AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, February 9, 20221 – 5:30 pm
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040

PURSUANT TO GOVERNMENT CODE SECTION 54953(e)(1), El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION TO THE PUBLIC FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 939-7365-3588# No participant code. Just press #.

To watch the meeting Livestream, please visit: https://www.elcaminohealth.org/about-us/leadership/board-meeting-stream
Please note that the Livestream is for **meeting viewing only,** and there is a slight delay; to provide public comment, please use the phone number listed above.

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

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1. CALL TO ORDER/ROLL CALL	Lanhee Chen, Board Chair		**5:30 – 5:31 pm**
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Lanhee Chen, Board Chair		**information** **5:31 – 5:32**
3. PUBLIC COMMUNICATION a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.* b. Written Correspondence	Lanhee Chen, Board Chair		**information** **5:32 – 5:35**
4. ADJOURN TO CLOSED SESSION	Lanhee Chen, Board Chair	*public comment*	**motion required** **5:35 – 5:36**
5. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Lanhee Chen, Board Chair		**information** **5:36 – 5:37**
6. CONSENT CALENDAR *Any Board Member may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair		**motion required** **5:37 – 5:38**
Approval *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board Study Session (12/01/2021) b. Minutes of the Closed Session of the Hospital Board Meeting (12/08/2021) ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** *Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*:* c. Credentialing and Privileges Report d. Bylaws ***Reviewed and Recommended for Approval by the Investment Committee*** *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: e. Investment Advisory Firm Update			
7. *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: **STRATEGIC PLANNING UPDATE**	Dan Woods, Chief Executive Officer		**discussion** **5:38 – 7:08**
8. *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: **FY22 Q2 STRATEGIC METRICS**	Dan Woods, Chief Executive Officer		**discussion** **7:08 – 7:23**

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at (650) 988-8254 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
9. *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: **Q2 FY22 FINANCIALS**	Carlos Bohorquez, Chief Financial Officer		**discussion** **7:23 – 7:33**
10. Report involving *Gov't Code Section 54957(b) for discussion and report on personnel matters:* **CEO REPORT** a. Update (verbal) b. Pacing Plan	Dan Woods, Chief Executive Officer		**discussion** **7:33 – 7:43**
11. Report involving *Gov't Code Section 54957(b)* for discussion and report on personnel performance matters – Senior Management: **EXECUTIVE SESSION**	Lanhee Chen, Board Chair		**discussion** **7:43 – 7:53**
12. ADJOURN TO OPEN SESSION	Lanhee Chen, Board Chair		**motion required** **7:53 – 7:54**
13. RECONVENE OPEN SESSION/ REPORT OUT	Lanhee Chen, Board Chair		**information** **7:54 – 7:55**
To report any required disclosures regarding permissible actions taken during Closed Session.			
14. CONSENT CALENDAR ITEMS: *Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair	*public comment*	**motion required** **7:55 – 7:56**
Approval a. Minutes of the Open Session of the Hospital Board Study Session (12/01/2021) b. Minutes of the Open Session of the Hospital Board Meeting (12/08/2021) c. Plans, Policies, and Scope of Services ***Reviewed and Recommended for Approval by the Finance Committee*** d. FY21 Period 6 Financials e. Mountain View ED & Inpatient On-Call Interventional Radiology Panel Agreement Renewal f. Enterprise Radiology Professional Services Agreement Renewal ***Reviewed and Recommended for Approval by the Medical Executive Committee*** g. Medical Staff Report ***For Information from the Governance Committee*** h. Board Member Benefits			
15. QUALITY COMMITTEE REPORT	Julie Kliger, Board Member Holly Beeman, MD, Chief Quality Officer		**information** **7:56 – 8:06**
16. CEO REPORT	Dan Woods, Chief Executive Officer		**information** **8:06 – 8:16**
17. BOARD COMMENTS	Lanhee Chen, Board Chair		**information** **8:16 – 8:19**
18. ADJOURNMENT	Lanhee Chen, Board Chair	*public comment*	**motion required** **8:19 – 8:20 pm**

Upcoming Regular Meetings: March 9, 2022; April 13, 2022; May 11, 2022; May 23, 2022 (Joint with Finance Committee); June 8, 2022

Upcoming Special Meetings - Education/Retreat: Date TBD (Joint Board and Committee Education); February 23, 2021 (Retreat); April 27, 2022 (Board Education)

El Camino Health

Minutes of the Open Session of the
Special Meeting to Conduct a Study Session of the
El Camino Hospital Board of Directors
Wednesday, December 01, 2021

Pursuant to Government code section 54953(e)(1), El Camino Health will not be providing a physical location to the public for this meeting. Instead, the public is invited to join the open session meeting via teleconference at:

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair **Peter C. Fung, MD** **Julie Kliger, MPA, BS** **Julia E. Miller,** Secretary/Treasurer **Jack Po, MD, Ph.D.**** **Bob Rebitzer,** Vice Chair **Carol A. Somersille, MD** **George O. Ting, MD** **Don Watters** **John Zoglin**	None ****via teleconference	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 5:30 pm by Chair Chen. A verbal roll call was taken. All Board members were present at roll call. Chair Chen reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.	
2. ADOURN TO CLOSED SESSION	**Motion**: to adjourn to closed session at 5:33 pm. **Movant:** Miller **Second:** Somersille **Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 5:33 pm***
3. AGENDA ITEM 6: RECONVENE OPEN SESSION/ REPORT OUT	Open Session reconvened at 6:59 pm by Chair Chen. Agenda items 3 -5 were addressed in the closed session. During the closed session, no actions were taken.	
4. AGENDA ITEM 7: BOARD COMMENTS	No comments were noted.	
5. AGENDA ITEM 8: ADJOURNMENT	**Motion**: to adjourn at 7:00 pm. **Movant:** Kliger **Second:** Fung **Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:00 pm***

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

Lanhee Chen Chair, ECH Board of Directors	Julia E. Miller Secretary, ECH Board of Directors

Prepared by: Stephanie Iljin, Manager, Administration

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, December 8, 2021

Pursuant to Government code section 54953(e)(1), El Camino Health will not be providing a physical location to the public for this meeting. Instead, the public is invited to join the open session meeting via teleconference at:

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair	**John Zoglin**	None
Peter C. Fung, MD		
Julie Kliger, MPA, BS		
Julia E. Miller, Secretary/Treasurer		
Jack Po, MD, Ph.D.**		
Bob Rebitzer, Vice Chair		
Carol A. Somersille, MD		
George O. Ting, MD		
Don Watters	**via teleconference	

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 pm by Chair Chen. A verbal roll call was taken. All Board members were present at roll call, excluding Directors Fung, Po, Rebitzer, and Zoglin. Chair Chen reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020. **Director Po joined at 5:31 pm. Director Fung joined at 5:36 pm. Director Rebitzer joined at 5:37 pm.*	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Chen asked the Board of Directors for declarations of conflict of interest with any items on the agenda, and none were reported.	
3. PUBLIC COMMUNICATION	None	
4. BOARD ASSESSMENT	Dan Woods, CEO, introduced George Anderson, a consultant with Spencer Stuart, engaged in assessing the El Camino Hospital Board of Directors' effectiveness. Mr. Anderson reviewed improvements to include dialogue on strategy, meeting practices, composition and succession, committee structure, and working dynamics. He further detailed critical areas of focus on strategic planning, quality of care and service, financial oversight, executive performance, risk management, communication, and governance. He asked the Board of Directors for their feedback, and none was noted at this time.	
5. ADJOURN TO CLOSED SESSION	To adjourn to closed session at 5:12 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (11/10/2021), Chief Quality Officer Base Salary; pursuant to *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report (Medical Staff Credentials and Privileges Report); pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, an Executive Session with the CEO and a CEO Report.	***Adjourned to closed session at 5:12 pm***

	Motion: to adjourn to closed session at 5:12 pm **Movant**: Miller **Second**: Fung **Ayes**: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters **Noes**: None **Abstentions**: None **Absent**: Zoglin **Recused**: None	
6. AGENDA ITEM 13: RECONVENE OPEN SESSION/ REPORT OUT	Open Session reconvened at 7:45 pm by Chair Chen. Agenda items 6-11 were addressed in the closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (11/10/21), Chief Quality Officer Base Salar, and the Credentialing and Privileges Report by a unanimous vote in favor of all members present and participating in the meeting (Director Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, and Watters). Director Zoglin was absent.	
7. AGENDA ITEM 14: CONSENT CALENDAR ITEMS	Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. Chair Chen requested to pull item 17c – Policy Revisions. **Motion:** To approve the consent calendar to include: a. Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings b. Minutes of the Open Session of the Hospital Board Meeting (11/08/21) c. Policy Revisions d. FY21 Period 4 Financials e. Intent to Reimburse: Resolution f. Mountain View OBGYN Call Panel Renewal (Physician Contract) g. Executive Compensation Committee Community Member Composition & new Community Member Appointments h. Medical Staff Report **Movant:** Watters **Second:** Kliger **Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters **Noes:** None **Abstentions:** None **Absent:** Zoglin **Recused:** None	***Consent calendar approved***
8. AGENDA ITEM 15: CEO REPORT	Dan Woods, CEO, reported HR and Nursing administration have engaged representatives from our nursing union PRN and are discussing creating different careers ladders for our nursing staff. We are also in the initial discussion with SEIU regarding several career ladder classifications as further disclosed that we have hired a diversity manager who will start December 30th and is currently exploring internships for both high school and college students. He concluded that the Auxiliary donated 2,803 volunteer hours for October.	
9. AGENDA ITEM 16: BOARD COMMENTS	*No comments were made.*	

	**Director Ting left the meeting at 7:50 pm.*	
10. AGENDA ITEM 17: ADJOURNMENT	**Motion**: to adjourn at 7:51 pm. **Movant:** Kliger **Second:** Watters **Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersile,Watters **Noes:** None **Abstentions:** None **Absent:** Ting, Zoglin **Recused:** None	***Meeting adjourned at 7:51 pm***

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

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Stephanie Iljin, Manager, Administration

EL CAMINO HOSPITAL BOARD OF DIRECTORS

February 9, 2022

Plans, Policies and Scope of Services for Approval

Department	Policy Name	Type of Change	Type of Document	Notes	Committee Approvals
New Business					
Clinical Engineering	1. Environment of Care Medical Equipment Management Plan	Revised	Plan	1. Updated plan with FY22 goals and ph objectives	• Central Safety • Patient and Employee Safety Committee • ePolicy Committee
Hazardous Material Management	2. Environment of Care - Hazardous Materials Management Plan	Revised	Plan	1. Updates goals and objectives for FY2022	• Hazardous Materials Work Group • Central Safety • Patient and Employee Safety • ePolicy Committee
Security Management	3. Environment of Care Security Management Plan 4. Environment of Care Safe Environment Management Plan	Revised Revised	Plan Plan	1. Updated goals and objectives for FY2022 2. Updated FY2022 goals	• Central Safety • Patient and Employee Safety Committee • ePolicy Committee
Employee Wellness & Health	5. HR - Respiratory Protection – Plan	Revised	Plan	1. Minor changes replace "medical evaluation" for "respirator medical evaluation"	• HR Leadership • ePolicy Committee
Emergency Management	6. Earthquake Response Plan 7. Hospital Surge Plan	Revised Revised	Plan Plan	1. Updated references and attachments 2. Updated references	• Emergency Management Committee • ePolicy Committee

Current Status: *Pending* **PolicyStat ID:** *10437129*

Origination:	*04/2018*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/2021*
Next Review:	*1 year after approval*
Owner:	*Jeff Hayes: Dir Clinical Engineering IT*
Area:	*Clinical Engineering*
Document Types:	*Plan*

Environment of Care Medical Equipment Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

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

- Maintaining a current accurate ***inventory*** of equipment included in the program
- Ensuring all equipment receives an ***initial inspection*** prior to use
- Ensuring ***preventive maintenance*** is performed pursuant to a risk-based equipment maintenance strategy and schedule
- Providing timely and effective ***corrective maintenance services***
- ***Reporting, investigating and resolving*** incidents, problems and failures involving equipment in a timely and effective fashion
- Assist in the development and/or provide training materials in coordination with Hospital Educator
- Ensuring equipment is ***cybersecurity*** safe and providing support for medical ***device integration***.

Developing and providing training materials in coordination with Hospital Educator

SCOPE AND APPLICATION:

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

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

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

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC.02.04.01, EC.02.04.03
2. California Code of Regulations, Title 22, sections 70837, 70853
3. NFPA 99,2012
4. HITRUST
5. NIST

AUTHORITY

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

PROGRAM ORGANIZATION AND RESPONSIBILITIES

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

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

    1. Cataloging all medical devices and equipment and determining which devices are deemed critical and to be included in the scheduled maintenance program
    2. Maintaining an accurate inventory of all the devices deemed critical
    3. Performing initial safety tests and inspections of all medical equipment
    4. Inspecting and maintaining equipment that does not meet the criteria to be listed individually in the maintenance program through a series of scheduled environmental inspections and testing
    5. Performing and documenting maintenance activities through the design and implementation of the equipment management program, to include coordination of the initial risk assessments
    6. Developing written plans and operating procedures

7. Identifying training needs
8. Providing technical consultation and assistance with equipment end user training
9. Initial response to, investigation and reporting of incidents, potential Safe Medical Devices Act issues and Sentinel Events

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

D. A multi-disciplinary Central Safety Committee (CSC) ensures that the program remains in alignment with the core values, direction, and goals of the organization by providing leadership, determining priority and assessing the utility and efficacy of changes to the program. The CSC maintains and tracks all applicable information through the Safety Trends report and acts as a clearinghouse for action items and recommendations, as well as a forum for leveraging issues, and developing program imperatives.
The CSC meets regularly throughout the year and, as part of the standing agenda, receives and reviews reports and summaries of actions taken, deficiencies, issues and performance improvement relative to equipment management, as well as several other pertinent functions and disciplines.

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

RISK ASSESSMENT

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

- Risk-based initial & scheduled inspections, testing and maintenance
- Ongoing Equipment Safety Management methods and protocols, including those designed to address operator/user errors and equipment failures
- Incident Report review/evaluation through the applicable Information Collection and Evaluation System and the EM/ISC

- Device-related hazard alerts and product recalls
- Environmental and Hazard Surveillance rounds
- Communications with customers (end users)
- Root Cause Analysis of medical equipment related significant events
- Information Technology Security

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

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

B. The risk-based criteria for inclusion in the medical equipment preventive maintenance (PM) program includes:

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

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

C. Medical device product recalls and alert notifications are managed through a system involving Clinical Engineering, Facility Services, Materials Management, Safety, Risk and the equipment user departments. As medical equipment alerts, product recalls and manufacturer letters are received, they are researched through the Clinical Engineering department. When the alert or the recall involves equipment supported by Clinical Engineering, the equipment/product user department and Clinical Engineering check inventory and take action, as prescribed in the notice. Clinical Engineering provides the CSC with relevant data where it is tracked and monitored for follow up on the alert.

D. The investigation and reporting of device-related incidents involving death, serious injury, serious illness, or posing a significant impact on care or an occupational hazard are managed through an ad hoc administrative investigation team (Incident Reporting System). The Team is comprised of individuals who collectively possess the technical, clinical, and operational skill sets necessary to effectively evaluate the surrounding circumstances and determine the need for reporting under the Safe Medical Devices Act (SMDA) requirements.
    The SMDA investigation process and ensuing investigative reports are instrumental in discovering user error issues that provide impetus for training improvements. In instances when the governmental criteria are met, the investigation and root cause analysis is documented on the FDA "*MedWatch"* report form, in accordance with the SMDA policy. In addition, the user's department under the direction of Risk Management completes an incident report. This report is used to document user errors; as well as other

equipment use management issues such as cannot duplicate problem, equipment abuse, and unsafe practices.

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

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

   - Capabilities, limitations and special applications of equipment
   - Basic operations and safety precautions
   - Emergency procedures
   - Skills necessary to perform equipment maintenance
   - Processes for reporting program problems, failures, and user errors.

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

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

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

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

PERFORMANCE MEASURE

FY-~~21~~2022 Performance Indicators

This year the performance ~~improvements~~improvement will ~~be:~~focus on Asset Management and Cybersecurity.

- ~~Raise confidence level of the active assets in the inventory to greater than 90%. Currently we are at an 84% confidence level of assets active in the database. This will be accomplished by tracking scheduled~~

~~work orders on an asset by various sub status codes to assure the asset is a valid active asset and should remain in the inventory~~

- ~~Develop 2 network indicators that will alert potential monitoring network failures. These indicators will provide solutions to preemptively resolve potential issues within the networked monitoring system.~~

- Raise the asset confidence level currently at 95% to 98%. This confirms 98% of medical devices receive a completed maintenance.
- Create network micro segmentation to greater than 98% of all networked medical devices.

PROGRAM EFFECTIVENESS

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

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

ANNUAL PROGRAM EVALUATION

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued effectiveness of program on an annual basis, the ~~Utility Systems~~Medical Equipment Management Plan/Program is evaluated relative to its ***objectives, scope, effectiveness and performance*****.** This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

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

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

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

Attachments

Medical Equipment Risk Level Assignment Form.doc

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Catherine Carson: Senior Director Quality [PS]	01/2022
ePolicy	Jeanne Hanley: Policy and Procedure Coordinator [PS]	12/2021
Patient and Employee Safety Committee	Delfina Payer: Projects Coordinator	11/2021
Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2021
	Jeff Hayes: Dir Clinical Engineering IT	09/2021

Current Status: *Pending* **PolicyStat ID:** *10437078*

Origination:	*02/2018*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/2021*
Next Review:	*1 year after approval*
Owner:	*Lorna Koep: Director Environmental Svcs*
Area:	*Hazardous Materials Management*
Document Types:	*Plan*

Environment of Care - Hazardous Materials Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino ~~Hospital~~Health is committed to providing a safe, accessible and effective Environment of Care, consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, visitors, employees and staff. The intent of this plan is to protect human health and the environment from risks related to hazardous materials and waste by identifying materials that need special handling and implementing processes to minimize the risk of unsafe use and improper disposal of hazardous materials.

A. Goals:
   Based on areas of improvement noted in the FY-~~20~~2021 Annual Evaluation, the performance improvement indicators for FY-~~21~~2022 will be:

   1. Staff can describe the process for accessing a Safety data sheet (> 95%)
   2. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes. (> 95%)

      ~~Staff knowledge on proper labeling of biohazardous waste containers.~~

B. Objectives:
   Specific objectives of the FY-~~21~~2022 Hazardous Materials and Waste Management Plan include the following:

   1. All employees will have access to Safety Data Sheets (SDS) on line.

      ~~All Hazardous Materials Business plans will be submitted to the Santa Clara County Department of Environmental Health.~~

   2. Ongoing training for staff on the new NIOSH 800 regulations.
   3. Updated the Code Orange spill response reporting form.

4. Refresher and initial decontamination training will be offered to staff at least one time in FY ~~21~~2022.
5. Initial and annual HAZWOPER training will be offered to identified individuals in FY ~~21~~2022.
6. Develop, educate and implement the Handling of Hazardous Drugs (USP 800) plan in FY ~~21~~2022.
7. Review, revise and educate staff on the changes to the hospital container waste guide based on opportunities for improvement identified during the hazardous waste inspections with the county
8. Spill response training will be offered to staff who respond to spills and code orange events (e.g., EVS, Engineering, Lab etc.).

   ~~Any corrective actions from the 2020/21 Santa Clara County medical and biohazardous waste inspections will be tracked through the Central Safety Committee.~~
9. ~~Implement a controlled substances~~Surveillance and education for appropriate usage of non -retrievable waste container (CSRX) program in FY ~~21~~2022.

SCOPE AND APPLICATION:

The Hazardous Materials and Waste Management Plan apply to patients, employees, and visitors at all areas of El Camino ~~Hospital~~Health . This plan applies to all operations, processes, activities and departments involved in the selection, procurement, handling, storage and disposal of hazardous materials. For the purposes of this plan, the term "hazardous materials" may apply to the following:

- Hazardous substances (as listed and defined under CERCLA , 40 CFR 300),
- Hazardous Materials (as addressed in the OSHA Hazard Communication Standard & Director's list 8 CCR 339),
- Designated wastes under the federal and state regulations,
- Listed carcinogens and reproductive hazards, under 22 CCR 12000 (Prop. 65),
- Compressed gases,
- Chemotherapeutic agents (CYTOTOXIC),
- Radioactive materials, refer to "Nuclear Medicine - Radioactive Spills Procedure"
- Potentially infectious materials (as defined in the Blood borne Pathogen Standard) and Medical wastes (as defined in the Medical Waste Management Act),
- Pesticides (Title 3, Division 6, Health & Safety Code, Section 25500),
- Universal Waste (batteries, fluorescent light bulbs), or
- Any other material which the user or Administering Agency has reasonable basis to classify as harmful to living organisms or the environment.

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

- Program planning/design, implementation, the measurement of outcomes and performance improvement;
- Risk Assessments; Identification, analysis and control of risks;
- Reporting and investigating including incidents, accidents and failures;
- Occupational health and safety;
- Control of exposures to potentially harmful conditions/industrial hygiene;
- Orientation, education and training;
- Environmental maintenance, testing and inspection;
- Examining and addressing safety issues

The hazardous materials and waste management plan and associated policies, procedures and programs are instituted by the Central Safety Committee through a multi-disciplinary approach which integrates the efforts of key functional areas, including but not limited to EVS, Infection Control (IC Committee), Engineering, Laboratory, Nursing, and Security

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC.02.02.01
2. Code of Federal Regulations, Title 29, Sections 1910.101-106, 120, 1000, 1030, 1200, 1450;
3. Code of Federal Regulations, Title 40, Section 261 et seq.;
4. California Code of Regulations, Title 8, Sections 3203, 4650, 5076, 5144, 5155, 5191, 5193, 5194;
5. Title 22, Sections 66261 et seq., 12000;
6. Title 17, Section 30100;
7. Title 3, Section 6145 et seq., 6600 et seq.;
8. California Health and Safety Code, Sections 117600 et seq.;
9. NFPA 30.

AUTHORITY

The El Camino ~~Hospital~~Health Leadership Team provides vision, leadership, support, and appropriate resources to the program. In accordance with its bylaws, the El Camino ~~Hospital~~Health leadership has given the Central Safety Committee the authority to ensure that this plan is developed and implemented. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the Hazardous Materials and Waste Work Group.

PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. **Clinical Laboratory:** Hazardous material and waste management in the Pathology and Clinical Laboratories, and the implementation of the Chemical Hygiene Plan, is the responsibility of the Laboratory Director/Manager.

B. **Radiation Safety Committee:** Radioactive materials and waste management is the responsibility of the site Radiation Safety Officer and the Radiation Safety Committee.

C. **Hazardous Materials and Waste Management Workgroup:** The Hazardous Materials and Waste Management Workgroups or designee in collaboration with the Central Safety Committee is responsible for the overall management of the hazardous materials and waste program. These include:
    - Coordinating the initial assessment of risks,
    - Program design,
    - Developing the facility's written plan and program objectives for each year,
    - Establishing, monitoring and assessing Performance Improvement dimensions
    - Identifying training needs,
    - Regulatory tracking/interpretation**,**
    - Assistance with departmental implementation,

- Initial response investigation and reporting of significant events, and
- Program evaluations.

D. **Central Safety Committee (CSC):** The CSC, as part of the standing agenda, receives and reviews reports and summaries of actions taken related to Hazardous Materials and Waste Management. The Committee also identifies and analyzes issues and seeks there timely resolution. Agenda items include**:**
   - Issues requiring action, recommendations or approval,
   - Issues requiring monitoring/periodic or ongoing review,
   - Needs that are multi-disciplinary in nature,
   - Regulatory updates, and
   - Performance Data review.

RISK ASSESSMENT

Risks associated with the management of hazardous materials and wastes are typically identified and assessed through facility-wide processes, such as routine safety rounds , product inventory management, the facility's Safety Trends reports, Central Safety Committee review, and the incident reporting application. The risk profile with respect to hazardous wastes includes, but is not limited to: risk of occupational and occupant exposures; fires and chemical reactions; releases; nosocomial infections; and legal exposures.

Key factors driving the level of relative risk include the likelihood of an unwanted event coupled with the magnitude of the consequences. These factors are typically associated with the volume of chemical substances, constituents, inherent physical or chemical properties, concentration and handling practices, as well as invasive procedures involving blood or other potentially infectious materials and waste handling. Identified high risk areas to which additional resources and attention are directed are listed below.

- Clinical Laboratories and the Pathology department
- The Operating Room
- Sterile Processing department
- Material Management
- Facility Engineering
- Pharmacies
- Environmental Services (EVS)
- Gastroenterology (GI)
- Oncology/Hematology
- Radiology
- High volume patient care areas

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

The plan provides processes for the following.

A. The facility developed and maintains an inventory that identifies hazardous materials and waste used, stored, and generated using criteria consistent with applicable laws and regulations as follows:
   - A Hazardous Materials Business Plan is kept current in accordance with local and state regulations and ordinances.

- The facility's policy and procedure requires each department to update a department chemical inventory.

B. Selection, handling, and use of hazardous materials and waste: Products and substances containing chemical constituents deemed to be hazardous will be identified, evaluated and listed by recognizable names within department-specific inventories. Department managers (in conjunction with the EH&S Manager) will evaluate waste streams to ensure waste materials from all processes, procedures and operations are correctly characterized and classified, per regulatory criteria. Department programs include waste minimization components, such as procurement and inventory control. For each hazardous material used and handled, the department manager will provide a corresponding Safety Data Sheet (SDS). These documents will remain readily available to employees at all times and should form the basis for department-specific training and written procedures for proper handling, storage, safe use and spill procedures. Containers of hazardous substances are labeled in accordance with applicable regulations with appropriate hazard communication and expiration dates.

C. The facility monitors use and disposal of hazardous gases and vapors including, but not limited to:
   - Formaldehyde
   - Various compressed gas cylinders, including oxygen, medical air, nitrous oxide and nitrogen.

D. Hazardous Materials and waste emergency procedures address the following:
   - Incidental and major spills: Emergency procedures and materials are implemented that provide preventative, precautionary measures, response procedures, and appropriate personal protective equipment (PPE). The EH&S Manager participates with department managers in the development and implementation of emergency procedures.
   - Small, relatively innocuous hazardous material spills: These spills are addressed by the individual causing or discovering the spill or appropriately trained staff. The containment materials will be used for proper spill cleanup.
   - Large spills: These spills will be handled by contracted vendor and/or emergency response agency personnel. In the event of a release or exposure involving radioactive materials, the Radiation Safety Officer will immediately be notified and will coordinate the response.
   - Clean-up procedures: Department managers will ensure that appropriate spill procedures and spill control materials are readily available for use within close proximity of where hazardous substances are stored, used or handled. Additionally, facilities engineering maintains a chemical spill cart to supplement existing spill materials and PPE.
   - Personal protective equipment: Department managers will ensure that appropriate personal protective equipment (PPE) is readily available for use within close proximity of where hazardous substances are stored, used or handled. Exposure management equipment, materials, suppression systems, alarm systems and other features of the hazardous materials and waste management program are inspected and maintained primarily through Facilities Services, in concert with the EH&S Manager. Examples include, but are not limited to:
     - Mechanical ventilation
     - Administrative controls
     - Personal Protective Equipment (PPE)
     - Periodic exposure monitoring for operations that involve the handling of solvents, reagents, fixatives and other chemicals that may produce fugitive emissions, volatilize or otherwise off-gas

into occupied spaces and/or work areas. **(See PM records and monitoring records).**

- Personnel monitoring, system assessments, local exhaust ventilation/scavenger units and alarm systems for the control of waste anesthetic gases (including nitrous oxide).
- Reporting and investigation of hazardous materials incidents:

  The EH&S Manager will ensure all releases and exposure incidents are duly investigated and reported to the Central Safety Committee and appropriate agencies.

E. Documentation is maintained that includes required permits and licenses in Facility Services

F. As prescribed by governmental standards, hazardous waste is manifested for transport to a permitted, licensed treatment, storage and disposal facility (TSDF), by a licensed contracted hazardous waste hauler in accordance with applicable regulations (See Manifests).

G. Hazardous materials and waste are properly labeled in accordance with pertinent laws and regulations i.e. DOT shipping requirements, NFPA Placards, Title 22, etc.

H. Hazardous materials and waste storage and processing areas are separated from other areas of the facility as follows:

- Where hazardous materials or wastes are stored, physical barriers separate incompatible materials. Applied release prevention measures include diversionary structures, bins, tubs, berms, secondary containment, etc. Hazardous materials are used and stored under adequate general ventilation or local exhaust ventilation.
- Hazardous wastes are collected and accumulated on site in a main accumulation area and in satellite accumulation areas near the point of generation. These accumulation areas are provided with structural features, containers, signage, equipment, and supplies conducive to occupational safety, spill prevention and control, and environmental protection **(Hazardous waste storage area inspection check list).**
- Bio-hazardous waste is contained within rigid, leak resistant, labeled containers; accumulated on-site within secured and designated areas. Sharps waste is transported by a licensed hauler and incinerated by a permitted facility. Regulated medical (bio-hazardous and sharps) waste is segregated from solid municipal wastes at the point of generation.

I. Education and Training:

All employees attend General Hospital Orientation at the time of hire and annual training where general information and education regarding the management of hazardous materials and wastes is provided. Departments will also conduct training that is specific to processes, materials; precautions and relative risk associated with job function and work practices, to include:

1. Elements of the written programs, interpretation of labeling and hazard warning systems, specific SDS information (physical and health hazards, precautions), proper storage, waste Management, emergency procedures and incident reporting (including spills, releases and exposures);
2. Department manager(s) will verify that each employee possesses the required core competencies relative to the safe and effective use of products and substances deemed hazardous;
3. Technical consultative support is provided through the Safety and Security Services Department, as requested;
4. The education department and each department manager will periodically revisit their training

materials and modify, adjust and improve, as indicated, to reflect:

- Organizational experiences and learning
- Results of risk assessments, hazard surveillance rounds, audits, inspections
- Changes in pertinent regulations, codes or standards
- Recommendations from the Central Safety Committee or the Safety and Security Services Department

PERFORMANCE

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Integrated Safety Committee recommendations.

A. Intent and Requirement: To monitor, assess and improve staff knowledge, skills and competencies with respect to hazardous materials and waste.

B. The FY-~~21~~2022 Performance Improvement Indicators are as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Hazardous Materials Management	Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes	Safety	>~~90~~95%
Hazardous Materials Management	~~Staff knowledge on proper labeling of biohazardous waste containers.~~Staff can describe the process for accessing a Safety data sheet.	Safety	>~~90~~95%

C. Process and Frequency of Measurement

Data will be collected through safety rounds.

PROGRAM EFFECTIVENESS

The Central Safety Committee evaluates the effectiveness of the program, including the appropriateness of design, outcomes of implementation; training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action(s) taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the hazardous materials and waste program to include: hazardous surveillance results; inspections by regulatory agencies; spills, releases or other emergencies; management of the hazardous waste accumulation area; occupational exposures to hazardous materials; and hazardous materials and waste reduction efforts.

ANNUAL PROGRAM EVALUATION

On an annual basis, the Hazardous Materials and Waste program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Integrated Safety Committee and the Safety Officer.

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

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

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Catherine Carson: Senior Director Quality [PS]	01/2022
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator [PS]	12/2021
Patient and Employee Safety	Delfina Payer: Projects Coordinator	11/2021
Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2021
Hazardous Materials Work Group	Lorna Koep: Director Environmental Svcs	09/2021
	Lorna Koep: Director Environmental Svcs	09/2021

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Owner:	*Matthew Scannell: Director Safety & Security Services*
Area:	*Security Management*
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Environment of Care Security Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

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

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

A. Goals:
   Based on areas of improvement noted in the FY ~~2020~~2021 Annual Evaluation, the performance improvement indicators for FY ~~2021~~2022 will be:
   1. 10 % reduction in the number of reportable workplace violence incidents over FY ~~2020~~2021.

      ~~Security staff response time to emergency codes less than three minutes. Target is 95 % or higher.~~
   2. Reduce the number of reported thefts on campus by 10% over FY ~~20~~21 totals
   3. Security Officer (non recordable) Injury rate of <5% per 100 employees for FY 22.

B. Objectives:

   Specific objectives of the FY ~~2021~~2022 Security Management Plan include the following:
   - Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess and control security risks, vulnerabilities, protect sensitive areas, and to track access control.
   - Work with nursing to identify and proactively plan for potential Code Gray patients.

- Use the Code Gray critiques to improve response with a focus of ensuring the safety of the staff and patients during these events.
- Further implement the ~~Preventing~~Prevention of Workplace Violence Plan to reduce workplace violence incidents.
- Ensure timely and effective responses to security emergencies. Less than three minutes response time
- Ensure quality and effective responses to service requests.
- Report and investigate incidents of theft, vehicle accidents, threats, and property damage.
- Review the current infant abduction prevention system in the women's hospital for comparison to newer technology.
- Periodically inspect and test all security systems, devices and equipment.
- Promote security awareness and education.
- Enforce various medical center rules and policies.
- Establish and implement critical program elements to include measures to safeguard people, equipment, supplies, and medications and to control traffic in and around the Medical Center and the outlying medical offices.
- Enforce ~~our~~ visitor ID program in various locations across both campuses.
- Review and revise as needed post orders for security staff in the Taube and Sabroto buildings.

  ~~Upgrade RFT monitors to Windows 10.~~
- Replace DVR's with NVR's to improve security camera retention and quality.
- Train all security staff on CPR.
- Replace the visitor management system from an excel and word application to an actual management system (Omnigo).
- Secure funding for an outside vendor to conduct a MV security risk assessment.

SCOPE AND APPLICATION:

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

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

- Further develop a comprehensive patrol plan for the Medical Center and the outlying medical offices
- Sustain Nonviolent Crisis Intervention training for all security officers
- Improve/enhance Emergency Department physical and technological security
- Program planning/design, implementation and the measurement of outcomes and performance improvement.
- Risk assessments, identification, analysis, and control of risks.

- Reporting and investigating including incidents, accidents and failures.
- Orientation, education and training of staff and officers.
- Use and maintenance of equipment, such as lights, locks and barriers, C-cure 9000 systems and alarms.
- Traffic control and the security of sensitive areas.
- Evaluate the effectiveness of the infant monitoring systems.
- Upgrade the C-Cure 9000 system to increase functionally of systems including the use of cameras.

REFERENCES:

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

AUTHORITY

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

PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. **Security Director:**

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

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

   1. Provides security personnel and site management of security operations, compiling relevant information from incident reports and security service date to form the basis for quarterly reports submitted to the Central Safety Committee, functional oversight and responsibility for the day to day operations of the Security department and the implementation of the program.
   2. Assures employees receive all security related training, report situations involving threats or the

perception of an unsafe work place to the Security ~~Workgroup~~Work Group, assures employees follow security instructions for their areas, and contacts the Director of Security with all security related issues.

C. **Security Department:**

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

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

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

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

RISK ASSESSMENT

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

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

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

PROGRAM EFFECTIVENESS

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

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

PERFORMANCE

EoC Area	Indicator	Responsible Dept./Function	Target
~~Security~~Security	~~10 % reduction in the number of reportable workplace violence incidents over FY 2020.~~10% reduction in the number of reportable workplace violence incidents over FY 2021.	~~Security~~Security	~~10 % Decrease from FY 2020 statistics~~10% Decrease from FY 2021 statistics
~~Security~~	~~Security staff response time to emergency codes less than three minutes. Target is 95 % or higher.~~	~~Security~~	~~> 95%~~
Security	Security Officer (non recordable) Injury rate of <5% per 100 employees for FY 22.	Security	< 5% per 100 employees
~~Security~~Security	~~Reduce the number of reported thefts on both campuses by 10% over FY 20 totals~~Reduce the number of reported thefts on both campuses by 10% over FY 2021 totals	~~Security~~Security	~~10 % Decrease from FY 2020 statistics~~10% Decrease from FY 2021 statistics

ANNUAL PROGRAM EVALUATION

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

- The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.

- The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant policy and procedures, technology, and practices that add value and elements conducive to continuous regulatory compliance.
- The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

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

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Catherine Carson: Senior Director Quality [PS]	01/2022
ePolicy	Jeanne Hanley: Policy and Procedure Coordinator [PS]	12/2021
Patient and Employee Safety Committee	Delfina Payer: Projects Coordinator	11/2021
Central Safety	Matthew Scannell: Director Safety & Security Services [JH]	10/2021
	Matthew Scannell: Director Safety & Security Services [JH]	10/2021

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Document Types:	*Plan*

Environment of Care Safe Environment Management Plan

COVERAGE:

This Safe Environment Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics. It covers all employees, contractors, volunteers, students, registry personnel and anyone working under the facility's auspices.

PROGRAM OBJECTIVES AND SCOPE:

El Camino ~~Hospital~~Health and associated Outpatient Clinics are committed to providing a safe, accessible and effective Environment of Care (EOC), consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, employees and visitors. This plan describes a comprehensive facility-wide Safe Environment Management Plan that describes the process for:

1. Identification and minimization of safety risks
2. Maintenance of a safe environment

Based on areas of improvement noted in the FY-~~20~~2021 Annual Evaluation, ~~patient fall prevention/assistance continues to be the most common, and rising cause of injury accounting for 35% of those reported in FY20. The~~the primary FY-~~21~~2022 performance improvement project for Safety Management involves continuing revision of the initiatives to reduce work-related injuries to further focus on Staff Safety Management Systems. In particular, the focus is on improving our work related injury/illness ~~resulting from assisted patient falls~~related to needlesticks and bloodborne pathogen exposure and the reduction of MSD injuries among our EVS population (highest incident).

~~A. Objectives:~~

~~Specific objectives of the FY-21 Safe Environment Management Plan include the following:~~

~~1. The Patient- and Employee- Fall Prevention Committees continue to partner to identify opportunities for prevention. An after fall huddle/report is under consideration; training and provision of gait belts is being evaluated; sit/stand/walk aids encouraged; and 3 low frame beds are now available for fall risk patients.~~

~~2. Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving~~

~~communication is being strategized to promote equipment use and fall prevention.~~

3. ~~Deploy new Accident Injury & Exposure Report (AIER) utilizing the RLDatix system.~~

A. Objectives:

Specific objectives of the FY-2022 Safe Environment Management Plan include the following:

1. Standardize insulin syringe product across the Enterprise
2. Enterprise wide needle conversion
3. Implement an EVS Ergonomic & Injury Prevention Program with the goal of reducing MSD injuries among our EVS population
4. Continue to develop our Safety Rounds program

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .02.01.03, .02.06.01, Code of Federal Regulations, Title 29, Sections 1910 et seq., 1910.1450
2. California Code of Regulations, Title 8, Sections 3203 et seq., 5191;
3. California Code of Regulations, Title 22 70837, 70739.

AUTHORITY

In accordance with its bylaws, the El Camino ~~Hospital~~Health Leadership has given Employee Wellness and Health Services (EWHS) and the Central Safety Committee (CSC) the authority to ensure that the plan is formulated appropriately and carried out effectively. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the EH&S Manager and the Safety and Security Director in collaboration with EWHS. EH&S Manager and the Safety and Security Director in concert with EWHS and the Central Safety Committee has oversight over the Workplace Safety Program, which includes reducing injuries and workers compensation claims.

PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. **El Camino ~~Hospital~~Health Leadership Team**

   The hospital leadership team provides the program vision, leadership, support and appropriate resources to ensure environmental health and safety.

B. **Environmental, Health and Safety Manager and Safety and Security Director** collaborate to compile reports submitted to the Central Safety Committee,

C. **Hospital Safety Officer (Ken King):**
   - Has the authority to intervene whenever conditions pose an immediate threat to life or health, or property damage.
   - Is appointed by the hospital CEO.
   - Provides to the Executive Committee annual summary reports, Issues identified by the CSC, and policies and procedures as applicable for Executive Committee review.

D. **Central Safety Committee (CSC)**

The CSC ensures that the safe environment program remains in alignment with the organization's core values, goals and social purpose by providing direction, determining priorities, and assessing/approving program changes. The Central Safety Committee provides a forum for and ensures the timely resolution of action items, issues, and risks. This committee also addresses recommendations, grants approvals, leverages issues, and develops program imperatives. The charter of the CSC is to:

- Develop strategic goals and annual performance targets relative to the environment of the Hospital
- Carry out analysis and seek resolution of Environment of Care Management issues,
- Prioritize goals and resources,
- Ensure coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, and
- Establish and approve infrastructures to support Performance Improvement techniques.

E. **Department Managers**

Department Managers are responsible for the provision of a safe working environment for staff, patients, and visitors through full implementation of established EOC programs. This responsibility can include the identification of occupational risks, staff training, the development and management of specific safety policies and procedures, and injury investigation.

F. **Employees**

All employees are responsible to participate in safety training, as required, as well as to demonstrate core competencies in the given subject matter. Employees must ensure their behaviors, work practices and operations are safe, responsible and in alignment with facility and departmental procedures, applicable training and the provisions of this plan.

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

Implementation of the safety plan is contingent upon the incorporation of safety principles into the culture and routine clinical and business practices at all levels of the organization. Another imperative of successful program implementation is the integration of cross-functional management systems and processes that relate to the environment provided for members, employees and visitors, as well as aspects of public health and environmental protection. These program components and processes are coordinated through the Safety Officer and processes are monitored through the Central Safety Committee. They include:

A. Supervision of all grounds and equipment through the implementation of the Safe Environment Program, Fire Prevention Program, Security Management Program, Hazardous Materials and Wastes Program, Medical Equipment Management Program and Utilities Management Program and an ongoing Hazardous Surveillance Rounds process.

B. Risk Assessments, which proactively evaluate the impact of building, grounds, equipment occupants and internal physical systems on patients and public safety, are accomplished primarily through the use of Hazard Surveillance Rounds.

C. The Central Safety Committee, whose make-up includes Administration, Clinical Services, Operation

Support Services, Physicians and other appropriate organizational representatives, examines safety issues, including failures, exposures, personal injury and hazards.

D. Incidents ~~ofstaff~~of staff, patient and/or visitor injuries and incidents, attributed to environmental conditions or safety hazards are reported and investigated through Risk Management and EH&S departments and reported to the Central Safety Committee.

E. Occupational injury, illness and exposure data is monitored and tracked on an ongoing basis these include the following:
   - Historical Workers' Compensation data.
   - Injury frequencies by type
   - Injuries by department
   - OSHA "recordable" injuries
   - Ergonomic/Repetitive Motion Injuries

F. Effective, ongoing surveillance, inspection and testing of operational safety elements and components of the environment is achieved through the use of Safety Rounds coordinated by the EH&S Manager, supply and equipment recalls and alerts (shared by ~~Materiel~~Material Management and Clinical Engineering) and preventive maintenance surveys conducted by engineering. Hazard Surveillance Rounds are conducted at least semi-annually in areas where patients are served and annually in other areas.

G. Product safety recalls - Recall notices are sent from the vendor, Clinical ~~Technology~~Engineering or Material Management Departments. Notices are forwarded to department managers for follow up and resolution. Documentation is kept by departments and reported to the Central Safety Committee monthly by Clinical ~~Technology~~Engineering or Materials Management.

H. Patient safety is evaluated through hazard surveillance, utilities and equipment preventative maintenance, and incident reports.

I. Safety Educational Programs are implemented through the development, review, and evaluation of education programs designed to promote health, safety and environmental regulatory compliance.
   1. All employees at the time of hire are required to attend General Hospital Orientation. This includes information presented by EH&S personnel, where general information and education regarding the environment of care and safety are provided.
   2. At the department level, training is specific to processes, materials, precautions and work practices/behaviors relative to the individual job functions and risks (can include roles during safety inspection, accident/incident reporting, notification and recall processes, preventative maintenance and correct use of equipment). Department managers will verify that each employee possesses the required core competencies with respect to safety and the environment of care. Technical consultative support is provided through EH&S.
   3. Human Resources, EH&S and department managers will periodically revisit their training materials and modify, adjust and improve as indicated, to reflect:
      - The results of education and training needs assessments as determined through employee interview and written test/quiz scores and determinations made by the Central Safety Committee.
      - Organizational experiences and learning, including relevant performance indicator results reported and discussed by the Central Safety Committee.

- Results of risk assessments, environmental hazard surveillance rounds, audits, inspections and environmental and industrial hygiene monitoring.
- Injury/illness trends.
- Changes in applicable laws, regulations, codes or standards.
- Integrated Safety Committee or EH&S manager recommendations.
- Continuing education in Environment of Care areas will be conducted at least annually utilizing the on line safety fair, or presentations by manager or technical expert.

J. The mandatory training and education program provides required EOC elements, to include Safe Environment, Fire Prevention, Secure Environment, Medical Equipment, Utility Management, Hazardous Materials & Waste Management, Emergency Management, and Infection Control.

K. Department specific safety plans are used to detail the specific hazards, safety precautions, and emergency plans for that area.

L. Management of Hazardous Materials and Waste is conducted in a manner that controls risks of harm as well as ensures compliance with applicable legal requirements. Program implementation will include employee training, identification and inventory of the hazardous materials and the identification and management of hazardous waste streams.

M. Identifying and addressing significant concerns pertaining to the management of equipment, utilities and facility grounds.

N. The establishment of an effective Emergency Management program which is written using a multi-hazard functional planning approach and is based on the nationally recognized "Hospital Incident Command System" model. Semi- annual exercises are conducted to test program effectiveness.

O. No Smoking Policy: El Camino ~~Hospital~~Health has a facility-wide no-smoking policy. No smoking is allowed on the campus property. Smoking cessation education, information, and options are provided to patients who smoke. Security, along with the entire medical center staff monitors compliance with this smoking policy.

P. Other Environmental Considerations:

   a. The hospital will plan, develop and maintain an environment that is safe, supports healing assists in achieving positive patient outcomes and consistently meets patients' needs.

   b. Facility Services, with Administration, EH&S, and Infection Prevention will ensure planning for remodels, renovations, alterations, modifications and new facilities takes into consideration appropriate space, equipment, privacy, utility systems, etc.

      1. Design criteria for size configurations, equipment, utilities and life safety systems will include:
         - Office of Statewide Health Planning and Development (OSHPD) permitting protocols
         - Uniform Building Code- 24 CCR, section 420A et seq
         - AIA Guidelines for Design and Construction of Health Care Facilities
         - Life Safety Code- NFPA 101
         - Standards, specifications and criteria referenced by health care community or industry consensus
      2. Appropriateness of Space, Furnishings, and Equipment:

Facilities Services will work with Nursing and Administration to make certain the design of remodeled areas and new spaces and the maintenance of existing areas are comfortable, safe, and aesthetically pleasing.
Engineering maintains utilities and services to ensure the mechanical ventilation system provides acceptable levels of temperatures, relative humidity and removal of odors. Adequate space is provided within patient rooms for personal property, clothing and grooming articles.

3. Appropriate Privacy and Confidentiality

   Facilities Services and clinical staff will ensure appropriate confidentiality, auditory and visual privacy. Efforts to accomplish this include:

   - Space & equipment arrangement
   - Privacy curtains and partitions
   - Assisting patients (when appropriate) to don gowns while preserving patient privacy and dignity
   - Access to telephones for private conversations (where clinically appropriate). Reasonable accommodations will be given to physically challenged patients
   - White boards should only display patient information for staff members (no diagnostic, patient condition, disposition or other sensitive/personal information)
   - Staff will respect the rights of patients and refrain from conversations involving medical condition, diagnoses, prognoses or any other personal information in open/public areas.
   - Confidential patient documentation that is no longer needed will be managed in a secure and appropriate manner from the point of generation to final disposition.

PROGRAM PERFORMANCE

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Central Safety Committee recommendations.

A. Intent and Requirement
   To monitor, assess and improve staff knowledge, skills and competencies with respect to their roles and responsibilities to the Safe Environment Management Plan.

B. Performance Standard
   The FY-~~21~~2022 Performance Improvement ~~Indicators~~indicators are:

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Reduce employee injuries related to ~~assisted patient~~slips, trips and falls.	EWHS / ~~Fall~~Falls Committee	Reduce employee injuries related to ~~assisted patient~~ falls by ~~25~~15%.
~~Safety~~	~~Deploy new AIER injury reporting system under RLDatix~~	~~EWHS~~	~~We expect this implementation will increase end-user satisfaction. Increase injury investigation completion within 3 days after the injury by 10%.~~

C. Frequency of Measurement and Process

All injury data is collected through Accident Injury and Exposure Reports (AIER). Incidents will be reviewed by the applicable committee as appropriate for corrective actions and then reported to the Central Safety committee monthly.

EVALUATION OF PROGRAM EFFECTIVENESS

Through the Safety Trends report and the Central Safety Committee, the effectiveness of the program, including the appropriateness of design, outcomes of implementation, training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the safety program to include: hazardous surveillance reports, occupational illness/injury investigation reports, staff educational surveys, security incidents, medical device incidents, fire drills, and disaster exercises

ANNUAL PERFORMANCE EVALUATION

On an annual basis, the safe environment program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Safety Officer and approved by the Central Safety Committee.

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

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Catherine Carson: Senior Director Quality [PS]	01/2022
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator [PS]	12/2021
Patient and Employee Safety Committee	Delfina Payer: Projects Coordinator	11/2021
Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety	11/2021
	Matthew Scannell: Director Safety & Security Services [JH]	10/2021

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Owner:	*Mari Numanlia-Wone: Mgr Emp Wellness & Health Svcs*
Area:	*Employee Wellness & Health*
Document Types:	*Plan*

HR - Respiratory Protection - Plan

COVERAGE:

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

PURPOSE:

To provide a safe and effective environment of care through the appropriate use of respiratory protective equipment. El Camino Hospital policy and procedures for the selection, use and maintenance of respirators must be followed to comply with Federal OSHA Standard 29 CFR 1910.134, 1910.139 (Standard for respiratory protection for mycobacterium tuberculosis), and Cal/OSHA General Industry Safety Order CCR Title 8, 5144.

POLICY STATEMENT:

Whenever possible, through the use of engineering controls, the level of airborne hazardous substances in the work environment will be below levels that require the use of respiratory protection. When this is not possible, protection of employees from exposure will be through the correct use of respiratory protective equipment. Respirators are the least preferred method of protection from inhalation hazards and shall not be used in any work area unless approved through Employee Wellness and Health Services (EWHS).

REFERENCES:

- Respiratory Protection - Aerosol Transmissible Disease (ATD) Respiratory Protection Program

PROCEDURE:

A. Responsibility for Respiratory Protection
   1. Employee Wellness and Health Services (EWHS) is responsible for the development and implementation of the Respiratory Protection Program, with accountability to the Central Safety Committee and Safety Officer for effectiveness.
      a. Program administration is conducted by EWHS in collaboration with departmental managers.
   2. Department Managers are responsible for identifying potential airborne hazards, and notifying EWHS. Further evaluation of any hazard that might require respiratory protection will be evaluated by EWHS. When respirators are required, managers will ensure that employees are in compliance with all requirements of the respiratory protection program including medical clearance for respirator use,

training, appropriate fit testing (as required), proper respirator inspection fit checks prior to use, and maintenance of respirator.

3. Employees who are required to use respirators for protection are to follow all guidelines and procedures in accordance with instructions and training. They should report any environmental observations or health conditions which might affect the effectiveness of their protection to their supervisor or EWHS. The respirator user is responsible for routine inspection, cleaning, maintenance and storage of their respirators, and must report any defective equipment immediately to their supervisor.

B. Aerosol Transmissible Diseases (ATD)

1. El Camino Hospital provides the protections required by Cal/OSHA Section 5199 if a disease or pathogen requires airborne infection isolation or droplet precautions. See ~~*Safety 1.13.1*~~ *Aerosol Transmissible Disease (ATD) Respiratory Protection Program* for specific requirements and procedures.

C. Respirator Selection

1. **Powered Air-Purifying Respirators (PAPRs)** – PAPRs are the primary protective equipment to be used by staff when assisting patients in airborne isolation or during high-hazard procedures (see *Respiratory Protection - Aerosol Transmissible Disease (ATD) Respiratory Protection Program*).

   a. ~~Medical~~Respirator medical evaluations and fit testing are not required for use of positive air purified respirators (PAPRS).

2. **Full / Half-face Respirators** – Staff requiring the use of full or half-face respirators shall receive annual respirator medical ~~evaluations~~evaluation and fit testing.

   a. ~~Medical~~Respirator medical evaluations will be coordinated by EWHS ~~and done in the Pulmonary Function Lab by Respiratory Therapy~~

3. **Chemical PAPRs** – PAPRs with chemical filters may be utilized for specific hazards involving contaminated patients. Fit testing and respirator medical evaluations are not required for PAPR use. Training on the use of chemical PAPRs for Emergency Department staff will be conducted during the ~~Decontamination Training~~decontamination training. Supplemental staff training may be done at the time of the event.

4. **N-95 Masks/Respirators** - N-95 filter masks shall be used only in areas where it has been determined that PAPRs cannot be utilized (i.e., Operating Rooms, MRI).

   a. ~~Medical~~Respirator medical evaluations for N-95 filter-mask respirators will be coordinated as needed through EWHS.

   b. In the event of a situation where N-95 masks must be used, just-in-time respirator medical evaluations and fit testing will be coordinated by EWHS.

D. Responsibility for Equipment

1. Each department is responsible for respirator related costs including maintenance, replacement parts, as well as specialized annual training and fit testing.

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

N95 Resp Fit Qx Respirator Evaluation Form.pdf
N95 Respirator Competency Checklist.pdf

Approval Signatures

Step Description	Approver	Date
Board of Directors	Stephanie Iljin: Manager Administration	pending
MEC	Catherine Carson: Senior Director Quality [PS]	01/2022
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator [PS]	12/2021
HR Leadership and CHRO	Tamara Stafford: Dir Talent Development & EWHS	11/2021
	Mari Numanlia-Wone: Mgr Emp Wellness & Health Svcs	11/2021

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Area:	*Emergency Management*
Document Types:	

Emergency Management - Earthquake Response Plan

I. COVERAGE:

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

II. PURPOSE:

To ensure safety of patients, staff and visitors in the event of a major earthquake.

III. REFERENCES:

- HICS 306 - Clinical Department Status Form
- HICS 306 - Non Clinical Department Status Form
- HICS 251 – Facility System Status Report

IV. PROCEDURE:

Defined as “Provides system specific methods and appropriate actions required to perform a specific task for effective management of patient care, clinical or non-clinical issues.”

A. Response

1. Refer to attachment - HICS Critical Action Guide for guidance in responding to an earthquake.
2. Recovery from a major, nearby earthquake can take days, weeks or months, depending on its magnitude.
    a. Each department shall maintain a staffing callback list and will notify employees of staffing needs.
    b. Staff are also instructed to check the hospital website (www.elcaminohospital.org) social media, and to tune into KCBS (740 AM) for information on staffing needs at the hospital.
    c. Respond in accordance with this procedure and those developed by your department. A large-scale incident may develop into a Code Triage.
    d. Refer to checklists at the end of this document.

B. Training
All employees receive training on emergency preparedness plans and codes at General Hospital

Orientation upon hire and annually thereafter through Computerized Safety Training Program. Training is evaluated by a questionnaire provided to staff upon completion of the computerized training program and by actual drills.

C. Hazard Mitigation

1. The Safety Rounds Team inspects all departments in the hospital for hazards annually. Clinical departments are inspected semiannually, once by the Safety Rounds Team and once by staff in the department. This team evaluates equipment bracing, general safety and life safety deficiencies. A report of identified hazards is sent to each department manager and plant operations for correction. A report of correction is sent to the Hospital Safety Officer.

2. A major earthquake in the Bay Area could require activation of any one or a combination of the following El Camino Hospital emergency plans for:

- Fire
- Evacuation
- System failures
- Mass Casualty Incident (MCI)

V. CHECKLISTS:

Staff Response Checklist

Immediately upon sensing a significant earthquake:

☐	Remain in the building. Move away from windows, shelving or other furnishings/equipment that may topple or fall on you. Watch for falling objects such as ceiling tiles or light fixtures. Have patients cover their faces with bed linens for protection from falling glass. DO NOT: run for exits, stand in doorways or use elevators.
☐	Protect your head from falling debris. Find shelter under a sturdy desk/table or against an inside wall. **Duck, cover and hold till shaking stops.**
☐	If you are outside, get into open space away from buildings or power lines.
☐	Triage your immediate area. Identify major potential hazards such as fire, hazardous materials spill/release, flooding, electrical/trip hazards, and injuries to others nearby.
☐	Report significant findings to your supervisor.
☐	Minimize hazards to reduce further damage or injury. Turn off damaged equipment, and clear away debris for safe pathways. Prepare to extinguish a fire, avoid a hazardous materials spill/ release, flooding, and evacuate the area as necessary, taking medical records.
☐	Prepare for aftershocks. Move items that are likely to fall or move during an aftershock to a safer location (on the floor, out of the path, etc.).
☐	Units that have medical gases should be prepared to use emergency shutoff valves if necessary.
☐	*<u>Do not</u>* use hospital telephone system to call home or other family members as these lines will most likely be overloaded and urgently needed for hospital business.
☐	Be prepared to respond to changing work hours and duty assignments when directed. The hospital reserves the right to cancel vacations and days off, if necessary, in order to maintain

	critical hospital services.

Departments Checklist

☐	Supervisors are to report damages/injuries to the Hospital Command Center (HCC).
☐	Complete HICS 306 form:
	• Clinical Department Status Form • Non Clinical Department Status Form
☐	If instructed by the HCC, follow evacuation procedures.
☐	Do not immediately clean up damage from earthquake until photos have been taken to document damage, except for debris blocking exit hallways or evacuation routes.

Nursing Checklist

☐	Institute emergency life-saving procedures and medical attention to personnel and patients on the unit.
☐	Be prepared to relocate or evacuate personnel and patients from unit, taking records and medications, if possible.
☐	Move patients to interior walls, away from windows and glass; pull curtains; lock patient bed wheels (except newborn isolettes or infant cribs, which are prone to tip); place side rails up.
☐	Clean up any spilled medication, drugs or other hazardous materials.
☐	Ensure that ambulatory patients wear shoes to protect their feet from broken glass or sharp objects.
☐	Nursing and surgery personnel evaluate the medical gas and vacuum system in their area and report status to the HCC. It may be necessary to use portable oxygen and back-up anesthesia sources.

Engineering Checklist

☐	Assess damage and report the status of all critical utilities (HVAC, electrical, water, sewer, medical air and vacuum systems) to the HCC on the HICS 251 - Facility System Status Report.

All Clear

☐	Return to your normal work duties, unless otherwise directed. Dial Ext. 55 for all emergencies at the Mountain View and Los Gatos campuses. Dial 9-911 at other locations.

Note: Following the emergency incident, the Department Manager(s) of the affected area(s) shall participate in a debriefing and provide all documentation to the Documentation Unit Leader.

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

Attachments

Earthquake - Bed Availability Discharge Form.docx
Earthquake - HICS Critical Action Guide.docx

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Catherine Carson: Senior Director Quality [PS]	01/2022
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator [PS]	12/2021
Emergency Management Committee	Steve Weirauch: Mgr Environmental Hlth&Safety	12/2021
	Steve Weirauch: Mgr Environmental Hlth&Safety	12/2021

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Area:	*Emergency Management*
Document Types:	

Emergency Management - Hospital Surge Plan

I. PLANNING ASSUMPTIONS:

Assumptions are statements of conditions accepted as true and that have influence over the development of a system. The following were identified as surge capacity planning assumptions:

A. The need to self-sustain care within the facility for a minimum of 96 hours without re-supply of equipment, supplies and staff.

B. The inability to expect mutual aid from outside your facility for at least 96 hours.

C. The expectation that 40% of staff will not report to work due to inability to get there, illness or safety concerns.

D. Reported surge capacity must be that which exists above average daily occupancy (census).

E. Average Daily Occupancy (census) is computed as the average daily number of occupied beds over the preceding year.

F. Austere Nurse-to-Patient ratio of 1:5 for Critical Care Beds (Monitored Beds) and 1:20 for other Medical Surgical Beds (Unmonitored).

G. Measure resources only under hospital control.

II. DEFINITIONS:

- **Risk Communication** – The process of providing concise, comprehensible, and credible information, as needed to make effective decisions regarding risks. In emergency management/incident response, risk communication is generally considered to be providing a service to those outside of the incident command system, with the goal of influencing behavior.[1]
- **Joint Information Center (JIC)** – A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should collocate at the JIC.[2]
- **Joint Information System (JIS)** – A system that integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, timely information during crisis or incident operations. The mission of the JIS is to provide a structure and system for developing and delivering coordinated interagency messages; develop, recommend, and execute public information plans and strategies on behalf of the Incident Commander (IC); advise the IC concerning public affairs issues that could affect a response effort; and control rumors and inaccurate information that could undermine public confidence in the emergency response effort.[3]

[1] Adapted from Baruch Fischhoff. Risk Perception and Risk Communication. Prepared for D. Kamien (ed) The McGraw-Hill Handbook of Terrorism, August 11, 2004.

[2] As defined by National Incident Management System (NIMS).

[3] As defined by NIMS.

III. REFERENCES:

A. Emergency Operations Plan

B. Crisis Care Management Plan (Plan to Ration Resources)

C. EMTALA - Providing Emergency Services to Individuals Outside the Emergency Department

D. Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA)

E. COVID-19 Control Plan

F. Pandemic Plan

G. Infection Control: Seasonal Influenza Plan

IV. COMMUNICATIONS SYSTEMS

A. Overview
During a surge situation, communication among county hospitals (specifically, buddy hospitals designated by the **County of Santa Clara Hospital Mutual Aid System Memorandum of Understanding [MOU])**, and between hospitals and the **Santa Clara County Public Health Department Emergency Operations Center (EOC)** is essential. Below is information from the Countywide Medical Response System Coordinator outlining communications between hospitals and the EOC during an emergency situation.

B. EMResource

1. *If EOC is "Not Activated:"*
    - Immediately change your facility's EMResource status to Internal Disaster (black) or other appropriate ED Diversion or Trauma Bypass status. This change will cause the EMS Duty Chief to be immediately paged by EMResources as well as County Communications.
    - Contact the EMS Duty Chief to notify Public Health of the potential need for EMS support/response.
    - The EMS Duty Chief is available by contacting County Communications via the "red phone" located in the Emergency Department.
        - If the "red phone" is not accessible, contact the EMS Duty Chief at (408) 998-3438.
    - In the event of total landline telephone failure, hospitals may contact County Communications on the **EMS Command SB EMS 2** radio and request the EMS Duty Chief.
        - The radios are available in the Emergency Department and from the Director of Safety/Security.
2. *If EOC is at "Limited Activation" or "Full Activation":*

- Contact the EOC directly for all requests, status reports, and coordination.
- In cases when the EOC status is identified as "Monitoring," follow the process above. (The "Monitoring" status is an internal Public Health Department designation that means that the EOC is at a heightened level of readiness. This may occur at times where intelligence indicates that the medical-health system may be impacted locally, regionally, or statewide.)
- In the event of landline telephone failure, the EOC may be contacted by using the **EMS Command SB EMS 2** radio.
  - Hospitals should also monitor EMS Command SB EMS 2 radios, as additional communication instructions may be identified (need to access RACES/ARES, HAM radio, etc.) should landline communications fail.

3. *Contact EOC by Using EMS* ***Command SB EMS 2*** *radios*
   Hospitals may also communicate with the EOC by using EMS Command SB EMS 2 when allocated for an event. In such cases, hospitals will be informed via all available communications means (EM Resources, radio, landline, email contacts, etc.) that the channel is available.
4. *Documentation*
   Upon request, each hospital should submit (email, fax, Amateur Radio Packet) the *Hospital Status Report Form* (DOC-9) to the EOC within five minutes of notification. It is not necessary to complete the entire form within five minutes, but only the information that is known at the time of the request. A complete or updated form may be submitted at any time.
   - **Note:** See attachment: Public Health Emergency Communications Reference Guide for more information on communication between hospitals and the EOC.

V. RISK COMMUNICATIONS:

To the fullest extent possible under the circumstances of healthcare surge, El Camino Health will provide the community with accurate information about the nature of the healthcare surge. The following points should be kept in mind:

- Moving to a population-based set of treatment protocols represents a radical departure from patient-based decision making. It is essential that efforts be made well in advance of a surge event to generate public understanding and acceptance for the change.
- Messages should be as consistent and timely as possible at all stages.
- Official health and medical care messages should be delivered through public media by the Santa Clara County Public Health Officer, the California State Health Officer, a representative of the Centers for Disease Control and Prevention (CDC), or the Surgeon General, depending on the level of communication necessary.
- Spokespersons at all levels (local, state, regional, and federal) should coordinate their messages.
- Modes of communication should be tailored to the type of information to be communicated, the target audience for which it is intended, and the operating condition of media outlets, which may be directly affected. The need to include languages other than English and the use of alternative communication channels outside of usual media outlets are examples of specific concerns. Also, specificity and details within messages would vary by target population (affected area vs. neighboring area vs. the rest of the state).

A. Realities of Risk Communication[1]

   1. Telling the truth increases credibility

2. Informing the public of your progress will help maintain order
3. Bad communication can escalate the situation
4. Communication is the job of everyone who deals with people during a crisis

B. Who Needs Information in a crisis
1. Victims – sick, wounded, contaminated
2. Families of victims and non-victims
3. Personnel – medical staff, volunteers, resource personnel, security
4. Worried-Well – internal and external
5. Emergency Responders – community, state, national
6. Media (public)

C. Responding to the Worried-Well
- People who are upset have difficulty hearing and understanding. It is important to acknowledge their fear and concern and provide a gathering place and resources such as counselor, clergy, phone, TV news, water, and food. It is also important to provide accurate information as it becomes available even if it's not good news. The Public Information Officer (PIO) or designee should offer regular updates which avoid jargon and provide actionable next steps.

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[1] Adapted from: Navy Environmental Health Center (NEHC) Risk Communication Program.

VI. TRANSPORTATION:

A. Overview
The transportation of resources – including supplies, equipment, pharmaceuticals, patients and personnel, either to or from the facility, is an essential element of successfully managing a surge situation. It is important to plan ahead and know the transportation options available to the facility. The inability to access roads and facilities must also be taken into account in planning, and alternative methods taken into consideration.

B. Roles and Responsibilities
1. ***Incident Commander*** *will implement and coordinate hospital transfer agreements, as needed.*
2. ***Logistics/Material Management*** *will direct operations associated with maintenance of the physical environment, and adequate food, shelter and supplies.*
3. ***Transportation Unit Leader*** *is responsible for assessing and requesting additional transportation needs, both internally and externally.*
4. ***Care Coordination Staff*** *will offer patients or family rides home at discharge by taxi if they are having problems with transportation.*
5. ***Nursing Directors, Managers, and Supervisors*** *will organize, or realign and transfer staff, as needed.*

C. Transportation of Resources

1. *Staff (employees, contract workers, volunteers, etc.)*
    a. Transportation to and from work, alternate care sites, etc., as needed.
    b. Assist with transportation of staff family members, as needed.
2. *Patients*
    a. See ***Emergency Management - Hospital Surge Plan - Patient Management***, with attached forms.
3. *Supplies, Materials, and Equipment (Acquiring and Transferring)*
   Local and distant transportation routes may be compromised due to the specific disaster. Hospitals need to:
    a. (Pre-event) Identify, in advance, alternate routes and means of transportation.
    b. (During event) Contact the State Department of Transportation for specific information regarding road conditions.[1]

[1] California Department of Health Services/PricewaterhouseCoopers, *Volume 1: Hospitals Management & Administrative Draft*, 2007.

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

Public Health Emergency Communications Reference Guide.docx

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Catherine Carson: Senior Director Quality [PS]	01/2022
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator [PS]	12/2021
Emergency Management Committee	Steve Weirauch: Mgr Environmental Hlth&Safety	12/2021
	Steve Weirauch: Mgr Environmental Hlth&Safety	12/2021

Summary of Financial Operations

Fiscal Year 2022 – Period 6

7/1/2021 to 12/31/2021

Executive Summary - Overall Commentary for Period 6

- Continued strong financial results for Period 6 driven by:
  - Outpatient procedural activity and growth in emergency department visits
  - When adjusted for volume increase, costs are being managed effectively
  - Year-over-year improvement in commercial payor mix from 40.8% to 43.7%
- Total gross charges, a surrogate for volume, were favorable to budget by $41.2M / 10.5% and $65.5M / 17.8% higher than the same period last year.
  - Favorable outpatient charges of $45.9M were partially offset by a marginally unfavorable charge variance for inpatient services -$5.3M.
- Net patient revenue was favorable to budget by $15.5M / 15.8%% and $20.7M / 22.5% higher than the same period last year due to continued strong growth and stable payor mix.
- Operating margin was favorable to budget by $10.5M / 141.0% and $11.1M / 160.3% better than the same period last year.
- Operating EBIDA was favorable to budget by $11.2M / 77.2% and $11.7M / 83.7% better than the same period last year.
- Net days in A/R decreased from 58.8 to 50.1 days, this is attributed to the anticipated payment of aged claims by a large commercial payor.
- Unrealized gains on our investments of $16.1M contributed to Net Income of $35.6M which is $19.8M / 125.0 % favorable to budget and $28.7M / (44.6%) lower than prior year.

El Camino Health

Operational / Financial Results: Period 6 – December 2022 (as of 12/31/2021)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	255	266	(10)	-3.9%	245	10	4.1%	---	---	---
	Total Acute Discharges	1,744	1,788	(44)	-2.4%	1,595	149	9.3%	---	---	---
	Adjusted Discharges	3,576	3,232	344	10.6%	3,010	566	18.8%	---	---	---
	Emergency Room Visits	6,281	4,638	1,643	35.4%	5,065	1,216	24.0%	---	---	---
	OP Procedural Cases	13,706	9,872	3,834	38.8%	14,538	(832)	(5.7%)	---	---	---
	Gross Charges ($)	433,046	391,856	41,190	10.5%	367,494	65,552	17.8%	---	---	---
Operations	Total FTEs	3,061	3,052	9	0.3%	2,873	188	6.5%	---	---	---
	Productive Hrs. / APD	28.7	31.3	(2.6)	(8.4%)	30.0	(1.3)	(4.4%)	---	---	---
	Cost Per CMI AD	16,698	17,952	(1,254)	(7.0%)	16,257	440	2.7%	---	---	---
	Net Days in A/R	50.1	49.0	1.1	2.3%	46.5	3.6	7.7%	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	113,033	97,572	15,461	15.8%	92,289	20,744	22.5%	138,547	82,105	
	Total Operating Revenue ($)	116,681	101,673	15,008	14.8%	95,368	21,313	22.3%	152,743	109,602	
	Operating Margin ($)	**18,016**	**7,475**	**10,541**	141.0%	**6,922**	**11,094**	160.3%	**1,915**	**3,836**	
	Operating EBIDA ($)	**25,608**	**14,452**	**11,156**	77.2%	**13,940**	**11,668**	83.7%	**11,188**	**10,741**	
	Net Income ($)	35,596	15,818	19,778	125.0%	64,279	(28,682)	(44.6%)	8,124	7,343	
	Operating Margin (%)	**15.4%**	**7.4%**	**8.1%**	110.0%	**7.3%**	**8.2%**	112.7%	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**21.9%**	**14.2%**	**7.7%**	54.4%	**14.6%**	**7.3%**	50.1%	**8.3%**	**9.8%**	
	DCOH (days)	335	325	10	3.2%	377	(42)	(11.1%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021. 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 30, 2021. Dollar amounts have been adjusted to reflect monthly averages.
DCOH total includes cash, short-term and long-term investments.

El Camino Health

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

Operational / Financial Results: YTD FY2022 (as of 12/31/2021)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	265	248	17	6.9%	240	25	10.5%	---	---	---
	Total Acute Discharges	10,492	9,951	541	5.4%	9,330	1,162	12.5%	---	---	---
	Adjusted Discharges	20,713	18,472	2,240	12.1%	17,547	3,166	18.0%	---	---	---
	Emergency Room Visits	33,367	25,438	7,929	31.2%	25,122	8,245	32.8%	---	---	---
	OP Procedural Cases	77,443	61,448	15,995	26.0%	77,134	309	0.4%	---	---	---
	Gross Charges ($)	2,511,327	2,251,434	259,893	11.5%	2,105,782	405,545	19.3%	---	---	---
Operations	Total FTEs	3,017	3,049	(32)	(1.0%)	2,788	229	8.2%	---	---	---
	Productive Hrs. / APD	28.6	31.9	(3.3)	(10.2%)	30.9	(2.2)	(7.2%)	---	---	---
	Cost Per CMI AD	16,291	17,952	(1,661)	(9.3%)	16,875	(584)	(3.5%)	---	---	---
	Net Days in A/R	50.1	49.0	1.1	2.3%	46.5	3.6	7.7%	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	637,954	570,042	67,913	11.9%	532,989	104,966	19.7%	831,284	492,628	
	Total Operating Revenue ($)	660,049	592,476	67,573	11.4%	556,320	103,730	18.6%	911,456	657,613	
	Operating Margin ($)	**88,387**	**39,552**	**48,835**	123.5%	**35,884**	**52,503**	146.3%	**11,489**	**23,016**	
	Operating EBIDA ($)	**133,095**	**81,886**	**51,209**	62.5%	**78,266**	**54,829**	70.1%	**67,130**	**64,446**	
	Net Income ($)	100,940	85,869	15,071	17.6%	177,512	(76,572)	(43.1%)	48,747	44,060	
	Operating Margin (%)	**13.4%**	**6.7%**	**6.7%**	100.6%	**6.5%**	**6.9%**	107.6%	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**20.2%**	**13.8%**	**6.3%**	45.9%	**14.1%**	**6.1%**	43.3%	**8.3%**	**9.8%**	
	DCOH (days)	335	325	10	3.2%	377	(42)	(11.1%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021
DCOH total includes cash, short-term and long-term investments.

El Camino Health

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

Period 6 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 12/31/2021)
($000s)

	Period 6- Month			Period 6- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	13,426	7,400	6,025	78,671	39,460	39,210
Los Gatos	7,494	3,133	4,361	25,886	17,949	7,937
Sub Total - El Camino Hospital, excl. Afflilates	**20,919**	**10,533**	**10,386**	**104,556**	**57,409**	**47,147**
Operating Margin %	**18.6%**	**10.9%**		**16.6%**	**10.2%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**16,295**	**7,846**	**8,449**	**10,620**	**44,569**	**(33,950)**
El Camino Hospital Net Margin	**37,215**	**18,379**	**18,835**	**115,176**	**101,978**	**13,197**
ECH Net Margin %	**33.1%**	**19.0%**		**18.3%**	**18.1%**	
Concern	98	268	(169)	982	416	566
Foundation	1,148	(16)	1,164	985	(15)	1,000
El Camino Health Medical Network	(2,865)	(2,813)	(52)	(16,202)	(16,510)	308
Net Margin Hospital Affiliates	**(1,618)**	**(2,561)**	**943**	**(14,236)**	**(16,109)**	**1,874**
Total Net Margin Hospital & Affiliates	**35,596**	**15,818**	**19,778**	**100,940**	**85,869**	**15,071**

El Camino Health

CONFIDENTIAL
EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Board of Directors
From: Mark Adams, MD, FACS
Date: February 9, 2022
Subject: Renewal of MV ED & Inpatient On-Call Interventional Radiology Panel Agreement

Recommendation: Request that the Board of Directors approve delegating to the Chief Executive Officer the authority to execute a two-year renewal of the Mountain View Interventional Radiology ED & Inpatient Call Coverage Agreement at the current rate of $1,100 per day, for a total not to exceed annual compensation of $401,500, to be effective March 1, 2022.

Summary:

1. Situation: ECH has separate Interventional Radiology Call Panels at each campus in which Interventional Radiologists respond when needed for emergency evaluations and interventions for patients in the Emergency Department and for inpatient interventional radiology consults. The MV ED & Inpatient On-Call Interventional Radiology Panel consists of four (4) Palo Alto Medical Foundation ("PAMF") physicians who provide Interventional Radiology call coverage services at the existing rate of $1,100 per day for 24/7/365 coverage at the Mountain View campus. The current agreement expires February 28, 2022.

PAMF requested an increase to $1,200 per day upon renewal, however ECH rejected their request stating that the current rate already exceeds the 75th percentile for fair market value. PAMF agreed to renew the agreement for an additional two years at the current rate and terms.

2. Authority: According to the Physician Financial Arrangements Review and Approval Policy, Finance Committee recommendation and Board approval are required prior to the Chief Executive Officer signature of physician agreements that are greater than $250,000 in total annual compensation and exceed the 75th percentile for fair market value.

3. Background: Since March 2015, PAMF physicians have provided Interventional Radiology 24/7/365 call coverage services at the Mountain View campus.

4. Fair Market Value Assessment: Compensation will be constrained to a not to exceed amount of $1,100 per day and $401,500 per year, which is between the 75th percentile ($1,000) and 90th percentile ($1,160), according to the 2021 MD Ranger Radiology-Interventional ED Call Coverage Per Diem Report for general acute care hospitals in the SF Bay Area.

5. Legal and Compliance Reviews: On January 31, 2022, the Finance Committee recommended that the Board of Directors approve the renewal agreement. Legal and Compliance will review the final renewal agreement and compensation terms prior to execution by the Chief Executive Officer.

6. Outcomes: Physicians will participate in the peer review process for consultations related to Interventional Radiology call.

El Camino Health

CONFIDENTIAL
EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To:	Board of Directors
From:	Mark Adams, MD FACS, Chief Medical Officer
Date:	February 9, 2022
Subject:	Renewal of Enterprise Radiology Professional Services Agreement

Recommendation: Request that the Board of Directors approve delegating to the Chief Executive Officer the authority to execute a renewal of the Enterprise Radiology Professional Services Agreement for exclusive, 24/7/365 diagnostic imaging services to ECH patients, including mammography screenings and services to uninsured, indigent women in the ECH community, at a reduced, not to exceed annual compensation of $497,000, to be effective March 1, 2022 for a term of three years.

Summary:

1. Situation:

   - ECH is contracted with Silicon Valley Diagnostic Imaging, Inc. (SVDI) to provide exclusive, enterprise responsive review and interpretation of radiological 24/7/365 to ensure the emergency department and inpatient physicians can make immediate decisions as to appropriate patient care, regardless of the time or day for the services. This agreement expires February 28, 2022.

   - Currently, ECH pays an annual amount of $525,600, plus additional payments at Medicare rates for:

     - Charity Mammography Services $25,000 *(paid in FY21)*
     - Low Dose CT Scan and Lung Cancer Screens $15,172 *(paid in FY21)*
     - CT Calcium Scoring Tests $43,189 *(paid in FY21)*

   - ECH engaged ECG Management Consultants Inc. (ECG) to conduct an evaluation of our Radiology Program and perform a fair market value opinion for the renewal agreement. Based on the recommendations proposed by ECG, ECH will negotiate compensation and terms with SVDI for a three-year renewal term not to exceed $497,000 per year, plus the additional payments at Medicare rates for: 1) Charity Mammography Services, 2) Self-Pay patients for Low Dose CT Scan and Lung Cancer Screen, and 3) Self-Pay patients for CT Calcium Scoring.

   - The annual amount of $497,000 per year will include an at-risk pool amount that will be distributed to SVDI upon achievement of negotiated response and turnaround times.

2. Authority: According to Administrative Policies and Procedures 51.00, Finance Committee recommendation and Board approval are required prior to the Chief Executive Officer signature of physician agreements that exceed the 75th percentile for fair market value.

3. Background: Since 2009, SVDI has been providing exclusive enterprise 24/7/365 diagnostic imaging services to ECH patients.

4. Fair Market Value Assessment: ECG reviewed and determined that the proposed renewal agreement is commercially reasonable and above the 75th percentile for fair market value.

5. <u>Other Reviews</u>: The Finance Committee approved the proposed renewal agreement on November 11, 2021. Legal and Compliance will review the final renewal agreement and compensation terms prior to execution by the Chief Executive Officer.

6. <u>Outcomes</u>: The radiologists participate in quality assurance, risk management, utilization management, critical findings, and peer review activities. In the renewal agreement, performance standards and turn-around metrics will align with industry best practice targets, and progress will be reviewed on a quarterly basis. An at-risk compensation structure for meeting response and turn-around time metrics will be implemented in the renewal agreement.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Apurva Marfatia, MD, Enterprise Chief of Staff
Michael Kan, MD Chief of Staff Los Gatos
Date: February 9, 2022
Subject: Medical Staff Report – Open Session

Recommendation:

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

Summary:

1. Situation: The Medical Executive Committee met on January 27, 2022

2. Background: MEC received the following informational reports.

A. Quality Council – The Quality Council met on January 5, 2022. Reports and performance dashboards were reviewed and approved from the following ECH Departments/Service Lines:
   1. Annual PI Report Spine
   2. Spine Service Line Dashboard
   3. Urology Annual PI Report
   4. Urology Dashboard
   5. Annual PI Report Respiratory
   6. Respiratory Dashboard
   7. Annual PI Report Sleep Center
   8. Sleep Center Dashboard

B. Leadership Council – The Leadership Council met on January 11, 2022, and discussed the following:
   1. Medical Staff Donation ($1,000) Second Harvest
   2. 2022 Doctor's Day Gift
   3. Vice Chief of Staff: Nomination/Election Timeline
   4. Changes in Administrative Leadership
   5. Bias Training - Update

C. The CEO Report was provided
D. The CMO Report was provided
E. The CNO Report was provided

List of Attachments: None

Suggested Board Discussion Questions: None

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Governance Committee
From: Don Watters, Chair, Governance Committee
Date: February 9, 2022
Subject: Board Member Recruitment and Benefits

Purpose:

To update the Board on the recommendation from the Governance Committee regarding strategies for recruiting Board and Community Members to the Hospital Board and its Advisory Committees.

Recommendation(s):

At this time, the Governance Committee recommends that the El Camino Board of Directors not offer any additional compensation, including healthcare benefits, to members of the Board and its Advisory Committees.

Summary:

1. Situation: The Board requested that the Governance Committee recommend tactics that can attract exceptionally qualified appointed Board and Community Members. These tactics could include, but will not be limited to, healthcare benefits and other forms of compensation.

2. Authority: As the governing body of El Camino Hospital, the Board of Directors approves any compensation or benefits provided to members of the Hospital Board. The Governance Committee may make recommendations.

3. Background: The Governance Committee previously discussed offering medical benefits to Board members. Through those discussions, committee members raised the larger question of how other strategies might be employed to enrich the membership and discourse within the Board at El Camino Health.

4. Assessment: While there is limited market data available on what drives board members to serve on a specific organization's board, most individuals are attracted by the opportunity to stay involved in business-related issues, networking with peers and potential community recognition. Furthermore, these factors differ fairly significantly among for-profit and non-profit boards. While compensation can be a meaningful factor in attracting an individual to serve on a for-profit board, non-profit board members are more interested in the aspect of community service enabled by a tie to the mission of the organization. In addition, non-profit board service can be viewed, and utilized, as a stepping stone into board service at larger for-profit organizations.

From a benefits perspective, as it's generally very uncommon to provide benefits to board members, although this is less unusual among public health districts, given board members' employment status (21% of public health districts in CA provide benefits to board members, and 26% of these organizations pay their board members).

El Camino Health can also consider relationships with local universities and organizations that prepare executives for board positions. Leveraging these resources would allow for local expertise amongst Board and Committee members that would ultimately improve the governance of El Camino Health.

5. Other Reviews: During the assessment, El Camino engaged outside counsel, executive compensation and benefits consultant, plan carriers and administrators, and benefit consultants.

6. Outcomes: N/A

List of Attachments:

1. None

Suggested Board Discussion Questions:

1. None

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: El Camino Hospital Board of Directors
From: Julie Kliger, MPA, BSN, Quality Committee Chair
Holly Beeman, MD, MBA, Chief Quality Officer
Date: February 9, 2022
Subject: Quality, Patient Care and Patient Experience Committee

Purpose: To inform the Board of the work of the Quality Committee.
(The quality committee will meet 2 days before the board of directors meeting, which is after the submission of this memo.)

Summary:

1. Dr. Adams, CMO and Dr. Beeman, CQO have reviewed the Fiscal Year 2nd Quarter Board quarterly dashboard and provide the following overview.
   a. Safe Care:
      i. Focused efforts to reduce catheter associated urinary tract infections have been successful. The CAUTI rate has improved from 1.32 in Q1 to 0.79 in Q2. The last CAUTI was 9/18/2021.
   b. Timely:
      i. ED throughput continues to lag behind target. Contributing factors are increased patient volume, increased acuity of patients, the need for continued COVID testing, high inpatient census in CCU and PCU resulting in a patient's boarding in the ED while awaiting an available 'acuity appropriate' staffed bed.
         1. Interventions have included improvement in early discharge of inpatients. Care coordination teams have focused on proactive and timely discharge planning. A test only site was deployed at both campuses to decant these 'healthy' patients requesting COVID testing only from overwhelming already busy ED beds and care teams.
      ii. Stroke measures
         1. Time to IV therapy (TTITT) has been adversely affected by technical and training challenges of tele neurology program and delays in radiology CT reading times. Counter measures are in place for both of these improvement opportunities.
         2. Door to groin time is longer than desired for five of the seven stroke patients in Q2. A root cause analysis is currently underway to evaluate possible interventions.
   c. Effective Care:
      i. Risk adjusted readmission Index is increasing (lower is better). This is multifactorial and the three areas having the greatest impact (negatively) on readmissions are an increase in patients readmitted with heart failure, alcohol withdrawal/cirrhosis and post-partum hypertension. A counter measure to reduce readmissions of heart failure patients underway is to utilize post-discharge phone calls to ensure patients are complying with

discharge care plans. Management is focused on performing a deeper analysis of the root cause of alcohol and post-partum patients.

   ii. Sepsis mortality index is improving.
   iii. Elective inductions and primary cesarean section performance is improving.

d. Efficient Care:
   i. Length of Stay is improving but still not at target. Management is exploring optimizing palliative care and GIP programs to better transition terminal patients, who are also long length of stay patients, to more appropriate care settings.

e. Equitable care:
   i. Management and the quality team has engaged our new diversity and inclusion manager to join our teams to ensure we are proactively and aggressively focusing on opportunities to tackle how SDOH affect our patients and community.

f. Patient centered:
   i. Patient experience performance in OB and ECHMN are making small improvements. The change is directionally correct but not to the degree expected or desired. An OB concierge resource will be introduced in Q3 in addition to discharge phone calls to our OB patients, which are post-partum and lactation specific. The patient experience team is now working closely with ECHMN leadership to focus on improving patient experience.

   ii. **Attachments:** FY22 Q2 Board Quality and Safety Dashboard

El Camino Health

Month to Quality Committee of the Board: February 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FY22 end of December (unless otherwise specified)

Quality Domain	Metric	Baseline FY 21	Target FY 22	Performance FY22, Q1	FY22, Q2	FY22, Q3	FY22, Q4	FYTD22 Total
Safe Care	Serious Safety Events Rate (Rolling 12 month)	3.13	2.97	2.44	2.46			**2.62**
	Surgical Site Infections (SSI)	0.30	1.0 (SIR)	0.36	0.29			**0.31**
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.37	<= 0.75	1.32	0.79			**1.07**
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.53	<= 0.50	0.35	0.00			**0.18**
	Modified PSI-90 CMS HAC Reduction Program (composite)	0.919	0.90	0.846	0.873			**0.807**
Timely	HVI STEMI % 1st Medical Contact to Device Time w/I 90 minutes	100%	100%	100% (13/13)	NA (available only up to Q1)			**100%**
	Patient Throughput - Median Time Arrival to ED Departure	264 min	256 min	267 min	284 min			**275 min**
	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	57.5% (14/23)	50%	25% (1/4)	10% (1/10)			**14.3%**
	Stroke: Door-to-Groin <= 75 minutes	16.7% (3/18)	50%	50% (1/2)	14.3% (1/7)			**22.2%**
	Stroke: Door-to-Groin <= 90 minutes	50% (9/18)	NA	50% (1/2)	28.6% (2/7)			**33.3%**
Effective	Risk Adjusted Readmissions Index	0.93	0.92	1.07	*0.96			**1.01**
	Risk Adjusted Mortality Index	0.86	0.90	0.99	0.87			**0.92**
	Sepsis Mortality Index	1.08	1.03	1.06	0.97			**1.03**
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 0.63%	1.3%	1.8%	*0%			**1.2%**
	PC-02 NTSV C-Section	ENT: 26.3%	23.5%	25.8%	*24.1%			**25.1%**
	ECHMN: CMS 165 Controlling High Blood Pressure	59.0%	>= 59%	60.0%	59.0%			**59.0%**
	ECHMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	30.0%	<= 30	24.0%	26.0%			**25.0%**
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.29	1.30	1.35	1.33			**1.34**
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 19)	<=1	0.99	1.0 (CA: 1.0, NA: 0.99)			**0.99**
Equitable	Hospital Charity Care Support	$19.7 mil	NA	7.2 mil	11.5k			**18.7 mil**
	Clinic Charity Care Support	$14.9k	NA	7.5k	3.0k			**10.5k**
	Language Line Unmet Requests	0.72%	<1%	0.62%	0.36%			**0.50%**
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.0	NA	4.3	4.03			**4.15**
		White: 3.89		3.77	3.88			**3.83**
		Asian: 3.57		3.59	3.67			**3.63**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	79.6	79.7	82.0	80.2			**81.2**
	ED - Likelihood to Recommend (PG)	76.1	76.5	73.1	75.7			**74.5**
	ECHMN - Likelihood to Recommend Care Provider (NPS)	76.0	77.4	74.1	75.6			**74.8**
	MCH - HCAHPS Likelihood to Recommend	81.8	82.0	79.4	80.5			**80.2**
	OAS - HCAHPS Likelihood to Recommend	85.7	86.1	85.5	87.6			**86.5**

Report updated 1/25/2022

*data available up to November only

STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

OPEN SESSION CEO Report
February 9, 2022
Dan Woods, Chief Executive Officer

Operations

The Heart & Vsacular Institute (HVI) received the Chest Pain – MI (Heart Attack) Registry™ Platinum Performance Achievement Award for 2021 from the American College of Cardiology. This is the highest award possible to achieve for outcomes for this patient population.

El Camino Health (ECH) made significant strides towards advanced care supporting our patients:

- In the ED, stroke medication administration was decreased to 5 seconds versus 60 minutes by converting from TPA (Activase) to TNK (Tenecteplase) for time sensitive clot bursting.
- The Imaging department added three studies were in December 2021. These include Functional MRI for depression therapy tracking, PET PSMA – for diagnosis and tracking of prostate cancer, and PET Cerianna – for estrogen reception breast cancer.
- Los Gatos Hospital invested in a “first-in-state of California” advanced spine navigation system that delivers care 1) more efficiently, 2) with less anesthesia, and 3) more visibility for the surgeon.

Human Resources

During the month of January, El Camino Health (ECH) implemented various counter measures to address staffing challenges resulting from the recent surge in COVID-19 cases. Thus far, the organization has been able to navigate the pandemic with minimal impact on patient care.

ECH distributed six at home COVID-19 tests to every employee so they have the capability of self testing. As the current surge begins to subside, we will continue to do everything necessary to ensure safe and effective staffing so we are able to provide the excellent level of care our patient deserve.

Information Services

The Provider Optimization Project, focused on improving the clinic physician experience, has implemented improvements in the EMR (Electronic Medical Record) to promote physician efficacy and satisfaction. Several features have been activated including enhanced search capabilities and the reduction of 1 million non-value added messages to the physician inbox with training support provided in the clinics. Results have been a 23% reduction in physician time spent in the EMR after clinic hours (Pajama Time) and achievement of Epic Gold Stars Level 9 for this area.

El Camino Health is currently 1 of 3 organizations receiving designation of Gold Stars 10 for achieving “Value from Data” which translates to roughly 0.5% of all Epic organizations. Recently, year over year (YOY) metrics have been added to the CEO dashboard depicting growth we have experienced in various key areas related to volumes and charges.

A tiered patient alarm system reduces alarm fatigue for clinicians by providing a different sound and volume for alarms based upon changes in patient condition. Previously the informative, yellow, and red alarms had the same volume which was a challenge for differentiating changes in patient status.

Philanthropy

El Camino Health Foundation’s 2022 annual giving campaign launched on October 27 and concluded on December 10, 2021. Six hundred eighty eight employees participated, 61 for the first time. Together they contributed $159,246 through payroll deductions and one-time gifts (compared to $178,000 last year). This generous support demonstrates the staff's exceptional commitment to our patients and hospitals, and confidence that their gifts make a difference.

In November, the foundation received a $367,000 gift from the estate of Jeffrey Knowpow, a grateful patient. "Jeffrey was very thankful, very appreciate of what the Cancer Center did for him," his partner Cathy Kong recalled. "We were graced with El Camino Health. In the hospital, everyone was kind, compassionate and professional. The nurses were like family. He got the best care he possibly could."

Corporate & Community Health Services

The Chinese Health Initiative (CHI) continues the partnership with Santa Clara County Public Health to provide COVID-19 updates and resources in Mandarin by the county communication's officer. CHI continues the strong partnership with the Mountain View Library to provide bilingual webinars on nutrition by a registered dietitian. CHI hosted a Qigong series to celebrate the Lunar New Year and conducted a webinar on Healthy Habits attended by over 100 individuals.

The South Asian Heart Center engaged 744 new and prior participants in screening, education, and coaching programs to prevent heart disease and diabetes. Completed 1309 consultations, workshops, and health coaching appointments. Raised $110K in year-end donation telethon from the South Asian community.

Auxiliary

The Auxiliary donated 2,035 volunteer hours for the month of December.