El Camino Health

AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, March 9, 2022 – 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: 940-2186-8407# 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. ENTERPRISE STRATEGY	Dan Woods, Chief Executive Officer	*public comment*	**motion required 5:35 – 5:55**
5. QUALITY COMMITTEE REPORT	Julie Kliger, Chair of Quality Committee Dr. Holly Beeman, Chief Quality Officer		**information 5:55 – 6:15**
6. ADJOURN TO CLOSED SESSION	Lanhee Chen, Board Chair	*public comment*	**motion required 6:15 – 6:16**
7. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Lanhee Chen, Board Chair		**information 6:16 – 6:17**
8. CONSENT CALENDAR *Any Board Member may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair		**motion required 6:17 – 6:18**
Approval *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board (02/09/2022) b. Minutes of the Closed Session of the Hospital Board Study Session (02/23/2022) ***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			
9. *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: **EL CAMINO HEALTH MEDICAL NETWORK**	Vince Manoogian, Interim President of Medical Network		**discussion 6:18 – 6:43**

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
10. Report involving *Gov't Code Section 54957(b) for discussion and report on personnel matters:* **CEO REPORT** *(Verbal)*	Dan Woods, Chief Executive Officer		**discussion 6:43 – 6:53**
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 6:53– 7:03**
12. ADJOURN TO OPEN SESSION	Lanhee Chen, Board Chair		**motion required 7:03 – 7:04**
13. RECONVENE OPEN SESSION/ REPORT OUT	Lanhee Chen, Board Chair		**information 7:04 – 7:05**
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 7:05 – 7:06**
Approval 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 (02/09/2022) c. Minutes of the Open Session of the Hospital Board Study Session (02/23/2022) ***Reviewed and Recommended for Approval by the Medical Executive Committee*** a. Medical Staff Report b. Plans, Policies, and Scope of Services			
15. CEO REPORT a. Update b. Pacing Plan	Dan Woods, Chief Executive Officer		**information 7:06 – 7:16**
16. BOARD COMMENTS	Lanhee Chen, Board Chair		**information 7:16 – 7:19**
17. ADJOURNMENT	Lanhee Chen, Board Chair	*public comment*	**motion required 7:19 – 7:20 pm**

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

Upcoming Special Meetings - Education/Retreat: April 27, 2022 (Board Education)

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Dan Woods, Chief Executive Officer, El Camino Health
Date: March 09, 2022
Subject: El Camino Health Strategic Plan

Recommendation:

To approve the El Camino Health (ECH) five-year Strategic Plan Framework.

Summary:

1. Situation: The previous ECH strategic plan was created in 2017. ECH management and the Board have been engaged to update the organizational strategic plan. Management involved a strategic advisor to assist in analysis and high-level strategy development.
2. Authority: As the governing body of El Camino Hospital, the Board of Directors approves and oversees the execution of the organization's strategic direction. Ultimately, the El Camino Healthcare District Board of Directors has the authority to approve the overall strategy of the organization.
3. Background: The Board has frequently met with management and strategic advisors to discuss and provide feedback on the development of the strategic plan.
4. Assessment: Management has executed the strategic themes outlined in the 2017 strategic Plan – High Performing Organization; Consumer, Payer, Employer Alignment; and Physician Integration – and the impact has been significant. ECH has made considerable growth and advancement in providing care to our community over the past five years. In 2017, ECH maintained three (3) facilities, and through construction on the Mountain View campus, development of freestanding clinics and Urgent Care Centers, and the integration of the San Jose Medical Group clinics ECH has grown the physical footprint to thirteen.

   To sustain continued success at ECH and to adapt to changes in the healthcare industry El Camino Health has updated the Strategic Plan through a robust data analytics and consensus development process. Management garnered feedback and guidance from dozens of clinical leaders and administrative staff, conducted interviews with more than 30 internal and external stakeholders, and organized workgroups comprised of more than 50 total contributors.
5. Outcomes:

EL CAMINO HEALTH VISION 2027

Management has outlined a vision for what ECH should look like in 5 years: El Camino Health will be a network of facilities with capabilities that span the full continuum of care. It will offer a high-performing Medical Network with primary care practices and specialty care capacity through multiple physician alignment vehicles.

ECH will offer care solutions from a patient-centric point of view with an emerging digital/virtual footprint.

To fulfill this vision, ECH must leverage and address three main strategic priorities: 1) Aligning with Physicians, 2) Leading in Clinical Programs, and 3) Expanding our Geographic Reach. These priorities constitute the Strategic Framework (see Appendix A) which management will implement over the next 5 years.

Priority 1: Aligned Physicians

ECH will align with existing and new physicians by providing additional vehicles for alignment, tailored to meet the needs of our community physicians. Together, ECH and our aligned physicians will enhance the environment of care and ensure patient access to convenient, personalized care in their communities.

Priority 2: Leadership in Clinical Programs

ECH will expand its clinical programs into outpatient sites and network affiliates. ECH will maintain and expand its market leadership in these programs, creating and leveraging the enhanced reputation to enlarge the services offered into adjacent categories.

ECH will also address community needs through Investment programs like ECH's Mental Health and Addiction Services and the Community Partners programs. ECH will work to identify ways to leverage technology, contracting, or other resources to make the programs more sustainable. Additionally, ECH will continue to expand its clinical and innovation portfolio in areas that show potential benefit and alignment with the Health System Strategy.

Priority 3: Expanding Our Reach

ECH will quickly expand ECH's outpatient presence to position ECH to capture the outpatient growth volumes in the market, provide care closer to our patients, and provide physician alignment vehicles to increase physician loyalty to ECH. Over the next 5 years, ECH will increase patient access and convenience to ECH services.

Conclusion

El Camino Health has been a successful community asset for more than 60 years and has evolved significantly over that time. Given the current state of risk in the changing healthcare environment, and the future available opportunities, the proposed strategic framework will provide El Camino's management the ability to continue this evolution and ensure ECH's ability to fulfill the organizational mission to "Heal, relieve suffering and advance wellness" to our community for decades to come.

El Camino Health

Appendix A – Strategic Framework

El Camino Health Strategic Plan Framework

ECH Mission & Vision

Mission: To Heal, Relieve Suffering, and Advance Wellness

Vision: Provide consumers in the South Bay with a high quality, locally-oriented health system, across the full care continuum

Physician Alignment	Leadership in Clinical Programs	Expanding our Reach
Establish an aligned care network in the South Bay, across the care continuum	Focus resources to key programs with coverage and programing across the care continuum	Offer services closer to where our patients live

Patient-Centric Experience – Connected, consumer-focused network, designed to deliver a consistent, superior experience, while leveraging access and convenience

Item 05 - Quality Committee Report PLACEHOLDER

This document is in process and will be available on

Tuesday, March 8, 2022

(immediately following the Quality Committee Meeting on Monday, March 7, 2022.)

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Mary Rotunno, General Counsel
Date: March 09, 2022
Subject: Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings

Recommendation: To continue the determination made by the Board of Directors at its meeting on October 13, 2021 in Resolution 2021-10 acknowledging that there still exists a state of emergency due to the COVID-19 pandemic and to continue the findings by the Board of Directors to allow continued public participation by teleconference in Board and Advisory Committee meetings in accordance with the recommendation of the Santa Clara County Health Officer.

Summary:

1. Situation: At the October 13, 2021 Board Meeting, the Board of Directors adopted Resolution 2021-10, which made findings to continue holding virtual public meetings under the Ralph M. Brown Act based on the continued state of emergency due to the COVID-19 pandemic and that either (a) the state of emergency continues to directly impact the ability to meet safely in person, or (b) state or local officials continue to impose or recommend measures to promote social distancing.
   This Resolution relies on the September 21, 2021 recommendation by the Health Officer of the County of Santa Clara that public bodies continue to meet remotely due to their unique characteristics, such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to fully participate in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other recommendations at such meetings.

2. Authority: On March 17, 2020, in response to the COVID-19 pandemic, Governor Newsom issued Executive Order N-29-20 suspending certain provisions of the Brown Act in order to allow local legislative bodies to conduct meetings telephonically or by other means.
   On June 11, 2021, Governor Newsom issued Executive Order N-08-21, which placed an end date of September 30, 2021, for agencies to meet remotely.
   On September 16, 2021, Governor Newsom signed Assembly Bill 361 (2021) (“AB 361”) which allows for local legislative and advisory bodies to continue to conduct meetings via teleconferencing if the Board of Directors, by majority vote, make the findings set forth in paragraph 1 above, not later than thirty (30) days after teleconferencing for the first time under the AB 361 rules, and every 30 days thereafter.

3. Legal and Compliance Review: ECH outside counsel at Best Best & Krieger, LLP (“BB&K”), reviewed the legislation and prepared Resolution 2021-10.

Attachment:

1. Resolution 2021-10 - Resolution of the Board of Directors of El Camino Hospital Making Findings and Determinations Under AB 361 for Teleconference Meetings

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RESOLUTION 2021-10

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL MAKING FINDINGS AND DETERMINATIONS UNDER AB 361 FOR TELECONFERENCE MEETINGS

WHEREAS, all meetings of the El Camino Hospital's Board of Directors and Advisory Committees are open and public, as required by the Ralph M. Brown Act (Cal. Gov. Code §§ 54950 – 54963), so that any member of the public may attend, participate, and watch the Board of Directors and its Advisory Committees conduct their business;

WHEREAS, such meetings ordinarily take place on the campus of the Hospital, located at 2500 Grant Road, Mountain View, California, 94040, in the County of Santa Clara;

WHEREAS, ordinarily, the Ralph M. Brown Act imposes certain requirements on local agencies meeting via teleconference;

WHEREAS, the Legislature recently enacted Assembly Bill 361 (AB 361), which amended Government Code section 54953 to allow local agencies to use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) of section 54953 of the Government Code if the legislative body holds a meeting during a proclaimed state of emergency and determines by majority vote that, as a result of the emergency, either (a) meeting in person would present imminent risks to the health and safety of attendees, or (b) state or local official continue to impose or recommend measures to promote social distancing;

WHEREAS, the Governor issued a proclamation declaring a state of emergency on March4, 2020 due to the COVID-19 pandemic, pursuant to section 8625 of the California Emergency Services Act, and this proclaimed state of emergency currently remains in effect;

WHEREAS, on August 2, 2021, in response to the Delta variant, the Health Officer of the County of Santa Clara ordered all individuals to wear face coverings when inside public spaces;

WHEREAS, on September 21, 2021, the Health Officer of the County of Santa Clara issued a recommendation that public bodies continue to meet remotely due to their unique characteristics, such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to fully participate in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other recommendations at such meetings;

WHEREAS, AB 361 requires compliance with separate procedures for teleconference meetings during a state of emergency, found in subdivision (e) of Government Code section54953;

WHEREAS, AB 361 requires that the legislative body using the teleconferencing procedures of AB 361 make renewed findings by majority vote, not later than every thirty (30) days, that the legislative body has reconsidered the circumstances of the state of emergency, and that either (a) the state of emergency continues to directly impact the ability of the members to meet safety in person,

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or (b) state or local officials continue to impose or recommend measures to promote social distancing;

WHEREAS, the Board of Directors of the Hospital desires to make findings and determinations for meetings of the Board of Directors and its Advisory Committees consistent with AB 361 to utilize the special procedures for teleconferencing provided by AB 361 due to imminent risks to the health and safety of attendees, as well as Hospital staff and patients;

WHEREAS, in response to the COVID-19 pandemic, Hospital staff has set up hybrid in-person/teleconference public meetings, whereby members of the Board of Directors and Advisory Committee members and staff that can attend the meeting in-person on the campus of the Hospital can do so, while members of the public have the full ability to observe and comment on the meetings off-campus through the Hospital's virtual meeting platforms;

WHEREAS, the Board of Directors fully supports the public's right to participate in all meetings of the Board of Directors and its Advisory Committees, but acknowledges that it cannot require members of the public who wish to attend meetings in-person to submit proof of vaccination or negative test results;

WHEREAS, it is important that the Board of Directors ensure that Board members, Advisory Committee members and Hospital staff have a safe workplace and Hospital patients have a safe environment to receive care, to the maximum extent possible; and

WHEREAS, the Board of Directors desires to balance the rights of members of the public to participate in meetings of the Board of Directors and its Advisory Committees with the rights of the Board of Directors, Advisory Committee members and Hospital staff to conduct the meetings in a safe environment.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of El Camino Hospital, that:

1. The Board of Directors finds and determines that, as a result of the COVID-19 pandemic emergency, meetings of the Board of Directors and its Advisory Committees in which the public attends in-person on the campus of the Hospital would present imminent risks to the health and safety of the Board of Directors, Hospital staff, members of the public and patients of the Hospital.

2. The Board of Directors finds and determines that conducting such meetings in a hybrid in-person/teleconference model provides the safest environment for the Board of Directors, Advisory Committee members and Hospital staff to conduct business, while allowing for maximum public participation.

3. The Board of Directors finds and determines that the Health Officer of the County of Santa Clara has recommended measures to promote social distancing as one means to reduce the risk of COVID-19 transmission.

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4. The Board of Directors and its Advisory Committees shall conduct teleconference meetings under AB 361 in accordance with the requirements of AB 361, found in subdivision (e) of Government Code section 54953.

5. Through the duration of the state of emergency, if the Board of Directors desires to continue utilizing teleconferencing meetings under the special provisions of AB 361, the Board of Directors will make findings by majority vote not later than thirty (30) days after this meeting (or, if there is no meeting within thirty (30) days of this meeting, at the start of the next meeting), and not later than every thirty (30) days thereafter (or, if there is no meeting within thirty (30) days thereafter, at the start of the next meeting), that the Board of Directors has reconsidered the circumstances of the state of emergency and that either (a) the state of emergency continues to directly impact the ability of the public to meet safely in person, or (b) that state or local officials continue to impose or recommend measures to promote social distancing.

6. The findings of the Board of Directors set forth above apply to all meetings of the Board of Directors and its Advisory Committees, including, without limitation, the October 4, 2021 meeting of the Quality, Patient Care and Patient Experience Committee, which predated this Resolution.

PASSED AND ADOPTED at the regular meeting of the Board of Directors of El Camino Hospital held on October 13, 2021 by the following vote:

AYES: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin

NOES: None

ABSENT: None

ABSTAIN: None

ATTEST:

DocuSigned by:
Lanhee Chen
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Chair,
El Camino Hospital Board of Directors

DocuSigned by:
Julia Miller
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Secretary,
El Camino Hospital Board of Directors

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, February 09, 2022

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**		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**	**via teleconference	
Don Watters**		
John Zoglin**		

DRAFT

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 5:31 pm by Chair Chen. A verbal roll call was taken. All Board members were present at roll call, excluding Directors Rebitzer and Fung. 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 Rebitzer joined at 5:32 pm and Director Fung joined at 5:33 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	Chair Chen invited the members of the public to address the Board of Directors. A member of the public, identified as Amy Madsen addressed the Board for three minutes. Ms. Madsen's main concern was the visitor policy and the 48/72hr COVID testing requirement. Ms. Madsen asked for consideration of visitor policy change to 15 min testing requirements.	
4. ADJOURN TO CLOSED SESSION	To adjourn to closed session at 5:37 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (12/01/2021 & 12/08/2021); 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 Credentials and Privileges Report & Bylaws); pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: (Investment Advisory Firm Update); pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: (Strategic Planning Update); pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: (FY22 Q2 Strategic Metrics); pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: (Q2 FY22 Financials); pursuant to Gov't Code Section 54957 for discussion on personnel	***Adjourned to closed session at 5:37 pm***

	performance matters, an Executive Session with the CEO, and a CEO Report. **Motion:** to adjourn to closed session at 5:37 pm **Movant**: Miller **Second**: Watters **Ayes**: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	
5. AGENDA ITEM 13: RECONVENE OPEN SESSION/ REPORT OUT	Open Session reconvened at 8:07 pm by Chair Chen. Agenda items 5-12 were addressed in the closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (12/01/21 & 12/08/21), the Credentialing and Privileges Report, and the Investment Advisory Firm Recommendation by a unanimous vote in favor of all members present and participating in the meeting (Director Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, and Zoglin). The Board approved the Bylaws in favor of the following Directors: Director Chen, Fung, Kliger, Miller, Po, Rebitzer, Ting, Watters, and Zoglin.	
6. 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 14f –Enterprise Radiology Professional Services Agreement Renewal. Dr. Adams clarified that after further analysis this item falls below the 75th percentile and no longer meets the criteria for Board approval, and has already been approved through the Finance Committee. **Motion:** To approve the consent calendar to include: 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 d. FY21 Period 6 Financials e. Mountain View ED & Inpatient On-Call Interventional Radiology Panel Agreement Renewal g. Medical Staff Report h. Board Member Benefits **Movant:** Miller **Second:** Somersille **Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Consent calendar approved***
7. AGENDA ITEM 15: QUALITY COMMITTEE REPORT	Director Kliger referred the Board of Directors to the Quality Committee Report as submitted in the packet materials and introduced the new Chief Quality Officer, Dr. Holly Beeman. Director Kliger stated that there are still some opportunities for improvement on the dashboard,	

	especially in the area of stroke. Dr. Beeman provided some additional input to include the focused performance improvement on the following two measures: • The first measure is how much time it takes from presenting at the door to getting an IV. • The second measure is the time from the door to getting into the cath lab to have a rhombus removed. Dr. Beeman concluded that we have a medical director, project coordinator, and team that are very passionate and have identified some great opportunities on how we can improve here.	
8. AGENDA ITEM 16: CEO REPORT	Dan Woods, CEO, reported on the recent Omnicron COVID-19 surge and the implemented countermeasures to include distributing six at-home COVID-19 tests to every employee. He further disclosed that El Camino Health is currently 1 of 3 organizations receiving the designation of Gold Stars 10 for achieving “Value from Data” which translates to roughly 0.5% of all Epic organizations. Mr. Woods concluded that the Auxiliary donated 2,035 volunteer hours for December.	
9. AGENDA ITEM 17: BOARD COMMENTS	*No comments were made.*	
10. AGENDA ITEM 18: ADJOURNMENT	**Motion**: to adjourn at 8:24 pm. **Movant:** Ting **Second:** Miller **Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersile, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 8:24 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
Special Meeting to Conduct a Study Session of the
El Camino Hospital Board of Directors
Wednesday, February 23, 2022

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	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:** Po **Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 5:32 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:** Fung **Second:** Miller **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***

DRAFT

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 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: March 9, 2022
Subject: Medical Staff Report – Open Session

Recommendation:

To approve the Medical Staff Report, to include plans, policies, and scope of services.

Summary:

1. Situation: The Medical Executive Committee met on February 24, 2022

2. Background: MEC received the following informational reports.

a) Quality Council – The Quality Council met on February 2, 2022. Reports and performance dashboards were reviewed and approved from the following ECH Departments/Service Lines:
1. Infection Prevention PI Report
2. Infection Prevention Dashboard
3. Inpatient Acute Dialysis PI Report
4. Acute Dialysis Dashboard
5. Annual Performance Improvement Plan LG ICU
6. LG ICU Dashboard
7. Annual Performance Improvement Plan MC CCU
8. MV CCU Dashboard
9. Donor Network PI Report
10. Donor Network Dashboard

b) Leadership Council – The Leadership Council met on February 8, 2022 and discussed the following:
1. CME Software Demonstration
2. MICRA Donation
3. Doctors Day Jackets
4. Medical Director Quality Goals
5. MEC Membership
6. Vice Chief of Staff Interviews

c) The CEO Report was provided

d) The CMO Report was provided

List of Attachments: Plans, Policies, and Scope of Services

Suggested Board Discussion Questions: n/a

EL CAMINO HEALTH BOARD OF DIRECTORS

Plans, Policies, and Scope of Services
March 9, 2022

Department	Policy Name	Type of Change	Type of Document	Notes	Committee Approvals
New Business					
MCH	1. Scope of Service: Mother Baby – Enterprise	Revised	Scope of Svc	Minor changes	• UPC • MCH Exec. Committee • ePolicy Cmte
2C Medical	2. Scope of Service: 2C Medical Services – Mountain View	Revised	Scope of Svc	Changes in requirements for staff; last sentence deleted	• Dept Med Dir • ePolicy Cmte
NICU	3. Scope of Service – Neonatal Intensive Care Unit (NICU) – Enterprise	Revised	Scope of Svc	Minor changes	• Dept Med Dir • ePolicy Cmte
Compliance	4. Physician Financial Arrangements – Review and Approval	None	Policy	Regulatory approval timeframe	• Compliance Board • ePolicy Cmte
L&D	5. Obstetrical Emergency Department (OB ED) (MV) Scope of Service	Revised	Scope of Svc	Minor changes	• Dept Med Dir • UPC • ePolicy Cmte
Surgical Pediatrics	6. Scope of Service: Surgical & Pediatric Services – Mountain View	None	Scope of Svc	Regulatory approval timeframe	• Dept Med Dir • ePolicy Cmte
Rehab Services	7. Scope of Service: Rehabilitation Services	Revised	Scope of Svc	Minor changes	• Dept Med Dir • ePolicy Cmte
Material Mgmt	8. Scope of Service - Supply Chain	Revised	Scope of Svc	Updated Staffing/Skill Mix section	• Dept. Med. Dir • ePolicy Cmte
Laboratory & Pathology	9. Scope of Service - Anatomic Pathology 10. Scope of Service: Clinical Laboratory – Mountain View 11. Scope of Service: Clinical Laboratory – Los Gatos 12. Scope of Service: Pathology Services - Los Gatos	Revised Revised Revised None	All Scope of Svc	• Minor update • OP Lab Hours of Operation • Added PCR testing; minor changes • Regulatory approval timeframe	• Dept Med Dir • ePolicy Cmte

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Document Types:	*Scope of Service/ADT*

Scope of Service: Mother Baby - Enterprise

Types and Ages of Patient Served

The patient population consists of antepartum, induction, postpartum patients and healthy neonates. Unless contraindicated by admitting diagnosis or postpartum diagnosis, ~~or post-partum diagnosis,~~ all ~~post-partum~~postpartum patients should be admitted to the Mother~~-~~ Baby Unit where normal newborn care is delivered to the ~~couple~~couplet.

Assessment Methods

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Nursing care is provided by ~~a~~ registered ~~nurse~~nurses who assess, document~~,~~ and evaluate patient progress. The licensed vocational ~~nurses work~~nurse works under the direction of a registered nurse. The staff nurses are involved in ~~continual~~continually monitoring ~~of~~the quality of care and ~~the~~ performance improvement process.

For patients requiring resources not available in our unit, arrangements will be made to transfer the patient to another unit or facility.

Scope and Complexity of Services Offered

The unit provides total care and support to the patient~~/family~~ toward the positive discharge process. Care is given as directed and prescribed by the ~~physician~~provider. The nurse understands the family is an integral part of care ~~planning~~ and involves family members to the level of their ability and desire. The nursing staff coordinates all necessary needs for intervention and coordinates with any department specific ~~orders and~~order or treatment.

Appropriateness, Necessity and Timeliness of Services

The Department Manager, assisted by the Nursing Unit ~~Coordinator~~Coordinators and nursing staff, assess the appropriateness, necessity, and timeliness of service. The appropriateness is addressed in hospital and department specific policies and procedures, which are established in coordination with the medical staff~~, and the~~ and the Unit Partnership Councils.

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

Staffing

The Mother~~-~~ Baby Unit is staffed with a sufficient ~~numbers~~number of RNs, LVNs, and Administrative Support to provide established hours of nursing care based on the patient census and acuity. The staffing is provided per guidelines outlined in the department standards and Guidelines for Perinatal Care. Twenty-four hour neonatologist coverage is provided in the NICU in Mountain View and on-call in Los Gatos and is available for consultation.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the medical staff and nursing assessment. The neonate is observed in Labor & Delivery for a period of time to assess that they have stabilized their temperature and respiratory status. ~~The unit is designed to meet the needs of the patient.~~

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

Standard of Practice

The Mother-Baby Unit is governed by state regulations as outlined in Title 22, Joint Commission requirements, the American College of Obstetrics and Gynecology, California Children's Services (CCS), Guidelines for Perinatal Care (AAP & ACOG), NANN (Neonatal Nurses' Association) and Association of Women's Health, Obstetric and Neonatal ~~Nursing~~Nurses (AWHONN). It is also governed by recommendations from the American Academy of Pediatrics. Additional practices are described in Policies and Procedures.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	02/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2022
MCH Executive Committee	Nikki Le Bautista: Medical Staff Coord	01/2022
UPC	Liliana Bruzzese-Pisegna: Clinical Manager	11/2021
	Liliana Bruzzese-Pisegna: Clinical Manager	11/2021

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Document Types:	*Scope of Service/ADT*

Scope of Service: 2C Medical Services - Mountain View

Types and Ages of Patient Served

Medical Nursing Services provides care to patients ranging in age from adolescence to geriatric. The unit provides services to patients from adolescence to geriatric as defined in the department'sa population with a wide population with a wide array of medical conditions who meet departmental admission, discharge and transfer criteria, including the short stay (Outpatient). The primary patient population served consists of inpatients with a wide array of medical conditions and provision forMedical unit provisions services to outpatient medicalMedical-surgical cases and surgicalSurgical inpatient overflow.

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Assessment Methods

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

The staff participates in performance improvement processes relating to patient care delivery as well as patient/customer satisfaction in general.

Scope and Complexity of Services Offered

Medical Services provides 24-hour comprehensive nursing care predominantly to patients with acute medical conditions. Outpatient services include, but are not limited to blood transfusions, medication infusions, post renal biopsies, paracentesis with albumin replacement, and A-V fistula repair. Overflow surgical patients (due to lack of bed availability on Medical/Surgical Oncology and Surgical Nursing Services) are also included in the patients served. Patients requiring cardiac monitoring are not admitted to Medical Services.

The unit provides comprehensive nursing care primarily to medical patients. Medical/Surgical patients are admitted as overflow. Care is given as directed and prescribed by the physician. All non-nursing orders are communicated to the appropriate ancillary departments via the electronic health record (EHR). StaffNursing staff communicates specific patient needs and coordinate treatment and plan of care with all ancillary departments. The discharge planning process is initiated on admission, in collaboration with the physician(s)physicians, care coordinators, social workers, and patient and family/home caregivers. Multidisciplinary patient careDischarge rounds review and revises the plan of careare completed daily with the

Nursing staff and Care coordinators.

Appropriateness, Necessity and Timeliness of Services

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

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

Staffing/Staff Mix

~~A Clinical Manager oversees the operations of Medical Service on a 24-hour basis and reports to the Director of Medical/Surgical Services.~~

Medical Services has a skill mix of RNs, LVNs, and CNAs, and administrative support to provide ~~services~~care and service to patients and families. Staffing is ~~predicted~~based on patient census, budgeted hours ~~per patient day (HPPD) and adjusted according to the nursing intensity measurement system~~of care, and the Nursing Intensity Measurement System (NIMS), a patient classification system. The charge nurse assigned ~~on~~to each shift determines the prospective ~~and retrospective~~ staffing needs ~~based on NIMS and individual patient care needs~~for the oncoming shift, utilizing staffing tools that incorporate these factors. The competency of the staff is evaluated through observation of performance and skills competency validation. Staff education and training is provided to ~~assist in~~promote the achievement of performance standards.

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Requirements for Staff

- All staff complete a general hospital and department-specific orientation.
- HealthStream modules are reviewed annually by all staff.
- All staff are required to be BLS certified.
- RNs and LVNs must have a current California license. CNAs must hold a current certification by the State of California.
  ~~It is recommended that RN's & LVN's on Medical Services complete a basic renal course within the first year of employment.~~

Level of Service Provided

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

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

Standards of Practice

Medical Services is governed by state regulations as outlined in Title 22, standards established by the Joint

Commission on Accreditation of Healthcare Organizations and the Centers for Medicare and Medicaid (CMS). Additional practices are described in the Patient Care Services Policies and ~~Procedures~~procedures, departmental policies and procedures, and Clinical Practice Standards.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	02/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2022
Department Medical Director or Director for non-clinical Departments	Milagros Fisher: Clinical Manager	02/2022
	Milagros Fisher: Clinical Manager	02/2022

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

Types and Ages of Patient Served

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

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Assessment Methods

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

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

Scope and Complexity of Services Offered

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

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

Appropriateness, Necessity and Timeliness of Services

The clinical manager, in collaboration with the NICU medical director, care coordinator and nursing staff, will monitor that the services provided are appropriate, necessary, and done in a timely manner following policies

and procedures developed in collaboration with the medical staff and NICU Partnership Council (MV) and Maternal Child Health Partnership Council (LG).

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

Staffing/Skill Mix

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

Level of Service Provided

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

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

Standard of Practice

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

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	02/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2022
Department Medical Director or Director for non-clinical Departments	Melinda Porter: CNS/NP	01/2022
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Physician Financial Arrangements - Review and Approval

I. COVERAGE:

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

II. PURPOSE:

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

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III. POLICY STATEMENT:

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

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

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

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

IV. PROCEDURE:

A. **Administrative Standards:**

When creating or renewing a Physician financial arrangement, the following principles must be followed. This Policy applies to any Physician financial arrangement including, but not limit to: Medical Directorships, ED Call Panels, Professional Services, Panel Professional Services, Consulting, Lease, Education and Training, Conference Payment, and Physician Recruitment.

1. **All Physician Financial Arrangements:**

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

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

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

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

   c. Compensation cannot be revised or modified during the first twelve (12) months of any Physician financial arrangement. If the compensation is revised thereafter, it must be evidenced by a written amendment to the Physician Contract, signed by both parties before the increase in compensation takes effect. For example, if the increase in compensation is to take effect on April 1, the amendment must be signed by both parties on or before April 1 and the original Physician Contract must have been effective on or before March 31 of the prior year. The

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compensation cannot be changed for twelve (12) months after the effective date of such amendment.

d. All Physician Contract renewals must be signed before the expiration of the term of the existing Physician Contract.

e. Physician Contracts must be in writing and executed by the parties before commencement. Only the CEO of Hospital or designee by CEO in his or her absence may execute a Physician Contract, except Physicians Contracts that are real estate or equipment leases with Physicians may be signed by the Chief Administrative Services Officer ("CASO"). Physicians cannot be compensated for work performed, nor may a lease commence, prior to execution by both parties.

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

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

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

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

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

k. Attached to the final version of a Physician Contract **prior** to execution by Hospital must be a completed "Contract Cover Sheet and Summary of Terms" and a signed "Certification of Necessity and Fair Market Value" (Appendix A) (a Physician Lease Contract must also include a signed "Contract Certification" (Appendix B) and "Lease Contract Review Checklist" (Appendix C) to be reviewed and approved by Legal Services and Compliance.

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

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

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

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

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

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practice at the Hospital.

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

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

d. Medical Director Contracts must require Physician completion and submission of a physician time study reports each month, and each such report must be approved by the Designated Manager and the Compliance Department before any compensation is paid. There must be one or more internal review processes to verify that the Medical Director is performing the expected duties and tasks, of which the required time report is one example.

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

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

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

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

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

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

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4. **Physician Lease Contracts:**
   In addition to the criteria set forth in the *All Physician Financial Arrangements* section above (D.1), the following criteria must be met *before* creating, amending, or renewing a Physician Lease Contract:
   a. Attached to the final version of a Physician Lease Contract, and prior to execution, must be a completed "Lease Contract Review Checklist" (Appendix C) and an executed "Contract Certification" (Appendix B).
   b. The Physician Lease Contract shall confirm total measurement of the space to be utilized by Physician under the lease.
   c. The Physician Lease Contract must be supported by fair market value documentation from a property appraiser or brokers opinion of value.
   d. Tenant Improvements must be incorporated into the Physician Lease Contract as a Tenant expense.
   e. Physician must not use the space and the Hospital must not make the space available for use prior to the execution of the Physician Lease Contract by both parties.
   f. The Physician Lease Contract shall require that all property taxes are to be paid by the Tenant for Triple Net leases.
   g. Physician Lease Contracts are executed by the CEO or the CASO.
5. **Physician Education, Training and Conference Payment Contracts:**
   In addition to the criteria set forth in the *All Physician Financial Arrangements* section above (D.1) , the following criteria must be met *before* creating a new Education, Training and Conference Reimbursement Contracts and prior to attendance:
   a. Physician Education, Training and Conference Payment Contracts must be created and reimbursed in accordance with Hospital Policy Reimbursement of Business, Education and Travel Expenses.
   b. The Hospital's need for this training to be provided to the Physician shall be documented as part of the approval process.
6. **Physician Recruitment Contracts:**
   In addition to the criteria set forth in the *All Physician Financial Arrangements* section above (D.1), the following criteria must be met *before* creating a new Physician Recruitment Contract:
   a. Physician Recruitment Contracts must be created in accordance with the Physician Recruitment Policy Program, and must be presented to the Board for review before the recruitment proposal is developed.

B. **Approval of Physician Contracts:**
   1. Attached to the final version of a Physician Contract *before* CEO execution must be a completed "Contract Cover Sheet and Summary of Terms" and "Certification of Necessity and Fair Market Value"" (Appendix A).
   2. Attached to the final version of a Physician Lease Contract, *prior* to execution by the CEO or the CASO, must be a completed "Lease Contract Review Checklist" (Appendix C) and signed "Contract Certification" (Appendix B).
   3. Corporate Compliance and the General Counsel will verify the checklist, certification, and

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documentation accompanying all Physician Contracts (including FMV) prior to execution by the CEO or the CASO. Incomplete or missing checklist and certifications will be returned to the originator for completion.

4. All proposed Physician Contracts lacking the appropriate documentation will be returned to the originator for completion. No services may be performed under the Physician Contract or leases implemented until the Physician Contract is fully executed.
5. **CEO Approval:** The CEO will have authority to execute new, renewal and amended Physician Contracts (up to $250,000.00 in total possible compensation annually), except as set forth in Section 6) below.
6. **Board Approval:** If a new arrangement is over $250,000.00; or a renewal or amended agreement is over $250,000; or the annual increase is greater than ten percent (10%), the Board must approve prior to CEO execution of the Physician Contract.
   a. All physician financial arrangements that exceed 75% of fair market value (regardless of total annual compensation) must be reviewed by the Finance Committee of the Board and approved by the Board.
   b. If a new arrangement is over $250,000; or a renewal or amended agreement is over $250,000; or the annual increase is greater than ten percent (10%), the Finance Committee of the Board must approve prior to CEO execution of the Physician Contract, except as set forth in section 6(d).
   c. A memo prepared by the Designated Manager that justifies the Hospital's needs shall be provided to the Finance Committee and/or Board of Directors as necessary for approval as part of the approval documents.
   d. Notwithstanding Section 6(a) and (b), the CEO may execute without Board approval a new, renewal or amended Professional Services Agreement with El Camino Medical Associates (ECMA)so long as the total cash compensation to each individual physician employed by ECMA does not exceed 75% percentile of fair market value or $1,000,000 annually.

C. **Board Oversight and Internal Review Process:**

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

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

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

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

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D. **Exceptions:**

There are no exceptions to this Policy unless approved by the Board of Directors in advance.

E. **Review and/or Validate:**

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

F. **Policy Enforcement**

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

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Attachments

Appendix A: ECH Contract Cover Sheet and Summary of Terms
Appendix B: Contract Certification
Appendix C: Lease Contract Review Checklist

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Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	02/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2022
Director of Corporate Compliance	Diane Wigglesworth: Sr Dir Corporate Compliance	01/2022
	Diane Wigglesworth: Sr Dir Corporate Compliance	01/2022

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Area:	*Scopes of Service*
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Scope of Service - Obstetrical Emergency Department (OB ED) (MV)

Ages and Population Served:

The OB- ED provides care for pregnant women of childbearing age from 16 weeks gestation or greater across a ~~multi-cultural~~multicultural and diverse ~~socio-economic~~socioeconomic status who are experiencing problems associated with pregnancy.

Scope and Complexity of Services Offered:

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The OB- ED is an extension of the main Emergency Department. The scope of services of the OB- ED encompasses assessment, treatment, and evaluation of OB- ED patients. Reassessment is an integral part of the ongoing patient evaluation process. An RN is assigned to the OB- ED 24/7. Patients are triaged by the OB- ED RN upon arrival according to the **Obstetrical Emergency Severity Index** (Appendix A); they are seen on the basis of acuity~~,~~; otherwise they are treated on a first-come, first served basis. The nursing care assignment(s) is based upon the complexity of the patient's condition, the assessments and management required by the patient, the dynamics of the patient's status, and the patient census. Laboring patients are to be admitted to the labor unit as soon as possible. Patients in labor (without physician admission orders) will be transferred to the Labor and Delivery unit after an appropriate medical screening examination and stabilization in accordance with EMTALA regulations.

All non-pregnant patients presenting to the OB- ED will be quickly registered to the OB- ED, vital signs obtained, any necessary code teams called, if applicable, before being transferred by an RN to the Main Emergency Department for further evaluation and treatment.

Appropriateness, Necessity and Timeliness of Service:

On admission to the OB- ED, patients will be triaged by the OB- ED RN based on the Obstetrical Emergency Severity Index, Level 1-4. Following triage, a Medical Screening Examination is performed. Further assessment and treatment is provided in collaboration with the provider. An OB provider will see the patient within 30 minutes of notification by the OB- ED RN.

The Labor and Delivery nursing leadership, medical directors and charge nurses will assess the appropriateness, necessity and timeliness of the services provided for the OB- ED patient. A performance improvement process is in place to monitor the quality of care provided for all patients. The staff participates

in hospital-wide and unit -based performance improvement projects relating to quality of care.

Assessment Methods and Level of Service Provided:

The OB- ED RN triages each patient and determines priority of care based on physical, psychological and social needs, as well as factors influencing patient flow through the OB- ED. A multi-disciplinary team approach is used for patient assessment and treatment.

- Scheduled outpatient procedures i.e. non-stress tests (NST), versions, betamethasone injections – go directly to Labor and Delivery
- Scheduled inpatient procedures i.e. inductions, cesarean ~~sections~~births, labor patients with ~~PHYSICIAN~~provider admission orders – go directly to Labor and Delivery

Staffing:

The OB- ED is staffed 24 hours a day, seven days a week by OB Hospitalist and Labor and Delivery RN(s). All OB- ED RNs are certified in Advanced Cardiac Life Support (ACLS), Neonatal Resuscitation Program (NRP), and have competencies in EMTALA. The competency of the nursing staff is evaluated through observation of performance and skill competency. Staff education and training is provided to achieve a standard of performance that reflects an acceptable level of expertise and understanding of ongoing changes in practice. ~~Nurses assigned to triage have competencies in EMTALA and Obstetrical triage.~~ Staffing adjustments ~~to be~~are made based on patient acuity and ongoing assessment of patient condition
~~Standards of Practice:~~
~~All procedures, treatments, interventions, and medication administration performed by the OB-ED RN shall be documented in the electronic or paper medical record including the patient's response and outcomes~~.

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Standards of Practice:
All procedures, treatments, interventions, and medication administration performed by the OB ED RN shall be documented in the electronic health or paper medical record including the patient's response and outcomes.

The OB- ED is governed by state regulations as outlined in Title 22, and by the Center for Medicare and Medicaid (CMS) and federal regulations such as the Emergency Medical Treatment and Active Labor Act (EMTALA), the American College of Obstetrics and Gynecology (ACOG) and American Academy of Pediatrics (AAP) Guidelines of Perinatal Care, and Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). We also adhere to the standards established by The Joint Commission (TJC).

The OB- ED RNs follow hospital policies and procedures. Obstetrical nursing practice is systematic and includes nursing process, nursing diagnosis, decision making, analytic and scientific thinking and inquiry. Professional behaviors inherent in nursing practice are acquisition and application of a specialized body of knowledge and skills, accountability and responsibility, communication, autonomy, and collaborative relationships with others.

Appendix A

OB-ED Obstetrical Emergency Severity Index

Level 1 2-1:1 (RN to	**Level 2 1:1-2 (RN to Pts)**	**Level 3 1:2-3 (RN to Pts)**	**Level 4 1:3 (RN to Pts)**	**Labor & Delivery Patient**

Pt) Emergent Unstable Seen Immediately Requires Life Saving Measures	Urgent Stable Seen within 15 min	Semi-Urgent Stable Seen within 15-30 min	Non-Urgent Stable Seen within 30 min	Send Directly to Labor & Delivery For Registration and Care
Cardio-Respiratory Distress	**R/O Active Labor/SROM** **Regular UCs < 5 min apart;** **Pain Scale = 7-10**	**R/O Labor** **Irregular UCs > 37 weeks gestation;** **Pain scale = 4-6**	**R/O Latent Labor** **Mild, irreg. UCs > 37 weeks gestation; Pain Scale = 1-3**	**Scheduled *Outpatient* Procedures** **Injection, Version, NST**
Hemorrhage	**Previous C/S in Labor** **R/O Preterm Labor/PPROM**	**Nausea/Vomiting**	**Vaginal Discharge/ Vaginitis**	**Scheduled *Inpatient* Procedures** **Inductions, Cesarean Sections, Labor Patients with physician Admission Orders**
Eclampsia Seizure	**Significant Vaginal Bleeding for Gestational Age**	**SROM or Spotting > 37 weeks gestation**	**Abdominal Cramping <20 weeks**	
Umbilical Cord Prolapse	**Decreased Fetal Movement > 23 weeks gestation/ FHR Decelerations**	**Trauma/MVA/Fall**	**R/O UTI**	
Fetal Parts Presenting	**R/O Hypertension/ Preeclampsia**	**R/O SAB/Missed Abortion; Vaginal Bleeding/Cramping <20 weeks**	**Psychosocial Issues;** **Non-OB complaints**	
Birth Imminent	**R/O Pyelonephritis/ Kidney Stones**	**R/O DVT**		
No Fetal Movement	**Altered LOC** **Severe Depression/ Suicidal**	**BP Check;** **Hx Hypertension**		
Diabetic	**Hx Recent**	**Hx suicide attempt**		

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	Seizure;	
Coma/DKA	**Alert on Arrival**	
	Hx Diabetes, R/O Hypo/ Hyperglycemia	

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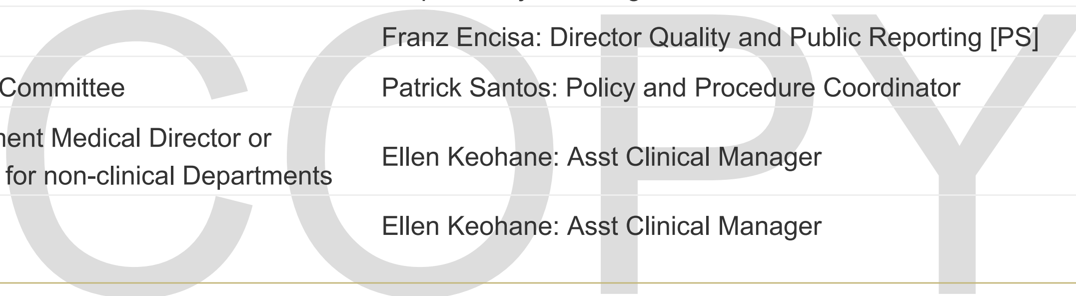

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Scope of Service: Surgical & Pediatric Services – Mountain View

Types and Ages of Patients Served

Surgical & Pediatric Services, a 37 bed unit located on 4A, provides care to patients ranging in age from infant to geriatric. The unit provides services to a wide spectrum of surgical & pediatric patients who meet departmental admission, discharge and transfer criteria.

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Assessment Methods

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

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

Scope and Complexity of Services Offered

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

Appropriateness, Necessity and Timeliness of Services

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

A performance improvement process is in place to identify opportunities for improvement in patient care

processes and measure performance for compliance on an on-going basis. The patient's progress is evaluated by physicians, nurses, members of other health disciplines, and patient and family satisfaction.

Staffing/Skill Mix IUW

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

Level of Service Provided

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

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

Standard of Practice

Surgical Nursing & Pediatric Services is governed by State regulations as outlined in Title 22 and Joint Commission on Accreditation of Healthcare Organizations standards, and adhere to the recommendations from the American Academy of Pediatrics. Additional practices are described in the Patient Care Policies and Procedures, departmental policies and procedures, and Clinical Practice standards.

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Scope of Service: Rehabilitation Services

Type and Ages of Patients Served

Rehabilitation Services serves young adult, adult and geriatric in-patients and out-patients. Neonates and pediatric patients up to two years of age are treated ~~under contract with a qualified~~in our NICU by an ECH provider.

Assessment Methods

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Therapeutic exercises/activities and modalities are provided to patients after assessment by licensed/ registered physical, occupational and speech therapists, as appropriate per departmental policies and procedures, who monitor patients' responses to therapy. All therapeutic activities follow an established plan of care documented in the timely evaluation or re-evaluation of the patient's status.

Scope and Complexity of Services Offered

Rehabilitation Services provides comprehensive specialty rehabilitation services for El Camino Hospital including inpatient and outpatient care. These services include Occupational Therapy (OT), Physical Therapy (PT), and Speech and Language Pathology (speech therapy (ST). The inpatient services cover all areas of the hospital. The highest volumes of patients seen are orthopedic patients including joint replacements; neurosurgical patients; neurological patients (especially post CVA); and medical-surgical patients. Pediatric and neonatal patients as well as psychiatric patients are occasionally treated.

The outpatient clinics at the ~~Park Pavilion and~~Outpatient Physical ~~Performance Institute (~~Rehabilitation of Mountain View and Outpatient Physical Rehabilitation of Los Gatos~~)~~ provide Occupational Therapy, Physical Therapy, and Speech and Language Pathology. All clinical areas of the patient population are served. The highest volume seen are orthopedic patients, especially those with lumbar and cervical injuries and joint replacements; pelvic floor dysfunction; industrial injuries; neurological patients, especially those post-CVA; general medicine patients; arthritis patients; post-surgical patients and those with cumulative trauma.

All specialty services are provided by skilled and licensed/certified professionals. Services are provided on a referral basis only. All staff works actively to promote and support the mission, vision, and values of El Camino Hospital.

Rehabilitation Services Provides:

PT	Back care training, gait training/ambulation, transfer training, manual therapy, therapeutic exercise

	programs, neuromuscular re-education, pelvic floor interventions, prosthetic training and modalities as appropriate.
OT	Evaluation and treatment of daily living, social, educational, play/leisure skills, work adjustment, sensorimotor evaluation and therapy, self-management, therapeutic adaptations, preventive techniques, cognitive evaluation and therapy, UE evaluation and treatment, neuromuscular re-education, splinting and therapeutic activities,
ST	Evaluation and treatment of speech and language disorders or dysphagia evaluation and treatment, including Vital Stimulation, evaluations and treatment of cognition impairments and assisting the radiologist with videofluoroscopic examinations.

Appropriateness, Necessity and Timeliness of Services

Rehabilitation Services assesses the appropriateness and necessity of therapeutic exercises/ activities and modalities by evaluating the patient's clinical history and current condition for pertinence to the therapy ordered. Criteria for the termination of rehabilitation services are described in the departmental policies and procedures.

The timeliness of services is addressed in departmental policies and procedures that describe the hours of operation, criteria for prioritization of patients/treatments, as well as performance of routine procedures.

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Staffing/Staff Mix

Rehabilitation Services hours of service for in-patient physical therapy are daily, 8:30 a.m. to 5:00 p.m.; Diminished staffing levels are scheduled during weekends and holidays.

IN-PATIENT	El Camino Hospital **Mountain View** (main building) 2500 Grant Road Mountain View, CA 94039-7025 Mail Stop: 4A 4AREH Phone: (650) 940-7269
El Camino Hospital **Los Gatos** 815 Pollard Mail Stop: LGH117 Los Gatos. CA 95032 Hours: Sunday - Saturday, 8:30 a.m. - 5:00 p.m. Legal holidays, except as listed: 8:30 am – 5:00 pm	

Outpatient rehabilitation services are provided Monday through Friday, 8:00 a.m. to 5:00 p.m. with the exception of all legal holidays, or by special appointment.

OUT-PATIENT	**Mountain View** Park Pavilion Building, 2nd Floor 2400 Grant Road Mountain View, CA 94040-4378 Mail Stop: PAR 210

	Phone: (650) 940-7285 Fax: (650) 965-2992
Los Gatos ~~Physical Performance Institute (PPI)~~ 555 Knowles Drive, Suite 100 M/S: KNO101 Los Gatos. CA 95032 Phone: (408) 866-4059 Fax: (408) 871-2347 Hours: Monday - Friday, 8:00 a.m. - 5:00 p.m. Closed on legal holidays	

The types of staff providing care and services include licensed/registered physical, occupational and speech therapists; licensed/registered physical and occupational therapy assistants; therapy aides and front desk staff.

Levels of Service Provided

The levels of services provided by the department are consistent with the therapeutic needs of the patients as determined by the medical staff.

Services are designed to meet patient needs by accurately performing procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which Rehabilitation Services meet patient needs.

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Standards of Practice

Rehabilitation Services is governed by state regulations as outlined in Title 22, Physical Therapy Practice Act, Occupational Therapy Practice Act and Speech Therapy Practice Act. The department also follows guidelines set forth by the American Occupational Therapy Association, American Physical Therapy Association and the American Speech, Hearing and Language Association. Additional practices are described in department policies and procedures (see below):

1. Physical Therapy:

   Physical Therapy assists in the prevention, correction or alleviation of pain, disability or deformity caused by injury or disease. Physical Therapy provides, but is not limited to, the following services:

   a. Functional evaluations and goal setting.
   b. Medical, neurological and orthopedic rehabilitation.
   c. Therapeutic exercise, including strengthening and flexibility training.
   d. Modalities: traction, moist heat, cold, electrotherapy, and ultrasound.
   e. Manual therapy: myofascial release, peripheral and spinal joint mobilization, soft tissue mobilization, and manual traction.
   f. Gait and transfer training.
   g. LE Prosthetic training.

h. Use of exercise equipment.
i. Balance and coordination training.
j. Patient, family and caregiver education and training.
k. Ergonomic assessments and injury prevention training.
l. Advancement of physical therapy rehabilitation programs
m. Aquatic therapy.
n. Evaluation and treatment of pelvic floor dysfunction

Advanced Practice Physical Therapy: Additional and separate current certification is required for any Physical Therapist performing procedures involving Electromyography or Electroneuromyography.

2. Occupational Therapy:

   Occupational Therapy provides for goal-directed, purposeful activity to aid in the development of adaptive skills and performance capacities by individuals of all ages who have physical disabilities and related psychological impairment(s). Such therapy is designed to maximize independence, prevent further disability, and maintain health. Occupational Therapy provides, but is not limited to, the following services:

   a. Functional evaluations and goal setting.
   b. Medical, neurological and orthopedic rehabilitation.
   c. Sensorimotor, cognitive and perceptual evaluation and rehabilitation.
   d. Balance and coordination training.
   e. Energy conservation training.
   f. Bed mobility and transfer training.
   g. Wheelchair fitting and mobility training.
   h. Activities of daily living (ADL) training.
   i. Advancement of Occupational Therapy rehabilitation programs.
   j. Feeding training.
   k. Patient, family and caregiver education and training.
   l. Recommendations for static and dynamic splinting.
   m. Therapeutic exercises.

3. Advanced Practice Occupational Therapy: Additional and separate current certification is required for any Occupational Therapist treating patients in the areas of:

   a. Hand Therapy – including, but not limited to, fabrication of static and dynamic splints, manual peripheral joint mobilization, soft tissue mobilization, UE prosthetic training
   b. Use of physical agent modalities
   c. Swallowing Assessment, Evaluation or Intervention

4. Speech and Language Pathology:

   Speech and Language Pathology services include screening, assessing and interpreting disorders of

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speech and language, oral-pharyngeal function, and cognitive/communicative disorders. Speech and Language Pathology provides, but is not limited to, the following services:

a. Diagnostic speech and language evaluation and goal setting.
b. Videofluoroscopy.
c. Cognitive evaluation and treatment.
d. Prosthetic assessment and training.
e. Dysphagia evaluation and treatment.
f. Advancement of Speech Therapy rehabilitation programs.
g. Patient, family and caregiver training.

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Scope of Service - Supply Chain

Types and Ages of Clients Served

The Supply Chain Department provides services to clinical, nursing, ancillary and support departments. In addition, some services are provided to outside entities.

Scope and Complexity of Services Offered

- **Contracting:** Implementation and oversight of vendor and supply contracts, manage effective contracting workflow for the organization and ensuring continuous improvement of the process for contract requests, drafting, approvals, execution and maintenance.
- **Distribution:** Provides supplies and materials to all clinical and ancillary departments. Maintains supply inventories in all assigned par location, Central, and Pyxis areas.
- **General Stores**: Maintains an economic level of warehoused supplies and distributes supplies to all hospital departments.
- **Group Purchasing Organization (GPO):** A group purchasing organization is an entity that helps healthcare providers-such as hospitals to realize savings and efficiencies by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors.
- **Receiving:** Ensures proper receipt and shipment of all supplies and equipment.
- **Purchasing:** Procures and controls purchase of the services, equipment & supplies. Ensures all goods, supplies, and inventory needed for the organization to operate are purchased in a timely and cost effective manner.
- **Supply Chain:** Management of the flow of goods and services from point of origin to point of consumption.
- **Value Analysis:** A systematic and critical assessment by an organization of every feature of aproduct to ensure that its cost is no greater than is necessary to carry out its functions.

Staffing/Skill Mix

- Buyer & Sr. Buyer
- Inventory Control Coordinator
- Material Handlers I & II
- Pyxis Coordinator
- Sr. Contract Administrator
- Supply Chain Director
- Supply Chain Manager

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- Strategic Sourcing Manager
- Supply Chain Supervisor
- Supply Chain Technician 1, 2, 3
- Value Analysis Coordinator

Level of Service Provided:

The Supply Chain Department provides services under hospital policy and procedure guidelines.

Standards of Practice:

The Supply Chain Department is governed by local, state and federal regulations, and the Department of Health Services and Joint Commission requirements.

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Scope of Service - Anatomic Pathology

Types and Ages of Patients Served

The Pathology Department of El Camino Hospital serves inpatients and outpatients of all ages~~ including satellite outpatients (from physician offices and clinics), emergency room patients, employees and physicians~~.

Assessment Methods

Pathology specimens are examined by pathologists. The specimens are processed and paraffin blocks and slides are prepared by histotechnologists and/or cytotechnologists according to established procedures. The slides are microscopically examined by the pathologists for diagnosis and inconsistencies with the patient data and history. The validity of these reports is confirmed by internal quality control policies and procedures as well as external proficiency testing.

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Scope and Complexity of Services Offered

The El Camino Pathology Department offers anatomic pathology services which includes surgical pathology with frozen sections, consultations with staff physicians, cytology, and autopsy Cytology, autopsy and routine processing and staining of tissue are performed at the Mountain View campus. Los Gatos Pathology provides stat pathology services on-site and sends routine services to Mountain View Pathology for processing.

Appropriateness, Necessity and Timeliness of Services

The Pathology Department assesses the appropriateness of requests for examinations such as autopsies, biopsies and frozen sections through departmental quality assessment policies and procedures.

The monitoring of turn-around times for STAT and routine procedures and final diagnostic reports is performed as an integral part of the performance improvement strategies. In order to facilitate the best patient care possible, our commitment to the hospital is to provide timely, complete, and accurate diagnostic reports to physicians and patient care departments, in addition to assisting patients who need to take their slides and reports to outside facilities for continued care.

Staffing

The Pathology Department has six board certified pathologists. The Pathology Department administrative office is staffed from 8:00 am to 4:30 p.m., Monday through Friday. A pathologist is on-call and available 24

hours a day, 365 days a year at both Mountain View and Los Gatos campuses.

Mountain View Histology Lab is staffed by licensed histotechnologists Monday through Friday from 3:00 a.m. to 5:00 p.m. Mountain View Cytology Lab is staffed Monday through Friday from 8:00 a.m. to 4:30 p.m. by a licensed cytotechnologist.

Level of Service Provided

We are a full service Pathology Department. Only special specimens or tests are sent to a reference laboratory. Special diagnostic stains or requests for special procedures are done every day as required for patient care. Quality control measures are in place to insure the accuracy of our stains and special procedures.

Standard of Practice

The Pathology Department follows the guidelines set forth in CLIA 88. Inspection is conducted on a biennial basis by The College of American Pathologists (CAP). The CAP inspection is accepted by the Joint Commission on Accreditation of Healthcare Organizations ((TJC) JOINT COMMISSION). The State of California, Department of Health Services also conducts a periodic inspection. (TJC) JOINT COMMISSION participates in that inspection of the laboratory as a part of their overall hospital accreditation survey.

Additionally, criteria for standards of practice are found in departmental policy and procedure.

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Scope of Service: Clinical Laboratory - Mountain View

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Types and Ages of Patients Served

El Camino Hospital Laboratory serves patients in all age groups of our community, including hospitalized patients, Emergency Room patients, Dialysis patients, ambulatory outpatients, industry clients, employees, and physicians.

Assessment Methods

All laboratory testing is performed and reviewed by California-licensed Clinical Laboratory Scientists (CLS), using FDA-approved and appropriately validated equipment and methods supported by CAP-mandated policy and procedure manuals. Internal quality control materials and external proficiency testing samples ensure the accuracy of the tests performed. The Laboratory Information System (LIS) assists each CLS with the evaluation of patient results, using automated statistical review of QC results, automated comparison of patient results to normal reference ranges by age and sex, and automated comparisons to previous results for that patient (delta checks). Pathologists provide 24-hour availability (either on-site or on-call) for any desired consultations with physicians or laboratory staff.

Scope and Complexity of Services Offered

El Camino Hospital Laboratory offers on-site diagnostic services in Chemistry, Hematology, Coagulation, Urinalysis, Microbiology, Parasitology, Immunology & Serology, Therapeutic Drug Monitoring, Transfusion Services, Point-of-Care Testing, and Technical Support (for the registration, collection, transport, and reporting of specimens).

Appropriateness, Necessity, and Timeliness of Services

El Camino Hospital Laboratory works with our physicians, both directly and through our pathologists, to assess the appropriateness of laboratory testing, including the use of blood components, hepatitis evaluations, manual differentials, cardiac injury markers, and many others.

El Camino Hospital Laboratory monitors its in-lab turnaround times for STATs and for morning rounds to ensure that physicians receive timely information necessary for the treatment of their patients. Our goals include 1-hour in-lab STAT turnaround (where physically possible) and 90% result availability by 8:00am for

morning rounds.

El Camino Hospital Laboratory currently refers the majority of its esoteric testing to Laboratory Corporation of America (Labcorp). The Laboratory has an on-line connection with Labcorp for collection requirements, test ordering, order status, and results.

Staffing

El Camino Hospital Laboratory is staffed 24 hours per day, 365 days per year to provide inpatient and emergency services whenever needed. The staff includes administrative and managerial personnel, Clinical Laboratory Scientists, Technical Support phlebotomy and clerical personnel, and Laboratory Information System specialists. **Hospital outpatient services** are routinely available weekdays 6:00am – 8:00pm, ~~weekends~~Saturday 6:00am – 2:30pm, and by arrangement when services are necessary. **Off-site draw stations** are generally available weekdays, 8:00am – 5:30pm.

Level of Services Provided

El Camino Hospital Laboratory is a full-service laboratory. Less than 3% of all tests ordered are referred to an outside laboratory. The Laboratory dispatches all phlebotomy services for the collection of blood specimens. Where possible, STATs are completed within one hour of specimen receipt, and most orders are complete within 24 hours. Inpatient results are available in the EHR (Electronic Health Record) immediately upon release from the Laboratory, and ~~outpatient~~for those physicians who do not have access to the EHR, results are printed nightly and delivered to physician offices daily, Monday through Friday. The Laboratory also operates an off-site draw station - patient service center for the added convenience of patients and physicians.

Standard of Practice

El Camino Hospital Laboratory complies with all regulations and standards set forth by CLIA'88, the College of American Pathologists (CAP), the California State Department of Health Services, the Joint Commission on Accreditation of Healthcare Organizations ((TJC) JOINT COMMISSION), and the FDA. The Laboratory is accredited biannually by CAP. (TJC) JOINT COMMISSION reviews the Laboratory as part of its accreditation of El Camino Hospital.

In addition to meeting current regulatory compliance standards, El Camino Hospital Laboratory supports the standards of medical practice at El Camino Hospital by providing accurate, reliable, and timely laboratory services in order to facilitate the best possible patient outcomes.

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ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2022
Department Medical Director or Director for non-clinical Departments	Laura Gutierrez: Director Laboratory & Pathology Services	01/2022
	Laura Gutierrez: Director Laboratory & Pathology Services	01/2022

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Owner:	*Laura Gutierrez: Director Laboratory & Pathology Services*
Area:	*Scopes of Service*
Document Types:	*Scope of Service/ADT*

Scope of Service: Clinical Laboratory - Los Gatos

Types and Ages of Patients Served

El Camino Hospital of Los Gatos Laboratory serves patients in all age groups of our community, including hospitalized patients, Emergency Room patients, Dialysis patients, ambulatory outpatients, industry clients, employees, and physicians.

Assessment Methods

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All laboratory testing is performed and reviewed by California-licensed Clinical Laboratory Scientists (CLS), using FDA-approved and appropriately validated equipment and methods supported by CAP-mandated policy and procedure manuals. Internal quality control materials and external proficiency testing samples ensure the accuracy of the tests performed. The Laboratory Information System (LIS) assists each CLS with the evaluation of patient results, using automated statistical review of QC results, automated comparison of patient results to normal reference ranges by age and sex, and automated comparisons to previous results for that patient (delta checks). Pathologists provide 24-hour availability (either on-site or on-call) for any desired consultations with physicians or laboratory staff.

Scope and Complexity of Services Offered

El Camino Hospital of Los Gatos Laboratory offers basic on-site routine and STAT testing in Chemistry, Hematology, Coagulation, Urinalysis, Immunology & Serology, and Therapeutic Drug Monitoring. The Laboratory has a full service Transfusion Services department, offers Point-of-Care Testing, and Technical Support (for the registration, collection, transport, and reporting of specimens). With the exception of Rapid PCR testing for COVID-19, RSV, Influenza A and B and MRSA, STAT gram stains, rapid kit testing for Strep A,~~ RSV, and Influenza A and B,~~ KOH, Wet Mount, and Occult Blood, all Microbiology samples submitted for culture and sensitivities are referred to the Mountain View Microbiology Laboratory.

Appropriateness, Necessity, and Timeliness of Services

El Camino Hospital of Los Gatos Laboratory works with our physicians, both directly and through our pathologists, to assess the appropriateness of laboratory testing, including the use of blood components, hepatitis evaluations, manual differentials, cardiac injury markers, and many others.

The Laboratory monitors its in-lab turnaround times for STATs and for morning rounds to ensure that

physicians receive timely information necessary for the treatment of their patients. Our goals include 1-hour in-lab STAT turnaround (where physically possible) and 90% result availability by 8:00am for morning rounds.

The majority of its esoteric testing is referred to Laboratory Corporation of America (Labcorp). The Laboratory has an on-line connection with Labcorp for collection requirements, test ordering, order status, and results.

Staffing

El Camino Hospital of Los Gatos Laboratory is staffed 24 hours per day, 365 days per year to provide inpatient and emergency services whenever needed. The staff includes managerial personnel, Clinical Laboratory Scientists, Technical Support phlebotomy and clerical personnel. **Hospital outpatient services** are available weekdays 8:00am –6:00pm, weekends 8:00am – 2:30pm.

Level of Services Provided

El Camino Hospital of Los Gatos Laboratory offers basic routine and STAT testing. The Laboratory dispatches all phlebotomy services for the collection of blood specimens. Where possible, STATs are completed within one hour of specimen receipt, and most orders are complete within 24 hours. Inpatient and Outpatient results are available in Electronic ~~Medical~~Health Record (~~EMR~~EHR) immediately upon release from the Laboratory. For physicians who do not have access to the EHR, ~~and outpatient~~ results are printed nightly and delivered to physician offices daily, Monday through Friday.

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Standard of Practice

El Camino Hospital of Los Gatos Laboratory complies with all regulations and standards set forth by CLIA'88, the College of American Pathologists (CAP), the California State Department of Health Services, The Joint Commission (TJC), and the FDA. The Laboratory is accredited biannually by CAP. TJC reviews the Laboratory as part of its accreditation of El Camino Hospital

In addition to meeting current regulatory compliance standards, the Clinical Laboratory supports the standards of medical practice at El Camino Hospital by providing accurate, reliable, and timely laboratory services in order to facilitate the best possible patient outcomes.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	02/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2022

Step Description	Approver	Date
Department Medical Director or Director for non-clinical Departments	Laura Gutierrez: Director Laboratory & Pathology Services	01/2022
	Laura Gutierrez: Director Laboratory & Pathology Services	01/2022

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Area:	*Scopes of Service*
Document Types:	*Scope of Service/ADT*

Scope of Service: Pathology Services - Los Gatos

Types and Ages of Patients Served

The Pathology Department of El Camino Hospital Los Gatos serves inpatients and outpatients of all ages including satellite outpatients (from physician offices and clinics), emergency room patients, employees and physicians.

Assessment Methods

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Routine Histology and Cytology specimens are transported to the Mountain View Pathology laboratory for processing. Pathology specimens are examined by Pathologists and Pathology Assistants under the supervision of a Pathologist. The specimens are processed and paraffin blocks and slides are prepared by Histotechnologists and/or Cytotechnologists according to established procedures. The slides are microscopically examined by the pathologists for diagnosis and inconsistencies with the patient data and pertinent previous cytologic and/or histologic materials. The validity of these reports is confirmed by internal quality control policies and procedures as well as external proficiency testing. Special diagnostic stains or requests for special procedures are done every day as required for patient care. Quality control measures are in place to insure the accuracy of our stains and special procedures.

Scope and Complexity of Services Offered

The El Camino Hospital Pathology Department offers anatomic pathology services which include surgical pathology, including intraoperative consultation, frozen sections, cytology and autopsy.

Appropriateness, Necessity and Timeliness of Services

The Pathology Department assesses the appropriateness of requests for examinations such as autopsies biopsies and frozen sections through departmental quality assessment policies and procedures.

The monitoring of turn-around times for STAT and routine procedures and final diagnostic reports is performed as an integral part of the performance improvement strategies. In order to facilitate the best patient care possible, our commitment to the hospital is to provide timely, complete, and accurate diagnostic reports to physicians and patient are departments, in addition to assisting patients who need to take their slides and reports to outside facilities for continued care.

Staffing

The Medical Director serves as Chair of the Department of Pathology and serves on committees as designated by the hospital and medical staff. All six Pathology Department pathologists are certified in anatomic and clinical pathology by the American Board of Pathology. A Cytology Technologist is available upon request (pre-scheduled) to assist with FNA procedures (specimen adequacy check). Cytology cases are occassionally screened on-site and Surgical Cases are signed out daily by the Pathologist.

Hours of Operation

A Pathologist is on-site Monday through Friday 8am to 5 pm and available on-call after hours and on weekends and holidays.

Standard of Practice

The Pathology Department follows the guidelines set forth in CLIA 88. Inspection is conducted on a biennial basis by The College of American Pathologists (CAP). The CAP inspection is accepted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The State of California, Department of Health Services also conducts a periodic inspection. JCAHO participates in that inspection of the laboratory as a part of their overall hospital accreditation survey.

Additionally, criteria for standards of practice are found in departmental policy and procedure.

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

Finance

For the month ending January 31, 2022, produced net operating revenue, after expenses, of $11.8 million. Net income was unfavorable to budget by $34.5 million and $19.8 million lower than the same period last year. This is attributed the instability in the capital markets which resulted in unrealized losses of $31.5 million in the month of January. Please note these results are preliminary as they have not been presented and reviewed by the Finance Committee.

On March 1st. Global Healthcare Exchange (GHX) informed us that our Supply Chain department is one of the Top 50 in North America. This recognition is given to health care organizations which demonstrate a commitment to building and executing a supply chain strategy that removes unnecessary waste, drives greater efficiencies and, as a result, raises the quality of patient care.

In the past couple of weeks we completed our annual updates with the credit rating agencies. I'm pleased to share that Standard & Poor's affirmed our 'AA' rating with a 'Stable' outlook. In order to provide the organization with additional flexibility in the future, we added Fitch Ratings to our credit. Fitch assigned a 'AA-' rating with a 'Stable' outlook to our Revenue and General Obligation bonds. Both agencies were complementary of the operational initiatives which have enabled us to rebound from the impact of the various Covid waves, but did highlight the need to effectively / carefully deploy capital over the next 5-10 years.

Operations

In response to the shortage of healthcare workers, El Camino Health (ECH) launched a transition to acute care program, as one of many initiatives used to promote recruitment into our nursing workforce. Over 300 nurses applied to the program and 14 were selected and joined ECH in January.

El Camino Health submitted an application of accreditation to create a Pharmacy Residency Program to support ongoing advancement of pharmacy resident student at El Camino Health.

Human Resources

El Camino Health validated 100% compliance with the Santa Clara County health order to ensure all staff are fully vaccinated and have received their booster shot by the March 1 deadline.

ECH continues its journey towards building a High Reliability Organization. Recently, the organization has launched an inititative geared towards created a 'Just Culture' and the development of Leader Skill and Universal Skills training.

El Camino Health conducted its Annual Service Awards celebration recognizing employees across the organization for their years of service, outstanding leadership and excellence in nursing.

Information Services

As Cybersecurity threats increase world-wide, the ECH Cybersecurity Team has achieved an "Advanced" security rating for our organization and has reduced external vulnerabilities by 98.5 percent. The team has worked diligently to provide protection from attack vectors associated with recent geopolitical tensions and a serious vulnerability risk known as Log4j through improvements in the areas of vulnerability management, security tool capabilities, adaptive perimeter defenses and user education.

Real Time Prescription Benefits are now available in the EMR to enable physician real time checking of medication cost based upon patient insurance information. This capability provides cheaper alternatives to patients and prevents surprises when prescriptions are filled and retrieved at pharmacy locations.

To meet the immediate need for tracking COVID Booster vaccinations, a COVID Booster Form and Dashboard was configured within a week in the Service Now application allowing Employee Health Services to securely monitor and report out COVID vaccination status in alignment with clinical and HIPAA privacy requirements.

Philanthropy

El Camino Health Foundation continues to judiciously allocate the nearly $2.7 million COVID-19 Emergency Response Fund. In January, $50,000 was apportioned to underwrite hotel stays for employees who work double shifts and live more than 20 miles from the hospital.

This month, El Camino Health Foundation celebrated Santa Clara Sporting Club. SCSC, a youth soccer club, has held a Goals for a Cure fundraiser and donated the proceeds to the Free Mammogram Program every year since 2009. Their latest gift, $50,000, brings their cumulative giving over 14 years to $515,000. To minimize risks posed by COVID-19, El Camino Health Foundation President Andrew Cope and Imaging Services Service Line Leader Josh Schreckengost taped a video thank you that the club shared with its members and on social media.

The Judge Lorraine Kendall Cancer Center received a gift that can provide an annual endowment of $200,000 per year for the Cancer Center in honor and memory of Judge Lorraine Kendall.

Corporate & Community Health Services

Concern has enhanced its digital engagement platform with a mobile first design to improve the user experience and allow easy access to all services. Concern launched personalized coaching with certified coaches to help employees address work life balance, sleep, stress management and burn out. This is a competitive advantage and meets the expectation of some of our top customers.

The Chinese Health Initiative (CHI) established a new partnership with the Sunnyvale library to provide bilingual webinars by registered dietitians. For American Heart Month, CHI partnered with the Women's Heart Center to host a webinar by Dr. Lombard. CHI held their annual volunteer appreciation event with over 30 volunteers in attendance.

The South Asian Heart Center engaged 550 participants in screening, education and coaching programs and completed over 750 consultations and coaching sessions. The center hosted five lifestyle workshops and health information events attended by 325 community members. Dr. Lombard was a keynote speaker at a community health huddle.

Auxiliary

The Auxiliary donated 2,081 volunteer hours for the month of January.

Revised January 3, 2022

FY22 Hospital Board Pacing Plan – Q1		
JULY - NO MEETING	**August 18, 2021**	**September 22, 2021 (Rescheduled)**
	Regular Items: • Board Recognition • Committee Reports (GC, FC, ECC) • Quality Committee Report (Board Quality Dashboard) • Medical Staff Report (Closed) With Q4 Appt. and Resignation Summary) • Executive Session • Public Communication	**Regular Items:** • Board Recognition • Committee Reports (IC, CAC) – Written Memo as needed • Quality Committee Report • Executive Session • Public Communication
	Consent Calendar Approvals: • Board (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Medical Staff Report (Open) • FY 21 Period 11 Financials • Credentialing and Privileges Report	**Consent Calendar Approvals:** • Board (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Credentials and Privileges Report
	Informational Items: • CEO Report w/Auxiliary, Foundation Reports	**Informational Items:** • CEO Report • FY22 Period 1 Financials
	Specific Items: Approvals: • FY21 Period 12 Financials • FY22 Organizational Performance Goals • Board Action Plan	**Specific Items:** Approvals: • FY21 Patient Safety Claims Report (Annual)
	Discussion: • Enterprise Risk Management • Strategic Plan	Discussion: • FY21 Strategic Plan Metrics (Final)

Revised January 3, 2022

FY22 Hospital Board Pacing Plan – Q2		
October 13, 2021	**November 10, 2021**	**December 8, 2021**
Regular Items: • Board Recognition • Committee Reports (FC, ECC, CAC,) • Quality Committee Report (Open Consent) • Executive Session • Public Communication	**Regular Items:** • Board Recognition • Committee Reports (GC meeting, ECC) • Quality Committee Report (Open Session Discussion Board Quality Dashboard) • Executive Session • Public Communication	**Regular Items:** • Board Recognition • Committee Reports • Quality Committee Report (Open Consent) • Executive Session • Public Communication
Consent Calendar Approvals: • Board Minutes (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Annual 403(b) Audit • Participant Cash Balance Plan Audit • Closed Session QC Report (C&P, QC Minutes) • FY21 CB Plan Report	**Consent Calendar Approvals:** • Board Minutes (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Medical Staff Report (Open) • Annual Safety Report for the Environment of Care • Closed Session QC Report (C&P, QC Minutes) • Reappoint Carlos Bohorquez to PHHH Board (term expires)	**Consent Calendar Approvals:** • Board (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Letters of Rebuttable Presumption • FY22 P3 Financials • Closed Session QC Report (C&P, QC Minutes)
Informational Items: • CEO Report Incl. Auxiliary and Foundation Reports (Foundation Report in Person)	**Informational Items:** • CEO Report Incl. Auxiliary Foundation Reports • FY22 Period 3 Financials	**Informational Items:** • CEO Report Incl. Auxiliary, Foundation Reports • MV Site Plan Status (From Nov. FC)
Specific Items: Approvals: • FY22 Period 2 Financials • FY21 Audit • FY21 Organizational Performance Goal Score • FY21 Organizational Performance (Incentive) Goal Achievement (Score) • FY22 Executive Base Salaries, Salary Ranges • FY21 CEO Incentive Comp. Individual Score and Payment • Capital Purchase – 2660 Grant Road	**Specific Items:** Approvals: • Board Action Plan • FY21 Compliance Summary • FY22 Period 4 Financials (Quarterly Financial Report)	**Specific Items:** Approvals: •
Discussion: • Governance Best Practices	Discussion: • FY22 Strategic Plan Metrics Update (Q1 Results) • ECHMN (SVMD) Semi-annual Report	Discussion: • Strategic Planning Update • ERM – Follow Up Discussion • Board Assessment

Revised January 3, 2022

FY22 Hospital Board Pacing Plan – Q3		
January 2022 – NO MEETING	**February 9, 2022**	**March 9, 2022**
	Regular Items: • Board Recognition • Committee Reports (FC, CAC, GC)?? • Quality Committee Report (Open Discussion Board Quality Dashboard) • Medical Staff Report (Closed) (With Q2 Appt. and Resignation Summary) • Executive Session • Public Communication	**Regular Items:** • Board Recognition • Committee Reports (GC, CAC) • Quality Committee Report (Exception Report/Underperforming Metrics) • Executive Session • Public Communication
	Consent Calendar Approvals: • Board (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Medical Staff Report (Open) • Period 5 Financials • Closed Session QC Report (C&P, QC Minutes)	**Consent Calendar Approvals:** • Board (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Closed Session QC Report (C&P, QC Minutes)
	Informational Items: • CEO Report Incl. Auxiliary, Foundation Report, ERM	**Informational Items:** • CEO Report Incl. Auxiliary, Foundation Reports • FY 21 Period 7 Financials
	Specific Items: Approvals: • FY 22 Period 6 Financials (Quarterly Financial Report) • Board Member Benefits • ~~Proposed Revised Community Benefits Policy (Delegation to FC)~~	**Specific Items:** Approvals: • Draft Revised Long-Term Operating and Capital Financial Plan • ~~PBX Call Center Scope of Service~~ • Strategic Plan Approval (Open Session)
	Discussion: • Strategic Planning Update • Strategic Plan Implementation - Q2 FY22 Metrics *** February 23, 2022: Board Retreat - Understanding Systemness and System Alignment & Building an Outpatient Strategy*	Discussion: • ~~MSO Education~~ • Enterprise Risk Management (Follow-up Discussion)

Revised January 3, 2022

FY22 Hospital Board Pacing Plan – Q4		
April 13, 2022	**May 11, 2022**	**June 8, 2022**
Regular Items: • Board Recognition • Committee Reports (GC, CAC, FC, ECC) • Quality Committee Report (Open Consent) • Medical Staff Report (Closed) (With Q3 Appt. and Resignation Summary) • Executive Session • Public Communication	**Regular Items:** • Board Recognition • Committee Reports • Quality Committee Report (Open Discussion Board Quality Dashboard) • Executive Session • Public Communication	**Regular Items:** • Board Recognition • Committee Reports (IC, GC, ECC, FC, CCC) • Quality Committee Report (Open Consent) • Executive Session • Public Communication
Consent Calendar Approvals: • Board (Open and Closed) • Policies • Physician Agreements • Committee Recommendations (GC, CAC, ECC, FC) • Medical Staff Report (Open) • FY21 Period 7 and 8 Financials • Closed Session QC Report (C&P, QC Minutes) • Letters of Rebuttable Presumption	**Consent Calendar Approvals:** • Board (Open and Closed) • Policies • Physician Agreements • Committee Recommendations • Approval of Auxiliary Officers • Closed Session QC Report (C&P, QC Minutes)	**Consent Calendar Approvals:** • Board (Open and Closed) • Policies • Physician Agreements • Med Staff Report (Open) w/Clinical Contracts • FY22 Master Calendar • FY22 Committee Goals • FY22 Committee and Liaisons Appointments • Closed Session QC Report (C&P, QC Minutes) • FY21 Period 10 Financials
Informational Items: • CEO Report w/Auxiliary, Foundation Reports • MV Site Plan Status (From March FC)	**Informational Items:** • CEO Report w/Auxiliary, Foundation Reports	**Informational Items:** • CEO Report w/Auxiliary, Foundation Reports • Individual Goals • Executive Performance Incentive Plan • MV Site Plan Status (from June FC)
Specific Items: Approvals:	**Specific Items:** Approvals: • Board Quality Dashboard • FY21 Period 9 Financials (Quarterly Financial Report)	**Specific Items:** Approvals: • FY22 CEO Salary and Contract • FY22 Community Benefit Plan
Discussion:	Discussion: • Strategic Plan Implementation FY21 Q3 Metrics and Review, Draft FY22 Strategic Plan Goals and Metrics • FY22 Budget Preview (Assumptions) • ECHMN Semi-Annual Report *** May 24: Joint Meeting with Finance Committee*	Discussion: • FY22 Strategic Plan Goals and Metrics • FY22 Capital and Operating Budget • CQO Salary • Anesthesia Group