AGENDA
MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Tuesday, April 23, 2024 – 4:30 pm

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

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 986 7850 6344# No participant code. Just press #.**

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

Please note that the link 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.

VALUE PROPOSITION STATEMENT: Setting the Standard for the best healthcare experience in the Bay Area by delivering dependable clinical excellence in a caring, convenient way.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**4:30 – 4:31 pm**
2	**AB 2449 – REMOTE PARTICIPATION**	Bob Rebitzer, Board Chair	Possible Motion	**4:31 – 4:32**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**4:32 – 4:33**
4	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for people to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Bob Rebitzer, Board Chair	Information	**4:33 – 4:35**
5	**CONSENT CALENDAR ITEMS:** *Items removed from the Consent Calendar will be considered at the end of the regular agenda.* a. Approve Hospital Board Open Session Minutes (03/13/2024) b. Approve Minutes of the Closed Session of the Hospital Board (03/13/2024) c. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee d. Approve New ECHB Committee Governance Policy as Reviewed and	Bob Rebitzer, Board Chair	Motion Required	**4:35 – 4:50**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	Recommended for Approval by the Governance Committee e. Approve Physician Financial Arrangements Review and Approval Policy as Reviewed and Recommended for Approval by the Finance Committee and Compliance and Audit Committee f. Receive P8 Financials g. Receive FY24 ECHB Pacing Plan h. Receive FY24 ECHB Follow Up Items			
6	**BOARD OFFICER ELECTIONS PROCEDURE**	Bob Rebitzer, Board Chair	Discussion	**4:50 – 4:55**
7	**CEO REPORT**	Dan Woods, Chief Executive Officer	Information	**4:55 – 5:00**
8	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	Motion Required	**5:00 – 5:01**
9	*Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*: **APPROVE CREDENTIALING AND PRIVILEGING REPORT**	Mark Adams, MD, Chief Medical Officer Shreyas Mallur, MD, Associate Chief Medical Officer	Motion Required	**5:01 – 5:05**
10	*Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs*: **BOARD STRATEGY SESSION**	Dan Woods, Chief Executive Officer	Discussion	**5:05 – 7:50**
	(a) Fine-tuning our Strategy	Dan Woods, Chief Executive Officer and Management Team Lanhee Chen, Director Jack Po, MD, Vice Chair Don Watters, Director	Discussion	
	(b) 2027 Performance Milestones	Dan Woods, Chief Executive Officer and Management Team	Discussion	
	(c) Best Practices for Setting and Evaluating Enterprise Goals	Dan Woods, Chief Executive Officer Bob Miller, Chair, Executive Compensation Committee Heidi O'Brien, Mercer	Discussion	
11	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	Motion Required	**7:50 – 7:51**
12	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	**7:52 – 7:53**
13	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:53 – 7:59**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
14	**ADJOURNMENT** **APPENDIX**	Bob Rebitzer, Board Chair	Motion Required	**8:00**

Next ECHB Regular Meetings: May 8, 2024; June 12, 2024

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, March 13, 2024

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

Board Members Present
Bob Rebitzer, Chair
Julia E. Miller, Secretary/Treasurer (*at 5:47 pm*)
Jack Po, MD, Ph.D., Vice-Chair (*at 5:34 pm*)
Lanhee Chen, JD, PhD
Wayne Doiguchi
Carol A. Somersille, MD
George O. Ting, MD
Don Watters
Peter Fung, MD
John Zoglin**

Others Present
Dan Woods, CEO
Mark Adams, MD, CMO
Holly Beeman, MD, CQO
Carlos Bohorquez, CFO
Shahab Dadjou, President, ECHMN
Ken King, CAO
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO
Theresa Fuentes, CLO
Omar Chughtai, Chief Growth Officer

***via teleconference*

Others Present (cont.)
Prithvi Legha, MD, Chief of Staff, Mountain View Campus
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology
Douglas Hubert, Member of the Public**
Joe Ebisa, Member of the Public**
Sherman Tran, Member of the Public **

Board Members Absent
None

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:32 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. Directors Chen, Doiguchi, Fung, Rebitzer, Somersille, Ting, Watters, and Zoglin were present constituting a quorum. Directors Miller and Po were absent at roll call. Director Miller joined the meeting, in person, at 5:47 pm. Director Po joined the meeting, in person, at 5:34 pm.	**The meeting was called to order at *5:32 p.m.***
2. AB-2449 – REMOTE PARTICIPATION	No AB-2449 requests were received by the members of the Board. Director John Zoglin participated remotely under normal Brown Act teleconferencing requirements.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board if any member had a conflict of interest with any items on the agenda. None were reported.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board. No members commented during the allotted time.	
5. VERBAL MEDICAL STAFF REPORT	Dr. Legha provided a verbal medical staff report to the Board. Dr. Legha highlighted that the time had arrived for medical staff leadership to begin considerations for elections for the next set of medical staff leaders. Dr. Legha also provided a timeline to receive a final list of candidates for the leadership positions.	

6. QUALITY COMMITTEE REPORT	Director Somersille provided the Quality Committee Report and highlighted a discussion from the Quality Committee regarding governance language in the Quality Committee Charter, which the committee had turned over to the Governance Committee for review and guidance. Director Somersille also discussed planning efforts to formally collaborate with the Compliance and Audit committee, per the Quality Committee charter.	
7. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 5:42 pm. **Movant**: Chen **Second**: Po **Ayes**: Chen, Doiguchi, Fung, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Miller **Recused**: None	***Recessed to closed session at 5:42 p.m.***
8. AGENDA ITEM 16: CLOSED SESSION REPORT OUT	The open session was reconvened at **7:14 p.m.** by Chair Rebitzer. Agenda Items 8-15 were addressed in closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report was approved by a unanimous vote of all Directors present (Directors Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin).	***Reconvened Open Session at 7:14 p.m.***
9. AGENDA ITEM 17: CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Item E) *Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee,* was removed. Regarding the Generative Artificial Intelligence Usage Policy under item E) *Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee,* Ms. Fuentes advised that the policy had not yet been finalized for approval by the Compliance and Audit Committee and would need to be tabled until the recommendation was received from the Committee. Regarding the Physician Wellness Policy under item E) *Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee,* Director Somersille requested that the policy be renamed to *Physician Wellness Support Policy* and shared a request to include workshops under the coaching section. It was explained that the policy outlined services available to physicians via the Employee	***Consent Calendar item E was removed for further discussion*** ***Consent Calendar (minus item E) Approved*** ***Generative Artificial Intelligence Usage Policy removed from the Consent Calendar*** ***Consent Calendar item E Approved.***

	Assistance Plan (EAP) so content modifications could not be made by the Hospital or Board of Directors through this policy. **Motion:** To approve the consent calendar items with the removal of Item E. **Movant:** Miller **Second:** Somersille **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None **Motion:** To approve consent calendar item E) *Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee* without the Generative Artificial Intelligence Usage Policy. **Movant:** Watters **Second:** Miller **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Actions:*** *Staff to implement approved title revision to the Physician Wellness Support Policy*
10. AGENDA ITEM 18: APPROVE REAL ESTATE PROPERTY ACQUISITION (APN 406-27-022)	**Motion:** To approve real estate property acquisition (APN 406-27-022) **Movant:** Po **Second:** Ting **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Acquisition of real estate property approved.***

11. AGENDA ITEM 19: APPROVE REAL ESTATE PROPERTY ACQUISITION (APN 305-17-004)	**Motion:** To approve real estate property acquisition (APN 305-17-004) **Movant:** Po **Second:** Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Acquisition of real estate property approved.***
12. AGENDA ITEM 20: ADOPT RESOLUTION 2024-01: AUTHORIZING THE PURCHASE OF FIFTY-ONE (51%) MEMBERSHIP INTEREST IN SPINE SPORTS SURGERY CENTER LLC	**Motion:** To approve resolution 2024-01 **Movant:** Miller **Second:** Po **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Resolution 2024-01 adopted***
13. AGENDA ITEM 21: CEO REPORT	Mr. Woods provided a CEO report including recognition of Directors Doiguchi, Miller, and Somersille for attending the State of the Valley conference. Mr. Woods also recognized CFO, Carlos Bohorquez who was one of 12 individuals being honored with the Silicon Valley Business Journal Latinx Business Leadership Award for 2024.	
14. AGENDA ITEM 22: BOARD ANNOUNCEMENTS	Chair Rebitzer shared the date for the Board's upcoming meeting on April 23rd. Dr. Adams recognized CNO, Cheryl Reinking, for receiving an award from the West Valley Community Services at their Chefs of Compassion Banquet. Director Somersille also recognized CNO, Cheryl Reinking, for receiving a proclamation from the County Board of Supervisors.	
15. AGENDA ITEM 23: ADJOURNMENT	**Motion:** To adjourn at 7:31 pm **Movant:** Po **Second:** Miller **Ayes**: Chen, Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Meeting adjourned at 7:31 p.m.***

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

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Julia Miller, Secretary/Treasurer

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: 03/21/2024 – Tracy Fowler, Director, Governance Services
Reviewed by Legal: 03/25/2024 – Theresa Fuentes, Chief Legal Officer

Department	Policy Name	Revised?	Doc Type	Notes	Committee Approvals
New Business					
Risk Mgmt & Patient Safety	1. Administrative: Averse Event Reporting to Regulatory or State Licensing Agencies	Revised	Policy	1. Updated Procedure section	• ePolicy • Leadership Council • MEC
Emergency Mgmt	1. COVID-19 Control Plan	Revised	Plan	1. Updated Procedure section	• Emergency Mgmt Committee • Infection Prevention • ePolicy • MEC
NICU	1. Scope of Service: Neonatal Intensive Care Unit (NICU) – Enterprise	Revise	Scope of Service	1. Minor updates	• Medical Director • ePolicy • MEC
Medical, Surgical, Ortho, & Oncology (LG)	1. Scope of Service – Medical, Surgical, Orthopedics and Oncology – Los Gatos	Revised	Scope of Service	1. Updated Sections: Staffing/Staff Mix, Requirements for Staff	• UPC • ePolicy • MEC

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Theresa Fuentes, Chief Legal Officer
Date: April 23, 2024
Subject: ECH Board Policy Update

Recommendation(s):

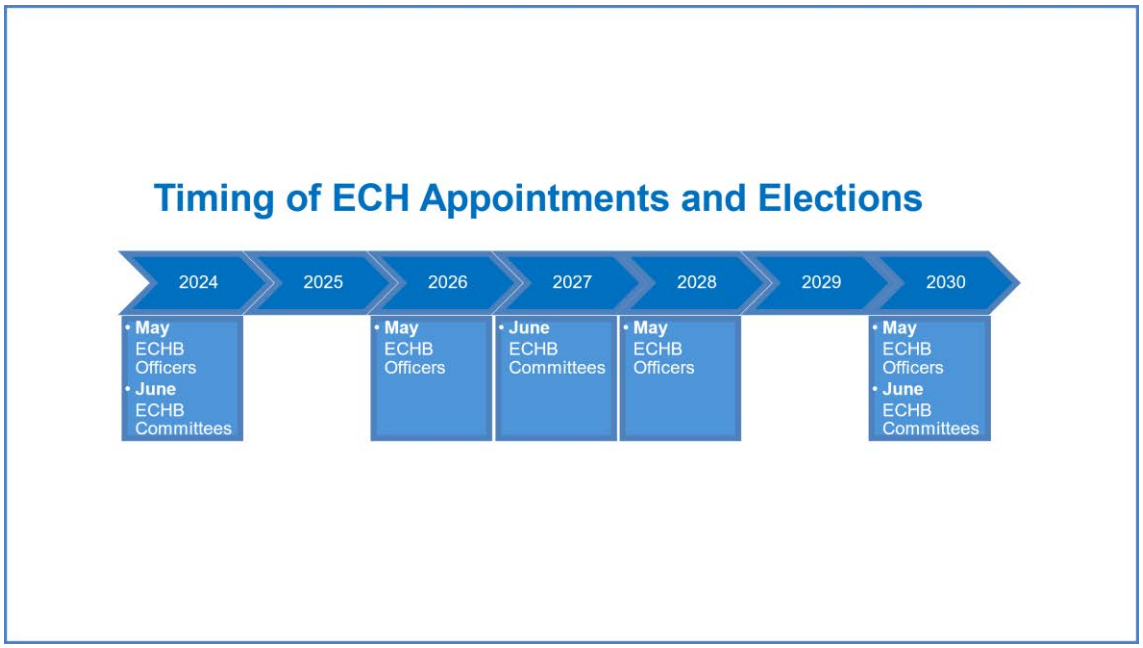
To recommend approval of El Camino Hospital Board Committee Governance Policy.

Summary:

El Camino Hospital Board Committee Governance Policy

The Committee Governance Policy is a new policy that was created to establish consistency across the Board committees regarding term, appointment, removal, and membership on Committees, and attendance and meeting expectations. Committee Charters will be updated to cite this new policy.

The Committee Governance Policy was reviewed and recommended for Board approval at the March 12, 2024, Governance Committee meeting. The Governance Committee recommended that the terms for committee members be updated to **three years** and this update is reflected in the policy. As such, the Board will renew appointments for all committee members in June 2024 for the period of June 2024-June 2027. New or replacement Committee members who are appointed during the three-year cycle of 2024-2027 will serve partial terms until the next appointment cycle, as illustrated below.



This policy will streamline and provide efficiencies for the Board as the reappointment process for all Committees will only need to be completed every three years, instead of yearly. It will also ensure transparent, accountable Committee operations, subject to periodic review for relevance and operational efficiency. This policy complements bylaws and charters by offering consistency and a more detailed and flexible framework for committee operations. It contributes to organizational effectiveness, alignment with strategic goals, and enhanced governance.

Policy	Changes	Effective Date
El Camino Hospital Board Committee Governance Policy	NEW POLICY. For best governance practices to ensure consistency around the governance of committees.	After ECHB approval – April 23, 2024

List of Attachments:

1. DRAFT El Camino Hospital Board Committee Governance Policy

El Camino Health

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	

Coverage:
All Members of the El Camino Hospital Board of Directors ("Board") and Board Advisory Committees ("Committees"). The Governance Committee shall review this policy at least every three (3) years to ensure that it remains relevant and appropriate.

Authority:
The Board has established the following standing Advisory Committees pursuant to Article 7.6 of the El Camino Hospital Bylaws: Compliance and Audit Committee; Executive Compensation Committee; Finance Committee, Governance Committee, Investment Committee; and Quality, Patient Care, and Patient Experience Committee. The Committees have the authority granted to them per the Bylaws and the Committee Charter. Committees may study, advise and make recommendations to the Board on matters within the committee's area of responsibility as stated in the Committee Charter. The authority of committees is limited to advisory recommendations except in responsibilities directly delegated by the Board. Committees may provide recommendations for the Board to consider, which recommendations may be considered, adopted, amended or rejected by the Board in the Board's sole discretion. Committees shall have no authority to take action or otherwise render decisions that are binding upon the Board or staff except as otherwise stated in the Bylaws, the Committee's Charter, or majority action of the Board. To the extent of any conflict with the Committee Charter, this policy controls.

Membership:
Each committee shall have the membership as stated in the Committee Charter but must be composed of at least two members of the Board ("Directors"), as well as people who are not members of the Board. Director membership on any single Committee shall not constitute a quorum of either Board or Healthcare District Board membership. The Chair of a committee is its presiding officer. In the absence of the Chair, the Vice-Chair (or if no Vice-Chair, any member of the Committee as determined by the Chair or the Board) shall perform the duties of the Chair.

Appointment and Removal:
The Board Chair shall appoint and remove the Director Members and Committee Chairs, subject to approval of the Board. Committee Chairs may appoint and remove a Vice-Chair at the Committee Chair's discretion. If the Committee Chair is not a Board Director, a Vice Chair must be appointed who is a Director, in which case the Director Vice-Chair shall be appointed the same as any other Director.

Term
Members of the committee, including the Chair and Vice-Chair, serve a term of three years (or partial term for off-cycle appointments), at the pleasure of the Board. The Board has authority to remove committee members at any time either with or without the Committee's recommendation, in the Board's sole discretion. Members of committees, including the Chair and Vice-Chair shall serve until such time as the Committee member resigns, is not reappointed, is removed, or is otherwise unable to serve.

El Camino Health

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	

If a community member wishes to vacate a position, the committee member shall submit a written resignation letter addressed to the Chair of the Committee and the Chair of the Board, with a copy to the CEO and Governance Services.

Attendance:

Committee members are expected to attend in person and meaningfully participate in all committee meetings absent extenuating circumstances. Remote virtual participation is generally only allowed for just cause or emergency situations such as physical or family medical emergency, childcare, illness, disability, or Board or Committee related travel. Remote virtual participation must comply with the requirements of the Ralph M. Brown Act. Committee members may be removed from the Committee for repeated failure to satisfy attendance requirements.

If a member is absent or virtual for two meetings in a calendar year, the Committee Chair shall contact that member and remind the member of this policy. If the member continues to be absent or virtual despite the warning, the Committee shall consider a recommendation to the Board for removal.

Meetings:

All Committees shall have a Committee Charter approved by the Board.

Committee meetings shall be open to the public except for items permitted to be discussed in closed session and held in accordance with the provisions of the Ralph M. Brown Act. At least 72 hours before a committee meeting, Governance Services shall post an agenda containing a brief, general description of each item of business to be discussed at the committee meeting. The posting shall be accessible to the public.

The minutes of each committee meeting, including any recommendation of a committee, shall include a summary of the information presented and the recommended actions. ECHB staff will prepare minutes for each meeting. Draft minutes will be provided to the committee at the next available committee meeting for committee member review and approval. Once approved, minutes will be made a part of the Board's permanent records.

A majority of the members of each committee shall constitute a quorum for the transaction of business.

Only members of the committee are entitled to make, second or vote on any motion or other action of the committee. Each committee member shall be entitled to one vote on all matters considered by the committee. A simple majority vote of the members of the Committee shall designate approval of a motion.

All committee communications must go through the designated committee Chair.

The specific committees and their respective responsibilities are as stated in the Charter for each Committee.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Theresa Fuentes, Chief Legal Officer
Date: April 23, 2024
Subject: ECH Board Policy Update

Recommendation(s):

To recommend approval of Physician Financial Arrangements – Review and Approval Policy

Summary:

The Physician Financial Arrangements – Review and Approval Policy was reviewed and recommended for Board approval at the February 28, 2024, Compliance and Audit Committee ("CAC") and at the March 25, 2024, Finance Committee ("FC") meeting.

This policy establishes processes and approvals that must be followed before the Hospital may enter a direct or indirect financial arrangement with a physician. The policy was updated to reflect current industry best practices, and to provide more flexibility for compliance and legal oversight of physician contracting. The updated policy requires FC approval for any physician compensation arrangement that exceeds 75% of fair market value, and both FC and Board approval for any physician compensation arrangement that exceeds 90% of fair market value. The CEO, or CEO designee, has authority to sign physician contract arrangements to the limits as approved in the separate signature authority policy.

Report:

The Physician Financial Arrangements – Review and Approval Policy requires annual summary reporting to the FC and CAC. The FC and CAC reviewed and approved the FY23 Annual Summary Report on Physician Financial Arrangements (Medical Directorships, Call Panels, and Professional, Management, and Consultative Services).

For information purposes, the FC and CAC approved the annual summary reporting as required. The approved documents are available for review on the Board Portal as Supplemental Materials.

List of Attachments:

1. REDLINE Physician Financial Arrangements Policy

Physician Financial Arrangements - Review and Approval

COVERAGE:

All El Camino Hospital staff, Contract Personnel, Physicians, Healthcare Providers, and the Governing Board.

PURPOSE:

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

POLICY STATEMENT:

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

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

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

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

PROCEDURE:

A. Administrative Standards:

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

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

1. All Physician Financial Arrangements:

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

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

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

determine the seventy-fifth percentile of FMV.

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

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

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

e. Physician Contracts must be in writing and executed by the parties before commencement of services. Exceptions on a case by case basis may be evaluated and approved by Legal and Compliance as long as such exception complies with Stark Law requirements. Only the CEO of Hospital or designee by CEO ~~in his or her absence~~ may execute a Physician Contract, except Physicians Contracts that are real estate or equipment leases with Physicians may be signed by the Chief Administrative Services Officer ~~.~~("CASO"), and IT agreements may be executed by the Chief Information Officer (CIO). ~~.~~ Execution of physician contracts by CEO, CMIO, CASO, or CEO designee must comply with the general signature authority and limits established in the Signature Authority policy.

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

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

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

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

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

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

k.l. All Physician Contracts must comply with the review and documentation process established through the contracts management system, as approved by Legal and Compliance. ~~ttached to the final version of a Physician Contract prior to execution by Hospital must be a completed "Contract Cover Sheet and Summary of Terms" and a signed "Certification of Necessity and Fair Market Value" (Appendix A) (a~~ Physician Lease Contracts must also include a signed "Contract Certification" (Appendix B) and "Lease Contract Review

Checklist" (Appendix C) to be reviewed and approved by Legal Services and Compliance.

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

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

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

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

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

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

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

   d. Medical Director Contracts must require Physician completion and submission of a physician time study reports each month in the manner specified in the contract, and each such report must be approved by the Designated Manager

and the Compliance Department before any compensation is paid. There must be one or more internal review processes to verify that the Medical Director is performing the expected duties and tasks, of which the required time report is one example. *Please refer to Appendix "D" 'Medical Director Time Report Guidelines' for more detailed guidance on completion of time report.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Physician Recruitment Contracts:
In addition to the criteria set forth in the *All Physician Financial Arrangements* section above (D.1), the following criteria must be met *before* creating a new Physician Recruitment Contract:

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

by the Board. ~~presented to the Board for review before the recruitment proposal is developed~~.

B. Approval of Physician Contracts:

1. Attached to the final version of a Physician Contract *before* CEO execution must be a completed questionnaire in the contracts management system addressing terms, necessity, and fair market value. Documentation of fair market value must be submitted in the contracts management system. ~~"Contract Cover Sheet and Summary of Terms" and "Certification of Necessity and Fair Market Value"" (Appendix A).~~
2. Attached to the final version of a Physician Lease Contract, *prior* to execution by the CEO or the CASO, must be a completed "Lease Contract Review Checklist" (Appendix C) and signed "Contract Certification" (Appendix B).
3. Corporate Compliance and Legal, as needed, ~~and the General Counsel~~ will verify the checklist, certification, and documentation accompanying all Physician Contracts (including FMV) prior to execution by the CEO or the CASO. Incomplete or missing checklist and certifications will be returned to the originator for completion.
4. All proposed Physician Contracts lacking the appropriate documentation will be returned to the originator for completion. No services may be performed under the Physician Contract or leases implemented until the Physician Contract is fully executed, or an exception has been granted by Compliance and Legal in accordance with Stark Law requirements.
5. CEO Approval: The CEO or the CEO's designee will have authority to execute new, renewal and amended Physician Contracts (up to the authority as stated in the Signature Authority policy) ~~$250,000.00 in total possible compensation annually)~~, except as set forth in Section 6) below.
6. Board Approval: ~~If a new arrangement is over $250,000.00; or a renewal or amended agreement is over $250,000; or the annual increase is greater than ten percent (10%), T~~the Board must approve prior to CEO or CEO designee execution of ~~the~~ Physician Contracts for the following arrangements:~~.~~

    a. All physician financial arrangements, including Professional Services Agreements for the El Camino Health Medical Network that exceed 75% of fair market value (regardless of total annual compensation) must be reviewed by the Finance Committee of the Board. All physician financial arrangements that exceed 90% of fair market value must also be reviewed and approved by the Board. ~~and approved by the Board~~.

    ~~b. If a new arrangement is over $250,000; or a renewal or amended agreement is over $250,000; or the annual increase is greater than ten percent (10%), the Finance Committee of~~

~~the Board must approve prior to CEO execution of the Physician Contract, except as set forth in section 6(d).~~

~~c.~~

~~d.~~c. ~~Notwithstanding Section 6(a) and (b),~~ Tthe CEO may execute without Board approval a new, renewal or amended Professional Services Agreement with El Camino Medical Associates (ECMA)so long as the total cash compensation to each individual physician employed by ECMA does not exceed 75% percentile of fair market value or the CEO's signature authority. ~~$1,000,000 annually.~~

C. Board Oversight and Internal Review Process:

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

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

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

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

D. Exceptions:

There are no exceptions to this Policy except as indicated herein.~~unless approved by the Board of Directors in advance.~~

E. Review and/or Validate:

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

F. Policy Enforcement

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

El Camino Health

Summary of Financial Operations

Fiscal Year 2024 – Period 8

7/1/2023 to 02/29/2024

Operational / Financial Results: Period 8 – Feb 2024 (as of 02/29/2024)

PERIOD 8 - RESULTS

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'Aa3'	S&P 'AA'	Fitch AA-	Performance to Rating Agency Medians
Activity / Volume	ADC	304	315	(10)	(3.3%)	315	(11)	(3.4%)	---	---	---	---
	Total Acute Discharges	1,732	1,832	(100)	(5.4%)	1,718	14	0.8%	---	---	---	---
	Adjusted Discharges	3,477	3,422	55	1.6%	3,391	86	2.5%	---	---	---	---
	Emergency Room Visits	6,571	5,582	989	17.7%	5,449	1,122	20.6%	---	---	---	---
	OP Visits / OP Procedural Cases	11,316	11,768	(452)	(3.8%)	10,065	1,251	12.4%	---	---	---	---
	Gross Charges ($)	503,356	498,873	4,483	0.9%	449,197	54,158	12.1%	---	---	---	---
Operations	Total FTEs	3,422	3,487	(65)	(1.9%)	3,330	92	2.7%	---	---	---	---
	Productive Hrs. / APD	28.2	29.5	(1.3)	(4.3%)	27.2	1.0	3.8%	---	---	---	---
	Cost Per CMI AD	19,629	19,005	625	3.3%	18,170	1,460	8.0%	---	---	---	---
	Net Days in A/R	51.3	54.0	(2.7)	(5.0%)	55.8	(4.5)	(8.0%)	47.9	49.7	45.9	
Financial Performance	Net Patient Revenue ($)	119,672	119,401	271	0.2%	109,680	9,992	9.1%	329,311	115,267	---	
	Total Operating Revenue ($)	126,548	124,478	2,070	1.7%	114,275	12,273	10.7%	373,348	142,369	146,668	
	Operating Margin ($)	**9,110**	**9,377**	**(267)**	(2.9%)	**9,053**	**57**	0.6%	**4,066**	**6,122**	**1,613**	
	Operating EBIDA ($)	**18,058**	**17,340**	**718**	4.1%	**17,297**	**761**	4.4%	**24,030**	**13,952**	**9,533**	
	Net Income ($)	31,149	12,210	18,940	155.1%	(960)	32,109	3344.5%	16,237	9,681	4,107	
	Operating Margin (%)	**7.2%**	**7.5%**	**(0.3%)**	(4.4%)	**7.9%**	**(0.7%)**	(9.1%)	**1.1%**	**4.3%**	**1.1%**	
	Operating EBIDA (%)	**14.3%**	**13.9%**	**0.3%**	2.4%	**15.1%**	**(0.9%)**	(5.7%)	**6.4%**	**9.8%**	**6.5%**	
	DCOH (days)	269	325	(56)	(17.1%)	252	18	7.0%	262	336	243	

Moody's Medians: Not-for-profit and public healthcare annual report; September 7, 2023. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 7, 2023. Dollar amounts have been adjusted to reflect monthly averages.
Fitch Ratings: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; July 25, 2023. Dollar amounts have been adjusted to reflect monthly averages.

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

El Camino Health

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

Operational / Financial Results: YTD FY2024 (as of 02/29/2024)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'Aa3'	S&P 'AA'	Fitch AA-	Performance to Rating Agency Medians
Activity / Volume	ADC	308	293	15	5.2%	302	6	2.1%	---	---	---	---
	Total Acute Discharges	14,885	14,459	426	2.9%	14,509	376	2.6%	---	---	---	---
	Adjusted Discharges	29,060	28,213	847	3.0%	28,106	955	3.4%	---	---	---	---
	Emergency Room Visits	53,489	51,468	2,021	3.9%	50,059	3,430	6.9%	---	---	---	---
	OP Visits / OP Procedural Cases	90,265	96,257	(5,992)	(6.2%)	91,569	(1,304)	(1.4%)	---	---	---	---
	Gross Charges ($)	4,166,868	4,024,917	141,951	3.5%	3,758,193	408,675	10.9%	---	---	---	---
Operations	Total FTEs	3,366	3,463	(98)	(2.8%)	3,284	82	2.5%	---	---	---	---
	Productive Hrs. / APD	28.0	29.7	(1.8)	(5.9%)	28.0	(0.0)	(0.1%)	---	---	---	---
	Cost Per CMI AD	18,743	19,005	(262)	(1.4%)	17,742	1,001	5.6%	---	---	---	---
	Net Days in A/R	51.3	54.0	(2.7)	(5.0%)	55.8	(4.5)	(8.0%)	47.9	52.6	45.9	
Financial Performance	Net Patient Revenue ($)	974,413	975,031	(617)	(0.1%)	907,215	67,198	7.4%	2,634,489	922,137	---	
	Total Operating Revenue ($)	1,023,122	1,019,340	3,781	0.4%	939,595	83,527	8.9%	2,986,783	1,138,954	1,173,346	
	Operating Margin ($)	**99,544**	**88,703**	**10,841**	12.2%	**88,282**	**11,262**	12.8%	**32,524**	**48,975**	**12,907**	
	Operating EBIDA ($)	**166,377**	**153,955**	**12,422**	8.1%	**151,336**	**15,041**	9.9%	**192,237**	**111,617**	**76,267**	
	Net Income ($)	186,436	110,461	75,975	68.8%	150,923	35,514	23.5%	129,896	77,449	32,854	
	Operating Margin (%)	**9.7%**	**8.7%**	**1.0%**	11.8%	**9.4%**	**0.3%**	3.6%	**1.1%**	**4.3%**	**1.1%**	
	Operating EBIDA (%)	**16.3%**	**15.1%**	**1.2%**	7.7%	**16.1%**	**0.2%**	1.0%	**6.4%**	**9.8%**	**6.5%**	
	DCOH (days)	269	325	(56)	(17.1%)	252	18	7.0%	262	336	243	

Moody's Medians: Not-for-profit and public healthcare annual report; September 7, 2023. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 7, 2023. Dollar amounts have been adjusted to reflect monthly averages.
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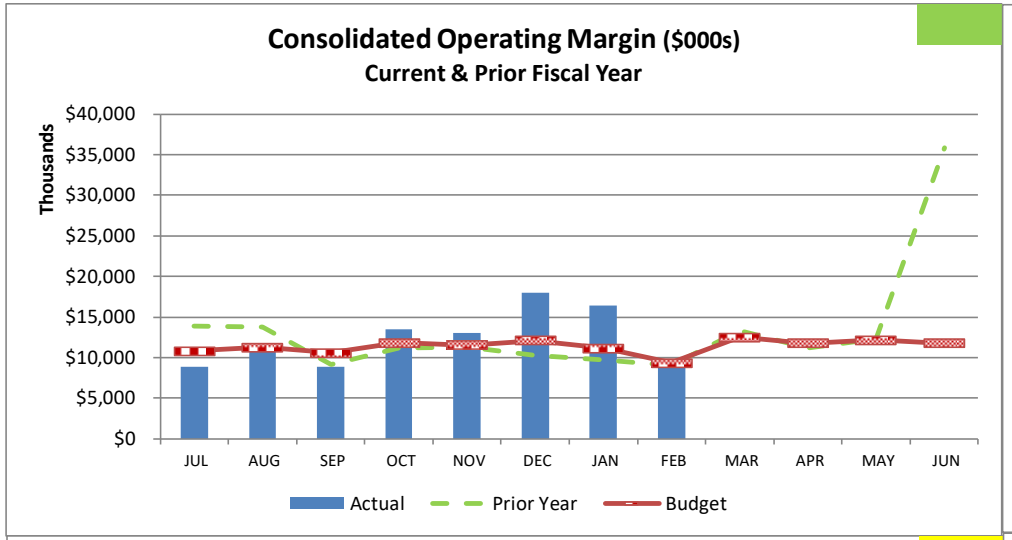
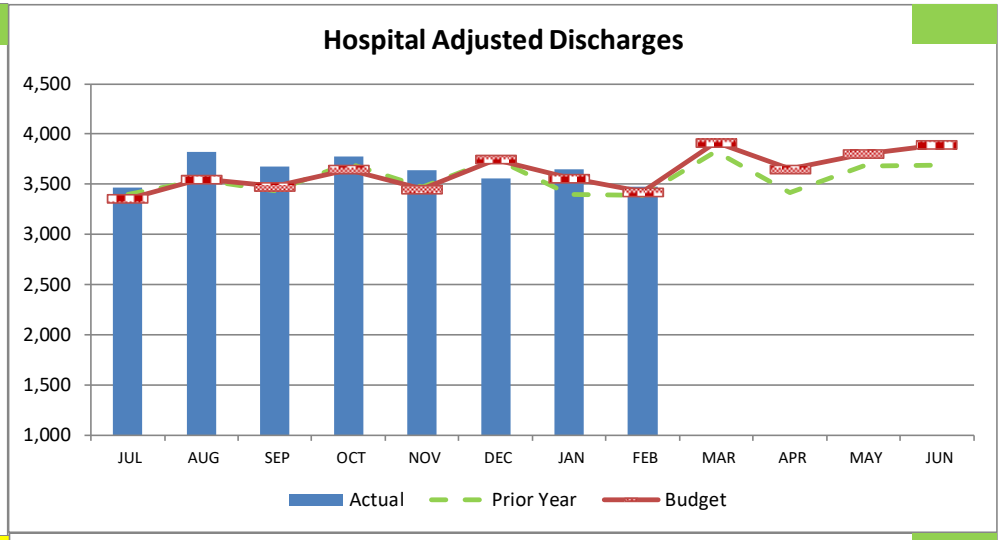
Notes: DCOH total includes cash, short-term and long-term investments.
OP Visits / Procedural Cases includes Covid Vaccinations / Testing.

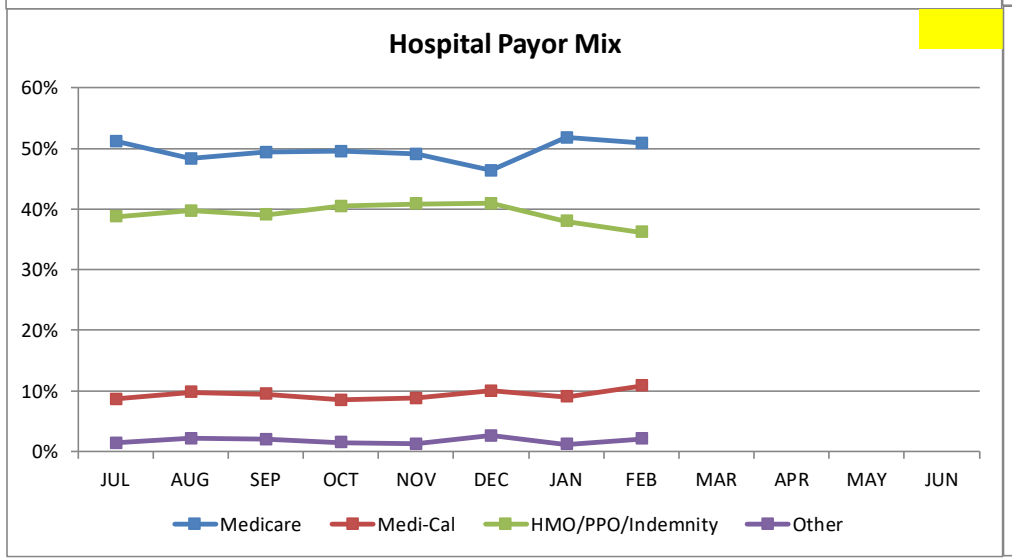
El Camino Health

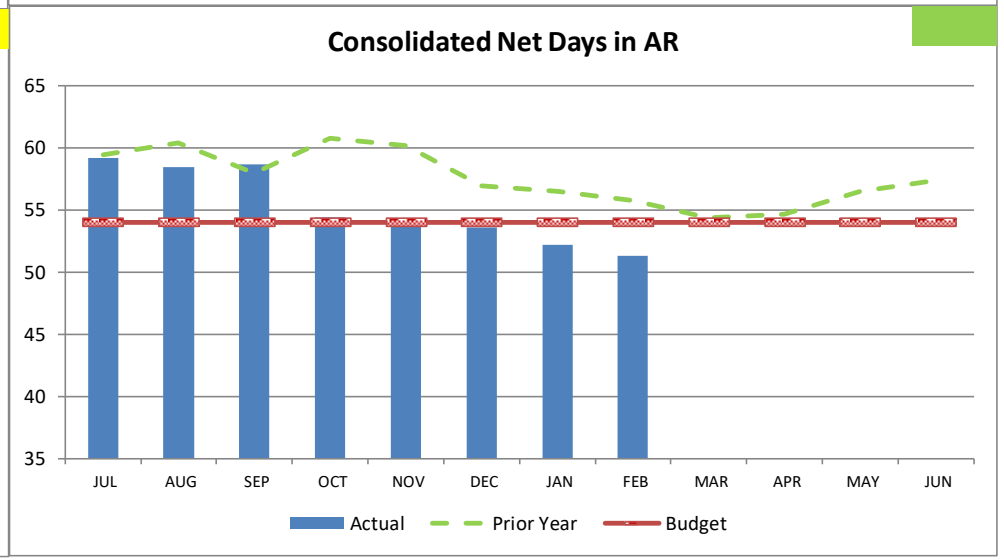
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

YTD FY2024 Financial KPIs – Monthly Trends









El Camino Health

Consolidated Balance Sheet (as of 02/29/2024)

($000s)

ASSETS		Unaudited
CURRENT ASSETS	**February 29, 2024**	**June 30, 2023**
Cash	206,910	230,765
Short Term Investments	94,609	129,245
Patient Accounts Receivable, net	213,487	218,528
Other Accounts and Notes Receivable	16,198	20,413
Intercompany Receivables	16,026	15,186
Inventories and Prepaids	46,532	45,037
Total Current Assets	**593,762**	**659,174**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	22,803	20,731
Plant & Equipment Fund	473,133	407,526
Women's Hospital Expansion	31,379	30,735
Operational Reserve Fund	210,693	207,898
Community Benefit Fund	17,472	17,743
Workers Compensation Reserve Fund	13,498	13,498
Postretirement Health/Life Reserve Fund	22,966	24,242
PTO Liability Fund	36,633	35,252
Malpractice Reserve Fund	1,713	1,885
Catastrophic Reserves Fund	31,858	28,042
Total Board Designated Assets	**862,149**	**787,551**
FUNDS HELD BY TRUSTEE	**18**	**-**
LONG TERM INVESTMENTS	**627,994**	**474,670**
CHARITABLE GIFT ANNUITY INVESTMENTS	**977**	**948**
INVESTMENTS IN AFFILIATES	**35,137**	**33,262**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,961,813	1,862,363
Less: Accumulated Depreciation	(846,543)	(791,528)
Construction in Progress	142,922	168,956
Property, Plant & Equipment - Net	**1,258,191**	**1,239,791**
DEFERRED OUTFLOWS	56,449	57,204
RESTRICTED ASSETS	36,101	36,339
OTHER ASSETS	167,908	166,528
TOTAL ASSETS	**3,638,687**	**3,455,466**

LIABILITIES AND FUND BALANCE		Unaudited
CURRENT LIABILITIES	**February 29, 2024**	**June 30, 2023**
Accounts Payable	46,607	50,862
Salaries and Related Liabilities	31,936	24,408
Accrued PTO	37,523	36,104
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	12,585	11,295
Intercompany Payables	12,582	12,362
Malpractice Reserves	1,863	1,863
Bonds Payable - Current	10,820	10,400
Bond Interest Payable	1,535	7,890
Other Liabilities	11,737	11,968
Total Current Liabilities	**169,487**	**169,450**
LONG TERM LIABILITIES		
Post Retirement Benefits	22,966	24,242
Worker's Comp Reserve	13,498	13,498
Other L/T Obligation (Asbestos)	27,811	29,543
Bond Payable	441,234	454,806
Total Long Term Liabilities	**505,509**	**522,088**
DEFERRED REVENUE-UNRESTRICTED	**1,294**	**1,103**
DEFERRED INFLOW OF RESOURCES	**91,334**	**91,871**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,606,699	2,417,300
Board Designated	216,458	209,043
Restricted	47,905	44,611
Total Fund Bal & Capital Accts	**2,871,062**	**2,670,954**
TOTAL LIABILITIES AND FUND BALANCE	**3,638,687**	**3,455,466**

El Camino Health

El Camino Hospital Board												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/9	9/13	10/11	11/8	12/6	JAN	2/7	3/13	4/23	5/8	6/12
STANDARD												
Public Communication		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Committee Reports (Informational and Consent item, unless requested)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Consent Approvals		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Executive Session		✓	✓	✓	✓	✓		✓	✓		✓	✓
CEO Report		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
COMPLIANCE												
Annual Corporate Compliance Summary					✓							
EXECUTIVE PERFORMANCE												
CEO Assessment Results Discussion			✓									
CEO Performance Evaluation & Compensation				✓								
Executive Incentive Approvals				✓								
FINANCE												
Financials		✓		✓				✓			✓	
Budget Review & Approval												✓
MEDICAL NETWORK												
Bi-Annual Report			✓						✓			
STRATEGY												
Strategy Update, Strategic Vision					✓			✓		✓		
Board Retreat										✓		
QUALITY												
Quality Committee Focused Review			✓		✓			✓			✓	
Medical Staff Report			✓		✓				✓			✓
GOVERNANCE												
Board Self-Assessment & Action Plan												
ECHB Officer Elections (Bi-annual)										✓	✓	
Director, Committee Member, and/or Chair Appointments					✓							✓
Committee Charter Review												✓

Last Update: 03/13/2024

FY24 ECHB MEETING FOLLOW UP ITEMS

Subject	Actions	Notes	Status
March ECHB Meeting			
ECHMN Semi-Annual Report	Next Meeting	Come back with a proposal for access metric. (Based on 3NA discussion)	Paced for April 23, 2024 ECHB meeting
	Next Report	Include data re: IPA on next report - Specifics of the IPA strategy - Economic consequences and financial impact on ECH	Paced for September 2024 ECHB meeting (pending finalization of FY25 pacing plan)
November ECHB Meeting			
Annual Compliance Report	Future Meeting	AI Governance needs to be added to pacing plan	Paced for June ECHB meeting
October ECHB Meeting			
Consolidated Financial Report	Next report	Consider a plan for RFP for Auditor – work for Finance Committee and Compliance and Audit Committee	Paced for next report – October 2024
Culture of Safety	Future Meeting	For board retreat, joint education, or conferences: Discuss goal setting and how to balance between stretch goals and goals that are insufficiently aggressive and how to set metrics correctly.	Paced for April 23, 2024 ECHB meeting

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Theresa Fuentes, Chief Legal Officer
Date: April 23, 2024
Subject: Election of Officers

Recommendation:

To provide information to the El Camino Hospital Board of Directors (Board) regarding the upcoming election of officers for El Camino Hospital (ECH).

Summary:

1. **Situation**: The terms of the current officers for ECH expire June 30, 2024. As a result, an officer selection process is recommended to be conducted at the May Board meeting. The Board's current policy regarding Nomination and Selection Procedures should be updated and recommended edits to the Procedures will be presented to the Governance Committee for review before coming to the Board. In the meantime, this memorandum provides information to the Board consistent with the current Nomination and Selection Procedures in compliance with hospital bylaws and California law.

2. **Authority**: ECH is a nonprofit public benefit corporation. Article VIII, Section 8.1 of the ECH bylaws states that the "officers of the Corporation [ECH] shall consist of the Chairperson, the Vice Chairperson, the Secretary and the Treasurer and such other persons who are specifically designated as Officers by the Board." In addition, the Bylaws state that the "offices of the Secretary and Treasurer shall be held by the same person."[1]

   Pursuant to California Corporations Code § 5213 all California nonprofit public benefit corporations must have (1) a chair of the board, or a president [Chief Executive Officer], or both, (2) a secretary, (3) a treasurer or a chief financial officer, or both, and (4) any other officers as shall be stated in the bylaws or determined by the board.

   Every other year, the Board should designate by Resolution the officers of the corporation. The Chief Executive Officer and Chief Financial Officer should be officially designated as officers by virtue of their positions, the bylaws, and California law. The Chairperson and Vice Chairperson are Board directors elected by the Board. The Secretary/Treasurer can be either a Board director elected by the Board (as has been the case in recent years) or can be the ECH Chief Legal Officer or other qualified ECH staff member designated by the Board at the Board's discretion.

   Any current director of the El Camino Hospital Board is eligible to serve as Chairperson, Vice Chairperson, or Secretary/Treasurer, except the Secretary/Treasurer cannot serve concurrently as Chairperson under California law. Per Article 8.3 of the Bylaws, all officer terms are for two years, subject to any employment agreement, and a director "may not serve more than two (2) consecutive terms as Chairperson."

[1] It is recommended that the requirement for the offices of Secretary and Treasurer to be held by the same person be updated in the next revision of the bylaws because ECH has a Chief Financial Officer who can be designated by the Board as an officer to perform the duties of a treasurer in accordance with California law.

3. **Background**: The current officers selected by the Board are Director Bob Rebitzer as Chairperson, Director Jack Po as Vice Chairperson, and Director Julia Miller as Secretary/Treasurer. All terms expire June 30, 2024, and all are eligible to serve a consecutive term, including the Chairperson.

4. **Assessment:** The Nomination and Selection Procedures was last adopted by the Board in May 2022, and should be updated with input from the Governance Committee for clarity and use in future years. Elections can be held this year using the existing document, the bylaws, and California law. After elections are completed this fiscal year, the Board will be asked to adopt a resolution appointing the officers of the corporation, which will remain in effect for two years until the next selection process.

5. **Recommended Election Process for May 2024:** All Board members who are interested in running for Chairperson, Vice-Chairperson, or Secretary/Treasurer should state their interest to the Chief Executive Officer **no later than May 1, 2024**. Position Statements will not be required. Unless the Board directs otherwise, the process will be as follows, consistent with prior years:

    - The names of directors who have stated their interest to the CEO by May 1, 2024, and the position in which they are interested, will be identified on the May Board agenda.
    - During the public session of the May Board meeting, each candidate will provide a brief verbal statement (10 minutes) regarding their interest, and their priorities and goals if elected to the position.
    - The Board will ask any questions of the candidates.
    - If there is only one candidate for a position, the board shall consider a motion to elect that candidate.
    - If there is more than one candidate for a position, the balloting process will be as stated in Section 7 of the attached Nomination and Selection Procedures dated 5/11/22.

List of Attachments:

1. Nomination and Selection Procedures dated 5/11/22 (to be updated)

HOSPITAL BOARD OFFICERS
NOMINATION AND SELECTION PROCEDURES
FOR FY24

Approved 05/11/2022

Any current Director of the El Camino Hospital Board is eligible to serve as a Hospital Board Officer. The new Hospital Board Officer terms begin the 1st day of July. El Camino Hospital Board Officer elections shall be held in June annually (if needed). Following the election, it shall be the role of the Board Chair-Elect to work with the Hospital CEO in May and June to develop a slate of Board Advisory Committee Chairs and members for the following fiscal year and to present the slate to the Board for approval in June.

Hospital Board Chair:

1. Interested Directors will declare their interest to the CEO or designee by no later than the 1st day of April. If requested by the CEO, interested Directors will prepare a one-page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the attached Hospital Board Chair competencies, no later than the 15th day of April.

2. Position Statements will be distributed to Board members along with other routine Hospital Board materials one week in advance of the June meeting.

3. Position Statements will be made available to the public and posted on the El Camino Hospital web-site when the Hospital Board materials are issued to the Board.

4. Standard questions for Hospital Board Chair:

    a. What do you see as the ECH strategic priorities over the coming two years?
    b. Name three defining roles of an effective Board Chair.
    c. How would you judge the success of your leadership and the Board at the end of your term?

5. At the June meeting, interested Directors will present the information below, in public session, in the sequence outlined. Approximately 25 minutes will be allocated to each interested Director: five (5) minutes for the Position Statement, ten (10) minutes for responses to standard questions, and (10) ten minutes to respond to general questions from the board and public:

    a. Each interested Director will read his or her Position Statement
    b. Each interested Director will provide responses to the standard questions. (Directors will present one question at a time in random order.)
    c. The Public will be invited to ask interested Directors any questions related to the candidate's interest in the position, and relevant experience as it relates to the Hospital Board Chair competencies
    d. The Board will be invited to ask interested Directors any additional questions related to an interested Director's candidacy.

6. Upon review and discussion of the candidates, the Board will vote in public session. The current Chair will facilitate the discussion and voting process.

7. The Hospital Board Chair will be elected by the Board in accordance with the following procedure at a meeting where a quorum is present.

    a. Preliminary Balloting

        i. Each Board member shall vote for a candidate via electronic submission or paper ballot simultaneously to a neutral party who will announce the vote cast by each Director.
        ii. In the event a majority is not achieved, the vote will be announced for each candidate and the candidate receiving the lowest number of votes will be dropped from the next ballot.
        iii. This procedure will continue until one candidate receives a majority of the votes cast.
        iv. In the event a tie vote occurs (e.g., 3-3 or 4-2-2), interested Directors may be asked additional questions by Hospital Board members and the balloting procedure will continue until a majority is achieved by one candidate.

    b. Selection of a Board Chair

        i. Following the preliminary balloting, the Board shall consider a motion to elect the candidate who has received the majority of the votes in his/her favor.
        ii. If a motion pursuant to Section 7(b)(i) is not adopted by a majority of the Board members present at the meeting when a quorum is present, the Board shall continue to consider motions until a Board Chair is elected.

Hospital Vice-Chair:

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

4. The Vice Chair is the presumptive Chair at the end of the current Chair's term.

Hospital Secretary/Treasurer:

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair and the Hospital Vice-Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT I April 23, 2024

FINANCE:

- **February YTD**
  - **Total Operating Revenue: $126.5M** ($2.1M / 1.7% vs. budget)
    - $12.3M / 10.7% higher than the same period last year
  - **Operating EBIDA: $18.1M** ($0.7M / 4.1% vs. budget)
  - **Net income: $31.1M** ($18.9M / 155.1% vs. budget)
    - Mainly attributed to strong investment income
- **FY24 YTD**
  - **Total Operating Revenue: $1,023M** ($3.8M / 0.4% vs. budget)
    - $83.5M / 8.9% higher than the same period last year
  - **Operating EBIDA: $166.4M** ($12.4M / 8.1% vs. budget)
    - $15.0M / 9.9% higher than the same period last year

Initiatives to reduce denials / increase cash collections continue to yield results as Net Days in A/R are 5.0% favorable to target and 8.0% better than the same period last year.

NURSING: On March 21st, the Nursing Division's Professional Development Council sponsored a National Certified Nurses Day, to acknowledge 748 El Camino Health nurses who have earned and currently maintain the highest credentials in their specialty.

HUMAN RESOURCES: At the 57th Annual Employee Service Awards, over 200 employees' milestone anniversaries and our annual Excellence Award winners were celebrated. Annual employee engagement survey is in progress. To continue to have Diversity, Equity, Inclusion and Belonging (DEIB) at our forefront, we recognized Black History Month and Lunar New Year. In addition, we hosted a virtual panel discussion about the Social Drivers of Health. El Camino Health has received official notification from SEIU to amend the current collective bargaining agreement expiring in June 2024.

INFORMATION SERVICES:

- **Cybersecurity**
  - All email services are now enabled with next-generation email anti-fraud defenses, preventing over 2 million monthly fraudulent emails
  - ECH IT Security Governance Committee approved new password security policy
  - Privileged Access Management system protects highly sensitive user accounts and logins.

CORPORATE HEALTH SERVICES: Concern's new mental health program, "Wellness Checks for Residents" served and connected 45 residents for visits with mental health professionals. The Chinese Health Initiative continues to provide unparalleled wellbeing solutions with their recent webinars "Depression & Social Anxiety" and colon cancer prevention. The South Asian Heart Center engaged 336 new and prior participants in screening to prevent heart disease and diabetes and completed 646 consultations.

FOUNDATION: Through period 8, The Foundation has raised over $5.8M, which is 59% of the FY2024 fundraising goal. In March, The Foundation received two notable gifts; The Robert Noyce Trust ($2M) to enhance our medical services and a $50,000 donation to launch the NICU Parent Support Program. A benefit celebration for the Orchard Pavilion, Center for Women & Newborns raised $96,000.

GOVERNMENT RELATIONS + COMMUNITY PARTNERSHIPS: ECH's grant partners continue to acknowledge our support through a variety of channels, advocating our active role in making the communities we serve healthier. The *Community Connections* newsletter continues to be well-received.

MARKETING: In May, El Camino Health will launch a new advertising campaign that is built around compelling patient stories of recovery and renewal of life. Additionally, efforts to enhance communications outreach technology are underway for Cancer, Heart, Ortho and Women's service line.

AUXILIARY: The Auxiliary donated 3,685 volunteer hours for the month of February. This brings our combined hours for FY23 to 30,692.

A05c1. Administrative- Adverse Event Reporting to Regulatory or State Licensing Agencies-History-Changes

Status **Pending** PolicyStat ID **14529351**

Origination	06/2007	Owner	Michael Coston: Director Quality and Public Reporting
Last Approved	N/A	Area	Risk Management & Patient Safety
Effective	Upon Approval	Document Types	Policy
Last Revised	10/2023		
Next Review	3 years after approval		

Administrative: Adverse Event Reporting to Regulatory or State Licensing Agencies

COVERAGE:

All employees and physicians of El Camino Hospital.

PURPOSE:

- To provide guidance to the organization regarding which adverse events are reported to regulatory agencies and identify the process for such reporting.

STATEMENT:

It shall be the policy of El Camino Hospital to report an adverse event, as defined within Health and Safety Code §1279.1 (below), to the California Department of Public Health (CDPH) no later than five days after the event has been detected or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. It is also our policy to investigate the source of the event, initiate any mitigation actions that may be indicated and cooperate fully with CDPH throughout the process. It is additionally our policy to review and revise, as appropriate, any policy and procedure related to the adverse event.

DEFINITIONS:

"**Adverse event**" includes *any* of the following:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed

consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
9. An infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
11. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs

while the patient is being cared for in a health facility.

16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall.
23. A patient death or serious disability associated with the use of restraints or bedrails.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of the facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

"**Serious disability**" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

"State Licensing Agency" means the relevant state licensing agency with regulatory jurisdiction over a healing arts licensee in Medical Board of California, the Podiatric Medical Board of California, the Board of Psychology, the Dental Board of California, the Dental Hygiene Board of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the California Board of Occupational Therapy, the Acupuncture Board, and the Physician Assistant Board.

"**Sexual Misconduct**" means inappropriate contact or communication of a sexual nature.

PROCEDURE:

A. **Notification and Reporting of Adverse Event**

1. Staff shall immediately notify ~~Quality, Safety &~~ Risk ~~(formerly Clinical Effectiveness)~~ ~~Department~~Management if an adverse event as defined above occurs and complete an ~~electronic incident~~iSAFE report.
2. ~~Quality, Safety &~~ Risk Management staff shall determine whether a report to a regulatory agency is required.
3. Designated ~~Quality, Safety &~~ Risk Management staff shall submit the initial report to CDPH or other required regulatory agency, as well as serve as liaison with that agency during the subsequent investigation process. Disclosure of individually identifiable patient information is permitted and shall be consistent with applicable law. The reports shall be submitted pursuant to the requirements set forth by CDPH.
4. The report to CDPH and related investigative materials shall be maintained by ~~the Quality, Safety &~~ Risk ~~Department~~Management.

B. **Notification and Reporting of Patient Allegation of Sexual Abuse or Sexual Misconduct to State Licensing Agencies**

1. In accordance to the Business and Professions Code 805.8, any allegation of sexual abuse or sexual misconduct made against a licensee by a patient, if the patient or the patient's representative makes the allegation in writing, shall file a report to the state licensing agency within 15 days of receiving the written allegation of sexual abuse or sexual misconduct.
2. ~~Quality, Safety &~~ Risk Management staff shall determine whether a report to a state licensing agency is required.
3. ~~Designated Quality, Safety &~~ Risk Management staff shall submit the initial report to state licensing agency, as well as serve as liaison with that agency during the subsequent investigation process. Disclosure of individually identifiable patient information is permitted and shall be consistent with applicable law. The reports shall be submitted pursuant to the requirements set forth by Business and Professions Code, SB 425 and the respective state licensing agency. Refer to Attachment A.
4. The report to state licensing agencies and related investigative materials shall be maintained by ~~the Quality, Safety &~~ Risk ~~Department~~Management.

C. **Disclosure of Adverse Event to Patient or Patient's Representative**:

Disclosure of the adverse event shall occur in accordance with Administrative-Disclosure of Unanticipated Outcome Information policy and in advance of CDPH and/or state licensing agency reporting. The patient or the party responsible for the patient shall **not** be provided with a copy of the report. The report to CDPH and/or state licensing agencies should **not** be placed in the patient's medical record.

D. **Investigation and Development of Plan of Correction**:

An investigation into the cause of the event shall be undertaken, using root cause analysis, intensified review or other approved investigative process by ~~Quality, Safety &~~ Risk Management staff in accordance with Administrative: Serious Reportable Event policy. The investigation will be conducted for the purpose of the evaluation and improvement of the quality of care in the hospital. It shall be the responsibility of ~~Quality, Safety &~~ Risk Management staff to coordinate the initial investigation and support the root cause analysis or other approved investigative process within the framework of the quality committees within the hospital. Documents prepared pursuant to the investigation should **not** be placed in the patient's medical records, but should be retained by ~~the Quality, Safety &~~ Risk ~~Department~~Management. ~~Quality, Safety &~~ Risk ~~Department~~Management shall be responsible for development of any plan of correction required by regulatory agencies.

E. **Penalties Incurred**:

If a penalty is imposed as a result of an adverse event report to CDPH, and the decision is made to contest it, El Camino ~~Health~~Hospital legal counsel shall be contacted, within 10 days of our notice of the penalty, to request an adjudicative hearing, pursuant to Health and Safety Code §100171 and the provisions of Government Code 11400 and 11500 et seq. Payment of outstanding penalties will be paid only if, **1)** the findings have not been reversed in whole or in part and, **2)** the appeal process has been exhausted.

REFERENCES:

Health and Safety Code 1279.1(b)
Administrative: Disclosure of Unanticipated Outcome Information
Administrative: Patient Safety/Unusual Occurrence Incident
Business and Proessions Code 805.8

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

Adverse Event Reporting to Regulatory or State Licensing Agencies Policy Attachment A.pdf

Approval Signatures

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

MEC	Michael Coston: Director Quality and Public Reporting [PS]	03/2024
Leadership Council	Michael Coston: Director Quality and Public Reporting [PS]	02/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2023
	Heidi Yamat: Director AR&L and Public Reporting [PS]	10/2023

History

Sent for re-approval by Yamat, Heidi: Director AR&L and Public Reporting on 10/10/2023, 3:50PM EDT

Last Approved by Yamat, Heidi: Director AR&L and Public Reporting on 10/10/2023, 3:50PM EDT

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 10/17/2023, 9:45AM EDT

Edited by Santos, Patrick: Policy and Procedure Coordinator on 10/17/2023, 9:48AM EDT

> Reworded Quality, Safety and Risk Department to Risk Management; included iSAFE report.

Last Approved by Yamat, Heidi: Director AR&L and Public Reporting on 10/17/2023, 9:48AM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/17/2023, 9:49AM EDT

> ePolicy 10/13/23

Responsibilities transferred to new account by Santos, Patrick: Policy and Procedure Coordinator on 10/26/2023, 3:54PM EDT

> The previous owner's account (*Heidi Yamat: Director AR&L and Public Reporting*) was deactivated, so all of their responsibilities were transferred to *Michael Coston: Interim Regulatory Accreditation and Licensing Con*.

Last Approved by Coston, Michael: Director Quality and Public Reporting on 2/23/2024, 12:19PM EST

> Leadership Council 1/9/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 3/28/2024, 5:25PM EDT

> MEC 3/28/24

A05c2. COVID-19 Control Plan-History-Changes

Status **Pending** PolicyStat ID **11390121**

Origination	09/2020	Owner	Bryan Plett: Mgr Environmental Hlth&Safety
Last Approved	N/A	Area	Emergency Management
Effective	Upon Approval	Document Types	Plan
Last Revised	03/2024		
Next Review	1 year after approval		

COVID-19 Control Plan

COVERAGE:

All El Camino Health staff, medical staff and volunteers

PROGRAM ADMINISTRATION:

The El Camino Health Infection Prevention and Emergency Management groups are responsible for designing, implementing, evaluating, and maintaining the El Camino Health COVID-19 Control Plan. The team collaborates with representatives from Employee Wellness and Health Services, Nursing, Hospital Administration, Emergency Department, Facilities, and Clinical Laboratories. Input from other departments/individuals with required expertise is sought as needed.

REFERENCES:

- Center for Disease Control (CDC) Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

DEFINITION:

COVID-19 is an illness caused by the SARS-CoV-2 virus. Person to person transmission is widespread throughout the globe and community transmission in California and the United States is occurring.

PROCEDURE:

A. Identification and evaluation of patients with possible COVID-19 infection
Early identification of a Patient Under Investigation (PUI):

1. Rapid identification of individuals with compatible symptoms and relevant travel/ exposure history and institution of appropriate isolation measures are critical in reducing the risk of COVID-19 transmission.
2. The criteria are intended to serve as guidance for evaluation and testing for coronavirus. Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19. COVID-19 has a wide range of symptoms, ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. These include the following: cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat or new loss of taste and smell.

B. COVID-19 testing
    1. Rapid SARS-CoV-2, RT-PCR (Cepheid - done at El Camino Health Clinical Lab)
        a. An order is placed in the EHR
        b. This is performed at ECH Clinical Laboratory and does not require a signed requisition.
        c. Place surgical mask on the patient.
    2. Appropriate PPE to wear during test collection
        a. N-95 respirator plus face shield/ goggles OR PAPR (powered air-purifying respirator)
        b. Gown
        c. Gloves
    3. A nasopharyngeal (NP) swab should be collected to test for COVID-19.

C. Management of Emergency Department Patients
    1. Triage: Rapid identification and isolation of patients who may be infectious follow Respiratory Screening Criteria which includes: cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat or new loss of taste and smell, or exposure to COVID-19 person.
    2. Patients meeting any of these criteria:
        a. Place surgical mask on the patient.
        b. Patients with respiratory symptoms will be triaged in the respiratory assessment area of the ED.
        c. Patients will be roomed in designated COVID containment area.
        d. ~~Notify the charge nurse immediately.~~
        e. Once the patient is in an isolation room, keep the door to the room closed.
        f. ~~Contact Facilities Engineering to verify negative/neutral airflow in the room.~~
        g. Implement Airborne and Contact Isolation and ensure that everyone entering the room is wearing appropriate PPE as required.

h. Place an "**AIRBORNE AND CONTACT ISOLATION**" sign on the door.

i. All persons entering the room must perform hand hygiene and then don:

i. Powered Air-Purifying Respirator [PAPR] or N-95 Mask (staff must be fit-tested before wearing an N-95).
Note: If an aerosol-inducing procedure (i.e., intubation, nebulized medication, nasal pharyngeal swabbing) is planned, maintain airborne precautions.

ii. Gloves

iii. Isolation Gown

iv. Face shield if using N-95 mask

3. COVID tested patients, with pending results, discharged from ED:

a. Teach the patient about infection control practices to use at home including good handwashing, cough etiquette, and wearing a surgical mask during close contact with others in the home.

b. Patient should remain at home pending COVID-19 results.

c. Give the patient a surgical mask to wear as they leave the hospital, and several surgical masks to take home

d. Give the patient a copy of the two handouts found on the ECH Toolbox:

i. SCCPHD Suspected-Case Information Sheet

ii. SCCPHD Confirmed-Case Information Sheet

4. After the patient leaves the ED

a. Keep exam room empty with door closed with appropriate isolation signage for 1 hour after the last aerosol-generating procedure was performed (including nebulized medication). Obtaining an NP swab does not require the room to be empty for one hour.

b. Clean room with approved hospital disinfectant including blood pressure cuff, stretcher, counters, bedside table etc. Discard contaminated supplies.

D. Management of Suspected or Positive Inpatients

1. Suspected COVID inpatients - patient remains in current room while ECH testing is conducted.

a. Door to room is kept closed until COVID result obtained

b. Patient's assigned RN will collect COVID swab under Airborne Contact precautions if needed

c. If positive, patient to be transferred to COVID containment unit.

2. Patients being admitted who are positive for COVID-19

a. Prior to admission the accepting primary nurse must

i. Contact Facilities Engineering to ensure the room is verified as "Negative Airflow/Pressure" or "Neutral Aiflow/Pressure."

ii. Airborne and Contact Isolation: required for all patients

b. Preferably, patients are to be placed in a single patient room with the door closed.

c. Patients may be be cohorted in semi-private rooms if the following criteria are meet:

i. No other infection isolation in place (examples: RSV, MRSA, CRE)

ii. Both patients are in the same phase of COVID infection; Phase 1 being 0-10 days and Phase 2 being 10-21 days.

iii. Patient is not suspected to be false positive for COVID

iv. Follow general cohorting principles; same gender, similar age and mental status. Patient from same household, related, partners, may be cohorted.

v. Review patient criteria with Assistant Hospital Manager prior to cohorting.

d. Post the "**appropriate isolation**" signage on the door of the patient's room.

e. **Only essential staff** should enter the room (attending physician, assigned RN, RT). Instruct non-essential personnel not to enter the patient room.

i. Staff that should not enter the room includes, nutrition and food services staff, social work, and care coordination such as case management.

f. All staff must wear appropriate PPE for type of isolation and use proper donning and doffing sequence when entering and exiting the room.

g. Patients must remain in a negative/neutral air pressure room until COVID is no longer suspected or positive. The decision to discontinue precautions should be made in consultation with Infection Prevention.

h. Educate patients about the reasons for isolation precautions. In addition, they should be instructed to cover their mouth and nose with a tissue when coughing or sneezing.

i. The patient should remain in his/her room at all times with the doors closed unless emergency diagnostic or therapeutic procedures (e.g., CAT scan, surgery, etc.) are urgently required and cannot be performed in the patient's room.

j. When leaving his/her room, the patient must disinfect hands, put on a clean hospital gown, and a surgical mask.

k. Notify the Pathology Department prior to autopsy procedures for deceased patients with suspected or confirmed COVID.

l. The isolation room where the patient has resided is considered contaminated for 1 hour (>99.9% removal efficiency) after the patient leaves and should remain vacant with doors closed for that interval of time. The room must remain vacant for 1 hour, followed by discharge

cleaning of the room for isolation patients

3. Maternal Child Health specific work flows - see Elemeno
4. Code blue and crash cart management for positive COVID patients (see attachment, **Crash Cart Management Code Blue for COVID-19 Patient**).
5. Trash and Linen
    a. Place a trash receptacle into the anteroom or in hallway.
    b. Place trash, including discarded gowns and gloves, into the anteroom or in room trash receptacle.
    c. Place discarded N-95 respirators, PAPR visors, and face shields into the regular trash receptacle outside of the patient's room, if soiled or damaged.
    d. Trash will be transported by EVS per normal protocol.
    e. Sharps and non-hazardous pharmaceutical containers will be collected by assigned staff.
    f. Soiled linen is transported and laundered in the same manner as all hospital linen. It is placed in a bag designated for soiled linen and must remain in the patient's room or anteroom until it is transported for laundering.
6. Cleaning and disinfection of environment
    a. Room Pre-Occupancy Preparation
        i. Place soiled linen collection container in anteroom, or in patient room if no anteroom.
        ii. EVS to place dedicated cleaning equipment in anteroom or in patient room for nursing staff to utilize. Nursing staff will request additional supplies or disinfectant as needed.
    b. Room Occupancy / Daily Room Cleaning Procedures & Personal Protective Equipment (PPE)
        i. EVS/Unit Support to perform one cleaning/entry modified daily occupied room cleaning.
        ii. EVS to wear airborne (PAPR) and contact precautions while in patient's room.
        iii. EVS staff to perform modified, <15 min cleaning high touch areas in close proximity to the patients, bathroom and floor.
        iv. EVS will perform terminal room clean when patient is transferred or discharged.
    c. Discharge or transfer Room Cleaning
        i. EVS/Unit Support follow designated procedures for specialized discharge cleaning of COVID+ patient rooms. EVS will adhere to designated room closure time requirements prior to entering

room.

ii. Personal Protective Equipment

- Perform hand hygiene prior to entering room and immediately after removing PPE.
- Entry after designated room closure, EVS staff must wear gown, gloves, surgical mask, and eye protection.
- Immediate entry (no room closure), EVS staff must wear gown, gloves, PAPR.
- Remove and discard PPE in anteroom.
- If there is no anteroom, remove gloves, gown, eye protection, PAPR in room.

iii. Following cleaning, EVS will notify supervisor to report that cleaning is complete. The supervisor must visually inspect the room then will remove the isolation signage and inform nursing unit staff that the room has been cleaned and is ready for re-occupancy.

iv. Notify Facilities Engineering that the room no longer requires negative/neutral airflow.

7. Cleaning and disinfection of equipment – Cleaned/disinfected equipment should remain in room until UV Disinfection is complete.
    a. Equipment and/or devices that are not disposable must be cleaned to remove any blood or body fluids and disinfected with the approved hospital disinfectant. Cleaning, disinfection, and UV Disinfection must be completed before the equipment is stored in the clean equipment area and before being used for other patients.
    b. Clean and disinfect equipment in the room or in the anteroom.
    c. Equipment surface(s) must be THOROUGHLY WET with the disinfectant agent and allowed to remain undisturbed for the contact time specified by the surface disinfectant.
    d. Persons cleaning/disinfecting equipment in a room housing a suspected or positive COVID patient must wear appropriate PPE. If cleaning/ disinfecting equipment in the anteroom, wear a gown and gloves.
8. Transport of suspected or positive COVID patients – Nursing staff always accompany the patient
    a. Place a surgical mask on the patient during transport.
    b. The patient should remain in his/her room at all times with the doors closed unless emergency diagnostic or therapeutic procedures (e.g., CAT scan, surgery, etc.) are required and cannot be performed in the patient's room.
    c. Before leaving the room, the patient should disinfect his/her hands, put on

a clean hospital gown, and put on a surgical mask.

d. Nursing staff transfers the patient to a wheelchair or gurney.

e. Use a clean sheet that was not stored in the room to completely cover the patient before leaving the room.

f. Transporters should follow the recommended sequence of donning PPE prior to entering the patient's room. The transporter should follow the recommended sequence of doffing PPE and eye protection, but should keep his/her surgical mask on during transport.

g. The transporter should continue to wear surgical mask and eye protection during transport.

h. Bring a clean surgical mask in the event the patient's mask becomes wet during transport.

i. Notify the area to which the patient is being transported that the patient is a suspected or positive for COVID so that appropriate accommodations can be made. If possible, schedule suspected or positive COVID patients at the end of the day.

    i. Notify Facilities Engineering so that proper precautions can be implemented (e.g., placement of a HEPA filter in area).

j. Staff in receiving location are to wear appropriate PPE prior to patient contact.

k. Surgery patients must be transported directly from their room to Operating Room.

9. ~~Visitor Restriction~~

~~a. Visitor restrictions will be put into place following state and county recommendations.~~

~~b. All requests for patient visitors will be directed to the Assistant Hospital Manager/Hospital Supervisor (AHM/HS). The AHM/HS will determine if the visitation meets exceptions criteria and will coordinate visit with requesting department. The AHM/HS will ensure that visitor restrictions are followed, including visitation time limitations.~~

~~c. COVID positive patients~~

~~i. No visitors~~

~~ii. Exception: Compassionate visit~~

- ~~Approved by Infectious Disease physician~~
- ~~Appointment time in advance~~
- ~~Visitor must be accompanied by Infection Prevention (IP) RN or RN designee~~
- ~~Visitor must wear appropriate PPE as instructed by IP RN~~
- ~~Visit will be time limited~~

~~d. Non-COVID patients~~

~~i. Visitors will be allowed per current hospital visitation guidelines posted in The ECH Toolbox under COVID~~

~~ii. Exceptions:~~

- ~~Pediatric patients will be allowed one support person.~~
- ~~Maternal-Child will be allowed one support person.~~
- ~~End of Life~~
  - ~~Patient must have a DNR and a notation from the physician that the patient has <48 hours to live.~~
  - ~~Only immediate family is allowed in the room, defined as a sibling, spouse, offspring, or parents~~
  - ~~Visits are limited to 2 hours~~
  - ~~Up to three people at a time~~
- ~~Patients with Physical, Intellectual, and/or Developmental Disabilities and/or Cognitive Impairments~~
  - ~~One support person be allowed to be present with the patient when medically necessary~~
  - ~~Must stay in the room and be asymptomatic for COVID~~
  - ~~Support persons may be screened prior to entering the clinical areas~~

~~e. The patient's care team will provide education on visitor restrictions to the family and designated visitors.~~

~~f. Encourage video and phone call visits~~

~~g. All approved visitors are required to be screened and remain in patient room during visit. Visitor time limits will apply.~~

Visitor Restriction

a. Visitor restrictions will be put into place following state and county recommendations.

b. All requests for patient visitors will be directed to the Assistant Hospital Manager/Hospital Supervisor (AHM/HS). The AHM/HS will determine if the visitation meets exceptions criteria and will coordinate visit with requesting department. The AHM/HS will ensure that visitor restrictions are followed, including visitation time limitations.

c. COVID positive patients

i. Exception: Compassionate visit

- Compassionate visits are limited to patients who have a terminal condition or are in the active stages of dying (probable within next 48 hours).
- Prior to visitation AHM will screen family member(s) based on following:
    - Has the family member lived with or had close contact to this patient or any infected person within 10 days? (i.e., the last date of exposure must be greater than 10 days. This is calculated from the date the patient tested positive and the date the patient was admitted).
        - If "No" close contact within 10 days - Screen for symptoms: if asymptomatic, can visit (exception will be granted for vaccine status and testing)
        - If "Yes" - Screen for symptoms: must be fully vaccinated and asymptomatic to visit; if not vaccinated and/or any COVID-like symptoms = they may not visit (per PHD guidelines they are on home quarantine)
- Prior to visitation AHM will:
    - Visitation approval for 1 time visitation only.
    - One to two close family members will be allowed – designated by family (prior to COVID screening questions)
- Prior to visitation AHM will have a pre-scheduled conversation to review process with approved visitor(s):
    - Inform family time of visitation will be 30 minutes
    - A Palliative Care staff or RN designee assigned to supervise visitation will contact patient's family to set up date, time for visit and will meet approved visitors at front lobby prior to scheduled visit.
- Upon visitor arrival, the Palliative Care staff or RN will observe visitor perform hand hygiene and validate face mask in place
    - The Palliative Care staff or RN will escort visitors directly to patient's room
    - Prior to entry the Palliative Care staff or RN will instruct, assist, and observe visitors on donning appropriate PPE, gown and gloves.
    - After visitation the Palliative Care staff or RN will instruct, assist, and observe visitors doffing PPE and

performing hand hygiene. Then immediately escort visitors to front lobby entrance

d. Non-COVID patients
    i. Visitors will be allowed per current hospital visitation guidelines
e. The patient's care team will provide education on visitor restrictions to the family and designated visitors.
f. Encourage video and phone call visits
g. All approved visitors must remain in patient room during visit. Visitor time limits will apply.
h. If visitors are not adhering to guidelines staff are to call Security for assistance.

10. Potential health care worker and patient exposures process
    a. Definition of Exposure: Any unprotected (no PPE used) contact with a patient diagnosed with or suspect for COVID before initiation of appropriate isolation precautions.
    b. Infection Prevention responsibilities:
        i. Review the medical record for any suspicion of COVID to ascertain whether proper isolation measures were instituted.
        ii. ~~Review the patient's status with an attending physician or designee.~~
        iii. Determine whether any potential exposure to hospital personnel occurred.
        iv. Determine whether any potential exposure to patients occurred.
        v. Report exposures to Employee Health and Wellness Services.
    c. Responsibilities of Employee Health and Wellness Services (EWHS):
        i. Supervisors are required to submit a list of the names and employee ID numbers of employees that meet exposure criteria to Employee Health by the end of the business day on which the supervisor is notified. .
        ii. Follow up on employees that meet the exposure criteria
        iii. Contact the supervisors of departments with exposed employees. The supervisors are emailed an exposure follow-up form which states that a COVID exposure has occurred in their department, giving the name and MRN of the patient.
        iv. Provide self-monitoring instructions to all health care personnel that meet exposure criteria.
        v. Record all exposures and exposed employee information.
        vi. Arrange for post-exposure education and monitoring.

vii. Exposed employees must measure their own temperatures twice daily and can continue to work as long as they do not have either fever >100.4°F or respiratory symptoms such as (e.g. cough, shortness of breath or trouble breathing, muscle pain, new loss of sense of smell)

d. Potential Exposure of Fully Vaccinated Health Care Worker

i. Fully vaccinated is defined as ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine.

ii. During critical staffing shortages employees can continue to work after a high risk exposure at work or at home if they meet the criteria below:

a. The staff are fully vaccinated

b. They remained asymptomatic since the current COVID-19 exposure.

E. Employees diagnosed with COVID-19 are restricted from work for 10 days from the positive test date or 24 hours after the resolution of symptoms whichever is longer.

1. Employees must obtain Employee Wellness and Health Services (EWHS) clearance prior to returning to work.

F. Employee Masking and Monitoring

1. All employees will complete Employee Wellness Monitoring for at the beginning of each on-site work day.

2. All employees will participate in the Universal Masking Program.

G. Engineering Controls

1. **Mountain View:**

a. Patient Care Units:

i. There are designed Airborne Isolation Rooms (AIRs), with anterooms and alarms, dispersed throughout the facility that meet all of the code requirements in place when they were constructed. They each provide 100% Exhaust and do not return air to the building. These rooms are always “negative/neutral” to the surrounding spaces and are the preferred spaces for isolation needs. Nursing is responsible to advise Engineering before use. Engineering will verify and document performance and will continue to do so daily until the isolation is lifted.

ii. Under normal conditions, air handlers introduce a combination of Outside Air (OSA) and Recirculated Air (RA) into the facility. Some air is captured, filtered, and returned to the building and a percentage is exhausted and replaced with fresh OSA. These percentages were set by code requirements.

iii. In the event that it becomes desirable to prevent air from being recirculated in the building, the air handlers can be automatically adjusted to provide 100% OSA to the Patient Care Areas and to exhaust all air to the outdoors. The individual patient rooms can also be adjusted to provide a “negative/neutral” airflow to the surrounding spaces. It is worthy to note, that while the patient room can be made “negative/neutral”, the air changes will not be equivalent to those in a designed AIR. Also, of note, there would be no proper anteroom, and no automated alarm mechanism.

iv. It is critical that any rooms that are converted be meticulously tracked so that admitting and nursing are fully aware of their status. In this scenario, Engineering assumes responsibility for documenting daily pressure checks to ensure that the rooms remain “negative/neutral” to the surrounding areas, regardless of whether they are in use.

b. Emergency Department:

i. There is a designed Airborne Isolation Room (AIR), with anteroom, that meets all of the code requirements in place when it was constructed. It provides 100% Exhaust and does not return air to the building. This room is always “negative” to the surrounding spaces and is the preferred space for isolation needs. ED is responsible to advise Engineering before each use. Engineering will then verify and document performance.

ii. Under normal conditions, air handlers introduce a combination of Outside Air (OSA) and Recirculated Air (RA) into the facility. Some air is captured, filtered, and returned to the building and a percentage is exhausted and replaced with fresh OSA. These percentages were set by code requirements.

iii. In the event that it becomes desirable to prevent air from being recirculated in the building, the air handlers can be adjusted to provide 100% OSA to the Emergency Department and to exhaust all air to the outdoors. Additionally, the Clinical Decision Unit (CDU) Exam Rooms can also be adjusted to provide a “negative/neutral” airflow to the surrounding spaces. It is worthy to note, that while these exam rooms can be made “negative/neutral,” the air changes will not be equivalent to those in a designed AIR. Also, of note, there would be no proper anteroom, and no automated alarm mechanism.

iv. Again, it is critical that any rooms that are converted be meticulously tracked so that ED staff and nursing are fully aware of their status. In this scenario, Engineering assumes responsibility for documenting daily pressure checks to ensure that the rooms remain “negative/neutral” to the surrounding areas, regardless of whether they are in use.

2. **Los Gatos**:
    a. Patient Care Units:
        i. There are designed Airborne Isolation Rooms (AIRs), some with anterooms and alarms, dispersed throughout the facility that meet all of the code requirements in place when they were constructed. They each provide 100% Exhaust and do not return air to the building. These rooms are always “negative” to the surrounding spaces and are the preferred spaces for isolation needs. Nursing is responsible to advise Engineering before use. Engineering will verify and document performance and will continue to do so daily until the isolation is lifted.
        ii. Under normal conditions, air handlers introduce a combination of Outside Air (OSA) and Recirculated Air (RA) into the facility. Some air is captured, filtered, and returned to the building and a percentage is exhausted and replaced with fresh OSA. These percentages were set by code requirements.
        iii. In the event that it becomes desirable to prevent air from being recirculated in the building, the air handlers can be manually adjusted and retrofitted to provide 100% OSA to the Patient Care Areas and to exhaust all air to the outdoors. However, because of the lack of sophistication of the equipment, this will interfere significantly with our ability to maintain temperature control in the facility during extreme temperatures, both high and low. The individual patient rooms can be retrofitted using HEPA scrubbers exhausted through the windows and manually blocking off air return diffusers to provide a “negative/neutral” airflow to the surrounding spaces. It is worthy to note, that while the patient room can be made “negative/neutral”, the air changes will not be equivalent to those in a designed AIR. Also, of note, there would be no proper anteroom, and no automated alarm mechanism.
        iv. It is critical that any rooms that are converted be meticulously tracked so that admitting and nursing are fully aware of their status. In this scenario, Engineering assumes responsibility for documenting daily pressure checks to ensure that the rooms remain “negative/neutral” to the surrounding areas, regardless of whether they are in use.
    b. Emergency Department:
        i. There are no designed Airborne Isolation Rooms (AIRs) in the Emergency Department. However, there are two rooms each split into two “bays” that have manual controls that can make each room “negative/neutral” to the corridor. There are no anterooms, no automatic alarms, and only a manual gauge.

H. Sputum Induction and Bronchoscopy Procedures
    1. During these procedures, staff in the patient room must wear a PAPR (not an N-95

respirator).

2. Sputum Induction
    a. The patient must wear a surgical mask during transport to and from sputum induction booths.
    b. Cough- and aerosol-inducing procedures such as nebulizer treatments, sputum induction, bronchoscopy and endotracheal intubation may facilitate transmission of the COVID virus to health care workers.
    c. Sputum induction should be performed on COVID patients only when medically necessary.
    d. Patients with diagnosed or suspected COVID must undergo sputum induction in the patient's airborne isolation room or in a HEPA-filtered sputum induction booth.

3. Bronchoscopy
    a. Cough- and aerosol-inducing procedures such as nebulizer treatments, sputum induction, bronchoscopy and endotracheal intubation may facilitate transmission of the COVID virus to health care workers.
    b. Bronchoscopy should be performed on suspected COVID patients only when medically necessary.
    c. Patients with diagnosed or suspected COVID requiring bronchoscopy must have the procedure performed in an airborne Isolation Room or area or HEPA-filtered room (e.g., Endoscopy Suite).
    d. Patients must remain in the room until coughing has subsided. Advise the patient to cover his/her mouth and nose with a tissue when coughing.
    e. A surgical mask must be worn by the patient during transport.
    f. The procedure room must not be used for at least 1 hour following bronchoscopy to allow sufficient time for appropriate ventilation.

I. Clinical Laboratory Procedures

1. COVID Testing
    a. Send specimens to Clinical Laboratory via transport and NOT the pneumatic tube.
    b. The Clinical Laboratory will perform a COVID PCR test and will call all positive results.

2. Other Clinical Laboratory Tests
    a. Do NOT order viral isolation (culture) to be performed at ECH. Specimens will not be accepted for viral isolation/culture.
    b. PCR testing (rapid influenza/RSV and Respiratory Panel) may be ordered.

J. Coordination with the Santa Clara County Public Health Department (SCCPHD)

1. All Positive, Negative and Indeterminate COVID results are immediately sent to

SCCPHD via the CALREDIE / ECH Epic interface.

2. ~~Upon notification of a COVID positive patient, Infection Prevention (IP) will report case to SCCPHD.~~

K. Supply Management Procedures

1. Extended use of PPE to ensure supply during surge.
2. Departments bring 24-hour Supply Request form to Central Supply to obtain allocated PPE.
3. Central Supply will monitor PPE levels and report out shortages.
4. As requested report supply levels to SCCPHD.

L. COVID Capacity

1. Designated COVID areas
    a. MV: CCU rooms 3114, 3125 to 3132; PCU rooms 3117 to 3124; 3C rooms 3309, 3323 & 3324; 2C rooms 2309, 2323, 2324, 2328, & 2329; 4A rooms 4101, 4110, 4117, 4124, 4133, and one L&D room.

M. Surge Plan – see attachment - *Patient Surge for COVID* for order of patient placement.

1. ~~MV hospital will be the primary location for all admitted COVID positive patients~~
2. ~~COVID positive patients admitted or being admitted in LG will be transferred to MV campus to designated COVID area~~
3. ~~If the MV hospital reaches maximum capacity for admitted COVID positive patients, LG hospital will utilized.~~
4. Nursing Documentation Standards for High Surge
    a. If an active 'All Facilities Letter' allowing temporary waiver for hospital surge documentation requirement is available through the local CDPH, then the organization shall seek approval to limit nursing documentation requirements.
    b. In the event of a severe staffing shortages impact the entire organization, nursing assessment and care documentation will be reduced to essential items for the safe care of the patient.
    c. The intent of modified documentation standards is to allow nurses to prioritize direct patient care in the event of patient surge and diminished resources to meet patient care needs. The priorities of documentation are to support safe and effective patient care and communicate information among health care team members to promote continuity of care.
    d. Only the chief nursing officer (CNO) or designee can authorize the implementation of modifications to usual documentation standards based on patient census and nurse availability. The CNO may choose to implement modified standards for a service line or an individual unit(s) (such as the CCU).
    e. Modified documentation for High Surge shall be authorized by the CNO or

designee for specific conditions, such as:

i. Nursing assignments over California mandated nurse to patient ratios for majority of shifts.

ii. Alternative nursing assignment models or Team based nursing assignments or sustained utilization of nursing staff from other departments to support patient care (*i.e. OR, Cath Lab, Women's Hospital RNs assisting in CCU to Med/Surg areas*)

f. The surge standards will remain in place until the CNO or designee revokes them. The CNO shall revoke the surge standards when available nursing resources are sufficient to carry out the usual and customary documentation standards.

g. The organization's Director of Quality and Public Reporting will keep record of when High Surge documentation standards are implemented and discontinued.

h. The Nursing Documentation Standards for High Surge represent the minimum required documentation. When feasible, additional documentation above the minimum standard should be completed.

i. The time period that the surge documentation standards are in effect should be noted in the patient's medical record.

j. Nursing staff should utilize the HIGH Surge Documentation option within EPIC.

- See attachment, **Documentation Standards for HIGH SURGE: Tipsheet for EPIC** for full details.

i. Modified documentation standards will applied to:

- Admission assessment
- Vital sign & hemodynamic monitoring
- Shift assessments
- Rounding
- Fall Risk
- Lines, Drains and Airways (LDAs)
- Intake and Output
- Discharge Instructions

ii. Care will be continued, but documentation will not be required for:

- Plan of Care
- Patient Teaching
- Hygiene (baths, oral care, cath care, etc.)
- Turning or repositioning
- Infection control practices

iii. Continue to follow current documentation policies for:

- Pain assessment and management
- Medication administration
- Restraints
- Blood Administration
- Critical Labs / Critical Values

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Attachments

COVID 19 Testing Program.pdf

Crash Cart Management Code Blue for COVID-19 Patient

Documentation Standards for HIGH SURGE-Guidelines for Disater Doumentation.pdf

Documentation Standards for HIGH SURGE.pdf

Patient Surge for COVID Plan (2024)

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	03/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	03/2024
Infection Prevention Committee	Delfina Madrid: Quality Data Analyst	02/2024
Emergency Management Committee	Bryan Plett: Mgr Environmental Hlth&Safety	01/2024
	Bryan Plett: Mgr Environmental Hlth&Safety	12/2023

History

Comment by Potolsky, Alicia: Associate Chief Nursing Officer on 5/12/2021, 3:52PM EDT

> Added statement regarding AFL availability for surge documentation

Draft saved by Potolsky, Alicia: Associate Chief Nursing Officer on 2/28/2022, 12:09PM EST

Edited by Potolsky, Alicia: Associate Chief Nursing Officer on 3/15/2022, 1:35PM EDT

> Updated Visitation for COVID patients with more detials and eliminating the need for Infectious Disease physcian approval.

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 9/6/2022, 5:25PM EDT

> Updating owner

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 11/2/2022, 1:04PM EDT

Last Approved by Peck, Daniel: Mgr Environmental Hlth&Safety on 11/2/2022, 2:44PM EDT

> No changes needed.

Draft saved by Peck, Daniel: Mgr Environmental Hlth&Safety on 1/31/2023, 3:54PM EST

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 3/13/2023, 3:38PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 3/30/2023, 4:12PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 4/3/2023, 3:31PM EDT

Responsibilities transferred to new account by Santos, Patrick: Policy and Procedure Coordinator on 4/14/2023, 12:55PM EDT

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

Edited by Santos, Patrick: Policy and Procedure Coordinator on 6/2/2023, 12:42PM EDT

> Changes made; using draft version.

Last Approved by Scannell, Matthew: Director Safety & Security Services on 6/2/2023, 12:48PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 6/5/2023, 2:47PM EDT

> Per meeting on 6/2/23 to transfer ownership.

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 6/5/2023, 3:12PM EDT

> Per meeting on 6/2/23 to transfer ownership.

Last Approved by Scannell, Matthew: Director Safety & Security Services on 6/7/2023, 5:48PM EDT

Last Approved by Madrid, Delfina: Quality Data Analyst on 6/23/2023, 2:52PM EDT

> Approved by ICC 11/2/23

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 6/28/2023, 2:21PM EDT

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 7/11/2023, 9:54AM EDT

Sent for re-approval by Santos, Patrick: Policy and Procedure Coordinator on 10/5/2023, 2:56PM EDT

> Restarting to include updated attachment

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 12/12/2023, 9:22AM EST

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 1/19/2024, 10:24AM EST

> Updated attachment (Patient Surge for COVID Plan), per email from Alicia Potolsky.

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 1/30/2024, 10:30AM EST

Last Approved by Madrid, Delfina: Quality Data Analyst on 2/13/2024, 11:36AM EST

> ICC Approved 2/6/24

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 3/11/2024, 11:20AM EDT

> ePolicy 3/8/24

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 3/11/2024, 11:21AM EDT

> Removed "No Visitor" verbiage, per ePolicy recommendation

Last Approved by Coston, Michael: Director Quality and Public Reporting on 3/28/2024, 5:23PM EDT

> MEC 3/28/24

A05c3. Scope of Service- Neonatal Intensive Care Unit - NICU- - Enterprise-History-Changes

Status **Pending** PolicyStat ID **15173866**

Origination	06/2017	Owner	Melinda Porter: CNS/NP
Last Approved	N/A	Area	Scopes of Service
Effective	Upon Approval		
Last Revised	02/2024		
Next Review	2 years after approval		

Scope of Service: Neonatal Intensive Care Unit (NICU) - Enterprise

Types and Ages of Patient Served

Neonates up to 28 days of age (Los Gatos [LG]) or 44 weeks corrected gestational age (Mountain View [MV]) who are clinically unstable and in need of intensive care. Infants may be transferred from Labor & Delivery or the Mother/Baby unit after birth or admitted from the emergency room, doctor's office, or home post discharge. Neonates with medical/surgical conditions requiring specialized services may be transported to a tertiary center.

Assessment Methods

Nursing care is provided by registered nurses (RN) who assess, document, and evaluate patient progress. The staff nurses are involved in continual monitoring of quality of care and the performance improvement process.

For patients requiring resources not available in the El Camino Hospital NICU, arrangements will be made to transfer the patient to another facility.

Scope and Complexity of Services Offered

The NICU at Mountain View is a California Children's Services (CCS) Level III Community Neonatal Intensive Care Unit, with a capacity of ~~20~~24 licensed beds. The NICU at Los Gatos is a Level II Community Neonatal Intensive Care Unit, with a capacity of 2 licensed beds.

The unit provides total care and support to the patient/family toward the positive discharge process or

until transfer to another facility. Care is given as directed and prescribed by the physician. The nurse understands the family is an integral part of care planning and involves family members to the level of their ability and desire. The nursing staff coordinates all necessary needs for intervention and coordinates with any department specific orders and treatment.

Appropriateness, Necessity and Timeliness of Services

The clinical manager, in collaboration with the NICU medical director, care coordinator and nursing staff, will monitor that the services provided are appropriate, necessary, and done in a timely manner following policies and procedures developed in collaboration with the medical staff and NICU Partnership Council (MV) and Maternal Child Health Partnership Council (LG).

A continuous performance improvement process is in place to monitor on-going performance. This process is designed to assess all aspects of care. The patient's progress is evaluated by nursing, medical staff, and patient and family satisfaction.

Staffing/Skill Mix

The NICU is staffed with sufficient numbers of RNs, respiratory therapists (RT) and neonatologists/pediatric hospitalists to provide the established hours of care, based on patient census and acuity. The staffing is provided per guidelines outlined in the department standards, The American Academy of Pediatrics Guidelines for Perinatal Care, and Title 22.

Level of Service Provided

The level is consistent with the needs of the patient as determined by the medical staff and nursing assessment. The Level III NICU in Mountain View has 24 hour in-house neonatology/pediatric hospitalist coverage and the Level II NICU in Los Gatos has 24 hour on-call neonatology coverage.

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

Standard of Practice

The NICU is governed by state regulations as outlined in Title 22 and California Children's Services (CCS), the Joint Commission requirements, the American College of Obstetrics and Gynecology American Association of Pediatrics Guidelines of Perinatal Care, and National Association of Neonatal Nurses (NANN).

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	03/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	03/2024
Department Medical Director or Director for non-clinical Departments	Melinda Porter: CNS/NP	02/2024
	Melinda Porter: CNS/NP	02/2024

History

Draft saved by Porter, Melinda: CNS/NP on 2/5/2024, 7:39PM EST

Edited by Porter, Melinda: CNS/NP on 2/5/2024, 7:40PM EST

> Updated # of beds to 24 for new MV NICU, added hospitalists to physician coverage in MV.

Last Approved by Porter, Melinda: CNS/NP on 2/5/2024, 7:40PM EST

Last Approved by Porter, Melinda: CNS/NP on 2/16/2024, 1:27PM EST

> Approved via email review by Dharshi Sivakumar, Medical Director MV NICU, Rupal Patel, Medical Director LG NICU, Jody Charles, NICU Clinical Manager MV, and Annie Perez, Interim MCH Manager LG.

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 3/11/2024, 11:22AM EDT

> ePolicy 3/8/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 3/28/2024, 5:23PM EDT

> MEC 3/28/24

A05c4. Scope of Service - Medical- Surgical- Orthopedics and Oncology - Los Gatos-History-Changes

Status **Pending** PolicyStat ID **15298116**

Origination	02/2018	Owner	Christine Yoo: Clinical Manager
Last Approved	N/A	Area	Scopes of Service
Effective	Upon Approval	Document Types	Scope of Service/ADT
Last Revised	02/2024		
Next Review	3 years after approval		

Scope of Service - Medical, Surgical, Orthopedics and Oncology - Los Gatos

Types and Ages of Patient Served

Medical Surgical Nursing Services provides services to patients from adolescence to geriatric as defined in the department's admission criteria. The primary patient population served consists of inpatients with a wide array of medical conditions and provision for services to outpatient medical-surgical cases and surgical inpatient overflow.

Assessment Methods

Nursing care is provided by a registered nurse utilizing the nursing process. Registered nurses provide direct supervision to clinical support caregivers (certified nursing assistants – CNAs) in the provision of patient care.

Scope and Complexity of Services Offered

Medical Surgical Nursing Services provides 24-hour nursing care to:

a. Medical, surgical, orthopedic, neurologic, oncology and telemetry monitored patients
b. Procedural inpatients & out patients

Care is given as directed and prescribed by the physician. All non-nursing orders are communicated to the appropriate ancillary departments via the computerized Electronic Health Records. Staff communicates specific patient needs and coordinate treatment and plan of care with all ancillary departments. The discharge planning process is initiated on admission, in collaboration with the

physician(s), care coordinators/social workers, and patient and family/home caregivers. Multidisciplinary patient care rounds are conducted that includes formal review and revision of the plan of care.

Appropriateness, Necessity and Timeliness of Services

The Clinical Manager and shift charge nurses assess the appropriateness, necessity and timeliness of service. The appropriateness of services is addressed in "Patient Care Services Policies & Procedures"which are established in collaboration with the medical staff.

Patient's progress is evaluated by physician(s), nurses, members of other health disciplines as well as by the patient and family.

Staffing/Staff Mix

The Clinical Manager oversees the operations of Medical/Surgical/Telemetry/Orthopedic/Oncology Services on a 24-hour basis and reports to the ~~Director of~~Associate Chief Nursing Officer. The Medical Surgical Nursing Services~~. The Medical Surgical Nursing Services~~ has a skill mix of RNs, clinical support and administrative support to provide care and service to patients.

A charge nurse is assigned and staffing is determined based on hours per patient day (HPPD) and adjusted according to the ~~nursing intensity measurement system (NIMS)~~Nursing Workload Acuity Score, a patient classification system. The charge RN for each shift determines prospective staffing needs based on ~~NIMS~~the Nursing Workload Acuity Score and individual patient care needs.

The competency of the staff is evaluated annually. Staff education and training is provided to meet and validate performance standards.

Requirements for Staff

- All staff must complete orientation as specified in the department specific orientation module.
- The Heath Stream modules are reviewed annually by all staff.
- All staff are required to be BLS certified.
- RN's caring for Telemetry patients are required to have ~~ACLSRNs~~ACLS. RNs must have a current California license and CNAs must be currently certified by the State of California.

Level of Service Provided

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

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

Standards of Practice

Medical Surgical Nursing Services is governed by state regulations as outlined in Title 22 and standards established by The Joint Commission. Additional practices are described in the Patient Care Services Policies & Procedures and Clinical Practice Standards.

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Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	03/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	03/2024
Department Medical Director or Director for non-clinical Departments	Christine Yoo: Clinical Manager	02/2024
	Christine Yoo: Clinical Manager	02/2024

History

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> Replaced NIMs with Nursing Workload Acuity Score. Approved by UPC

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