El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

# AGENDA
## SPECIAL MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

**Monday, August 6, 2018 – 5:30pm**
El Camino Hospital | Conference Rooms A&B (ground floor)
2500 Grant Road Mountain View, CA 94040

John Zoglin will be participating via teleconference from 1005 Los Altos Avenue Los Altos, CA 94024.

**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 | | **5:31 – 5:32** |
| **3.** | **ADJOURN TO CLOSED SESSION** | Lanhee Chen, Board Chair | | **motion required 5:32 – 5:33** |
| **4.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Lanhee Chen, Board Chair | | **5:33 – 5:34** |
| **5.** | **CONSENT CALENDAR**<br>*Any Board Member may remove an item for discussion before a motion is made.*<br>***Approval***<br>*Gov't Code Section 54957.2:*<br>a. Minutes of the Closed Session of the Hospital Board Meeting (June 13, 2018) | Lanhee Chen, Board Chair | | **motion required 5:34 – 5:36** |
| **6.** | *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters:<br>- Medical Staff Report | Imtiaz Qureshi, MD, Mountain View Chief of Staff; Linda Teagle, MD, Los Gatos Chief of Staff | | **motion required 5:36 – 5:41** |
| **7.** | **ADJOURN TO OPEN SESSION** | Lanhee Chen, Board Chair | | **motion required 5:41 – 5:42** |
| **8.** | **RECONVENE OPEN SESSION/ REPORT OUT**<br>To report any required disclosures regarding permissible actions taken during Closed Session. | Lanhee Chen, Board Chair | | **5:42 – 5:43** |
| **9.** | **CONSENT CALENDAR ITEMS:**<br>*Any Board Member or member of the public may remove an item for discussion before a motion is made.*<br>***Approval***<br>a. Minutes of the Open Session of the Hospital Board Meeting (May 9, 2018)<br>***Reviewed and Recommended for Approval by the Medical Executive Committee***<br>b. Medical Staff Report | Lanhee Chen, Board Chair | *public comment* | **motion required 5:43 – 5:44** |
| **10.** | **ADJOURNMENT** | Lanhee Chen, Board Chair | | **motion required 5:44 – 5:45pm** |

A copy of the agenda for the Special Board Meeting will be posted and distributed at least twenty four (24) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

**Minutes of the Open Session of the**
**El Camino Hospital Board of Directors**
**Wednesday, June 13, 2018**
**2500 Grant Road, Mountain View, CA 94040**
**Conference Rooms F&G (ground floor)**

| Board Members Present | Board Members Absent | Members Excused |
|---|---|---|
| **Lanhee Chen,** Chair | None | None |
| **Jeffrey Davis, MD** | | |
| **Neysa Fligor** | | |
| **Peter C. Fung, MD** | | |
| **Gary Kalbach** | | |
| **Julie Kliger, RN** | | |
| **Julia E. Miller,** Secretary/Treasurer | | |
| **Bob Rebitzer** | | |
| **David Reeder** | | |
| **John Zoglin**, Vice Chair | | |

| 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 5:30pm by Chair Chen. A silent roll call was taken. Director Reeder joined the meeting at 5:31pm during Agenda Item 5: Governance Committee Report. All other Board members were present at roll call. | |
| **2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Chair Chen asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were reported. | |
| **3. AGENDA ITEM 5: GOVERNANCE COMMITTEE REPORT** | This item was taken out of order.<br><br>Director Fung and Director Kalbach described the proposals as further detailed in the packet. They highlighted the results of the FY18 Board Assessment, including the on-boarding of four new Board members and progress made over the last year.<br><br>The Board discussed the Proposed FY19 Board Goals including 1) how best to measure the goals, including potentially using a SMART (specific measurable, attainable, relevant, time-bound) goal format, 2) concerns that the goals were too process-based, and 3) how best to reflect the Board's strategic and oversight roles.<br><br>Director Reeder suggested that Goal #2 include a tactic that "the Board will conduct themselves in accordance with the Standards of Conduct." Director Zoglin commented that Board membership on Committees does not need to be increased. In response to Director Fligor's question, Cindy Murphy, Director of Governance Services, noted that there is a District document, "Guidelines for Communication with the CEO," which can be amended to match the Hospital's Proposed Communication Protocol if the District Board wishes to do so.<br><br>**Motion:** To approve the Proposed Communication Protocol.<br><br>**Movant**: Fung<br>**Second**: Kalbach<br>**Ayes**: Chen, Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None | ***Communication Protocol approved*** |

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| | **Absent**: None<br>**Recused**: None<br><br>**Motion:** To approve the FY19 Board Goals, amended as follows: 1) modifying Goal #2 to add a tactic that "the Board will conduct themselves in accordance with the Standards of Conduct;" and 2) removing tactic #5 ("Consider increasing representation of Board members on key Committees") from Goal #3.<br><br>**Movant**: Reeder<br>**Second**: Kalbach<br>**Ayes**: Chen, Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder<br>**Noes**: Zoglin<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None<br><br>The Board requested that the Governance Committee review the Board's concerns and comments about the goals (as noted above) and propose revisions to the goals to address them.<br><br>Chair Chen left the meeting at 5:57pm and Vice Chair Zoglin assumed the role of Chair. | ***FY19 Board Goals approved*** |
| **4. AGENDA ITEM 3: QUALITY COMMITTEE REPORT** | Director Reeder, Chair of the Quality Committee, described the overall performance on the FY18 Quality Dashboard.<br><br>In response to Director Zoglin's questions, the Board discussed the progress against targets on the quality dashboard. Conversation included discussion around: 1) the use of stretch goals, 2) the Quality Committee's review of trends (deep dives, especially when trends are unfavorable), and 3) how to methodically evaluate processes and performance rather than chasing trends. Director Zoglin expressed concerns about the organization's performance.<br><br>Director Reeder reported that the Committee 1) will be reviewing the organization's LEAN activities and 2) recommended the FY19 Organizational Goals for approval.<br><br>In response to Director Davis' question, Mark Adams, MD, Interim CMO, reported that the quality dashboard is reviewed by the Medical Executive Committee.<br><br>**Motion:** To approve the Proposed FY19 Quality Dashboard.<br><br>**Movant**: Reeder<br>**Second**: Davis<br><br>The Board discussed 1) outstanding questions and concerns from Board members on the dashboard; 2) potential delegation to the Committee; and 3) utilization of and deference to the subject matter expertise of the Committee members.<br><br>Director Rebitzer noted that the dashboard should include outpatient focus as ECH's ambulatory presence expands.<br><br>Director Kliger commented that the set of data on the dashboard come from well-reasoned and historically relevant perspective.<br><br>Directors Rebitzer and Kliger suggested that any Board members interested in additional education about the dashboard attend a Quality Committee meeting.<br><br>**Ayes**: Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin | ***FY19 Quality Dashboard approved*** |

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| | **Noes**: Miller, Zoglin<br>**Abstentions**: None<br>**Absent**: Chen<br>**Recused**: None<br><br>Director Reeder outlined the Performance Improvement and Patient Safety Plan as recommended by the Quality Committee.<br><br>**Motion:** To approve the Performance Improvement and Patient Safety Plan.<br><br>**Movant**: Reeder<br>**Second**: Fung<br>**Ayes**: Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Chen<br>**Recused**: None | ***Performance Improvement & Patient Safety Plan approved*** |
| **5. AGENDA ITEM 4: FINANCE COMMITTEE REPORT** | Iftikhar Hussain, CFO, provided an overview of the FY18 Period 10 Financials, noting that:<br><br>- Performance continues to be good, noting that early results in May are favorable.<br>- Volume has eased off following the flu season.<br>- For payor mix, commercial insurance decreased 3.6% in April.<br><br>The Board and Mr. Hussain discussed the changes in the payor mix.<br><br>Mr. Hussain also reviewed the FY19 Capital and Operating Budget. He noted that 1) FY19 operating margin is budgeted at 9% (Mr. Hussain described the decrease compared to the prior year due to $15 million investment in ECH's ambulatory infrastructure, depreciation as projects are finished, and unusual favorable items from FY18 that are not expected in FY19); 2) capital spending is projected at $310 million, primarily related to capital projects on the Mountain View campus; 3) the Community Benefit endowment fund has $900,000 available for FY19 and 4) the charge increase is 4.09%.<br><br>In response to Director Kliger's question, Mr. Hussain described the utilization of licensed beds at the Los Gatos campus noted on the financials and planned growth in the FY19 budget. The Board requested additional detail about capacity that reflects private rooms rather than the assumption of as many as four people per room.<br><br>In response to Director Reeder's question, Mr. Hussain described the planned programmatic development and growth to balance changes in the payor mix.<br><br>**Motion:** To approve the FY18 Period 10 Financials and the FY19 Capital and Operating Budget.<br><br>**Movant**: Zoglin<br>**Second**: Kalbach<br>**Ayes**: Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Chen<br>**Recused**: None<br><br>Mr. Hussain described staff's recommendation to switch to a new Enterprise Resource Planning (ERP) system for human resources, finance, and supply | ***FY18 Period 10 Financials and the FY19 Capital and Operating Budget approved*** |

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| | chain, ultimately a proposed $9.65 million capital spend.<br><br>In response to Director Rebitzer's question, Mr. Hussain described the financial savings (support costs, staffing changes).<br><br>Deb Muro, CIO, commented that the current system has been in place since 1994 and that most systems have a 10-year lifecycle. She noted that once the platform is in place there can be ongoing upgrades to the software.<br><br>In response to Director Miller's question, Ms. Muro outlined the implementation schedule (HR and Finance: 1 year and Supply Chain (6-8 months).<br><br>**Motion:** To approve the ERP System purchase.<br><br>**Movant**: Zoglin<br>**Second**: Kalbach<br>**Ayes**: Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Chen<br>**Recused**: None | ***ERP System Purchase approved*** |
| **6. PROPOSED FY19 COMMUNITY BENEFIT PLAN** | Barbara Avery, Director of Community Benefit, provided an overview of the FY19 Community Benefit Plan. She explained that there were 63 proposals received and 49 recommended to be funded, a 50% increase since FY17. She also reviewed the funding amounts requested and approved in prior years and recommended for FY19. Ms. Avery highlighted the timeline and process of the grant cycle, the new online grant platform, grant application process and assessment, and the Community Benefit Advisory Council's review.<br><br>In response to Director Fligor's questions, Ms. Avery noted that the decreasing trend in District applications may be due to the geographic restrictions on the use of District funds. She also described the consideration and use of reserve funds for extraordinary need throughout the year.<br><br>Director Davis suggested pursuing grant matches with other organizations.<br><br>**Motion:** To approve the Proposed FY19 Community Benefit Plan.<br><br>**Movant**: Miller<br>**Second**: Reeder<br>**Ayes**: Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Chen<br>**Recused**: None | ***FY19 Community Benefit Plan approved*** |
| **7. PUBLIC COMMUNICATION** | There were no comments from the public. | |
| **8. ADJOURN TO CLOSED SESSION** | **Motion:** To adjourn to closed session at 6:59pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (May 9, 2018), the Minutes of the Closed Session of the Joint Meeting of the Corporate Compliance/Privacy and Internal Audit Committee and the Hospital Board (May 9, 2018), the Minutes of the Closed Session of the Executive Compensation Committee Meeting (May 24, 2018), and the Minutes of the Closed Session of the Joint Meeting of the Finance Committee and the Hospital Board (May 29, 2018); pursuant to *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets and *Gov't Code Section 54957.6* for a conference with labor negotiator Dan | ***Adjourned to closed session at 6:59pm*** |

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| | Woods; pursuant to *Health and Safety Code* 32155 for deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report; pursuant to *Health & Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets, *Health and Safety Code* 32155 for deliberations concerning reports on Medical Staff quality assurance matters, and *Gov't Code Section 54956.9(d)(2)* – conference with legal counsel – pending and threatened litigation: CEO Report on New Services and Programs, Quality Assurance Matters, and Legal Matters; pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: Governance Committee Report; pursuant to *Gov't Code Section 54957.6* for a conference with labor negotiator Bob Miller: Proposed FY19 CEO Base Salary and Salary Range; and pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: Executive Session.<br><br>**Movant**: Fung<br>**Second**: Kalbach<br>**Ayes**: Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Chen<br>**Recused**: None | |
| **9. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT** | Open session was reconvened at 9:20pm by Chair Chen who had rejoined the meeting during the closed session Agenda Item 13. Agenda items 9-16 were addressed in closed session. Directors Fung and Kalbach were not present when open session was reconvened.<br><br>During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (May 9, 2018), the Minutes of the Closed Session of the Joint Meeting of the Corporate Compliance/Privacy and Internal Audit Committee and the Hospital Board (May 9, 2018), the Minutes of the Closed Session of the Joint Meeting of the Finance Committee and the Hospital Board (May 29, 2018), the Minutes of the Closed Session of the Executive Compensation Committee Meeting (May 24, 2018), and the Medical Staff Report by a unanimous vote in favor of all members present (Directors Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, and Zoglin; Director Chen was absent). | |
| **10. AGENDA ITEM 18: CONSENT CALENDAR** | Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. No items were removed.<br><br>**Motion:** To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting (May 9, 2018); Minutes of the Open Session of the Joint Meeting of the Corporate Compliance/Privacy and Internal Audit Committee and the Hospital Board (May 9, 2018); Minutes of the Open Session of the Joint Meeting of the Finance Committee and the Hospital Board (May 29, 2018); FY19 Auxiliary Slate of Officers; Proposed FY19 Organizational Goals; FY18 Period 9 Financials; Medical Director, Stroke & Neurology (Enterprise); Medical Director, Cancer Center (Enterprise); Medical Director, Radiology Services & Breast Center; Medical Director, Radiation Oncology (MV); Medical Director, Cardiac Catheterization Lab (MV); Medical Director, Respiratory Care Services (MV); Charity Care Policy; Proposed FY19 Master Calendar; Proposed FY19 Advisory Committee Goals; Proposed FY19 Slate of Advisory Committee Chairs and Members; Proposed Revisions to Advisory Committee Charters; Minutes of the Open Session of the Executive Compensation Committee Meeting (March 22, 2018); Draft Revised Executive Compensation Policies; the | ***Consent calendar approved*** |

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| | Medical Staff Report; and for information: FY19 Executive Base Salaries and Salary Ranges; Update on Major Construction Projects in Progress (MV campus); and Progress Against FY18 Advisory Committee Goals.<br><br>**Movant**: Reeder<br>**Second**: Fligor<br>**Ayes**: Chen, Davis, Fligor, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: Fung and Kalbach<br>**Recused**: None | |
| **11. AGENDA ITEM 19: FY19 CEO SALARY RANGE AND BASE SALARY** | This item was deferred. | |
| **12. AGENDA ITEM 20: CEO REPORT** | Directors Fung and Kalbach rejoined the meeting. Dan Woods, CEO, discussed the current progress toward achievement of the FY18 organizational goals and the recent groundbreaking use of aquablation to treat symptomatic benign prostatic hypertrophy by urologists in Los Gatos. He reported that ECH is in the process for applying for its 4th Magnet Designation. He highlighted the organization's activities for Hospital Week including a robotics symposium.<br><br>He also acknowledged the Foundation's recent fundraising achievements and the Auxiliary's contribution of 7,052 volunteer hours in April.<br><br>Mr. Woods reported that ECH affiliate Silicon Valley Medical Development, LLC opened an urgent care center in Cupertino in May. | |
| **13. AGENDA ITEM 21: BOARD COMMENTS** | Director Fligor suggested that staff consider alternative scheduling for the Board's closed session. | |
| **14. AGENDA ITEM 22: ADJOURNMENT** | **Motion**: To adjourn at 9:28pm.<br><br>**Movant**: Fung<br>**Second**: Kliger<br>**Ayes**: Chen, Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin<br>**Noes**: None<br>**Abstentions**: None<br>**Absent**: None<br>**Recused**: None | ***Meeting adjourned at 9:28pm*** |

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

_____ _____

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services
Sarah Rosenberg, Contracts & Board Services Coordinator

# ECH BOARD MEETING AGENDA ITEM COVER SHEET

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| | **Item:** | Medical Staff Report – Open Session<br>El Camino Hospital Board of Directors<br>August 6, 2018 |
| | **Responsible party:** | Linda Teagle, MD. Chief of Staff Los Gatos |
| | **Action requested:** | Approval |
| | **Background:**<br>The Medical Executive Committee met on June 28, 2018. We received the following reports:<br>1. Patient Care Policies – Approved<br>2. AMION electronic ER call schedule will be launched via The Toolbox in July and is also accessible via mobile devices.<br>3. CNO Report – Cheryl Reinking reported that the TJC open window for survey begins in July. She provided the high areas for focus from the Mock Survey: Infection Prevention, Malignant Hyperthermia Protocol, Medication Management and Security and Preop Procedure.<br>4. The Chief of Staff informed the MEC that all medical staff members and allied health would be sent the Professional Conduct Behavioral Policy and requested to attest to being informed of the expectations and agreement to abide to the responsibilities.<br>5. Medical Director of Quality and Patient Safety reported that utilization of Red Blood Cells had declined by 31% over the past three years and that the ECH program was acknowledged for its achievements by experts from John Hopkins Hospital.<br>6. CMO Report – Interim CMO Mark Adams presented the FY 19 Organizational Goals with emphasis on the quality of care metrics: ED Throughput, Mortality Index and Readmissions Index.<br>7. The MEC also reviewed the Quality and Safety Dashboard and performance for April 2018. | |
| | **Board Advisory Committee(s) that reviewed the issue and recommendation, if any:** None | |
| | **Summary and session objectives**: To obtain approval of the Medical Staff Report | |
| | **Proposed Board motion:** To approve the Medical Staff Report | |
| | **LIST OF ATTACHMENTS:**<br>1. Patient Care Policy Summary and Policies | |

# SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL - Board

**8-Aug-18**

## DOCUMENTS WITH MINOR REVISIONS

| Document Name | Department | Type of Document | Summary of Policy Changes |
|---|---|---|---|
| Scope of Service – Health Information Management Systems (HIMS) | HIMS | Scope | Additions to Scope of Service includes and updated Staffing/Skill Mix |
| Utilization Management Plan | Care Coordination Medical Staff | Plan | Minor Changes to Procedure |
| Scope of Service - Surgical and Pediatrics | Patient Care Services | Scope | Grammatical |
| Scope of Service - Environmental Services | EVS | Scope | Minor additions to support services |
| CPWC - Scope of Service | CPWC | Scope | Updated staff postitions, outdated terms, support group meetings and orientation |
| Scope of Service | Rehabilitation Services | Scope | Deleted Massage, corrected mailstop and hours of operation |
| Scope of Service - Patient Financial Services | Patient Accounts | Scope | Clarified Services Offered |
| Scope of Service- Imaging Services | Imaging | Scope | Added additional ACR language to align with regulatory compliance; Listed campus modalities separately; Added ECG and EEG specifics |

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**SCOPE OF SERVICE**
**Health Information Management Services**

## Scope and Complexity of Services Offered

Health Information Management Services is organized to support the collection, maintenance, dissemination and use of patients' ~~medical~~ health information in a timely and accurate manner according to governmental, professional and institutional guidelines and is considered the custodian of the El Camino Hospital Legal Medical Record. The purposes of the legal medical record are to:

1. Facilitate the diagnosis and treatment of the patient
2. To aid quality assurance and peer review activities by documenting the standards and patterns of care of El Camino Hospital and it's individual practitioners and providing data for administrative and medical decisions.
3. Serve as the legal health record for El Camino Hospital
4. Provide data for quality measures, health research, planning, and regulatory data submission
5. Verification of services and treatment covered by insurance.

## Scope of Services includes:

Physician Suspension
Coding/Abstracting
Release of Information
Dictation / Transcription
Analysis for chart completion
Record Retrieval and Retention
Birth Recording
Management of the electronic/paper legal medical record
Scanning of paper documents for legal medical record
Quality audits – Joint Commission standards
Patient Identity
Documentation Management for Clinic Services
Patient Portal Services for Electronic Health Record

## Types and Ages of Clients Served

Patients all types and ages and their representatives
Medical Staff
Administration
Insurance Companies
Clinical Staff
Allied Health Professionals
Attorneys
Other Health Care Organizations
Government Agencies
All Hospital Departments

## Assessment Methods

HIM staff skill sets are evaluated using job competencies specific to their job function.
Quality audits are performed routinely for record management functions, coding and abstracting, data collection, release of information and transcription.

## Appropriateness, Necessity and Timeliness of Services

Health Information Management Services is staffed seven days per week from 7:00 am to 5~~9~~:00 pm and open to the public for release of information M-F 8:00 am to 4:30 pm. Holiday~~s~~ coverage varies.

## Staffing/Skill Mix

Leadership is provided by ~~two~~ three registered health information management professionals, credentialed by the American Health Information Management Association, which include a ~~manager~~ supervisor with a RHIT credential , a manager with a CCS credential ~~and~~ a director with an RHIA ~~and RHIT~~ credential~~s~~. Coding staff hold either a Certified Coding Associate (CCA) or Certified Coding Specialist (CCS) credential. All other staff must meet minimum job competencies.

## Level of Service Provided

Health Information Management Services provides services under hospital and departmental policy and procedure guidelines.

## Standards of Practice

Health Information Management Services is governed by state and federal regulations including Title 22 and the Medicare Conditions of Participation, and standards established by the Joint Commission on Accreditation of Healthcare Organizations.

## I. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| ePolicy Committee: | 6/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 6/09 |

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|---|---|
| **TITLE:** | Utilization Management Plan |
| **CATEGORY:** | Patient Care Services |
| **LAST APPROVAL:** | 01/2016 |

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|---|---|---|---|---|
| **TYPE:** | ☐ Policy | ☐ Protocol | ☑ Plan | ☐ Scope of Service/ADT |
| | ☐ Procedure | ☐ Standardized Process/Procedure | | |

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| **SUB-CATEGORY:** | *Care Coordination, Medical Staff* |
| **OFFICE OF ORIGIN:** | *Care Coordination* |
| **ORIGINAL DATE:** | 10/2015 |

## I. COVERAGE:

All El Camino Hospital Employees and ~~Physicians~~ Medical Staff

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## II. POLICY STATEMENT:

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

## III. PROCEDURE:

### AUTHORITY AND RESPONSIBILITY FOR THE UTILIZATION REVIEW PLAN

1. Board of Directors

   The responsibility for ensuring a comprehensive, organized effective Utilization ~~Review~~ Management Plan encompassing the continuum of health care ultimately rests with the Board of Directors. The Board delegates authority to the medical staff and senior leadership for development, implementation and maintenance of the Utilization Review Plan, as delineated in this plan and in applicable policies, procedures and bylaws.

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2. Senior Leadership

   Senior leadership will facilitate the effective performance of the Utilization ~~Review~~ Management Plan providing active support and allocating adequate resources to the implementation of the plan.

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3. Medical Staff and Hospital Departments

The medical staff and hospital departments will review the results of utilization management activities related to their areas of clinical and support services. Each department will take appropriate action based on the recommendations made as part of ongoing performance improvement.

4. Professional Review Committees

   a. Committee Structure

      The Medical Executive Committee has delegated the responsibility for implementation of the Utilization Management Plan to the Utilization Management Committee (UMC).

   b. Composition

      The Utilization Management Committee (UMC) Chair will be recommended by the hospital Chief Medical Officer and approved by the MEC. The members of the UMC will be appointed by the UMC Chair. The UMC will be composed of two (2) or more physicians of the active staff who broadly represent the services of the medical staff. Each appointed member of the committee shall have a vote.

      The committee will be assisted by other professional personnel. Representatives from Administration, Health Information Management, Care Coordination, Quality/Clinical Effectiveness ~~Management~~, Pharmacy and Nursing, as well as directors of reporting ancillary departments may attend the committee meetings as non-voting members.

      Upon invitation from the Chair~~man~~, other representatives of the Hospital or Medical Staff may attend meetings. The Physician Advisor and the Care Coordinator (CC) will function as an extension of the UMC. The Chairman or other designated Members of the committee shall serve as the Physician Advisor (PA) if there is not an appointed advisor available, or when hospital appointed Pas are not available.

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

      ~~The Chairman and other designated members of the committee shall serve as Physician Advisor (PA) when Hospital-Appointed Physician Advisor(s) are not available.~~

      When the UMC makes a recommendation regarding a physician's practice management, the issue will be referred to the appropriate department for further action.

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c. Meetings

The UMC shall meet and report to the Medical Executive Committee quarterly or more frequently as needed as determined by the UMC Chair.

5. Physician Advisor

Physician Advisors serve as a resource to the hospital and medical staff in evaluating the appropriateness of patient admission and continued stays when necessary. Other medical staff committee members will provide specialty consultation as needed. In the absence of designated Physician Advisor, Utilization Management Committee members will serve as Physician Advisor as necessary. Physician Advisors are responsible for:

a. Determining the medical necessity of hospital admission, hospital continued stay and ancillary services on referred cases.

b. Contacting the attending physician to obtain additional information regarding the medical necessity of the admission, continued stay and/or service, as necessary.

c. Discussing patient medical necessity for an admission or continued stay of a referred case with the assigned Care Coordinator

d. Serving as a resource to the hospital by identifying utilization issues, recommending improvement opportunities and defining educational needs.

**UTILIZATION MANAGEMENT PLAN GOALS AND OBJECTIVES**

Through implementation of an effective ~~case management~~ Care Coordination Program, the hospital will further its commitment to the community we serve by providing quality health care in a cost effective manner. This program's focus is to:

1. Establish and maintain an effective, collaborative, Utilization Management Plan across the continuum of care.

2. Assess the appropriateness of the treatment setting including the medical necessity of patient placement in observation status, hospital inpatient admissions, continued stay, professional services, and identification of opportunities for providing quality care more economically in alternate care settings.

3. Assess the appropriateness, efficacy and efficiency of the services and resources provided to the

patient and to promote the patient's right to actively participate in treatment decisions.

4. Identify patterns of under-utilization, over-utilization, and inefficient use of resources and recommend and/or initiate actions to improve the use of health care services.

5. Establish a mechanism for the review of outlier cases based on extended length of stay and/or extraordinarily high costs.

6. Initiate and/or recommend improvement plans when areas of inappropriate utilization are identified and to evaluate the effectiveness of the improvement plans.

7. Achieve and maintain compliance with applicable standards and regulations, including contractual agreements with third-party payers and external review entities, when agreements are consistent with professionally recognized standards of care.

8. Provide concurrent identification of and, where possible, appropriate intervention in issues related to utilization of resources, risk management and quality of care.

9. Encourage the incorporation of established quality and utilization performance standards in the daily operating plans of each department, committee and service.

10. Promote continuity of care and services by identifying all patients in need of post hospital care and assuring that they have an appropriate, timely plan for discharge.

11. Serve as an advocate for appropriate care, treatment, and discharge decisions that are based on recognized standards of care and not solely on the reimbursement determinations of external review entities.

12. Communicate utilization information and provide education on appropriate utilization of resources in a collaborative, collegial manner to individual practitioners, departments, committees, senior leadership, the Medical Staff, and the Board of Directors.

**PROGRAM ELEMENTS**

1. Criteria

   The effort of the members of the Care Coordination Department is directed toward assessment of patients and their medical records to determine appropriateness of admission, level of care setting, continued stays, resource utilization and aftercare needs. Such assignments utilize InterQual® Level of Care Criteria and active participation in the care of patients through

interaction with physicians and multidisciplinary unit rounds.

2. Types of Review - The review process is applied to all patients regardless of payer source.

   a. Pre-admission Review (when applicable)

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

   b. Admission Review and Concurrent Review

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

   c. Outlier Case Review Meetings

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

   d. Escalation Process - Cases that do not meet InterQual® criteria are escalated. The following process will be followed:

      1) The CM determines that InterQual® criteria are not met, i.e.; the patient could safely go to another level of care and/or there is no barrier to discharge other than not having discharge orders.

      2) The CM initiates a discussion with the Attending Physician to determine if the patient can be discharged or if other clinical information qualifies the stay and/or change in level of care.

3) If unable to come to an agreement, the Care Coordinator escalates the case to a Physician Advisor who takes action.

4) The Care Coordinator will document all interventions and activity related to escalation in the electronic record.

e. Denials and Appeals

1) Denials

Questionable admissions, continued stays and discharges identified by the Care Coordinators are escalated using the escalation process. The appropriateness of issuing a formal denial is determined by the Physician Advisor following consultation with the Attending Physician. Specific procedures and standardized letters are used for purposes of notifications of physicians, patients, and payers as required according to the specifications of each review organization or third party payer.

2) Appeals

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

i. A discussion will be held with the attending physician to initiate the appeals process.

ii. The attending physician will be asked to assist with the appeal process by providing additional information to justify patient hospital stay.

iii. An appeal letter will be drafted by the RAAC and sent certified mail~~ed~~ to the insurance carrier.

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

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

1) Facilitation of patient discharge as soon as an acute level of care is no longer

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required.

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

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

   i. Placement in alternative care facilities

   ii. Referrals to home health care

   iii. Provision for initial contact with appropriate community resources including hospice

   iv. Communication with the patient, patient's family and attending physician which is documented in the medical record

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

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

**RESPONSIBILITIES OF COMMITTEE**

It is the responsibility of the Utilization Management Committee is to review, analyze, report, and where appropriate, make recommendations to support and improve efficient and optimal patient care. Committee activities are as follows:

1. Evaluation of Utilization Data includes regular review and reports of the following:

   a. Admissions

   b. Continued stay

c. Professional services

d. Length of stay

e. Denials

f. Medicare 1 day stays

g. Readmission within 30 days/same diagnosis

h. Appropriateness of operative and invasive procedures

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2. There will be ad hoc monitoring for Potential Service Outliers ~~as needs arise~~, such as:

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a. Length of stay

b. Over utilization and underutilization of resources

c Level of care considerations

d. Extraordinary high cost cases

e. Patient care contracted services

f. Utilization of high cost drug and biological

g. Professional services

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3. Recommendations and Communication

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

**REPORTING AND EXCHANGE OF INFORMATION**

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

**CONFLICT OF INTEREST**

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

**CONFIDENTIALITY**

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

**PLAN EVALUATION, AMENDMENT AND REVISION**

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

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

## IV. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| Utilization Management Committee<br>Patient Care Leadership (Policy Day): | 5/2018 |
| ePolicy Committee: | 6/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 1/16 |

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

**SCOPE OF SERVICE**
**Surgical ~~Nursing~~ & Pediatric Services – MOUNTAIN VIEW**

## Types and Ages of Patients Served

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

## Assessment Methods

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

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

## Scope and Complexity of Services Offered

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

## Appropriateness, Necessity and Timeliness of Services

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

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

## Staffing/Skill Mix IUW

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

## Level of Service Provided

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

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

## Standard of Practice

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

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| Patient Care Leadership (Policy Day): | 2/2018 |
| ePolicy Committee: | 2/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 1/11 |

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

**SCOPE OF SERVICE**
**Environmental Services**

## Types and Ages of Patients/Clients Served

The Environmental Services Department serves El Camino Hospital inpatients/residents, outpatients, visitors and hospital personnel of all ages.

## Assessment Methods

The primary purpose of the Environmental Service Department is to maintain a clean, aseptic, and aesthetically attractive hospital for the comfort and protection of patients/residents, visitors and hospital personnel. These goals are continuously assessed by Infection/Environment of Care team rounds, department performance improvement (PI), nursing rounds, and administrative rounds.

## Scope and Complexity of Services Offered

The Environmental Services staff consists of environmental services, laundry services, and unit support personnel qualified to perform the services as outlined by the department. The following is an outline of the duties and responsibilities of the Environmental Services Department.

| Environmental/Unit Support/Laundry Services | Additional Unit Support Services |
|---|---|
| Patient/ room cleaning | Vocera operation |
| Discharge patient/ room cleaning | Patient/resident transport |
| UV Light disinfection cleaning | Morgue transport |
| Non-patient area cleaning | iCare/EPIC use for discharge room cleaning and patient and non-patient transport |
| Carpet care/cleaning | 24 Hour availability of patient food |
| Sanitize hallway floors | Laboratory - Blood Bank units |
| Restroom cleaning | Maternal Child Health late tray deliveries |
| Wall washing | |
| Care of equipment | |
| Stripping and refinishing | |
| Housekeeping safety | |
| Window/glass cleaning | |
| Curtain/Cubical cleaning | |

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| Environmental/Unit Support/Laundry Services | Additional Unit Support Services |
|---|---|
| Bed making | |
| Cleaning of Central Supply | |
| Medical Office Building | |
| Pest control | |
| Infection control | |
| Hand and glove washing | |
| Nursery cleaning | |
| Cleaning of Labor and Delivery | |
| Cleaning of Surgery | |
| Regular waste disposal | |
| Recycling waste disposal | |
| Confidential Waste disposal | |
| Medical waste disposal | |
| Linen distribution | |

**Appropriateness, Necessity, and Timeliness of Services**

Please refer to the standard policy and procedures manual for detailed information for timeliness of services, hours of operation, how to contact the department for immediate service, special projects, audio visual equipment, and outside services i.e. pest control, window cleaning.

**Staffing**

The Environmental Services Department is staffed 24 hours a day, seven days a week with environmental services and unit support employees, and eight hours a day, seven days a week with linen services.

**Level of Service Provided**

The level of service provided is consistent with patient/residents needs and the needs of all the

hospital departments and the medical office building. Performance improvement and quality control activities are in place to measure and access the degree to which the department meets patient/resident and hospital department needs.

**Standards of Practice**

The Environmental Services Department is governed by state regulations, such as Title 22, Joint Commission on Accreditation of Healthcare Organizations standards, and the American Society of Environmental Services.

**I. APPROVAL:**

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| Director of EVS: | 5/2018 |
| ePolicy Committee: | 6/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 12/06,06/09, 10/15 |

| | |
|---|---|
| **TITLE:** | CPWC : Scope of Service |
| **CATEGORY:** | Patient Care Services |
| **LAST APPROVAL:** | August 2015 |

| | | | | |
|---|---|---|---|---|
| **TYPE:** | ☐Policy ☐procedure | ☐Protocol ☐Plan | ☐Practice Guideline ☑Scope of Service | ☐Standardized Procedure |
| **SUB-CATEGORY:** | Cardiac & Pulmonary Wellness Center | | | |
| **OFFICE OF ORIGIN:** | Cardiac & Pulmonary Wellness Center | | | |
| **ORIGINAL DATE:** | May 1995 | | | |

## I. COVERAGE:

El Camino Hospital Cardiac Pulmonary Wellness Center

## II. PURPOSE:

- To describe the Cardiac & Pulmonary Wellness Center Unit

## III. DEFINITIONS (if applicable):

N/A

## IV. REFERENCES:

N/A

## V. PROCEDURE:

A. General Unit Description

1. The Cardiac & Pulmonary Wellness Center ~~(Rehab)~~ ~~Unit~~ 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 Manager, ~~Nursing Unit Coordinator,~~ CR registered nurses, PR registered nurses, exercise physiologists (EP), a respiratory therapist (RT), and ~~education specialist RN, a Cardiac Pulmonary Rehab Assistant~~ and an Administrative Assistant.
3. Supervisory coverage is provided by the Medical Directors, and the Unit Manager during hours of operation. In the manager's absence, ~~the Nursing Unit Coordinator or~~ a CR or PR nurse will be designated in charge. (See Policy and Procedure Organization Chart, and Unit 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. Unmonitored 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 periodically.

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, hearing and vision problems.
3. 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 are scheduled before the first session of exercise. Informational lectures addressing cardiac risk factors are held throughout the month.
4. The Women's Heart Support Group is a community service for women living with coronary artery disease.
5. 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.
6. 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.
7. 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 Support Group is a community service for individuals living with pulmonary disease from a diagnosis of mycobacterium avium. The group meets every other monthquarterly.

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, CPR committee, Patient Care Leadership Meeting, All

Leaders Meeting, Chest Pain, Heart Failure, Performance Improvement/Quality, and CORE.

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 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.
   3. Staff Problems will be resolved at the time of occurrence. If no resolution, the chain of command will be followed from Program Manager to Director of Critical Care Services and finally to the Chief Nursing Officer.
   4. 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.
   5. 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, ~~memos~~ 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 4:1 for monitored programs and for 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 ~~two~~ weeks. Orientation will include: equipment set up, telemetry set up, oxygen monitoring and delivery systems, ~~completing unit scavenger hunt,~~ entering charges in the EH~~E~~R, 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~~, and Healthy Heart Beat Newsletter~~.
3. 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, knowledge of the various components of the pulmonary programs including the Better Breather's Club Support Group and Newsletter, and Mycobacterium Avium Support Group.

## VI. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| UPC Committee: | 2/2018 |
| ePolicy Committee: | 6/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | *05/97, 04/98, 10/00, 12/03, 01/04, 06/06, 12/07, 12/08, 10/12, 7/13, 8/15* |

## VII. ATTACHMENTS: (N/A)

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

**SCOPE OF SERVICE**
**Rehabilitation Services**

## Type and Ages of Patients Served

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

## Assessment Methods

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

## Scope and Complexity of Services Offered

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

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

All specialty services are provided by skilled and licensed/certified professionals. Services are provided on a referral basis only. All staff works actively to promote and support the mission, vision, and values of El Camino Hospital. ~~Massage Therapy is available in Mountain View to inpatients by patient request. Massage is only available during limited days and hours, and there is an out of pocket expense associated with this service..~~

## Rehabilitation Services Provides:

**PT** - Back care training, gait training/ambulation, transfer training, manual therapy,~~,~~ therapeutic exercise programs, neuromuscular re-education, pelvic floor interventions, prosthetic training and modalities as appropriate.

**OT -** Evaluation and treatment of daily living, social, educational, play/leisure skills, work adjustment, sensorimotor evaluation and therapy, self-management, therapeutic adaptations, preventive techniques, cognitive evaluation and therapy, UE evaluation and treatment, neuromuscular re-education, splinting and therapeutic activities,

**ST -** Evaluation and treatment of speech and language disorders or dysphagia evaluation and treatment, including Vital Stimulation, evaluations and treatment of cognition impairments and assisting the radiologist with videofluoroscopic examinations.

**Appropriateness, Necessity and Timeliness of Services**

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

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

**Staffing/Staff Mix**

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

**IN-PATIENT** El Camino Hospital **Mountain View** (main building)
2500 Grant Road
Mountain View, CA 94039-7025
Mail Stop: ~~ECH 2F (~~4A ~~after 11/09)~~ 4AREH
Phone: (650) 940-7269

El Camino Hospital **Los Gatos**
815 Pollard
Mail Stop: LGH117
Los Gatos. CA 95032
Hours: Sunday - Saturday, 8:30 a.m. - 5:00 p.m.
Legal holidays, except as listed:
8:30 am – 5:00 pm

Outpatient rehabilitation services are provided Monday through Friday, 8:00 a.m. to ~~6~~5:00 p.m. with the exception of all legal holidays, or by special appointment.

**OUT-PATIENT** **Mountain View**
Park Pavilion Building, 2nd Floor
2400 Grant Road
Mountain View, CA 94040-4378
Mail Stop: PAR 210
Phone: (650) 940-7285
Fax: (650) 965-2992

**Los Gatos**
Physical Performance Institute (PPI)
555 Knowles Drive, Suite 100
M/S: KNO101
Los Gatos. CA 95032
Phone: (408) 866-4059
Fax: (408) 871-2347

Hours: Monday - Friday, 8:00 a.m. - ~~6~~5:00 p.m.
Closed on legal holidays

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

**Levels of Service Provided**

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

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

**Standards of Practice**

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

1. Physical Therapy:

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

a. Functional evaluations and goal setting.
b. Medical, neurological and orthopedic rehabilitation.
c. Therapeutic exercise, including strengthening and flexibility training.
d. Modalities: traction, moist heat, cold, electrotherapy, and ultrasound.
e. Manual therapy: myofascial release, peripheral and spinal joint mobilization, soft tissue mobilization, and manual traction.
f. Gait and transfer training.
g. LE Prosthetic training.
g. Use of exercise equipment.
h. Balance and coordination training.
i. Patient, family and caregiver education and training.
j. Ergonomic assessments and injury prevention training.
k. Advancement of physical therapy rehabilitation programs
l. Aquatic therapy.
m. Evaluation and treatment of pelvic floor dysfunction

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

2. Occupational Therapy:

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

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

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

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

3. Speech and Language Pathology:

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

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

4. ~~Massage Therapy – Mountain View~~

~~This is an adjunct service to the standard Rehabilitation Services. It is meant to be therapeutic only in so far as it helps the patient to relax, self-manage pain, and move with more ease. It is not meant to include "manual therapy", "soft tissue mobilization" or specific techniques utilized by Physical Therapists under physician orders. It is provided to the following types of patients:~~

~~a. Inpatients on medical/surgical floors, with approval of each primary physician~~
~~b. Inpatients on pre-partum and post-partum floor~~

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## I. APPROVAL:

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| Originating Committee or UPC Committee | |
| (name of) Medical Committee (if applicable): | |
| ePolicy Committee: | 6/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| Historical Approvals: | 3/12 |

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

**SCOPE OF SERVICE**
**Patient Financial Services**

## Types and Ages of Clients Served

The Patient Financial Service Division provides services to all El Camino Hospital patients and employees.

## Scope and Complexity of Services Offered

The Patient Financial Services Division provides patient scheduling and ~~–~~registration, financial counseling, Price Estimates as well as ~~payor and patient billing and collection services~~ billing to insurance carriers and collections for both Hospital Billing and Professional Billing.. The scope of these services includes the overall management and control of the hospital's R~~r~~evenue ~~c~~Cycle. Services ~~provided include, but are not limited to~~ including for not limited to:~~:~~

- Collecting patient demographic, ~~social~~, financial and medical information.
- Providing Estimates for scheduled services to determine and communicate out of pocket expenses for our Patients
- Assisting and counseling patients so they can fulfill their financial obligation to the hospital
- Provide Financial Assistance, Extended Payment Arrangements, Discounts and Charity Care. To also give instructions and help our patients link to Government Programs
- Providing information to patients regarding hospital services and programs
- Submitting clean, timely and compliant claims to ~~payors~~ Insurance Carriers and patients
- Collecting and ensuring that insurance and patient payments are appropriate
- Explaining insurance and contractual terms to patients and their families
- ~~Training and assisting Service Line Mmanagers to help them process timely, complete and compliant charges~~ **Formatted:** Highlight
- Managing the hospital's accounts receivables
- Collecting patient co-pays and deductibles

## Staffing

The staff providing services includes Patient Service Representative ~~sSchegistrars~~, ~~registrars~~, ~~f~~Financial ~~c~~Counselors, and ~~p~~Patient ~~a~~Account ~~r~~Representatives, M~~m~~anagers, ~~s~~Supervisors, Directors and staff support positions.

## Level of Service Provided

The Patient Financial Services Division provides services under hospital and divisional policy and procedure guidelines.

## Standard of Practice

Where applicable, the Patient Financial Services Division is governed by state and federal guidelines and Department of Health Services and Joint Commission on Accreditation of Healthcare Organizations requirements.

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| CFO: | 6/2018 |
| ePolicy Committee: | 6/2018 |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | 10/15 |

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

**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. ~~STAT exams are to be started within 1 hour of physician's order.~~ Performance standards and quality initiatives are in place to measure outcomes and meet patient and clinician needs. ~~The hospital maintains a **Picture Archiving and Communication System (PACS),** where all~~All ~~images, tracings and~~ Patient reports and exam records can be accessed upon request and are stored ~~indefinitely~~indefinitely as part of the patient's Electronic Health Record (EHR). Images are stored in the hospital's Picture Archiving and Communication System (PACS), while EEG and ECG tracings are stored in their respective archives~~; PACS does not store raw data. PACS is routinely maintained by the ECH IT department.~~.

## ~~Types and Ages of Patients Served~~Patient Types

Exams and procedures are performed on ~~Imaging Services serves~~ inpatients, outpatients and emergency department patients. Patient age groups served are neonatal, pediatric, adolescent, adult and geriatric. ~~of all ages from newborn to geriatric.~~

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

## ~~Scope and Complexity of~~ Services Offered

~~Inpatient and outpatient diagnostic procedures are performed at two facilities, Mountain View and Los Gatos.~~ Imaging Modalities on ~~T~~the **Mountain View** Campus are:~~provides~~

| | |
|---|---|
| ~~-~~General Diagnostic Radiography~~,~~ | Fluoroscopy |
| Magnetic Resonance Imaging (MRI) | Computerized Tomography (CT) |
| Nuclear Medicine | PET/CT |
| Ultrasound | Echocardiography |
| Mammography | Vascular Imaging |

Scope:

Non-Invasive Vascular studies ECG and EEG

Interventional Radiology~~.~~ ~~There is an off-site facility located adjacent to the hospital within Melchor Pavilion that provides general diagnostic Radiography services.~~

Imaging Modalities on the ~~**El Camino Hospital**~~ **Los Gatos** Campus are~~provides~~:

| | |
|---|---|
| General Diagnostic Radiography~~,~~ | Fluoroscopy |
| Magnetic Resonance Imaging (MRI) | Computerized Tomography (CT) |
| Nuclear Medicine | Ultrasound |
| Echocardiography | Mammography |
| Vascular Imaging | Non-Invasive Vascular studies |
| ECG and EEG | Interventional Radiology~~.~~ ~~There is an off-site facility located adjacent to the hospital within Melchor Pavilion that provides general diagnostic Radiography services.~~ |

ECG and EEG Specifics

Muscles in the heart carry electrical charges which change as the heart beats. These changes are recorded as an Electrocardiogram. The terms EKG and ECG are synonymous and are often used interchangeably, though ECG is the newer and preferred term. EEGs record brain-wave activity.

Services Available:

A. Routine ECGs
B. Stress Testing
    1. Treadmill only
    2. Treadmills with Radioactive Isotope (in conjunction with Nuclear Medicine)
    3. Medication-Induced Stress Tests (Lexiscan, Dipyridamole)
    4. Stress Echocardiography
C. Routine EEGs

Scope:

~~A.~~D. Continuous EEG (cEEG)

Nuclear Medicine ~~-~~Specifics

The following exams are approved for on-call services:

A. GI Bleed: Patient must be actively bleeding in order for the study to render diagnostic value.
B. Lung V/Q Scan
C. Gallbladder (HIDA Scan)
D. Stress Tests, * must be coordinated with Nuclear Medicine and scheduled only if all resources are ~~when~~ available. ~~(and timing is not affected by more emergent exams).~~

## Staffing Guidelines for ~~HOURS OF SERVICE~~ Operating Room Coverage~~PERATING ROOM~~

At least two (2) radiologic technologists are scheduled to cover the operating room Monday through Friday until 4:30pm at the Mountain View campus, 3:30pm at the Los Gatos campus. After these times and on weekends, the department utilizes the OR call schedule for surgery cases. ~~It is imperative that the~~ The surgery department will work~~s~~ very closely with the Imaging Services department during the scheduling of exams that require radiological support. ~~Exams should be scheduled consecutively to maximize efficient use of imaging personnel and equipment resources.~~ ~~*ECG and EEG SPECIFIC*~~

~~Muscles in the heart carry electrical charges which change as the heart beats. These changes are recorded as an Electrocardiogram. The terms EKG and ECG are synonymous and are often used interchangeably, though ECG is the newer and preferred term. Similarly, EEGs record brain wave activity.~~

~~Services Available:~~

- ~~Routine ECGs~~
- ~~Stress Testing~~
  - ~~Treadmill only~~
  - ~~Treadmills with Radioactive Isotope (in conjunction with Nuclear Medicine)~~
  - ~~Medication Induced Stress Tests (Lexiscan, Dipyridamole)~~
  - ~~Stress Echocardiography~~
- ~~Routine EEGs~~
- ~~Continuous EEG (cEEG)~~

Scope:

## 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 ~~and~~ as well as any possible contraindications, and bring ~~any~~ these concerns to the Radiologist.

The timeliness of radiologic services is addressed in departmental ~~policies and~~ 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 QRR system.

### ~~*CONSULTING SERVICES,*~~ Radiologists~~ADIOLOGISTS:~~

Diagnostic and therapeutic radiologic services are available by board-~~-~~certified or board-~~-~~eligible radiologists. Silicon Valley Diagnostic Imaging (SVDI) is contracted to ensure radiology services are available 24 hours a day. Licensure information of contracted radiologists is maintained in the Medical Staff office. SVD~~DV~~I provides a Radiation Safety Officer to oversee the Radiation Protection Plan and Radiation Safety Committee.

Service Hours: Hours of service are according to the Radiologists' posted schedule, which includes~~ing~~ call hours to provide additional consultation or ~~be called on site~~ to perform ~~an~~ 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 24 ~~hours~~hours; exceptions include the unavailability of comparison exams.

STAT~~tat~~ 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. ~~(See Hospital Stroke Policy for current guidelines on turn around for stroke patients).~~ Referring p~~P~~hysicians may denote their preference~~s~~ for obtaining reports, e.g., ~~including but not limited to, such as~~ fax, electronic distribution, mail, etc.

Modality Protocols:

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

Protocols are reviewed and approved by the Radiologists biennially (every 2 years), and revised as needed in between the regular review period. Modality protocols ~~reside in ePolicy as mandated by hospital standard.~~ are maintained by the department and are accessible by all clinical staff members. Clinical situations ~~may~~ often warrant protocol adaptation due to unique patient circumstances~~, or other extenuating circumstances.~~ or presentation.

## Staffing/Skill Mix and Requirements

The Director of Imaging Services oversees the Imaging Services Operations. The director ~~may be~~is supported ~~by one or more~~ clinical ~~and/or support~~ managers and supervisors. The daily work of each modality is organized by ~~a clinical~~the C~~c~~harge T~~t~~echnologist ~~per~~ in each modality and/or shift.

This department has a Coordinator of Quality and Education that supports the director ~~in all things~~ related to q~~Q~~uality, regulatory and c~~C~~ompliance activities. The Imaging Services Clinical Instructor 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. ECG techs are also assigned to work with the De Anza College EKG Technology Program externship students.

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~~is~~ 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 are registered by the American Registry of Radiologic Technologists (ARRT) and have graduated from an accredited Radiologic Technology program. All Radiologic Technologists hold a current ~~"CRT" (~~Certified Radiologic Technologist (CRT) license~~s~~ as required by the State of California, Title 17. In addition, all technologists who perform fluoroscopy or mobile fluoroscopy hold a current Fluoroscopy permit, and Mammographers hold a current state Mammography certificate. Ultrasound procedures are performed or supervised by Sonographers who are registered by the American Registry of Diagnostic Medical Sonographers (ARDMS). Nuclear Medicine procedures are performed ~~or supervised~~ by Nuclear Medicine Technologists who hold a current ~~"CNMT" (~~Certified Nuclear Medicine (CNMT) certificate as required by the State of California, Title 17.

Scope:
**Other clinical and support staff providing services to patients in this area may include, but are not limited to:**

Consulting Services, Cardiologists: Echocardiography and ECG studies are ~~is~~ read by various contracted groups and independent cardiologists, according to their schedules.

Consulting Services, Neurologists: EEGs are read by various contracted groups and independent neurologists, according to their schedules.

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

Consulting Services, Medical Physicists: Imaging Services maintains a contract ~~with Sutter Health Physics~~ for consultation on an "as needed" basis and for routine quarterly surveys in Nuclear Medicine, as well as ~~and~~ annual surveys for all other equipment, as required. ~~They are available for m~~Medical physics assessment requests, such as fetal dose calculation or~~,~~ personnel badge review, ~~etc.~~may be requested. ~~All services are available within the contract.~~ 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:

SVDI 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 ~~with~~ has a multidisciplinary membership that meets quarterly to review any radiation safety concerns.

Clinical Engineering (Imaging Services Equipment):

The Clinical Engineering Department works closely with vendors to provide~~s~~ all equipment preventive maintenance~~,~~ based on the manufacturer's recommendations.~~,~~ ~~and service of all Imaging equipment, and T~~retains ~~t~~hese records are retained for review. ~~See hospital policy 5.07 Medical Equipment Inspection and Planned Maintenance.~~

## Standards of Practice

~~Imaging Services is~~Radiation and radioactive materials are ~~governed by California Department of Public Health, Radiologic Health Branch, state regulations Titles 17 and 22, and t~~The Nuclear Regulatory Commission. The Department follows guidelines set forth by these agencies as well as the American

Scope:
College of Radiology (ACR), the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL), and standards established by the Joint Commission. ~~on Accreditation of Healthcare Organizations~~.

## 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 ~~staff~~. ~~See ECH Policies 28.00 "Responsible Use of Technology Resources & Information" and 31.00 "~~

## Hours of Operation

| Modality | Inpatient Hours | Outpatient Hours | Call Hours | Exams Approved by Department for On–Call Services |
|---|---|---|---|---|
| ***Diagnostic Imaging*** | 24/7 | Mountain View Campus<br>M-F: 7am to 7pm<br><br>Los Gatos Campus<br>M-F: 7am to 5:30pm | None | OR Cases or Influx of Patients |
| ***Computed Tomography*** | 24/7 | Mountain View Campus<br>M-F: 8am to 4:30pm<br>Sat: 9am-1pm<br><br>Los Gatos Campus<br>M-F: 7:30am to 5pm | None | N/A |

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

**SCOPE OF SERVICE**
**Imaging Services**

Scope:

| | | | | |
|---|---|---|---|---|
| ***Ultrasound*** | Mountain View Campus<br>24/7<br>Los Gatos Campus<br>M-F: 7:30am to 4pm | Mountain View Campus<br>M-F 8am-3:30pm<br>Los Gatos Campus<br>M-F: 8am-3:30pm<br>*excludes holidays | Mountain View Campus<br>None<br>Los Gatos Campus<br>M-F: 4 pm to 7:30am<br>S/S: 24 hours | Stat US in order of priority:<br>1. Suspected Ruptured AAA, aortic aneurysm<br>2. Scrotal US: torsion, pain<br>3. Pelvic US: ectopic, ruptured ectopic, torsion, bleeding in pregnancy |
| **Modality** | **Inpatient Hours** | **Outpatient Hours** | **Call Hours** | **Exams Approved by Department for On–Call Services** |
| ***ECHO*** | Mountain View Campus<br>M-F: 7am to 5:30pm<br>S/S: 7:30am-5:30pm<br>Los Gatos Campus<br>M-F: 7:30am to 4pm | Mountain View Campus<br>M-F: 8am-4pm<br>Los Gatos Campus<br>M-F: 8am-3:30pm<br>*excludes holidays | Enterprise Call:<br>M-F: 4pm to 7am<br>S/S: 24 hours | Stat ECHOs and surgical or CCL procedures involving Echo staff |
| ***Magnetic Resonance Imaging*** | *Mountain View Campus*<br>*24/7*<br>*Los Gatos Campus*<br>*24/7* | Mountain View Campus *M-F: 7:30am- 6pm*<br>*Los Gatos Campus*<br>*M-F: 09:00am-5:00pm* | Mountain View Campus<br>*No Call*<br>*Los Gatos Campus*<br>*No Call* | *MV & LG ED physicians triage and prioritize requests. Stat MRI in order of priority:*<br>1. *R/O cord compression*<br>2. *Stroke/Bleed*<br>3. *Compression fracture spine*<br>4. *Appendicitis in pregnant patients*<br>5. *Others as they come on first come first serve* |
| ***Mammography*** | *M-F: 7am to 4:30pm* | Mountain View Campus<br>*M-F: 7:30am to 4pm*<br>Los Gatos Campus<br>*W&F: 8am to 3:30pm* | *N/A* | *N/A* |

Scope:

| | | | | |
|---|---|---|---|---|
| ***Nuclear Medicine*** | *M-F: 8am to 4pm* | *M-F: 8am to 4pm* | *M-F: 4pm – 8pm*<br><br>*S/S: 24 hours*<br><br>*To order dose 10pm-2am* | *GI Bleed*<br><br>*Lung V/Q Scan*<br><br>*Gallbladder (HIDA Scan)*<br><br>*Stress Tests must be coordinated with Nuclear Medicine and scheduled only if all resources are available ~~when available~~* |
| ***Interventional Radiology (LG)*** | *M-F: 8am to 5pm*<br><br>*Off-hours: OR* | *T-F: 7am-3:30pm*<br><br>*Off-hours: OR* | *S/S: 7am to 7pm*<br><br>*Off-hours: OR* | *Stat Interventional Exams* |
| **Modality** | **Inpatient Hours** | **Outpatient Hours** | **Call Hours** | **Exams Approved by Department for On–Call Services** |
| ***ECG*** | *M-F: 7am to 11pm*<br><br>*S/S: 7am to 11pm*<br><br>*After these hours, the floor nurses, flex nurse and/or ED techs will perform ECGs* | *M-F: 8:30am-4:30pm* | *N/A* | *N/A* |
| ***EEG*** | *M-F: 7:30am to 10pm*<br><br>*Routine EEG tests may roll over to next day* | *M-F: 9am and 1pm*<br><br>*No scheduled EEGs on Mondays or the day after a holiday* | *S/S: 8am to 11:30pm* | *cEEG (Continuous EEG)*<br><br>*STAT EEG Exams* |
| ***Radiologist*** | *Review the current Radiologist's schedule for hours and call.* | *Review the current Radiologist's schedule for hours and call.* | *Review the current Radiologist's schedule for hours and call.* | *Stat Fluoroscopy cases after hours* |

## Approvals

| APPROVING COMMITTEES AND AUTHORIZING BODY | APPROVAL DATES |
|---|---|
| Imaging Services: | 03/29/2018 |
| Imaging Services Medical Director:<br>Imtiaz Qureshi, M.D. | 06/04/2018 |

Scope:

| | |
|---|---|
| ePolicy Committee: | 06/2018 |
| Pharmacy and Therapeutics (if applicable): | NA |
| Medical Executive Committee: | |
| Board of Directors: | |
| | |
| Historical Approvals: | *02/2017* |