El Camino Health

AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, November 10, 2021 – 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: 942-6630-8345# No participant code. Just press #.

To watch the meeting Livestream, please visit: https://www.elcaminohealth.org/microsites/communitybenefit2021/
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 – 5:31pm**
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 – 5:33**
4. Q1 FY 2022 FINANCIAL RESULTS	Carlos Bohorquez, Chief Financial Officer		**information 5:33 – 5:48**
5. QUALITY COMMITTEE REPORT	Julie Kliger, Chair of Quality Committee Dr. Mark Adams, Chief Medical Officer		**information 5:48 – 5:58**
6. ADJOURN TO CLOSED SESSION	Lanhee Chen, Board Chair	*public comment*	**motion required 5:58 – 5:59**
7. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Lanhee Chen, Board Chair		**information 5:59 – 6:00**
8. Health and Safety Code Section 32155 **QUALITY COMMITTEE REPORT**	Julie Kliger, Chair of Quality Committee Dr. Mark Adams, Chief Medical Officer		**information 6:00 – 6:05**
9. CONSENT CALENDAR *Any Board Member may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair		**motion required 6:05 – 6:06**
Approval *Gov't Code Section 54957.2:* a. **Minutes of the Closed Session of the Hospital Board Meeting (10/13/2021)** ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** *Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*:* b. **Credentialing and Privileges Report**			

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at **(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. Gov't Code Section 54956.9(d) for a conference with legal counsel – pending or threatened litigation: **FY21 COMPLIANCE REPORT**	Diane Wigglesworth Sr. Dir. Of Corporate Compliance Mary Rotunno, General Counsel		**discussion** **6:06 – 6:11**
11. Health and Safety Code Section 32106(b) for a report and discussion involving health care facility trade secrets: **ECHMN SEMI-ANNUAL REPORT**	Vince Manoogian, Interim President of ECHMN		**discussion** **6:11 – 6:41**
12. *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: **FY22 STRATEGIC METRICS**	Dan Woods, Chief Executive Officer		**discussion** **6:41 – 6:56**
13. Report involving *Gov't Code Section 54957(b) for discussion and report on personnel matters:* **CEO REPORT** a. Update (verbal) b. Pacing Plan	Dan Woods, Chief Executive Officer		**discussion** **6:56 – 7:01**
14. Report involving *Gov't Code Section 54957(b)* for discussion and report on personnel performance matters – Senior Management: **EXECUTIVE SESSION**	Lanhee Chen, Board Chair		**discussion** **7:01 – 7:21**
15. ADJOURN TO OPEN SESSION	Lanhee Chen, Board Chair		**motion required** **7:21 – 7:22**
16. RECONVENE OPEN SESSION/ REPORT OUT	Lanhee Chen, Board Chair		**information** **7:22 – 7:23**
To report any required disclosures regarding permissible actions taken during Closed Session.			
17. 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** **7:23 – 7:24**
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 Meeting (10/31/21) c. Policy Revisions ***Reviewed and Recommended for Approval by the Finance Committee*** d. FY21 Period 2 Financials ***Reviewed and Recommended for Approval by the Medical Executive Committee*** e. Medical Staff Report			
18. CEO REPORT	Dan Woods, Chief Executive Officer		**information** **7:24 – 7:28**
19. BOARD COMMENTS	Lanhee Chen, Board Chair		**information** **7:28 – 7:29**
20. ADJOURNMENT	Lanhee Chen, Board Chair	*public comment*	**motion required** **7:29 – 7:30pm**

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

Upcoming Special Meetings - Education/Retreat: December 1, 2021 (Joint Board and Committee Education); February 23, 2021 (Retreat); April 27, 2022 (Board Education)

El Camino Health

Summary of Financial Results Q1 FY2022

Carlos Bohorquez, Chief Financial Officer

November 10, 2021

Executive Summary: □ □ □□□□□□ Results □as of □□□□□□□□□□

- Q1 FY2022 results reflect a full recovery from the effects of the Covid pandemic
- Revenue has been particularly strong which is attributed to record volumes across most inpatient / outpatient service lines, strategic pricing initiative implemented on July 1st and stable payor mix
- Higher than expected volumes are resulting in unfavorable to budget trends for total FTEs, salaries / wages and other expenses, but not significant enough to negatively impact margins
- Despite strong Q1 financial results, we anticipate staffing shortages and higher than expected inflation to negatively impact operating EBIDA margins in the 2-□□ range in Q2 & Q□
- □nderperformance by our investment portfolio has resulted in unfavorable to budget net margin

□ey □tili□ation Statistics: □ □ □□□□□ □as of □□□□□□□□□

Key Statistics	Month to Date PY	CY	Budget	Variance (%) CY vs PY	CY vs Budget	Year to Date PY	CY	Budget	Variance (%) CY vs PY	CY vs Budget
ADC	246	268	234	9.1%	14.5%	236	265	238	12.0%	11.4%
Utilization MV	64%	71%	62%	10.8%	15.5%	61%	70%	63%	14.1%	11.2%
Utilization LG	32%	32%	29%	1.5%	10.1%	32%	33%	29%	3.2%	12.9%
Utilization Combined	54%	59%	52%	9.1%	14.5%	52%	58%	52%	12.0%	11.5%
Adjusted Discharges	2,860	3,441	2,958	20.3%	16.3%	8,698	10,325	8,976	18.7%	15.0%
Total Discharges (Exc NB)	1,546	1,771	1,564	14.6%	13.3%	4,640	5,257	4,799	13.3%	9.5%
Total Discharges	1,873	2,215	1,940	18.3%	14.2%	5,704	6,491	5,926	13.8%	9.5%
Inpatient Activity										
MS Discharges	1,040	1,160	1,020	11.5%	13.8%	3,056	3,485	3,147	14.0%	10.7%
Deliveries	357	464	399	30.0%	16.3%	1,140	1,322	1,194	16.0%	10.7%
BHS	93	120	109	29.0%	10.2%	296	332	337	12.2%	(1.6%)
Rehab	51	32	36	(37.3%)	(11.1%)	145	116	120	(20.0%)	(3.3%)
Outpatient Activity										
Total Outpatient Cases	15,123	17,048	12,858	12.7%	32.6%	45,210	50,523	39,696	11.8%	27.3%
ED	2,951	4,341	3,027	47.1%	43.4%	9,230	12,889	9,358	39.6%	37.7%
OP Surg	500	572	435	14.4%	31.4%	1,506	1,763	1,283	17.1%	37.4%
Endo	214	221	187	3.3%	18.2%	699	731	614	4.6%	19.1%
Interventional	178	177	168	(0.6%)	5.4%	529	575	523	8.7%	9.9%
All Other	11,280	11,737	9,040	4.1%	29.8%	33,246	34,565	27,919	4.0%	23.8%
Hospital Payor Mix										
Medicare	48.4%	45.6%	47.4%	(5.8%)	(4.0%)	47.9%	47.2%	47.5%	(1.4%)	(0.6%)
Medi-Cal	7.5%	8.7%	7.9%	16.5%	9.3%	7.2%	8.3%	7.9%	15.3%	5.4%
Commercial	41.9%	43.9%	42.5%	4.6%	3.0%	42.5%	42.3%	42.5%	(0.5%)	(0.5%)
Other	2.2%	1.8%	2.1%	(15.9%)	(15.9%)	2.4%	2.1%	2.1%	(9.7%)	1.3%

El Camino Health

Operational □□inancial Results: □ □ □□□□□□ □as of □□□□□□□□□□

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($ thousands)		Current □ear	□udget	□ariance to □udget	Performance to □udget	Prior □ear	□ariance to Prior □ear	□ariance to Prior □ear	□oody□s □A□□	S□P □AA□	Performance to Rating Agency □edians
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Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021.
S&P Medians: □.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August □0, 2021.
DCOH total includes cash, short-term and long-term investments.

El Camino Health

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Consolidated Statement of Operations *($000s)*

as of

Period 3 FY 2021	Period 3 FY 2022	Period 3 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
357,838	420,182	358,915	61,267	17.1%	**Gross Revenue**	1,030,188	1,245,092	1,092,965	152,127	13.9%
(267,829)	(315,406)	(266,701)	(48,705)	(18.3%)	**Deductions**	(768,638)	(934,059)	(812,677)	(121,382)	(14.9%)
90,009	**104,776**	**92,214**	**12,562**	**13.6%**	**Net Patient Revenue**	**261,549**	**311,032**	**280,288**	**30,744**	**11.0%**
3,996	3,479	3,595	(116)	(3.2%)	**Other Operating Revenue**	12,994	10,340	10,740	(400)	(3.7%)
94,005	**108,256**	**95,809**	**12,446**	**13.0%**	**Total Operating Revenues**	**274,543**	**321,373**	**291,028**	**30,345**	**10.4%**
					OPERATING EXPENSE					
48,136	53,629	49,813	(3,816)	(7.7%)	**Salaries & Wages**	142,306	160,569	152,986	(7,583)	(5.0%)
12,798	14,862	14,257	(605)	(4.2%)	**Supplies**	42,511	44,540	42,636	(1,903)	(4.5%)
14,949	14,800	14,381	(419)	(2.9%)	**Fees & Purchased Services**	42,233	43,372	43,508	136	0.3%
4,498	3,676	4,282	606	14.2%	**Other Operating Expense**	11,677	10,851	13,453	2,601	19.3%
1,428	1,418	1,403	(15)	(1.1%)	**Interest**	4,287	4,254	4,202	(53)	(1.3%)
5,795	5,902	5,659	(242)	(4.3%)	**Depreciation**	16,354	17,785	17,083	(703)	(4.1%)
87,604	**94,286**	**89,795**	**(4,491)**	**(5.0%)**	**Total Operating Expenses**	**259,367**	**281,371**	**273,867**	**(7,505)**	**(2.7%)**
6,401	**13,970**	**6,014**	**7,956**	**132.3%**	**Net Operating Margin**	**15,176**	**40,002**	**17,162**	**22,840**	**133.1%**
(9,557)	(18,378)	8,033	(26,411)	(328.8%)	**Non Operating Income**	46,803	(8,181)	22,161	(30,341)	(136.9%)
(3,156)	**(4,408)**	**14,047**	**(18,455)**	**(131.4%)**	**Net Margin**	**61,979**	**31,821**	**39,322**	**(7,501)**	**(19.1%)**
13,624	**21,289**	**13,076**	**8,213**	**62.8%**	**Operating EBIDA**	**35,816**	**62,041**	**38,446**	**23,595**	61.4%
14.5%	19.7%	13.6%	6.0%		**Operating EBIDA Margin**	13.0%	19.3%	13.2%	6.1%	
6.8%	12.9%	6.3%	6.6%		**Operating Margin**	5.5%	12.4%	5.9%	6.6%	
-3.4%	-4.1%	14.7%	(18.7%)		**Net Margin**	22.6%	9.9%	13.5%	(3.6%)	

El Camino Health

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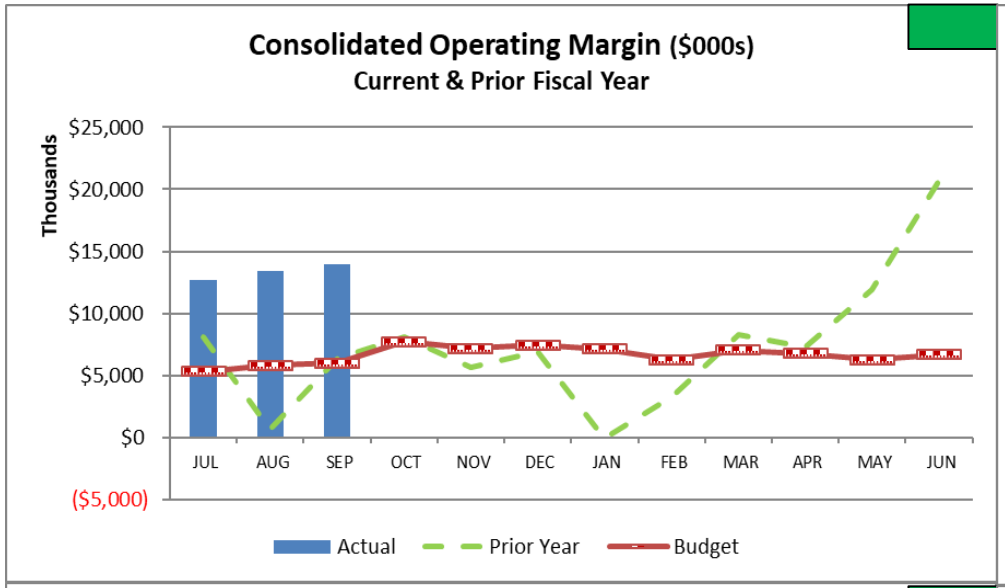

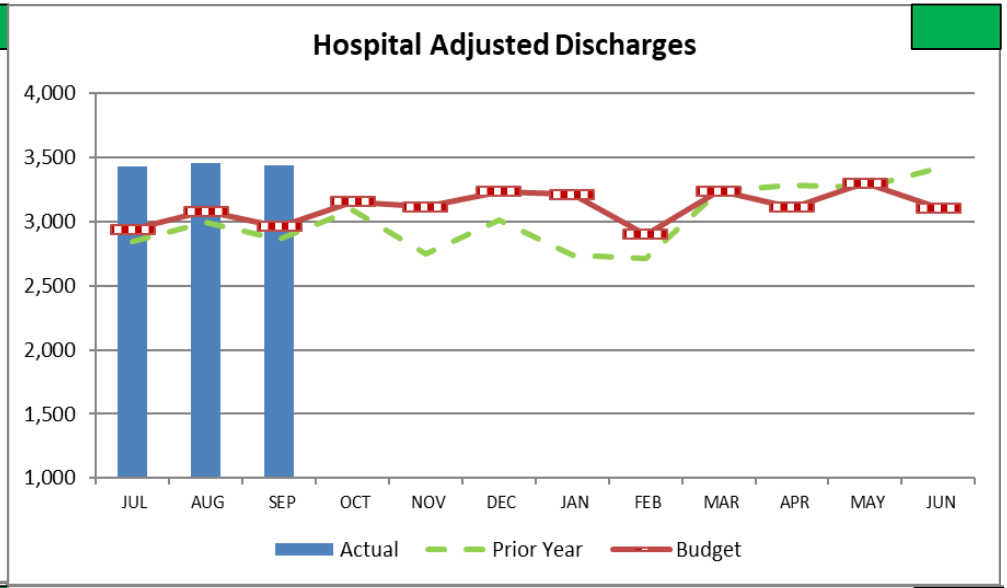

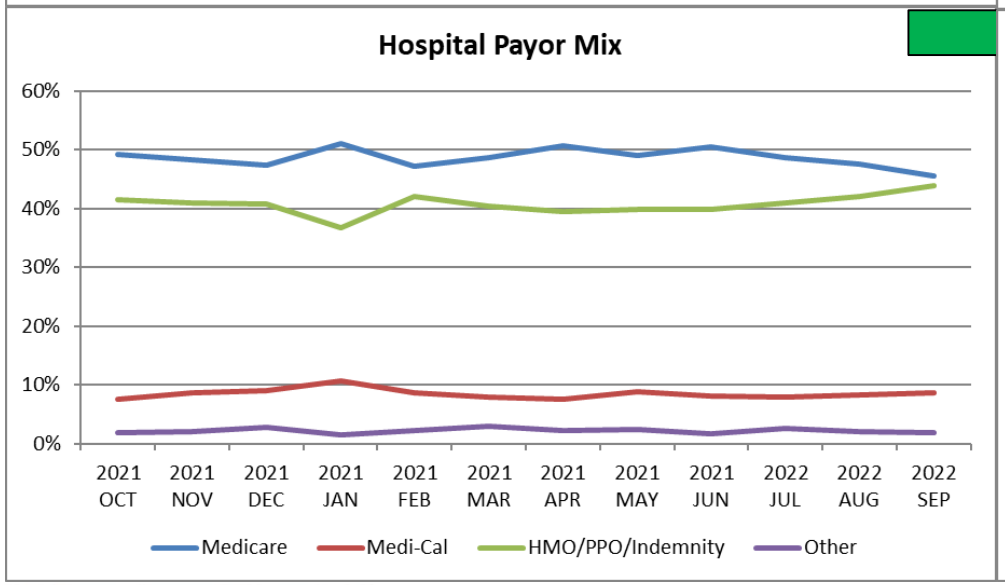

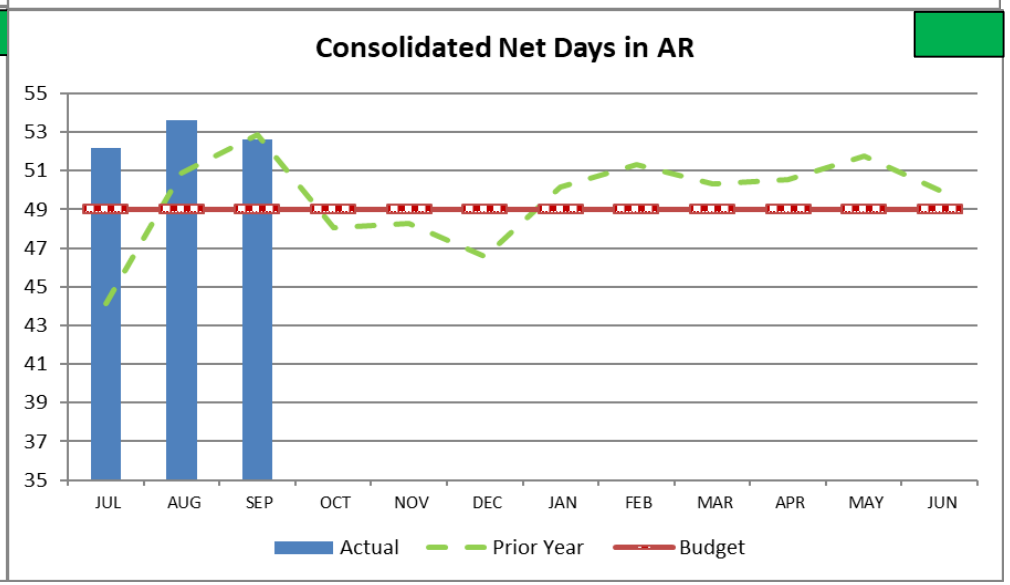

El Camino Health

El Camino Health

EL CA□INO □OSPITAL □OARD O□ DIRECTORS
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To: El Camino Hospital Board of Directors
□rom: Julie □liger, Quality Committee Chair
Mark Adams, MD, CMO
Date: November 10, 2021
Su□□ect: Quality, Patient Care and Patient Experience Committee Report

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

Summary:

1. The committee chair, Ms. □liger, reviewed the current and future state of quality and safety performance as it relates to the pandemic. CO□ID-19 will remain with us well into the near future so it is important that we understand how the organization will adapt to be able to meet this demand while continuing to move forward on all quality, safety, and experience fronts. CO□ID-19 will no longer be considered the primary driver of quality results but rather just another factor among many that influence our care outcomes.

2. Cheryl Reinking, CNO, reviewed the most recent patient story which came from a patient who was recently discharged from the hospital. The patient reported that they were served an after dinner snack consisting of a sandwich with an apple slice despite the fact that they were allergic to apples. Ms. Reinking then reported that the organization is assessing two technology solutions: one, a forced food allergy documentation function in *Epic* and a methodology to order meals for the next morning after hours.

□. Mark Adams, CMO, provided an overview of the Q1 Board Quarterly Quality and Safety Dashboard. Highlights included:

    a. Safe Care:
        i. There has been an unexpected spike in CAUTI's during this quarter. The CA□TI incidents were localized to a few specific nursing units. Root cause analysis revealed that there was a lapse in technique in those areas which has been addressed by enhanced education by our infection control nurses.
    b. Timely:
        i. ED throughput continues to lag behind target. Contributing factors are increased volume and staffing challenges, increased acuity of the patients seeking care requiring more complex workups, and the need for continued CO□ID-19 testing. Attempts are being made to ramp up staffing but this takes time in the face of a severe nursing shortage. CA staffing ratio mandates further complicate our ability to respond to volume surges even when staff is present. Hospitalist staffing has increased to try to meet this increased demand. Alternatives to current laboratory CO□ID testing are being considered such as the rapid lateral assay point of care tool method.
    c. Effective Care:
        i. Readmission Index is elevated above the Premier Top Performers benchmark which is now 0.9□. A multi-pronged approach has been

implemented which includes the following teams: weekly readmission review which provides a Pareto analysis to focus the work, ERAS/Surgical complications, Cancer care, non-ventilator hospital acquired pneumonia, post-acute care and heart failure. This work is also supplemented by the newly initiated Cipher Discharge Phone Calls and the Care Companion.

ii. Sepsis Mortality Index continues to be elevated. Premier Top Performers benchmark is now 1.0□. There is now an additional sepsis coordinator to identify and follow sepsis patients. Sepsis Order Set composition is being adjusted and it's use emphasized as this correlates with improved successful treatment.

iii. PC-02 C/S rate: this has remained above target of 2□.□□. There is a wide variation among practitioners with some well below target and some approaching □0□. Efforts are being made to counsel those above the target.

d. Efficient Care: No issues

e. Equitable Care: No issues

f. Patient-Centered Care:

i. Trends are positive but still below the new FY22 targets. Interventions now underway include Leader Rounding, Discharge Phone Calls, Nurse Leader Rounding, WeCare Service Standards, Active complaints and grievances processing and resolution, Care Team Coaching, Physician Partnership, Service Recovery Training, Digital Strategy, and Texting to Patients.

Committee members expressed concern regarding the increasing indices for readmission, mortality, and sepsis mortality. Our data analytics company, Premier, recently changed their proprietary algorithms which has resulted in an increase in the indices for those measures across the board and across the country. However, efforts were reviewed that are being deployed to reverse the overall trends.

□. □ince Manoogian, Interim President of S□MD, and □te Burness, □P of Quality S□MD, presented the quarterly S□MD/ECHMN quality report. ECHMN has established true north pillars, one of which is quality and service. For quality, the goals are: achieve top decile HEDIS composite score by end of calendar year 202□ and achieve MIPS composite exceptional rating annually. 8 MIPS metrics have been selected based on importance to patient care and impact on financial reimbursement as the Quality Measures. The results for FY 22 Q1 is a composite score of □.□. The target composite score for FY22 is 3.6. ECHMN has added "soft stops" to some of the measures, updated the "tip sheets" for the staff and providers and we are retraining the staff. ECHMN has been working with the EPIC ICare team to implement "Heathy Planet" which will allow us to do population health management. We are also working on implementing the EPIC "HEDIS Module" for our fully capitated health plans. We anticipate going live with both of these products in early 2022.

Finally, the Net Promoter Score for ECHMN continues to be monitored. NPS is calculated by asking patients to rate on a 1 to 10 scale their likelihood to recommend. The percent of 9's and 10's is reduced by the number of 1's through 5's. (6, 7, and 8's do not count□ The Net Promoter Score for August 2021 was □□.□, which is down from the previous month of □□.□; ECMHN is in the process of implementing Press Ganey as the patient satisfaction tool.

ECHMN submitted the 2020 MIPS quality data in March. CMS announced in August, that ECHMN scored 100□.

ECHMN has also received Credentialing Delegation status from Blue Shield effective October 1, 2021. The credentialing department has approved □□ initial appointments and 8 reappointments in the first quarter of FY22.

Committee members expressed concern regarding the level of some of the metrics and the need for improvement. Questions were also asked re the complaints and grievances.

Attachments: FY22 Q1 Board Quality and Safety Dashboard

El Camino Health

Month to Quality Committee of the Board: November 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 22 (unless otherwise specified by*)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 21	FY 22	FY22, Q1	FY22, Q2	FY22, Q3	FY22, Q4	FYTD22 Total
Safe Care	Serious Safety Events Rate (Rolling 12 month)	3.13	2.97	2.54				2.54
	Surgical Site Infections (SSI)	0.30	1.0 (SIR)	*0.39				0.39
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.37	<= 0.75	1.32				1.32
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.53	<= 0.50	0.35				0.35
	Modified PSI-90 CMS HAC Reduction Program (composite)	0.919	0.90	0.846				0.846
Timely	HVI STEMI % 1st Medical Contact to Device Time w/I 90 minutes	100%	100%	data available up to June as of 10/25				NA
	Patient Throughput - Median Time Arrival to ED Departure	264 min	256 min	267 min				267 min
	Stroke: tPA <= 30 minutes	57.5% (23/14)	50%	25% (1/4)				25%
	Stroke: Door-to-Groin <= 75 minutes	16.7% (3/18)	50%	50% (1/2)				50%
Effective	Risk Adjusted Readmissions Index	0.93	0.92	*1.04				1.04
	Risk Adjusted Mortality Index	0.86	0.90	0.99				0.99
	Sepsis Mortality Index	1.08	1.03	1.06				1.06
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 0.63%	1.3%	*1.4%				1.4%
	PC-02 NTSV C-Section	ENT: 26.3%	23.5%	*25.4%				25.4%
	ECHMN: CMS 165 Controlling High Blood Pressure	59.0%	<= 59%	57.5%				57.5%
	ECHMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	30.0%	<= 30	28.3%				28.3%
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.23	1.00	0.96				0.96
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 19)	<=1	0.99				0.99
Equitable	Hospital Charity Care Support	$19.7 mil	NA	7.2 mil				7.2 mil
	Clinic Charity Care Support	$14.9k	NA	7.5k				7.5k
	Language Line Unmet Requests	0.72%	<1%	0.62%				0.62%
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.0	NA	4.3				4.30
		White: 3.89		3.77				3.77
		Asian: 3.57		3.59				3.59
Patient-Centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	79.6	79.7	82.0				82.0
	ED - Likelihood to Recommend (PG)	76.1	76.5	73.1				73.1
	ECHMN - Likelihood to Recommend Care Provider (NPS)	76.0	77.4	74.1				74.1
	MCH - HCAHPS Likelihood to Recommend	81.8	82.0	79.4				79.4
	OAS - HCAHPS Likelihood to Recommend	85.7	86.1	85.5				85.5

Report updated 11/3/21

*data available up to August only

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

OPEN SESSION CEO Report
Novem□er □□□□□□□
Dan □ oods□Chief Executive Officer

Operations
Managing hospital acquired pressure injuries □HAPI□has been a challenge throughout the pandemic. An increase in HAPI has been noted throughout the country particularly in critical care units. CO□ID patients have presented unique challenges due to oxygen delivery devices and unique positioning requirements such as the prone position which causes pressure on areas of the body not usually affected. Our nurses including our wound and ostomy nurses have attended conferences throughout the country □via □oom□and accessed best practices from their professional organizations to insure best practices are being used to prevent pressure injuries to these patients and others who are at high risk. We are pleased to report that the organization has not reported any Stage □ or □ pressure ulcers in the past □ months. The diligence and preventative measures the staff are taking is keeping our patient safe and preventing undue harm.

Mountain □iew Women□s Imaging Center achieved Accreditation for Breast MRI from the American College of Radiology

□uman Resources
As mandated by the CDPH El Camino Health achieved a 100□ Covid-19 vaccination compliance rate according to the criteria established by the CDPH. A total of □9 employees were granted either a religious or medical exemption from being fully vaccinated while all other employees are fully vaccinated. Access to Booster shot clinics is being coordinated through our Employee Wellness and Health Services department.
Total Rewards and HR Operations staff developed and implemented the Critical Staffing Pay Bonus program and which saw □□0 covered shifts for the first payperiod in October. This bonus program has significantly aided our ability to consistently staff our operations and will continue for the forseeable future.
The Human Resources Business Partners initiated consulting work with □0 Team □ Index departments to assist in their ability to improve their overall Employee Engagement results. Specially designed action oriented packets for each department were presented and 1:1 meetings with each leader were conducted including review of best practice information from Press Ganey. Employee Engagement Action Plans for all departments are due by October □0.

□ ar□eting and Communications

For the open enrollment period, to create brand awareness of El Camino Health's primary care services for the commercial and Medicare markets, a new primary care campaign launched. It includes, direct mail, digital advertising, social media ads, out-of-home, new landing pages and nurture emails.

To raise awareness of breast cancer risk, El Camino Health sponsored the American Cancer Society's Making Strides Against Breast Cancer October event and launched a targeted nurture breast cancer campaign to invite consumers to take care of their breast health by completing a health risk assessment □HRA□and make an appointment with a primary care physician □PCP□

Multiple SEM □search engine marketing□campaigns continue to run in market for a number of services lines.

Marketing supported the production of the □th Annual Maternal Mental Health Symposium with over 1,000 registrants.

Information Services

Dr. □ristin Andruska, a Neurologist from the California Movement Disorders Center, is live on the El Camino Health Epic "Community Connect" system. A total of 16 independent physicians are now using Epic as their EMR through the El Camino Health Community Connect Program.

The El Camino Health Medical Network has converted to a new □irtual □isit Platform designed for healthcare that integrates with Epic for scheduled appointments. Over 1□00 virtual visits have been completed.

Additionally, □irtual visits are conducted for identified patients post hospital discharge to facilitate continuity of care and promote a healthy recovery.

A Nurse Impact Dashboard is saving time nurses spend charting while tracking documentation compliance, blood administration safety, and proficiency metrics across workflows in one place. Nurses and nurse managers can use this tool to get a sense of how they□e doing in key areas or assess the performance of nurses they supervise, increasing productivity and efficiency.

El Camino Health's newest version of the "MyCare Now" Digital Front Door Mobile App has implemented new features to engage and prepare patients for Surgery and Childbirth with over 10□0 active users per month.

Philanthropy

On October 20, El Camino Health Foundation held a salon for major donors to the Fulfilling the Promise fundraising initiative for mental health & addiction services. The outdoor event took place at the Los Altos home of Leslie and Jerry Behar, which was formerly the residence of Adobe founder Chuck Geschke. Thirty-five guests attended and had the opportunity to hear from Scrivner Center Service Line Director Joe Sandoval and Chief Medical Director □alpana Nathan, MD. Dr. Nathan talked about her reasons for coming to El Camino Health and about the impact of our pioneering mental health programs. Joe spoke about the growth of the programs, the impact of CO□ID-19, and the vision for the future. Guests were particularly moved when he read a letter from a grateful patient. CEO Dan Woods introduced Dr. Nathan and reaffirmed El Camino Health's longstanding commitment to provide these services to our community. Guests were able to mingle and ask questions when the formal program concluded.

Corporate □ Community □ealth Services

Concern worked with a security audit firm to conduct the first phase of an in-depth audit of data security and compliance. Concern is working toward a SOC 2 certification. This is an expectation of discerning customers who expect the highest level of data security.

The South Asian Heart Center has engaged 2□0 participants in a comprehensive year-long Aim to Prevent Program. The center hosted three educational events with 1□0 attendees.

The Chinese health Initiative held an annual virtual appreciation event for the Chinese- Speaking Physician Network.The event was well attended and showcased El Camino Health H□I with a presentation by Dr. Chad Rammohan on Structural Heart/ Transcatheter □alve Therapies.The Presentation was impressive and really engaged the physician audience.

Auxiliary

The Auxiliary donated □,□□0 volunteer hours for the month of August.

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: November 10, 2021
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

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 March 4, 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 section 54953;

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,

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.

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
71D3D3DB297E475...
Chair,
El Camino Hospital Board of Directors

DocuSigned by:
Julia Miller
30CE6DD9439C4ED...
Secretary,
El Camino Hospital Board of Directors

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, October 13th, 2021

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

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

****via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 pm by Chair Chen. A verbal roll call was taken. All Board members were present at roll call, excluding Director Kliger. Director Rebitzer joined at 6:24pm. 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. 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. AB 361 RESOLUTION ADOPTING FINDINGS TO CONTINUE VIRTUAL PUBLIC MEETINGS DURING STATE OF EMERGENCY	**Motion:** To approve the resolution 2021-10 with findings under AB 361 to allow the board and advisory committees to meet in-person with teleconference participation for the public due to the ongoing state of emergency for the COVID-19 pandemic and the recommendation of the Santa Clara County Health Officer. **Movant:** Miller **Second:** Fung **Ayes:** Chen, Fung, Miller, Po, Somersille, Ting, Watters, Zoglin **Noes:** None **Absentions:** None **Absent:** Kliger and Rebitzer **Recused:** None	
4. PUBLIC COMMUNICATION	None	
5. BOARD ASSESSMENT PROGRESS UPDATE	Dan Woods, CEO, opened the discussion introducing George Anderson from SpencerStuart. George Anderson presented the 1st year Milestones and the 5 emerging themes of the Board Review. The 5 emerging themes are: • Board dialogue and alignment on strategy • Select board meeting practices	

	• Board composition and succession • Use of board committees • Boardroom working dynamics	
6. QUALITY COMMITTEE REPORT	Director Ting spoke in the absence of Director Kliger. Director Ting shared that the COVID Pandemic is viewed as Chronic Vs Acute and quality monitoring and analysis planning should be thought of that way. Director Ting shared a patient letter that lauded the fanstastic care at El Camino Health but also highlighted some areas of opportunity, for example, the discharge instructions. Director Fung requested for follow up regarding the patient letter and attention to the continuation of care. Director Ting continued the discussion by sharing the results of the Press Ganey Engagement survey and highlighted areas of opportunity including staffing feeling safe to address issues and teams working well together.	

7. FY22 PERIOD 2 FINANCIALS	Carlos Bohorquez, CFO, opened the discussions by presenting the August 2021 financial results and highlighted the following:
	
	• Strong operating / financial results for Period 2 were attributed to the following:
	  ○ Despite being out-of-network with Anthem, August gross charges were favorable to budget and higher than the same period last year
	  ○ Strong volume / patient activity was attributed to ER visits which are consistent with pre-Covid levels, continued strong procedural volumes at both campuses and improvement in payor mix
	• Total gross charges, a surrogate for volume, were favorable to budget by $42.9M / 11.4% and $79.5M / 23.4% higher than the same period last year
	• Net patient revenue was favorable to budget by $9.1M / 9.6% and $18.8M / 22.0% higher than the same period last year
	• Operating expenses were $1.7M /1.9% unfavorable to budget, which is primarily attributed to higher than expected volume versus budget and increase in ED visits in August
	• Operating margin was favorable to budget by $5.8M / 130.4% and $12.7M / 1956.2% better than the same period last year
	• Operating EBIDA was favorable to budget by $9.1M / 70.3% and $14.5M / 196.3% better than the same period last year	

8. FY21 AUDITED FINANCIAL REPORT	Carlos Bohorquez, CFO, opened the discussion by introducing Joelle Pulver from Moss Adams to present on the FY21 Audited Financial Report. Joelle Pulver shared a brief overview of the 2021 Audit Results which included: • Scope of Services • Auditor Report of the Consolidated Financial Statements • Asset and Deferred Outflows • Liabilities, Deferred Inflows and Net Position • Net Patient Service Accounts Receivable • Income Statements Year to Year Comparison • Community Benefit Expense • Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial • Deficiencies in Internal Control.	

9. ADJOURN TO CLOSED SESSION	To adjourn to closed session at 6:30 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (09/22/21); pursuant to *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report (Medical Staff Credentials and Privileges Report); pursuant to Gov't Code Section 54957 for discussion on personnel matters, the FY21 Audited Financial Report; pursuant to Gov't Code Section 54956.8, for a conference with Real Property Negotiator; pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, FY21 Individual Performance Incentive Scores and Payouts and FY21 CEO Incentive Individual Score & Payout; pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, an Executive Session with the CEO and a CEO Report. **Motion:** to adjourn to closed session at 6:30 pm **Movant**: Miller **Second**: Watters **Ayes**: Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Kliger **Recused**: None	***Adjourned to closed session at 6:30 pm***
10. AGENDA ITEM 20: RECONVENE OPEN SESSION/ REPORT OUT	Open Session reconvened at 8:22 pm by Chair Chen. Agenda items 10-18 were addressed in the closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (9/22/21), the Credentials and Privileges Report, and the purchase of Parcel number 19326005 for $14.66 million by a unanimous vote in favor of all members present and participating in the meeting (Director Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters and Zoglin). Director Kliger was absent.	
11. AGENDA ITEM 21: CONSENT CALENDAR ITEMS	Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. Director Somersille pulled item 21b – Policy Revisions and 21c – NICU Professional Agreement for discussion. Chair Chen pulled item 21d – FY21 Annual Organization Goal Results for discussion. **Motion:** to approve the consent calendar excluding item 21b, 21c and 21d. **Movant:** Fung **Second:** Walters **Ayes:** Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Kliger **Recused:** None Chair Chen called for discussion regarding agenda item 21d.	***Consent calendar approved***

	Chair Chen noted there was a clerical error in the originally published calculations. This has been fixed and resolved. **Motion:** to approve item 21d - FY21 Annual Organization Goal Results for discussion. **Movant**: Miller **Second**: Fung **Ayes**: Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Kliger **Recused**: None Chair Chen called for discussion regarding agenda item 21b. Director Somersille requests to pull and table the approval of the medical staff peer review policy until after the study session at the end of this month due to missing information. **Motion:** to table 21b – Peer Review policy until the October 27th study session. All other policies are approved in 21b. **Movant**: Somersville **Second**: Miller **Ayes**: Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Kliger **Recused**: None Chair Chen called for discussion regarding agenda item 21c. Director Somersille asked if the agreement was fair market value, which was confirmed. **Motion:** to approve 21c - NICU Professional Agreement for discussion. **Movant**: Somersille **Second**: Watters **Ayes**: Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Kliger **Recused:** None	
12. AGENDA ITEM 22: FY21 AUDITED FINANCIAL REPORT	**Motion:** to approve the FY21 Audited Financial Report **Movant**: Watters **Second**: Ting **Ayes**: Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Kliger **Recused**: None	
13. AGENDA ITEM 23: FY21 CEO	**Motion:** to approve the FY21 CEO Incentive Compensation Payment in the amount of $34,931.	

INCENTIVE COMPENSATION PAYMENT	**Movant**: Chen **Second**: Miller **Ayes**: Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Kliger **Recused**: None	
14. AGENDA ITEM 24: CEO REPORT	Dan Woods, CEO, reported that the Los Gatos campus received the the 2021 Maternity Honor Roll Award for reducing caesarean rates among low risk, first births (below 23.9%). El Camino Health Foundation was notified that Judge Lorraine Kendall, who passed away at our Mountain View hospital on June 3, 2021, left a seven figure gift in her will, designated for the Cancer Center. The Chinese Health Initiative launched a comprehensive Physical and Emotional Well-Being Health Education Program taught by registered dietitians and a clinical psychologist. This is in conjunction with the American Heart Association on a Mandarin Hypertension Management Program. Mountain View Mayor Ellen Kamei visited to present a Certificate of Recognition in honor of El Camino Health's 60th anniversary. She commended our dedication to our patients and to the community. El Camino Health announced that it is providing foundational support for local health initiatives by investing $3.5 million in grants and sponsorships in fiscal year 2022. This translates to support for 44 different programs at school districts, nonprofit organizations, safety-net clinics and community service agencies dedicated to addressing the health needs of local underserved and vulnerable community members. 1,890 volunteer hours donated in the month of August.	
15. AGENDA ITEM 25: BOARD COMMENTS	None	
16. AGENDA ITEM 26: ADJOURNMENT	**Motion**: to adjourn at 8:36 pm. **Movant:** Zoglin **Second:** Watters **Ayes:** Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Kliger **Recused:** None	***Meeting adjourned at 8:36 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

BOARD
Policies for Review
November 2021

Policy Owner/Dept.	Policy Name	Type of Change	Type of Document	Notes	Committee Approvals
OR	Perioperative Services - Los Gatos (Outpatient Surgery/Short Stay Unit, Post Anesthesia Care Unit, Operating Room & Central Sterile Processing Department)	Revised	Scope of Service	Added "Robotic Procedures, e.g.: Da Vinci, Makoplasty, Rosa, Mazor, and Omni" to SCOPE. Deleted "team support personnel (TS)" from STAFFING PLAN. Changed "0830" to "0730" Under Scheduling 1. Elective Surgery and Procedures. Changed "0653" to "0650" under STAFFING PATTERNS, Operating Room:, paragraph six. Under OPERATING ROOM STANDARDS OF CARE, Nursing Process:, Assessment: 1) changed "Short Stay OPS/SS" to "PreOp"; 2) pluralized "consent" to "consents"; and, 3) added "When Outpatient Surgery/PreOp is closed (nights, weekends and holidays) this assessment process is performed by the O.R. RN.".	Dept. of Surgery
CPWC	Scope of Service	Revised	Scope of Service	Removed location of center, updated to correct manager titles, up for 3 year review	UPC and Department Medical Director
Imaging Services	Scope of Service Imaging Services	Revised	Scope of Svc.	Updated coverage hours for NM. Updated radiologist calendar link.	Dept. Medical Director, Dr. Qureshi
Environment of Care Emergency Management	Emergency Operations Plan	Revised	Plan	Re-added Men's Clinic in LG, added reference to Business Continuity plan	Central Safety & Emergency Management Committee
Radiation Safety	Personnel and Medical Staff Monitoring Dosimetry	Revised	Policy	Minor verbiage changes, up for 3 year review	Radiation Safety and the Department of Surgery
Talent Development Department - HR	Scope of Service	Revised	Scope of Service	Updated to reflect current processes	HR leadership and CHRO
Medical Staff Office	Medical Staff Peer Review	Revised	Policy	Edits made to reflect current review process, attachments updated and deleted non relevant ones	Practitioner Excellence Committee

El Camino Health

Origination:	*10/2015*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/2021*
Next Review:	*3 years after approval*
Owner:	*Tonya Stuart: Dir Perioperative Svcs*
Area:	*Scopes of Service*
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Perioperative Services - Los atos Outpatient Surgery Short Stay nit Post Anesthesia Care nit Operating Room Central Sterile Processing Department

SCOPE

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

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

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

Outpatient Surgery Short Stay nit Los atos

SCOPE

The OPS/SS nit conducts pre-admission and admission services:

- **Pre-Admission Program** Patients scheduled for surgery are invited to attend the pre-admission program which facilitates early assessment, admission health testing, patient/family teaching, as well as financial counseling.
- **Admission** Patients to be admitted on the day of surgery/invasive procedure are admitted through the

OPS/SS □nit.

- **Post Operative Procedure** □patients on the day of the surgery/invasive procedure are returned to the OPS/SS □nit to complete their recovery and be discharged to home.

STA□□IN□ PLAN

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

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

Monday □Friday: 0□□0 hours to 2□00 hours

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

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

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

Post Anesthesia Care □nit □PAC□□□ Los □atos

SCOPE

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

STA□□IN□ PLAN

PAC□ utilizes ACLS certified RNs to provide direct patient care with the assistance of clinical support personnel. Clinical support personnel provide direct patient care under the supervision of the RN and provide patient transportation. A ratio of RN/PT is progressive, beginning at 1:1 until airway patency is stable, and then maintained at 1:2 until the patient is transferred out of the PAC□. A charge nurse is assigned daily to make assignments and direct patient care.

Staffing: - Consists of RNs and CNAs.

Normal business hours are:

~~**Staffing:** - Consists of RNs.~~
~~Normal business hours are:~~
Monday □Friday: 0□00 hours to 2□□0 hours, on call only 2□00 hours to 0□00 hours.
~~Saturday: on call 0□00 hours to Monday 0□00 hours.~~
~~Sunday: on call 0□00 hours to Monday 0□00 hours.~~

Saturday: on call 0□00 hours to Monday 0□00 hours.

Sunday: on call 0□00 hours to Monday 0□00 hours.

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

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

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

Operating Room □ Los ~~□ato~~□atos

SCOPE

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

Common procedures include:

Laparoscopic Cholecystectomy

Colon Resection

Lumbar Laminectomy

Major Spinal Fusion with Instrumentation

Hysterectomy/Hysteroscopy

Total Hip and □nee Joint Replacement

Arthroscopy/ACL

Endoscopic Carpal Tunnel

Brachytherapy

Lithotripsy

□rological Procedures

SWT elbow foot

Ophthalmology

Radical Prostatectomy

~~Laparoscopic Cholecystectomy~~
~~Colon Resection~~
~~Lumbar Laminectomy~~
~~Major Spinal Fusion with Instrumentation~~
~~Hysterectomy/Hysteroscopy~~
~~Total Hip and □nee Joint Replacement~~
~~Arthroscopy/ACL~~
~~Endoscopic Carpal Tunnel~~
~~Brachytherapy~~
~~Lithotripsy~~
~~□rological Procedures~~
~~SWT elbow foot~~
~~Ophthalmology~~

~~Radical Prostatectomy~~
Laparoscopy Assisted Procedures, e.g.: LA□H, Bowel Resection Laparoscopic and open General, Thoracic and GYN Oncology procedures
~~Thoracoscopy, Thoracotomy, Bronchoscopy~~

Thoracoscopy, Thoracotomy, Bronchoscopy

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

STA□□IN□ PLAN

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

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

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

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

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

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

Staffing: Consists of RNs, ST, ORA□s, and Business Office personnel.
~~Normal business hours:~~
~~Monday □ Friday □ 0□□□ hours to 2□1□ hours, on call only 2□00 hours to 0□00 hours.~~
~~Saturday □ Sunday □ On Call 0□00 hours to Monday 0□00 hours.~~

Normal business hours:

Monday □ Friday □ 0□□□ hours to 2□1□ hours, on call only 2□00 hours to 0□00 hours.

Saturday □ Sunday □ On Call 0□00 hours to Monday 0□00 hours.

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

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Minimum requirements for RNs are: BCLS, age specific competencies, Malignant Hypertension S-S module, Moderate Sedation S-S module, Correct-Site □erification S-S module, Surgical Consent S-S module.
~~Minimum requirements for STs are: Successful completion of ST training program, BCLS, age specific competencies.~~
~~Minimum requirements for ORA□s are: BCLS, successful completion of the anesthesia assistant training and ORA Aseptic Technique and Sterile I□ System Setup program. A percentage of RNs are ACLS and CNOR certified.~~

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

Minimum requirements for ORAs are: BCLS, successful completion of the anesthesia assistant training and ORA Aseptic Technique and Sterile I System Setup program. A percentage of RNs are ACLS and CNOR certified.

S R ICAL SER ICES

O ECTI ES:

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

OALS:

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

Description of the Operating Room

The Operating Room suite is located on the second floor of the main building of the Hospital. The suite consists of eight operating rooms with support areas for instruments and equipment.
~~Services using the Operating Room are, ENT, Plastic, Podiatry, Orthopedics, rology, Ophthalmology, GYN, General, Neurosurgery, ascular, Thoracic and Oral/Dentistry. Elective surgery is scheduled Monday through Friday from 0 0 hours to 1 0 hours, according to a block scheduling system. Surgery volume is a mix of both In and Out Patient populations.~~

Services using the Operating Room are, ENT, Plastic, Podiatry, Orthopedics, rology, Ophthalmology, GYN, General, Neurosurgery, ascular, Thoracic and Oral/Dentistry. Elective surgery is scheduled Monday through Friday from 0 0 hours to 1 0 hours, according to a block scheduling system. Surgery volume is a mix of both In and Out Patient populations.

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

The Operating room consists of a mix of RNS, ORTs, and Ancillary Personnel. Activities are performed by the RN, ORT, ORA, and office personnel, all with appropriate training. The unit uses AORN Recommended

Standards of Practice and Standards of Care established by the OR and approved by the Hospital administration, Chief of Surgery, and the Hospital Board of Directors. The department uses Title 22 and AORN standards as guidelines for staffing. Staffing levels are based on an acuity system which takes into account patient acuity, staff skill level, staffing training needs, equipment, OR protocols, infection control and patient safety requirements. The RN performs circulating duties. The RN and/or ORT perform scrub duties. RN assessments and nursing diagnoses are the basis for care planning for the surgical patient in the OR. Performance Improvement programs track data associated with SCIP measures, National Patient Safety Goals and Intradepartmental initiatives for improved patient care outcomes.

Scheduling:

1. **Elective Surgery and Procedures:**

   ORs are scheduled by Block designation. Block holders are expected to maintain 0 utilization. Blocks have varying release times depending on the nature of the block assignment. Changes in block allocations are made by the Operating Room Committee based on results of utilization and requests for time.

   Elective surgeries are scheduled through the OR schedulers Monday through Friday between ~~08 0~~0 0 hours and 1 0 hours.

   Special procedures are scheduled according to physician and staff availability i.e., Pain control and Cardioversions.

2. **rgent Surgery and Procedures:**

   Definition of rgent is: Case must be scheduled within 12-2 hours. rgent cases are given the first available time slot. The surgeon notifies the OR schedulers or charge nurse when an urgent case arises.

. **Emergency Surgery and Procedures:**

   OR Definition:

   Case must begin within 1-2 hours. When the surgery schedule does not accommodate an emergency case, the surgeon has the option of pre-empting other cases. The surgeon will accomplish this by communicating with the anesthesiologist and surgeon who will be bumped.

   Staff called in for emergencies will be ready to start case preparation within 0 minutes of notification.

   Physicians notify the OR charge nurse or the Hospital shift supervisor for emergency cases after hours.

   Endoscopy Center Definition:

   Procedure must begin within 1-2 hours. When the Endoscopy schedule does not accommodate an emergency procedure, the physician has the option of pre-empting another procedure. The physician is responsible for notifying the physician he is bumping. If the procedure occurs outside scheduled hours, the call system will be activated.

   Emergency Endoscopy cases are also performed in the Critical Care nit, the Operating Room and the

Emergency Department. The Endoscopy staff is available 2□ hours a day for emergencies.

□. **Pre-Admission Program:**

The patient scheduled at least □2 hours before scheduled surgery is invited via phone call to attend the Pre-Admission Program. Those who decline will receive preoperative instructions and preoperative data collection over the phone.

STA□□IN□ PATTERNS

Operating Room:

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

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

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

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

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

~~Shift report is at 0□□□ hours for the day shift and 1□□□ hours for the evening shift.~~

Shift reports take place in the morning, afternoon and evening

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

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

The staffing pattern describes the usual number and skill mix required each day. It is based on projected caseload, patient acuity, and the block allocations. It is adjusted when blocks change, a permanent change in case load occurs, as staff training needs are identified, when patient acuity changes or O.R. protocols dictate. ~~When staff members are scheduled, supervision is assigned to the OR Manager or charge nurse on the day shift and a charge nurse on the evening shift, weekends and holidays. No charge nurse is assigned when the O.R. is covered by call staff only. Weekend/holiday charge nurses have completed all competencies, have at least one year experience in the O.R. and have completed the charge nurse orientation. The Nursing Supervisor for the Hospital is available as a resource for both charge nurses and nurses on call. The charge nurse may be the circulating nurse. The variable is the level of activity in the department and the complexity of the case□s□and availability of other personnel.~~

When staff members are scheduled, supervision is assigned to the OR Manager or charge nurse on the day shift and a charge nurse on the evening shift, weekends and holidays. No charge nurse is assigned when the O.R. is covered by call staff only. Weekend/holiday charge nurses have completed all competencies, have at least one year experience in the O.R. and have completed the charge nurse orientation. The Nursing

Supervisor for the Hospital is available as a resource for both charge nurses and nurses on call. The charge nurse may be the circulating nurse. The variable is the level of activity in the department and the complexity of the case□s□and availability of other personnel.

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

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

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

Post Anesthesia Care □nit □PAC□□:

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

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

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

Responsi□ilities of On-Call Staff □em□ers:

Staff members on-call for emergencies is responsible for maintaining communication with the Hospital. ~~Beepers are provided and staff members are expected to test pagers to assure they are working~~. The department or Nursing supervisor is to be notified each time a change in the communication link is made from pager to phone.

Staff members must be able to arrive at the Hospital within □0 minutes from notification by phone ~~or beeper~~.~~N~~Patients~~.~~Patients will be recovered in the CC□ when PAC□ is closed and staffing warrants coverage.

OPERATIN□ ROO□ STANDARDS O□ CARE

Nursing Process:

The nursing process is applied to the care of patients in the O.R. The circulating RN is responsible to ensure

the process is used as the basis for each patient's care.

- **Assessment**

  Assessment begins in the Outpatient Surgery/~~Short Stay OPS/SS~~PreOp Unit for Outpatients or AM admits, and in the nursing unit from which a surgery patient will come. An RN receives the patient and begins the assessment including the verification process to ensure the correct patient with complete and correct identification has informed consent for the anticipated procedure. Data collected by the admitting RNs and physician, test results and other information are reviewed to identify extraordinary needs. The circulating RN reviews the preoperative assessment and verifies the patient's name, birthdate, medical record number, history and physical, ~~consent~~consents, patient's anticipated procedure and boarding pass are consistent. Care is then transferred to the O.R. RN. When Outpatient Surgery/PreO is closed nights, weekends and holidays, this assessment process is performed by the O.R. RN.
- **Nursing Diagnosis**

  Patients coming to the O.R. have these nursing diagnoses:

  1. Potential for anxiety due to:
     a. Loss of personal control
     b. nowledge deficit
     c. nfamiliar setting
  2. Potential for injury due to:
     a. Loss of protective reflexes
     b. Loss of sensation
     c. Immobility
     d. Contact with high energy equipment
  3. Potential for infection due to endogenous and exogenous sources.
  4. Potential for hypothermia due to evaporation, conduction or radiation.
  5. Potential for alteration in comfort due to surgical intervention.
- **Planning**

  The RN from the OPS/SS nit or nursing floor reviews the medical record and assesses the patient to determine the degree of the patient's risk related to the nursing diagnoses and whether additional diagnoses apply.

  Specific areas of assessment are mental/emotional status, limitations to communication, limitations to mobility, hypothermia risk, nutritional status, and pain and skin condition.

  Additional data used in care planning include age, medications, allergies, type of surgery, anticipated length of surgery, co-morbidities, laboratory and test results, completion of medical orders and preoperative instructions.

  The medical plan of care is integrated in several ways. The surgeon will include special requests at the time the procedure is scheduled or contact the O.R. charge nurse before the case to communicate needs.

The medical record and preference card are used to integrate the plan of care.
The goals for perioperative nursing care include but are not limited to:

1. Maintain autonomy
2. Free of nosocomial infection
3. Maintain skin integrity
4. Free of injury
5. Maintain temperature
6. Experience minimal discomfort
7. Maintain adequate coping mechanisms
8. Experience a caring and supportive environment
9. ~~Maintain patient's rights.~~Maintain patient's rights.
   The initial care plan is either written on the Perioperative Nursing Record or communicated to the O.R. team.

~~The initial care plan is either written on the Perioperative Nursing Record or communicated to the O.R. team.~~

- **Intervention**

Independent nursing actions may include:

1. **Adherence to Universal Protocol and Correct Site Verification Marking Patient Site Marking occurs outside Surgical SuiteTime Out performed by RD in the Surgical Suite prior to start of procedure**
2. Monitoring, proper positioning and security
3. Skin preparation
4. Maintaining aseptic field
5. Safety procedures
6. Providing information and emotion support
7. Facilitating communication
8. Accommodating physical limitations
9. Pain management
10. Selection of grounding sites for electrical devices
11. Performing surgical counts sponges, needles and instruments
12. Handling of specimens

- **Evaluation**

The circulating RN evaluates patient care at the conclusion of each case. The extent of the evaluation depends on the level of consciousness of the patient.

The skin is assessed for signs of injury. The patient's temperature is recorded in PACU. Adverse patient responses are reported either verbally or through the Quality Review Report.

Documentation

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

□O□ERNIN□ R□LES □OR T□E OPERATIN□ ROO□

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

□loc□ Schedule:

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

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

□tili□ation:

- Block holders are expected to maintain □0□ utilization.
- □tilization is monitored on a monthly basis and reported at the O.R. Committee.
- If utilization falls below □0□, the chair of the O.R. Committee will contact the physician or group to notify them of their utilization results for that month.
- If utilization continues below □0□ for three months, block time will be adjusted or relinquished and the time will be reassigned.
- When block time is released prior to the designated release time, unused time is not counted against utilization □e.g.: vacations□ This provides the O.R. the ability to open up this time for scheduling well in advance of the normal release time.
- When block time is released for three consecutive months, the allocated block will be canceled.

Start Times:

- Surgery □start time□is defined as □**patient in-room time**□□
- For surgeries starting at □:□0am, the anesthesiologist, surgeon and nursing personnel must arrive at a time that allows for all required procedures, processes and documentation to be completed in order for transport of the patients into the operating rooms to begin at □:1□am. The patient should be in the O.R. suites no later than □:□0am. All lab work, H&P and preoperative requirements must be ordered and completed to avoid delays in patient preparation.
- Physicians are expected to arrive in the O.R. at their scheduled start time unless otherwise notified by the O.R. that their scheduled start time has changed. Surgeons should arrive at the time needed in order for patient preparation to be complete for transport to begin on time.
- When a physician is consistently late for his/her scheduled surgery, the Chair of the O.R. Committee will contact the surgeon to discuss the expectations regarding start times and the implications of continued late arrival. After three warnings, the surgeon will no longer be allowed to schedule in the AM time slots. The surgeon will lose block time privileges and/or □:□0am start time privileges for three months. **Late arrival is defined as □□ minutes**□
- The O.R. will postpone a surgery if the physician is more than □0 minutes late.

Schedule Delays:

- If a scheduled surgery is taking longer than originally scheduled and will be impacting the start time of the following physician, anesthesiologists and O.R. personnel will collaborate to find another room that can accommodate an earlier start time for the delayed surgeon.
- The O.R. will make every attempt to notify a physician at least □0 minutes in advance if a delay in his/her starts time is anticipated.

□rgent□Emergent Add-On Cases:

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

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board of Directors	Stephanie Iljin: Supv Exec Administrative Svcs	pending
□PC	Tonya Stuart: Dir Perioperative Svcs [JH]	10/2021
	Tonya Stuart: Dir Perioperative Svcs [JH]	10/2021
MEC	Catherine Carson: Senior Director Quality [JH]	10/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	10/2021
Department of Surgery Exec.	Faerie □amora-Lopez: Medical Staff Coord	09/2021

El Camino Health

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Cardio Pulmonary □ ellness Center : Scope of Service

I□CO□ERA□ E:

El Camino Hospital Cardiac Pulmonary Wellness Center

II□P□RPOSE:

To describe the Cardiac & Pulmonary Wellness Center □nit and Scope of Services

III□PROCED□RE:

A. General □nit Description

1. ~~The Cardiac & Pulmonary Wellness Center located on the first floor of the old main hospital building.~~ The unit provides space for exercise equipment, education instruction and staff office space.
2. The staff includes a Medical Director for cardiac rehabilitation □CR□, a Medical Director for pulmonary rehabilitation □PR□, a ~~Program~~Clinical Manager, CR registered nurses, PR registered nurses, exercise physiologists □EP□, ~~a~~ respiratory ~~therapist~~therapists □RT□, and and an Administrative Assistant.
3. Supervisory coverage is provided by the Medical Directors, and the ~~□nit~~Clinical Manager during hours of operation. In the manager□s absence, a CR or PR nurse will be designated in charge. □See Policy and Procedure Organization Chart, and □nit Job Description Binder.□

B. Services Offered

1. The CR client population exercise in an outpatient, supervised individualized exercise program. Monitored clients are on continuous telemetry while exercising. □nmonitored clients are provided with telemetry monitoring based on medical necessity. Graduates of these programs ~~may continue in maintenance based on medical necessity or~~ are referred to appropriate community partners as requested. Reports to all clients physicians are sent upon request .
2. Clients in the CR program are admitted by physician referral with diagnoses of coronary artery disease, myocardial infarction, open-heart surgery, PCI-percutaneous coronary intervention, stable angina, valve repair/replacement and heart transplant and specific categories of heart failure. Clients are also considered for diagnosis of arrhythmia, hypertension, congestive heart failure or pacemaker implantation. Many may have co-morbid conditions of aging such as musculoskeletal conditions,

diabetes, hypertension, hyperlipidemia, hearing and vision problems.

- Clients are admitted into the program for various lengths of stay based on medical necessity. One hour classes meet on Monday, Wednesday and Friday scheduled throughout the day. Intake interviews and an orientation are scheduled before the first session of exercise. ~~Informational~~Educational lectures addressing cardiac risk factors are held ~~throughout the month~~on Wednesdays after the exercise session.
- The Women's Heart Support Group is a community service for women living with coronary artery disease.
- The client population of the Pulmonary Rehabilitation program consists of patients that participate in a closely supervised outpatient instructional and exercise conditioning program. They are monitored by oximetry and vital signs, and, if warranted, telemetry.
- Clients in the PR program are admitted by physician referral with a diagnosis of COPD, chronic Bronchitis, bronchiectasis, persistent asthma, interstitial lung disease, cystic fibrosis and pre and post lung transplant with documentation of decreased pulmonary function. Many have co-morbid conditions of aging such as heart disease, HTN, arthritis, hearing and vision problems.
- The average length of stay for PR patients is based on medical necessity. Classes meet Tuesdays and Thursdays. Each session includes didactic instruction and exercise. Intake interviews are completed prior to program entry.

8. Exercise Maintenance classes are one hour sessions of exercise. Clients are graduates of the ~~CR and~~ PR classes with special need who are not yet appropriate for transition to independent exercise.
9. The Better Breather's Club is a community service for individuals living with pulmonary disease. The group meets once a month ~~and includes a support group~~. A Better Breather's Newsletter is delivered to all members.
10. The Mycobacterium Avium/ Interstitial Lung Disease Support Group is a community service for individuals living with pulmonary disease ~~from a diagnosis of mycobacterium avium~~. The group meets ~~every other month~~quarterly.

C. Meeting/Committees:

1. Formal staff meetings are held on a quarterly basis and more frequently as needed. There is a unit representative on the following committees: Safety Committee, Central Partnership Council, Patient Care Leadership Meeting, ~~All Leaders Meeting~~Peer Review, ~~Chest Pain, Heart Failure, Performance Improvement/Quality, and CORE~~and Nursing Research Council.

D. Problem Resolution:

1. Problems with patients and clients are solved on an individual basis at the time of complaint. If resolution is not achieved the chain of command will be followed, first to the ~~Program~~Clinical Manager, then to the Director of Critical Care Services, then to the Director of Clinical Quality and Patient Safety, Director of Risk Management and Patient Safety and finally to the Chief Nursing Officer.
2. Client medical safety issues are resolved at the time of occurrence by the clinical staff, consulting the appropriate Medical Director, and/or client's physician. If no resolution, the client may not participate in the exercise program. Medical Rounds are held weekly with medical directors.
- Staff Problems will be resolved at the time of occurrence. If no resolution, the chain of command will be followed from ~~Program~~Clinical Manager to Director of Critical Care Services and finally to the

Chief Nursing Officer.

- Physician problems will be resolved at the time of occurrence. If no resolution, the Medical Director will be consulted, the Programs Manager, Senior Medical Director for Physician Services, or Chief Medical Director.
- Hospital problems will be resolved in an interdisciplinary manner at the time of occurrence using the appropriate resources.

E. Communication

1. Communication in the unit will occur on an ongoing basis via personal communication, emails, staff meetings and voice mail.

F. Staffing

1. Staffing for CR and PR will always include at least one RN for monitored clients and an EP, or RT with ACLS training to maintain appropriate staff ratios. Average staff to client ratio is 1 ~~for monitored programs and for~~but may vary for both CR and PR programs; and 10:1 for CR and PR maintenance programs. Staff may be increased based on patient acuity. Intake interviews will be assigned only to staff trained in the process. One PR or CR staff is required for supervision of the support groups.

G. Orientation

1. All new staff will have general hospital orientation. Orientation to the unit will last for a period up to four weeks. Orientation will include: equipment set up, telemetry set up, oxygen monitoring and delivery systems, entering charges in the EHR, providing emergency care, locating unit procedures in the toolbox, reviewing the unit manual, reviewing phone voicemail system, staff schedules, reviewing the intake interview, outcome measurement process, and quality control measures, conducting warm-up/cool down exercises, monitoring exercise sessions, recognizing the physiological signs of exercise intolerance, reviewing educational content and materials, patient referral and evaluation system including registration process, and adapting techniques for clients with special needs.
2. Orientation to the CR program will include interpreting exercise prescriptions for clients, recording patient progress in the different phases of the program, using the computerized telemetry charging system, interpreting ECG strips, reviewing individual treatment plans, risk factor reduction lectures, patient and physician follow-up communication, women's heart support group.
- Orientation to the PR Programs will include, planning and scheduling sessions, recording patient progress, individualized treatment plans, computerized charting system, monitoring of exercise programs, maintenance of oxygen delivery systems, and knowledge of the various components of the pulmonary programs including the Better Breather's Club Support Group and Newsletter, and Mycobacterium Avium/ Interstitial Lung Disease Support Group.

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	10/2021
Department Medical Director or Director for non-clinical Departments	Julee Arbuckle: Clinical Mgr	09/2021
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Scope of Service - Imaging Services

Scope:

The Imaging Department Scope of Service is provided by ECH to ensure that all patients treated will receive high quality care in an expedient and professional manner. Performance standards and quality initiatives are in place to measure outcomes and meet patient and clinician needs. Patient reports and exam records can be accessed upon request and are stored indefinitely as part of the patient□s Electronic Health Record □EHR□. Images are stored in the hospital□s Picture Archiving and Communication System □PACS□.

Patient Types

Exams and procedures are performed on inpatients, outpatients and emergency department patients. Patient age groups served are neonatal, pediatric, adolescent, adult and geriatric.

Imaging Services provides support to all departments located within the two El Camino campuses. Imaging studies are performed upon receipt of a written or electronic request from a physician or licensed independent practitioner.

Services Offered

Imaging Modalities on the □**ountain** □**iew** Campus are:

General Diagnostic Radiography
Magnetic Resonance Imaging □MRI□
Nuclear Medicine
□ltrasound
Mammography
Fluoroscopy
Computerized Tomography □CT□
PET/CT
□ascular Imaging
Interventional Radiology

Imaging Modalities on the **Los** □**atos** Campus are:

General Diagnostic Radiography
Magnetic Resonance Imaging □MRI□
Nuclear Medicine
□ascular Imaging
Interventional Radiology
Fluoroscopy
Computerized Tomography □CT□
PET/CT
□ltrasound
Mammography

Nuclear □edicine-Specifics

On-call services are provided on a limited basis ~~after hours and~~ on weekends. The following exams are approved for on-call services:

A. □**l □leed:** Patient must be actively bleeding in order for the study to render diagnostic value.
B. **Lung □□ Scan**
C. □**all□ladder □□IDA Scan**□
D. **Stress Tests□□must □e coordinated with Nuclear □edicine and scheduled only if all resources are availa□le**□

Interventional Radiology

Types and ages of patients served:
Adult inpatients and outpatients. Adolescent patients who are at least 1□ years of age AND weigh 80 pounds □□.□ kg□or more.

Staffing □uidelines for Operating Room Coverage

At least two □2□radiologic technologists are scheduled to cover the operating room Monday through Friday until □:□0pm at the Mountain □iew campus, □:□0pm at the Los Gatos campus. After these times and on weekends, the department utilizes the OR call schedule for surgery cases. The surgery department will work very closely with the diagnostic charge tech or modality operations manager during the scheduling of exams that require radiological support.

Appropriateness□Necessity and Timeliness of Services

Imaging Services assesses the appropriateness and necessity of diagnostic and therapeutic procedures by evaluating the patient□s clinical history for pertinence to the exam ordered, as well as evaluating the exam history in order to avoid unnecessary duplication of procedures. Prior to interventional or special procedures, the technologist and/or Imaging Services RN will review exam indications as well as any possible contraindications, and bring these concerns to the Radiologist.

The timeliness of radiologic services is addressed in departmental procedures which describe how to contact a radiologist after hours, as well as performance of routine and stat procedures.

STAT exams are to be started within 1 hour of physician□s order.

Imaging Services follows hospital-wide policies for reporting incidents by utilizing the electronic incident reporting system.

Radiologists

Diagnostic and therapeutic radiologic services are available by board-certified or board-eligible radiologists. Silicon □alley Diagnostic Imaging □S□DI□is contracted to ensure radiology services are available 2□ hours a day. Licensure information of contracted radiologists is maintained in the Medical Staff office. S□DI provides a Radiation Safety Officer to oversee the Radiation Protection Plan and Radiation Safety Committee.

Service □ours: Hours of service are according to the Radiologists□posted schedule, which includes call hours to provide additional consultation or to perform emergency procedures on site. Teleradiology is available after posted hours seven days a week.

Imaging Reports: Reports for all Imaging exams are generally available within 2□ hours; exceptions include the unavailability of comparison exams. STAT interpretations are available for all imaging studies; exceptions include when there are multiple stat patients, issues with patient condition, and/or a delay in securing

radioisotopes. Referring physicians may denote their preference for obtaining reports, e.g., fax, electronic distribution, mail, etc.

Turnaround Times □TAT□		
Patient Class	End Exam to Results	
Target	Max	
ED	□0 mins	□□ mins
IP	□ hours	□ hours
OP □except mammo□	□ hours	2□ hours

Mammography

A. All BIRADS Results
    1. A written lay summary is provided to all patients, and report provided to health care provider within □0 days of examination.
    2. Copy of lay letter to patient included in patient□s EHR.
B. □Suspicious□or □Highly suggestive of malignancy□
    1. Communicated to patient within five □□□business days from the interpretation date.
    2. Communicated to health care provider within three □□□business days from the interpretation date.
C. BIRADS 0 □Incomplete□or □Needs additional imaging□
    1. Communicated to patient within five □□□business days from the interpretation date.
    2. Report provided to health care provider within three □□□business days of the interpretation date.

□odality Protocols:

All modality protocols are established based on current standards of practice and other key criteria, which include clinical indication, contrast administration, age, patient size and body habitus. In addition to these key criteria, CT Protocols include the expected radiation dose range.

Protocols are reviewed by the modality Quality Teams and approved by the Radiologist section chief biennially □every 2 years□ Protocols are revised as needed in between the regular review period. Modality protocols are maintained by the department and are accessible by all clinical staff members. Clinical situations often warrant protocol adaptation due to unique patient circumstances or presentation.

Staffing□S□ill □ix and Re□uirements

The Senior Systems Director has oversight of entire Imaging Service line across the Health System. The Assistant Director oversees department Operations. The director is further supported by clinical managers. The daily work of each modality is organized by the Charge Technologist in each modality and/or shift.

This department has a Coordinator of Quality and Education that supports the director related to quality, regulatory and compliance activities. The Imaging Services ~~Clinical Instructor~~Education Coordinator oversees students from the Foothill College Radiologic Technology Program and assists with onboarding of new staff. Specific sonographers are assigned to work directly with students from the Foothill College Diagnostic Medical Sonography Program.

RNs are assigned from the nursing division to provide nursing care, Monday through Sunday, either scheduled or on call. Off-hour nursing coverage for emergent cases may be provided by direct care nursing staff assigned by the nursing supervisor. Radiology Nurses hold current Advanced Cardiac Life Support □ACLS□and Pediatric Advanced Life Support □PALS□certification.

Technologists have graduated from an accredited Radiologic Technology program and are registered by the American Registry of Radiologic Technologists □ARRT□in their respective modalities. All Radiologic Technologists hold current Certified Radiologic Technologist □CRT□licenses as required by the State of California, Title 1□. In addition, all technologists who perform fluoroscopy or mobile fluoroscopy hold a current

Fluoroscopy permit, and Mammographers hold a current state Mammography certificate. □ltrasound procedures are performed or supervised by Sonographers who are registered by the American Registry of Diagnostic Medical Sonographers □ARDMS□ Nuclear Medicine procedures are performed by Nuclear Medicine Technologists who hold a current Certified Nuclear Medicine □CNMT□certificate as required by the State of California, Title 1□. Scope of Practice or Practice Standards for technologists are established by the professional societies that represent them.

Other clinical and support staff providing services to patients in this area may include□□ut are not limited to:

Consulting Services□Interventional Radiologists: Routine and emergent interventional procedures are performed by contracted physicians at both campuses.

Consulting Services□□ edical Physicists: Imaging Services maintains a contract for consultation on an □as needed□basis and for routine quarterly surveys in Nuclear Medicine, as well as annual surveys for all other equipment, as required. Medical physics assessment requests, such as fetal dose calculation or personnel badge review, may be requested. The Imaging Department retains survey records and annual physics surveys, which are available for review. Physicists supervise equipment monitoring activities, review the findings, and make recommendations regarding radiation exposure factors, ACR quality guidelines, and quality analysis.

Radiation Safety Officer □RSO□AND Radiation Safety Committee:

S□DI provides a Radiation Safety Officer □RSO□for hospital-wide needs. The RSO oversees the Radiation Protection Plan and the Radiation Safety Committee. The Radiation Safety Committee has a multidisciplinary membership that meets quarterly to review any radiation safety concerns.

Clinical Engineering □Imaging Services E□uipment□:

The Clinical Engineering Department works closely with vendors to provide all equipment preventive maintenance based on the manufacturer□s recommendations. These records are retained for review.

Standards of Practice

Radiation and radioactive materials are governed by California Department of Public Health, Radiologic Health Branch, state regulations Titles 1□ and 22, and the Nuclear Regulatory Commission. The Department follows guidelines set forth by these agencies as well as the American College of Radiology □ACR□, and standards established by the Joint Commission..

Security Considerations

Imaging Services follows all hospital security policies and procedures to ensure compliance with hospital security mandates. Radiology applications and PACS user access is available to Imaging Services staff, Radiologists contracted with El Camino Hospital, students, and other El Camino Hospital staff as deemed appropriate by Imaging Services leadership.

□ours of Operation

□odality	Inpatient □ours	Outpatient □ours	Call □ours	Exams Approved □y Department for On□Call Services
Diagnostic Imaging	2□/□	**□ountain □iew Campus** M - F: □am - □pm	None	OR Cases or Influx of Patients
Los □atos Campus M - F: □am - □pm				

□odality	Inpatient □ours	Outpatient □ours	Call □ours	Exams Approved □y Department for On□Call Services
Computed Tomography	2□/□	**□ountain □iew Campus** M - F: 8am to ~~□~~□pm Sat: 8:□0~~pm~~ ~~Sat: 9~~am - ~~1pm~~11am	None	N/A
Los □atos Campus M - F: □:□0am - □pm				
□ltrasound	**□ountain □iew Campus** 2□/□	**□ountain □iew Campus** M □F: 8am-□:□0pm	**□ountain □iew Campus** None	Stat □S in order of priority: 1. Suspected Ruptured AAA, aortic aneurysm 2. Scrotal □S: torsion, pain □. Pelvic □S: ectopic, ruptured ectopic, torsion, bleeding in pregnancy
Los □atos Campus ~~M - F: □:□0am to □pm~~2□/□	**Los □atos Campus** M - F: 8am - □:□0pm □excludes holidays	**Los □atos Campus** M - F: □pm - 12am Sa/Su: □:~~□~~0am ~~S/S: 2□ hours~~ - 12am		
□agnetic Resonance Imaging	**□ountain □iew Campus** 2□/□	**□ountain □iew Campus** M - F: ~~□:□~~08am - ~~□~~□pm	**□ountain □iew Campus** *No Call*	*MV & LG ED physicians triage and prioritize requests. Stat MRI in order of priority:* 1. *R/O cord compression* 2. *Stroke/Bleed* □. *Compression fracture spine* □. *Appendicitis in pregnant patients*

□odality	Inpatient □ours	Outpatient □ours	Call □ours	Exams Approved □y Department for On□Call Services		
				□. *Others as they come on first come first serve*		
Los □atos Campus 2□/□	**Los □atos Campus** M - F: ~~9~~8:□0am - ~~□~~□pm	**Los □atos Campus** *No Call*				
□ammography	N/A	**□ountain □iew Campus** M - F: □:□0am - □pm	N/A	*N/A*		
Los □atos Campus M - F: 8am - □:□0pm						
Nuclear □edicine	M - F: □am - □:□0pm	M - F: 8am - □:□0pm	~~M - F: 8am - □:□0pm~~	~~M - F: □:□0pm □ □:□0pm~~ ~~S/S: 2□ hours~~	Sa/Su: □a - □p	*GI Bleed* *Lung V/Q Scan* *Gallbladder (HIDA Scan)* *Stress Tests must be coordinated with Nuclear Medicine and scheduled only if all resources are available.*
Interventional Radiology □□ □□	M - F □:□0am-□:□0pm Off-Hours: Cath Lab and/or OR	M - F □:□0am-□:□0pm Off-Hours: Cath Lab and/or OR	Holidays and Weekends □□aries□ 8:00am-□:□0pm	*Stat Interventional Exams*		
Interventional Radiology □**L**□□	M - F □:□0am - □:□0pm Off-hours: OR	M - F □:□0am - □:□0pm Off-hours: OR	S/S: □am - □pm Off-hours: OR	*Stat Interventional Exams*		
Radiologist	Review the current Radiologist□s schedule for hours and call. ~~https://sites.google.com/a/svdi.org/www/~~	*Stat Fluoroscopy cases after hours*				

□odality	Inpatient □ours	Outpatient □ours	Call □ours	Exams Approved □y Department for On□Call Services
	~~echcalendar~~https://app.qgenda.com/landingpage/svdi			

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	10/2021
Department Medical Director or Director for non-clinical Departments	Aletha Fulgham: Assistant Director Imaging Svc	09/2021
	Aletha Fulgham: Assistant Director Imaging Svc	09/2021

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Emergency Operations Plan

CO□ERA□E:

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

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

P□RPOSE:

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

STATE□ENT:

The Plan describes a comprehensive "all hazards" command system for coordinating the six critical areas: communications, resources and assets, safety and security, staffing, utilities, and clinical activities. The overall response procedures include single emergencies that can temporarily affect demand for services,

along with multiple emergencies that can occur concurrently or sequentially that can adversely impact patient safety and the ability to provide care, treatment, and services for an extended length of time.

El Camino ~~Hospital~~Health has established the necessary policies and procedures to achieve preparedness and respond to and ~~recovery~~recover from an incident. These current plans and procedures are exercised and reviewed to determine and measure functional capability. The Emergency Operations Plan complies with the National Incident Management System (NIMS) components.

RESPONSI□ILITIES:

A. Leadership

The hospital's leaders are involved in the planning activities and the development of the Emergency Operations Plan. The administrators, and department heads are represented in the Emergency Management Committee.

B. Emergency Program Management

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

C. The Emergency Management Committee

The Emergency Management Committee is a group of multidisciplinary hospital representatives, including leadership, clinical and non-clinical representatives from key departments.

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

D. Hospital Incident Command System

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

PLANNIN□

A. Hazard Vulnerability Analysis

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

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

B. Community Involvement

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

C. Mitigation & Preparedness

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

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

D. Hospital Command Center

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

- Hospital Command Center (HCC)
- HICS Chart
- ~~HICS Position Mission Statements~~HICS Roles Information Guide

E. Inventory & Monitoring of Assets & Resources

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

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

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

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

Emergency Operations Plans

A. Response

A response procedure to an emergency can include the following:

- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the hospital to new patients
- Staged evacuation
- Total evacuation.

1. HICS shall be activated as outlined in: Activation and Termination of Hospital Incident Command System -HICS ~~– Activation and Termination~~
2. Staff respond to the emergency as outlined in: Code Triage

B. Sustainability

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

C. Recovery Procedures

The return to normal operations from an emergency will utilize the procedures outlined in Activation and Termination of Hospital Incident Command System (HICS ~~– Activation and Termination~~).

D. Incident Levels and Phases

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

patients are arriving at hospital Emergency Department at a time when buildings and utilities are damaged or disrupted and personnel are affected.

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

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

E. Alternate Care Site

In a major emergency situation, there is a possibility that the buildings or spaces in which patient care is normally provided will be rendered unusable. In this event, an alternate care site will designated as a location on the facility grounds or within the community. More information on the selection of Alternate Care Sites is available in ~~EM~~Emergency Management - Hospital Surge Capacity Plan ~~– Surge Plan - 03.00 Hospital Surge Capacity Plan –~~ Alternate Care Sites.

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

Communication □anagement

A. Internal Communication & Staff Notification

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

B. Notification & Communication with External Authorities

When an emergency plan is initiated, the appropriate external authorities and community resources will be notified. Contact information can be found in: ***HICS - Communication with Hospitals, City, County and State***.

C. Communication with Patients & Family

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

D. Communication with Media

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

E. Communication with Suppliers

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

F. Communication with other ~~Health~~health care ~~Organizations~~organizations

1. A working relationship has been established with other ~~healthcare~~health care organizations within Santa Clara County. A Memorandum of Understanding (MOU) is in place to share resources as needed and available.
2. Key information to share with the other ~~healthcare~~health care organizations includes:
    a. Command systems & other command center information
    b. Names & roles of command center system
    c. Resources & assets to be potentially shared
    d. Process for the dissemination of patient & deceased individual names for tracking purposes
    e. Communication with third parties
3. Inter-agency communications is maintained through several channels:
    - Telephone
    - 2-Way Command Radio
    - EM-Resources – ~~online~~on-line hospital status reporting in real-time
    - WebEOC – web-based system for sharing status and requesting resources
    - Amateur Radio - volunteer radio operator system
4. Patient information that must be shared with the other healthcare organizations, local or state health departments, or other law enforcement authorities on the whereabouts on patients during an emergency will be transmitted in accordance with applicable laws and regulations.

G. Alternate Care Site Communications

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

RESO□RCE □ ASSET □ ANA□E□ ENT

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

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

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

B. Monitoring Resources and Assets

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

SEC□RIT□ □ SA□ET□ □ ANA□E□ ENT

A. Managing Hazardous Waste

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

B. Biological, Radiological & Chemical Isolation & Decontamination

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

C. Access & Egress Control

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

D. Traffic Control

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

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

STA□□ □ ANA□E□ ENT

A. Roles and Responsibilities

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

If staff is not available for handling critical tasks defined by the Job Actions Sheets, staff will be drawn from the appropriate departments or, if none are available, from the labor pool.

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

B. Managing Staff Support Activities

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

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

C. Managing Staff Family Support Activities

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

D. Training and Identification of Staff

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

□ANA□IN□ □TILITIES

During an emergency, alternate means will be provided for essential utility systems as identified in the plan. These utility systems are identified as well as alternate means for providing the services. The organization will

assess the requirements needed to support these systems such as fuel, water, and supplies for a period of time identified. This assessment includes the requirements for 96 hours without community support.

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

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

Refer to **□tility Systems - E□uipment Inventory** and **□tilities Systems or E□uipment □ailure Response** for more information

□ ANA□IN□ PATIENT CLINICAL □ S□PPORT ACTI□ITIES

A. Clinical Activities

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

B. Evacuation Activities

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

C. Vulnerable Patients

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

D. Personal Hygiene and Sanitation Requirements

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

E. Mental Health Services

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

F. Mortuary Services

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

G. Patient Tracking: Internal & External

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

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

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

DISASTER PRI□ILE□ES

A. Volunteer Licensed Independent Practitioners (LIP)

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

The Medical Staffing Office is responsible for granting disaster privileges to volunteer LIP and will distinguish volunteer LIP from other LIP's. Refer to Policy/Procedure: Medical Staff- Privileging Licensed Independent Practitioners During Disaster Events.

B. Other Licensed Volunteers (non-LIP)

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

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

E□ER□ENC□ RESPONSE PLANS

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

- Closed Point of Dispensing (POD)
  - This plan coordinates the hospital planning and response actions during a public health emergency requiring medical countermeasures given to a group of people at risk of exposure to a disease in accordance with public health guidelines or recommendations.
- ~~Earthquake~~Earthquake

    - This plan is to ensure safety of patients, staff and visitors in the event of a major earthquake
- Hospital Evacuation / Shelter in Place
    - This plan provides a framework for sheltering-in-place and evacuation when hazardous conditions develop to the degree that the facility and/or first responders must take action to protect patients, visitors and staff.
- Hospital Surge
    - This plan is intended to assist the hospital in thinking through critical issues related to healthcare surge in emergency situations
- ~~Mass Fatality~~Mass Fatality
    - This plan is designed to outline the management and disposition of large numbers of human remains as a result of a natural disaster, epidemic, pandemic or other catastrophic event
- Pandemic
    - This plan is intended to protect employees, physicians, volunteers, patients, contractors, and visitors minimizing exposure to a pandemic influenza event
- Post-Disaster Business Continuity Plan
    - This plan ensures the continuity of mission essential services after a wide range of emergencies and incidents.

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

PLAN E□AL□ATION AND PER□OR□ANCE I□ PRO□E□ENT

A. The following events will be reviewed and critiqued to determine the effectiveness of the Emergency Management Plans.
    1. Planned exercises
    2. Actual events impacting or having the potential to impact hospital operations.
B. Assessment is conducted through the analysis of the information and reports that create an overall critique of the disaster event or exercise to determine:
    1. If plans and job actions are appropriately designed.
    2. The level of performance of systems and individuals.
    3. The level of improvement from prior events.
    4. The effectiveness of redesigned plans and job actions.
C. Opportunities for improvement are continuously evaluated and implemented through the Emergency Management Committee.

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	10/2021
Emergency Management Committee	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2021
	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2021

El Camino Health

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Owner:	*Aletha Fulgham: Assistant Director Imaging Svc*
Area:	*Imaging Services*
Document Types:	*Policy*

Radiation Safety - Personnel and □edical Staff □onitoring and Dosimetry

~~I□CO□ERA□E:~~

CO□ERA□E:

All El Camino Hospital staff, medical staff, and volunteers

~~II□P□RPOSE:~~

P□RPOSE:

To provide a means of monitoring occupational radiation exposures affecting ECH personnel and contractors and provide a standardized process of oversight for all medical center dosimetry accounts and utilization.

~~III□POLIC□ STATE□ENT:~~

POLIC□ STATE□ENT:

All persons employed by El Camino Hospital and medical staff members must wear a dosimeter if they are working or observing in a controlled environment where ionizing radiation is present and are likely to receive a dose in excess of 10□ of the annual occupational dose limits in a year from sources external to the body. The following is the procedure by which this monitoring is accomplished.

~~I□□DE□INITIONS:~~

~~NA~~

~~□□RE□ERENCES:~~

RE□ERENCES:

1. American College of Radiology □Radiation Safety
2. CA Department of Public Health
3. Title 1□, California Code of Regulations, section 20.1201

- Nuclear Regulatory Commission-Title 10, Code of Federal Regulations, Part 20
- Policy: Declared Pregnant Radiation Worker

~~□I□PROCED□RE:~~

~~A□□adge Assignment~~

PROCED□RE:

A□□adge Assignment

1. El Camino Hospital is contracted with a radiation dosimeter monitoring service.
2. Service is initiated by providing the first and last name, birth date or last four digits of the Social Security Number for the individual requesting the dosimeter. If the person has previously held a dosimeter either here at El Camino Health or elsewhere, the entire Social Security number must be provided to ensure continuity of records.
- Radiation dosimeters are exchanged monthly. Dosimeters are received and distributed by the Imaging Services Department to all departments who use them on a regular basis. Subaccount managers or their designee are responsible for distributing the dosimeters to individuals in their department.
    a. Prior month□s dosimeters are to be collected and sent back to the company for interpretation each month. Each dosimeter holder is responsible to ensure their dosimeter is available for processing by the □th of the month. If the dosimeter is not available to the subaccount manager by this time, the dosimeter is considered unreturned. Those who fail to return their dosimeters as required may be subject to progressive discipline.
    b. Subaccount managers or their designee are responsible for returning dosimeters to the ~~imaging dept.~~Imaging department by the □th of the month or the following Monday. Subaccount managers or their designee are responsible for reconciling returned dosimeters with that month□s dosimeter packing list ***prior*** to returning badges to Imaging. For any unreturned or unused badge□s□, subaccount managers or their designee, will provide written documentation as to the reason for the missing or unused badge□s□and include this documentation with the returned badges.
    c. Badges returned after that month□s batch has been mailed will be held for shipment with the next month□s badges.
    d. Badges returned after one □1□year will not be sent to the radiation dosimeter monitoring service.
    e. Spare badges are available upon request for employees and physicians as needed. A spare can be requested from M□ or LG Imaging Control or by completing the dosimeter request form located on the toolbox here: Dosimeter Request Form
    f. The dosimetry monitoring service will provide monthly reports, which are reviewed by the Radiation Safety Officer upon receipt.
- Personnel whose exposure exceeds ALARA □As Low as Reasonably Achievable□limits are notified by the Radiation Safety Officer or his designee. Recommendations follow ECH ALARA guidelines as outlined within the Radiation Protection Program and correspond with the State of California Department of Public Health Services Radiation Control Regulation, Title 1□.

~~A□Agencies□□endors□□isitors□etc□~~

□□Agencies□□endors□□isitors□etc□

1. Any visitors, vendors, physician observers, outside agency personnel and/or students, should wear their own dosimeter, which are to be provided by their place of employment or school.
2. If not provided by outside source, the hospital will issue a dosimeter to any individual whose anticipated dose is expected to exceed 10□ of the annual dose limit while at the facility.

~~□□Proper □se of Dosimeters~~

C□Proper □se of Dosimeters

1. The tab at the top of the dosimeter labeled □Remove□should not be removed until ready for use. This tab will denote whether the dosimeter was used or unused. This allows tracking of unused badges for compliance monitoring.
2. Dosimeters are to be worn as instructed by the Radiation Safety Officer. Dosimeters shall be worn outside of personal protective shields except for fetal monitoring badges which are worn underneath the radiation protective shield.
□. Those individuals that work on both campuses should have separate dosimeters for each site. Dosimeters are not to be taken between campuses.
□. Those individuals routinely working with radioactive materials will wear a ring dosimeter in addition to the whole body dosimeter.
    a. Hand exposures are measured on those individuals that dispense nuclear pharmaceuticals and on request by individuals that may have ~~an increased risk of~~consistent exposure to ~~the main x-ray beam~~radiation of the hand.
□. Dosimeters should be left in the hospital after the worker has completed their day□s activity to maintain consistent and accurate readings.
    a. Proper on site storage of dosimeters is provided by the hospital ~~using a pocketed holder with space for each user~~.
    b. This holder is to be stored in an environment that is limited to local background radiation exposure to ensure the integrity of the dosimeter.
□. As per policy **Declared Pregnant Radiation □ or□er Policy**, a fetal monitoring badge will be made available to the employee once a pregnancy is declared. See policy for more information on this process and proper use of the fetal dosimeter.
□. Dosimeter holder may be subject to disciplinary action for non-compliance of this policy, subject to HR and MEC policies.

~~C□Exposure Records~~

D□Exposure Records

1. In compliance with Title 1□, monthly and cumulative records of exposure are available to the employee during their term of employment at El Camino Hospital.
2. Exposure records of all El Camino Hospital employees are available to future and concurrent employers

by a written signed release from the requesting employee.

- When dosimetered employees leave the organization, they may complete a written release and provide their personal email so their final dose may be emailed to them once their last dosimeter readings are available.
- With the exception of high radiation risk workers, or those with specific regulatory requirements for dosimeter monitoring, whose primary work duties put them at increased risk of radiation exposure, personnel may be considered for removal from the vendor list. Should any previously badged person wish to reinstate their dosimeter, he/she may do so by contacting the subaccount manager or designee.
- Personnel whose badge readings are M minimal for consecutive months have the option to no longer receive a monthly personal dosimeter. The RSO and their direct supervisor or manager will need to approve this change, and a Dosimeter Declination Form must be completed. Exceptions are high radiation risk workers, or those with specific regulatory requirements for dosimeter monitoring whose primary work duties put them at increased risk of radiation exposure.
- All ALARA and overexposure records will be communicated to badge holders within 10 days of receipt of such records. In the event of a significant overexposure, approaching Nuclear Regulatory Commission limits, the badge holder will be notified verbally. If the radiation safety committee is not in possession of current contact information, HR or the medical staff office will be contacted to obtain current contact information for purposes of notification.
- Monitored staff are made aware of their ~~end of the year~~ dose records at least on an annual basis.

8. The Radiation Safety Committee and Radiation Safety Officer reserve the right to discontinue dosimeters based on prior dose history and occupational criteria.

Attachments

A. Dosimeter Declination Form

B. Authorization to Release Occupational Radiation Exposure History

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

Attachments

81 8 Rev 0 2021 Auth to Realease Occupational Radiation Exposure History non NCR.pdf
Dosimeter Declination Form

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	09/2021

Step Description	Approver	Date
Dept. of Surgery	Faerie □amora-Lopez: Medical Staff Coord	09/2021
Radiation Safety	Toni Murphy: Quality Coordinator	0□/2021
Imaging Services Leadership	Aletha Fulgham: Assistant Director Imaging Svc	0□/2021
	Aletha Fulgham: Assistant Director Imaging Svc	0□/2021

El Camino Health

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Owner:	*Tamara Stafford: Dir Talent Development & EWHS*
Area:	*Scopes of Service*
Document Types:	*Scope of Service/ADT*

Scope of Service - Talent Development Department

Types and Ages of Clients Served

The ~~Education Services~~Talent Development Department provides services to all El Camino Hospital employees at all sites.

Scope and Complexity of Services Offered

The ~~Education Services~~Talent Development Department ~~including,~~ provides orientation, training, organizational development financial and administrative support to ensure staff competency and promote professional growth. The department is also involved in internal communication activities. ~~In addition, the department oversees the Environment of Care via the Central Safety Committee and its various workgroups.~~ Services provided include, but are not limited to:

- General Hospital Orientation and site-specific orientation for new employees, contracted and temporary staff and volunteers.
- Annual training and review on topics as required by regulatory and accrediting organizations and state and federal law, such as emergency management, infection control, general safety and Corporate Compliance.
- Professional and personal growth classes for such as personal computer skills, service delivery skills, supervisory and management skills.
- Support to all hospital departments on planning, designing and delivering department-specific training.
- Managing clinical and other educational rotations; liaison between schools and enterprise.
- Serving as an educational resource to staff and patients.
- Coaching all levels of staff.
- Tracking of attendance at on-site education events and cardiopulmonary resuscitation, advanced cardiac lifesaving, pediatric advanced lifesaving and neonatal resuscitation training. Assistance with locating, scheduling and registering for the above classes.
- Management of the El Camino Hospital Tuition Assistance Fund ~~and Employee Education Fund.~~
- Production of internal communication newsletters, presentations and events. Instructional design
- Consulting with managers and staff to best decide the focus and implementation of education.
  ~~Planning and carrying out educational exercises that test our emergency management policies and procedures, including following up on issues identified during these exercises.~~
  ~~Facilitation and coordination of workgroups that address safety in the environment of care.~~

- Management of the performance evaluation process
- Oversight of employee engagement and recognition activities.

Staffing

The staff providing services includes ~~an education coordinator~~talent development specialists, ~~safety management specialist~~ and administrative staff. A director ~~and manager provide~~provides operational oversight. Additional instructors may be contracted as needed.

Level of Service Provided

The ~~General Education~~Talent Development Department provides services under hospital policy and procedure guidelines.

Standard of Practice

The ~~General Education~~Talent Development Department is governed by state and federal regulations including the State of California Department of Health Services and the Occupational and Safety Health Administration, national boards of certification for specialty nurses as well as standards established by the Joint Commission on Accreditation of Healthcare Organizations.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	10/2021
HR Leaders including CHRO	Tamara Stafford: Dir Talent Development & EWHS	09/2021
Contributor Input	Tamara Stafford: Dir Talent Development & EWHS	08/2021
	Tamara Stafford: Dir Talent Development & EWHS	08/2021

El Camino Health

CONFIDENTIAL

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: □oard of Directors
From: □ ar□□dams□□ D□Chief □ edical Officer
Date: □ovem□er 10□2021
Subject: □ edical Staff Peer Revie□ Policy

Purpose:

Present the revised □ edical Staff Peer Revie□ Policy for □oard approval

Recommendation:

□pprove the policy revision as stated.

Authority:

□ hile the tho□sands of policies □sed □y El Camino Health are maintained □y management□reg□latory □odies e□pect the □oard of Directors to ass□me final responsi□ility for these policies.

Situation:

The 2013 □ edical Staff Peer Revie□ is overd□e for revision and m□st □e □pdated to align it □ith the recent medical staff □yla□ changes as □ell as □ring it into compliance □ith C□ Title 22□C□ S Conditions of Participation□and The □oint Commission medical staff standards.

Background:

Professional physician peer revie□ is an e□pected and re□□ired f□nction of the organi□ed medical staff □O□ S□. Traditionally□this □as accomplished □y specialty specific departments □hich often created inconsistent res□lts as this □as then limited to smaller gro□ps of physicians often in competition □ith each other ma□ing o□□ective determinations diffic□lt and reprod□ci□le. □ased on recommendations from e□perts in this area s□ch as The □reeley Company and Horty Springer Health □a□□many organi□ations have moved to a more modern approach to peer revie□ □hich is characteri□ed □y the term □ □lti-Specialty Peer Revie□. This involves the creation of an enterprise □ide peer revie□ process that is concentrated in a single □ody □hich is made □p of dedicated□specifically trained physicians that are separate from departments□elected leaders□and medical politics. Peer revie□ triggers are then developed to ass□re that all appropriate cases are revie□ed. The El Camino Health medical staff engaged an o□tside cons□ltant t□o years ago to assist in the development of a □ □lti-Specialty Peer Revie□ process. The cons□ltant helped the medical staff revise the □yla□s to adopt this approach. □yla□ changes □ere then made at that time and these □ere approved □y the medical staff at large prior to the onset of the pandemic.

□ ore recently there have □een some minor ad□□stments to the □yla□s and the policy that descri□es the act□al peer revie□ process needed to □e revised to □ring it into compliance □ith the □yla□ changes as □ell as ass□ring compliance □ith reg□latory agencies. The policy revisions □ere first proposed □y the medical staff office director and staff □ith g□idance from the cons□ltant. The revisions □ere then s□□mitted for revie□ to o□r medical staff e□pert o□tside attorney□Ross Camp□ell. The revisions □ere then revie□ed □y the O□ S □eadership Co□ncil □hich then s□□mitted them to the □ edical E□ec□tive Committee for final approval.

□genda □tem □ame Here
□ eeting Date

Assessment:

The policy revisions incl□de streamlining the definitions□revising the responsi□ilities to match the □yla□ changes already approved. The revisions introd□ce the □se of trac□ing and trending metrics to a□gment individual case reviews. The use of predetermined "triggers" determine most peer revie□ cases altho□gh referrals can □e made □y any concerned party as this is essential for a high relia□ility organi□ation. Emphasis on timeliness is incl□ded as past peer revie□ often □as delayed months and sometimes years.

The transition to this □ □lti-Specialty Peer Revie□ approach has proceeded □etter than e□pected □ith the ne□ly formed committee □or□ing at a very high level as confirmed □y the recent internal a□dit presented to the □oard Compliance Committee.

List of Attachments:

1. □ edical Staff Peer Revie□ Policy
2. □ edical Staff Peer Revie□ Policy – □ttachment □
3. □ edical Staff Peer Revie□ Policy – □ttachment □

El Camino Health

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Owner:	*Raquel Barnett: Director Medical Staff Services*
Area:	*Medical Staff*
Document Types:	*Policy*

Medical Staff Peer Review

COVERAGE:

All ECH Medical and Hospital Staff

PURPOSE:

To ensure that the hospital system, through the activities of its medical staff, (1) identifies opportunities for improvement of the delivery of clinical care, (2) ~~provides~~identifies educational resources and forums for practitioners, (3) identifies professional practice trends that impact quality of care and patient safety ~~by assessing the ongoing professional practice of individuals granted clinical privileges or scope of practice guidelines and~~through the quality management and peer review process, (4) when necessary, uses the results of such ~~assessments~~reviews, to perform focused professional practice evaluations (FPPE) ~~and~~ to assist medical staff members and allied health practitioners (AHPs) in providing safe, high quality patient care.

POLICY:

It is the policy of El Camino Hospital to have a process for peer review of the medical staff to evaluate the quality of care provided to patients. A peer or peers of the Practitioner responsible for the patient's care will participate in the review as described below. All activities related to peer review are protected by California Evidence Code 1157 and will remain confidential.

DEFINITIONS:

1. **Practitioner:** The word Practitioner used throughout this policy means both licensed independent practitioner and allied health practitioner.
2. **Focused professional practice evaluation (FPPE):**
   The establishment and confirmation of an individual practitioner's ~~current~~privilege-specific competency at the time when he/she requests new privileges, either at initial appointment or as a current member of the medical staff, and is also used to evaluate and monitor ~~concerns based on a medical disciplinary cause or reason~~a practitioner's ability to provide safe, high quality care. FPPE is a time-limited period or process in which a designated number of procedures, admissions, or consults, etc., are ~~raised through the OPPE or other processes~~reviewed, during which the Medical Staff evaluates and determines a practitioner's professional competence. ~~These activities include, but are not limited to, what is typically called proctoring or focused review, depending on the nature of the circumstances.~~

   ~~**Ongoing Professional Practice Evaluation (OPPE):**~~

~~The routine, ongoing monitoring and evaluation of competency for medical staff members as defined by the six Joint Commission/ACGME general competencies described below.~~

- ~~Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life~~
- ~~Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others~~
- ~~Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care~~
- ~~Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams~~
- ~~Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society~~
- ~~Systems-Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare~~

3. **Peer:** A "peer" is an individual practicing in the same profession and who has a sufficient level of clinical knowledge and experience in the relevant subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, a peer is an individual who is well-trained and competent in that specialty area.
4. **Peer review:** "Peer review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve quality of care and patient safety. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or by a system. During this process, the practitioner is not considered to be "under investigation" for the purposes of reporting requirements under the Healthcare Quality Improvement Act. Peer review is conducted using multiple sources of information including, but not limited to:
    - the review of individual cases
    - the review of aggregate data for compliance with general rules of the medical staff and clinical standards
    - use of rate measures in comparison with established medical staff goals using benchmarks or norms as guidelines
5. **Peer review body**: The peer review body designated to perform the initial review by the ~~medical executive committee~~Medical Executive Committee (MEC) or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital. The ~~initial~~primary peer review body will be the Practitioner Excellence Committee (PEC) unless otherwise designated below for specific types of case reviews or circumstances by the Medical Executive Committee.

6. **Conflict of interest**: A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion
    1. An absolute conflict of interest would result if the physician is the provider under review or is a first degree relative or spouse.
    2. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source.
    3. Merely practicing in the same specialty and/or same geographic area does not automatically result in a finding of a conflict of interest. It is the obligation of the individual reviewer or committee member to disclose to the committee the potential conflict. It is the responsibility of the peer review body in consultation with the Chief of Staff and if necessary Medical Executive Committee to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in the peer review process.

RESPONSIBILITIES:

~~A. The primary responsibilities of the Practitioner Excellence Committee (PEC) are to:~~

~~1. Define and maintain the practitioner performance indicators and targets for the General Competencies in collaboration with the appropriate departments and specialties and approved by the MEC.~~

~~2. Evaluate practitioner performance for these indicators to determine if improvement opportunities exist either through case review or using aggregate data for patterns and trends.~~

~~3. Assure accountability by the medical staff departments for the development of improvement plans when appropriate~~

~~4. Oversee any other medical staff specialty specific peer review activities~~

~~B. There are a number of practitioner performance areas that fall outside of the purview of the PEC and are handled by other bodies or individuals. These include:~~

~~1. Behavior- Individual behavioral events will be adjudicated by the appropriate Medical Staff leadership as delineated in the Medical Staff Code of Conduct~~

~~2. Utilization- Concurrent individual utilization issues will be handled by the Utilization Review process Utilization- Concurrent individual utilization issues will be handled by the Utilization Review process.~~

~~3. Infection Control- Policies and practices will be the responsibility of the Infection Control Committee and the MEC~~

~~4. Blood Use- Blood use policies will be the responsibility of the MEC~~

~~5. Medication Use- Medication policy and formulary decisions will be the responsibility of the Pharmacy and Therapeutics Committee (P & T) and the MEC~~

~~6. Patient Safety- Policies regarding patient safety will be the responsibility of the Patient Safety Committee and MEC~~

~~7. Health Information Management- Policies regarding documentation, manual and/or electronic, will be the responsibility of the MEC~~

~~PROCEDURE:~~

A. The primary responsibilities of the Practitioner Excellence Committee (PEC) are to:

1. Define the indicators for peer review for approval by the MEC as outlined in Attachment B.
2. Evaluate practitioner performance for these indicators to determine if improvement opportunities exist either through case review or using aggregate data for patterns and trends.
3. Assure accountability by the medical staff departments for the development of FPPE and/or improvement plans when appropriate
4. Oversee any other medical staff specialty specific peer review activities.

B. Peer Review Data Management:

1. All ~~OPPE/FPPE/~~peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, rules and regulations, state and federal laws, and regulations pertaining to confidentiality and non-discoverability, i.e. Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and ~~Appropriate State~~Evidence Code 1156, 1157. Discussions of peer review are confined to meetings and committees designated to perform this function. Discussion may include fact finding and phone calls between medical staff members, the practitioner and peer review bodies. Confidentiality of the process includes protecting the identity of the individuals making the complaints to medical staff.
2. The medical staff will use the provider-specific ~~OPPE~~peer review results in making its recommendations to the Credentials Committee and/~~FPPE and peer review results in making its recommendations to the Credentials Committee and/~~or MEC regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
3. The Medical Staff Services Department and/or ~~Quality Department~~Peer Review team in Risk Management will keep provider-specific quality information in a secure location. Provider-specific quality information consists of information related to:
    a. Individual practitioner performance data
    b. The individual practitioner's role in sentinel events, significant incidents, or near misses
    c. Correspondence to the physician regarding commendations, comments regarding practice performance, and corrective action
4. ~~Only the final~~Final determinations of the peer review process and any subsequent actions or recommendations and correspondences between the committee and the practitioner are considered part of an individual provider's quality file. ~~Any written or electronic documents related to the review process other than the above shall be considered working notes of the committee and shall be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, preliminary case rating, questions and notes~~
5. ~~Aggregate peer~~Peer review data, formal investigations and corrective actions will be retained ~~for ten years after the most recent reappointment of the provider~~permanently. ~~Information related to formal investigations and corrective actions will be retained forever.~~
6. Peer review information in the individual practitioner's quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or Medical Staff Services or Quality Department employee(s) to the extent necessary to carry out their assigned responsibilities.

7. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:
    a. The specific provider (to the extent that the Chief of Staff believes such access is appropriate and as consistent with the Medical Staff Bylaws)
    b. The Chief of the Medical Staff
    c. Medical staff Department Chiefs (for members of their departments only)
    d. Members of the Medical Executive Committee (MEC), Credentials Committee, ~~Credentials~~Practitioner Excellence Committee (PEC), ~~Practitioner Excellence Committee,~~ and Medical Staff Services professionals for purposes of considering reappointment or corrective action
    e. Medical staff leaders and quality staff supporting the peer review process
    f. Individuals surveying for government agencies or accrediting bodies with appropriate jurisdiction (e.g. The Joint Commission or state/federal regulatory bodies)
    g. Individuals with a legitimate purpose for access as determined by the hospital Governing Board
    h. Chief Medical Officer, and designees as necessary for support of medical staff peer review functions
    i. The hospital Chief Executive Officer(CEO) when information is needed for the CEO's involvement in the process of immediate formal corrective action as defined by the medical staff bylaws and rules and regulations
    j. Peer review committees and Judicial Review Committees
    k. Medical staff and/or hospital consultants or attorneys, as deemed necessary by the Chief of Staff, Chief Executive Officer, or Medical Staff Services professionals
    l. No copies of peer review documents will be created and distributed unless authorized by medical staff or hospital policy.

C. **Circumstances requiring peer review:**

1. Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedures for conducting peer review for an individual case and ~~for aggregate performance measures~~peer review triggers are ~~described in Attachments~~found in Attachment A and B~~, C, and D~~.
2. Sources of information for peer review ~~and OPPE~~ will include but not be limited to outcome data, aggregate reports of coded outcomes of care, review of operative and other invasive procedures, incident reports, patient complaints, patterns of blood and medication usage, resource use data such as length of stay, morbidity and mortality data.
3. Method of obtaining data for ~~OPPE~~peer review may include medical record review, direct observation, monitoring of diagnostic and treatment techniques and outcomes, and discussion with other care providers.
4. In the event that a decision is made by the Governing Board to investigate a practitioner's performance or that circumstances warrant the evaluation of one or more providers with privileges, the Medical Executive Committee or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as described in the medical staff bylaws and rules and regulations.

D. **Circumstances requiring external peer review:**

1. Either the PEC, Leadership Council, MEC or the Governing Board can make determinations on the need for external peer review. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the determining bodies indicated above.
2. Circumstances that may result in external peer review include the following:
    a. Litigation: when potential for a lawsuit exists when there are vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly affect a practitioner's membership or privileges
    b. Lack of internal expertise: when no one on the medical staff or allied health staff has adequate expertise in the specialty under review; or when practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as describe above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or Governing Board.
    c. Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees.
    d. Credibility: when or if the medical staff or board needs to verify the overall credibility of the internal peer process typically as an audit of routine peer review findings.
    e. Benchmarking: when an organization is concerned about the care provided by its physicians relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved.
    f. Miscellaneous issues: when the medical staff needs an expert witness for a fair hearing or for evaluation of a credential file.

E. **Individual case review and ~~timeframe~~ time-frame**

1. Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases ~~for review will~~to be ~~identified based on the Medical Staff Case Review Indicators. The goal is for routine cases to be~~ completed within ninety (90) days from the date the ~~chart~~case is ~~reviewed by the quality department staff~~referred to the peer reviewer and complex cases to be completed within ~~one hundred and twenty (~~120~~)~~ days. ~~Exceptions may occur based~~The rating system for determining results of individual cases is listed in Attachment C on ~~case complexity or reviewer availability. The timelines for this process are described in Case~~the Confidential Review ~~Process~~Form (~~Attachment B~~CRF). ~~The rating system for determining results of individual case reviews is described in the Quality Review Worksheet (Attachment E). The results of all cases reviewed will be maintained and reported on a regular basis.~~

~~Rate and rule indicator data evaluation~~

~~1. Evaluation of the aggregate physician performance measures via either rate or rule indicators data will be the responsibility on an ongoing basis by the PEC as described in (Attachment D). All results will be maintained, reported and acted upon in the manner described in the OPPE policy.~~

F. **Oversight and reporting**

1. Direct oversight of the peer review process is delegated by the MEC to the PEC. The responsibilities of the PEC related to peer review are described in the medical staff bylaws. The PEC will report to the MEC regarding PEC activities. The MEC will report to the Governing Board at least quarterly, and as frequently as necessary regarding peer review activities. The MEC has overall oversight

responsibility for the PEC and shall conduct a performance review of the PEC on a regular basis.

G. **Practitioner Excellence Committee (PEC) Responsibilities:**

1. ~~Measurement System Management~~Peer Review Indicators.

   a. At least annually, review ~~all the~~the peer review indicators, ~~targets,~~ screening tools and referral systems for effectiveness recommended by the medical staff department chiefs and recommend changes to the MEC. The PEC will have the authority to develop and implement specialty-specific indicators if not provided by the departments in a reasonable time-frame. List of indicators in Attachment B.

   ~~Data from sub-specialty databases supported by the hospital shall be shared with the PEC based on MEC approved indicators.~~

   ~~As needed, make recommendations on requests for additions or deletions to the indicators, criteria or targets used by the medical staff to evaluate practitioner performance to the MEC for approval.~~

   b. Design and approve focused studies when necessary to further analyze practitioner performance.

   ~~In coordination with the Credentials Committee, define the appropriate content and format for practitioner performance feedback reports and reappointment profiles as approved by the MEC.~~

2. Evaluation of Practitioner Performance /Evaluation of Individual Cases

   a. ~~Perform~~If initial ~~practitioner~~ review ~~of all cases identified based on approved Case Review indicators. If initial~~has been carried out by a recognized peer review ~~has been carried out by a recognized peer review~~ subcommittee (see #5 below), then the PEC shall either decide to accept the subcommittee review or to re-review the case. PEC has the prerogative to do the initial review of any case meeting its review criteria in lieu of a specialty peer review committee.

   b. Obtain reviews and recommendations from specialists on the medical staff or from external specialists when required.

   c. Communicate with the practitioner involved with the case as needed to obtain input prior to making determinations that opportunities for improvement may exist.

   d. Make determinations regarding individual practitioner opportunities for improvement based on: individual or multiple case reviews and/or aggregate rate data.

   e. Perform focused practice evaluation when necessary to further define if an improvement opportunity exists.

   f. Identify and communicate potential Hospital systems or nursing practice opportunities for improvement.

~~Evaluation of Rate and Rule Indicators~~

~~a. Perform regular review for individual practitioner outliers as defined by the approved acceptable target levels from medical staff Rule or Rate indicator data for all practitioner competencies within the PEC scope. This function may be delegated by the PEC to an individual PEC member or to a subcommittee.~~

~~b. Identify potential individual practitioner opportunities for improvement or determine if focused practice evaluation is needed to define if an improvement opportunity exists.~~

~~c. Identify potential medical staff wide opportunities for improvement.~~

~~d. Identify and communicate potential nursing practice or hospital system opportunities for improvement.~~

~~Improvement Opportunity Accountability~~

~~a. The role of the PEC is to assure when opportunities for improvement are identified, the appropriate individuals are notified of the issues and a reasonable improvement plan is developed.~~

~~Oversight of Other Medical Staff Physician Excellence Committees~~

~~a. Some medical staff departments or committees will continue to evaluate practitioner performance as a quality control mechanism or for educational purposes. Such discussions will be considered part of the medical staff quality function and are protected from discovery as long as the appropriate policies and procedures of the PEC are followed. The PEC will oversee the process used to perform this evaluation and the indicators selected by the specialty for the following areas:~~

~~i. Image Based Specialties (Pathology, Radiology): Routine quality reviews of diagnostic image interpretation by practitioners (e.g. surgical pathology or cytology slides, radiological images) will be performed internally. Department wide and practitioner specific data based on MEC approved indicators will be reported to the PEC as rule or rate data at least every six months. Cases potentially meeting case review indicator criteria will be referred to the Quality Department to be reviewed by the PEC using the case review process.~~

~~ii. Emergency Department: Perform routine quality reviews based on departmental criteria. Cases resulting in significant adverse outcomes potentially related to practitioner care as defined by Review indicators will be referred to the PEC.~~

~~iii. OB/Perinatal Specialties: Perform routine quality reviews based on departmental criteria. Cases resulting in significant adverse outcomes potentially related to practitioner care as defined by Review indicators will be referred to the PEC.~~

~~iv. Pediatrics/Neonatal Specialties: Perform routine quality reviews based on departmental criteria. Cases resulting in significant adverse outcomes potentially related to practitioner care as defined by Review indicators will be referred to the PEC.~~

~~v. Heart Vascular Institute (HVI): Perform routine quality reviews based on departmental criteria. Cases resulting in significant adverse outcomes potentially related to practitioner care as defined by Review indicators will be referred to the PEC.~~

~~vi. Interdisciplinary Practice Committee: Perform routine review of cases related allied health professionals based on medical staff criteria.~~

3. Oversight of Other Medical Staff Peer Review Peer Review Committees

   a. The medical staff subcommittees identified below have been approved by MEC to conduct specialty specific peer review. The PEC reviews all determinations made by these peer review committees in their meetings and has oversight of their peer review process.

      i. Pathology

      ii. Radiology Peer Review Committee

      iii. Emergency Department

      iv. Perinatal Peer Review Committee

v. Pediatrics Peer Review Committee

~~**Department (or Specialty) Peer Review Responsibilities**~~

~~1. Case Review may be carried out for any case triggers that a Department or Specialty line deem significant and useful. Any cases fitting the case review indicators shall be passed on to the PEC.~~

~~2. Aggregate Rate data shall be the responsibility of the Department as well.~~

~~3. Mortality and Morbidity (M&M) Conferences shall also be the responsibility of the Department or Service Line Specialty. It is anticipated that this activity is the most important in moving the quality needle since it involves all hospital personnel involved in patient care for that specified area. It will be education based and will maintain close collaboration with the Departmental and PEC Review Activity as there is a strong two-way case sourcing opportunity to be exercised. M&M can identify cases that may require Peer Review and Peer Review should identify cases where there are educational yields.~~

H. **Membership of PEC**

1. The PEC will be comprised of 9 to ~~11~~12 voting members who are active members of the medical staff. The committee shall be composed of at least one member from each of the following specialties: Internal Medicine/Hospitalist, General Surgery, Subspecialty Surgery, OB/GYN, Intensivist, Cardiology, Radiology and Emergency Medicine. The remaining committee members shall be appointed from at large with a maximum of three members from any single specialty. Practitioners from other specialties may be invited to the meeting as needed.
2. The CMO, the Chief of Staff, and the ~~quality~~peer review or medical staff support personnel as determined by the Chair are ex-officio members of the PEC.

I. **Appointment and Terms**

1. The Chief of Staff will appoint the members of the PEC based on the recommendations from the department chiefs and the PEC Chair and approved by the MEC.
2. Voting members will be appointed for a three-year term except for initial committee members who will have staggered terms to initiate the process (i.e. 1/3 for 4 years, 1/3 for 2 years and 1/3 for 3 years).
3. Voting members may be appointed for additional terms without limit.

   ~~Chair selection~~
4. Chair selection: The PEC Chair will be appointed by the Chief of Staff, and approved by the MEC.
5. To be eligible for appointment as Chair, the individual must be a current voting PEC member and have served as a voting PEC member at some point in time for at least one year. The Chair will serve for a term of one year and may have an unlimited number of consecutive terms as long as the chair is eligible to be PEC member. The PEC Chair will be an ex-officio member of the MEC.

J. **Member Responsibilities**

1. PEC members will be expected to attend at least two thirds (2/3) of the scheduled PEC meetings over a twelve- month period and perform assigned case reviews according to peer review policies and procedures to maintain membership. If a member fails to fulfill their responsibilities, they will be replaced using a process similar to that used for initial appointment to the PEC. PEC members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing PEC responsibilities. PEC members will be

expected to maintain an ECH email for electronic connection and work flow.

2. If a member of the medical staff who is not a PEC member is requested to perform a case review, it is that individual's responsibility to perform that review in a timely manner according to PEC policies.

K. **Meetings**

1. The PEC will meet at least 10 times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of 50% of the voting PEC members at a regularly scheduled meeting. A majority will consist of a majority of voting PEC members present.

L. **FPPE for Quality Concerns:**

1. Peer Review Committees may determine that a practitioner requires a FPPE for Quality Concerns either due to a single egregious case or due to concerns with a pattern of quality concerns. PEC monitors FPPE compliance monthly. The role of the PEC is to assure when opportunities for improvement are identified, the appropriate individuals are notified of the issues and a reasonable improvement plan is developed either through PEC, peer review subcommittee, medical director or department chief.
2. Practitioners placed on FPPE as part of the OPPE process shall be referred to PEC for approval and shall be monitored by PEC and the appropriate speciaty-specific sub-committee, if applicable.

M. **Statutory Authority**

1. This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and Appropriate California Peer Review Statues. All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities.

N. **Applicability of Medical Staff Bylaws**. The time-lines and/or methods set forth in this policy for completion of the professional practice evaluation process shall not operate to prevent the hospital or its Medical Staff from taking immediate action as necessary to prevent a substantial likelihood of injury to one or more patients as provided in hospital's Medical Staff Bylaws or to conduct further investigations or impose corrective action according to the process set forth in the hospital's Medical Staff Bylaws.

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

Attachments

Attachment A Case Flow
Attachment C Case Review Form
Attachment B Peer Review Indicators

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	09/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	09/2021
Practitioner Excellence Committee	Jeanne Hanley: Policy and Procedure Coordinator	08/2021
	Raquel Barnett: Director Medical Staff Services [JH]	08/2021

TITLE:

Attachment A

Peer Review Case Review Process Flow General Guidelines for Management of PEC Committee

Action	Procedure	Time
Case athering and Screening	Potential cases shall be gathered from the hospital information management system, from generic screens and from individual reports incident and informal. All cases will be screened by nurse peer review coordinators using the Peer Review triggers as a guideline along with clinical judgment. Any questions about necessity for review will be sent to the Chair of PEC. ~~If they contain a potential Case Review issue, the case~~If review is warranted, case will be entered into the peer review system for referral to the appropriate peer review committee. ~~will be sent for review~~. If the case is reviewed in one of the approved peer review subcommittees, the case will ~~get initial review there but will be tagged for over review by the~~be sent for final review by PEC. The subcommittees will be encouraged to use a mirror review process to the one elaborated below.	working days ~~of case receipt~~after review of the event by peer review team, referral is entered into peer review database.

TITLE:

Case Summary and Reviewer Assignment	~~QD~~ A referral report for each peer review committee is generated monthly and case assignments are made in advance of the specific peer review committee scheduled meeting. The peer review team provides a case summary, identifies key issues and assigns case to a physician reviewer ~~per the Peer Review policy~~. Initial reviewer shall be a member of the committee or designated by the Chair of the Committee. PEC Cases will be typically assigned to committee members on a rotating basis or based on specialty specific expertise. ~~. However, if based on the nature of the case, the QD identifies the potential need for review by a physician with a specific specialty expertise; the QD will~~	~~working days of receiving the chart.~~ Referral report monthly to assign reviewers based on scheduled peer review meeting
	~~contact the PEC Chair for case assignment.~~	
Initial Physician Review	The physician reviewer reviews the case and completes initial review section of Case Review Form for the physician whose care is being reviewed	Review will be completed within 2 weeks of ~~assigning chart~~case assignment.
Completed Case Review orm	Completed reviews will be submitted to the ~~QD~~ peer review team by the physician reviewer ~~immediately upon completion to enter into the case review tracking system.~~ Only cases with completed case rated forms will be place on the ~~PEC~~ peer review committee's agenda.	Expectation is that reviews are to be provided by at least days prior to the Committee meeting~~, the review will be provided to the committee. Late or incomplete reviews will be deferred to the next meeting.~~

TITLE:

Initial Reviews Rated □uality of Care Appropriate	~~Initial reviews that find appropriate physician care are submitted to the QD. The PEC Chair reviews these cases and, if there are no concerns, the~~Cases rated as care appropriate by the physician reviewer ~~cases~~ are reported to the PEC in summary form and placed on the PEC agenda. Any concerns raised results in presentation of the case to the entire PEC.	
Initial Reviews Rated Opportunity for Improvement □inor or □a□or	Reviews indicating potential Opportunity for Improvement Minor □OFMi□and/or Opportunity for Improvement Major □OFMa□are presented to the committee for discussion and confirmation or change in preliminary scoring. If the committee feels that care may be OFMi or OFMa, it will communicate with the involved physician□s□~~by letter with signature receipt~~prior to final case rating. The involved physician□s□are informed of the key questions regarding the case and asked to respond in writing and, at the option of either the physician or the PEC, appear in person to answer specific questions in a limited timeframe.	Physician under review will respond to committee within 2 weeks. If no response, ~~the physician will be notified by letter to respond within 2 weeks or the committee will finalize rating based on the available information~~. The peer review team will contact the physician by phone to determine if physician is unavailable due to special circumstances. If no response within this time frame after such attempts, case will be presented to PEC for final rating.

Communicating □indings to Physicians	For final case reviews indicating appropriate and OFMI physician care, the involved physicians are informed of the decision by routine letter. Physicians with final case reviews of ~~OFMi or~~ OFMa care are informed of the decision by certified letter with copies to the ~~sent to the Department Chief and~~ peer review file.	All completed case review findings will be communicated by letter to the involved physician within ~~□~~ □ business days of the Committee meeting or final PEC meeting~~.~~

TITLE:

Action	Procedure	Time
Appeal Process	If the involved physician disagrees with the final rating of a case, he/she has the right to ask for a review by the MEC whose decision shall be final. Additionally, if a Department Chief disagrees with the PEC care rating, then they also have the right to ask the MEC to review the case. The MEC has the final authority on case ratings. If the practitioner disagrees with the final MEC rating then he/she has the right to place a letter of rebuttal in their quality file.	
Trac ing Review indings	The ~~QD~~ peer review team~~department~~ will enter the results of all final review findings into the database for tracking.	Results will be entered in the database within weeks of the Committee meeting finalizing the rating.
Improvement plan development	If the results indicate a need for individual physician performance improvement, the issue will be referred to the appropriate Department Chief. The Department Chief will work to create and implement the improvement action plan. The PEC Chair shall be ready to assist the Department Chief if requested.	The Department Chief will create and implement the improvement plan within 0 days of the Committee decision.

TITLE:

□edical Executive Committee involvement	If Committee Chair or Department Chief has concerns that the improvement plan may be more complex than usual, they will discuss the issue with the MEC Chair for resolution. Recommendations that may result in "adverse action" □e.g., restriction of privileges or membership□will be addressed in accordance with the procedures in the Medical Staff Bylaws and Rules.	Committee Chair will discuss with the MEC Chair within □0 days of the Committee decision.
Referrals to the □ospital Performance Improvement Committee	For those cases determined to have potential opportunities for improving system performance or potential issues with nursing care, the Committee Chair will communicate the issue to the appropriate Hospital Committee.	The hospital committee receiving the referral will discuss the issue and communicate action plan to the PEC/MEC.
□igh-ris□ Cases	Sentinel Events requiring peer review, will have immediate review by the Practitioner Excellence Committee Chair or	Initial Physician review will be performed within three □□□working days of sentinel

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Action	Procedure	Time
	designee.	event case identification, with committee discussion at the next committee meeting or within 30 days of the event if there is not regularly scheduled meeting within 30 days.
	Additional information such as a literature search, second opinion, or external peer review may be necessary before making a decision on action.	If additional information is needed, the timelines may be extended after approval from the governing body or its designee or the Medical Executive Committee.
Precautionary or Summary Suspensions	The processes and time frames in this document do not apply to precautionary suspensions or summary suspensions under the Medical Staff Bylaws and Rules.	Refer to the Medical Staff Bylaws and Rules.

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Attachment B
Peer Review Triggers for Review

Peer Review Committee	Indicator	Indicator description
PEC, Perinatal, Pediatrics	Unanticipated death	As identified by pre reviewer screening or by use of severity adjusted outcomes to identify unexpected or low probability deaths. **Surgical:** Peri-procedural mortality w/in 30 days of initial procedure excluding palliative care, r severe trauma or deaths post procedures undertaken to diagnose/treat patient's underlying condition; **Medical:** Deaths of medical inpatients excluding admissions for palliative care, end stage disease, or medical conditions with known expected death rates (e.g. end stage CHF, acute AMI, pneumonia) or deaths in the ED of patients presenting in stable condition; **Perinatal:** maternal death within 30 days, newborn or intrapartum fetal death with gestational age greater than 25 weeks excluding infants with severe congenital anomalies;
PEC, Pediatrics	Transfer to another facility for significant/unanticipated change in clinical condition.	Includes: neonatal transfer to another facility for higher level of care. Exclusion: transfers for higher level of services not available or transfers not based on potential physician care issues
PEC	Concern regarding potential missed/ misdiagnosis resulting in significant change in patient treatment plan.	Includes transfer to ICU or invasive procedure interventions
PEC, Perinatal, Pediatrics	Unanticipated Cardiac or Respiratory arrest	**Perinatal:** Includes all maternal and neonatal clinical alerts.
PEC	Unplanned return to ICU at same admission	
PEC	Patient admitted for medical condition (non-surgical) with complication resulting in additional interventions	Additional intervention: Unanticipated ICU transfer or need for unanticipated surgical procedures.
PEC	Autopsy with unexpected findings potentially affecting patient care.	Findings of autopsy that were not known prior to death with potential impact on clinical course and treatment.
PEC	Significant tissue discrepancy between pre and post op diagnosis in the absence of treatment prior to surgery	Exclusions: Documented prior treatment by biopsies, excisions, radiation therapy or chemotherapy or procedures monitored by rates (non malignant hysterectomies, appendectomy, percutaneous needle biopsy and gallbladder procedures)

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Attachment B

Peer Review Triggers for Review

PEC	Delay in treatment/consultation resulting in ~~significant deterioration in~~ change in patient condition	
PEC	Risk management referral for significant clinical concern not otherwise classified.	Risk Mgt referral not otherwise covered by specific review indicators
PEC	Unanticipated readmission of medical inpatients 7 days after discharge for problems related to initial condition	
PEC	Major perioperative complication of patient undergoing anesthesia	Inclusion: Perioperative cardiac/resp arrest, acute MI, and central neurological deficit.
PEC	Unanticipated removal of an organ during surgical procedure	
PEC	Significant complication of a surgery/procedure resulting in prolonged inpatient stay	Inclusion: Length of stay greater than 2 times Medicare LOS. Exclusions: Staged procedures or patients with known high pre operative morbidity or severe trauma or emergent cases.
PEC	Unanticipated return to surgery for a significant complication.	Inclusion: Evisceration, repair of organ, retroperitoneal hemorrhage or obstruction Exclusion: Failed dialysis access, unrelated procedures, planned returns
PEC	Significant intra or post procedural complications	Inclusion: Additional procedures required due to medical or surgical complications of the original procedure, prolonged procedures taking longer than expected based on patient's condition
PEC	Unplanned readmission of a surgical/procedural patient within 30 days of procedure for problems related to initial procedure	
PEC	Unscheduled admission following outpatient procedure requiring inpatient admission to critical care	
PEC	Removal of iatrogenic foreign body	Inclusion: Those events where it was identified that the foreign body was left during an ECH procedure
PEC	Emergent CABG or CT surgery due to Cardiology procedure complication	

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Attachment B

Peer Review Triggers for Review

	Significant Complications of endoscopy, colonoscopy or ERCP	Includes: Any prolonged procedure taking longer than expected based on patient's condition, prolonged length of stay (greater than 48 hours) or critical care admission.
	Acute coronary artery closures related to an interventional cardiology procedure	
Perinatal	Possible permanent or serious infant injury	Inclusions: Shoulder dystocia resulting in asphyxia or Erb's palsy, skull fracture, brachial palsy, paralysis, etc. Any injury which will require significant follow-up beyond a palliative nature.
Perinatal	Post delivery maternal readmission within 7 days	
Perinatal	Eclampsia	Exclusion: patients presenting with full eclampsia with no prenatal care provided by medical staff.
Perinatal	Mother transferred to ICU post-delivery	Exclusion: Patients in ICU pre delivery
Perinatal	Excessive maternal intra or peripartum blood loss	Inclusion: Transfusion of greater than 1.5L or >1L with transfusion of ≥ 1 unit PRBC
Perinatal	Induction/Elective C-Section < 39 weeks	Inclusion: induction of labor and/or c-section for patients <39 weeks gestation. Exclusion: documented indication for early induction and/or c-section
Pediatrics	Newborn readmission for jaundice	Inclusion: newborn readmitted within 10 days of initial discharge for hyperbilirubinemia requiring treatment
Pediatrics	Unanticipated transfer to high level of care for neonate	Inclusion: neonates admitted to NICU from MBU. Exclusion: does not include neonates admitted to NICU directly from delivery.
Pediatrics	Readmission of term and preterm infants within 10 days of discharge	Inclusion: newborns with unplanned readmissions <10 days after discharge. Exclusion: does not include ED or hospital visits with discharge <24 hours.
Radiology	Radiology read discrepancy	
Emergency Department	Return to ED within 72 hours	

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Summary of Financial Operations

Fiscal Year 2022 – Period 2

7/1/2021 to 08/31/2021

Executive Summary - Overall Commentary for Period 2

- Strong operating / financial results for Period 2 were attributed to the following:
  - Despite being out-of-network with Anthem, August gross charges were favorable to budget and higher than the same period last year
  - Strong volume / patient activity was attributed ER visits which are consistent with pre-Covid levels, continued strong procedural volumes at both campuses and improvement in payor mix
- Total gross charges, a surrogate for volume, were favorable to budget by $42.9M / 11.4% and $79.5M / 23.4% higher than the same period last year
- Net patient revenue was favorable to budget by $9.1M / 9.6% and $18.8M / 22.0% higher than the same period last year
- Operating expenses were $1.7M /1.9% unfavorable to budget, which is primarily attributed to higher than expected volume versus budget and increase in ED visits in August
- Operating margin was favorable to budget by $5.8M / 130.4% and $12.7M / 1956.2% better than the same period last year
- Operating EBIDA was favorable to budget by $9.1M / 70.3% and $14.5M / 196.3% better than the same period last year

Operational / Financial Results: Period 2 – August 2022 (as of 8/31/2021)

PERIOD 2 - RESULTS

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	271	240	31	12.8%	241	30	12.5%	---	---	---
	Total Acute Discharges	1,781	1,638	143	8.7%	1,618	163	10.1%	---	---	---
	Adjusted Discharges	3,456	3,080	375	12.2%	2,995	461	15.4%	---	---	---
	Emergency Room Visits	5,587	4,158	1,429	34.4%	3,966	1,621	40.9%	---	---	---
	OP Procedural Cases	12,839	10,635	2,204	20.7%	12,102	737	6.1%	---	---	---
	Gross Charges ($)	418,615	375,752	42,862	11.4%	339,121	79,493	23.4%	---	---	---
Operations	Total FTEs	2,989	3,048	(59)	(1.9%)	2,749	241	8.8%	---	---	---
	Productive Hrs. / APD	28.3	32.1	(3.8)	(11.8%)	31.1	(2.7)	(8.8%)	---	---	---
	Cost Per CMI AD	15,988	17,952	(1,964)	(10.9%)	17,469	(1,481)	(8.5%)	---	---	---
	Net Days in A/R	53.6	49.0	4.6	9.4%	50.9	2.7	5.4%	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	104,482	95,320	9,163	9.6%	85,672	18,810	22.0%	138,547	82,105	
	Total Operating Revenue ($)	108,228	98,919	9,309	9.4%	90,003	18,225	20.2%	152,743	109,602	
	Operating Income ($)	**13,384**	**5,809**	**7,576**	130.4%	**651**	**12,733**	1956.2%	**1,915**	**3,836**	
	Operating EBIDA ($)	**21,959**	**12,895**	**9,064**	70.3%	**7,410**	**14,549**	196.3%	**11,188**	**10,741**	
	Net Income ($)	27,680	12,154	15,526	127.7%	29,293	(1,613)	(5.5%)	8,124	7,343	
	Operating Margin (%)	**12.4%**	**5.9%**	**6.5%**	110.6%	**0.7%**	**11.6%**	1610.0%	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**20.3%**	**13.0%**	**7.3%**	55.6%	**8.2%**	**12.1%**	146.4%	**8.3%**	**9.8%**	
	DCOH (days)	371	325	46	14.2%	337	34	10.1%	306	355	

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

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

Operational / Financial Results: YTD FY2022 (as of 8/31/2021)

YTD FY2022 - RESULTS

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	263	239	24	10.0%	232	31	13.5%	---	---	---
	Total Acute Discharges	3,486	3,236	250	7.7%	3,094	392	12.7%	---	---	---
	Adjusted Discharges	6,884	6,017	867	14.4%	5,838	1,046	17.9%	---	---	---
	Emergency Room Visits	10,609	8,432	2,177	25.8%	8,001	2,608	32.6%	---	---	---
	OP Procedural Cases	24,906	20,508	4,398	21.4%	23,808	1,098	4.6%	---	---	---
	Gross Charges ($)	824,910	734,051	90,859	12.4%	672,350	152,560	22.7%	---	---	---
Operations	Total FTEs	2,968	3,022	(55)	(1.8%)	2,719	249	9.2%	---	---	---
	Productive Hrs. / APD	28.3	32.5	(4.2)	(12.8%)	31.1	(2.8)	(8.9%)	---	---	---
	Cost Per CMI AD	15,806	17,952	(2,146)	(12.0%)	16,952	(1,147)	(6.8%)	---	---	---
	Net Days in A/R	53.6	49.0	4.6	9.4%	50.9	2.7	5.4%	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	206,256	188,074	18,182	9.7%	171,540	34,716	20.2%	277,095	164,209	
	Total Operating Revenue ($)	213,117	195,219	17,898	9.2%	180,538	32,579	18.0%	303,819	219,204	
	Operating Income ($)	**26,032**	**11,147**	**14,884**	133.5%	**8,775**	**17,257**	196.7%	**3,830**	**7,672**	
	Operating EBIDA ($)	**40,752**	**25,370**	**15,382**	60.6%	**22,193**	**18,559**	83.6%	**22,377**	**21,482**	
	Net Income ($)	36,229	25,275	10,954	43.3%	65,135	(28,906)	(44.4%)	16,249	14,687	
	Operating Margin (%)	**12.2%**	**5.7%**	**6.5%**	113.9%	**4.9%**	**7.4%**	151.3%	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**19.1%**	**13.0%**	**6.1%**	47.1%	**12.3%**	**6.8%**	55.6%	**8.3%**	**9.8%**	
	DCOH (days)	371	325	46	14.2%	337	34	10.1%	306	355	

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

El Camino Health

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

Key Statistics: Period 2 and YTD (as of 08/31/2021)

	Month to Date			Variance (%)		Year to Date			Variance (%)	
Key Statistics	**PY**	**CY**	**Budget**	**CY vs PY**	**CY vs Budget**	**PY**	**CY**	**Budget**	**CY vs PY**	**CY vs Budget**
ADC	241	271	240	12.5%	12.8%	232	263	239	13.5%	10.0%
Utilization MV	62%	71%	64%	14.4%	11.5%	60%	69%	64%	15.8%	9.1%
Utilization LG	33%	35%	29%	5.1%	18.7%	32%	33%	29%	4.0%	14.3%
Utilization Combined	53%	60%	53%	12.5%	12.8%	51%	58%	53%	13.5%	10.0%
Adjusted Discharges	2,995	3,456	3,080	15.4%	12.2%	5,838	6,884	6,017	17.9%	14.4%
Total Discharges (Exc NB)	1,618	1,781	1,638	10.1%	8.7%	3,094	3,486	3,236	12.7%	7.7%
Total Discharges	2,017	2,196	2,019	8.9%	8.8%	3,831	4,279	3,986	11.7%	7.3%
Inpatient Activity										
MS Discharges	1,045	1,178	1,074	12.7%	9.7%	2,016	2,329	2,128	15.5%	9.5%
Deliveries	414	444	405	7.2%	9.8%	783	858	795	9.6%	7.9%
BHS	115	114	116	(0.9%)	(1.9%)	203	210	228	3.4%	(8.1%)
Rehab	48	44	43	(8.3%)	2.3%	94	85	84	(9.6%)	1.2%
Outpatient Activity										
Total Outpatient Cases	15,216	17,150	13,755	12.7%	24.7%	30,087	33,458	26,839	11.2%	24.7%
ED	3,114	4,311	3,120	38.4%	38.2%	6,279	8,552	6,331	36.2%	35.1%
OP Surg	495	560	440	13.1%	27.2%	1,006	1,187	847	18.0%	40.1%
Endo	228	243	223	6.6%	9.0%	485	511	427	5.4%	19.7%
Interventional	164	187	183	14.0%	2.2%	351	393	355	12.0%	10.7%
All Other	11,215	11,849	9,789	5.7%	21.0%	21,966	22,815	18,878	3.9%	20.9%
Hospital Payor Mix										
Medicare	48.0%	47.5%	47.5%	(1.0%)	(0.0%)	47.6%	48.1%	47.5%	1.0%	1.1%
Medi-Cal	6.9%	8.3%	7.6%	20.5%	8.9%	7.1%	8.1%	7.9%	14.8%	3.3%
Commercial	42.1%	42.1%	42.8%	0.2%	(1.5%)	42.9%	41.5%	42.5%	(3.1%)	(2.4%)
Other	3.0%	2.0%	2.1%	(33.7%)	(5.0%)	2.5%	2.3%	2.1%	(7.0%)	8.3%

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Income Statement: Rolling 12 Monthly Trend *($000s)*

	FY2021										FY2022			
	Period 3	**Period 4**	**Period 5**	**Period 6**	**Period 7**	**Period 8**	**Period 9**	**Period 10**	**Period 11**	**Period 12**	**Period 1**	**Period 2**	**YTD FY2022**	**Rolling 12 Monthly Average**
	Sep-20	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**		
Operating Revenues:														
Gross Revenue	357,838	366,453	341,648	367,494	335,788	314,620	387,620	375,480	381,888	408,078	406,295	418,615	824,910	371,818
Deductions from Revenue	(267,829)	(275,898)	(253,051)	(275,206)	(245,993)	(229,347)	(290,449)	(280,577)	(286,346)	(295,840)	(304,521)	(314,132)	(618,654)	(276,599)
Net Patient Revenue	90,009	90,554	88,597	92,289	89,795	85,273	97,171	94,903	95,542	112,238	101,774	104,482	206,256	95,219
Other Operating Revenue	3,996	4,024	3,234	3,079	4,427	3,352	3,537	3,692	5,385	4,706	3,116	3,746	6,861	3,858
Total Operating Revenue	**94,005**	**94,578**	**91,831**	**95,368**	**94,222**	**88,625**	**100,708**	**98,595**	**100,927**	**116,945**	**104,889**	**108,228**	**213,117**	**99,077**
Operating Expenses:														
Salaries, Wages and Benefits	48,136	49,061	47,222	48,774	53,636	48,592	52,025	50,616	48,138	48,101	53,000	53,940	106,940	50,103
Supplies	12,798	13,496	13,641	14,519	13,888	13,587	15,421	14,256	15,241	15,156	15,109	14,569	29,678	14,307
Fees & Purchased Services	14,949	12,982	14,264	14,035	15,825	14,770	15,139	15,761	15,923	19,915	14,390	14,182	28,572	15,178
Other Operating Expenses	4,498	3,721	3,512	4,100	3,819	1,097	3,536	3,662	3,496	6,002	3,598	3,577	7,175	3,718
Interest	1,428	1,429	1,428	1,428	1,428	1,392	1,399	1,400	1,400	1,367	1,419	1,418	2,837	1,411
Depreciation	5,795	5,798	6,068	5,591	5,689	5,903	4,931	5,606	4,808	5,740	4,727	7,157	11,884	5,651
Total Operating Expenses	**87,604**	**86,487**	**86,136**	**88,446**	**94,284**	**85,341**	**92,450**	**91,301**	**89,006**	**96,281**	**92,242**	**94,844**	**187,086**	**90,368**
Operating Margin	**6,401**	**8,091**	**5,695**	**6,922**	**(62)**	**3,285**	**8,258**	**7,294**	**11,921**	**20,664**	**12,648**	**13,384**	**26,032**	**8,708**
Non-Operating Income	(9,557)	(27,499)	64,968	57,357	39	14,349	18,965	29,151	16,666	20,041	(4,099)	14,296	10,197	16,223
Net Margin	**(3,156)**	**(19,408)**	**70,663**	**64,279**	**(23)**	**17,633**	**27,223**	**36,445**	**28,588**	**40,705**	**8,549**	**27,680**	**36,229**	**24,931**
Operating EBIDA	**13,624**	**15,318**	**13,192**	**13,940**	**7,055**	**10,580**	**14,588**	**14,301**	**18,130**	**27,771**	**18,793**	**21,959**	**40,752**	**15,771**
Operating Margin (%)											12.1%	12.4%	12.2%	8.8%
Operating EBIDA Margin (%)											**17.9%**	**20.3%**	**19.1%**	**15.9%**

El Camino Health

Financial Overview: Period 2 – August 2022

Period ending 8/31/2021

Financial Performance

- August operating income was $13.4M compared to a budget of $5.8M, resulting in a favorable variance of $7.6M
- August volumes and revenues continue to be stronger than budget as demonstrated by:
  - Adjusted discharges were favorable to budget by 375 cases / 12.2% and 461 cases / 15.4% above the same period last year
  - Favorable variance of gross charges of $42.9M was primarily driven my favorable Outpatient activity:
    - Inpatient gross charges: Favorable to budget by $15.4M / 7.9% variance primarily driven by cath. lab, maternal/child services, emergency services, and corresponding ancillary services
    - Outpatient gross charges: Favorable to budget by $26.1M / 15.2% variance primarily driven by emergency services, surgery, cath. lab, imaging services, and corresponding ancillary services
  - Operating Expenses were unfavorable to budget by $1.7M / 1.9% driven by the level of patient activity
    - SWB were unfavorable by $2.2M / 4.2%
    - Supplies were favorable by $132K / 0.9%
    - All other discretionary non-volume driven expenses were favorable to budget by $0.4M
    - Additional expenses attributed to Covid-19 were $565K in August and $1.1M YTD
- Non Operating Income includes:
  - Favorable variance in non-operating revenue is primarily due to unrealized gains on investments

Financial Overview: Period 2 – August 2022 (cont.)

Period ending 8/31/2021

Financial Performance

Hospital Operations:

- Adjusted Discharges (AD): Favorable to budget by 375 ADs / 12.2% and above prior year by 461 ADs / 15.4%:
  - Mountain View: Favorable to budget by 238 ADs / 9.8% and above prior year by 318 ADs / 13.4%
  - Los Gatos: Favorable to budget by 137 ADs / 20.5% and above prior year by 143 ADs / 21.7%
- Operating Expense Per CMI Adjusted Discharge: $15,988 which is 10.9% favorable to budget

  Note: Excludes depreciation and interest

El Camino Health Medical Network (ECHMN) Operations:

- August's total visits of 21,326 or 920 visits per day reflect an increase of 6.2% and 2.8% over the prior month's activity of 20,084 total visits or 910 visits per day. Nearly all clinics saw increases in patient volumes in August.
- August's total visits were favorable to budget by 5% and 3.8% greater than budget YTD
- Net income for the month of August was favorable to budget nu $133K or 4.9% bringing the YTD variance to a favorable $175K or 3.3%. Compared to August and YTD FY2021, ECHMN's net income is favorable $1.0M and $722K respectively

Financial Overview: YTD FY2022 (as of 8/31/2021)

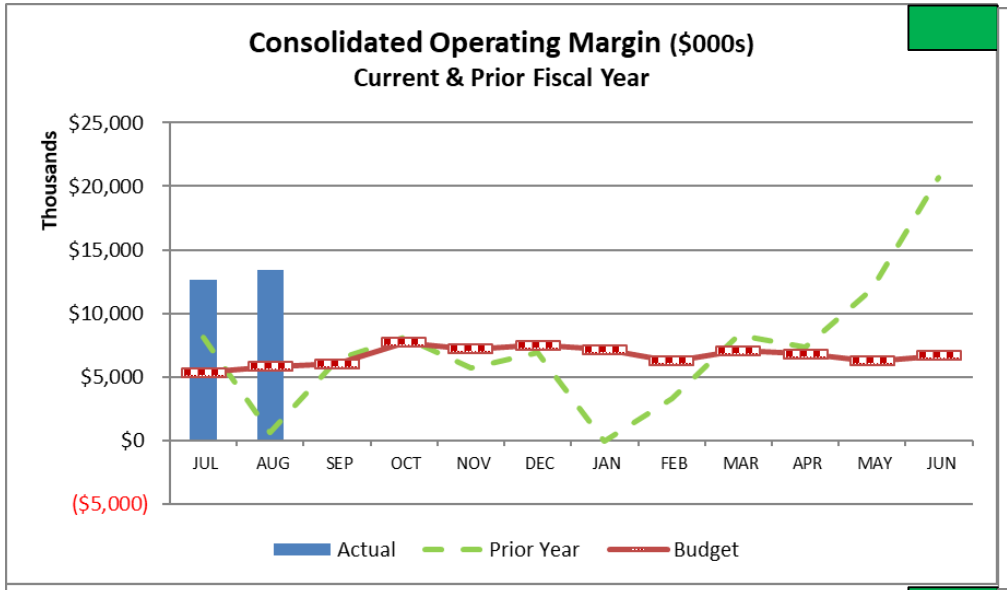
Consolidated Financial Performance

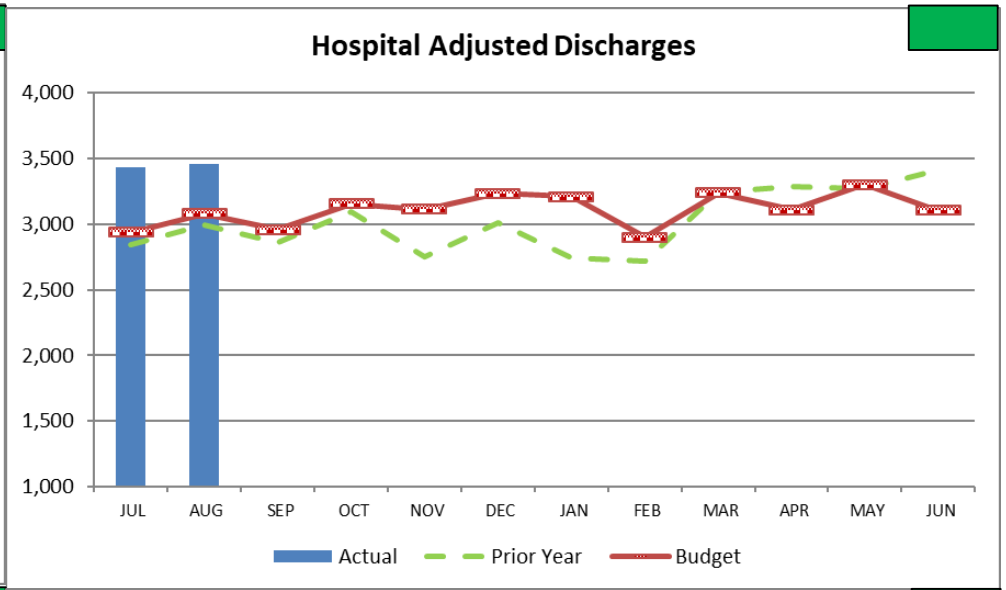
- YTD FY2022 operating margin of $26.0M compared to the budget of $11.1M
- Year-over-year operating margin is $17.2M higher than the same period last year, which is primarily due to the strength in volumes as exhibited by growth in Adjusted Discharges, Emergency Room Visits, and Surgeries. In addition, while revenue has driven improved year over year performance, expense management has been effective.
- Strong volumes continue to be the primary driver of favorable performance to budget
  - Adjusted discharges are 6,884 / 14.4% favorable to budget and 1,046 / 17.9% higher than the same period last year
- Operating expenses are $187.1M / 1.6% unfavorable to budget
  - Operating expense per CMI adjusted discharge: $15,806 which is 12.0% favorable to budget. This demonstrates consistent and effective management of variable expenses

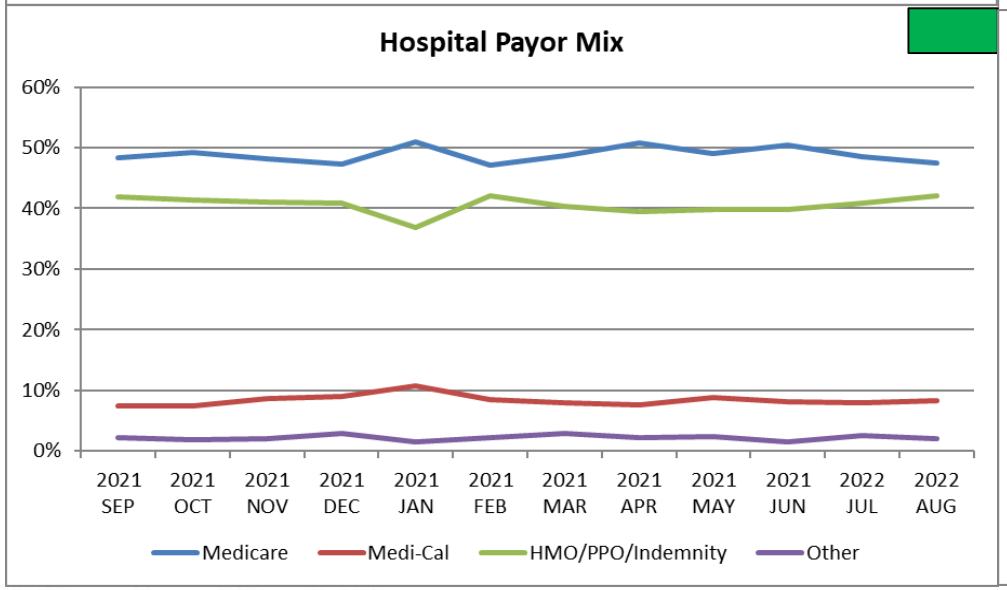
Note: Excludes depreciation and interest expense

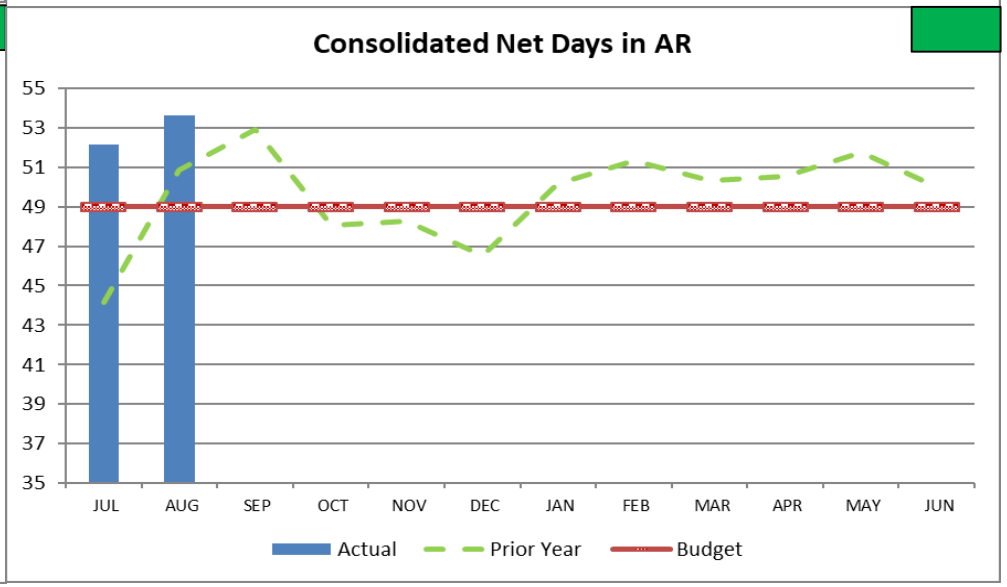
APPENDIX

YTD FY2022 Financial KPIs – Monthly Trends









El Camino Health

Investment Scorecard (as of 6/30/2021)

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY21 Budget	Expectation Per Asset Allocation
Investment Performance		**CY 2Q 2021 / FY 4Q 2021**		**Fiscal Year-to-Date 2021**		**8y 8m Since Inception (annualized)**		**FY 2021**	**2019**
Surplus cash balance*		$1,453.0	–	--	--	--	–	–	--
Surplus cash return		3.7%	3.7%	19.4%	18.5%	6.9%	6.7%	4.0%	5.6%
Cash balance plan balance (millions)		$358.9	–	--	--	--	–	–	--
Cash balance plan return		4.5%	4.3%	25.2%	22.3%	9.2%	8.3%	6.0%	6.0%
403(b) plan balance (millions)		$731.5	–	--	--	--	–	–	--
Risk vs. Return		**3-year**				**8y 8m Since Inception (annualized)**			**2019**
Surplus cash Sharpe ratio		0.88	0.92	--	--	0.99	1.00	–	0.34
Net of fee return		9.3%	9.2%	--	--	6.9%	6.7%	–	5.6%
Standard deviation		8.8%	8.4%	--	--	6.2%	6.0%	–	8.7%
Cash balance Sharpe ratio		0.88	0.90	--	--	1.06	1.03	–	0.32
Net of fee return		11.3%	10.4%	--	--	9.2%	8.3%	–	6.0%
Standard deviation		11.2%	10.1%	--	--	7.9%	7.3%	–	10.3%
Asset Allocation		**CY 2Q 2021 / FY 4Q 2021**							
Surplus cash absolute variances to target		5.6%	< 10% Green < 20% Yellow	--	--	--	–	–	--
Cash balance absolute variances to target		4.7%	< 10% Green < 20% Yellow	--	--	--	–	–	--
Manager Compliance		**CY 2Q 2021 / FY 4Q 2021**							
Surplus cash manager flags		22	< 24 Green < 30 Yellow	--	--	--	–	–	--
Cash balance plan manager flags		24	< 27 Green < 34 Yellow	--	--	--	–	–	--

*Excludes debt reserve funds (~$6 mm), District assets (~$42 mm), and balance sheet cash not in investable portfolio (~$160 mm). Includes Foundation (~$42 mm) and Concern (~$15 mm) assets.

El Camino Health

Period 2 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 8/31/2021)

($000s)

	Period 2- Month			Period 2- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	10,806	6,008	4,798	23,683	11,348	12,335
Los Gatos	4,886	2,758	2,129	7,223	5,545	1,678
Sub Total - El Camino Hospital, excl. Afflilates	**15,693**	**8,766**	**6,927**	**30,906**	**16,893**	**14,013**
Operating Margin %	**15.3%**	**9.3%**		**15.3%**	**9.1%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**14,291**	**5,998**	**8,293**	**10,020**	**13,544**	**(3,525)**
El Camino Hospital Net Margin	**29,984**	**14,764**	**15,220**	**40,925**	**30,437**	**10,488**
ECH Net Margin %	**29.2%**	**15.7%**		**20.2%**	**16.5%**	
Concern	428	129	299	744	145	599
ECSC	0	0	0	0	0	0
Foundation	(124)	1	(126)	(275)	32	(308)
El Camino Health Medical Network	(2,607)	(2,740)	133	(5,165)	(5,340)	175
Net Margin Hospital Affiliates	**(2,303)**	**(2,610)**	**306**	**(4,696)**	**(5,162)**	**466**
Total Net Margin Hospital & Affiliates	**27,680**	**12,154**	**15,526**	**36,229**	**25,275**	**10,954**

Consolidated Balance Sheet (as of 08/31/2021)

($000s)

ASSETS

CURRENT ASSETS	August 31, 2021	UnAudited June 30, 2021
Cash	134,717	151,641
Short Term Investments	279,145	284,262
Patient Accounts Receivable, net	185,573	166,283
Other Accounts and Notes Receivable	5,532	9,540
Intercompany Receivables	12,003	15,116
Inventories and Prepaids	27,320	23,079
Total Current Assets	**644,290**	**649,921**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	21,407	20,932
Plant & Equipment Fund	270,969	258,191
Women's Hospital Expansion	30,401	30,401
Operational Reserve Fund	123,838	123,838
Community Benefit Fund	16,142	18,412
Workers Compensation Reserve Fund	17,002	16,482
Postretirement Health/Life Reserve Fund	30,840	30,658
PTO Liability Fund	32,989	32,498
Malpractice Reserve Fund	1,996	1,977
Catastrophic Reserves Fund	25,124	24,874
Total Board Designated Assets	**570,708**	**558,264**
FUNDS HELD BY TRUSTEE	**(0)**	**5,694**
LONG TERM INVESTMENTS	**608,745**	**603,211**
CHARITABLE GIFT ANNUITY INVESTMENTS	**746**	**728**
INVESTMENTS IN AFFILIATES	**34,392**	**34,170**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,845,507	1,799,463
Less: Accumulated Depreciation	(755,954)	(742,921)
Construction in Progress	60,479	94,236
Property, Plant & Equipment - Net	**1,150,032**	**1,150,778**
DEFERRED OUTFLOWS	24,188	21,444
RESTRICTED ASSETS	29,346	29,332
OTHER ASSETS	112,307	86,764
TOTAL ASSETS	**3,174,755**	**3,140,306**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	August 31, 2021	UnAudited June 30, 2021
Accounts Payable	32,777	39,762
Salaries and Related Liabilities	44,449	50,039
Accrued PTO	33,633	33,197
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	13,025	12,990
Intercompany Payables	11,882	14,704
Malpractice Reserves	1,670	1,670
Bonds Payable - Current	9,430	9,430
Bond Interest Payable	1,659	8,293
Other Liabilities	16,365	16,953
Total Current Liabilities	**167,190**	**189,338**
LONG TERM LIABILITIES		
Post Retirement Benefits	30,839	30,658
Worker's Comp Reserve	17,002	17,002
Other L/T Obligation (Asbestos)	6,161	6,227
Bond Payable	483,501	479,621
Total Long Term Liabilities	**537,502**	**533,509**
DEFERRED REVENUE-UNRESTRICTED	**58,389**	**67,576**
DEFERRED INFLOW OF RESOURCES	**45,862**	**28,009**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,143,056	2,097,010
Board Designated	191,445	193,782
Restricted	31,311	31,082
Total Fund Bal & Capital Accts	**2,365,812**	**2,321,874**
TOTAL LIABILITIES AND FUND BALANCE	**3,174,755**	**3,140,306**

El Camino Health

Consolidated Statement of Operations *($000s)*

Period 2 ending 08/31/2021

Period 2 FY 2021	Period 2 FY 2022	Period 2 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
339,121	418,615	375,752	42,862	11.4%	**Gross Revenue**	672,350	824,910	734,051	90,859	12.4%
(253,449)	(314,132)	(280,433)	(33,700)	(12.0%)	**Deductions**	(500,809)	(618,654)	(545,977)	(72,677)	(13.3%)
85,672	**104,482**	**95,320**	**9,163**	**9.6%**	**Net Patient Revenue**	**171,540**	**206,256**	**188,074**	**18,182**	**9.7%**
4,331	3,746	3,599	146	4.1%	**Other Operating Revenue**	8,998	6,861	7,145	(284)	(4.0%)
90,003	**108,228**	**98,919**	**9,309**	**9.4%**	**Total Operating Revenues**	**180,538**	**213,117**	**195,219**	**17,898**	**9.2%**
					OPERATING EXPENSE					
47,739	53,940	51,781	(2,159)	(4.2%)	**Salaries & Wages**	94,170	106,940	103,173	(3,767)	(3.7%)
16,893	14,569	14,701	132	0.9%	**Supplies**	29,713	29,678	28,380	(1,298)	(4.6%)
14,366	14,182	14,515	333	2.3%	**Fees & Purchased Services**	27,284	28,572	29,127	554	1.9%
3,596	3,577	5,026	1,449	28.8%	**Other Operating Expense**	7,179	7,175	9,170	1,995	21.8%
1,431	1,418	1,401	(17)	(1.2%)	**Interest**	2,859	2,837	2,799	(37)	(1.3%)
5,328	7,157	5,686	(1,471)	(25.9%)	**Depreciation**	10,559	11,884	11,423	(460)	(4.0%)
89,352	**94,844**	**93,111**	**(1,733)**	**(1.9%)**	**Total Operating Expenses**	**171,763**	**187,086**	**184,072**	**(3,014)**	**(1.6%)**
651	**13,384**	**5,809**	**7,576**	**130.4%**	**Net Operating Margin**	**8,775**	**26,032**	**11,147**	**14,884**	**133.5%**
28,642	14,296	6,346	7,950	125.3%	**Non Operating Income**	56,360	10,197	14,127	(3,930)	(27.8%)
29,293	**27,680**	**12,154**	**15,526**	**127.7%**	**Net Margin**	**65,135**	**36,229**	**25,275**	**10,954**	**43.3%**
7,410	**21,959**	**12,895**	**9,064**	**70.3%**	**Operating EBIDA**	**22,193**	**40,752**	**25,370**	**15,382**	60.6%
8.2%	20.3%	13.0%	7.3%		**Operating EBIDA Margin**	12.3%	19.1%	13.0%	6.1%	
0.7%	12.4%	5.9%	6.5%		**Operating Margin**	4.9%	12.2%	5.7%	6.5%	
32.5%	25.6%	12.3%	13.3%		**Net Margin**	36.1%	17.0%	12.9%	4.1%	

El Camino Health

El Camino Hospital – Mountain View
Statement of Operations *($000s)*
Period 2 ending 08/31/2021

Period 2 FY 2021	Period 2 FY 2022	Period 2 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUES					
262,710	315,308	291,100	24,208	8.3%	**Gross Revenue**	522,140	619,436	569,863	49,573	8.7%
(195,324)	(236,926)	(218,159)	(18,768)	(8.6%)	**Deductions**	(385,562)	(461,509)	(426,012)	(35,497)	(8.3%)
67,386	**78,382**	**72,942**	**5,440**	**7.5%**	**Net Patient Revenue**	**136,578**	**157,927**	**143,851**	**14,076**	**9.8%**
1,436	1,459	1,530	(71)	(4.7%)	**Other Operating Revenue**	2,999	2,551	3,010	(459)	(15.3%)
68,822	**79,840**	**74,472**	**5,369**	**7.2%**	**Total Operating Revenues**	**139,576**	**160,478**	**146,861**	**13,617**	**9.3%**
					OPERATING EXPENSES					
37,413	42,588	40,915	(1,673)	(4.1%)	**Salaries & Wages**	73,888	84,549	81,532	(3,017)	(3.7%)
12,710	10,856	11,164	307	2.8%	**Supplies**	23,262	22,203	21,609	(595)	(2.8%)
6,248	6,408	7,132	724	10.2%	**Fees & Purchased Services**	12,442	13,393	14,422	1,030	7.1%
2,242	2,361	3,367	1,006	29.9%	**Other Operating Expense**	4,795	4,628	6,130	1,502	24.5%
1,431	1,418	1,401	(17)	(1.2%)	**Interest**	2,859	2,837	2,799	(37)	(1.3%)
4,238	5,403	4,485	(918)	(20.5%)	**Depreciation**	8,495	9,186	9,021	(165)	(1.8%)
64,283	**69,034**	**68,463**	**(570)**	**(0.8%)**	**Total Operating Expenses**	**125,741**	**136,795**	**135,513**	**(1,282)**	**(0.9%)**
4,539	**10,806**	**6,008**	**4,798**	**79.9%**	**Net Operating Margin**	**13,836**	**23,683**	**11,348**	**12,335**	**108.7%**
28,196	14,291	5,998	8,293	138.3%	**Non Operating Income**	54,642	10,020	13,544	(3,525)	(26.0%)
32,735	**25,097**	**12,006**	**13,091**	**109.0%**	**Net Margin**	**68,478**	**33,703**	**24,893**	**8,810**	35.4%
10,209	**17,627**	**11,894**	**5,733**	**48.2%**	**Operating EBIDA**	**25,190**	**35,705**	**23,168**	**12,537**	54.1%
14.8%	22.1%	16.0%	6.1%		**Operating EBIDA Margin**	18.0%	22.2%	15.8%	6.5%	
6.6%	13.5%	8.1%	5.5%		**Operating Margin**	9.9%	14.8%	7.7%	7.0%	
47.6%	31.4%	16.1%	15.3%		**Net Margin**	49.1%	21.0%	16.9%	4.1%	

El Camino Health

El Camino Hospital – Los Gatos
Statement of Operations *($000s)*
Period 2 ending 08/31/2021

Period 2 FY 2021	Period 2 FY 2022	Period 2 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
68,515	93,140	75,851	17,289	22.8%	**Gross Revenue**	134,370	185,942	146,386	39,556	27.0%
(52,704)	(70,710)	(56,711)	(13,998)	(24.7%)	**Deductions**	(104,233)	(144,354)	(108,779)	(35,575)	(32.7%)
15,811	**22,430**	**19,140**	**3,290**	**17.2%**	**Net Patient Revenue**	**30,137**	**41,587**	**37,607**	**3,980**	**10.6%**
389	297	270	26	9.8%	**Other Operating Revenue**	795	563	537	26	4.8%
16,200	**22,727**	**19,411**	**3,317**	**17.1%**	**Total Operating Revenue**	**30,932**	**42,151**	**38,145**	**4,006**	**10.5%**
					OPERATING EXPENSE					
8,333	9,483	8,571	(911)	(10.6%)	**Salaries & Wages**	16,219	18,655	17,050	(1,605)	(9.4%)
3,628	3,401	3,243	(159)	(4.9%)	**Supplies**	5,482	6,928	6,182	(746)	(12.1%)
3,103	3,331	3,211	(120)	(3.7%)	**Fees & Purchased Services**	5,752	6,664	6,390	(274)	(4.3%)
407	183	684	501	73.2%	**Other Operating Expense**	546	563	1,089	527	48.3%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
816	1,442	944	(498)	(52.8%)	**Depreciation**	1,638	2,118	1,889	(229)	(12.1%)
16,288	**17,841**	**16,653**	**(1,188)**	**(7.1%)**	**Total Operating Expense**	**29,638**	**34,928**	**32,600**	**(2,328)**	**(7.1%)**
(88)	**4,886**	**2,758**	**2,129**	**77.2%**	**Net Operating Margin**	**1,294**	**7,223**	**5,545**	**1,678**	**30.3%**
0	0	0	0	0.0%	**Non Operating Income**	0	0	0	0	0.0%
(88)	**4,886**	**2,758**	**2,129**	**77.2%**	**Net Margin**	**1,294**	**7,223**	**5,545**	**1,678**	**30.3%**
728	**6,329**	**3,702**	**2,627**	**71.0%**	**Operating EBIDA**	**2,932**	**9,341**	**7,434**	**1,907**	25.7%
4.5%	27.8%	19.1%	8.8%		**Operating EBIDA Margin**	9.5%	22.2%	19.5%	2.7%	
-0.5%	21.5%	14.2%	7.3%		**Operating Margin**	4.2%	17.1%	14.5%	2.6%	
-0.5%	21.5%	14.2%	7.3%		**Net Margin**	4.2%	17.1%	14.5%	2.6%	

El Camino Health

El Camino Health Medical Network
Statement of Operations *($000s)*
Period 2 ending 08/31/2021

Period 2 FY 2021	Period 2 FY 2022	Period 2 Budget 2022	Variance Fav (Unfav)	Var%	$000s	YTD FY 2021	YTD FY 2022	YTD Budget 2022	Variance Fav (Unfav)	Var%
					OPERATING REVENUES					
7,896	10,167	8,801	1,366	15.5%	**Gross Revenue**	15,840	19,532	17,801	1,731	9.7%
(5,420)	(6,497)	(5,563)	(934)	(16.8%)	**Deductions**	(11,015)	(12,790)	(11,185)	(1,605)	(14.3%)
2,476	**3,670**	**3,238**	**432**	**13.4%**	**Net Patient Revenue**	**4,826**	**6,742**	**6,616**	**126**	**1.9%**
1,768	900	999	(99)	(9.9%)	**Other Operating Revenue**	3,743	1,772	1,998	(226)	(11.3%)
4,243	**4,571**	**4,237**	**334**	**7.9%**	**Total Operating Revenues**	**8,569**	**8,514**	**8,614**	**(100)**	**(1.2%)**
					OPERATING EXPENSES					
1,540	1,449	1,818	370	20.3%	**Salaries & Wages**	3,157	2,911	3,636	725	19.9%
551	309	285	(24)	(8.6%)	**Supplies**	904	527	569	42	7.4%
4,593	4,139	3,707	(432)	(11.7%)	**Fees & Purchased Services**	8,267	7,821	7,414	(407)	(5.5%)
919	981	926	(55)	(5.9%)	**Other Operating Expense**	1,727	1,864	1,852	(12)	(0.6%)
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
260	300	241	(59)	(24.5%)	**Depreciation**	401	555	482	(74)	(15.3%)
7,863	**7,177**	**6,977**	**(201)**	**(2.9%)**	**Total Operating Expenses**	**14,455**	**13,679**	**13,954**	**275**	**2.0%**
(3,620)	**(2,607)**	**(2,740)**	**133**	**(4.9%)**	**Net Operating Margin**	**(5,886)**	**(5,165)**	**(5,340)**	**175**	**(3.3%)**
0	(0)	0	(0)	0.0%	**Non Operating Income**	0	(0)	0	(0)	0.0%
(3,620)	**(2,607)**	**(2,740)**	**133**	**(4.9%)**	**Net Margin**	**(5,886)**	**(5,165)**	**(5,340)**	**175**	**(3.3%)**
(3,359)	**(2,307)**	**(2,499)**	**192**	**(7.7%)**	**Operating EBIDA**	**(5,486)**	**(4,610)**	**(4,858)**	**248**	(5.1%)
-79.2%	-50.5%	-59.0%	8.5%		**Operating EBIDA Margin**	-64.0%	-54.1%	-56.4%	2.3%	
-85.3%	-57.0%	-64.7%	7.6%		**Operating Margin**	-68.7%	-60.7%	-62.0%	1.3%	
-85.3%	-57.0%	-64.7%	7.6%		**Net Margin**	-68.7%	-60.7%	-62.0%	1.3%	

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital □oard of Directors
From: □p□rva □ arfatia□□ D□Enterprise Chief of Staff
□ ichael □an□□ D Chief of Staff □os □atos
Date: □ovem□er 10□2021
Subject: □ edical Staff Report – Open Session

Recommendation:

To approve the □ edical Staff Report□incl□ding Policies and Proced□res identified in the attached list and the Delineation of Privileges.

Summary:

1. Sit□ation: The □ edical E□ec□tive Committee met on Octo□er 28□2021

2. □ac□gro□nd: □ EC received the follo□ing informational reports.

a□ □□ality Co□ncil – The □□ality Co□ncil met on Septem□er 1□2021. Reports and performance dash□oards □ere revie□ed and approved from the follo□ing ECH Departments/Service □ines:

1. □nn□al P□Report □□trition Services
2. □□trition Services Dash□oard
3. Pharmacy □C □□2021 Report and Data
4. Pharmacy □□ality Co□ncil Dash□oard
5. H□□Dash□oard
6. Care Coordination □□2021 □nn□al Performance □mprovement Report
7. Care Coordination □□2021

□□ □eadership Co□ncil – The □eadership Co□ncil met on Octo□er □□2021 and disc□ssed the follo□ing:

1. Health □nformation □ anagement
2. Election Process
3. Physician Portal
4. □ edical Staff/□PP D□es Report
5. CO□□D-19 □accine □ andate
6. OPPE□□ D-Stat □mplementation□Specialty Specific □ndicators

c□ The CEO Report □as provided
d□ The C□ O Report □as provided
e□ The C□O Report □as provided

List of Attachments: Policies and Proced□res

Suggested Board Discussion Questions: □one