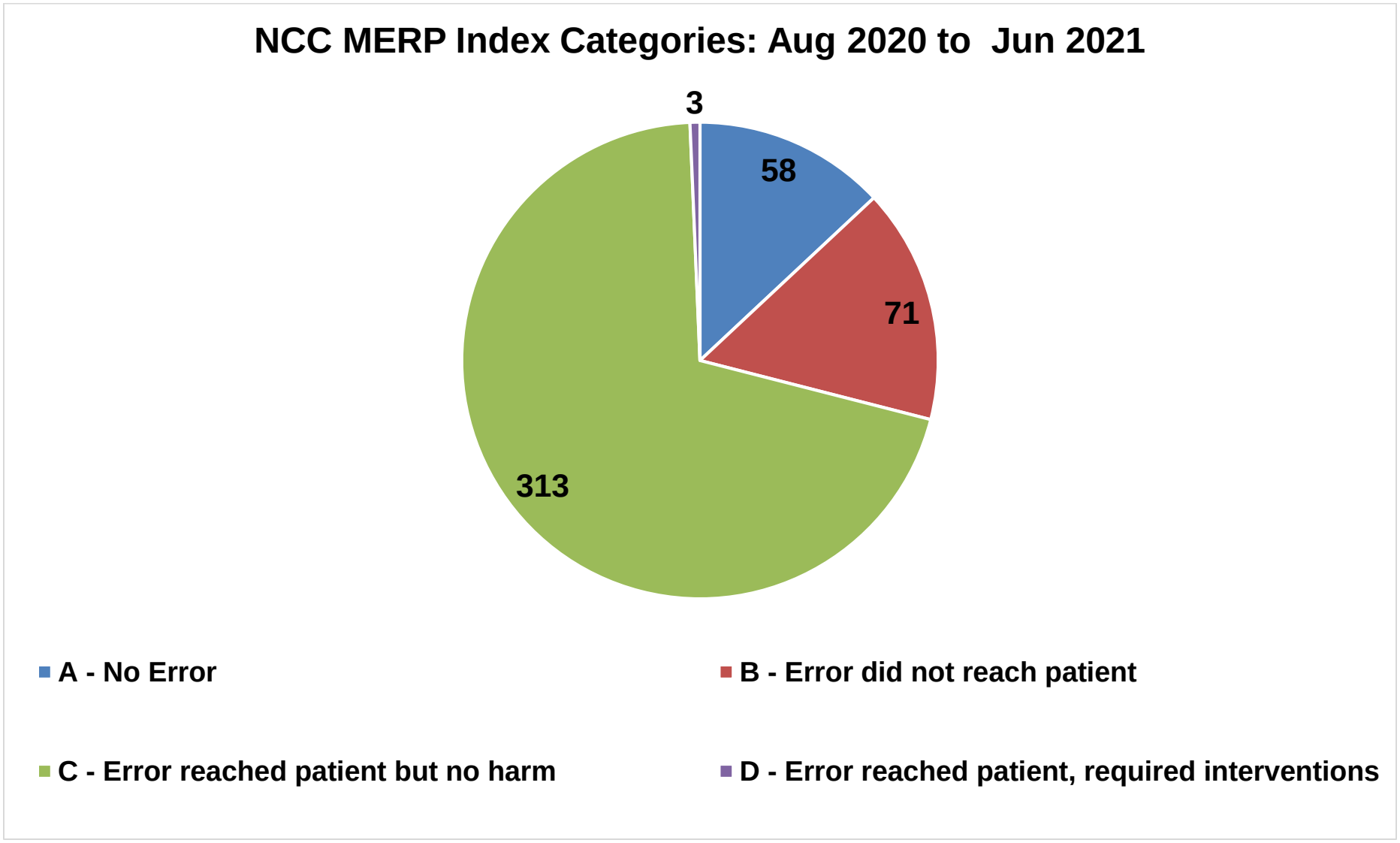
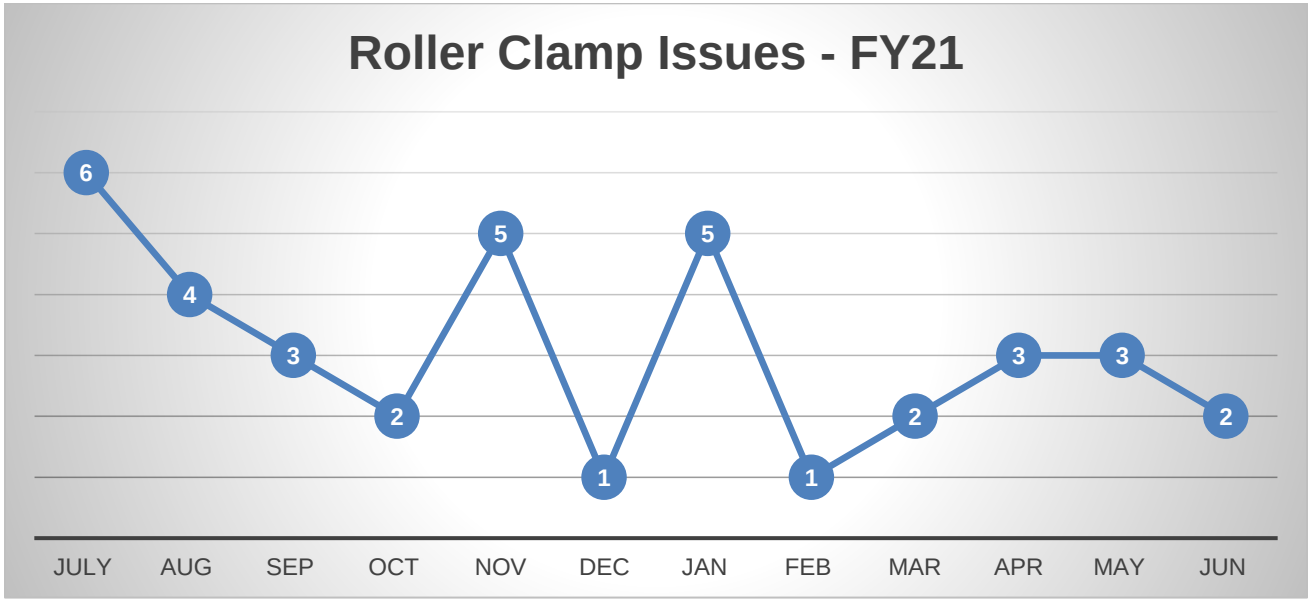

NCC MERP Index Categories: Aug 2020 to Jun 2021
3
58
71
313
A - No Error
B - Error did not reach patient
C - Error reached patient but no harm
D - Error reached patient, required interventions

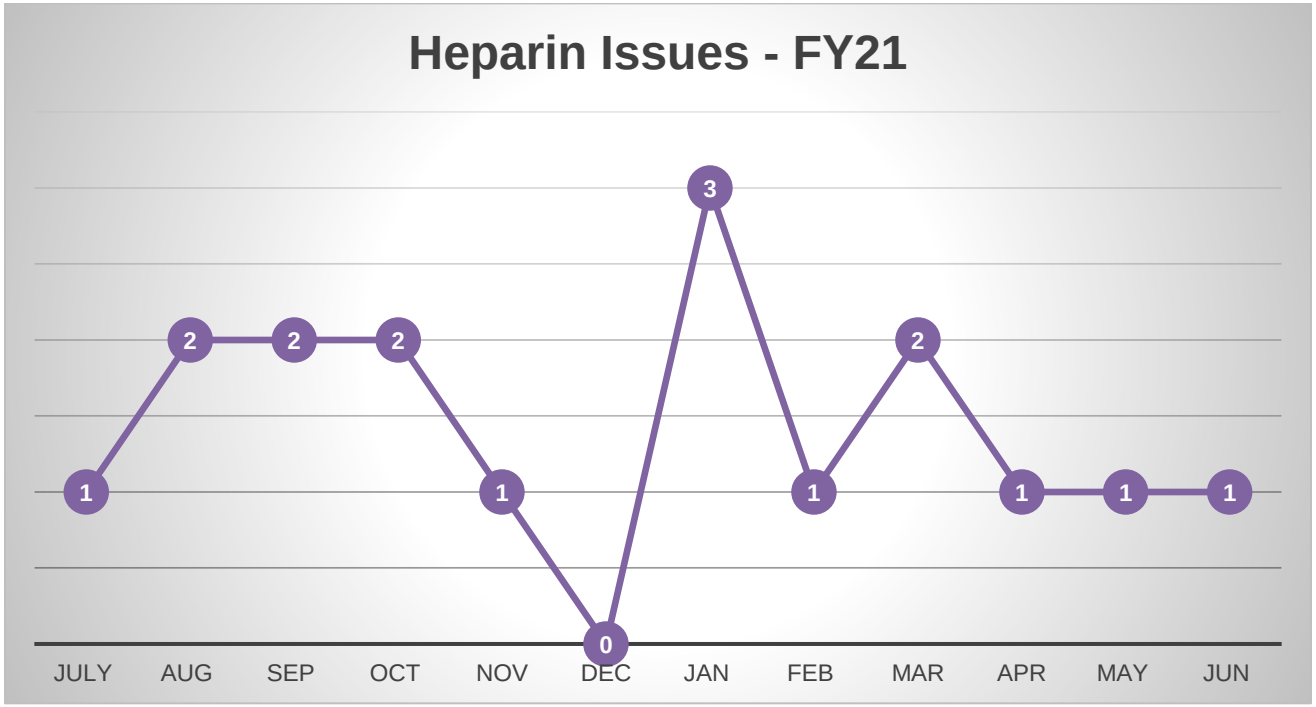
Sub-groups were formed to perform in depth review of the medication errors:

A. **Roller Clamp:** 37 total roller clamp errors reported during FY21 (FY20= 47), which contributed to missed or delayed medication administration. The barriers identified by nursing include distraction, forgetting, interruptions and rushing. As a corrective action plan, as a visual reminder, laminated signs were a posted with the slogan "Let it drip before you drift". Audit results and trends were reported to Med Safety Committee. Overall, there has been a decline in incidents reported, however the percentage of error rate is insignificant compared to the number IV doses administered (well below 0.1%). Continue for FY2022.



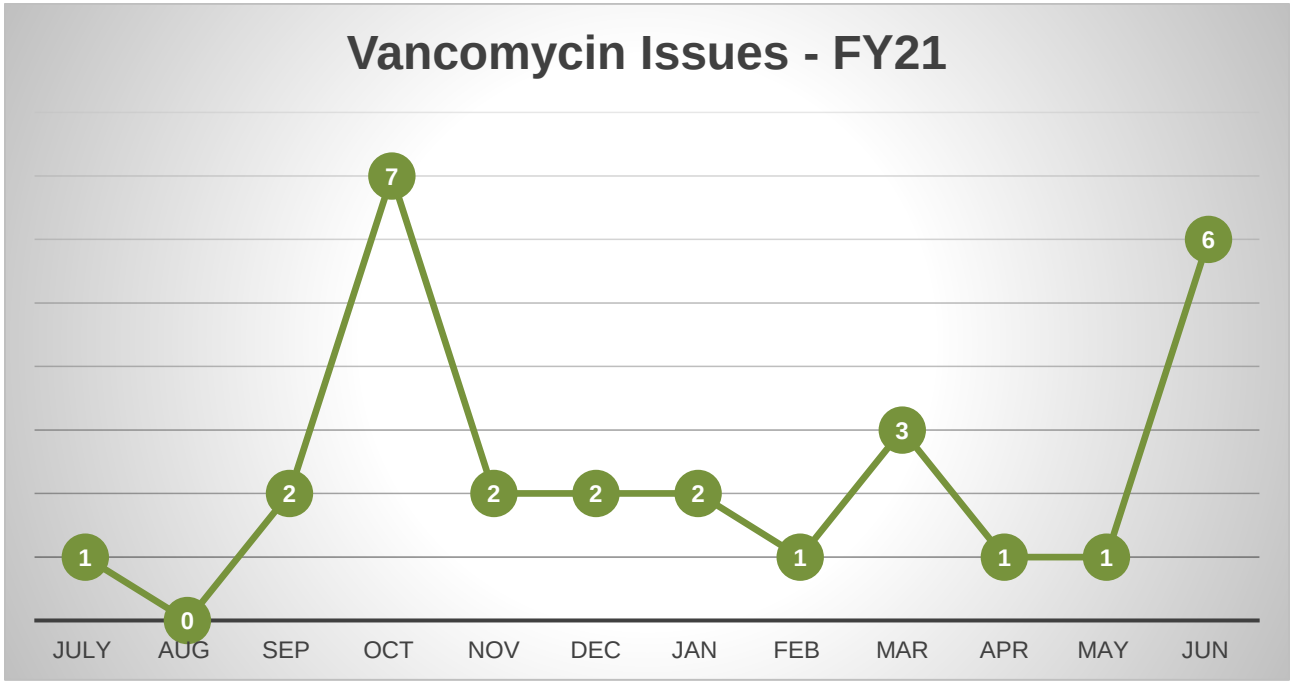
Roller clamp errors = 37

B. **Heparin:** 17 total Heparin errors reported during FY21 (FY20=23). Med Safety investigated the details of all errors. Nursing had reinforcement the education on "Anticoagulation Agents/Heparin" through mandatory annual Health Stream modules (completed 10/31/2020) that includes real cases derived from the medication errors that were reported. Heparin orders using Anti-Xa parameter went live in July 2021. Overall, errors appear to be trending down. Goal will be continued on to FY2022.



Heparin errors = 17

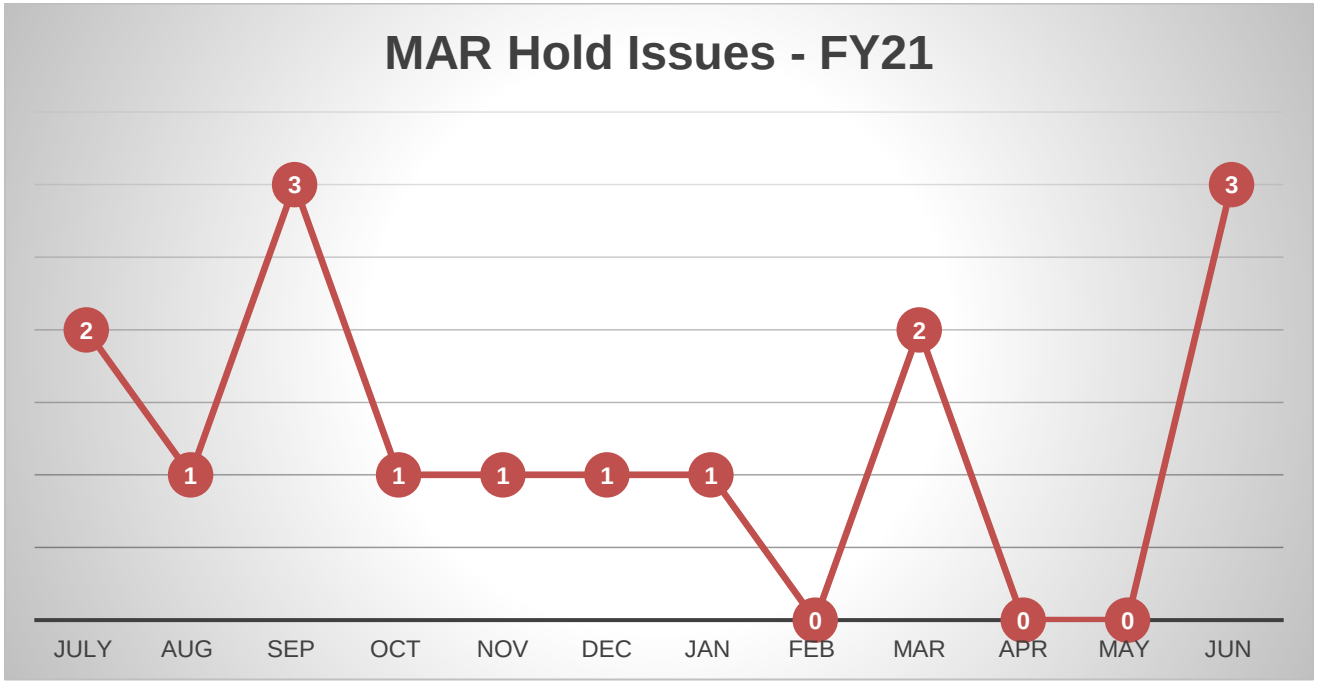
C. **Vancomycin:** 28 total Vancomycin errors reported during FY21 (FY20 = 25). RFS go-live on 8/11/20, where a MAR display for when trough results are due within 2 hours of a Vanco IV dose being due. Three of June errors were due to MAR hold, which resulted in delay of vancomycin administration. Goal will be carried on to FY2022.



Vancomycin = 28

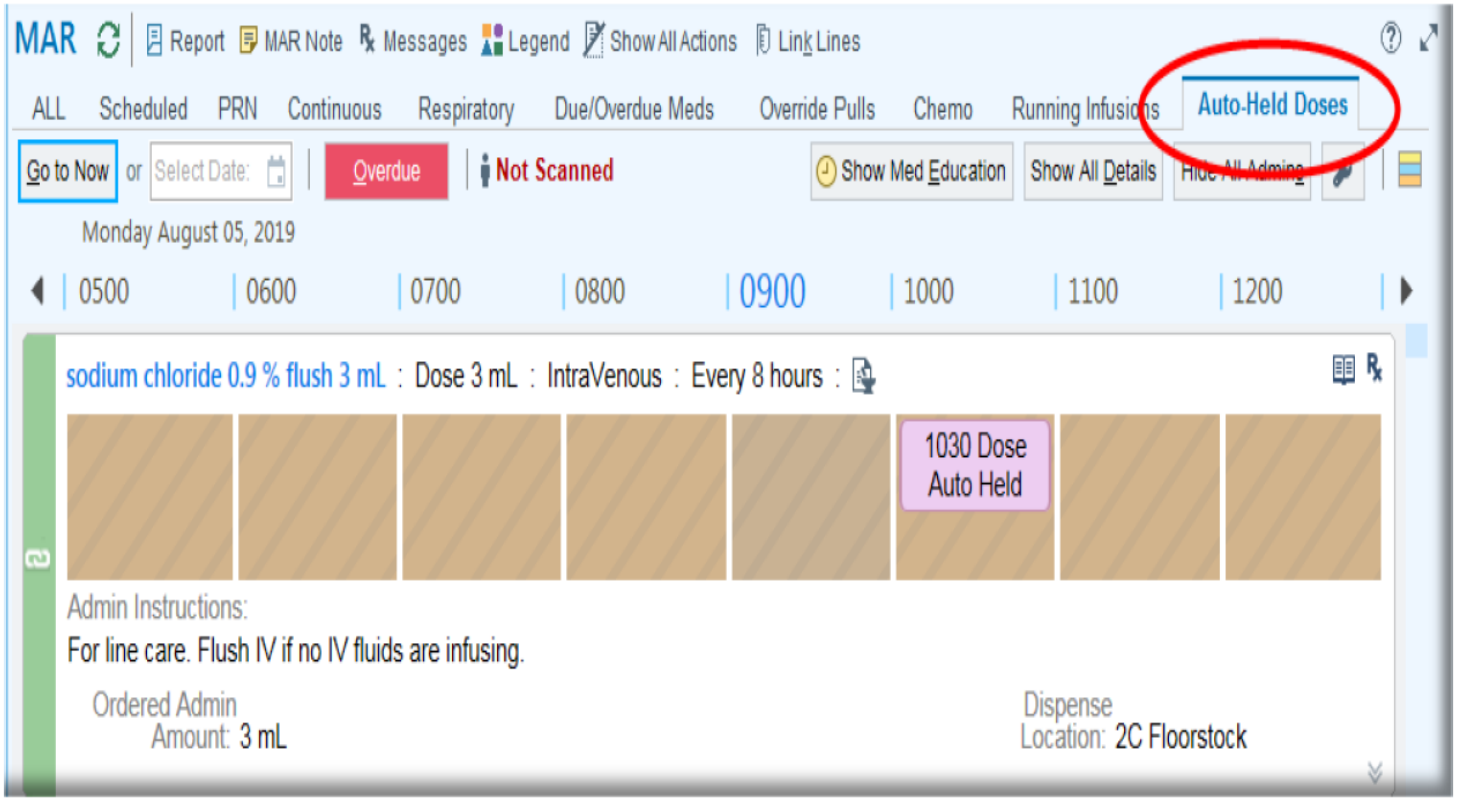
El Camino Health

D. **MAR Hold/Phase of Care:** Total of 15 MAR Hold errors were reporting during FY21 (Unchanged from FY20). Orders go on MAR Hold when a patient transfers to a procedural area. When the patient transfers back to the inpatient unit, RNs should release signed and held orders and review "Auto Held" doses with the provider to determine which orders should be given, not given or rescheduled. Medications appear in tab on the MAR if the orders haven't been released or if the provider hasn't completed medication reconciliation. These MAR hold errors resulted in late or omitted medication. The process was reviewed and vetted with iCare, Pharmacy and Nursing team. Team proposed corrective action plans that include reinforcing the staff education. This continues to be a challenge. Goal will be continued on to FY2022.



MAR hold errors = 15

MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN



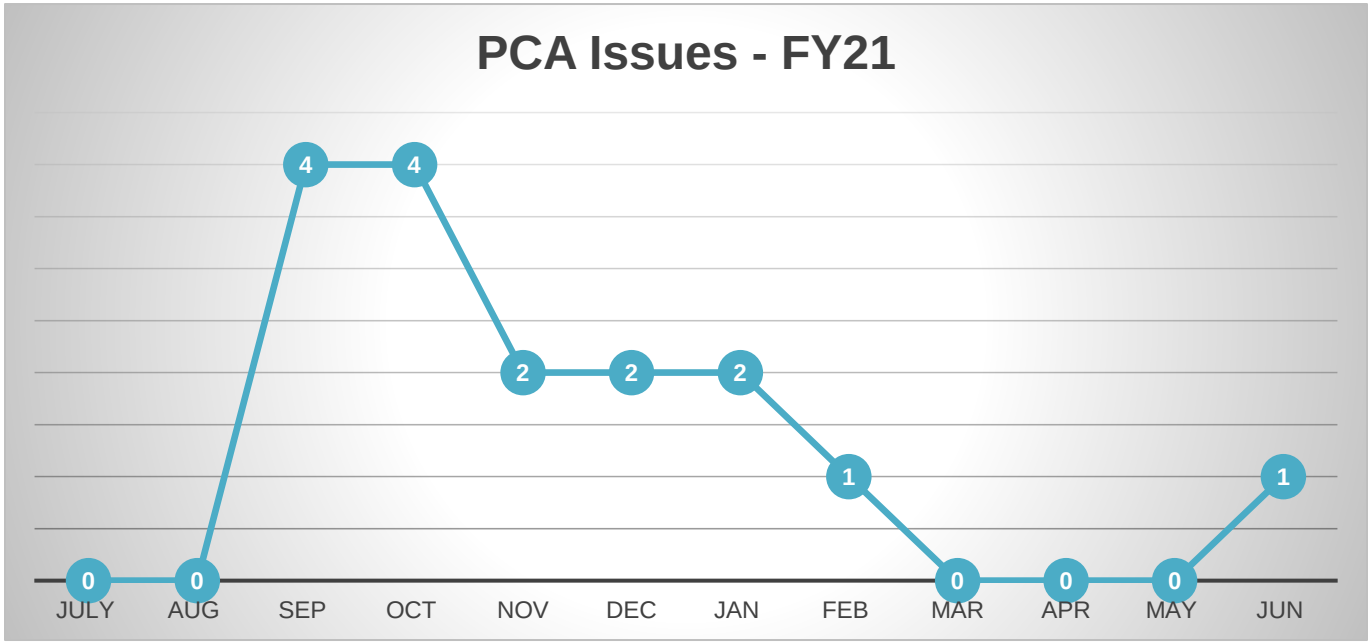
Auto-Held MAR tab to makes it easier for nurses to see auto-held doses at a glance and reduce concern of missed doses

Medications will automatically disappear from the auto-held tab once all auto-held doses are addressed as given or not given. The Auto-Held Doses tab will remain empty if all auto-held doses have been addressed or there are no current auto-held medications.

E. PCA: Total of 16 MAR Hold errors were reporting during FY21 (FY20 = 15).Two major changes occurred to prevent confusion in terminology used in ordering PCA in iCare and entering the information into Alaris pump:

1. iCare and Alaris data fields were matched up to make it easier for the user to enter the data into the pump settings.

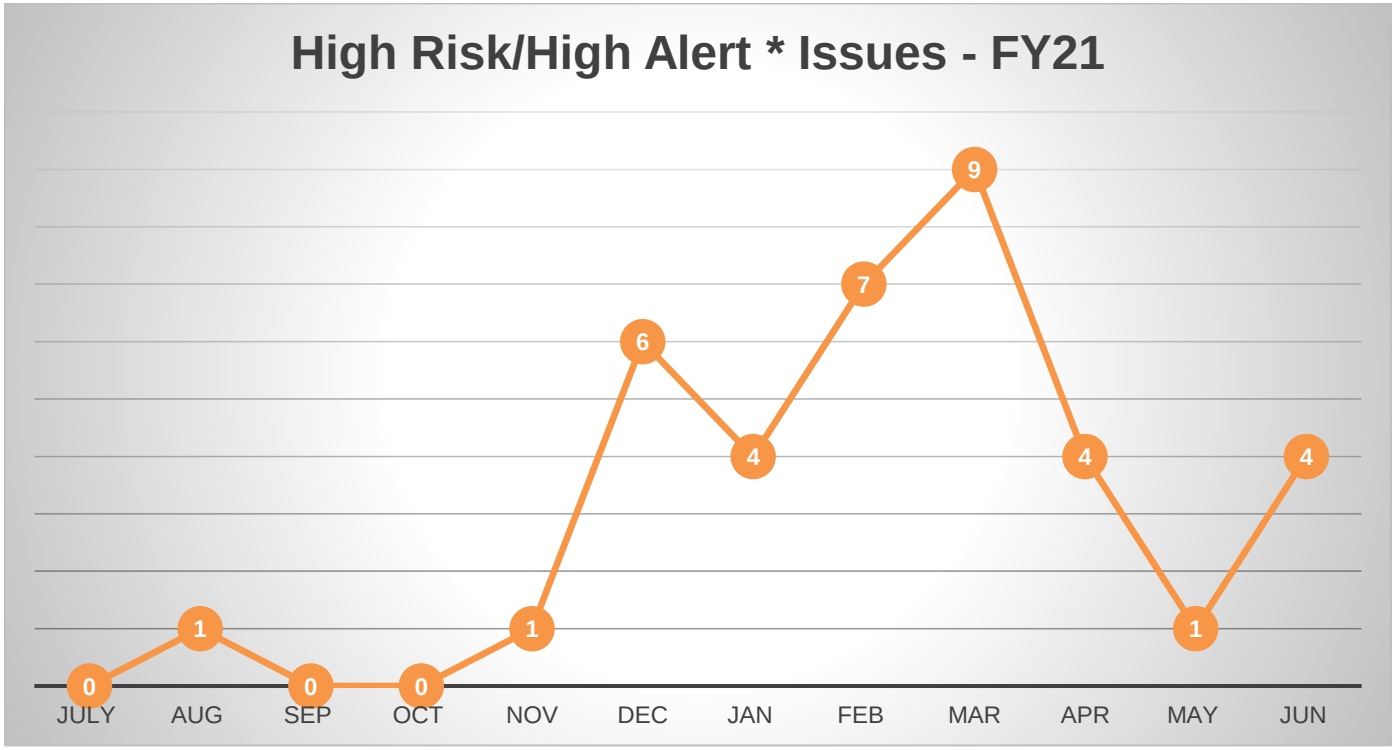
2. Loading dose was eliminated as it was getting confused with bolus dose. Epic release was in January 2021. Overall, the errors appears to be trending down. Therefore, discontinue for FY2022.



PCA errors = 16

MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN

F. High Risk/High Alert (HR/HA): New focus in 2021. Reported 37 errors during FY21. HR/HA medication* are defined in the hospital policy. For Med Safety reporting, Heparin and PCA are being tracked separately, therefore excluded from this category. Continue goal for FY2022.



HR/HA errors = 37

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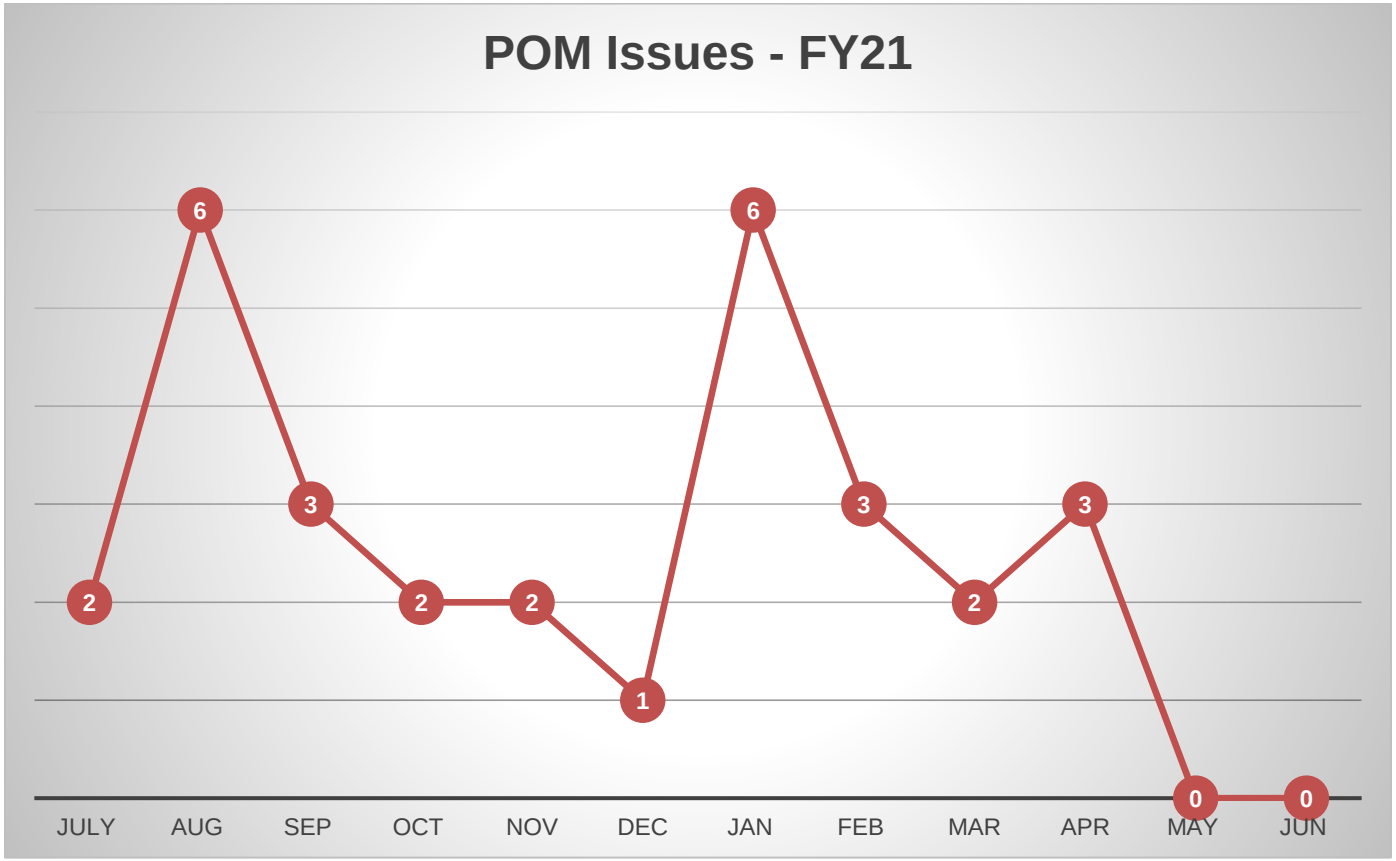
G. Patient Own Medication (POM): New focus in 2021. Reported 30 errors during FY21. POM errors appear to be trended down in the last few month. No further trending required. Goal discontinued for FY2022.



POM errors = 30

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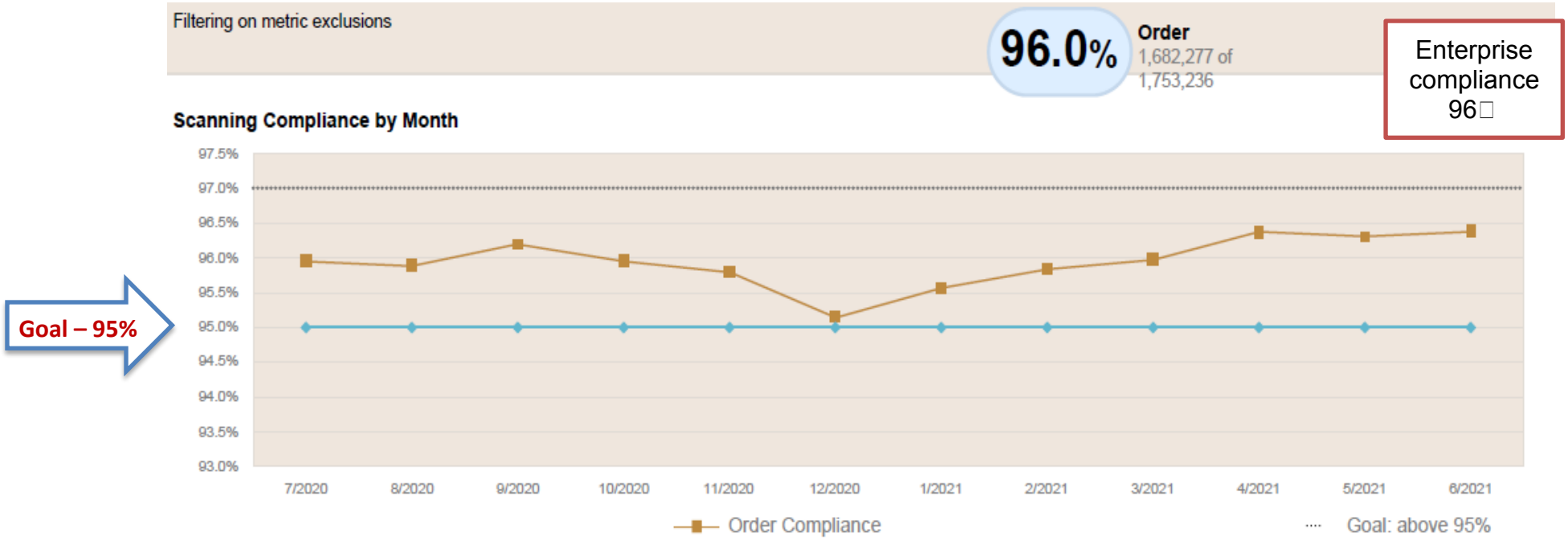
II. Barcode Scanning Trends:

Barcode scanning compliance for the enterprise was reported as 96% with a goal of 95% for Orders. Los Gatos campus & the MV Infusion center have been above the threshold for FY21, which was consistent with FY20. Some of the challenges that encountered were around network connectivity in Mental Health/Behavior Health buildings. Continue to focus on areas for troubleshooting. Goal will be continued on to FY2022 MERP.



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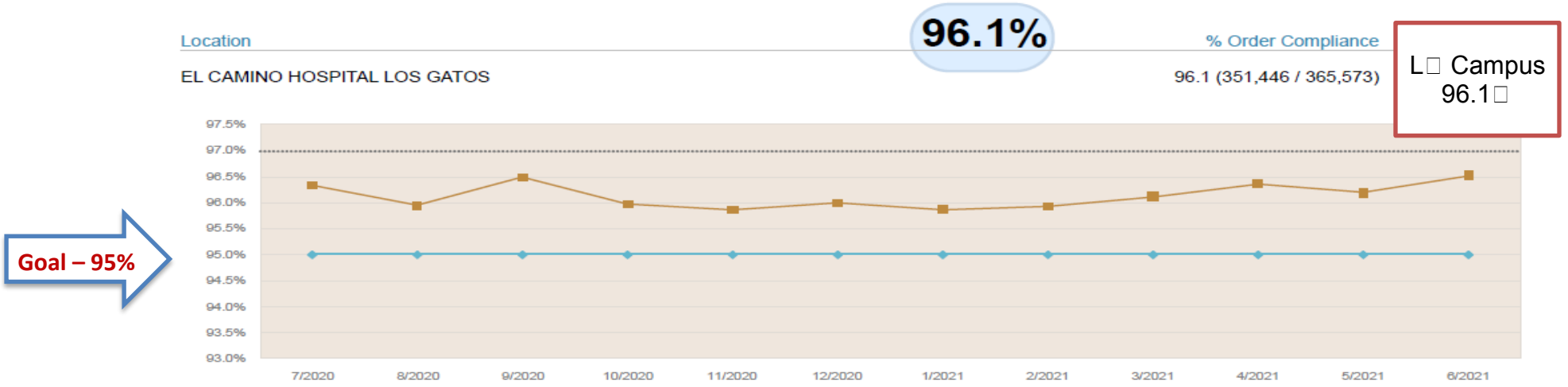
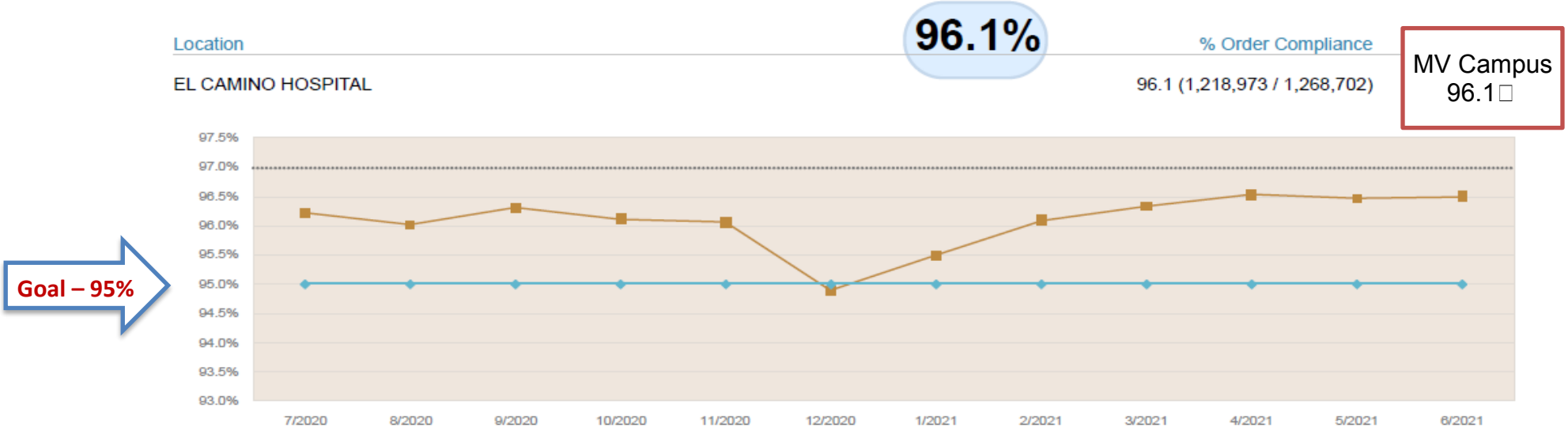
MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN



L□ Campus 96.1□

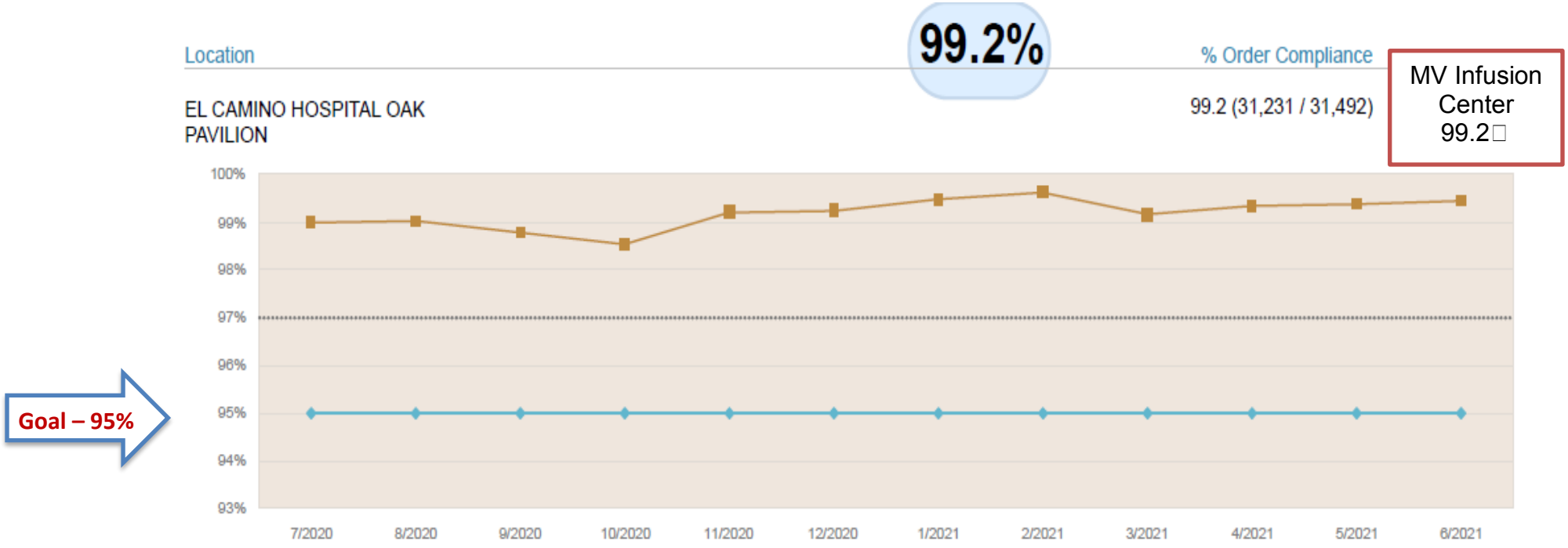
Goal – 95%



MV Campus 96.1□

Goal – 95%

MEDICATION ERROR REDUCTION PLAN (MERP) FY2021 ANNUAL REVIEW & FY2022 PLAN



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IV. Alaris Guardrail Infusion Compliance: See Attachment- A FY2021 Alaris pump report.

V. Antimicrobial Stewardship Program (ASP) highlights:

- Expanded Antibiotics Renal Dosing Protocol for Adult Patients to include ED and perioperative patients
- Expanded Extended Infusion of Piperacillin-Tazobactam (Zosyn) Protocol for Adult Patients to allow pharmacists to convert between extended and intermittent infusion to mitigate IV medication access issues
- Provided formal education to medical staff and pharmacists regarding updates in antimicrobial therapeutics (e.g. uncomplicated gonococcal infection, COVID-19 management including bamlanivimab, casirivimab/imdevimab and tocilizumab)
- Published updated antibiogram and disseminated a summary of year-to-year changes for 2021 to assist providers in empiric therapy selection
- Managed antimicrobial shortages and backorders (e.g. cefotetan, bacitracin, ceftolozane/tazobactam)
- Worked with microbiology team to incorporate CLSI updates for 2021
- Revised Vancomycin Per Pharmacy Protocol to include dosing guidance for OB patients
- Optimized antibiotics in General Medicine Sepsis Admission Order Set
- Provided antibiotic recommendations for OB Sepsis Guidelines and Order Set
- Completed medication use evaluation for monoclonal antibody therapies for COVID-19 which resulted in institutional switch from bamlanivimab to casirivimab/imdevimab

- Notified providers of EUA dosing change for casirivimab/imdevimab in June 2021 and updated iCare/DoseEdge with new dose
- Developed new system list to identify patients at high risk of hospital-onset C. difficile infections in order to provide targeted ASP interventions
- Completed evaluation for vancomycin surgical prophylaxis dosing which resulted in workflow change to allow release of a single vancomycin 1g dose while awaiting patient weight, thereby minimizing delays to surgery
- Evaluated and summarized cases of ciprofloxacin use, provided education to pharmacy staff on appropriate use of ciprofloxacin
- Provided formal education to LG medical staff on therapeutic guideline updates, hospital C. diff trends, new antimicrobial stewardship program initiatives, and antimicrobial usage data

VI. External Resource Review:

1. Performed Quarterly Action items for FY 2021 and presented to Med Safety Committee
2. Performed 2020-2021 ISMP Targeted Medication Safety Best Practices for Hospital and presented to Med Safety Committee.

VII. FY 2022 Metrics & Goals:

1. Medication Errors that reached patients per 1000 adjusted patient days - **Discontinue ; Goal Met for FY21; continue to track as information**
2. Omitted Medication Errors that reached patients per 1000 adjusted patient days - **Discontinue; Goal Met for FY21; continue to track as information**
3. Review of High Risk/High Alert Medication errors **Continue**
4. MAR Hold **Continue**
5. Heparin **Continue**
6. Vancomycin **Continue**
7. PCA **Discontinue, but report out under HR/HA**
8. Roller Clamp **Continue**
9. Patient Own Meds (POM) **Discontinue**
10. Barcode Scanning compliance **Continue**
11. Alaris Guardrails compliance **Continue**
12. Wrong patient New

New Goal proposal:

1. Increase Near Miss/ Good Catch reporting for medication errors New
2. Reduce Incorrect Medication reached patients New

Presented to:

Med Safety on July 14th , 2021

Pharmacy & Therapeutics Committee on July 22nd, 2021

El Camino Health

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*1 year after approval*
Owner:	*Mari Numanlia-Wone: Mgr Emp Wellness & Health Svcs*
Area:	*Employee Wellness & Health*
Document Types:	*Plan*

COVID-19 Vaccine Plan

COVERAGE:

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

PURPOSE:

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

REFERENCES:

Santa Clara Health Department Masking Order 8/2/2021 https://covid19.sccgov.org/sites/g/files/exjcpb766/files/documents/Health-Officer-Order-August-2-2021.pdf

California Department of Public Health (CDPH) Vaccine Mandate for Healthcare Workers 8/6/2021 https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

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

PROCEDURE:

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

B. COVID-19 vaccination is a condition of hire and retention for all employees. All employees, physicians, contractors, volunteers, observers and students must be fully vaccinated (except in unusual and specific

circumstances as described in Procedure D.) as communicated by EWHS.

C. An individual is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a 2-dose series, or after one dose of a single dose vaccine).

D. Declinations will be considered under the following circumstances:

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

E. The COVID-19 Vaccine Plan includes the following features:

1. When additional vaccination recommendations are published by Santa Clara County Public Health (SCCPH), El Camino Hospital will inform staff about the following:
    a. Requirement(s) for vaccination
    b. Dates when COVID-19 vaccine(s) are available
    c. Vaccine(s) will be provided at no out of pocket expense to the employee
    d. Procedure for receiving the vaccination
    e. Procedure for submitting written documentation of vaccine obtained outside ECH, EWHS
    f. Procedure for declining
    g. Consequences for non-compliance with this plan
2. If vaccine shortages occur or if SCCPH, CDPH, and/or the CDC recommendations are altered, all or part of this plan may be modified, suspended, or revoked.
3. Staff will be educated on the following (this education may occur either at the time of the vaccination activity, or at the time of hire or as part of ongoing training and education, or any combination thereof):
    a. Benefits of COVID-19 vaccine
    b. Potential health consequences of COVID-19 illness for themselves and patients
    c. Epidemiology and modes of transmission, diagnosis, and non-vaccine infection control strategies (such as the use of appropriate precautions & respiratory hygiene).
4. Visual cues for ID badges may be used to permit monitoring compliance with the above requirements.
5. All staff are responsible for compliance with this Plan.
6. Staff supervisors, managers and directors (as applicable to worker) are responsible for the enforcement of this Plan.

RESPONSIBILITIES

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

1. Receive the COVID-19 vaccine(s) provided by ECH and coordinated by EWHS

2. Or complete and submit a declination document to EWHS stating the reason for declining as described in the section above
3. Or provide current written proof of receipt of required COVID-19 vaccine(s) if not given by EWHS or designee including the date and type of vaccination received
4. Comply with Santa Clara Health Department mandate to wear a mask regardless of vaccination status while inside the hospital
5. Complete Employee Wellness Symptom Monitoring tool daily
6. Not report to work if experiencing any COVID-19 symptoms and call the EWHS Flu Hotline (650-988-7808)

B. **COVID-19 Testing**

1. Fully vaccinated staff are encouraged to test for COVID-19 frequently.
2. Unvaccinated Staff must test for COVID-19 twice a week.

C. **Universal Masking**

1. Regardless of COVID-19 vaccination status, all healthcare workers in every healthcare setting shall adhere to standard precautions during the care of patients in order to prevent disease transmission.
2. Masking is required at all times while inside the facility regardless of vaccination status.
3. Masking and eye protection is required at all times while in clinical areas (areas with patient access).

D. **Compliance**

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

E. **Reporting**

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

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

Attachments

COVID-19 Vaccine Exemption Request Form

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
MEC	Catherine Carson: Senior Director Quality [JH]	08/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	08/2021
Dept. of Medicine	Jeanne Hanley: Policy and Procedure Coordinator	08/2021
Infection Prevention Committee	Jeanne Hanley: Policy and Procedure Coordinator	08/2021
HR Leaders and CHRO	Mari Numanlia-Wone: Mgr Emp Wellness & Health Svcs [JH]	08/2021
	Mari Numanlia-Wone: Mgr Emp Wellness & Health Svcs	08/2021

El Camino Health

COVID-19 Vaccine Exemptions Request Review Process

A. Responsibilities

a. Staff

i. Staff is responsible to send completed COVID-19 Vaccine Exemption Request form to ehs@elcaminohealth.org.

ii. Staff must submit the necessary documentation to support the request.

1. Medical Exemption - Form provided to be completed by a licensed medical provider.

2. Religious Exemption – Statement that describes reasons for the exemption request.

b. Employee Wellness & Health Services (EWHS)

i. EWHS will receive all exemption requests.

1. An acknowledgement email will be sent to the employee.

2. Religious exemption requests will be forwarded to Human Resources.

3. Medical exemption requests will be saved in the employee's record (EWHS EMR system).

c. Human Resources (HR)

i. Human Resources will track all exemption request submissions and status.

ii. An acknowledgement email will be sent to the employee.

B. Review Process

a. Medical Exemptions

i. EWHS Medical Director will review all requests for medical exemptions.

ii. If more information is needed, EWHS will request such information from the employee by email.

iii. Employees will be notified by EWHS of the determination on their medical exemption request as soon as reasonably practicable after ~~within 5-10 working days from~~ submission of their exemption request~~due date~~.

iv. Approved Medical Exemptions

1. During the exemption evaluation process, in order to continue working, the employee must test for COVID-19 with either PCR or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.
2. Testing must occur twice weekly for unvaccinated exempt workers.
3. Once a medical exemption is approved, evaluation for reasonable work accommodation will be explained to the employee based on the essential function of the job and the duration of the medical exemption.
4. If work accommodation is available, the employee can continue to work under this medical exemption.
5. Once the duration of the exemption expires, if applicable, the employee is expected to comply with the COVID-19 vaccination mandate.
6. Employee must wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering face piece respirator if in clinical areas, at all times while in the facility.

v. Medical Exemptions Not Approved

1. If medical exemption is not approved, the employee will be provided an unpaid seven-day suspension period to decide whether they are willing to become compliant with the requirement.
2. To become complaint the employee must receive the first dose of a two dose series or one dose of a one-dose series.
3. If the employee decides to receive a two-dose series the employee can return to work but must continue to test twice/weekly and wear an N95 while on clinical areas for up to two weeks after the second dose.
4. If the employee decides to receive a one-dose series, the employee can continue to work but must continue to test twice/weekly and wear an N95 while on clinical areas for up to two weeks after vaccination.
5. If employee decides not to become compliant, employee will be terminated from employment and placed on a recall list.
6. Those on the recall list will be offered available future vacancies and are eligible based on either meeting all requirements (including all health screenings and requirements) and/or based on a change in pandemic conditions that would make employment of non-vaccinated employees acceptable.

b. Religious Exemptions

i. HR will review all requests for religious exemptions.
ii. ECH General Counsel will be consulted for legal advice on all religious exemptions that are not approved by HR and consult with outside counsel, as needed.

iii. If more information is needed, HR will request such information from the employee by email.
iv. Employees will be notified by HR of the determination on their religious exemption request as soon as reasonably practicable after ~~within 5-10 working days from~~ submission of their exemption request.~~due date.~~
v. Approved Religious Exemptions
    1. During the exemption evaluation process, in order to continue working , the employee must Test for COVID-19 with either PCR or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.
    2. Testing must occur twice weekly for unvaccinated exempt workers.
    3. Once a religious exemption is approved, evaluation for reasonable work accommodation will be explained to employee based on the essential function of the job.
    4. If work accommodation is available, the employee can continue to work under this religious exemption.
    5. Once the duration of the exemption expires, if applicable, the employee is expected to comply with the COVID-19 vaccination mandate.
    6. Employee must wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering face piece respirator, at all times while in the facility.

vi. Religious Exemptions Not Approved
    1. If religious exemption is not approved, the employee will be provided an unpaid seven-day suspension

period to decide whether they are willing to become compliant with the requirement.

2. To become complaint the employee must receive the first dose of a two dose series or one dose of a one-dose series.
3. If the employee decides to receive a two-dose series the employee can return to work but must continue to test twice/weekly and wear an N95 while on clinical areas for up to two weeks after the second dose.
4. If the employee decides to receive a one-dose series the employee can continue to work but must continue to test twice/weekly and wear an N95 while on clinical areas for up to two weeks after vaccination.
5. If employee decides not to become compliant, employee will be terminated from employment, and placed on a recall list.
6. Those on the recall list will be offered available future vacancies and are eligible based on either meeting all requirements (including all health screenings and requirements) and/or based on a change in pandemic conditions that would make employment of non-vaccinated employees acceptable.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital □oard of Directors
From: □ohn □oglin□Chair□□inance Committee
Date: □eptem□er□22□2021
Subject: □inance Committee Comm□nity □ em□er □ppointments

Recommendation:

□inance Committee recommends that the ECH □oard appoint □ill Hooper and Cynthia □te□art as comm□nity mem□ers of the □inance Committee.

Summary:

□he □inance Committee held an □d Hoc meeting on □□esday□□□g□st 31st to complete the final ro□nd of intervie□s □ith the t□o finalists □□ill Hooper and Cynthia □te□art□

□he committee voted to recommend that the □oard approve □oth candidates to □egin their role at the □eptem□er 27th □inance Committee meeting.

Situation:

1. □□thority: □one

2. □ac□gro□nd: □he □inance □d Hoc Committee □□ohn □oglin□Carol □omersille□□ D□□ ayne Doig□chi□ and Carlos □ohor□□e□□developed a recr□itment process □hich yielded a strong and diverse list of candidates. □he □d Hoc Committee revie□ed seven applications□intervie□ed fo□r candidates and selected t□o finalists for the □inance Committee to intervie□.

3. □ssessment: □he t□o recommended finalists have strong healthcare and finance □ac□gro□nds □hich □ill □e great additions to the □inance Committee.

4. Other Revie□s: □one

5. O□tcomes: □one

List of Attachments:

1. □ill Hooper CV
2. Cynthia □te□art CV

Suggested Committee Discussion Questions:

□one

Samreen Salehi

From: Bill Hooper <williamkhooper@yahoo.com>
Sent: Friday, July 23, 2021 2:30 PM
To: nominations
Subject: submission for Finance Committee

This email is a submission for consideration for the Finance Committee. My work experience is outlined below.

I have read through El Camino's published annual budget presentations and website. Those budget presentations appear extremely well done, with thorough staff work and analyses, providing your Finance Committee members excellent information to make informed decisions about budgets, plans, and finance matters.

My work experience as company president, as a manager and operator of several investment funds and related operating companies, and as a company director and university trustee has given me a great amount of hands-on experience overseeing and insuring financial excellence in many complex financial environments in real estate, technology, investment management, non-profit, and other industries.

My board experience is extensive, and I understand a board's role in focusing primarily on setting policy objectives and monitoring or evaluating progress on those policy objectives. Bill Miller, former CEO of SRI and former Provost at Stanford, former board chair and board member at several public companies said I was the best board member he had ever worked with because I devoted time, attention, and acumen to my board duties.

My financial experience is extensive, having prepared and assessed hundreds of budgets and financial plans for many complex profit and non-profit enterprises, managing audits and special audits, working cooperatively with executive teams and CFOs on all sorts of topics including improving operating results, improving accounting and reporting effectiveness, arranging debt and equity financing, investigating and correcting accounting or budget failures, etc.

At this time, I have adequate time and very strong interest to be of service to El Camino Hospital.

As a heads up, Finance Committee member Don Watters and I know each other, having met and worked together when I was a new associate at McKinsey & Co in the mid-1980s. Don is a lot smarter than I am, but I think I could make a solid contribution to your committee nonetheless.

I would be glad to meet and follow up with your staff or selection committee, if desired.

Sincerely, Bill Hooper

Menlo Park, CA

cell 650-766-1686

Education:

-AB Government, Dartmouth College, 1977; Class President, Co-Captain Varsity Basketball, Awarded Barrett All Around Achievement Cup

-MBA Stanford Graduate School of Business 1982

Work or Relevant Experience:

-McKinsey & Co.: associate 1982-1985; served as a consultant on business strategy and operations issues for McKinsey clients

-Woodside Hotels: Vice President 1985-1988 and President 1988-2007; operated 6 upscale hotels and 6 restaurants and 4 spas, significantly improved revenues and profits

-Co owner and co-operator Monterey Plaza Hotel: 1993-2007; purchased, upgraded and turned around this iconic hotel

-Co Founder Trinitas Partners and Pomona Farming: 2008-2019; capitalized, co-founded and co-operated a group of agriculture-focused investment funds and operating companies, which today have over $1 bil in assets under management (retired in 2018).

-Board member and Chairman of Borland Software (a NASDAQ firm): 2000-2009; also served as chair of audit, compensation, and governance committees, and lead independent director

-Trustee, Azusa Pacific University: 2008-2017; served on finance committee, chair of academic affairs committee, was invited to serve a second 9 year term and declined

-Director: several private companies

-Elder and Vice Chair Menlo Park Presbyterian Church: 2011-2104; co-lead the reformation of the church governance model and by laws

El Camino Health

Candidate Questionnaire

El Camino Hospital Board of Directors
Finance Committee Member

1. Identifying Information:

   Name: Bill Hooper

   Residence Address: 1845 Doris Drive, Menlo Park, CA 94025

   Email Address: williamkhooper@yahoo.com

   Phone Number: 650-766-1686

2. Please describe how your professional background demonstrates your knowledge and experience with the following:

   a. Demonstrated strategic financial effectiveness in an environment as a Financial Officer or General Manager.

      There are many elements of my knowledge and experience in strategic financial effectiveness. At the very foundation of my approach, overall, I pursue a standard of excellence in financial effectiveness. In addition, I seek a level of effectiveness that is determined by being specific, measurable, achievable, relevant, and timely. Also, I know and understand accounting, systems and procedures and internal controls, financial modeling and forecasting, as well as business strategy and management topics which are also a part of financial effectiveness. For 39 years, in multiple industry settings I either ran or oversaw accounting and finance functions in complex, multi-unit companies, in numerous investment funds and related operating companies, as a board member and as an audit committee chair for a publicly traded company and for several other private companies and a large, complex non-profit private university. I oversaw the hiring of audit services, the hiring and evaluation of financial and accounting management teams, the preparation of financial reports, the correction of accounting and process deficiencies, SEC compliance, SEC investigations and related repairs, forecasting and modeling. So, I have a lot of experience, across many sectors (real estate, hospitality, food service, software, investment and fiduciary management, farming), across many situations (hiring, firing, training, auditing, reporting, forecasting, SEC compliance, etc), and I have a "nose" for getting at issues that need to be dealt with. I also have a lot of very good experience assessing the quality and accuracy of financial forecasts and budgets, preparing reports that are understandable and clear, and making wise investment decisions.

Candidate Questionnaire

El Camino Hospital Board of Directors
Finance Committee Member

b. Experience (and an appreciation of) within an environment that places a high value on service and service excellence.

Excellence and high service starts with and derives from having an attitude, a posture, a discipline, and a heart that seeks the truth always, applies the "golden rule" always (treat others as we would like to be treated), and places others' interests ahead of our own. For over 10 years, I ran several investment funds, having a standard of excellence in reporting and fiduciary duty for our blue-chip institutional investors and private investors. We provided excellent reporting and excellent service to our investors. For over 10 years, I ran a high-end hotel and restaurant that placed high service at the top of our objectives, and we trained for high service, constantly monitored and measured high service, and executed high levels of service. As a board member, I felt the obligation for excellence in service, for the benefit of our shareholders and stakeholders.

c. Prior experience offering strategic insights in any of the following areas: (Circle all that applies to your experience)

Candidate Questionnaire

El Camino Hospital Board of Directors
Finance Committee Member

- Financial Services, Industry, Real Estate, (investment mgmt., hotels, restaurant, real estate, software, raising debt and equity)
- Background in Healthcare (little, advisor to and investor in primary care service company in Mexico City)
- South Bay Resident (Preferably Los Gatos Area) (Menlo Park)
- Large Complex Facility Construction (yes, in hotel construction)
- Healthcare Payer Experience (none)
- Candidates that would add gender/racial/cultural diversity to the Committee (no)
- Experience in a large corporate environment (yes)
- Healthcare Provider Experience (Preferably Hospital/ Health System) (no)

d. Are there any other aspects of the position description that you have experience with that are not specifically called out above? If so, please describe that experience.

I get along well with people, and have always received "high marks" for working well with others, and as a team member. I have a clear understanding and a lot of experience with the role of a board or committee member in setting policy and monitoring policy achievement, and in evaluation management teams (if appropriate in this case).

3. Why are you interested in being considered for a Finance Committee Member with El Camino Health?

My personal objective is to be of good service to other people. Medical services are the ultimate in important human services. El Camino Health is a large and important service to the community. I have a lot of business strategy, financial expertise, experience, wisdom and judgement that I wish to apply. Health care services and economics are changing, and my experience could be helpful. For all the these reasons, it would be terrific to contribute in some way to the very important mission of El Camino Health.

El Camino Health

Candidate Questionnaire

El Camino Hospital Board of Directors
Finance Committee Member

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

   Civil litigation that I would be glad to discuss, if desired.

5. Are you able to make the necessary time commitment?

   I believe I have the time and can easily make the time commitment (I do need further detail on the time commitment).

6. Would this position create a conflict of interest with any of your other commitments? No.

El Camino Health

Candidate Questionnaire

El Camino Hospital Board of Directors
Finance Committee Member

7. The El Camino Health Finance Committee Member position is a non-compensated (i.e. volunteer) and has a one-year renewable terms. Is this acceptable? Yes.

8. Please specify how you found out about this position? I saw the advertisement in the local weekly paper in Menlo Park.

Cynthia Stewart, MBA
408-483-5233 cstewart@powerpersonnel.com San Jose, CA

El Camino Hospital Board
Finance Committee

July 22, 2021

Dear Committee Board Members,

My name is Cynthia Stewart and I have been a resident of San Jose since the 1970's. I am writing to express my interest in becoming a member of the El Camino Finance Committee. I am thrilled that Carol Somersille, of whom I have known for over 16 years, has recommended that I apply for the position. As the founder of Power Personnel, a healthcare staffing agency and partner of El Camino Hospital, I am very familiar with the El Camino's mission, vision, and continued growth by meeting the needs of individuals in the community that it serves.

The following summary highlights my education, healthcare experience, financial experience, and business experience that I have gained through my 25 years of leading the Bay Area's most diverse healthcare staffing agency. Power Personnel has been an important contributor to the Bay Area healthcare community through our staffing of frontline clinical and non-clinical staff, our diversity and inclusion achievements, and our community involvement. The following video link that illustrates how our vision aligns with the mission and vision of El Camino Hospital. https://www.youtube.com/watch?v=fBM7DfIOAXM. I believe that my contributions will be a value-added benefit to the El Camino Hospital Financial Committee.

- Education:
  - Bachelor of Science, Marketing - San Jose State University.
  - Master of Business Administration, Finance - California State University, Eastbay.

- Background in Healthcare:
  - Founder and President of Power Personnel.
  - Power Personnel provides workforce resources to Northern California healthcare organizations.
  - Power Personnel has more than 25 years of exceptional service delivery to acute care hospitals, including teaching hospitals, high acuity-trauma centers, skilled nursing facilities, mental health facilities, and outpatient clinics. Some of our partners include El Camino Hospital, Stanford Health Care, Dignity Health, Santa Clara County, Alameda County, Vi of Palo Alto, The Sequoia's, The Terraces of Los Altos, and many others.

- Financial Effectiveness and Experience:
  - Through my hands on leadership of Power Personnel, we have experienced continuous growth and profitability for over 25 years.
  - We have been recognized by Staffing Industry Analyst as a member of the 100 Fastest Growing Healthcare Staffing Companies for 4 consecutive years.

- The success and growth of Power Personnel demonstrates my ability to implement successful business models and navigate the financial challenges in scaling a company that operates in a very diverse and dynamic healthcare market.

- Diversity and Inclusion

  - I am an African American Woman
  - Power Personnel is a 100% Women-Minority Owned Business Enterprise.
  - Over 75% of all Power Personnel temporary workers are ethnically diverse.
  - Over 75% of all Power Personnel internal employees are ethnically diverse.

- Community Involvement

  - Alameda County Project Roomkey
  - Central County Occupational Center – Employer of the Year
  - Work to Future – Employer Partner
  - San Jose Community Law School - Mentor
  - National Junior Basketball League - Sponsor
  - San Jose Leadership Group - Alumni

- Experience Working with Large Healthcare Clients
  - Power Personnel has over 20 years providing strategic workforce solutions to Stanford Health Care and Dignity Health. Both organizations are multi-system large scale healthcare institutions. We have helped these organizations to implement cost effective workforce solutions that are a critical component of their financial performance. We have also provided workforce solutions to El Camino Hospital to support its financial effectiveness.

- Membership and Associations
  - California Hospital Association (CHPAC)
  - California Staffing Professionals (CSP)
  - American Staffing Association (ASA)
  - Staffing Industry Analyst (SIA)

- Board Member Experience
  - San Jose Jack and Jill - Treasurer

Thank you for your consideration. I look forward to hearing from you.

Sincerely,

Cynthia Stewart

Cynthia Stewart, MBA

408-483-5233 cstewart@powerpersonnel.com San Jose, CA

HEALTH CARE EXECUTIVE

PRESIDENT

26 years of successful hands-on leadership and performance growth.

Seasoned health care executive creating innovative healthcare workforce solutions, balancing strategic decisions and financial disciplines with a commitment to diversity and inclusion in the workplace. Core strengths include:

- Relationship Building
- Risk Taking Confidence
- Ability to adapt to change, pivoting as required
- Budgeting and Fiscal Management
- Strategic Planning and Execution
- Client Partner and Strategic Advisor
- Ability to proactively execute strategic initiatives
- Fostering innovation through a perspective of diversity and inclusion

EXPERIENCE

Power Personnel, San Jose California
Founder and President – April 1994 to Present

Provides leadership while driving and managing the organizations healthcare services, operations, and experience. Key role in strategy and growth, client relationships, service delivery, quality and service excellence, performance improvement, and cultural excellence.

EDUCATION

Master of Business Administration (MBA), Finance, California State University, Eastbay

Bachelor of Science (B.S.), Marketing, San Jose University

MEMBERSHIPS AND ASSOCIATIONS

California Hospital Association (CHPAC)
California Staffing Professionals (CSP)
American Staffing Association (ASA)
Staffing Industry Analyst (SIA)

El Camino Health

Summary of Financial Operations
Pre-Audit FY2021 Results

Fiscal Year 2021 – Period 12

7/1/2020 to 06/30/2021

Executive Summary - Overall Commentary for Period 12

- Strong operating / financial results for Period 12 were attributed to the following:
  - Despite being out-of-network with Anthem, June gross charges were 15.0% higher than the prior 11 month average
  - Strong volume / patient activity was attributed to the start of the new OB group at our Mountain View Campus, significant rebound in ER volumes and continued strong procedural volumes at both campuses
    - ER visits were 33.1% higher than the prior 11 month average
    - Adjusted discharges were 14.8% higher than the prior 11 month average
  - Recognition of one-time revenue for supplemental programs of $8.56M
- Total gross charges, a surrogate for volume, were favorable to budget by $93.5M / 29.7% and $99.7M / 32.3% higher than the same period last year
- Net patient revenue was favorable to budget by $30.2M / 36.8% and $11.5M / 11.4% higher than the same period last year
- Operating expenses were $13.4M /16.2% unfavorable to budget, which is primarily attributed to higher than expected volume versus budget and significant number of procedural cases performed in June
- Operating margin was favorable to budget by $17.0M / 468.5% and $11.0M / 34.8% below the same period last year
- Operating EBIDA was favorable to budget by $17.7M / 176.3% and $9.8M / 26.1% below the same period last year

Operational / Financial Results: Pre-Audit Period 12 – June 2021 (as of 6/30/2021)

PERIOD 12 - RESULTS

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians 'A1'	Moody's Medians 'Aa3'	Performance to 'A1' Medians
Activity / Volume	ADC	269	234	35	15.0%	212	57	26.9%	---	---	---
	Total Discharges	1,789	1,586	203	12.8%	1,425	364	25.5%	---	---	---
	Adjusted Discharges	3,415	2,924	491	16.8%	2,791	624	22.4%	---	---	---
	Emergency Room Visits	5,620	4,440	1,180	26.6%	4,006	1,614	40.3%	---	---	---
	OP Procedural Cases	12,733	8,353	4,380	52.4%	10,289	2,444	23.8%	---	---	---
	Gross Charges ($)	408,078	314,599	93,479	29.7%	308,375	99,703	32.3%	---	---	---
Operations	Total FTEs	2,924	2,744	180	6.6%	2,668	256	9.6%	---	---	---
	Productive Hrs. / APD	28.4	31.9	(3.5)	(11.0%)	32.2	(3.8)	(11.8%)	---	---	---
	Cost Per CMI Adjusted Discharge	16,225	17,111	(886)	(5.2%)	15,743	482	3.1%	---	---	---
	Net Days in A/R	50.0	49.0	1.0	2.0%	51.9	(1.9)	(3.6%)	47.7	47.1	
Financial Performance	Net Patient Revenue ($)	112,238	82,074	30,165	36.8%	100,746	11,493	11.4%	106,723	257,000	
	Total Operating Revenue ($)	116,945	86,512	30,432	35.2%	108,768	8,177	7.5%	116,864	314,648	
	Operating Income ($)	**20,664**	**3,635**	**17,029**	468.5%	**31,695**	**(11,032)**	(34.8%)	**3,948**	**10,135**	
	Operating EBIDA ($)	**27,771**	**10,052**	**17,719**	176.3%	**37,522**	**(9,751)**	(26.0%)	**11,301**	**27,969**	
	Net Income ($)	40,705	6,968	33,737	484.2%	50,672	(9,967)	(19.7%)	8,219	18,726	
	Operating Margin (%)	**17.7%**	**4.2%**	**13.5%**	320.6%	**29.1%**	**(11.5%)**	(39.4%)	**2.9%**	**3.6%**	
	Operating EBIDA (%)	**23.7%**	**11.6%**	**12.1%**	104.4%	**34.5%**	**(10.8%)**	(31.2%)	**9.7%**	**8.9%**	
	DCOH (days)	388	264	124	47.0%	313	75	24.0%	254	264	

Notes:
1. Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect monthly averages.
2. DCOH total includes cash, short-term and long-term investments.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Operational / Financial Results: Pre-Audit YTD FY2021 (as of 6/30/2021)

YTD FY2021 - RESULTS

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians 'A1'	Moody's Medians 'Aa3'	Performance to 'A1' Medians
Activity / Volume	ADC	245	211	34	16.2%	227	18	7.9%	---	---	---
	Total Discharges	19,157	17,351	1,806	10.4%	18,966	191	1.0%	---	---	---
	Adjusted Discharges	36,226	32,156	4,070	12.7%	35,326	900	2.5%	---	---	---
	Emergency Room Visits	52,059	45,202	6,857	15.2%	56,334	(4,275)	(7.6%)	---	---	---
	OP Procedural Cases	160,728	95,074	65,654	69.1%	106,245	54,483	51.3%	---	---	---
	Gross Charges ($)	4,309,257	3,427,558	881,699	25.7%	3,648,324	660,933	18.1%	---	---	---
Operations	Total FTEs	2,841	2,620	221	8.4%	2,763	79	2.8%	---	---	---
	Productive Hrs. / APD	31.0	33.7	(2.8)	(8.2%)	32.6	(1.6)	(4.9%)	---	---	
	Cost Per CMI Adjusted Discharge	16,815	18,201	(1,385)	(7.6%)	17,243	(428)	(2.5%)	---	---	
	Net Days in A/R	50.0	49.0	1.0	2.0%	51.9	(1.9)	(3.6%)	47.7	47.1	
Financial Performance	Net Patient Revenue ($)	1,107,911	893,139	214,772	24.0%	982,696	125,215	12.7%	1,280,670	3,083,998	
	Total Operating Revenue ($)	1,156,342	947,971	208,371	22.0%	1,038,489	117,854	11.3%	1,402,368	3,775,777	
	Operating Income ($)	**87,244**	**(23,735)**	**110,979**	467.6%	**57,017**	**30,227**	53.0%	**47,381**	**121,614**	
	Operating EBIDA ($)	**170,690**	**55,823**	**114,867**	205.8%	**120,447**	**50,243**	41.7%	**135,606**	**335,624**	
	Net Income ($)	328,083	11,770	316,313	2687.4%	109,274	218,809	200.2%	98,622	224,710	
	Operating Margin (%)	**7.5%**	**(2.5%)**	**10.0%**	401.3%	**5.5%**	**2.1%**	37.4%	**2.9%**	**3.6%**	
	Operating EBIDA (%)	**14.8%**	**5.9%**	**8.9%**	150.7%	**11.6%**	**3.2%**	27.3%	**9.7%**	**8.9%**	
	DCOH (days)	388	264	124	47.0%	313	75	24.0%	254	264	

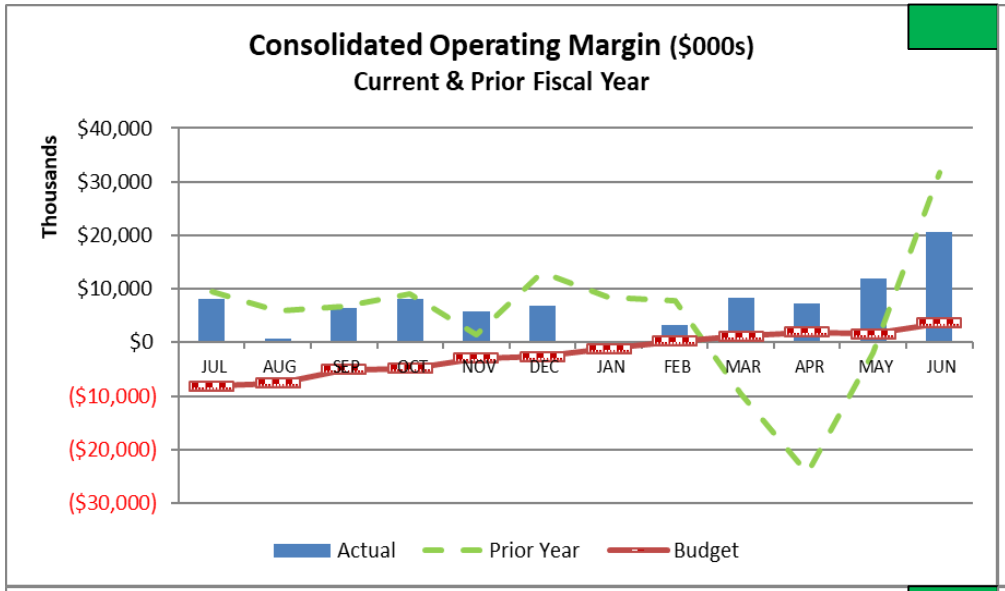
Notes:
1. Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020.
2. DCOH total includes cash, short-term and long-term investments.

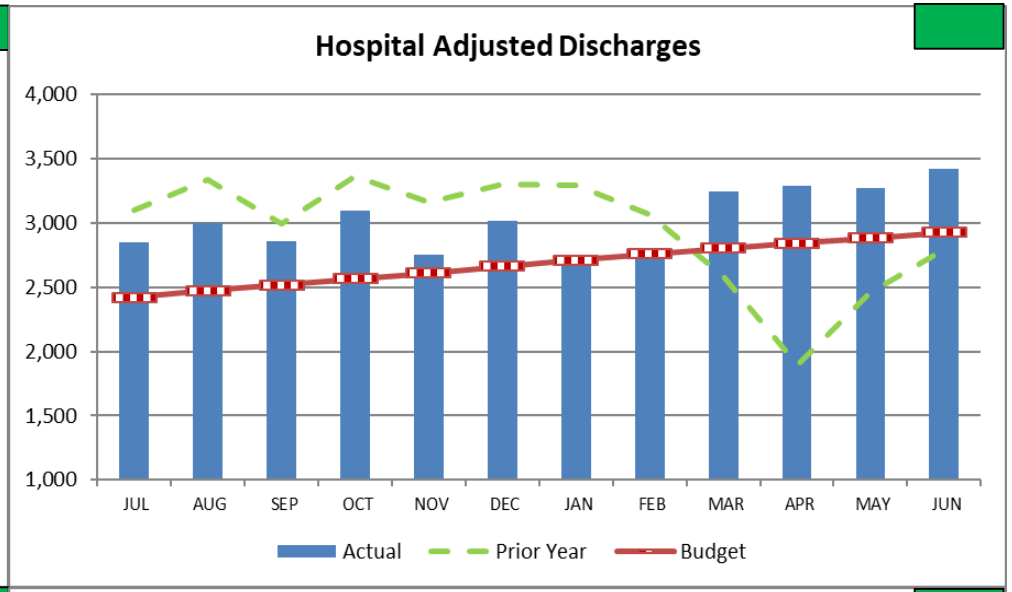
El Camino Health

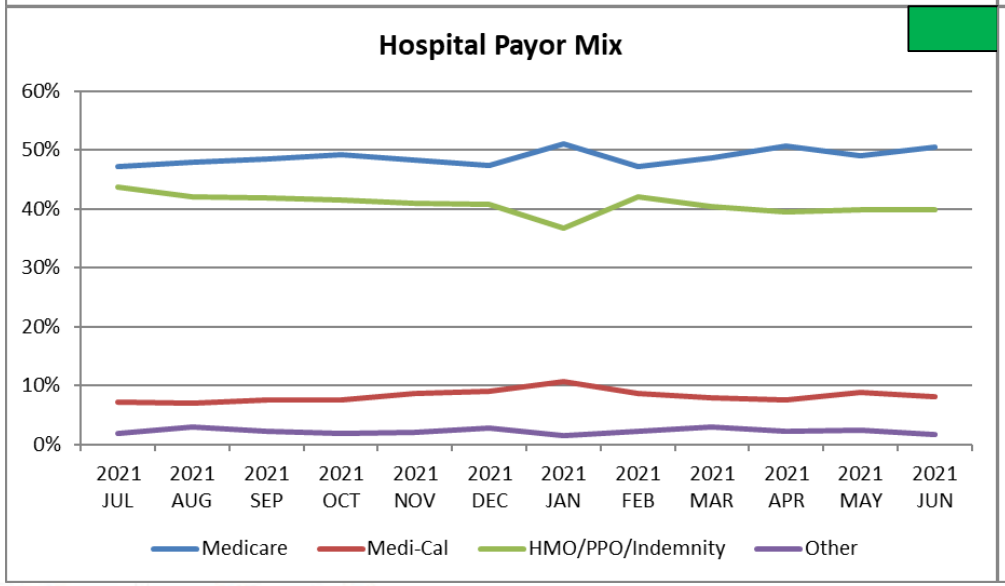
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

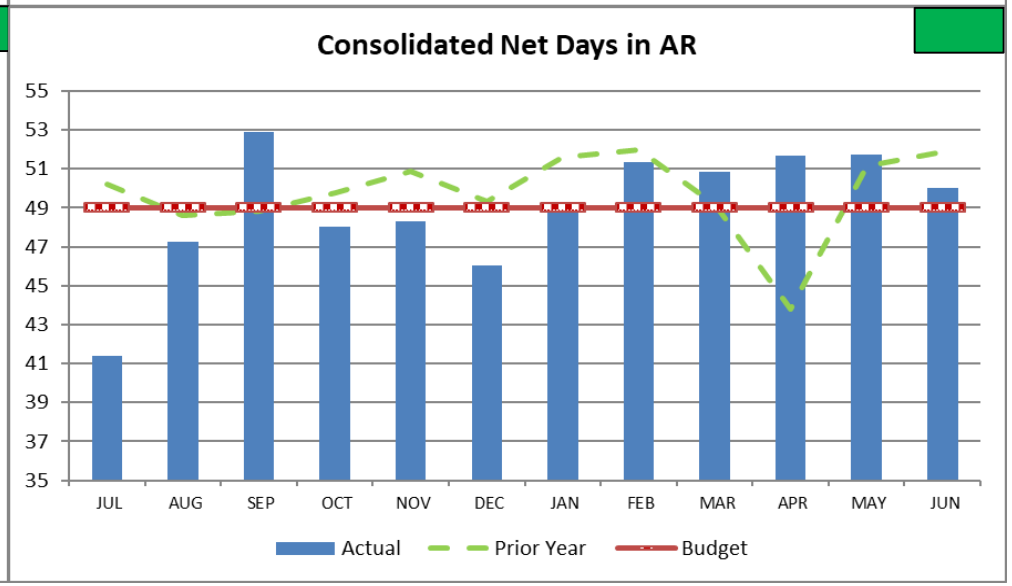
APPENDIX

YTD FY2021 Financial KPIs – Monthly Trends









El Camino Health

Period 12 and Pre-Audit YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 6/30/2021)

($000s)

	Period 12- Month			Period 12- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	19,736	4,538	15,198	91,033	(5,232)	96,266
Los Gatos	3,963	1,675	2,287	33,913	17,852	16,060
Sub Total - El Camino Hospital, excl. Afflilates	**23,698**	**6,213**	**17,485**	**124,946**	**12,620**	**112,326**
Operating Margin %	**21.4%**	**7.7%**		**11.4%**	**1.4%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**18,886**	**3,028**	**15,858**	**231,276**	**31,858**	**199,418**
El Camino Hospital Net Margin	**42,584**	**9,242**	**33,343**	**356,222**	**44,478**	**311,744**
ECH Net Margin %	**38.4%**	**11.5%**		**32.5%**	**5.1%**	
Concern	90	36	54	485	369	116
ECSC	0	0	0	(3)	0	(3)
Foundation	829	30	799	6,986	(159)	7,145
El Camino Health Medical Network	(2,798)	(2,339)	(459)	(35,607)	(32,917)	(2,689)
Net Margin Hospital Affiliates	**(1,879)**	**(2,273)**	**394**	**(28,138)**	**(32,707)**	**4,569**
Total Net Margin Hospital & Affiliates	**40,705**	**6,968**	**33,737**	**328,083**	**11,770**	**316,313**

Pre-Audit Consolidated Balance Sheet (as of 06/30/2021)

($000s)

ASSETS

CURRENT ASSETS	June 30, 2021	Audited June 30, 2020
Cash	151,641	228,464
Short Term Investments	284,262	221,604
Patient Accounts Receivable, net	166,283	128,564
Other Accounts and Notes Receivable	9,540	13,811
Intercompany Receivables	15,116	72,592
Inventories and Prepaids	23,079	101,267
Total Current Assets	**649,921**	**766,303**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	20,932	15,364
Plant & Equipment Fund	258,191	166,859
Women's Hospital Expansion	30,401	22,563
Operational Reserve Fund	123,838	148,917
Community Benefit Fund	18,412	17,916
Workers Compensation Reserve Fund	16,482	16,482
Postretirement Health/Life Reserve Fund	30,658	30,731
PTO Liability Fund	32,498	27,515
Malpractice Reserve Fund	1,977	1,919
Catastrophic Reserves Fund	24,874	17,667
Total Board Designated Assets	**558,264**	**465,933**
FUNDS HELD BY TRUSTEE	**5,694**	**23,478**
LONG TERM INVESTMENTS	**603,211**	**372,175**
CHARITABLE GIFT ANNUITY INVESTMENTS	**728**	**680**
INVESTMENTS IN AFFILIATES	**34,170**	**29,065**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,799,463	1,342,012
Less: Accumulated Depreciation	(742,921)	(676,535)
Construction in Progress	94,236	489,848
Property, Plant & Equipment - Net	**1,150,778**	**1,155,326**
DEFERRED OUTFLOWS	21,444	21,416
RESTRICTED ASSETS	29,332	28,547
OTHER ASSETS	86,764	3,231
TOTAL ASSETS	**3,140,306**	**2,866,153**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	June 30, 2021	Audited June 30, 2020
Accounts Payable	39,762	35,323
Salaries and Related Liabilities	50,039	35,209
Accrued PTO	33,197	28,124
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	12,990	10,956
Intercompany Payables	14,704	70,292
Malpractice Reserves	1,670	1,560
Bonds Payable - Current	9,430	9,020
Bond Interest Payable	8,293	8,463
Other Liabilities	16,953	3,222
Total Current Liabilities	**189,338**	**204,469**
LONG TERM LIABILITIES		
Post Retirement Benefits	30,658	30,731
Worker's Comp Reserve	17,002	16,482
Other L/T Obligation (Asbestos)	6,227	4,094
Bond Payable	479,621	513,602
Total Long Term Liabilities	**533,509**	**564,908**
DEFERRED REVENUE-UNRESTRICTED	**67,576**	**77,133**
DEFERRED INFLOW OF RESOURCES	**28,009**	**30,700**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,097,010	1,771,854
Board Designated	193,782	188,457
Restricted	31,082	28,631
Total Fund Bal & Capital Accts	**2,321,874**	**1,988,942**
TOTAL LIABILITIES AND FUND BALANCE	**3,140,306**	**2,866,153**

El Camino Health

El Camino Health

EL CAMINO □OSPITAL
□OARD MEETING COVER MEMO

To: El Camino Hospital Finance Committee
From: Jim □riffith, Chief Operating Officer
□en □ing, Chief Administrative Services Officer
Date: September 22, 2021
Su□□ect: MV Interventional Equipment (Cath Lab) Replacement including Addition of 6th Room, final Hospital Board funding being requested

Recommendation: The finance committee approved this request during its August meeting. The Board is requested to approve funding not to exceed □19.5 million to complete the construction and installation of interventional equipment to allow the operation of six (6) interventional labs on the Mountain View campus.

A detailed summary of the project is included in the Finance Committee August 9, 2021 material packet. Additional information is provided below in response to recent Board inquiries.

Additional Information:

1. Difference between the Funding Already Approved and the Current Request: The ECH Hospital Board approved the purchase of equipment for five existing and one new (□6) interventional room on the Mountain View campus in February of 2019. The expected cost of equipment (□12 million), plus initial planning and design (□1 million), did not include the cost of construction. The current request is a final pro□ect request based on the findings after working with the equipment vendor and OSHPD on technical and code requirements. The final cost of equipment is □13.99 million, based on the optimal configuration of the additional lab (□6.) The final construction and soft costs are □18.51 million, based on current code requirements.

2. Purpose and Timing of Multiple Bids: Construction costs reflect a competitive bidding process with several bidders at each trade level. Bidding occurs after equipment selection to provide bidders code compliant plans and technical specifications. The process steps ECH follows for pro□ects such as these are:
    1) Equipment Selection by Clinical Leads
    2) Equipment Funding Approval (to allow the vendor to work with architects/engineers for OSHPD plan
    3) Development of code-compliant plans & technical specifications to support new equipment
    4) OSHPD plan review & Approval (for Construction Permit)
    5) Competitive Bidding (at trade level)
    6) Final Board Approval (Current Step)
    7) Construct & Install Equipment
    8) Occupy each room as it is completed.
    9) Financial Review (approximately 1-year post first use of new equipment)

3. Purpose of Soft Cost & Contingency Funds: Soft costs include extensive design fees, continuous inspection, permit fees, and funding of any needed change orders based on OSHPD findings. The contingency covers potential cost changes for the 24-month construction phase.

4. Programs Needing Additional Capacity in Interventional Rooms: The business case for the additional interventional room (□6) focuses on growth in demand and the addition of new

physicians in the heart and vascular program. Cardiovascular physicians interested in bringing more cases to ECH have faced capacity constraints due to equipment downtime and room use by other services. The volume of these physicians forms the "backbone" of the financial case to add additional capacity to interventional services. At the same time, the 6th interventional room will also allow growth across multiple services including, but not limited to interventional vascular, interventional radiology, pulmonary intervention, and interventional neurology. In addition, some lower acuity cases from the crowded interventional rooms have been moved to Willow during construction, with careful consideration of safety and emergency coverage.

5. Purpose of Consultant Engagements: It is common practice with large projects to engage internal experts (physicians and planners) as well as external experts (equipment vendors and operations experts) to assure that the planned project is "right-sized" and fits "best practice." In this project, the following groups were consulted:

   Service Line Development Strategy. ECH operates a more complex interventional service than a typical community hospital. Therefore, evaluation of technological change across the full spectrum of services using the interventional rooms required review by internal user groups consisting of cardiologists, neurologists, pulmonologists, interventional radiologists, and electrophysiologists. This internal group – and the service administrators – advised ECH on the technologies needed to support their programs over the next 10 years.

   Equipment Upgrade Planning We engaged the services of an Interventional Imaging Equipment planner as a subject matter expert to determine the appropriate equipment and operational strategies to accommodate future growth in interventional care. A task force consisting of staff and medical directors for Interventional Cardiology, Electrophysiology, Interventional Radiology, Neurology, Vascular Intervention, Pulmonology, and Anesthesia has been actively involved in vetting the equipment needs and the three potential vendors. Taskforce members have conducted site visits to the Miami Heart in Florida, the UCSF Hybrid OR and Cath Lab, and the Stanford Cath Lab.

   Verification of Capacity An outside firm, A DirectImaging, validated the capacity limits of the current rooms. Management requested this review to assure that we are using our existing rooms as efficiently as possible, given the complex mix of services ECH delivers. The review indicates that most rooms are already operating at or over capacity. Therefore, the need for the 6th room is well justified.

6. Financial Department Review The CFO and finance department prepared and approved a detailed pro forma to analyze the financial cost/benefit of the 6th room. As a result, the 6th room yields a positive net present value of 26.6 million based on the capital investment of 5.8 million (for the 6th room), assuming a discount rate of 8 and 300 incremental annual cases year one reach 700 cases by year 6.

A complete write-up on the project and detailed visual PowerPoint is available in the finance committee material

El Camino Health

EL CAMINO □OSPITAL □OARD OF DIRECTORS
□OARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Carlos Bohorquez, Chief Financial Officer
Date: September 22, 2021
Su□□ect: Capital Funding Request: Pyxis MedStations Replacement Pro□ect

□□ Recommendation:

Finance Committee recommends the ECH Board approve capital funding not to exceed □6.64 million for the purchase and installation of 247 Pyxis MedStations.

□□ Summary:

a. Situation: Current Pyxis MedStations have been leased since 2009 and are now at the end of their useful life.
   - Pyxis MedStations are necessary to meet regulatory / compliance for medication safety and inventory control in the medical units and anesthesia
   - All MedStations are on Windows 7 platform which is no longer supported and creates IT vulnerabilities
   - The updated MedStations will optimize medication inventory and manage pharmacy spend

b. Authority: Policy requires that capital expenditures exceeding □1 million need Finance Committee and Board approval.

c. Background: Management has negotiated the following purchase terms
   - Total pro□ect cost to purchase 247 replacement Pyxis MedStations is □6.64 million
   - Purchase vs. lease is expected to save ECH □5.78 million over the next ten years
   - Monthly support and maintenance agreement: □297□ per year will begin in year 3

□□ List of Attachments:

a. None

□□ Suggested □oard Discussion □uestions:

a. What is the expected completion timeline of the pro□ect□

El Camino Health

EL CAMINO □OSPITAL □OARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams Chief Medical Officer
Date: September 22, 2021
Su□□ect: 2021 Medical Staff Development Plan (for FY22/23)

Purpose: Present the biennial medical staff development plan and proposed maximum recruitment expenditure for approval by the Board.

Recommendation: To approve the requested funding for the next two-year period (FY22/23) based on the Finance Committee recommendation.

Summary:

□□ Situation: It is vitally important that El Camino Health maintains a complete and well-balanced medical staff to provide appropriate medical care. To support this requirement, El Camino Health traditionally provides for income guarantee recruitment of physicians who can fulfill a community need and are willing to commit to relocating to our community to serve our patients. Therefore, the Finance Committee has reviewed and recommended that the Board approve this plan.

□□ Authority: This program requires sufficient funding, which must be approved by the Board.

□□ Background: Every two years, a thorough physician community needs assessment is obtained by a third party with expertise in this area. As in the past, EC□ was contracted for this purpose. Based on this community needs assessment, a list of potential physician recruitment targets are identified with a corresponding estimate of the costs associated with those targets. The costs are determined by the fair market value of the particular specialists' compensation needed to recruit them to our market. The previous FY 20/21 plan approved by the finance committee included 17 physicians for a total maximum recruitment support of □6,120,000.

□□ Assessment: Based on our analysis, the proposal being submitted includes a potential maximum of 19 physician income guarantee recruitment to include the following:

- Primary Care: 5
- Ob/□yn: 2
- Psychiatry: 2
- Neurology: 1
- ENT: 1
- □eneral Surgery: 3
- Orthopedic Surgery: 3
- Other: 2

This represents a total of 19, with an estimated potential cost of □6,950,000.

□□ Outcomes: This will provide flexibility to successfully recruit out-of-area physicians to fulfill a community need as opportunities arise.

El Camino Health

EL CAMINO □OSPITAL □OARD OF DIRECTORS
□OARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Apurva Marfatia, MD, Enterprise Chief of Staff
Michael □an, MD Chief of Staff Los □atos
Date: September 22, 2021
Su□□ect: Medical Staff Report – Open Session

Recommendation:

To approve the Medical Staff Report, including Policies and Procedures identified in the attached list and the Delineation of Privileges.

Summary:

□□ Situation: The Medical Executive Committee met on August 26, 2021

□□ Background: MEC received the following informational reports.

a) Dr. Marfatia, Chief of Staff, gave a presentation on the Overview of the year 2020

b) The CEO Report was provided and included the following updates:

1. Los □atos Outpatient Oncology received the □uardian of Excellence Award for Patient Experience.
2. COVID Vaccination rate was presented
3. Unconscious Bias Training has been completed by 95□ of Management staff
4. A new agreement was entered with the Anesthesia □roup, which was effective August 1, 2021

c) The CMO Report was provided and included the following updates:

1. FY21 Quality, Safety, and Experience Dashboard
2. Physician Engagement Survey Results were presented

List of Attachments: None

Suggested □oard Discussion □uestions: None

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Dan Woods, Chief Executive Officer; Carlos Bohorquez, Chief Financial Officer
Date: September 22, 2021
Subject: Joint Venture for Inpatient Rehabilitation Facility

Recommendation:

To enter into a transaction under an Operating Agreement with IRF Development 52, LLC, a Delaware limited liability company and a wholly-owned subsidiary of Kindred Healthcare Operating, LLC (Kindred) for the purposes of construction and development and ownership and operation of a fifty two (52) beds inpatient rehabilitation facility (the IRF). Also, to approve the attached Board Resolution allowing management to proceed in executing the transaction.

Summary:

1. Situation: The LG campus maintains a thirty (30) acute rehabilitation unit (ARU) managed by Kindred through a Management Services Agreement (MSA). The ARU is currently in a separate building and licensed under the El Camino Hospital (ECH) license. This ARU is licensed for 30 beds with capacity for 25 semi-private (shared) rooms. ECH seeks to expand the number of patients it serves and to update the facilities in which patients are treated.

2. Authority: As the governing body of El Camino Hospital, the Board of Directors must approve potential investments of over five million dollars.

3. Background: ECH desires to enter into an Operating Agreement with Kindred to form El Camino Health Rehabilitation Institute, LLC as a California limited liability company (the Company) for the purposes of construction and development and ownership and operation of the IRF on a parcel of real property located in Sunnyvale, California. The Company will enter into a Management and Administrative Services Agreement with CHC Management Services, LLC, a Missouri limited liability company (CHC) where Kindred will guarantee CHC's performance managing the IRF. The IRF addresses an important clinical service provided to the community El Camino Hospital serves. This transaction with Kindred would allow for expansion of services, while continuing care coordination and quality, and allow ECH to allocate its capital resources to other priorities.

4. Outcome: Management asks for approval based on the following material terms:

- *Contribution.* ECH's capital contribution under the Operating Agreement will be the value of current assets of the ARU, at $17.7 Million determined to be fair market value by third party valuation consultant.
- *Ownership Interest.* ECH will receive fifty-one (51%) ownership interest in the Company, while Kindred will receive a forty-nine percent (49%) interest for its contribution.
- *Other Agreements.* All other agreements, including the Management and Administrative Services Agreement will be negotiated at arm's length between the Company and fees will set at fair market value as determined by a third party valuation consultant.

Based on the above factors and negotiated terms, management seeks the Board's approval to enter into the transaction described herein.

List of Attachments:

1. Appendix A – Summary Term Sheet
2. Appendix B – Board Resolution 2021- 03

El Camino Health

Appendix A – Summary Term Sheet

TERM AREA	SUMMARY OF NEGOTIATED TERMS
Contributions	El Camino will contribute the fair market value of its assets of the ARU valued at $17.7 Million by a third party valuation consultant. Kindred will provide a cash contribution in the same amount.
Ownership	El Camino will received a fifteen-one percent (51%) (majority) ownership interest in the Company for its contribution and Kindred forty-nine percent (49%) for its contribution.
Governance	The number of Directors are three for El Camino Hospital and three for Kindred. Voting is in a block based on ownership interest with El Camino Hospital maintaining the majority of voting rights. Certain actions require unanimous vote of all Members.
Termination	Withdraw or transfer interest to another entity requires unanimous vote or written consent, including a right of first refusal if a Members is selling all its interests in the Company. Either party have an option to make an offer to buy out/sell interest in the Company, if: • ECH's tax exempt status is in jeopardy or other compliance concern with the law as described in the Operating Agreement • The Management and Administrative Services Agreement is terminated. Termination of this Management and Administrative Services Agreement by the Company is by mutual agreement or for cause. The Agreement is subject to unanimous vote of the Members under the Operating Agreement.

RESOLUTION 2021-03
OF THE BOARD OF DIRECTORS OF
EL CAMINO HOSPITAL

□t a meeting d□ly called on □eptem□er 22□2021□the □oard of Directors (the "□oard") of El Camino Hospital□a California nonprofit p□□lic □enefit corporation ("ECH")□does here□y a□thori□e□consent to□and adopt the follo□ing resol□tions:

WHEREAS□ECH owns and operates an acute rehabilitation unit ("□R□") with thirty □30□licenses □eds□and

WHEREAS□ECH see□s to e□pand the n□m□er of patients it serves and to □pdate the facilities in □hich patients are treated□and

WHEREAS□ECH desires enter into an Operating □greement □ith IR□ Development 52□ □□C□a Dela□are limited lia□ility company and a □holly-o□ned s□□sidiary of □indred Healthcare Operating, LLC ("□indred") □here□y the parties □o□ld form El Camino Health Reha□ilitation Instit□te□□□C as a California limited lia□ility company (the "Company") for the p□rposes of constr□ction and development and o□nership and operation of an inpatient reha□ilitation facility consisting of fifty t□o □52□□eds (the "IR□") on a parcel of real property located in the □an □ose□California□

WHEREAS, ECH □ill contri□□te the fair mar□et val□e of the □R□ assets for fifty-one percent □51□□ interest in the Company and □indred □ill contri□□te a capital contri□□tion e□□ivalent to the val□e of the □R□ assets□

WHEREAS□the Company □ill enter into a □anagement and □dministrative □ervices □greement □ith CHC □anagement □ervices□ □□C□a □isso□ri limited lia□ility company ("CHC") whereby Kindred will guarantee performance;

WHEREAS□the Operating □greement and □anagement and □dministrative □ervices □greement □ere negotiated at arm's length and evaluated by third party valuation consultants □the Operating □greement and together □ith the □anagement and □dministrative □ervices □greement, the "□ransaction Doc□ments"□□

WHEREAS□□ased □pon the presentations made to this □oard□and consideration of and deli□eration on the □enefits and ris□s to the ECH associated □ith the proposed transaction descri□ed a□ove □the "□ransaction")□this □oard □elieves the □ransaction is in the □est interests of ECH□and the comm□nities served □y ECH□and desires to approve the e□ec□tion of each of the □ransaction Doc□ments□and the doc□ments and transactions contemplated there□y.

NOW, THEREFORE, BE IT RESOLVED□□ased on the foregoing recitals and all information made availa□le to the □oard regarding material terms of the □ransaction Doc□ments□ that the □oard finds it to □e in the □est interest of ECH and the comm□nities served □y ECH□and here□y approves the effect□ation of the □ransaction thro□gh ECH's entrance into each of the □ransaction Doc□ments□□pon the material terms and conditions set forth therein.

RESOLVED FURTHER, that the □ransaction and the terms of the Operating □greement□ □anagement and □dministrative □ervices □greement□ and all transactions contemplated there□nder□are here□y approved.

RESOLVED FURTHER□that all actions ta□en □y the officers□agents□attorneys and employees of ECH in connection □ith the □ransaction are here□y ratified and confirmed.

RESOLVED FURTHER□that this □oard a□thori□es and directs all proper committees□ officers□agents□attorneys and employees of ECH to ta□e or ca□se to □e ta□en any and all s□ch actions deemed necessary or appropriate to effect□ate the □ransaction in a manner consistent □ith the intent of the foregoing resol□tions□incl□ding□□□t not limited to: □1□to carry o□t□or ca□se to □e carried o□t□all o□ligations of ECH □nder the □ransaction Doc□ments□incl□ding □itho□t limitation the e□ec□tion and delivery of the agreements□certificates□and opinions re□□ired □y the □ransaction Doc□ments□and □2□to perform□or ca□se to □e performed□s□ch other acts as they shall consider necessary or advisa□le in connection □ith the □ransaction.

RESOLVED FURTHER□that any and all actions previo□sly ta□en in f□rtherance of the transactions a□thori□ed or contemplated □y the foregoing resol□tions □y any of the officers of ECH □e□and here□y are□ratified□approved and confirmed as the tr□e acts and deeds of ECH incl□ding□□itho□t limiting the foregoing□the e□ec□tion□delivery□filing and/or recording of any agreements□certificates□filings□affidavits□instr□ments and other doc□ments as may □e or have □een necessary or appropriate in order to effect□ate the p□rposes of the foregoing resol□tions□ and the cons□mmation of the transactions contemplated there□y.

□*Signature Page Follows*□

IN WITNESS WHEREOF□the □oard of Directors of El Camino Hospital have e□ec□ted and adopted these Resol□tions at its meeting d□ly called and held on □eptem□er 22□ 2021□at □hich a □□or□m of the □oard □as present or represented.

□y: □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□
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OPEN SESSION CEO Report
September 22, 2021
Dan Woods, Chief Executive Officer

Operations

The Peter C. Fung, MD Stroke Center was awarded the Stroke Gold Plus award by the American Heart/Stroke Association for the 13th year running, recognizing our elite performance for evidence-based and timely care as reported to the national Get With the Guidelines registry.

The American Nurses Credentialing Center (ANCC) granted ECH's Practice Transition Program with "Accreditation with Distinction". The practice transition program is a rigorous training program which entails a year-long residency program for new graduate nurses. The accreditation program through ANCC requires the organization to write a thorough and complete document describing the program with very specific outcome standards including retention rates. Since 2016, ECH has managed to retain 92% new graduate residents matriculating through the program. A virtual site visit occurred in May which allowed many leaders and participants to demonstrate the value and excellence exhibited at ECH. The site visit clearly demonstrated the program's excellence which led to the ANCC decision to accredit the program for four more years.

Human Resources

On August 9, ECH implemented a COVID-19 vaccination policy, consistent with an order from the California Department of Public Health, that requires all staff to be fully vaccinated by September 30, 2021. This includes all employees, contractors, travelers and new hires unless precluded from doing so for medical or religious reasons. To date 96% of all El Camino Health staff have been fully vaccinated.

Following the implementation of this policy, ECH developed a COVID-19 Vaccine Exemption Request Review Process, which includes review of medical exemption requests by the Medical Director of Employee Health and review of all religious exemption requests by Human Resources and Hospital Counsel. To date we have accepted 14 requests for medical exemption and 40 requests for religious exemption.

Marketing and Communications

El Camino Health was the lead story in the San Francisco Chronicle article on Bay Area health systems battling delta virus and fatigue. It ran on the front page of the August 21, 2021 San Francisco Chronicle print version and was also picked up digitally - Sometimes I get home and I just sob': In Bay Area COVID wards, doctors battle delta, and fatigue.

In honor of El Camino Health's 60th year anniversary on September 1st, website and social media updates, internal communications, signage, videos, and press coverage were developed for launch on Sept 1st and throughout our anniversary year.

Information Services

HealthGorilla, a platform to provide patient diagnostic results to Independent physicians is now live. Currently 29 physicians signed up to have their patients' radiology and laboratory results routed to HealthGorilla for the continuum of care.

Epic's Cloud Computing for Predictive Analytics solution is now live which leverages the EMR's most cutting edge predictive models. Per the request of Epic's President/CEO, Judy Faulkner, a presentation on ECH's analytics program incorporating real time Enterprise Dashboards was presented to the CEO Forum at Epic's national Epic User Group by Dan Woods, Deb Muro and Robert Henehan. ECH is one of the leaders within Epic customers for use of Enterprise Dashboards.

Dr. Nangia, a Behavioral Health independent physician, is live on the Epic "Community Connect" system which allows referrals to the ECH Aspire program for adolescents.

Philanthropy

Between July 1, 2020 and June 30, 2021, the El Camino Health Foundation allocated $1,650,011.80 of unrestricted donations to support 16 new programs:

- Pharmacy: Outpatient weekend service, residency program, continuous glucose monitors for admitted patients with chronic, poorly managed diabetes
- Nursing: Performance Improvement/Lean Fellowship Program, Nurse Leader Scholar Program, OR Nurse Transition Program, sepsis nurse specialist, maintaining a patent IV, Wound and Ostomy Warriors
- Imaging Service: Dialog Health Mobile Communication
- Wound Care Center: Improving wound healing through nutritional support
- Concern Health: Healthcare Worker Pandemic Support Program
- Human Resources: Inclusion, Diversity, Equity, and Belonging Program
- Rehabilitation: Mobility technicians
- Patient Experience: iPads, charging stations, and stands

Planning for the 25th anniversary El Camino Heritage Golf Tournament, which will be held in person on Monday, October 25, 2021 at Sharon Heights Golf & Country Club, is in full swing. The response has been enthusiastic and the event is nearly sold out. The beneficiary will be the Cardiopulmonary Wellness Center and we expect to meet our fundraising goals.

The neuroscience service line received a donor contribution of $50,000 for the Peter C. Fung, MD Stroke Center to expand neurodiagnostics offerings with new equipment.

Corporate & Community Health Services

The South Asian Heart Center enrolled 265 participants in the Aim to Prevent Program and hosted two educational events with over 200 attendees.

The Chinese Health Initiative hosted a webinar presented by Dr. Andy Yu on pancreatic cancer in partnership with El Camino Health Cancer Center. Over 200 community members attended. Three other wellness workshops were offered with over 100 attendees.

The Department of Managed Health Care conducted their triannual clinical audit of Concern. Six auditors evaluated; Network adequacy, quality management, grievances and appeals and accessibility and service standards. The preliminary report will be available within 90 days.

Government Relations & Community Benefit

Government Relations

The Santa Clara County Board of Supervisors awarded a commendation to El Camino Health in honor of its 60th Anniversary. The commendation was co-sponsored by Supervisors Otto Lee and Joe Simitian. Supervisor Lee stated that all three of his daughters were born at El Camino. Supervisor Wasserman shared that El Camino Hospital Los Gatos saved his mom's life. Supervisor Joe Simitian highlighted how we are a wonderful long-time community partner on projects such as the ASPIRE program, AED deployment, COVID-19 testing and vaccinations, and Better Health Pharmacy.

Congresswoman Eshoo presented a 60th Anniversary Certificate of Special Congressional Recognition. The recognition also recognized efforts by El Camino Health in response to COVID19 in emergency, nursing, testing, and vaccinations.

Community Benefit

The Community Benefit staff launched FY22's grant partnerships. Staff is collecting and assessing FY21 data from Community Benefit reporters in departments throughout hospital campuses to determine Hospital Total FY2021 Community Benefit and compiling results from grant programs for year-end reports.

Auxiliary

The Auxiliary donated 1,878 volunteer hours for the month of June.