AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, August 21, 2019 – 5:30pm
El Camino Hospital | Conference Rooms A&B, F&G (ground floor)
2500 Grant Road Mountain View, CA 94040

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 -5:42**
4.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair; Mark Adams, MD, CMO		**information 5:42 – 5:57**
5.	**FY19 YEAR-END FINANCIAL REPORT** **ATTACHMENT 5**	Iftikhar Hussain, CFO	*public comment*	**possible motion 5:57 – 6:07**
6.	**FY19 BOARD SELF-ASSESSMENT REPORT AND ACTION PLAN** **ATTACHMENT 6**	Peter C. Fung, MD, Governance Committee Chair; Erica Osborne, Via Healthcare Consulting	*public comment*	**possible motion 6:07 – 7:37**
7.	**GOVERNANCE COMMITTEE REPORT** a. FY20 Hospital Board Competencies b. FY20 Board Education Plan	Peter C. Fung, MD, Governance Committee Chair	*public comment*	**possible motion(s) 7:37 – 7:57**
8.	**ADJOURN TO CLOSED SESSION**	Lanhee Chen, Board Chair		**motion required 7:57 – 7:58**
9.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information 7:58 – 7:59**
10.	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board Meeting (6/12/2019)	Lanhee Chen, Board Chair		**motion required 7:59 – 8:01**
11.	*Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Report	Imtiaz Qureshi, MD, Enterprise Chief of Staff; Linda Teagle, MD, Los Gatos Chief of Staff		**motion required 8:01 – 8:16**

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) 988-7504 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
12.	*Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Quality Committee Report	Mark Adams, MD, CMO; Julie Kliger, Quality Committee Chair		**discussion 8:16 – 8:26**
13.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets; *Gov't Code Section 54957.6* for conference with labor negotiator Dan Woods: - CEO Report on New Services and Programs and Labor Negotiations	Dan Woods, CEO		**discussion 8:26 – 8:36**
14.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – CEO: - FY19 CEO Performance Review	Lanhee Chen, Board Chair		**discussion 8:36 – 8:56**
15.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: - Executive Session	Lanhee Chen, Board Chair		**discussion 8:56 – 9:01**
16.	**ADJOURN TO OPEN SESSION**	Lanhee Chen, Board Chair		**motion required 9:01 – 9:02**
17.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Lanhee Chen, Board Chair		**9:02 – 9:03**
18.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Hospital Board Meeting (6/12/2019) b. Pathways Home Health and Hospice FY20 Budget (June – October) ***Reviewed and Recommended for Approval by the Finance Committee*** c. Cardiothoracic Surgery Panel (MV) d. Physician Income Guarantee Recruitment Loan, Colorectal Surgeon e. FY19 Period 11 Financials f. Medical Staff Development Plan g. Radiation Oncology Equipment Replacement h. Emergency Department Remodel Project ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** i. Quality Committee Member Appointments ***Reviewed and Recommended for Approval by the Medical Executive Committee*** j. Medical Staff Report k. Proposed Revised Medical Staff Bylaws ***Information***	Lanhee Chen, Board Chair	*public comment*	**motion required 9:03 – 9:06**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	l. Finance Committee Approvals m. Major Projects Update			
19.	**CEO REPORT** **ATTACHMENT 19**	Dan Woods, CEO		**information** **9:06 – 9:08**
20.	**BOARD COMMENTS**	Lanhee Chen, Board Chair		**information** **9:08 – 9:10**
21.	**ADJOURNMENT**	Lanhee Chen, Board Chair	*public comment*	**motion required** **9:10pm**

Upcoming Meetings:

Regular Meetings: September 11, 2019; October 10, 2019; November 6, 2019; December 11, 2019; February 12, 2020; March 11, 2020; April 15, 2020; May 13, 2020; May 26, 2020*; June 10, 2020

*Joint Meeting with Finance Committee

Education Sessions: October 23, 2019; April 22, 2020

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Julie Kliger, RN, Quality Committee Chair
Mark Adams, MD, CMO
Date: August 21, 2019
Subject: Quality, Patient Care and Patient Experience Committee Report

Purpose:

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

Summary:

1. Four Quality Committee candidates are being recommended to the Board. Three of the four candidates were able to join the August 5th session; one was unable to attend because of prior commitments. Caroline Currie, Alyson Falwell, and Krutica Sharma, MD were able to attend in person and meet the Committee members. After a question and answer session with the candidates, the Committee approved a motion to recommend these candidates plus Terrigal Burn, MD to the Board for approval. The Board will have an opportunity to approve these appointments in the consent calendar.

2. The August edition of the FY19 Organizational Goal and Quality Dashboard was reviewed. All metrics are stable or improving except for C.Diff. Preventive measures were discussed which include rigorous adherence to hand hygiene, C.Diff surveillance especially with nursing home admissions, and patient room disinfection. The Committee provided advice regarding enhancing hand hygiene compliance and asked for further information in an upcoming session.

3. The proposed enterprise FY20 quality and safety dashboard metrics were reviewed. New measures include HCAHPS discharge instructions, Surgical Site Infections (SSI), Classification of Serious Safety Events (SSE), PC-01 Elective deliveries prior to 39 weeks, ED throughput (Door to Admit), and NTSV C-section rate. Mortality index, Readmission index, Staff responsiveness HCAHPS, CAUTI, CLABSI, C. Diff., and Sepsis index will be retained.

4. As a follow up to the last meeting, a more in depth review was provided re PSI-4, PSI-18, and PSI-19. PSI-4 is defined as "Death Rate among surgical inpatients with serious treatable complications". Based on the review of 40 cases, 50% of the "serious treatable complications" were present on admission which indicates that not all of the cases were complications of surgery but rather "failure to rescue," which is a more accurate description of this indicator. 50% of the cases were complications of surgery and will be further investigated. The El Camino PSI-4 score of 202.13 is benchmarked against a Premier database mean of 130.28 and the national AHRQ benchmark of 170.00. A vigorous discussion ensued and the Committee will look for more details on this measure in the future.

   PSI-18 is OB Trauma (defined as a 3rd or 4th degree vaginal laceration) Vaginal Delivery with Instrument and PSI-19 is OB Trauma Vaginal Delivery without Instrument. The PSI-18 score is 222.2 compared to the Premier mean of 107.1 and the PSI-19 score is 23.74 compared to a Premier mean of 15.67. The greatest contributing factor is the population race/ethnicity of our El Camino patients with roughly 60% being Asian/Pacific Islander. Multiple studies have found significantly higher rates of OB trauma in that population. There are a number of interventions being implemented to address this challenge including reducing instrumentation, changing the method of episiotomy, and providing individual feedback to the obstetricians with education.

5. In response to a previous Committee inquiry, ED demographic data was provided to the Committee for review.

6. An overview of national best practice guidelines and principles for health system Board Quality Committees roles and responsibilities was provided for discussion. The principles include: 1) focus on governance, not operations; 2) accountability for quality/safety that mimics that of the Finance Committee; 3) oversight the integrity and reliability of the credentialing process; and 4) maintenance of a culture of openness and transparency. The discussion included an example of an ideal Quality Committee agenda and what information should be reported to the Board by the Quality Committee.

List of Attachments:

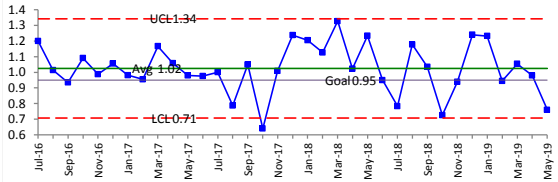
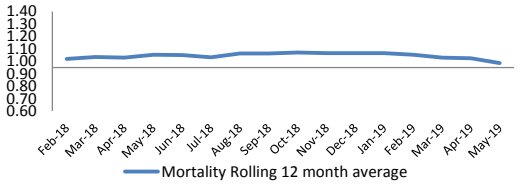
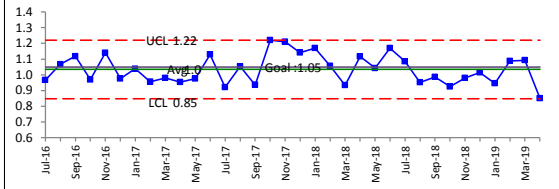
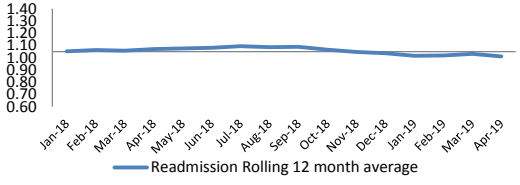
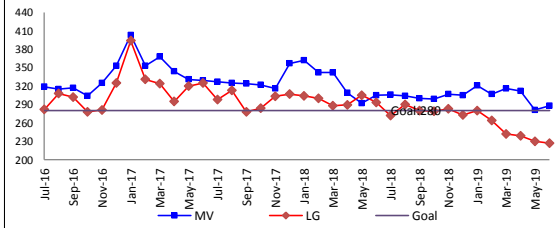
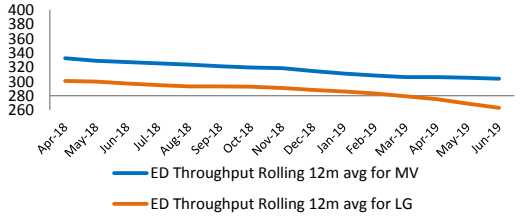
1. Quality and Experience Organizational Goals Dashboard

El Camino Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: August, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
Quality		**Month**	**FYTD**				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: May 2019*	0.76 (1.21%/1.58%)	1.00 (1.60%/1.61%)	1.06	0.95		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: April 2019*	0.85 (6.76%/7.95%)	0.99 (7.58%/7.64%)	1.08	1.05		
3	* Organizational Goal **Patient Throughput- Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients and Newborns)* *Date Period: June 2019*	MV: 288 mins LG: 227 mins	MV: 304 mins LG: 249 mins	(Q4 2017 to Q3 2018) MV: 336 mins LG: 302 mins	280 mins		

Definitions and Additional Information

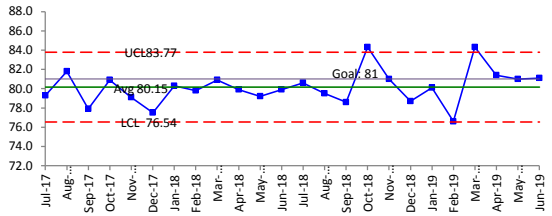
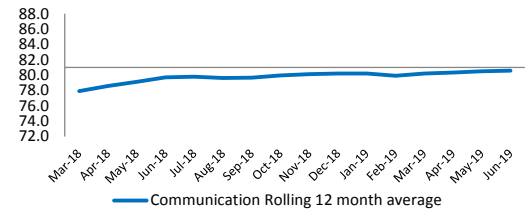
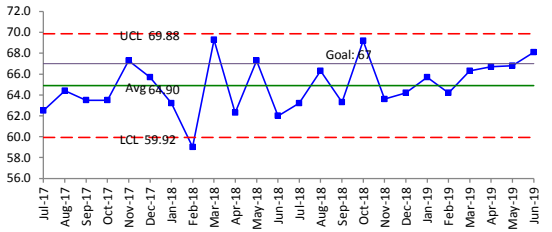
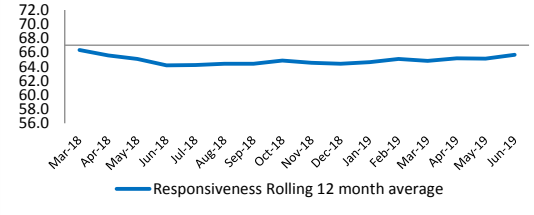
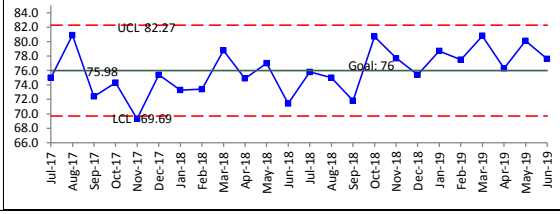
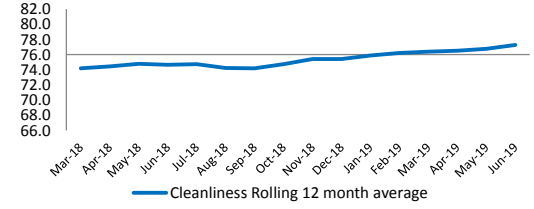
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Mortality Index is just above the expected value and increased slightly over February.	Catherine Carson			Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Readmission Index (All Patient All Cause Readmit) Observed/Expected	Readmission Index also increased in February. Weekly Readmission Review team found 67 Readmissions in February, with several due to UTI, medication side effects, and post-procedure infections. 10.5 % of these readmissions were sent for medical staff peer review due to complications.	Catherine Carson			Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Patient Throughput- Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients and Newborns)	In Mountain View, the Capacity Management Center continues to help support throughput and identify barriers. 3CW (MCH overflow) has been opened as a med/surg unit during certain times as well when there has been a need for telemetry or med/surg overflow. The ED providers continue to have focus on the initial work up time. There has been improvement in discharge by noon which helps to create capacity for admits from the ED. In Los Gatos, the team continues to review barriers and partner with providers to understand when delays occur. The Relay Robot has been put into use to support transport of specimens to the lab to reduce variation in turn-around times. The ED RNs hand-off transfer of care in one call to the floor RNs. Floor RNs also proactively attempt to call the ED to get report.	Cheryl Reinking, Michelle Gabriel; Heather Freeman			Arrival to Head in Bed. This metric is the median arrival to patient admitted time in the unit. It excludes psychiatric patients and newborns. This metric includes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery patients who arrive via the ED.	**iCare Report: ECH ED Arrival to Floor**

El Camino Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: August, 2019

	Service	FY19 Performance Month	FY19 Performance FYTD	HCAHPS Baseline Q4 2017 - Q3 2018	FY19 Target	Trend	Rolling 12 Months Average
4	* Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: June 2019*	81.1 (191/236)	80.6 (2490/3091)	80.0	81.0		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: June 2019*	68.1 (156/229)	65.7 (1933/2945)	65.1	67.0		
6	* Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: June 2019*	77.6 (180/232)	77.3 (2362/3056)	74.5	76.0		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	The following Nurse Communication Team projects continue: Leader Rounding, Enhanced interactions; whick include Bedside Handoff/Ppepp/Golden hour, and Care Team Coaching Appointment Process and Cards.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	The ongoing projects to address this HCAHPS domain include: Leader Rounding, Standardized Call Light Answer Process and Escalation Process, and Enhanced Interactions.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	The ongoing projects to address this HCAHPS domain include: Leader Rounding, Smile/Scan/Listen/Act which is Patient rounding for non-clinical staff, and Monthly Cleanliness Challenges.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**

El Camino Health

Summary of Financial Operations

Fiscal Year 2019 – Period 12

7/1/2018 to 06/30/2019

Financial Overview

Hospital Volume

June

- June volume as measured by Adjusted Discharges (AD) were favorable to both budget by 1.0% (32 ADs) and prior year by 8.5% (246 ADs). High inpatient volume driven service line growth initiatives in General, Gastroenterology, Pulmonary, Behavioral Health, and Spine Surgery cases. Outpatient service line growth in Endoscopy, Interventional Bronchoscopy, Cardiac Interventional, and Imaging (CT Scan).

Year to Date

- Year to Date Adjusted Discharges were unfavorable to budget by 0.7% (267 ADs) mostly due to the delay start of the LG infusion program. Excluding the LG infusion, we are off by .13% (46 ADs) YTD. Growth from prior year is 1.5% (530 ADs).
- YTD inpatient volume is below budget by 2.9% (613 cases) driven by MCH (342 cases) due to declining birth rate, Orthopedics/ Spine (253 cases) due to loss of physicians and ramp of new physicians, and HVI (146 cases) primary .
- YTD outpatient volume is below budget by 1.8% (2,752 visits) driven by LG Infusion (1,165 visits) due to delay in start of the program originally expected to begin in January. Service will begin in Q2 of FY20. Lab, and Behavioral Health visits continue to remain below budget.

Consolidated Financial Performance

June

- June Operating Margin was favorable to budget by $1.9M driven by $11 million unusual and non recurring items.

Year to Date

- YTD Operating Margin was favorable to budget by $26 million driven by $23 million in unusual non recurring items favorable revenue cycle by lowering denials and underpayments.

Hospital Payor Mix

- YTD, Commercial is 2.2 percentage points unfavorable to budget. Declining Commercial mix is linked to the decline in MCH volume and is a concern given that all other payer categories do not cover the cost of care.

Hospital Cost

- Productive FTEs were unfavorable to target by 1.3% for June but on target YTD.

Dashboard - ECH combined as of June 30, 2019

	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Hospital Volume								
Licenced Beds	443	443	443	-	443	443	443	-
ADC	227	236	257	(21)	239	242	247	(5)
Utilization MV	63%	65%	70%	-6%	66%	66%	68%	-1%
Utilization LG	28%	30%	32%	-3%	29%	30%	31%	-1%
Utilization Combined	51%	53%	58%	-5%	54%	55%	56%	-1%
Total Discharges (Excl NNB)	1,645	1,740	1,791	(51)	20,291	20,210	20,823	(613)
Consolidated Financial Perf.								
Total Operating Revenue	84,882	92,097	85,150	6,947	938,813	998,034	968,953	29,081
Operating Margin $	16,809	10,854	8,984	1,870	132,428	113,480	86,982	26,498
Operating Margin	19.8%	11.8%	10.6%	1.2%	14.1%	11.4%	9.0%	2.4%
EBIDA %	24.7%	16.8%	17.3%	-0.5%	20.0%	17.0%	15.3%	1.7%
Hospital Payor Mix								
Medicare	46.3%	49.2%	46.2%	3.0%	47.6%	49.1%	46.6%	2.5%
Medi-Cal	8.5%	7.4%	8.2%	-0.8%	7.8%	8.0%	8.0%	0.0%
Total Commercial	43.5%	40.2%	42.8%	-2.6%	42.1%	40.6%	42.8%	-2.2%
Other	1.6%	3.2%	2.8%	0.3%	2.5%	2.4%	2.7%	-0.2%
Hospital Cost								
Total FTE	2,585.2	2,752.8	2,774.4	(22)	2,578.7	2,681.7	2,709.1	(27)
Productive Hrs/APD	31.3	31.6	30.2	1	30.4	30.7	31.2	(0)
Hospital Balance Sheet								
Net Days in AR	50.7	45.6	48.0	(2)	50.7	45.6	48.0	(2.4)
Days Cash	505	500	449	51	505	500	449	51

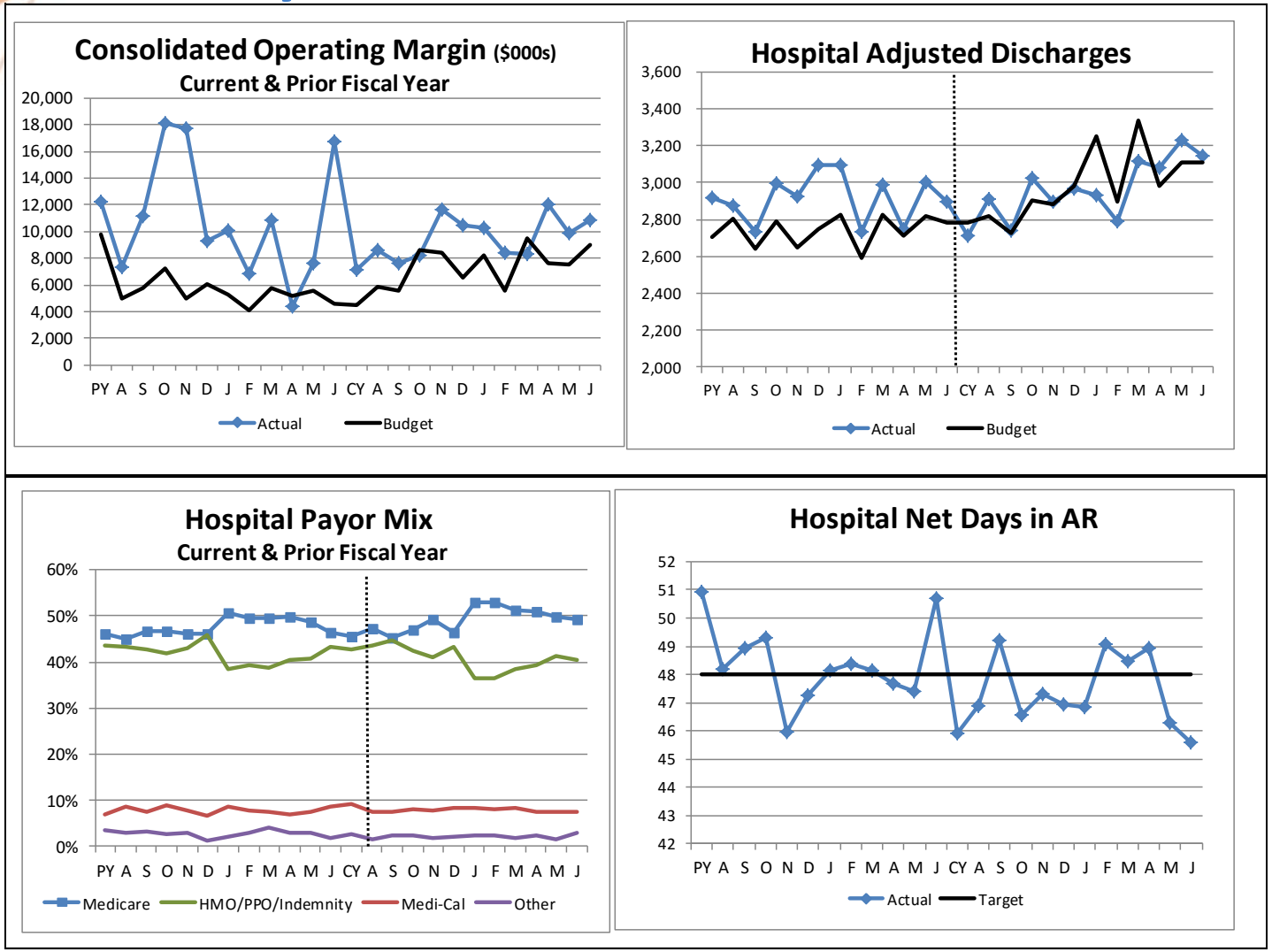
Beginning with the June FY 19 report, the Dashboard and the financial report has been updated to show the ECH consolidated results instead of just the Hospitals. The descriptions of the metrics indicate whether the data is hospital only.

Consolidated Statement of Operations ($000s)

Period ending 06/30/2019

Period 12 FY 2018	Period 12 FY 2019	Period 12 Budget 2019	Variance Fav (Unfav)	Var%	$000s	YTD FY 2018	YTD FY 2019	YTD Budget 2019	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
270,184	300,082	312,377	(12,296)	(3.9%)	**Gross Revenue**	3,298,115	3,557,853	3,570,368	(12,515)	(0.4%)
(188,734)	(214,080)	(232,216)	18,136	7.8%	**Deductions**	(2,404,362)	(2,605,594)	(2,650,863)	45,269	1.7%
81,451	**86,002**	**80,161**	**5,841**	**7.3%**	**Net Patient Revenue**	**893,753**	**952,260**	**919,505**	**32,755**	**3.6%**
3,431	6,095	4,989	1,106	22.2%	**Other Operating Revenue**	45,060	45,775	49,448	(3,674)	(7.4%)
84,882	**92,097**	**85,150**	**6,947**	**8.2%**	**Total Operating Revenue**	**938,813**	**998,034**	**968,953**	**29,081**	**3.0%**
					OPERATING EXPENSE					
33,212	41,619	43,804	2,185	5.0%	**Salaries & Wages**	472,748	514,544	516,568	2,024	0.4%
11,172	11,705	13,081	1,376	10.5%	**Supplies**	128,107	138,154	141,164	3,011	2.1%
16,224	19,254	10,794	(8,460)	(78.4%)	**Fees & Purchased Services**	120,971	140,983	130,493	(10,490)	(8.0%)
3,273	4,018	2,732	(1,286)	(47.1%)	**Other Operating Expense**	29,620	34,576	32,815	(1,761)	(5.4%)
(63)	246	1,425	1,179	82.8%	**Interest**	5,227	4,117	7,686	3,570	46.4%
4,256	4,401	4,331	(70)	(1.6%)	**Depreciation**	49,712	52,181	53,244	1,063	2.0%
68,073	**81,243**	**76,166**	**(5,076)**	**(6.7%)**	**Total Operating Expense**	**806,385**	**884,554**	**881,971**	**(2,583)**	**(0.3%)**
16,809	**10,854**	**8,984**	**1,870**	**20.8%**	**Net Operating Margin**	**132,428**	**113,480**	**86,982**	**26,498**	**30.5%**
4,233	8,162	2,067	6,095	294.9%	**Non Operating Income**	64,664	38,170	25,484	12,687	49.8%
21,042	**19,016**	**11,051**	**7,965**	**72.1%**	**Net Margin**	**197,092**	**151,650**	**112,466**	**39,184**	**34.8%**
24.7%	16.8%	17.3%	(0.5%)		**EBITDA**	20.0%	17.0%	15.3%	1.7%	
19.8%	11.8%	10.6%	1.2%		**Operating Margin**	14.1%	11.4%	9.0%	2.4%	
24.8%	20.6%	13.0%	7.7%		**Net Margin**	21.0%	15.2%	11.6%	3.6%	

Monthly Financial Trends



- Volume trend is positive the last quarter
- Operating Margin in June includes $12 million in unusual items
- Adverse trend in Payor mix with a decline in Commercial mix due mainly to drop in MCH volume
- Revenue cycle operation consistently better than targets and show a favorable trend

El Camino Hospital Investment Committee Scorecard

June 30, 2019

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY19 Year End Budget	Expectation Per Asset Allocation
Investment Performance		2Q 2019		Fiscal Year-to-date		6y 8m Since Inception (annualized)			2019
Surplus cash balance*		$1,028.7	--	--	--	--	--	$892.9	--
Surplus cash return		2.9%	2.8%	5.4%	5.7%	5.6%	5.5%	3.2%	5.6%
Cash balance plan balance (millions)		$277.6	--	--	--	--	--	$276.9	--
Cash balance plan return		3.1%	3.0%	6.0%	5.9%	7.8%	7.0%	6.0%	6.0%
403(b) plan balance (millions)		$514.1	--	--	--	--	--	--	--
Risk vs. Return		3-year				6y 8m Since Inception (annualized)			2019
Surplus cash Sharpe ratio		1.06	1.04	--	--	1.02	1.01	--	0.34
Net of fee return		7.2%	6.8%	--	--	5.6%	5.5%	--	5.6%
Standard deviation		5.4%	5.2%	--	--	4.9%	4.8%	--	8.7%
Cash balance Sharpe ratio		1.09	1.03	--	--	1.12	1.06	--	0.32
Net of fee return		8.8%	7.8%	--	--	7.8%	7.0%	--	6.0%
Standard deviation		6.7%	6.2%	--	--	6.3%	6.0%	--	10.3%
Asset Allocation		2Q 2019							
Surplus cash absolute variances to target		7.1%	< 10%	--	--	--	--	--	--
Cash balance absolute variances to target		6.9%	< 10%	--	--	--	--	--	--
Manager Compliance		2Q 2019							
Surplus cash manager flags		17	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		23	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$83 mm), District assets (~$41 mm), and balance sheet cash not in investable portfolio (~$128 mm). Includes Foundation (~$31 mm) and Concern (~$14 mm) assets. Budget adds back in current Foundation and Concern assets and backs out current debt reserve funds.

Hospital Balance Sheet

(in thousands)

	ASSETS		Audited
	CURRENT ASSETS	**June 30, 2019**	**June 30, 2018**
	Cash	117,697	118,992
	Short Term Investments	148,233	150,664
	Patient Accounts Receivable, net	128,589	124,427
	Other Accounts and Notes Receivable	3,230	3,402
	Intercompany Receivables	6,023	2,090
(1)	Inventories and Prepaids	63,708	75,594
	Total Current Assets	**467,481**	**475,171**
	BOARD DESIGNATED ASSETS		
	Plant & Equipment Fund	170,096	153,784
(2)	Women's Hospital Expansion	15,472	9,298
(3)	Operational Reserve Fund	139,057	127,908
	Community Benefit Fund	18,259	18,675
	Workers Compensation Reserve Fund	20,732	20,263
	Postretirement Health/Life Reserve Fund	29,812	29,212
	PTO Liability Fund	27,145	24,532
	Malpractice Reserve Fund	1,831	1,831
	Catastrophic Reserves Fund	19,678	18,322
	Total Board Designated Assets	**442,082**	**403,826**
(4)	**FUNDS HELD BY TRUSTEE**	**83,073**	**197,620**
	LONG TERM INVESTMENTS	**367,272**	**345,684**
	INVESTMENTS IN AFFILIATES	**44,217**	**32,412**
	PROPERTY AND EQUIPMENT		
	Fixed Assets at Cost	1,306,570	1,261,854
	Less: Accumulated Depreciation	(620,761)	(577,959)
	Construction in Progress	379,318	220,991
	Property, Plant & Equipment - Net	**1,065,127**	**904,886**
	DEFERRED OUTFLOWS	29,754	21,177
	RESTRICTED ASSETS - CASH	-	0
	TOTAL ASSETS	**2,499,006**	**2,380,776**

	LIABILITIES AND FUND BALANCE		Audited
	CURRENT LIABILITIES	**June 30, 2019**	**June 30, 2018**
(5)	Accounts Payable	38,194	49,925
	Salaries and Related Liabilities	30,185	26,727
	Accrued PTO	27,145	24,532
	Worker's Comp Reserve	2,300	2,300
	Third Party Settlements	12,526	10,068
	Intercompany Payables	1,002	125
	Malpractice Reserves	1,800	1,831
(6)	Bonds Payable - Current	8,630	3,850
(7)	Bond Interest Payable	9,201	12,975
	Other Liabilities	7,491	8,909
	Total Current Liabilities	**138,473**	**141,242**
	LONG TERM LIABILITIES		
	Post Retirement Benefits	29,812	29,212
	Worker's Comp Reserve	18,432	17,963
	Other L/T Obligation (Asbestos)	3,975	3,859
	Other L/T Liabilities (IT/Medl Leases)	-	-
(8)	Bond Payable	511,106	517,781
	Total Long Term Liabilities	**563,325**	**568,815**
	DEFERRED REVENUE-UNRESTRICTED	494	528
	DEFERRED INFLOW OF RESOURCES	10,006	22,835
	FUND BALANCE/CAPITAL ACCOUNTS		
	Unrestricted	1,344,626	1,243,529
	Board Designated	442,082	403,825
	Restricted	-	0
(9)	**Total Fund Bal & Capital Accts**	**1,786,708**	**1,647,355**
	TOTAL LIABILITIES AND FUND BALANCE	**2,499,006**	**2,380,776**

El Camino Health

June 2019 El Camino Hospital Comparative Balance Sheet Variances and Footnotes

(1) The decrease is primarily due to the annual actuarially determined Cash Balance GASB 68 calculation recorded at the end of each fiscal year, which in this instance was based on the calendar year 2018 market performance. As 2018 experienced poor investment returns, our Prepaid Pension Asset dropped in value by approximately $15M to a current calculation of $41M.

(2) The increase is due to the District making a transfer from its Capital Appropriation Fund in support of the upcoming renovation to the Women's Hospital.

(3) The increase is due to annual resetting of the 60 day Operational Reserve based on the new FY2019 budget that has started.

(4) Decrease is due to draws from the 2015A/2017 Bond Project funds for the on-going IMOB and BHS construction and semi-annual 2015/2017 bond payment

(5) Decrease is due to the yearend accruals that were paid out in July and August 2018.

(6) The increase is due to recognition of the first 2017 principal bond payment that will be in February 2020.

(7) Semi-annual bond payments of interest and principal were made on the 2015A and 2017 Bonds in February.

(8) Decrease is due to the establishment of FY2020 2015A and 2017 Bond Principal Payable moving to current bond payables.

(9) Increase in total Fund Balance is driven by y-t-d net income and that Capital Appropriate Fund transfer by District, discussed in item #2 above.

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (1 OF 2)

- **Plant & Equipment Fund –** original established by the District Board in the early 1960's to fund new capital expansion projects of building facilities or equipment (new or replacements). The funds came from the M&O property taxes being received and the funding depreciation expense at 100%. When at the end of 1992, the 501(c)(3) Hospital was performed by the District, the property tax receipts remained with the District. The newly formed Hospital entity continued on with funding depreciation expense, but did that funding at 130% of the depreciation expense to account for an expected replacement cost of current plant and property assets. It is to be noted that within this fund is an itemized amount of $14 million for the Behavioral Health Service building replacement project. This amount came from the District's Capital Appropriation Fund (excess Gann Limit property taxes) of the fiscal years of 2010 thru 2013 by various District board actions.

- **Women's Hospital Expansion –** established June 2016 by the District authorizing the amounts accumulated in its Capital Appropriation Fund (excess Gann Limit property taxes) for the fiscal years of 2014 and 2015 to be allocated for the renovation of the Women's Hospital upon the completion of Integrated Medical Office Building currently under construction. At the end of fiscal year 2018 another #6.2 million was added to this fund.

- **Operational Reserve Fund –** originally established by the District in May 1992 to establish a fund equal to sixty (60) days of operational expenses (based on the current projected budget) and only be used in the event of a major business interruption event and/or cash flow.

- **Community Benefit Fund –** following in the footsteps of the District in 2008 of forming its Community Benefit Fund using Gann Limit tax receipts, the Hospital in 2010 after opening its campus outside of District boundaries in Los Gatos formed its own Community Benefit Fund to provide grants/sponsorships in Los Gatos and surrounding areas. The funds come from the Hospital reserving $1.5M a year from its operations, the entity of CONCERN contributing 40% of its annual income each year (an amount it would have paid in corporate taxes if it wasn't granted tax exempt status), that generates an amount of $500,000 or more a year. $15 million within this fund is a board designated endowment fund formed in 2015 with a $10 million contribution, and added to at the end of the 2017 fiscal year end with another $5 million contribution, to generate investment income to be used for grants and sponsorships, in fiscal year it generated over $1.1 million of investment income for the program.

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (2 OF 2)

- **Workers Compensation Reserve Fund** – as the Hospital is self-insured for its workers compensation program (since 1978) this fund was originally formed in early 2000's by management to reserve cash equal to the yearly actuarially determined Workers Compensation amount. The thought being if the business was to terminate for some reason this is the amount in cash that would be needed to pay out claims over the next few years.

- **Postretirement Health/Life Reserve Fund –** following the same formula as the Workers Compensation Reserve Fund this fund was formed in the early 2000's by management to reserve cash equal to the yearly actuarially determined amount to fund the Hospital's postretirement health and life insurance program. Note this program was frozen in 1995 for all new hires after that date. At the end of fiscal year 2018, GASB #75 was implemented that now represents the full actuarially determined liability.

- **PTO (Paid Time Off) Liability Fund –** originally formed in 1993 as the new 501(c)(3) Hospital began operations, management thought as a business requirement of this vested benefit program that monies should be set aside to extinguish this employee liability should such a circumstance arise. This balance is equal to the PTO Liability on the Balance Sheet.

- **Malpractice Reserve Fund –** originally established in 1989 by the then District's Finance Committee and continued by the Hospital. The amount is actuarially determined each year as part of the annual audit to fund potential claims less than $50,000. Above $50,000 our policy with the BETA Healthcare Group kicks in to a $30 million limit per claim/$40 million in the aggregate.

- **Catastrophic Loss Fund –** was established in 1999 by the Hospital Board to be a "self-insurance" reserve fund for potential non-major earthquake repairs. Initially funded by the District transferring $5 million and has been added to by the last major payment from FEMA for the damage caused the Hospital by the October 1989 earthquake. It is to be noted that it took 10 years to receive final settlement from FEMA grants that totaled $6.8 million that did mostly cover all the necessary repairs.

El Camino Health

2019 Board Self-Assessment Report

Prepared by

Via Healthcare Consulting

Table of Contents

Introduction and Executive Summary

In the interest of enhancing its governance effectiveness, members of the El Camino Health (ECH) Board of Directors participated in a board self-assessment process in the summer of 2019. Erica Osborne, Principal at Via Healthcare Consulting, provided the consulting and analysis for this effort. This report provides a high-level summary of the issues that were raised during the process and includes a set of recommendations for board consideration.

Governance best practices call for boards to evaluate their performance regularly and adopt improvements to function better. This type of governance assessment can help a board ensure that governance structures, composition, policies and practices provide a platform for thorough oversight and deliberation, effective policy making, efficient decision making, and strong ties with and accountability to the community and external regulators. In today's rapidly changing marketplace, effective and efficient governance has never been more important to organizational performance.

Executive Summary

Overall, most ECH Board members believe the board continues to make progress. Members come to meetings reasonably well prepared and have done a better job maintaining a strategic focus over the past year. Board meetings are more efficient and most members appreciate the board chair's efforts to manage meeting agendas and keep the board on track. Individuals exhibit a high level of dedication and commitment and the addition of new board members has provided additional diversity and a better mixture of expertise. The survey results also indicate the board believes it has a good working relationship with the CEO and comments made during the interviews indicate that most are pleased with the work being done around organizational strategy.

The assessment also identified several opportunities for improvement. Members would like to better understand their responsibilities in the area of quality oversight and would benefit from additional discussions and education in this area. There is a desire to revisit meeting frequency, continue to streamline materials and increase the amount of discussion time during the board meetings. In addition, while most members agree that collegiality amongst board members has improved, several feel that additional sessions held outside the typical board meeting structure would allow board members to get to know one another better and come together as a more cohesive team.

We are pleased to present these results and look forward to discussing the findings with board members at the August 21, 2019 board meeting. It is important to note that this assessment process was designed to gauge the effectiveness and efficiency of the board as a whole, not of the individual board members. In addition, it was focused on the governance of the organization, not its management or operations.

Overview of the Process

This year's board self-assessment process consisted of two phases. The first phase involved the administration of a customized questionnaire to board members via the SurveyMonkey online survey tool. Board members were asked to rate their level of agreement on a scale of 1-5 – from strongly agree to strongly disagree – to 40 statements across six areas of board responsibility. Each section also invited open-ended responses. Eight out of nine ECH Board members responded.

The second phase of the assessment process included confidential telephone interviews with eight board members and six ECH executive team members. The interviews provided an opportunity to probe for greater clarity on the board's current state and solicit suggestions for improvement.

The six areas of Board responsibility covered by the survey were:

- Mission and Planning Oversight: Setting Strategic Direction
- Quality Oversight: Monitoring Performance Improvement
- Management Oversight: Enhancing Board-Executive Relations
- Legal and Regulatory Oversight: Ensuring Organizational Integrity
- Finance and Audit Oversight: Following the Money

Recommendations

Consultant's Recommendations

Based on the results of the 2019 ECH Board Self-Assessment Process and our extensive experience in the area of governance effectiveness, Via Healthcare Consulting offers the following recommendations for the ECH Board's consideration:

Quality Oversight

1. Consider adopting an actionable approach to providing effective quality oversight at ECH:
    - Review and discuss available approaches to quality oversight. Frameworks to consider might include IHI Framework for Governance of Health System Quality, AHRQ High Reliability Organizations, and LEAN Six Sigma among others.
    - Identify and incorporate aspects from the different frameworks to create a customized approach to quality oversight at ECH.
2. Hold an educational meeting or series of meetings focused on quality oversight. The purpose would be to provide additional education on the board's role in quality oversight including information on quality goals, indicators and how to interpret data. It would also provide an opportunity to discuss how ECH defines quality and what the organization's approach should be.

Meeting Effectiveness

3. Redesign meeting agendas, reducing the number of agenda items and increasing the time devoted to strategic discussions.
4. Restructure board meeting presentations to improve focus and promote dialogue.
5. Revisit meeting frequency to determine whether current schedule is optimal and adds value.
6. Implement board meeting evaluations to assess quality of materials, meeting mechanics and effectiveness of the meetings.

Ongoing Governance Education

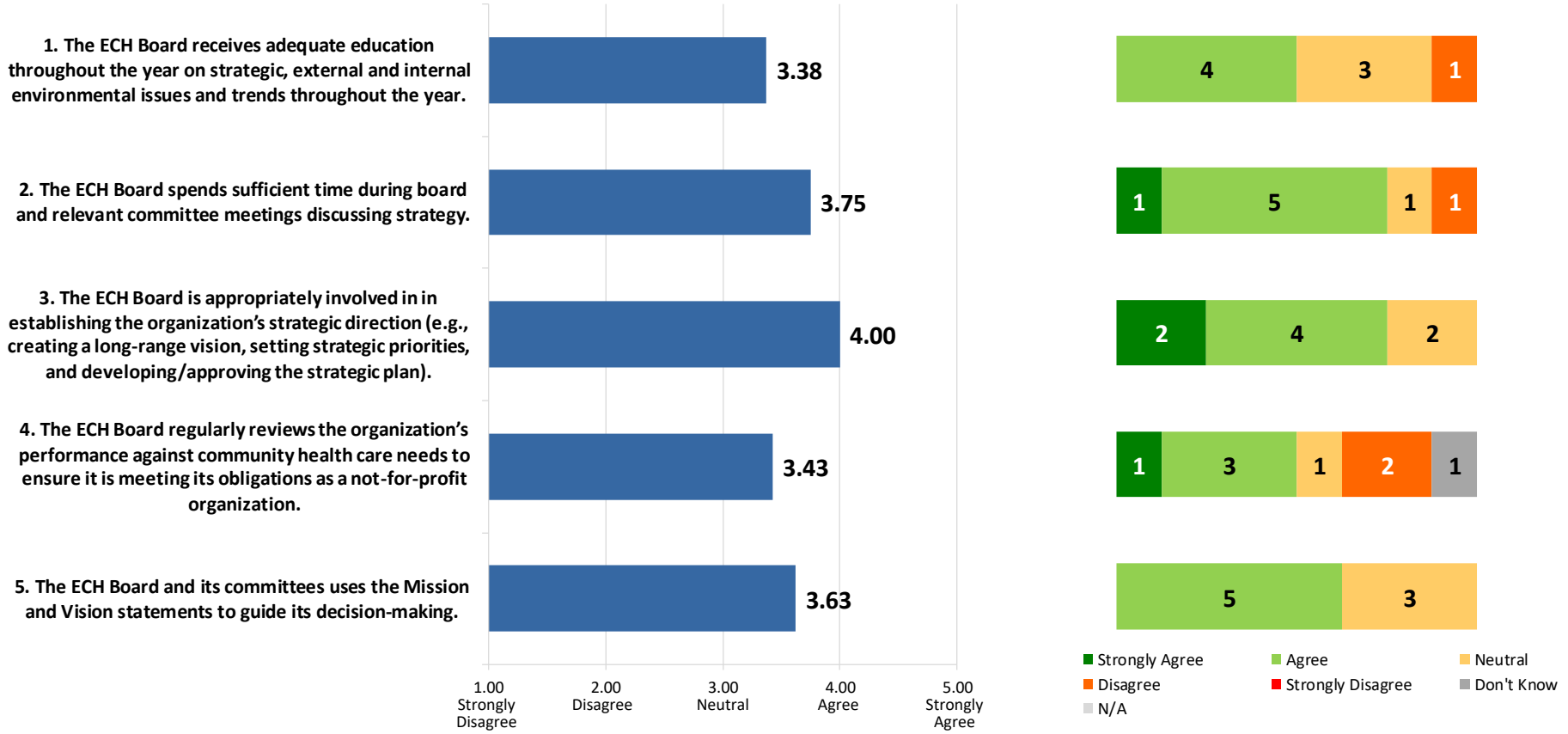
7. Increase opportunities for cross-committee meetings and encourage greater board and committee member participation.
8. Develop an intentional, multi-year strategy for ongoing board education. The intent would be to identify topics and modalities that would enhance the governance competencies and engagement of the ECH Hospital Board.

Board Culture

9. Convene board members outside the typical board meeting structure to facilitate greater cohesiveness and teamwork. This could include single agenda item meetings, philosophy sessions, strategic retreats that provide ample discussion time.

Board Self-Assessment Survey Results

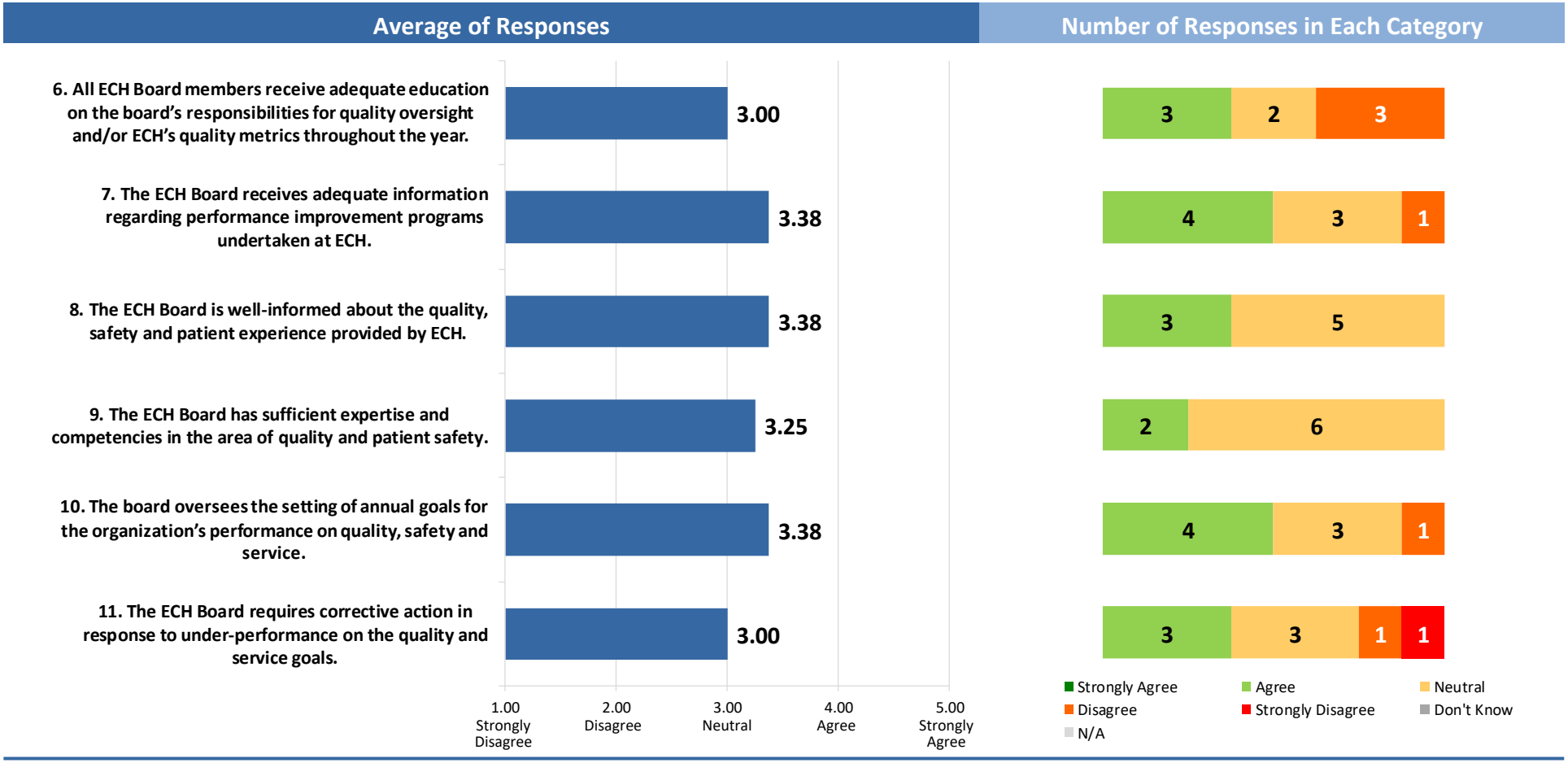
Mission and Planning Oversight: Setting Strategic Direction



Summary of Comments for Mission and Planning Oversight:

- The board has done much about education/discussion of the Board strategies. The CEO is doing a great job.
- The training we've had to date is limited. Trainers/consultants brought in to-date seem a bit 'junior' in knowledge and training skills.
- We have gotten much better in using meeting time for strategic and generative discussions. The board packets have become more focused and more pitched to the issues of governance. There is still considerable room to reduce the pure reporting part of the board packages and to help executives focus their presentations on board level issues and decisions.
- We still get bogged down in operational discussion and questions at the one foot level in discussion.
- #4—Not clear on what the definition of "regularly" is. We review health care needs as part of the tri-annual analysis. I am not sure if community need changes more frequently or if there is more regular data for us to review more often. Similarly, we get semi-annual performance reports. I believe that is sufficiently regular.
- #5 - The Mission and Vision statements were not referred to in recent decisions.
- There is insufficient interest, knowledge, and urgency on the board to discuss/evaluate the community health care needs/obligation. Rather, it is relying on the Community Benefit Advisory committee to do so, and it itself is largely staff driven. There is very little Board input and interaction.

Quality Oversight: Monitoring Performance Improvement

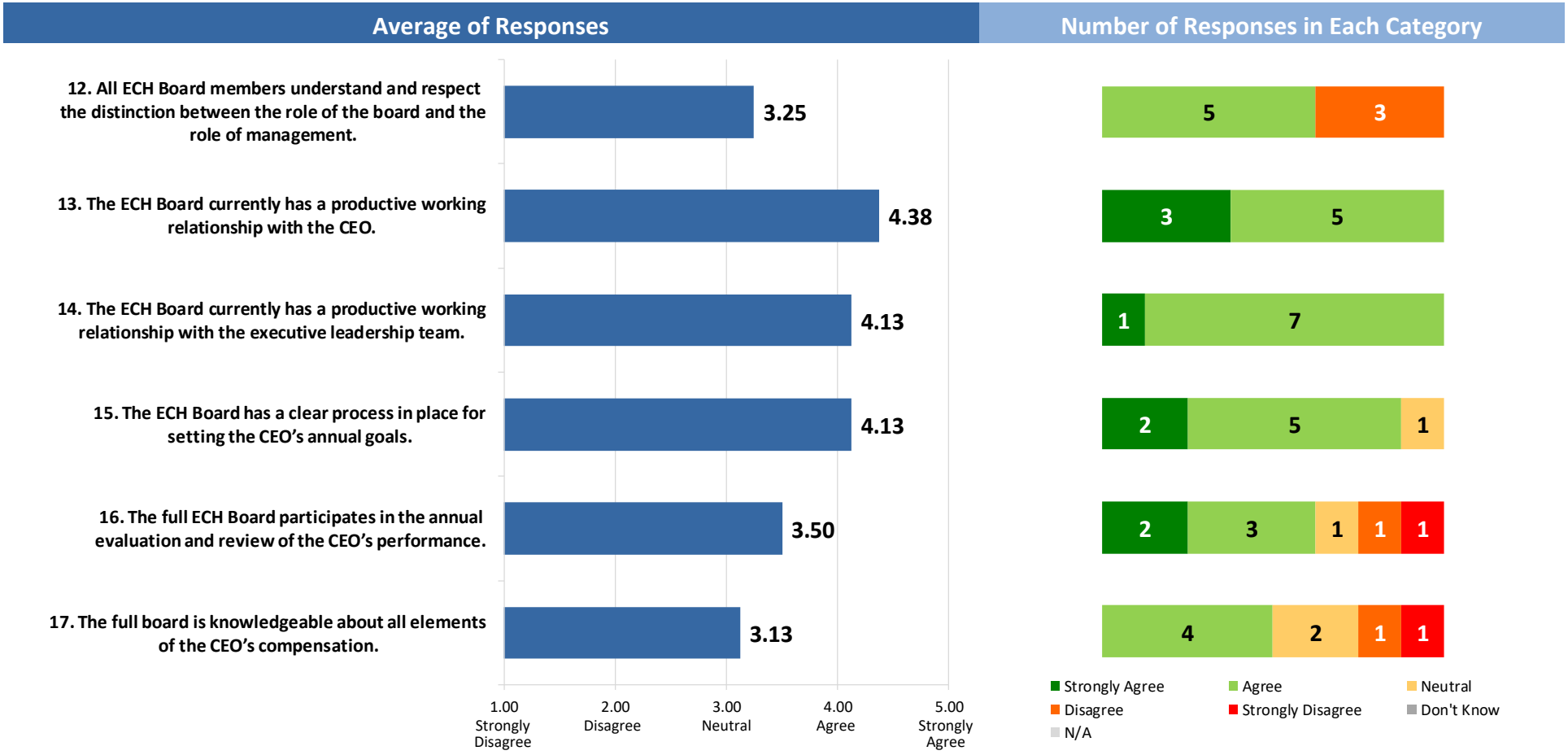


Summary of Comments for Quality Oversight:

- Some members are more knowledgeable than others regarding overall quality, safety and patient experience. Those on the Quality "Committee are familiar with them.
- Quality improvement methods are not well understood by the board. For example, most board members don't understand how to read a "run chart" which is how the metrics are presented.
- Quality" measurements are illusive for some. The CMO has his own view and the Chair of Quality has hers. Both have broad experience. It is sometimes hard to tell where goal setting is serving the patient or the staff (doctors). On this basis, the board can not be as effective as it should.
- Several members indicated that the quality reporting is inadequate and appears haphazard. One member stated they would have a difficult time stating what ECH's strategy is to improve the quality of the care we deliver.
- The staff is working hard and emphasizing areas of underperformance. Corrective actions are not necessary. Understanding, endorsement, and appreciation from the Board are better suited to enhance this effort.

- The quality subcommittee is undergoing considerable turnover. Our metrics are geared toward inpatient quality which is not sufficient as we grow our outpatient capabilities.
- May want to consider adding more technical/ subject matter expertise to the Quality Committee and providing more expert technical training.
- It is tough to balance the board's involvement with quality committee. While there is confidence in the Committee Chair's leadership, one member stated they have less confidence in this committee than in others.
- There is concern that all clinical (doctors/nurses) board members are on the committee and it was suggested that there may be a need for some balance from board members that have different/broader perspectives.
- When board has pushed on under-performance on quality goals, they have received defensive responses from management and the quality committee - the latter is concerning as it could imply the committee is being "captured" by executive team and not able to provide appropriate oversight.
- #8 - Not sure the quality/safety etc. is fully covered by current reports or in minutes, especially medical staff views on events.
- #9 - Can board members describe the safety program?
- # 10 - Haven't seen the board as a whole participate in setting annual organizational performance goals on quality, safety and service yet.
- Depends on how we define oversight. Goals appear to be given to board by quality committee vs. through active board discussion.

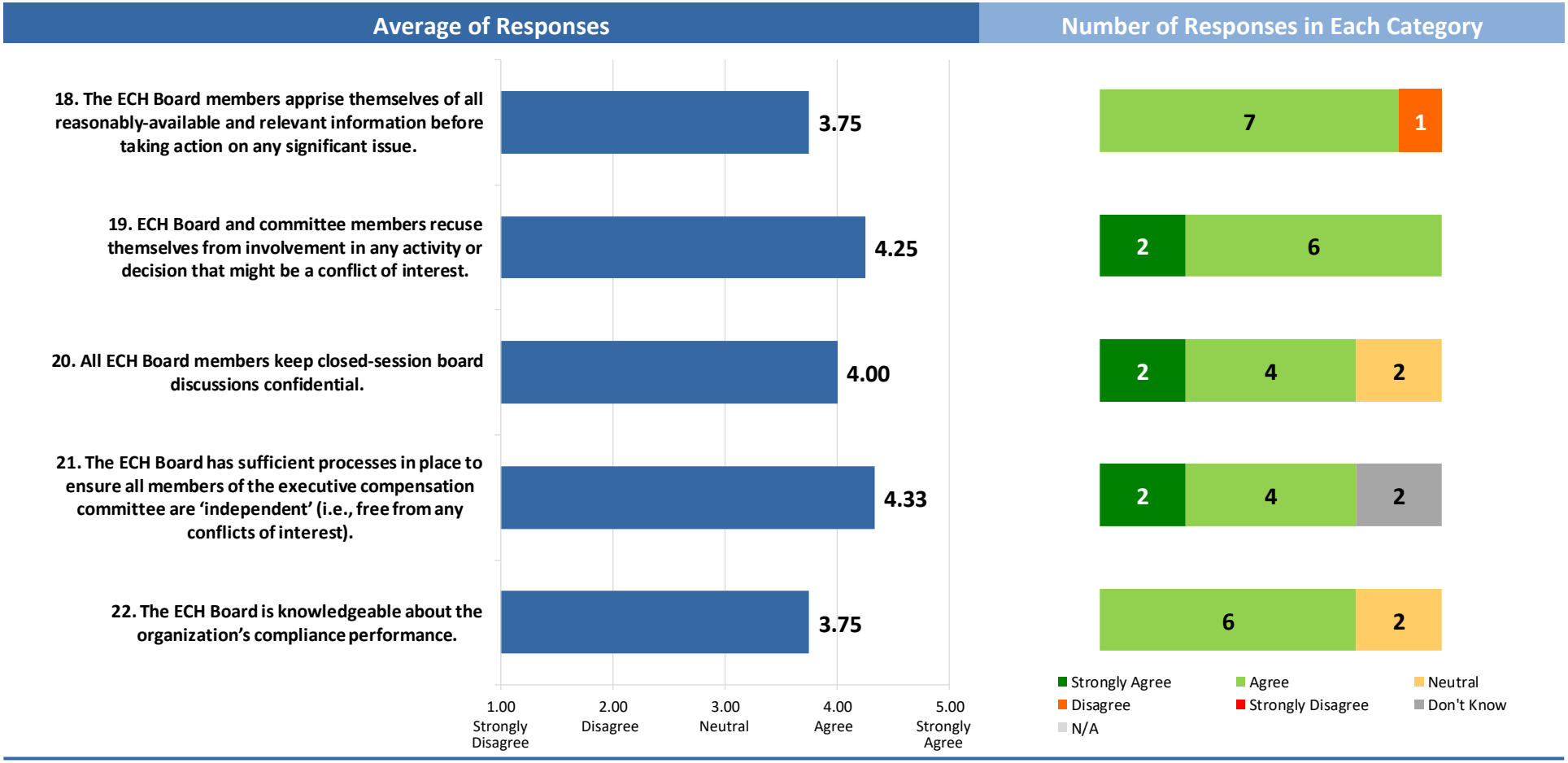
Management Oversight: Enhancing Board-Executive Relations



Summary of Comments for Management Oversight:

- We have made great progress as a board in understanding the different roles of management and board. However, there is much more work to do here. Board members at times receive management level reports rather than reports focused on board level issues and decisions. Executives are still learning how to pitch their presentations to the appropriate level. Under pressure, board members still seek to engage in issues best left to management to address.
- #12: This is impossible as all board members have different points of view and the requirements will vary based on circumstances (e.g., areas of underperformance may be require more board (any board) involvement).
- There is a great and close relationship of the board with the administrative staff. Board members are doing their best to govern and not to micromanage.
- Some board members are crossing over the management line, probing into operational details. This could be perceived as a lack of trust by the management team.
- The full board does not participate in review of the CEO's performance.
- Board may not know the full details of benefits for CEO but should we? Board does understand the broad brush of compensation parameters.

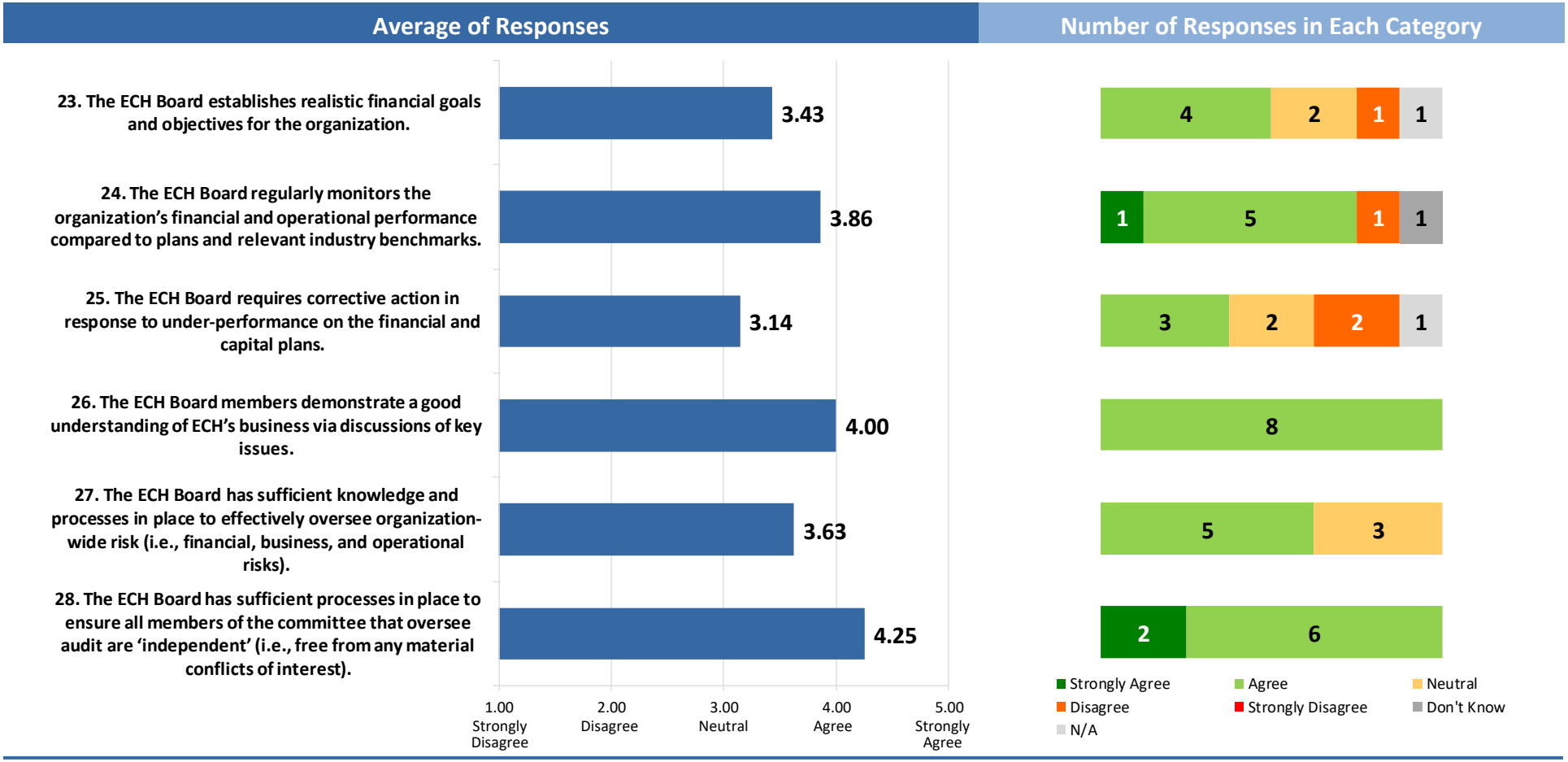
Legal and Regulatory Oversight: Ensuring Organizational Integrity



Summary of Comments for Legal and Regulatory Oversight:

- #18: This sometimes requires extra sessions with executive team to provide necessary analysis/background for major initiatives.
- Some board members, while better, share/imply results of closed session discussions even in open session.
- #22: I would say board members that are not on the Compliance Committee are "aware" vs knowledgeable regarding ECH's compliance performance — again that might be fine.
- Compliance in my view is too much geared toward process and "CYA" work and not enough toward raising substantive issues with accompanying strategic context. Compliance activity is ongoing and seems to comport with industry standards. But too often we receive reports on activities rather than reports of what the findings really mean.

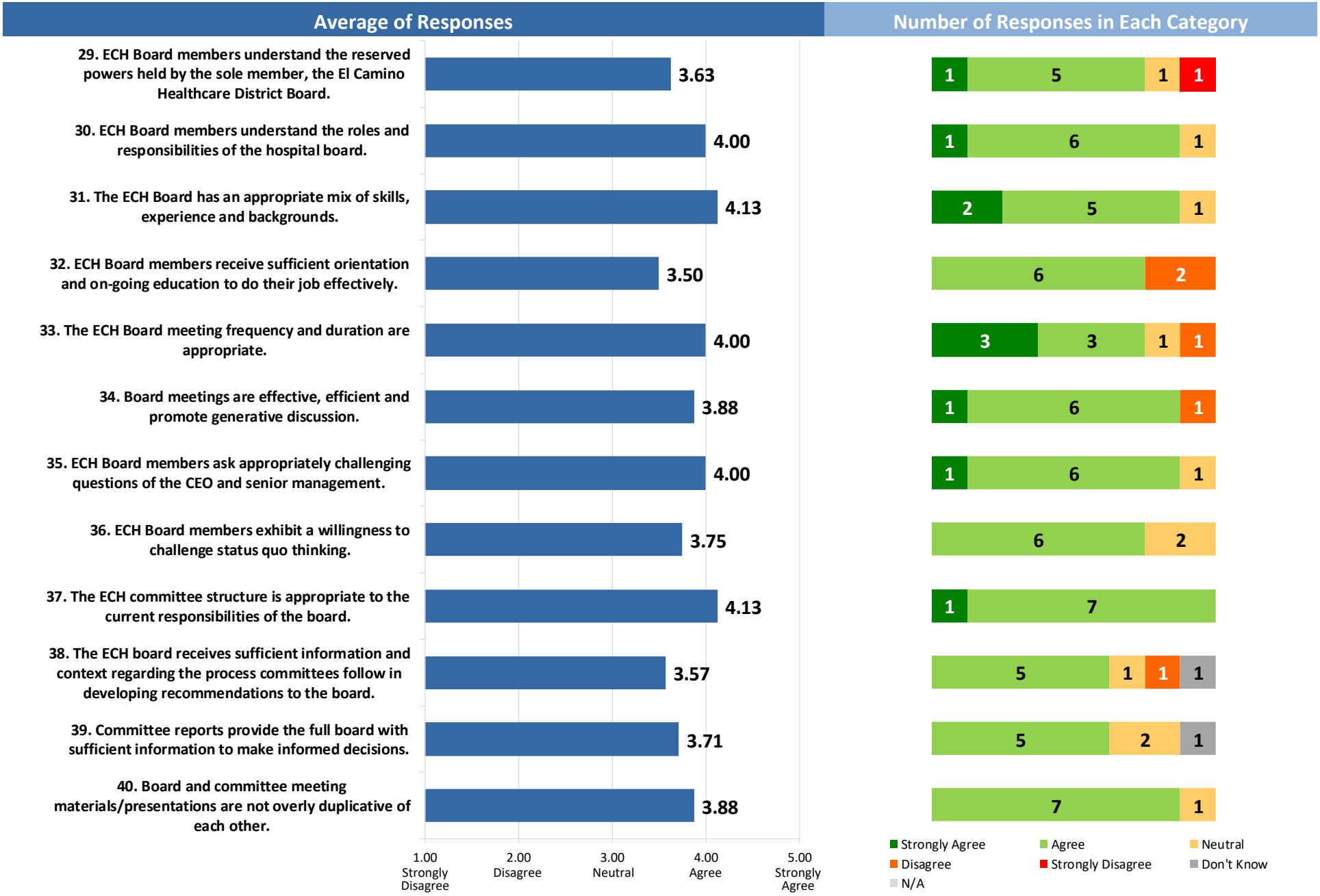
Finance and Audit Oversight: Following the Money



Summary of Comments for Finance and Audit Oversight:

- #24: Have not experienced the board regularly monitoring ECH's financial and operational performance compared to plans and industry benchmarks.
- Data demonstrates history of sandbagging operating and capital budgets. Capital budgets have never been hit, but processes have not changed. Improved access to benchmarks is tough in this industry - believe the importance of credit rating metrics are over stated.
- There is a need for greater "corrective action" on plans not met.
- The understanding of the financial matters varies amongst board members. The addition of two new members would improve our performance in these areas.
- The board does not spend enough time on the enterprise risk management work from Compliance Committee.

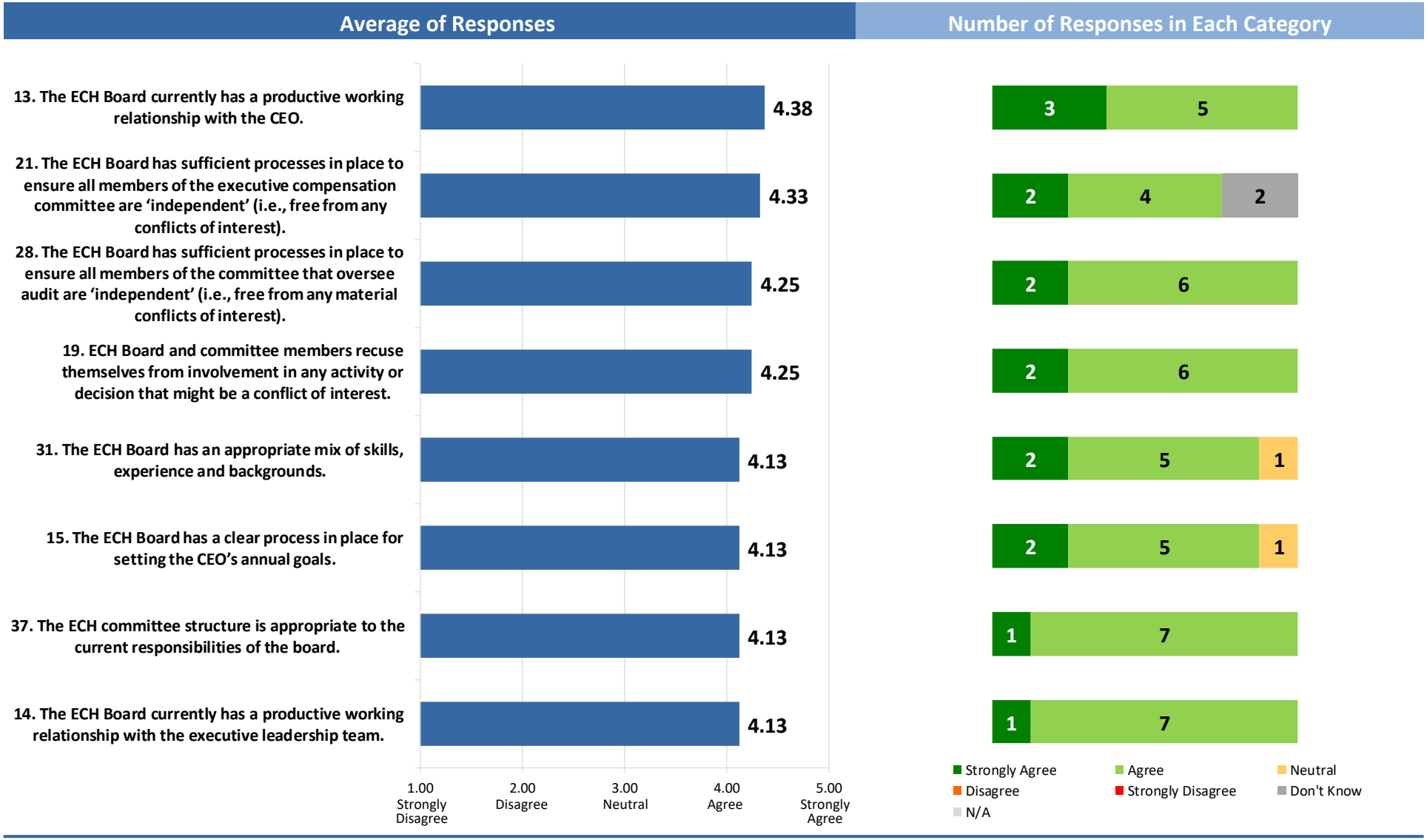
Board Effectiveness: Optimizing Board Functioning



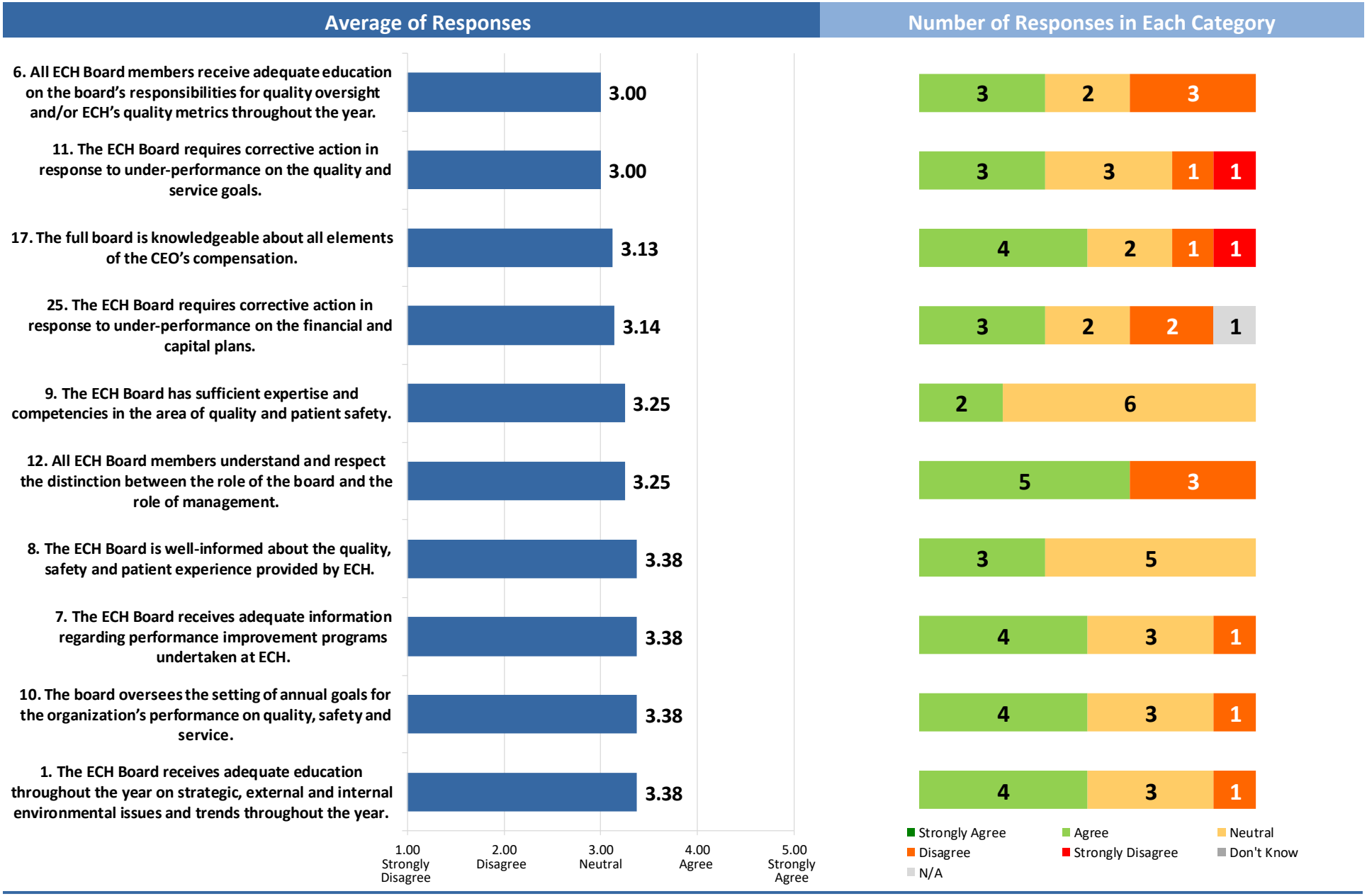
Summary of Comments for Board Effectiveness Oversight:

- At times, district board members have expressed concerns that the hospital board and its subcommittees represent a diminution of their powers. This seems to be to indicate that there is not adequate clarity on the reserved powers of the district board. Although our meetings are much more productive than when I joined, we still meet too frequently and the meetings are too long.
- #30: Need to work on processes/education to address the issue of members taking up un-do staff time with communications.
- Board competencies should improve with the addition of two new members in many areas. Board member orientation was deficient previously but is improving.
- #32: There is a desire to have the full board attend conferences either together every 2 or 3 years or rotating (e.g., 1/2 or 1/3 of board attending same industry conference every 2 or 3 years).
- It is tough to create the right balance in terms of information being presented to the board/committees - between too much information that includes duplicative reports and information committee members have already seen vs so little information that board is not fully informed. We are in a good position now, but there is a sense that this balance will continue to be a struggle.
- There is still room for improvement on the communication between the board and its committees, both in the context of the report to the board and feedback to the committees. The latter is frequently deficient.
- There is a desire for more summaries of key issues from each committee in the meeting packet vs having to read through ancillary packets of 600 pages.

Highest Rated Statements Across All Sections



Lowest Rated Statements Across All Sections



Additional Board Member Comments

- The effectiveness of the board is significantly better each year. We are on the right track and need to continue.
- Personality conflicts, micromanaging, duplication of view points have decreased tremendously in the last two years.
- We are fortunate to have a strong management leadership team beginning with our CEO.
- Meetings seem to be run on a time schedule which often preclude a healthy discussion and debate.
- ECH and the industry as a whole, is a highly complex industry requiring acumen in clinical care, operations, health plan, labor, physician plans, quality and reputation management. Not sure the Board has the breadth needed to guide and advise holistically.

Interview Summary

Interview Summary

Via Healthcare Consulting conducted interviews with all ECH Board members and seven key executives including Dan Woods, CEO, Jim Griffith, COO, Iftikhar Hussain, CFO, Mark Adams, MD, CMO, Cheryl Reinking, RN, CNO, Kathryn Fisk, CHRO, and Diane Wigglesworth, Sr. Dir., Corporate Compliance. This report summarizes the perspectives heard.

Summary of Findings

1. ***Overall, how effective*** *do you think the ECH Board is currently (on a scale of 1-10)? What are the* ***current strengths*** *of the ECH Board (things that help to accomplish ECH's overall Mission, or things that work well and that you would not want to 'lose')?*
    - The board is doing pretty well and there is still room for improvement
    - Members have been more strategically focused over the past year
    - Board members exhibit a high level of dedication and commitment
    - Most members come to meetings reasonably well prepared, having read materials
    - The board has a good working relationship with the CEO
    - The Board Chair does a good job facilitating board meetings and managing time
2. *What, if anything,* ***most concerns you*** *about the way the ECH Board is currently structured and functioning?*
    - Board members indicated that they are uncomfortable with their role in providing quality oversight especially as the organization realizes the vision of transitioning from a hospital to health system
    - Members would like more focused presentations that do not repeat what has been included in the packet and include discussion questions to encourage dialogue
    - Some commented that management at times appears defensive during presentations and this leads to a lack of trust on the part of the board members
    - Some members continue to struggle with the issue of governance vs management
    - Board members would like more discussion time during meetings
3. *What suggestions do you have for improving the board's ability to provide more effective oversight?*
    - Schedule additional offsite educational opportunities that are less structured, where board members can get to know each other better
    - Consider revisiting meeting frequency to determine whether current schedule is truly adding value
    - Several members indicated that the area of quality is broad and that it might make sense to consider moving in the direction of having a Chief Quality Officer
    - Increase opportunities for cross-committee meetings and encourage greater participation by both board and committee members
4. *How could the board be more effective in overseeing annual goal setting and the monitoring of performance against goals in the areas of quality and finance?*
    - Consider adding additional members with quality expertise to increase understanding of quality structure, metrics and goals

- Continue to create more opportunity for discussion around annual goals
- Clarify within the leadership what we mean by quality at ECH, agree on an approach, and hold education sessions on board's role in oversight and interpreting data
- Simplify the presentation and analysis around quality as current use of graphs and curves does not always tell the full story
- Consider how to generate urgency within the board given that the organization is performing well financially – are we looking far enough out in the future and anticipating upcoming issues that could impact the financial health of the organization?

5. *How can we restructure the board meetings/agendas to promote more strategic and generative discussions? What agenda topics could be delegated down to the committees to free up board time? Please share any practices you have seen work effectively at other boards you have served on.*
    - Reduce the number of agenda items to create more time for dialogue on critical issues and decisions
    - Continue to streamline board meeting packets
    - Presenters should avoid repeating what is included in the packets and engage the board in a dialogue vs providing a data dump
6. *What could be done to ensure that the board and committees are better informed about each other's work, processes, and decisions?*
    - Committee reports are better though there is still room to further summarize the information
    - Consider shortening the time provided for committee report outs and limit the amount of information being presented
    - Several board members commented that the relationship between the board and committees are not a problem
    - Committee chairs should be responsible for reporting back to committees on board actions and discussions
7. *What education/information would you like to receive?*

    Suggested *Topics:*
    - Transitioning to system governance
    - Board's role in quality oversight
    - Quality goals, indicators and how to interpret
    - Regular updates regarding legislative activities, policies, and market happenings
    - The distinction between Governance vs Management

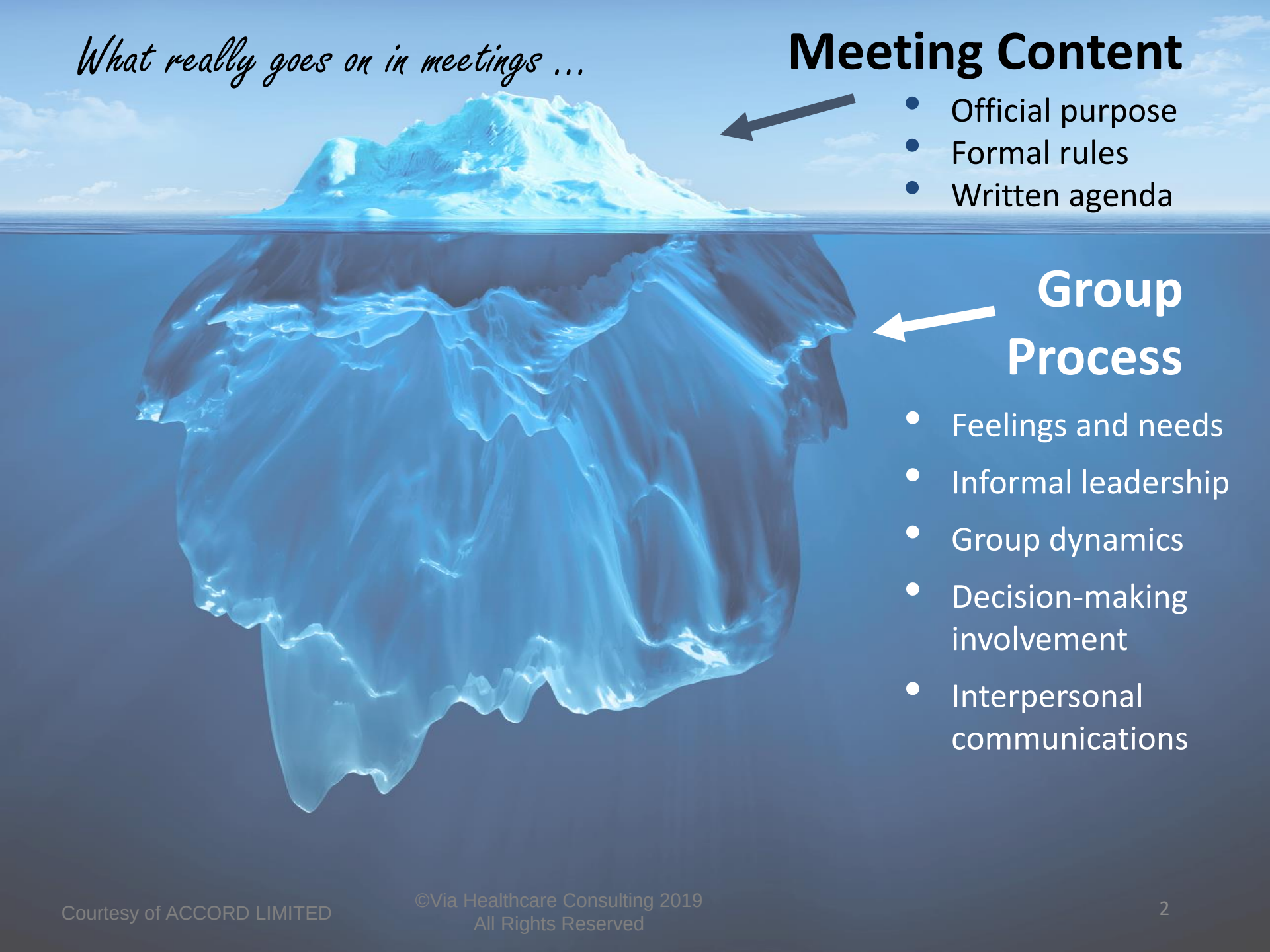
    Other Suggestions:
    - Attend conferences as a group to enhance relationships, build trust, and discuss presented material and how it relates to ECH
    - Provide board members with yearly calendar of educational opportunities

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2019 Board Self-Assessment Results

Via Healthcare Consulting
Board Meeting Presentation
August 21, 2019

What really goes on in meetings …



Meeting Content

- Official purpose
- Formal rules
- Written agenda

Group Process

- Feelings and needs
- Informal leadership
- Group dynamics
- Decision-making involvement
- Interpersonal communications

Courtesy of ACCORD LIMITED

Proposed Group Guidelines

1. Lower the water line
2. Be honest and kind
3. Declare it if you're playing devil's advocate
4. Avoid side conversations
5. Be fully engaged (no texting, e-mail, etc.)
6. Ensure all actions are assigned
7. Use a parking lot to move discussions forward
8. Agree together on which details of today's conversation will be shared outside this room

ECH 2019 Board Self-Assessment Process

- 40 closed-end questions with seven open-end questions
- Covering six areas of governance effectiveness
- 30-minute telephone interviews
- All board members participated
- Key executive leaders included in the interviews but did not participate in the written survey

Summary of Survey Results

Of the 10 Highest Rated…

- **3 from *Management***
- **2 from *Legal & Regulatory***
- **2 from *Board Effectiveness***
- **1 from *Finance and Audit***

Of the 10 Lowest Rated…

- ***6* from *Quality***
- **2 from *Management***
- **1 from *Finance and Audit***
- ***1 from Mission & Planning***

Clear Strengths

- Improved effectiveness and focus
- High level of dedication and commitment
- Reasonably well prepared and engaged
- Variety of perspectives and skills
- Strong working relationship with CEO

Areas of Opportunity

- Board's role in quality oversight
- Meeting effectiveness
- Ongoing governance education
- Enhanced board culture
- Governance - management distinction

Recommendations for Discussion

- Adopt a customized, actionable approach to effective quality oversight
- Redesign agendas to increase time for strategic discussions
- Restructure presentations to improve focus and promote dialogue
- Revisit meeting frequency to determine if current schedule is optimal
- Implement board meeting evaluations to assess effectiveness
- Develop a more intentional ongoing board education process

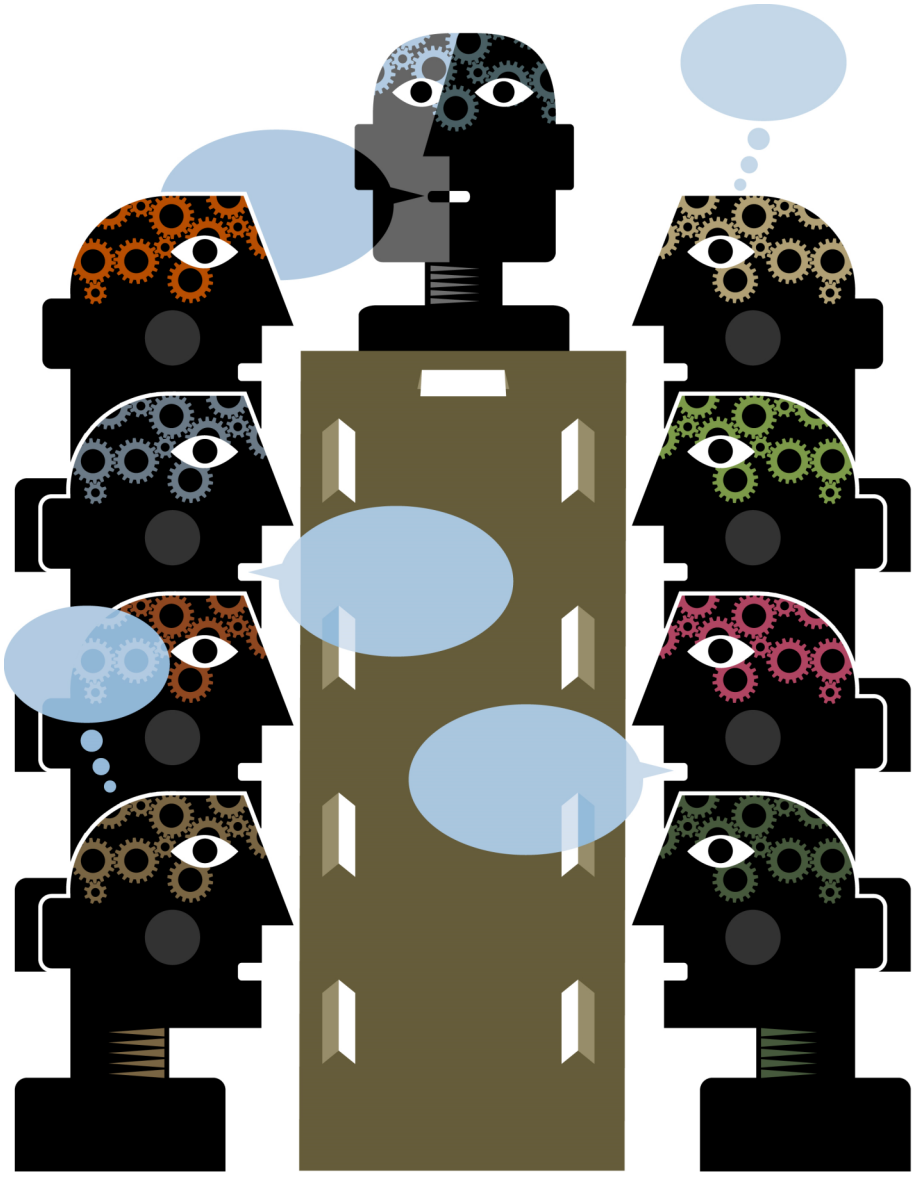
- Create a customized approach to quality oversight based on available frameworks and best practices
- Hold an educational meeting or series of meetings focused on enhancing board's oversight of quality
- Reduce the number of agenda items and increase the time devoted to strategic discussions
- Restructure board meeting presentations to improve focus and promote dialogue
- Revisit meeting frequency to determine whether current schedule is optimal and creates value
- Add 5-minute meeting evaluation discussion to each meeting agenda
- Develop an intentional, multi-year strategy for ongoing board education
- Increase opportunities for cross-committee meetings and encourage greater participation
- Convene board members outside typical meeting structure to facilitate greater cohesiveness and teamwork

Possible Action Plan Items

The Board's Evolving Role in Quality Oversight

Where to begin and why it matters

By Erica M. Osborne, MPH and Karma Bass, MPH, FACHE



The United States' healthcare delivery system is undergoing an unprecedented transformation. The implementation of the Affordable Care Act, the increasing focus on value, along with the introduction of new health technologies and the empowered consumer have brought about a fundamental shift in how care is delivered and paid for in this country.

In light of this shift, as well as continued challenges to their missions, non-profit hospitals and healthcare systems across the country are looking to transform their organizations. Among the many areas of change, organizations are increasingly focusing their attention on quality and patient safety. In response to the intensified focus on quality measurement and reporting across the healthcare industry, CEOs and board leadership teams together are striving to determine how best to leverage board assets in quality oversight and where to draw the distinction between governance and management. While the role of the board varies, appropriately, among organizations, most agree that boards need to engage differently around the oversight of quality and patient safety.

Because governance involves exercising accountability by setting policy and overseeing implementation, boards should start by focusing on what they can do and how they can adapt to a new, more engaged, and transparent governance model.

Defining Healthcare Quality

In order to have a meaningful conversation about quality of care and patient safety in the boardroom, it is imperative to first and foremost define what is meant by "quality." Boards pursuing the journey to enhance their effectiveness in quality oversight would be well served to spend time at a retreat or quality committee meeting discussing precisely what is meant by "quality and patient safety" in their organizations.

In 2001, the Institute of Medicine published ***Crossing the Quality Chasm: A New Health System for the 21st Century***. In this seminal publication, a six-pronged definition of healthcare quality was put forth that is generally considered to be the most complete and widely accepted. (See next page.) Regardless of the definition one chooses to apply, organizational leaders must carve out time to discuss and confirm a common understanding of what quality is for their particular organization.

It's a Journey, Not a Destination

As with any effort at improvement, enhancing a board's effectiveness in being

Quality in Healthcare, Defined

According to the Institute of Medicine, quality in healthcare is defined as care which is:

Safe and avoids inflicting injuries to patients from the care that is intended to help them.

Effective by providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit, thus avoiding underuse and overuse, respectively.

Patient-centered by providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely and reduces waits and sometimes harmful delays for both those who receive and those who give care.

Efficient by avoiding waste of equipment, supplies, ideas, and energy.

Equitable by providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. [1]

accountable for and knowledgeable about the safety and quality of patient care should be viewed as an ongoing process. The key to any successful journey involves knowing where you are starting from and building a map of where you want to go. While there are an increasing number of practices around quality oversight there are few universally-recognized "best practices" to follow. Therefore, each board should consider its current practices around quality and safety and determine the best process for fulfilling its oversight responsibilities given its individual circumstances.

Boards and board members are encouraged to engage in education, training, and conversation among colleagues. The best environment for quality improvement is one of honest inquiry and data-driven dialogue.

Success in this arena will require boards to become comfortable with uncertainty. The board will never know everything there is to know about patient quality and safety in their organizations. However, smart boards can stay engaged, ask good questions, and support the staff as they work on this critically important effort. Furthermore, the fact that many board members are not clinicians or possess health care expertise can be an advantage; healthcare is incredibly complex and at times those who work in it may fail to see the forest for the trees. Like the little child in the parable of the Emperor's New Clothes, board members can ask the seemingly obvious questions and, at times, help reorient an organization's focus.

Making the Case

Historically, quality oversight was delegated to the management or clinical staff and not considered to be the purview of the board. Directors often did not consider this a significant aspect of their governance role. "We aren't clinicians," they would often say, and "our focus is the mission and advocacy."

This, however, is changing in response to legal and regulatory requirements and increasing pressure from purchasers and payers to demonstrate improved quality of care. Health care organizations across the country are seeing a movement in which the board is playing a greater role in overseeing the quality and safety of care provided. This shift is being driven in large part because the environment in which non-profit boards operate has become increasingly challenging. Perceptions of the duties of the board have changed, and non-profit healthcare organizations are being scrutinized more closely than ever before. With a large number of federal and state agencies, the courts and other stakeholders' increasing willingness to second-guess board decisions, directors need to have a clear understanding of their legal responsibilities particularly as they relate to quality and safety oversight.

Legal & Regulatory Imperatives

With pay-for-performance and greater consumer scrutiny of care, healthcare organizations are being asked to be even more publicly accountable for their patient's care, especially if something goes wrong. Case law examples, changes in state statutes and accreditation standards by accrediting bodies throughout the sector have placed quality and patient safety clearly in the board's area of responsibility. Boards who have historically entrusted the oversight of quality and safety to the organization's executives and clinicians now find that they must also demonstrate accountability for and knowledge about the safety and quality of patient care.

The Moral Imperative

Along with the legal and regulatory imperatives, there is also a moral imperative to be considered. Governing boards of non-profit healthcare organizations hold the resources of their organization in trust for the community they serve and therefore are responsible for ensuring that their organization provides safe, effective, and appropriate care to all patients. Boards can accomplish this by planning for the delivery of necessary services and providing the appropriate level of resources and support needed to fulfill its commitment to improved organizational performance. Leadership, through its behavior and expectations for action, can also foster a culture that promotes safety and quality and emphasizes open communication and transparency. [2]

It's been said that anything that has the potential to harm the organization or its patients should be a concern of the board. Thus, effective boards are staying informed and seeking continuous training on this important issue.

Emerging Financial Imperative

[1] *Crossing the Quality Chasm: A New Health System for the 21st Century, Institute of Medicine, National Academy Press, 2001.*

[2] *Schyve, Paul. Leadership in Healthcare Organizations. San Diego: The Governance Institute, Winter 2009.*

As public and private payers increasingly link reimbursement to quality outcomes, the business case for quality oversight is no longer hypothetical. On the public side, the Centers for Medicare and Medicaid have implemented the value-based purchasing program attaching increasing amounts of reimbursement to clinical performance measures and rewarding high performing providers. Private insurers have also committed to moving away from fee-for-service payments and transitioning into value-based agreements. The movement to pay for performance rather than volume of services provided is intended to put financial pressure on healthcare providers to produce safe, efficient, high quality services. Those organizations that do not perform well on quality measures will see reimbursement reduced. With the growing concerns about the quality and cost of healthcare in this country, governing boards are being called upon to set the direction for their organizations and create an environment where clinicians, management, and the board work together to promotes behavioral change at the individual and organizational level. [3]

Fiduciary Responsibilities

Oversight of quality and patient safety is now widely recognized as a primary fiduciary duty of the healthcare governing board. Board members are required to carry out the fundamental duty of oversight with sufficient care, loyalty, and obedience. Boards may falter in many areas without drawing attention, but failure to fulfill these primary duties can lead to action by a number of groups, including the state attorneys general, federal regulators, or members of the public. It is therefore important that directors exercise diligence to meet these obligations, take the appropriate steps in exercising their fiduciary responsibilities, and avoid self-dealing. In fact, board members can shield themselves from personal liability for board actions even if something goes wrong by attending to their fiduciary duties closely and carefully documenting their decisions.

Boards have clear fiduciary responsibilities in this area for a variety of reasons. The most obvious is that the promotion of safe, high quality care is the healthcare industry's reason for being and is critical to maintaining the reputation of the individual organizations providing that care. In addition, the increased emphasis on regulatory enforcement is requiring that boards provide sufficient oversight of care for compliance purposes. A new focus on value and the relationship between quality, cost, and outcomes also impacts the responsibilities of the directors. These issues are so central to the business of delivering healthcare today that they demand the attention of the governing board.

The legal underpinnings of a board's fiduciary duties of care and obedience lend additional weight. The duty of care requires that members provide oversight of operational activities, ensure an effective compliance/risk management program exists, and exercise the proper amount of care when making decisions or taking action. Directors are expected to be aware of what is happening in the organization and make reasonable inquiries into those aspects that are unclear or they have concerns about. By ensuring that a reporting system is in place that provides reasonable up-to-date information, board members are able to keep a finger on the pulse of the organization. By conducting the appropriate level of due diligence and asking prudent questions, board members demonstrate that the decisions they make and the actions they take are informed and in the best interest of the organization.

When evaluating whether the board has met its fiduciary obligations, the courts, regulators and state attorneys general do not require perfection. Board members are not expected to know everything about a subject and are permitted to rely on the advice of management and outside experts. So long as it can be shown that the board conducted an appropriate level of due diligence to support an informed decision and that it acted in the best interest of the organization, the board has done its job. [4]

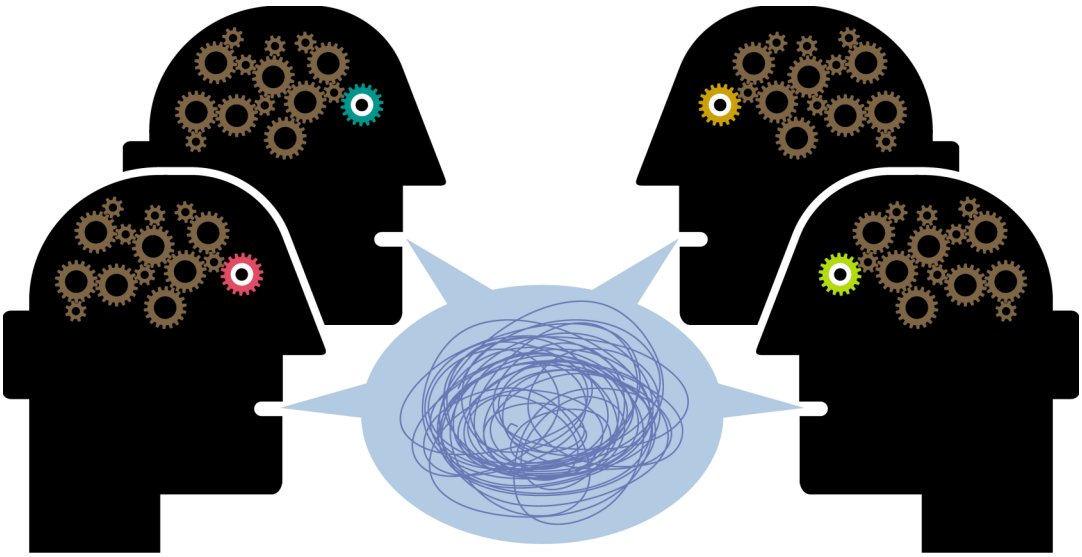
Ways Boards Can Engage

There are a variety of ways that boards can engage in quality oversight. Although there are an increasing number of practices around quality oversight there are few universally-recognized "best practices" to follow, each board should consider its current practices around quality and safety and select the practices it feels will best support its oversight of quality.

With the landscape of healthcare quality measurement and reporting shifting dramatically, hospital and healthcare organization boards are well-served to re-examine the ways in which they oversee the quality of care, service and safety provided in their organizations. We hope this briefing has provided food for thought.

[3] Transforming Care Delivery to Focus on Patient Outcomes: Why Boards Matter. Christine Izui AHA Center for Healthcare Governance, 2012.

[4] U.S. OIG. Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors. By Arianne N. Callender, Douglas A. Hastings, Michael C. Hemsley, Lewis Morris, and Michael W. Peregrine. U.S. Dept of Health and Human Services, 2007.



While it is not necessarily a comfortable topic for boards, quality and safety are central to what healthcare organizations do and therefore must be the purview of the board. We encourage boards to start with a conversation and keep talking. As the Chinese philosopher Lau Tsu said,

The journey of a thousand miles begins with a single step.

Ideas to Engage Your Board in Quality Oversight

- Define healthcare quality for the organization in partnership with the CEO and staff
- Support a culture that promotes safety and quality
- Ensure materials shown to prospective board members outline the board's responsibility for quality
- Incorporate an overview and discussion of the board's role in quality and safety oversight into new board member orientation
- Include the quality and safety oversight responsibilities in the board member job description
- Identify quality as a strategic pillar for the organization
- Set annual goals for the organization's performance on quality and patient safety
- Ensure that regular written and verbal reports are made to the full board on quality metrics, safety performance metrics, and any legal action or regulatory agency inquiry regarding patient care
- Require corrective action in response to underperformance on the quality and patient safety goals
- Incorporate board training on the organization's quality performance metrics at least once a year
- Call out the quality, risk management, and safety-related spending included in the annual budget
- Look for new board members who are willing to raise constructive questions and challenge ideas without losing collegiality which is particularly important for quality oversight
- Consider incorporating at least two quality and/or patient safety metrics in the organization's consolidated performance dashboard
- Include patient stories—without identifying them by name—as part of the quality report that is given to the board to humanize the statistics and data

Via Healthcare Consulting provides information and tools for boards and CEOs on quality oversight, governance effectiveness, board assessment and strategic planning. Visit ww.viahealthcareconsulting.com or contact us at (760) 271-0557 for more information.

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El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Peter C. Fung, MD, Chair, Governance Committee
Date: August 21, 2019
Subject: Governance Committee Report (Item 7a) - FY20 Hospital Board Member Competencies

Recommendation(s): To recommend that the El Camino Healthcare District Board adopt the Draft Competency Matrix.

Summary:

1. Situation: In FY19, the Governance Committee recommended and the Board adopted a revised competency matrix (see attached). Using the competency matrix, all Board members evaluated themselves and all other Board members resulting in identification of gaps in overall Board competencies. The gap analysis was then used to inform Board member retention and recruitment efforts.

2. Authority: One of the Governance Committee's chartered responsibilities is to define the necessary skill sets, diversity, and other attributes required for Board members to support Hospital strategy, goals, community needs and current market conditions and make recommendations to the Board regarding Board composition. With that in mind, the Governance Committee reviewed the competency matrix at its August 13, 2019 meeting.

3. Background: The Board has, over time, modified the highest priority competencies in response to changing Hospital strategy, goals, community needs and market conditions. Competency 3 (leadership of high performing organizations in other industries including Board experience) replaced healthcare industry experience and experience in clinical integration/continuum of care in FY19. The first terms of Directors Kliger and Rebitzer expire on June 30, 2020. The District Board's Ad Hoc Committee will likely begin to evaluate their reappointment in August or September 2019.

4. Assessment: There is a need to confirm the Board competencies for FY20.

5. Other Reviews: The Governance Committee recommended changing the word "reform" to "policy" in competency #5.

6. Outcomes: Recommendation for FY20 Board Competency Matrix. The El Camino Healthcare District Board has the ultimate authority to determine necessary competencies for El Camino Hospital Board Directors.

List of Attachments:

1. Draft Revised FY20 Board Competency Matrix

Suggested Board Discussion Questions:

1. Is the Revised Draft Competency Matrix adequate for FY20?
2. What are the top priority Board competencies for FY20?

DRAFT FY20 Competency Matrix
Rating Tool & Rating Scale

Level of Knowledge/Experience 1 = None (no background/experience) 2 = Minimal 3 = Moderate/Broad 4 = Competent 5 = Expert	Lanhee Chen	Peter C. Fung, MD	Gary Kalbach	Julie Kliger	Julia Miller	Jack Po, MD	Robert Rebitzer	George Ting, MD	Don Watters	John Zoglin
1. Understanding of complex market partnerships										
2. Long-range strategic planning										
3. Experience Leading High Performing Organizations, incl. Board Experience										
4. Finance/entrepreneurship										
5. Health care ~~reform~~policy										
6. Oversight of diverse business portfolios										
7. Complex partnerships with clinicians										
8. Experience in more than one area of the continuum of care										
9. Patient care quality and safety metrics										
1. **Analytical Thinker**: separates the important from trivial										
2. **Collaborative**: feels collaboration is essential for success										
3. **Community-Oriented**: always keeps stakeholders in mind										

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El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Peter C. Fung, MD, Chair, Governance Committee
Date: August 21, 2019
Subject: Governance Committee Report (Item 7b) - FY20 Board Education Plan

Recommendation(s):

To approve the Proposed FY20 Board Education Plan

Summary:

1. Situation: The Board continues to request ongoing education to support its work. As well, ongoing Board education is considered a best practice, vital to effective Board functioning.

2. Authority: It is within the Committee's chartered responsibilities to recommend an annual plan for Hospital Board and Committee member education, training and development.

3. Background: As noted in the FY19 Board Self-Assessment results, the Board members express a strong desire to become more effective in the area of Quality Oversight. In addition, the community members of the Board's Advisory Committees continue to express interest in at least annual updates on the Strategic Plan Implementation.

Recommendation**:**

FY20

- **A.** October 23, 2019 Joint Board and Committee Session – Strategic Plan Implementation Update and Committee Roundtables
- **B.** Board Retreat – The Board's Role in Quality Oversight. The Board Retreat is currently scheduled for February but the Governance Committee recommends moving this up and perhaps scheduling this topic over a series of retreat style meetings.
- **C.** April 22, 2020 Joint Board and Committee Session – (TBD) and Committee Roundtables
- **D.** Conference Attendance (AHA, Governance Institute, others as recommend by the Board and the leadership team)
- **E.** Governance Institute Membership Website Resources: White Papers, E-Briefings, Board Room Press, Webinars etc.

Long term – Develop a multi-year Board education plan that will be reevaluated for relevance annually

4. Assessment: N/A

5. Other Reviews: Governance Committee reviewed and voted to recommend the Board Education Plan at its August 13, 2019 meeting.

6. Outcomes: N/A

Governance Committee Report (Item 7c) - FY20 Board Education Plan
August 21, 2019

List of Attachments:

None.

Suggested Board Discussion Questions:

- Aside from Quality Oversight, what other topics should be included in the board' long term education plan?
- Shall the Board and/or Committee members attend off site conferences as a group? In small groups?

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, June 12, 2019
2500 Grant Road, Mountain View, CA 94040
Conference Rooms F&G (ground floor)

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair **Jeffrey Davis, MD** **Peter C. Fung, MD** **Gary Kalbach** **Julie Kliger** **Julia E. Miller,** Secretary/Treasurer **Bob Rebitzer** **George O. Ting, MD** **John Zoglin**, Vice Chair		None

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30pm by Vice Chair Zoglin. A silent roll call was taken. Directors Rebitzer and Ting arrived 5:32pm during Agenda Item 3: Board Recognition. Director Chen arrived at 5:36pm during Agenda Item 4: Quality Committee Report. Director Kalbach arrived at 6:01pm during Agenda Item 7: Proposed FY20 Operating and Capital Budget. All other Board members were present at roll call.	
2. POTENTIAL CONFLICTS 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. BOARD RECOGNITION	Jim Griffith, COO, recognized the ECH Stroke Care team for receiving designation from The Joint Commission as a Thrombectomy-Capable Stroke Center and their continued efforts to build a comprehensive stroke program. **Motion:** To approve *Resolution 2019-07*. **Movant:** Miller **Second:** Watters **Ayes:** Davis, Fung, Miller, Kliger, Rebitzer, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Chen, Kalbach, Ting **Recused:** None Shyamali Singhal, MD and Shane Dormady, MD thanked the Board for the recognition.	
4. QUALITY COMMITTEE REPORT	Director Kliger, Quality Committee Chair, explained that the Committee is moving to exception reporting and has requested a refreshed dashboard to include the FY20 organizational goals and continued visibility on ED throughput and the NTSV C-section rate. She also described the recruitment efforts of the Ad Hoc Committee, which will be interviewing candidates later in June. Dr. Adams noted that the dashboard is used throughout the organization, including by the medical staff, and is continually reviewed and updated. Director Fung expressed concerns with the term "mortality from	

	preventable surgical complications." Dr. Adams explained that the term is established by the Agency for Healthcare Research and Quality and the Quality Committee will be doing a deeper dive in this area at its August meeting. Director Rebitzer requested that upper and lower control limits be included on the ED Throughput goal on the dashboard.	
5. FY19 PERIOD 10 FINANCIALS	Iftikhar Hussain, CFO, provided an overview of the April financials: - Volume year-to-date is below target, but picked up in April due to 1) a late influx of flu/respiratory emergency room cases, 2) a new medical oncologist and GI physicians, 3) the purchase of a Mako robot for joint replacement (orthopedic cases), 4) growth in the lung nodule program, and 4) increased capacity in outpatient rehabilitation services. - Payor Mix: commercial business has not changed, but there has been an increase in Medicare patients - Days in AR and cash position remain strong In response to Director Fung's question, Mr. Hussain explained that SVMD is approximately $1.5 million ahead of budget; he also noted that management did not anticipate SVMD's acquisition of the Verity Clinics or entering into a PSA with the San Jose Medical Group in the development of the FY19 budget. In response to Director Kliger's question, Mr. Hussain described the clinical documentation improvement efforts and ECH's average length of stay (ALOS) performance versus the Milliman well-managed benchmark. **Motion:** To approve the FY19 Period 10 Financials **Movant:** Zoglin **Second:** Fung **Ayes:** Chen, Davis, Fung, Miller, Kliger, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Kalbach **Recused:** None	***FY19 Period 10 Financials approved***
6. PROPOSED FY20 ORGANIZATIONAL GOALS	Dan Woods, CEO, reviewed the proposed organizational goals regarding Quality & Safety, Service, People, and Growth, with a Finance threshold goal. Director Rebitzer commented that the employee engagement goal did not seem particularly meaningful and suggested that there may be better measures to use next year. Director Zoglin described the Finance Committee's reservations about the threshold finance goal of 95% of budget, due to the organization consistently outperforming budget for the last several years. Mr. Woods further described the people goal, noting that a higher level of employee engagement correlates with a better patient experience. **Motion:** To approve the Proposed FY20 Organizational Goals. **Movant:** Miller **Second:** Kliger **Ayes:** Chen, Davis, Fung, Miller, Kliger, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Kalbach	***FY20 Organiz-ational Goals approved***

	Recused: None	
7. FY20 OPERATING AND CAPITAL BUDGET	Mr. Hussain explained that the materials are almost the same as what the Board reviewed at the Joint Meeting with the Finance Committee. In response to Director Miller's questions, Mr. Hussain described FY20 investments with significant financial impacts, including $5 million in program changes, net benefit of $10 million in growth, and $7.7 million in strategic and innovative initiatives. Director Miller requested a different display of this information next year for better readability. Director Zoglin commented that the Finance Committee was not comfortable with the capital budget when only two-thirds of the budget has been spent for the last seven years. Mr. Hussain noted that variance arises when there are preliminary numbers or items to be considered for the next year and that if large, complex projects (like the Sobrato Pavilion) are finished later than expected, that will affect cash flow and projections. Mr. Woods noted that staff can provide clearer reports on capital project budgeting and cash management for the Finance Committee. Director Kliger suggested that any of the large quality-related financial investments should come to the Quality Committee for review. The Board and Mr. Hussain discussed workforce productivity, including the use of Action OI data and ECH's performance compared to other subscribers. The Board requested additional context about what better productivity means and what the Board should know and do from an oversight and policymaking perspective. In response to Director Miller's question, Mr. Hussain explained that despite a trend of declining deliveries, management projects growth in FY20 through OB/GYN physician recruitments. **Motion:** To approve the Proposed FY20 Operating and Capital Budget **Movant:** Fung **Second:** Kalbach **Ayes:** Chen, Davis, Fung, Miller, Kalbach, Kliger, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***FY20 Operating and Capital Budget approved***
8. PROPOSED FY20 COMMUNITY BENEFIT PLAN	Barbara Avery, Director, Community Benefit, provided an overview of the Community Health Needs Assessment (CHNA) and the FY20 Community Benefit Plan. She highlighted the timeline and process of the grant cycle, including the application and review by the Community Benefit Advisory Council (CBAC). She explained that there were 61 total proposals and 44 that were recommended by the CBAC for a total of $3.4 million in recommended funding. Ms. Avery reviewed the grants requests of $100,000 or more. She also described and the Board discussed the organization's Community Benefit (as defined by the IRS) in FY18 of $63.5 million, including government sponsored health care (unreimbursed Medi-Cal), subsidized health services (departments like Mental Health & Addiction services), financial assistance, grants and sponsorships, health professions education, clinical research, community benefit operations, and community health improvement services.	***FY20 Community Benefit Plan approved***

	In response to Director Watters' question, Ms. Avery described efforts to connect Hospital departments (care coordination/discharge planning) with appropriate grantees. Director Zoglin commented that the types of grant funding may be too broad and that the community benefit grant program should have a more narrow focus on providing healthcare services. Ms. Avery reported that 4% of grant funding ($141,000 out of $3.6 million) is for programs addressing housing instability and food insecurity. She suggested that the Board discuss this topic further and provide direction to staff ahead of the next funding cycle. **Motion:** To approve the Proposed FY20 Community Benefit Plan. **Movant:** Ting **Second:** Miller **Ayes:** Chen, Davis, Fung, Miller, Kalbach, Kliger, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
9. PUBLIC COMMUNICATION	Catherine Walke, RN, President of PRN, spoke regarding the negotiations between PRN and ECH and expressed concerns about compensation and benefits for nurses. Members of the public expressed concerns regarding management culture, the Hospital Convenience policy and canceled shifts, cost of living increases, executive compensation, per diem and benefits policies, patient safety, reduction of administrative staff, differentials, appropriate staffing, time management with increased responsibilities, and encouraged the Board to support the nursing staff and consider a fair and equitable contract with PRN.	
10. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:08pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (5/8/2019) and Minutes of the Closed Session of the Joint Meeting of the Finance Committee and the Hospital Board (5/28/2019); pursuant to *Health & Safety Code Section 32106(b)* and *Gov't Code Section 54857.6* for a conference with labor negotiator Dan Woods: FY20 Individual Executive Incentive Goals; 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; *Gov't Code Section 54857.6* for a conference with labor negotiator Bob Miller: FY20 CEO Salary Range; *Gov't Code Section 54857.6* for a conference with labor negotiator Kathryn Fisk: SEIU Update; pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: Proposed FY20 Strategic Plan Metrics; pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: SVMD Plan and Culture; pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets and *Gov't Code Section 54957.6* for conference with labor negotiator Dan Woods; *Gov't Code Section 54956.9(d)(2)* for conference with legal counsel – pending or threatened litigation: CEO Report on New Services and Programs, Labor Negotiations, and Legal Update; and pursuant to *Gov't Code Section 54957* for discussion and report on	***Adjourned to closed session at 7:08pm***

	personnel performance matters – Senior Management: Executive Session. **Movant:** Kalbach **Second:** Miller **Ayes:** Chen, Davis, Fung, Miller, Kalbach, Kliger, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
11. AGENDA ITEM 21: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 9:35pm by Chair Chen. Agenda items 11-20 were addressed in closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (May 8, 2019) and the Minutes of the Closed Session of the Joint Meeting of the Finance Committee and the Hospital Board (May 28, 2019), Minutes of the Closed Session of the Executive Compensation Committee Meeting (April 2, 2019), and the Medical Staff Report, including the credentials and privileges report, by a unanimous vote in favor of all members present (Directors Chen, Davis, Fung, Kalbach, Kliger, Miller, Rebitzer, Ting, Watters, and Zoglin).	
12. AGENDA ITEM 22: 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. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting (5/8/2019); Minutes of the Open Session of the Joint Meeting of the Finance Committee and the Hospital Board (5/28/2019); FY20 Auxiliary Slate of Officers; *Resolution 2019-08*: Approving Dissolution of the Independent Physicians of El Camino Hospital (IPECH); 2019 El Camino Hospital Community Health Needs Assessment; *Resolution 2019-09*: Delegating Authority to the CEO and the CFO to Enter into, Amend, Extend the Term of or Replace the Letter of Credit provided, now or in the future, in connection with the Series 2009A Bonds ($50,000,000); Minutes of the Open Session of the Executive Compensation Committee Meeting (4/2/2019); Medical Director, Infection Control (renewal); FY19 Period 9 Financials; FY20 Master Calendar; FY20 Committee Goals; FY20 Committee and Liaison Appointments; Infection Prevention Plan; Medical Staff Report; and for information: Finance Committee Approvals; Executive Compensation Committee Approvals, including FY20 Individual Executive Base Salaries and FY20 Executive Salary Ranges; Major Projects Update; Investment Committee Report. **Movant:** Miller **Second:** Kliger **Ayes:** Chen, Davis, Fung, Kalbach, Kliger, Miller, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Consent calendar approved***
13. AGENDA ITEM 23: FY20 CEO SALARY RANGE APPROVAL	Chair Chen noted that copies of the proposal were available for the public. **Motion:** To approve the FY20 CEO salary range, with a minimum, midpoint, and max of $919,000, $1,149,000, and $1,379,000 respectively. **Movant:** Rebitzer **Second:** Kliger	***FY20 CEO Salary Range approved***

	Ayes: Chen, Davis, Fung, Kalbach, Kliger, Miller, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
14. AGENDA ITEM 17: CEO REPORT	Dan Woods, CEO, described the use of voice-to-text throughout the organization, text updates integrated with the medical record for emergency room visits, ECH's 4th submission for Magnet program designation, the recent Leadership Mountain View seminar on cannabis and its negative effects on the adolescent brain, the Chinese Health Initiative's Diabetes Prevention Learning Series. He also described a new autonomous robot at the Los Gatos campus, text updates for families in the surgical waiting room. He thanked all of the nurses for their service and reported that this week (May 6-12th) is Nurses Week. He also described health career event for local high school students and the South Asian Heart Center's Scarlett Express Gala. Mr. Woods acknowledged the El Camino Hospital Foundation for its highest yielding year. He thanked Carol Carey, outgoing President of the ECH Axuiliary, for her service and welcomed incoming President Judy Van Dyck.	
15. AGENDA ITEM 22: BOARD COMMENTS	Director Davis thanked the Board for their work during his tenure as a Board member. He encouraged the Board to garner expertise to oversee the organization's development of an integrated delivery system and to acknowledge the Committee members and their work. He commended the Board for its support of behavioral health services and its pursuit of a competency-based board. The Board thanked Director Davis for his service.	
16. AGENDA ITEM 23: ADJOURNMENT	**Motion**: To adjourn at 9:46pm **Movant:** Fung **Second:** Kalbach **Ayes:** Chen, Davis, Fung, Kalbach, Kliger, Miller, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 9:46pm***

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

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Dan Woods, CEO
Date: August 21, 2019
Subject: Approval of Pathways Home Health and Hospice Operating and Capital Budget for the Period July 1, 2019 through October 30, 2019

Recommendation(s):

To approve the Pathways Home Health and Hospice ("Pathways") Operating and Capital Budget ("Budget") for the Period July 1, 2019 through October 30, 2019.

Summary:

1. Situation: El Camino Hospital ("ECH") is one of two classes of corporate members of Pathways. On June 27, 2019, the Pathways Board approved Pathways' Budget for the period July 1, 2019 through October 30, 2019. Four members of the ECH leadership team serve on the Pathways Board of Directors.

2. Authority: Pursuant to Section 5.01(f) of the Pathways Bylaws, approval of Pathways' Budget is only effective upon approval of both classes of Pathways' corporate members. Therefore, the ECH Board must approve the Pathways' Budget.

3. Background: The Budget is only for the period July 1, 2019 through October 30, 2019 pending approval of a Management Services Agreement and a revised FY20 Budget by the Pathways Board.

4. Assessment: This action is pursuant to the Pathways Bylaws.

5. Other Reviews: None.

6. Outcomes: Pathways Budget for the period July 1, 2019 through October 30, 2019 approved by ECH as required.

List of Attachments:

1. Pathways Budget for the period July 1, 2019 through October 30, 2019 as approved by the Pathways Board on June 27, 2019

Suggested Board Discussion Questions: None. This is a consent item.

PATHWAYS HOME HEALTH AND HOSPICE
BUDGET JULY 2019 - OCTOBER 2019
INFORMATION FORECAST NOVEMBER 2019 - JUNE 2020

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ASSUMPTIONS:

PATHWAYS MANAGEMENT

- July '19 through October '19
- Admissions growth 1% from July '19 through October '19
- 3% annual salary increase

CHI MANAGEMENT - INFORMATIONS

- November '19 through June '20.
- Admissions growth 3% from November '19 through June '20.
- Management fee 10% of total revenue to offset Pathways administrative cost
- 3% annual salary increase

ADMISSION AND VOLUME
BUDGET JULY 2019 - OCTOBER 2019
INFORMATION FORECAST NOVEMBER 2019 - JUNE 2020

	FY 18-19 (Forecast)	BUDGET JUL '19 - OCT '19	INFORMATION NOV '19 - JUN '20	ANNUAL FY 19-20	CHANGES	
HOSPICE						
ADMISSIONS	1,171	394	812	1,206	35	(avg. 3 admission per month)
Changes	-17.0%	1.0%	3.0%	3.0%		
Routine	93,452	31,462	64,812	96,274	2,822	
HOME HEALTH						
ADMISSIONS	2,086	702	1,447	2,149	63	(avg. 5 admissions per month)
Changes	-15.0%	1.0%	3.0%	3.0%		
Episodes	2,520	848	1,748	2,596	76	
TOTAL ADMISSIONS	3,257	1,097	2,259	3,356	98	

BUDGET JULY 2019 - OCTOBER 2019
INFORMATION FORECAST NOVEMBER 2019 - JUNE 2020

	BUDGET (JUL - OCT) $	INFORMATION FORECAST (NOV - JUN) $	ANNUAL FY 19-20 $	FORECAST FY 18-19 $	%
NET SERVICE REVENUE	$ 12,508,056	$ 25,217,310	$ 37,725,366	$ 36,200,423	
FOUNDATION	$ 666,666	$ 1,333,334	$ 2,000,000	$ 2,000,000	
TOTAL REVENUE	$ 13,174,722	$ 26,550,644	$ 39,725,366	$ 38,200,423	
DIRECT LABOR	$ 4,491,398	$ 9,055,042	$ 13,546,440	$ 13,012,253	35.95%
OTHER DIRECT LABOR	$ 1,508,216	$ 3,040,693	$ 4,548,909	$ 4,513,001	12.47%
PATIENT DIRECT EXPENSE	$ 1,436,161	$ 2,787,943	$ 4,224,104	$ 4,082,405	11.28%
TOTAL DIRECT	$ 7,435,775	$ 14,883,678	$ 22,319,453	$ 21,607,659	59.69%
GROSS MARGIN	$ 5,738,947	$ 11,666,966	$ 17,405,913	$ 16,592,763	
%	43.56%	43.94%	43.82%	43.44%	
OVERHEAD					
INDIRECT LABOR	$ 4,445,196	$ 5,592,827	$ 10,038,023	$ 13,839,476	36.23%
CHI MANAGEMENT FEE (10% of total revenue)		$ 2,655,064	$ 2,655,064		
OCCUPANCY	$ 214,350	$ 428,700	$ 643,050	$ 548,860	
IT & TELECOM	$ 623,246	$ 1,246,493	$ 1,869,739	$ 1,707,172	
PROFESSIONAL SERVICE	$ 731,060	$ 1,462,120	$ 2,193,180	$ 1,993,801	
A & G	$ 276,784	$ 553,566	$ 830,350	$ 790,808	
	$ 6,290,636	$ 11,938,770	$ 18,229,406	$ 18,880,117	
EBITDA	$ (551,689)	$ (271,804)	$ (823,493)	$ (2,287,354)	
INTEREST / DEPRECIATION	$ 390,398	$ 780,795	$ 1,171,193	$ 1,037,254	
OPERATING INCOME (LOSS)	**$ (942,087)**	**$ (1,052,599)**	**$ (1,994,686)**	**$ (3,324,608)**	
NON-OPERATING ACTIVITIES	266,667	$ 533,333	$ 800,000	$ 1,100,000	
NET INCOME (LOSS) EXCLUDING TRANSITIONS COST	**(675,420)**	**(519,266)**	**(1,194,686)**	**(2,224,608)**	
TRANSITIONS COST	$ -	$ 4,351,766	$ 4,351,766		
NET INCOME (LOSS) INCLUDING TRANSITIONS COST	**(675,420)**	**(4,871,033)**	**(5,546,453)**		

NET CHANGES
BUDGET JULY 2019 - OCTOBER 2019
INFORMATION FORECAST NOVEMBER 2019 - JUNE 2020

		BUDGET CHANGES (JUL '19 - OCT '19)		INFORMATION CHANGES (NOV '19 - JUN '20)	CHANGE $
FY 18-19 FORECAST OPERATING LOSS					**$ (3,324,608)**
BUDGET FY 19-20					
Revenue increase (replaced under-paid managed care with Medicare)		180,459		360,919	$ 541,378
Revenue increase	1%	122,890	3%	860,675	$ 983,565
Direct expense		(154,340)		(463,019)	$ (617,358)
Gross margin		149,010		758,575	$ 907,585
Expense increase					
Additional hiring (3.0 FTE)		125,517		251,033	$ 376,550
Annual raise	3%	195,018		390,037	$ 585,055
Health and dental insurance	8%	67,169		134,337	$ 201,506
Rent increase for the East Bay office		25,908		51,816	$ 77,724
General & administrative		13,180		26,360	$ 39,540
Depreciation		44,646		89,293	$ 133,939
Total Expense increase		471,438		942,876	$ 1,414,314
Expense savings					
Reduction in force and job restructure from 04/01/19		(298,193)		(596,385)	$ (894,578)
Savings from not replacing 2.0 fte physical therapist		(97,621)		(195,243)	$ (292,864)
Total expense savings		(395,814)		(791,628)	$ (1,187,442)
CHI (11/01/19-06/30/20)					
Reduction of Pathways overhead costs				(3,304,273)	$ (3,304,273)
CHI management fee				2,655,064	$ 2,655,064
Total transitions savings				(649,209)	$ (649,209)
NET CHANGES		**73,386**		**1,256,536**	**$ 1,329,922**
ANNUAL FY 19 - 20 OPERATING LOSS					**$ (1,994,686)**

INFORMATION FORECAST FROM NOV '19 - JUN '20
ESTIMATE TRANSITION COST TO CHI

		$ COST
SEVERANCE		
Executives		
Billing & Finance		
HR & Recruitment		
Director of Quality		
Director of Sales		
Director of Contract		
IT Dept.		
Marketing & Communications		
TOTAL	$	1,693,559
RETENTION		
Executives		
Director of HR		
Controller		
TOTAL	$	538,250
EPIC NET RESIDUAL VALUE	$	1,664,368
ELECTRONIC HEALTH RECORD EDUCATION & TRAINING TO HOMECARE HOMEBASE (EHR)		
Training & education (16 hours for field staff)	$	116,928
Productivity loss (20% first month, 10% 2nd month - field staff)	$	338,661
TOTAL ESTIMATE TRANSITIONS COST	**$**	**4,351,766**

IT - CAPITAL BUDGET FY 2019 - 2020

Type of Equipment (fax, computer, cell, printer, network, software, office space changes, etc.)	Requestor	Purposes & Dept	Capital Cost $	Professional Svcs.	Recurring Maint. & Supp	new or replace
Laptop/Tablet (40) Replacements	Brad Miller	Replacements	$ 40,000			Replace
Desktop (20) Replacements	Brad Miller	Replacements	$ 20,000			New
Laptop Net New Hires	Brad Miller	Net New Position Hires	$ 8,500			New
Microsoft Eenterprise Agreement	Brad Miller	Microsoft Licensing (Year 8)	$ 135,000			Replace
Manage Engine AD Audit	Brad Miller				$ 5,000	New
SF and EB Private Internet Lines	Brad Miller	DSL line at branch offices for volunteers and bereavement patients to use			$ 3,000	New
xMedius Enterprise Fax Upgrade	Brad Miller	Provide a HA and DR scenario for Fax system	$ 22,260	$ 1,595	$ 3,472	Replace
Cisco Umbrella Security	Brad Miller				$ 36,000	Replace
DR Project	Brad Miller	DR Project including phone system upgrade	$ 90,000			Replace
DR Testing and Run Book Development	Brad Miller	Develop quarterly procedures for testing our failover processes. Resolve any identied technical issues during the intital testing. Generate a DR Run Book to follow in the event of outage.		$ 40,000		New
Accounting software	Phuong Nhan	MS Dynamics version upgrade - current version is no longer supported	$ 10,000	$ 10,000	$ 3,500	Replace
Cisco Video Conferencing	Brad Miller	Multi-site Conference room video conferencing and recording solution.	$ 200,000	$ 50,000	$ 10,000	New
			$ 525,760	$ 101,595	$ 60,972	
		IT Annual Cost	**$ 688,327**			

EL CAMINO HOSPITAL
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, FACS, Chief Medical Officer
Date: August 21, 2019
Subject: Emergency and Inpatient Professional Services Panel Agreement for On-Call Cardiothoracic Surgery – Mountain View Campus

Recommendation(s):

To approve delegating to the CEO the authority to execute a two-year renewal agreement for the Emergency and Inpatient Professional Services Panel Agreement for On-Call Cardiothoracic Surgery for the Mountain View campus at the existing per diem rate of $1,200, not to exceed $438,000 annually, to be effective September 1, 2019.

Summary:

1. Situation: The Hospital has an Emergency and Inpatient Professional Services Agreement for On-Call Cardiothoracic Surgery Panel at the Mountain View campus in which cardiothoracic surgeons respond when needed for emergency evaluations and surgical interventions for patients in the Mountain View Emergency Department and Cath Lab.

   Currently, the Mountain View Campus has five (5) cardiothoracic surgeons contracted through Palo Alto Medical Foundation (PAMF) at the rate of $1,200/day, not to exceed $438,000 annually, which expires August 31, 2019.

2. Authority: According to Administrative Policies and Procedures 51.00, Finance Committee approval is required prior to the CEO signature of physician agreements that exceed an annual amount of $250,000, and Finance Committee and Board approvals are required for physician agreements that exceed the 75th percentile for fair market value.

3. Background: The current On-Call Cardiothoracic Surgery Panel Agreement with PAMF has been in place since 2013 for 365 days of coverage. In 2017, the Hospital's Board of Directors approved a two year renewal at the existing rate of $1,200/day.

4. Fair Market Value Assessment: The call coverage per diem rate of $1,200 is slightly above the 75th percentile ($1,120) and below the 90th percentile ($1,500) according to 2019 MD Ranger All Facilities General Acute Care Beds over 300 data for Cardiothoracic Surgery Call Coverage Services.

5. Other Reviews: Legal and Compliance will review the final agreement and compensation terms prior to CEO execution. The Finance Committee reviewed this proposal at its July 29, 2019 meeting and recommended it for approval.

6. Outcomes: Physicians will participate in the peer review process for consultations and subsequent surgeries related to Cardiothoracic Surgery call coverage.

List of Attachments: N/A

Suggested Board Discussion Questions: N/A

EL CAMINO HOSPITAL
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, FACS, Chief Medical Officer
Date: August 21, 2019
Subject: Income Guarantee Recruitment Loan for Colorectal Surgeon

Recommendation(s):

To approve delegating to the CEO the authority to execute a physician recruitment agreement with a not to exceed loan amount of $520,000 to recruit a new General/Colon Rectal Surgeon at the Los Gatos campus to meet the community need and succession planning for the community.

Summary:

1. Situation: There is a fundamental need to support growth and succession planning for General Surgeons who perform Colon Rectal Surgical services in the ECH community. The following data from the ECG assessment shows:

- Current Need: 8 Physicians
- Growth Need (over 3 years): 3 Physicians
- Succession Need (physicians over the age of 60): 9.4 Physicians

2. Authority: According to the Physician Recruitment Program Policy, Finance Committee and Board approvals are required prior to the CEO signature of physician recruitment agreements that exceed an amount of $500,000.

3. Background: Patients in the community are currently being referred to USCF and other healthcare organizations outside of the service area due to the limited access to Colon Rectal surgeons who are still actively providing procedural services. There are three (3) other aging (over the age of 60) Colon Rectal surgeons in the Los Gatos service area that are now only providing inpatient services and have stopped providing procedure and surgical services. These surgeons are also no longer sharing call, making it difficult for the sole physicians to manage the increase in volume.

4. Fair Market Value Assessment: The proposed loan amount of $520,000 is between the 50th percentile ($473,484) and 75th percentile ($533,565) according to SullivanCotter's Market Survey Data from 2018 for Colon and Rectal Surgery.

5. Other Reviews: The COO, Los Gatos Administrators, and the Service Line leaders all support this recruitment and confirm the community need. The Finance Committee reviewed and recommended approval of this proposal on July 29, 2019.

6. Outcomes: The surgeon is planning to establish a practice in the Los Gatos community in September 2019.

List of Attachments: N/A

Suggested Board Discussion Questions: None. This is a consent item.

El Camino Health

Summary of Financial Operations

Fiscal Year 2019 – Period 11

7/1/2018 to 05/31/2019

Financial Overview

Volume

May

- May operating income is favorable to budget by 51.4% ($4.7M) driven by favorable revenue 6.9% ($5.7M) offset by unfavorable operating expense -1.4% ($1.0M).
  - Mountain View operating income favorable by 104.1% ($7.0M)
  - Los Gatos operating income unfavorable by -89.2% (-$2.3M)
- May operating Income if favorable to prior year by 62.6% ($5.4M)

Year to Date

- YTD operating income is favorable to budget by 24.9% ($23.6M) driven by favorable revenue 1.9% ($16.3M) and favorable operating expense 0.9% ($7.2M). Favorable revenue is partially due to $18 million in unusual items and continued improvement to revenue cycle by lowering denials and underpayments.
  - Mountain View operating income favorable by 44.9% ($33.1M)
  - Los Gatos operating income unfavorable by -45.2% (-$9.5M)
- YTD operating income is unfavorable to prior year by by 1.0% ($1.2M)

Payor Mix

- YTD, Commercial is 2.2 percentage points unfavorable

Cost

- Prod FTEs were unfavorable to target for May by 1.5% and on target YTD.

Dashboard - ECH combined as of May 31, 2019

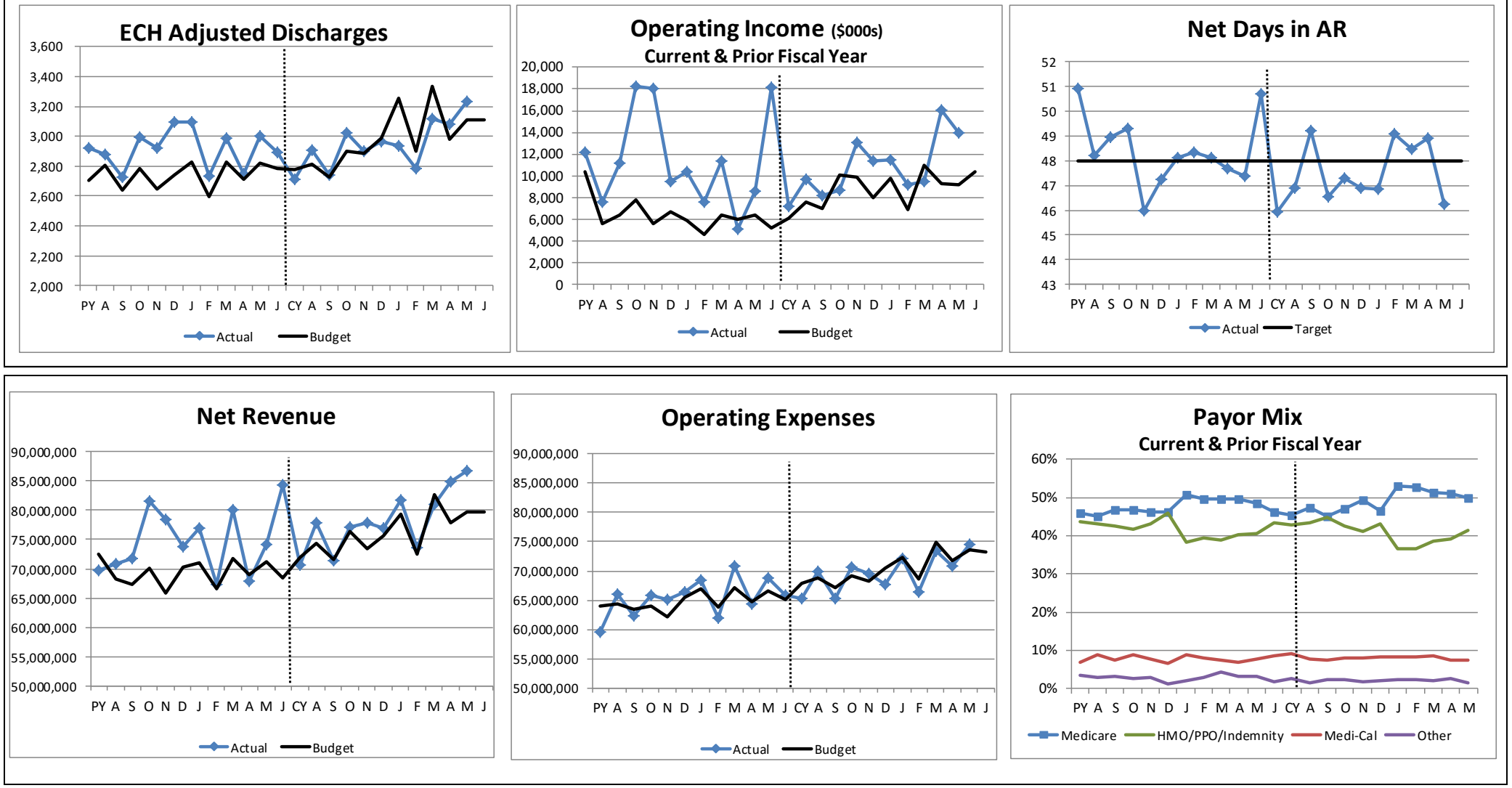
	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Volume								
Licenced Beds	443	443	443	-	443	443	443	-
ADC	219	245	252	(7)	240	243	247	(4)
Utilization MV	60%	67%	70%	-3%	66%	67%	68%	-1%
Utilization LG	26%	32%	30%	1%	30%	30%	30%	0%
Utilization Combined	49%	55%	57%	-2%	54%	55%	56%	-1%
Total Discharges (Excl NNB)	1,669	1,832	1,805	27	18,646	18,460	19,032	(572)
Financial Perf.								
Total Operating Revenue	77,398	88,563	82,761	5,802	839,262	884,026	867,625	16,401
Operating Income $	8,566	13,988	9,195	4,794	119,715	118,573	94,913	23,660
Operating Margin	11.1%	15.8%	11.1%	4.7%	14.3%	13.4%	10.9%	2.5%
EBIDA %	17.0%	20.9%	18.1%	2.8%	20.3%	19.2%	17.3%	1.9%
Payor Mix								
Medicare	48.6%	49.8%	46.5%	3.3%	47.7%	49.1%	46.6%	2.4%
Medi-Cal	7.6%	7.4%	8.3%	-0.9%	7.7%	8.0%	7.9%	0.1%
Total Commercial	41.1%	41.2%	42.6%	-1.4%	42.0%	40.6%	42.8%	-2.2%
Other	2.6%	1.6%	2.7%	-1.1%	2.5%	2.3%	2.6%	-0.3%
Cost								
Total FTE	2,564.2	2,737.3	2,739.4	(2)	2,578.2	2,675.4	2,703.2	(28)
Productive Hrs/APD	31.3	30.8	30.8	0	30.3	30.6	31.3	(1)
Balance Sheet								
Net Days in AR	50.7	46.3	48.0	(2)	50.7	46.3	48.0	(1.7)
Days Cash	505	495	449	46	505	495	449	46
Affiliates - Net Income ($000s)								
Hosp	17,733	(7,092)	9,541	(16,633)	172,204	120,613	99,384	21,229
Concern	(139)	(475)	69	(544)	801	1,779	811	967
ECSC	(30)	(25)	0	(25)	(91)	(102)	0	(102)
Foundation	22	(482)	61	(543)	1,738	2,074	1,251	823
SVMD	557	5,789	47	5,742	1,397	8,272	(31)	8,303

El Camino Hospital ($000s)

Period ending 05/31/2019

Period 11 FY 2018	Period 11 FY 2019	Period 11 Budget 2019	Variance Fav (Unfav)	Var%	$000s	YTD FY 2018	YTD FY 2019	YTD Budget 2019	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
277,853	309,755	310,951	(1,196)	(0.4%)	**Gross Revenue**	3,027,371	3,237,768	3,247,107	(9,339)	(0.3%)
(203,761)	(223,067)	(231,324)	8,256	3.6%	**Deductions**	(2,215,216)	(2,378,016)	(2,411,943)	33,927	1.4%
74,092	**86,688**	**79,627**	**7,061**	**8.9%**	**Net Patient Revenue**	**812,155**	**859,752**	**835,164**	**24,588**	**2.9%**
3,305	1,875	3,134	(1,258)	(40.2%)	**Other Operating Revenue**	27,107	24,274	32,461	(8,187)	(25.2%)
77,398	**88,563**	**82,761**	**5,802**	**7.0%**	**Total Operating Revenue**	**839,262**	**884,026**	**867,625**	**16,401**	**1.9%**
					OPERATING EXPENSE					
40,884	44,624	44,084	(540)	(1.2%)	**Salaries & Wages**	432,661	463,141	466,659	3,518	0.8%
11,556	13,338	12,560	(778)	(6.2%)	**Supplies**	116,771	125,298	127,619	2,321	1.8%
9,404	9,365	8,687	(677)	(7.8%)	**Fees & Purchased Services**	94,299	98,936	96,957	(1,979)	(2.0%)
2,368	2,708	2,459	(249)	(10.1%)	**Other Operating Expense**	25,265	26,967	26,659	(308)	(1.2%)
431	189	1,425	1,236	86.8%	**Interest**	5,290	3,871	6,261	2,390	38.2%
4,189	4,352	4,351	(1)	(0.0%)	**Depreciation**	45,259	47,240	48,557	1,317	2.7%
68,832	**74,575**	**73,567**	**(1,009)**	**(1.4%)**	**Total Operating Expense**	**719,547**	**765,453**	**772,712**	**7,259**	**0.9%**
8,566	**13,988**	**9,195**	**4,794**	**52.1%**	**Net Operating Income/(Loss)**	**119,715**	**118,573**	**94,913**	**23,660**	**24.9%**
9,167	(21,080)	346	(21,426)	(6185.0%)	**Non Operating Income**	52,489	2,040	4,471	(2,431)	(54.4%)
17,733	**(7,092)**	**9,541**	**(16,633)**	**(174.3%)**	**Net Income(Loss)**	**172,204**	**120,613**	**99,384**	**21,229**	**21.4%**
17.0%	20.9%	18.1%	2.8%		**EBITDA**	20.3%	19.2%	17.3%	1.9%	
11.1%	15.8%	11.1%	4.7%		**Operating Margin**	14.3%	13.4%	10.9%	2.5%	
22.9%	-8.0%	11.5%	(19.5%)		**Net Margin**	20.5%	13.6%	11.5%	2.2%	

Monthly Financial Trends



El Camino Health

Updated Quarterly
Last update 03/31/19

INVESTMENT SCORECARD AS OF MARCH 31, 2019

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY19 Year End Budget	Expectation Per Asset Allocation
Investment Performance		**1Q 2019**		**Fiscal Year-to-date**		**6y 5m Since Inception (annualized)**			**2018**
Surplus cash balance*		$999.8	--	--	--	--	--	$891.1	--
Surplus cash return		6.7%	6.7%	2.6%	2.6%	5.4%	5.2%	3.2%	5.3%
Cash balance plan balance (millions)		$270.6	--	--	--	--	--	$276.9	--
Cash balance plan return		8.3%	7.7%	2.9%	2.7%	7.6%	6.8%	6.0%	5.7%
403(b) plan balance (millions)		$496.8	--	--	--	--	--	--	--
Risk vs. Return		**3-year**				**6y 5m Since Inception (annualized)**			**2018**
Surplus cash Sharpe ratio		1.16	1.09	--	--	1.03	1.00	--	0.43
Net of fee return		6.9%	6.3%	--	--	5.4%	5.2%	--	5.3%
Standard deviation		4.8%	4.6%	--	--	4.7%	4.6%	--	6.7%
Cash balance Sharpe ratio		1.18	1.08	--	--	1.14	1.07	--	0.40
Net of fee return		8.3%	7.3%	--	--	7.6%	6.8%	--	5.7%
Standard deviation		6.0%	5.5%	--	--	6.1%	5.8%	--	8.1%
Asset Allocation		**1Q 2019**							
Surplus cash absolute variances to target		8.8%	< 10%	--	--	--	--	--	--
Cash balance absolute variances to target		5.4%	< 10%	--	--	--	--	--	--
Manager Compliance		**1Q 2019**							
Surplus cash manager flags		22	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		27	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$105 mm), District assets (~$38 mm), and balance sheet cash not in investable portfolio (~$100 mm). Includes Foundation (~$29 mm) and Concern (~$14 mm) assets. Budget adds back in current Foundation and Concern assets and backs out current debt reserve funds.

El Camino Health

Balance Sheet

(in thousands)

ASSETS

		May 31, 2019	Audited June 30, 2018
	CURRENT ASSETS		
	Cash	110,404	118,992
	Short Term Investments	150,050	150,664
	Patient Accounts Receivable, net	126,974	124,427
	Other Accounts and Notes Receivable	3,312	3,402
	Intercompany Receivables	4,914	2,090
(1)	Inventories and Prepaids	81,454	75,594
	Total Current Assets	**477,109**	**475,171**
	BOARD DESIGNATED ASSETS		
	Plant & Equipment Fund	167,411	153,784
(2)	Women's Hospital Expansion	15,472	9,298
(3)	Operational Reserve Fund	139,057	127,908
	Community Benefit Fund	17,990	18,675
	Workers Compensation Reserve Fund	22,232	20,263
	Postretirement Health/Life Reserve Fund	29,762	29,212
	PTO Liability Fund	26,476	24,532
	Malpractice Reserve Fund	1,831	1,831
	Catastrophic Reserves Fund	18,331	18,322
	Total Board Designated Assets	**438,561**	**403,826**
(4)	**FUNDS HELD BY TRUSTEE**	**88,901**	**197,620**
	LONG TERM INVESTMENTS	**363,153**	**345,684**
	INVESTMENTS IN AFFILIATES	**42,765**	**32,412**
	PROPERTY AND EQUIPMENT		
	Fixed Assets at Cost	1,301,542	1,261,854
	Less: Accumulated Depreciation	(616,414)	(577,959)
	Construction in Progress	369,328	220,991
	Property, Plant & Equipment - Net	**1,054,456**	**904,886**
	DEFERRED OUTFLOWS	20,626	21,177
	RESTRICTED ASSETS - CASH	-	0
	TOTAL ASSETS	**2,485,571**	**2,380,776**

LIABILITIES AND FUND BALANCE

		May 31, 2019	Audited June 30, 2018
	CURRENT LIABILITIES		
(5)	Accounts Payable	35,812	49,925
	Salaries and Related Liabilities	26,943	26,727
	Accrued PTO	26,476	24,532
	Worker's Comp Reserve	2,300	2,300
	Third Party Settlements	12,041	10,068
	Intercompany Payables	434	125
	Malpractice Reserves	1,831	1,831
(6)	Bonds Payable - Current	8,630	3,850
(7)	Bond Interest Payable	7,814	12,975
	Other Liabilities	8,509	8,909
	Total Current Liabilities	**130,789**	**141,242**
	LONG TERM LIABILITIES		
	Post Retirement Benefits	29,762	29,212
	Worker's Comp Reserve	19,932	17,963
	Other L/T Obligation (Asbestos)	3,965	3,859
	Other L/T Liabilities (IT/Medl Leases)	-	-
(8)	Bond Payable	510,545	517,781
	Total Long Term Liabilities	**564,204**	**568,815**
	DEFERRED REVENUE-UNRESTRICTED	596	528
	DEFERRED INFLOW OF RESOURCES	22,835	22,835
	FUND BALANCE/CAPITAL ACCOUNTS		
	Unrestricted	1,328,586	1,243,529
	Board Designated	438,561	403,825
	Restricted	-	0
(9)	**Total Fund Bal & Capital Accts**	**1,767,147**	**1,647,355**
	TOTAL LIABILITIES AND FUND BALANCE	**2,485,571**	**2,380,776**

El Camino Health

May 2019 El Camino Hospital Comparative Balance Sheet Variances and Footnotes

(1) Increase due to quarterly pension contributions to the plan.

(2) The increase is due to the District making a transfer from its Capital Appropriation Fund in support of the upcoming renovation to the Women's Hospital.

(3) The increase is due to annual resetting of the 60 day Operational Reserve based on the new FY2019 budget that has started.

(4) Decrease is due to draws from the 2015A/2017 Bond Project funds for the on-going IMOB and BHS construction and semi-annual 2015/2017 bond payment

(5) Decrease is due to the yearend accruals that were paid out in July and August 2018.

(6) The increase is due to recognition of the first 2017 principal bond payment that will be in February 2020.

(7) Semi-annual bond payments of interest and principal were made on the 2015A and 2017 Bonds in February.

(8) Decrease is due to the establishment of FY2020 2015A and 2017 Bond Principal Payable moving to current bond payables.

(9) Increase in total Fund Balance is driven by y-t-d net income and that Capital Appropriate Fund transfer by District, discussed in item #2 above.

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (1 OF 2)

- **Plant & Equipment Fund –** original established by the District Board in the early 1960's to fund new capital expansion projects of building facilities or equipment (new or replacements). The funds came from the M&O property taxes being received and the funding depreciation expense at 100%. When at the end of 1992, the 501(c)(3) Hospital was performed by the District, the property tax receipts remained with the District. The newly formed Hospital entity continued on with funding depreciation expense, but did that funding at 130% of the depreciation expense to account for an expected replacement cost of current plant and property assets. It is to be noted that within this fund is an itemized amount of $14 million for the Behavioral Health Service building replacement project. This amount came from the District's Capital Appropriation Fund (excess Gann Limit property taxes) of the fiscal years of 2010 thru 2013 by various District board actions.

- **Women's Hospital Expansion –** established June 2016 by the District authorizing the amounts accumulated in its Capital Appropriation Fund (excess Gann Limit property taxes) for the fiscal years of 2014 and 2015 to be allocated for the renovation of the Women's Hospital upon the completion of Integrated Medical Office Building currently under construction. At the end of fiscal year 2018 another $6.2 million was added to this fund.

- **Operational Reserve Fund –** originally established by the District in May 1992 to establish a fund equal to sixty (60) days of operational expenses (based on the current projected budget) and only be used in the event of a major business interruption event and/or cash flow.

- **Community Benefit Fund –** following in the footsteps of the District in 2008 of forming its Community Benefit Fund using Gann Limit tax receipts, the Hospital in 2010 after opening its campus outside of District boundaries in Los Gatos formed its own Community Benefit Fund to provide grants/sponsorships in Los Gatos and surrounding areas. The funds come from the Hospital reserving $1.5M a year from its operations, the entity of CONCERN contributing 40% of its annual income each year (an amount it would have paid in corporate taxes if it wasn't granted tax exempt status), that generates an amount of $500,000 or more a year. $15 million within this fund is a board designated endowment fund formed in 2015 with a $10 million contribution, and added to at the end of the 2017 fiscal year end with another $5 million contribution, to generate investment income to be used for grants and sponsorships.

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (2 OF 2)

- **Workers Compensation Reserve Fund** – as the Hospital is self-insured for its workers compensation program (since 1978) this fund was originally formed in early 2000's by management to reserve cash equal to the yearly actuarially determined Workers Compensation amount. The thought being if the business was to terminate for some reason this is the amount in cash that would be needed to pay out claims over the next few years.

- **Postretirement Health/Life Reserve Fund –** following the same formula as the Workers Compensation Reserve Fund this fund was formed in the early 2000's by management to reserve cash equal to the yearly actuarially determined amount to fund the Hospital's postretirement health and life insurance program. Note this program was frozen in 1995 for all new hires after that date. At the end of fiscal year 2018, GASB #75 was implemented that now represents the full actuarially determined liability.

- **PTO (Paid Time Off) Liability Fund –** originally formed in 1993 as the new 501(c)(3) Hospital began operations, management thought as a business requirement of this vested benefit program that monies should be set aside to extinguish this employee liability should such a circumstance arise. This balance is equal to the PTO Liability on the Balance Sheet.

- **Malpractice Reserve Fund –** originally established in 1989 by the then District's Finance Committee and continued by the Hospital. The amount is actuarially determined each year as part of the annual audit to fund potential claims less than $50,000. Above $50,000 our policy with the BETA Healthcare Group kicks in to a $30 million limit per claim/$40 million in the aggregate.

- **Catastrophic Loss Fund –** was established in 1999 by the Hospital Board to be a "self-insurance" reserve fund for potential non-major earthquake repairs. Initially funded by the District transferring $5 million and has been added to by the last major payment from FEMA for the damage caused the Hospital by the October 1989 earthquake. It is to be noted that it took 10 years to receive final settlement from FEMA grants that totaled $6.8 million that did mostly cover all the necessary repairs.

APPENDIX

El Camino Hospital – Mountain View ($000s)

Period ending 05/31/2019

Period 11 FY 2018	Period 11 FY 2019	Period 11 Budget 2019	Variance Fav (Unfav)	Var%	$000s	YTD FY 2018	YTD FY 2019	YTD Budget 2019	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
227,364	251,681	249,373	2,308	0.9%	**Gross Revenue**	2,483,199	2,657,054	2,635,811	21,243	0.8%
(167,004)	(178,923)	(185,951)	7,028	3.8%	**Deductions**	(1,814,077)	(1,947,365)	(1,961,916)	14,551	0.7%
60,361	**72,757**	**63,422**	**9,335**	**14.7%**	**Net Patient Revenue**	**669,122**	**709,689**	**673,895**	**35,794**	**5.3%**
3,084	1,492	2,893	(1,401)	(48.4%)	**Other Operating Revenue**	25,071	20,778	29,822	(9,044)	(30.3%)
63,444	**74,250**	**66,316**	**7,934**	**12.0%**	**Total Operating Revenue**	**694,193**	**730,467**	**703,717**	**26,750**	**3.8%**
					OPERATING EXPENSE					
34,026	36,981	36,683	(298)	(0.8%)	**Salaries & Wages**	360,079	385,747	388,946	3,199	0.8%
9,573	11,012	9,711	(1,301)	(13.4%)	**Supplies**	95,287	102,503	102,458	(46)	(0.0%)
7,962	7,808	7,326	(482)	(6.6%)	**Fees & Purchased Services**	79,538	82,966	82,145	(822)	(1.0%)
831	1,005	862	(142)	(16.5%)	**Other Operating Expense**	8,135	9,654	9,687	33	0.3%
431	189	1,425	1,236	86.8%	**Interest**	5,290	3,871	6,261	2,390	38.2%
3,496	3,537	3,619	82	2.3%	**Depreciation**	38,466	38,722	40,410	1,688	4.2%
56,318	**60,532**	**59,627**	**(905)**	**(1.5%)**	**Total Operating Expense**	**586,795**	**623,464**	**629,907**	**6,444**	**1.0%**
7,127	**13,717**	**6,689**	**7,029**	**105.1%**	**Net Operating Income/(Loss)**	**107,398**	**107,004**	**73,810**	**33,193**	**45.0%**
9,167	(21,080)	346	(21,426)	(6185.0%)	**Non Operating Income**	52,534	2,040	4,471	(2,431)	(54.4%)
16,294	**(7,362)**	**7,035**	**(14,398)**	**(204.6%)**	**Net Income(Loss)**	**159,932**	**109,043**	**78,281**	**30,762**	**39.3%**
17.4%	23.5%	17.7%	5.8%		**EBITDA**	21.8%	20.5%	17.1%	3.4%	
11.2%	18.5%	10.1%	8.4%		**Operating Margin**	15.5%	14.6%	10.5%	4.2%	
25.7%	-9.9%	10.6%	(20.5%)		**Net Margin**	23.0%	14.9%	11.1%	3.8%	

El Camino Hospital – Los Gatos($000s)

Period ending 05/31/2019

Period 11 FY 2018	Period 11 FY 2019	Period 11 Budget 2019	Variance Fav (Unfav)	Var%	$000s	YTD FY 2018	YTD FY 2019	YTD Budget 2019	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
50,489	58,074	61,578	(3,504)	(5.7%)	**Gross Revenue**	544,172	580,714	611,296	(30,582)	(5.0%)
(36,757)	(44,144)	(45,373)	1,229	2.7%	**Deductions**	(401,140)	(430,651)	(450,027)	19,376	4.3%
13,732	**13,930**	**16,205**	**(2,275)**	**(14.0%)**	**Net Patient Revenue**	**143,033**	**150,063**	**161,269**	**(11,206)**	**(6.9%)**
222	383	240	143	59.4%	**Other Operating Revenue**	2,036	3,496	2,639	857	32.5%
13,953	**14,314**	**16,445**	**(2,132)**	**(13.0%)**	**Total Operating Revenue**	**145,069**	**153,559**	**163,908**	**(10,349)**	**(6.3%)**
					OPERATING EXPENSE					
6,858	7,642	7,401	(241)	(3.3%)	**Salaries & Wages**	72,582	77,394	77,713	319	0.4%
1,983	2,326	2,849	523	18.4%	**Supplies**	21,485	22,795	25,162	2,367	9.4%
1,442	1,556	1,361	(195)	(14.3%)	**Fees & Purchased Services**	14,761	15,970	14,812	(1,157)	(7.8%)
1,538	1,703	1,597	(106)	(6.7%)	**Other Operating Expense**	17,130	17,313	16,971	(341)	(2.0%)
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
693	815	732	(84)	(11.4%)	**Depreciation**	6,793	8,518	8,147	(371)	(4.6%)
12,514	**14,043**	**13,940**	**(103)**	**(0.7%)**	**Total Operating Expense**	**132,752**	**141,989**	**142,805**	**816**	**0.6%**
1,439	**271**	**2,506**	**(2,235)**	**(89.2%)**	**Net Operating Income/(Loss)**	**12,317**	**11,569**	**21,103**	**(9,534)**	**(45.2%)**
0	0	0	0	0.0%	**Non Operating Income**	(45)	0	0	0	0.0%
1,439	**271**	**2,506**	**(2,235)**	**(89.2%)**	**Net Income(Loss)**	**12,272**	**11,569**	**21,103**	**(9,534)**	**(45.2%)**
15.3%	7.6%	19.7%	(12.1%)		**EBITDA**	13.2%	13.1%	17.8%	(4.8%)	
10.3%	1.9%	15.2%	(13.3%)		**Operating Margin**	8.5%	7.5%	12.9%	(5.3%)	
10.3%	1.9%	15.2%	(13.3%)		**Net Margin**	8.5%	7.5%	12.9%	(5.3%)	

Non Operating Items and Net Income by Affiliate

$ in thousands

	Period 11 - Month			Period 11 - FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Income (Loss) from Operations						
Mountain View	13,717	6,689	7,029	107,004	73,810	33,193
Los Gatos	271	2,506	(2,235)	11,569	21,103	(9,534)
Sub Total - El Camino Hospital, excl. Afflilates	**13,988**	**9,195**	**4,794**	**118,573**	**94,913**	**23,660**
Operating Margin %	**15.8%**	**11.1%**		**13.4%**	**10.9%**	
El Camino Hospital Non Operating Income						
Investments[2]	(16,721)	2,368	(19,089)	22,330	26,705	(4,375)
Swap Adjustments	(855)	(100)	(755)	(1,981)	(1,100)	(881)
Community Benefit	(24)	(300)	276	(3,683)	(3,300)	(383)
Pathways	333	0	333	(732)	0	(732)
Satellite Dialysis	0	(25)	25	542	(275)	817
Community Connect	0	(53)	53	0	(283)	283
SVMD Funding[1]	(3,693)	(1,219)	(2,474)	(11,725)	(13,409)	1,684
Other	(227)	(324)	97	(2,939)	(3,867)	929
Sub Total - Non Operating Income	**(21,080)**	**346**	**(21,426)**	**2,040**	**4,471**	**(2,431)**
El Camino Hospital Net Income (Loss)	**(7,092)**	**9,541**	**(16,633)**	**120,613**	**99,384**	**21,229**
ECH Net Margin %	**-8.0%**	**11.5%**		**13.6%**	**11.5%**	
Concern	(475)	69	(544)	1,779	811	967
ECSC	(25)	0	(25)	(102)	0	(102)
Foundation	(482)	61	(543)	2,074	1,251	823
Silicon Valley Medical Development	5,789	47	5,742	8,272	(31)	8,303
Net Income Hospital Affiliates	**4,807**	**177**	**4,630**	**12,021**	**2,031**	**9,990**
Total Net Income Hospital & Affiliates	**(2,285)**	**9,718**	**(12,003)**	**132,634**	**101,415**	**31,219**

El Camino Health

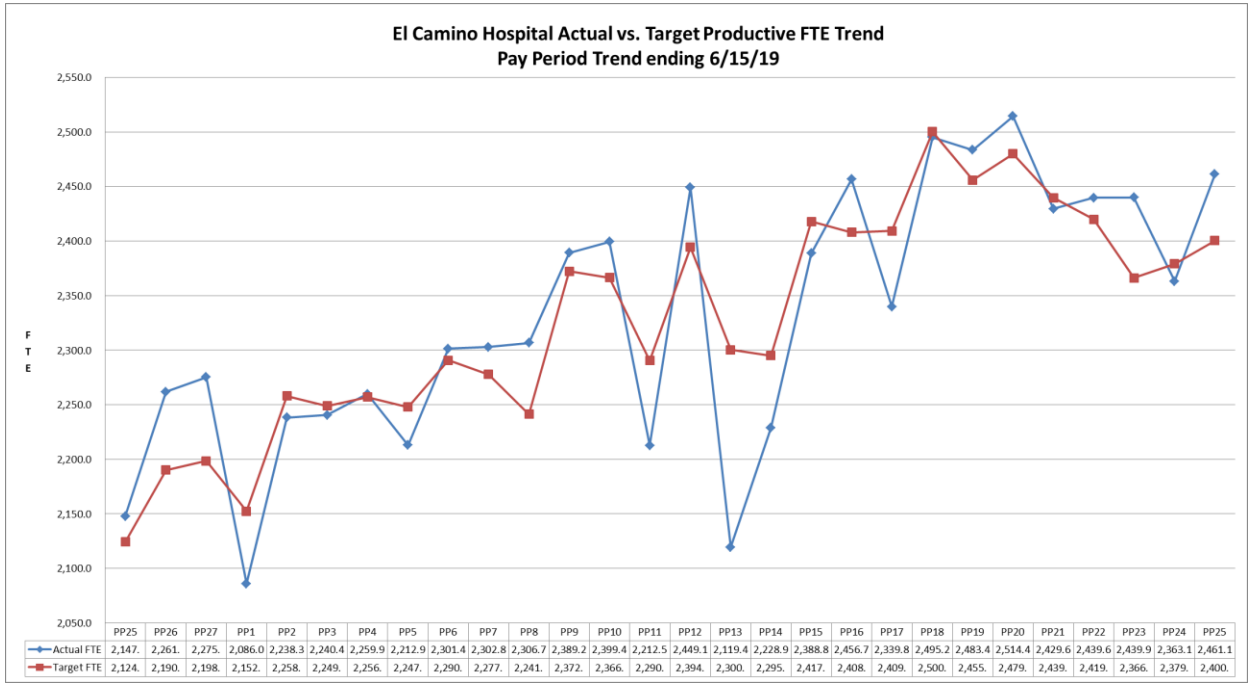
[1]Favorable variances for SVMD and Community Connect are due to delayed implementation

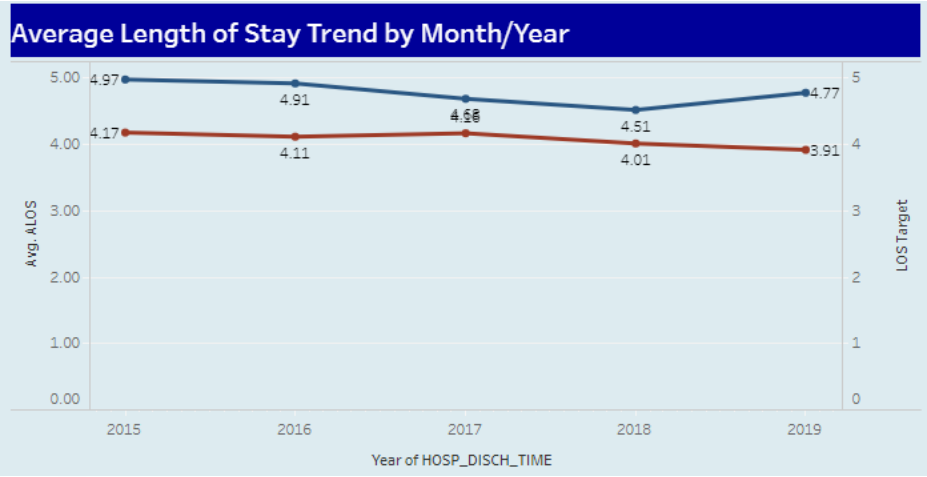
[2]Equity markets volatility is continuing

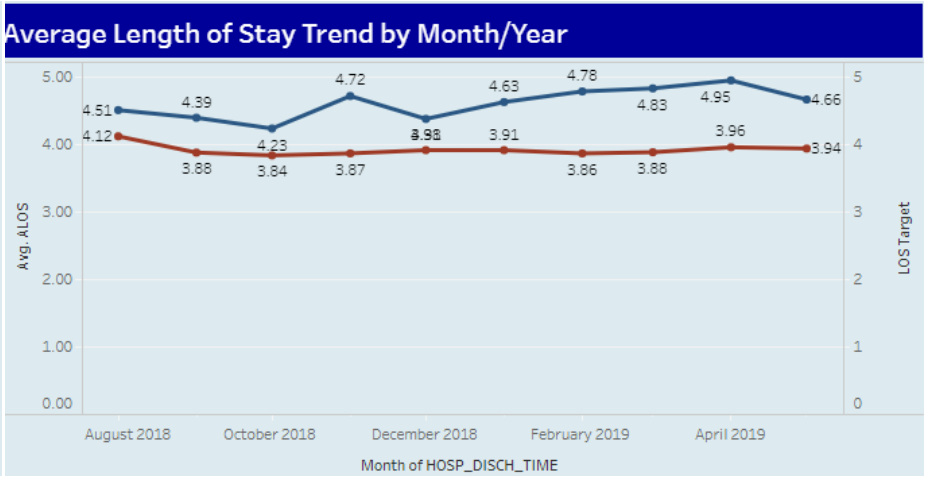
Productivity and Medicare Length of Stay

At or below FTE target. YTD we are slightly worse than budget (adjusted for volume). Ramp up for SJMG/SVMD beginning in PP19.

ALOS vs Milliman well-managed benchmark (red line). FY19 ALOS has increased due to long stay outlier cases beginning in January but improved in May







El Camino Health

El Camino Hospital Volume Annual Trends

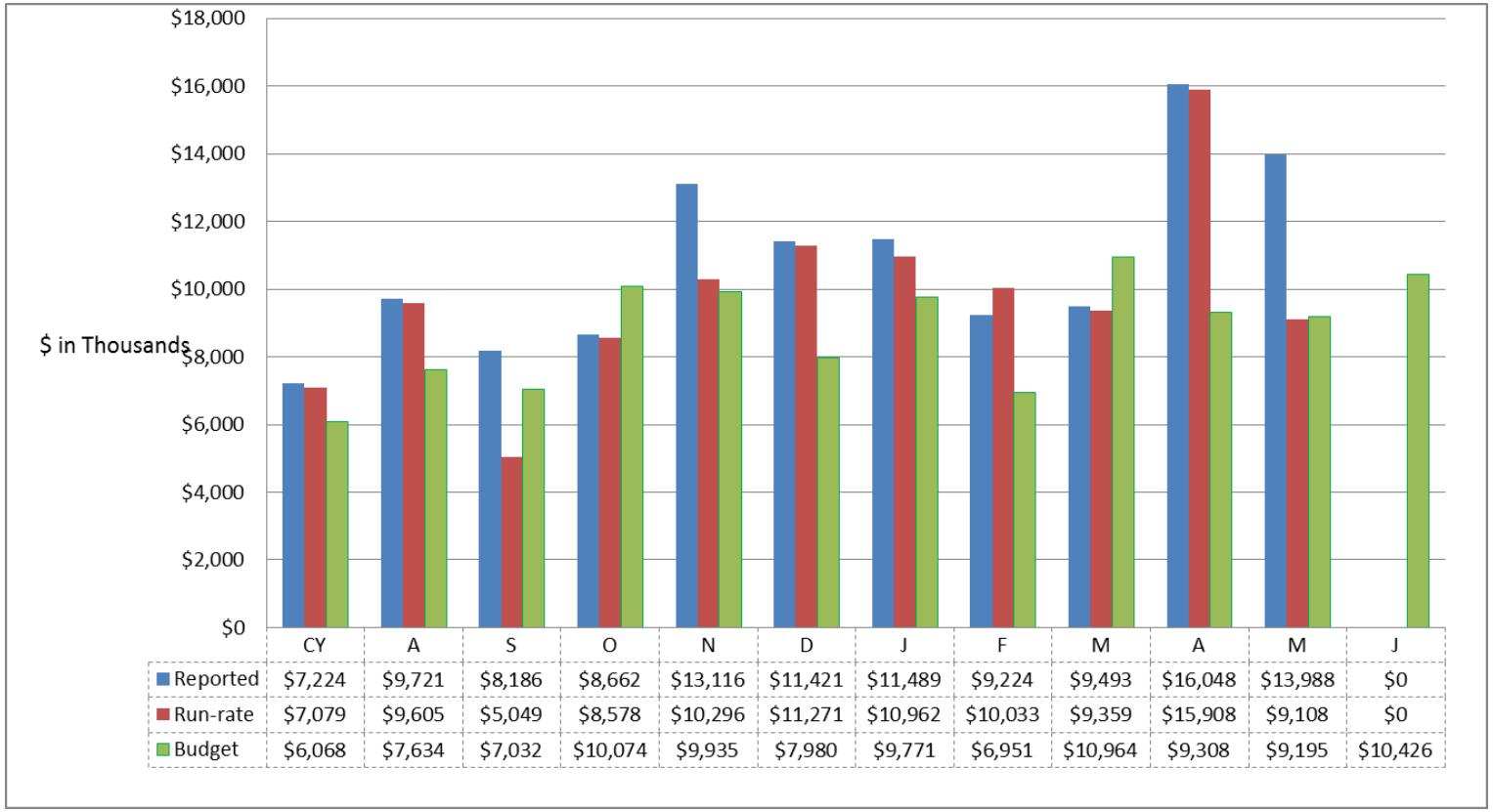
VOLUME BY SERVICE LINE

MONTH: 11-May | PROCEDURAL?: (All) | FACILITY: (All) | LEVEL OF DETAIL: Service Line

		ANNUAL TREND						FY19 Bud vs FY18		MONTH					YEAR				
		2014	2015	2016	2017	2018	2019(b)	Cases	Percent	PY	CY	Bud	Bud Var	PY Var	PY	CY	Bud	Bud Var	PY Var
IP	Behavioral Health	1,012	1,052	928	924	1,098	1,062	-36	-3.2%	107	113	89	24	6	1,021	1,070	976	94	49
	General Medicine & ..	4,165	4,592	4,459	4,960	5,285	5,325	40	0.8%	420	466	468	-2	46	4,897	4,736	4,881	-145	-161
	General Surgery	1,243	1,150	1,311	1,318	1,305	1,344	39	3.0%	107	127	122	5	20	1,162	1,289	1,219	70	127
	GYN	390	313	293	270	243	255	12	4.9%	16	21	20	1	5	224	216	234	-18	-8
	Heart and Vascular	1,859	1,998	2,001	2,204	2,372	2,445	73	3.1%	203	210	235	-25	7	2,181	2,100	2,243	-143	-81
	MCH	6,695	6,371	5,953	5,822	5,710	5,764	54	1.0%	485	495	490	5	10	5,232	4,974	5,278	-304	-258
	Neurosciences	667	672	677	688	870	907	37	4.3%	60	92	71	21	32	791	812	821	-9	21
	Oncology	606	564	652	594	632	726	94	14.9%	49	67	54	13	18	585	676	642	34	91
	Orthopedics	1,695	1,773	1,746	1,690	1,705	1,819	114	6.7%	134	140	142	-2	6	1,571	1,549	1,663	-114	-22
	Rehab Services	547	555	500	461	441	436	-5	-1.1%	41	52	37	15	11	402	473	399	74	71
	Spine Surgery	377	429	417	474	375	465	90	24.0%	19	33	45	-12	14	348	307	424	-117	-41
	Urology	172	169	234	257	255	274	19	7.4%	28	22	31	-9	-6	232	267	250	17	35
	Total	19,428	19,638	19,171	19,662	20,291	20,823	532	2.6%	1,669	1,838	1,805	33	169	18,646	18,469	19,032	-563	-177
OP	Behavioral Health	910	886	2,394	3,260	3,151	3,417	266	8.4%	248	260	329	-69	12	2,919	2,550	3,104	-554	-369
	Dialysis	1,059	155	6			0					0					0		
	Emergency	46,006	49,091	48,590	48,625	49,411	49,122	-289	-0.6%	4,090	4,148	4,316	-168	58	45,455	44,319	45,011	-692	-1,136
	General Medicine & ..	6,637	6,620	7,195	7,129	7,266	7,457	191	2.6%	663	740	623	117	77	6,642	7,387	6,823	564	745
	General Surgery	1,837	1,853	1,797	1,837	2,003	2,068	65	3.2%	180	160	193	-33	-20	1,834	1,777	1,895	-118	-57
	GYN	1,220	1,308	1,018	1,079	1,099	1,171	72	6.6%	85	138	88	50	53	1,017	1,297	1,054	243	280
	Heart and Vascular	2,570	2,712	3,795	4,361	4,364	4,410	46	1.1%	393	396	388	8	3	3,971	4,248	4,059	189	277
	Imaging Services	19,546	20,072	17,807	17,249	18,503	18,744	241	1.3%	1,649	1,659	1,657	2	10	16,940	17,466	17,068	398	526
	Laboratory Services	30,599	29,726	29,007	29,153	28,563	29,071	508	1.8%	2,298	2,429	2,529	-100	131	26,293	25,258	26,534	-1,276	-1,035
	MCH	5,034	4,826	5,092	5,576	5,642	5,928	286	5.1%	476	521	538	-17	45	5,192	5,026	5,416	-390	-166
	Neurosciences	110	61	127	125	114	155	41	36.0%	9	6	3	3	-3	107	75	140	-65	-32
	Oncology	4,015	4,179	14,329	18,541	19,276	22,037	2,761	14.3%	1,688	1,984	2,289	-305	296	17,684	18,991	19,712	-721	1,307
	Orthopedics	866	776	584	615	641	714	73	11.4%	74	77	53	24	3	582	693	657	36	111
	Outpatient Clinics	1,817	1,705	1,680	1,288	1,883	1,517	-366	-19.4%	144	106	130	-24	-38	1,728	1,471	1,390	81	-257
	Rehab Services	1,731	1,747	3,954	4,518	4,925	4,900	-25	-0.5%	453	497	457	40	44	4,503	5,066	4,456	610	563
	Sleep Center	160	223	498	368	242	300	58	24.0%	40	39	25	14	-1	209	312	273	39	103
	Spine Surgery	325	399	309	324	311	326	15	4.8%	30	27	19	8	-3	289	265	296	-31	-24
	Urology	1,755	1,771	1,739	1,898	2,053	2,058	5	0.2%	195	199	168	31	4	1,885	1,910	1,891	19	25
	Total	126,197	128,110	139,921	145,946	149,447	153,395	3,948	2.6%	12,715	13,386	13,806	-420	671	137,250	138,111	139,779	-1,668	861

ECH Operating Margin

Run rate is booked operating income adjusted for material non-recurring transactions



	CY	A	S	O	N	D	J	F	M	A	M	J
Reported	$7,224	$9,721	$8,186	$8,662	$13,116	$11,421	$11,489	$9,224	$9,493	$16,048	$13,988	$0
Run-rate	$7,079	$9,605	$5,049	$8,578	$10,296	$11,271	$10,962	$10,033	$9,359	$15,908	$9,108	$0
Budget	$6,068	$7,634	$7,032	$10,074	$9,935	$7,980	$9,771	$6,951	$10,964	$9,308	$9,195	$10,426

FY 2019 Actual Run Rate Adjustments (in thousands) - FAV / <UNFAV>													
Revenue Adjustments		J	A	S	O	N	D	J	F	M	A	M	YTD
	Mcare Settlmt/Appeal/Tent Settlmt/PIP	141	112	92	76	137	443	516	129	129	129	(79)	1,825
	BX/BS LD Settlement	-	-	-	-	-	-	-	-	-	-	-	-
	Medi-Cal Supplemental	-	-	-	-	-	-	-	-	-	-	-	-
	IGT Supplemental	-	-	-	-	2,672	-	-	-	-	-	-	2,672
	AB 915	-	-	2,875	-	-	-	-	-	-	-	1,282	4,157
	RAC Release	-	-	161	-	-	(305)	-	(1,005)	-	-	-	(1,149)
	Hospital Fee	-	-	-	-	-	-	-	-	-	-	3,717	3,717
	Various Adjustments under $250k	4	5	6	8	11	12	12	66	6	11	(41)	100
	Total	**145**	**116**	**3,137**	**84**	**2,820**	**150**	**528**	**(809)**	**135**	**140**	**4,880**	**11,325**

El Camino Health

El Camino Hospital

Capital Spending (in millions)

Category		Detail	Approved	Total Estimated Cost of Project	Total Authorized Active	Spent from Inception	FY19 Budget	FY 19 YTD Spent
CIP		ERP Upgrade			9.6	5.7	9.6	5.7
IT Hardware, Software, Equipment & Imaging					10.1	7.8	10.1	7.8
Medical & Non Medical Equipment FY 18					5.6	10.2	0.0	4.2
Medical & Non Medical Equipment FY 19					11.2	11.5	11.2	11.5
Facility Projects								
	1245	Behavioral Health Bldg	FY16	96.1	96.1	74.2	45.0	28.3
	1413	North Drive Parking Expansion	FY15	24.5	24.5	24.4	0.0	0.2
	1414	Integrated MOB	FY15	302.1	302.1	222.6	150.0	102.2
	1422	CUP Upgrade	FY16	9.0	9.0	8.4	0.8	0.8
	1430	Women's Hospital Expansion	FY16	135.0	135.0	6.4	10.0	3.2
		Demo Old Main & Related Site Work		30.0	30.0	0.0	2.0	0.0
	1502	Cabling & Wireless Upgrades	FY16	0.0	0.0	2.8	0.0	0.0
	1525	New Main Lab Upgrades		3.1	3.1	2.7	0.3	0.5
	1515	ED Remodel Triage/Psych Observation	FY16	5.0	5.0	0.0	4.6	0.0
	1503	Willow Pavilion Tomosynthesis	FY16	1.0	0.0	0.4	1.0	0.0
	1602	JW House (Patient Family Residence)		6.5	6.5	0.4	6.0	0.1
		Site Signage and Other Improvements		1.3	0.0	0.0	1.0	0.0
		Nurse Call System Upgrades		2.4	0.0	0.0	2.4	0.0
	1707	Imaging Equipment Replacement (5 or 6 rooms)		20.7	0.3	0.0	6.0	0.0
	1708	IR/ Cath Lab Equipment Replacement		19.4	19.4	0.0	5.0	0.9
	1804	SVMD Clinic @ North First Street		8.0	8.0	0.0	0.0	0.0
		Flooring Replacement		1.6	1.6	0.0	1.5	0.4
	1219	LG Spine OR	FY13	0.0	0.0	4.0	0.0	0.2
	1313	LG Rehab HVAC System & Structural	FY16	0.0	0.0	4.1	0.0	0.0
	1248	LG Imaging Phase II (CT & Gen Rad)	FY16	9.0	9.0	9.0	0.0	0.1
	1307	LG Upgrades	FY13	19.3	19.3	18.8	0.8	1.0
	1507	LG IR Upgrades		1.3	0.0	0.0	1.3	0.0
	1603	LG MOB Improvements (17)		5.0	5.0	5.0	0.5	0.0
	1711	Emergency Sanitary & Water Storage		1.5	1.5	0.3	1.3	0.1
		LG Modular MRI & Awning		3.9	3.9	0.4	3.5	0.3
		LG Nurse Call System Upgrade		0.8	0.0	0.0	0.5	0.0
		LG Observation Unit (Conversion of ICU 2)		0.0	0.0	0.0	0.0	0.0
	1712	LG Cancer Center		5.0	5.0	2.8	4.8	2.6
		Workstation Inventory Replacement		2.0	2.0	0.0	0.0	0.0
		Primary Care Clinic Development (2 @ $3 Million Ea		6.0	6.0	0.0	5.0	0.0
		Other Strategic Capital FY-19		5.0	5.0	0.0	15.0	0.0
		Willow SC Upgrades (35,000 @ $50)		1.8	1.8	0.0	1.8	0.0
		New 28k MOB (Courthouse Prop)		22.4	22.4	0.0	1.2	0.0
		80 Great Oaks Upgrades		4.5	4.5	0.0	0.0	0.0
		Primary Care Clinic (TI's Only) FY 17 (828 Wincheste		3.6	3.6	0.0	0.3	0.0
		All Other Projects		9.2	8.6	130.4	7.8	4.5
				765.8	738.3	517.2	279.5	145.7
GRAND TOTAL					**769.2**	**552.3**	**300.8**	**174.7**

El Camino Health

El Camino Hospital Capital Spending (in thousands) FY 2014 – FY 2018

Category	2014	2015	2016	2017	2018
EPIC	**6,838**	**29,849**	**20,798**	**2,755**	**1,114**
IT Hardware/Software Equipment	**2,788**	**4,660**	**6,483**	**2,659**	**1,108**
Medical/Non Medical Equipment	**12,891**	**13,340**	**17,133**	**9,556**	**15,780**
Non CIP Land, Land I, BLDG, Additions	**22,292**	**-**	**4,189**	**-**	**2,070**
Facilities Projects CIP					
Mountain View Campus Master Plan Projects					
1245 - Behavioral Health Bldg Replace	1,257	3,775	1,389	10,323	28,676
1413 - North Drive Parking Structure Exp	-	167	1,266	18,120	4,670
1414 - Integrated MOB	-	2,009	8,875	32,805	75,319
1422 - CUP Upgrade	-	-	896	1,245	5,428
Sub-Total Mountain View Campus Master Plan	**1,257**	**5,950**	**12,426**	**62,493**	**114,093**
Mountain View Capital Projects					
9900 - Unassigned Costs	470	3,717	-	-	-
0906 - Slot Build-Out	1,576	15,101	1,251	294	-
1109 - New Main Upgrades	393	2	-	-	-
1111 - Mom/Baby Overflow	29	-	-	-	-
1204 - Elevator Upgrades	30	-	-	-	-
0800 - Womens L&D Expansion	1,531	269	-	-	-
1225 - Rehab BLDG Roofing	241	4	-	-	-
1227 - New Main eICU	21	-	-	-	-
1230 - Fog Shop	80	-	-	-	-
1315 - 205 So. Drive TI's	500	2	-	-	-
0908 - NPCR3 Seismic Upgrds	1,224	1,328	240	342	961
1125 - Will Pav Fire Sprinkler	39	-	-	-	-
1216 - New Main Process Imp Office	1	16	-	-	-
1217 - MV Campus MEP Upgrades FY13	181	274	28	-	-
1224 - Rehab Bldg HVAC Upgrades	202	81	14	6	-
1301 - Desktop Virtual	13	-	-	-	-
1304 - Rehab Wander Mgmt	87	-	-	-	-
1310 - Melchor Cancer Center Expansion	44	13	-	-	-
1318 - Women's Hospital TI	48	48	29	2	-
1327 - Rehab Building Upgrades	-	15	20	-	22
1320 - 2500 Hosp Dr Roofing	75	81	-	-	-
1340 - New Main ED Exam Room TVs	8	193	-	-	-
1341 - New Main Admin	32	103	-	-	-
1344 - New Main AV Upgrd	243	-	-	-	-
1400 - Oak Pav Cancer Center	-	5,208	666	52	156
1403 - Hosp Drive BLDG 11 TI's	86	103	-	-	-
1404 - Park Pav HVAC	64	7	-	-	-
1405 - 1 - South Accessibility Upgrades	-	-	168	95	-
1408 - New Main Accessibility Upgrades	-	7	46	501	12

Category	2014	2015	2016	2017	2018
Facilities Projects CIP cont.					
1415 - Signage & Wayfinding	-	-	106	58	136
1416 - MV Campus Digital Directories	-	-	34	23	95
1423 - MV MOB TI Allowance	-	-	588	369	-
1425 - IMOB Preparation Project - Old Main	-	-	711	1,860	215
1429 - 2500 Hospital Dr Bldg 8 TI	-	101	-	-	-
1430 - Women's Hospital Expansion	-	-	-	464	2,763
1432 - 205 South Dr BHS TI	-	8	15	-	52
1501 - Women's Hospital NPC Comp	-	4	-	223	320
1502 - Cabling & Wireless Upgrades	-	-	1,261	367	984
1503 - Willow Pavillion Tomosynthesis	-	-	53	257	31
1504 - Equipment Support Infrastructure	-	61	311	-	60
1523 - Melchor Pavillion Suite 309 TI	-	-	10	59	392
1525 - New Main Lab Upgrades	-	-	-	464	1,739
1526 - CONCERN TI	-	-	37	99	10
Sub-Total Mountain View Projects	**7,219**	**26,744**	**5,588**	**5,535**	**7,948**
Los Gatos Capital Projects					
0904 - LG Facilities Upgrade	-	-	-	-	-
0907 - LG Imaging Masterplan	774	1,402	17	-	-
1210 - Los Gatos VOIP	89	-	-	-	-
1116 - LG Ortho Pavillion	24	21	-	-	-
1124 - LG Rehab BLDG	458	-	-	-	-
1307 - LG Upgrades	2,979	3,282	3,511	3,081	4,551
1308 - LG Infrastructure	114	-	-	-	-
1313 - LG Rehab HVAC System/Structural	-	-	1,597	1,904	550
1219 - LG Spine OR	214	323	633	2,163	447
1221 - LG Kitchen Refrig	85	-	-	-	-
1248 - LG - CT Upgrades	26	345	197	6,669	1,673
1249 - LG Mobile Imaging	146	-	-	-	-
1328 - LG Ortho Canopy FY14	255	209	-	-	-
1345 - LG Lab HVAC	112	-	-	-	-
1346 - LG OR 5, 6, and 7 Lights Replace	-	285	53	22	127
1347 - LG Central Sterile Upgrades	-	181	43	66	-
1421 - LG MOB Improvements	-	198	65	303	356
1508 - LG NICU 4 Bed Expansion	-	-	-	207	-
1600 - 825 Pollard - Aspire Phase II	-	-	-	80	10
1603 - LG MOB Improvements	-	-	-	285	4,593
Sub-Total Los Gatos Projects	**5,276**	**6,246**	**6,116**	**14,780**	**12,306**
1550 - Land Acquisition	-	-	24,007	-	-
1701 - 828 S Winchester Clinic TI	-	-	-	145	3,018
Sub-Total Other Strategic Projects	**-**	**-**	**24,007**	**145**	**3,018**
Subtotal Facilities Projects CIP	**13,753**	**38,940**	**48,137**	**82,953**	**137,364**
Grand Total	**58,561**	**86,789**	**96,740**	**97,923**	**157,435**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, CMO
Date: August 21, 2019
Subject: Medical Staff Development Plan (Income Guarantee Recruitment Plan)

Recommendation(s):

To approve the Medical Staff Development Plan (Income Guarantee Recruitment Plan) for FY 20-21 not to exceed $6,120,000 for the medical and surgical specialties identified in Attachment 1 to this memo.

Summary:

1. Situation: In order to meet community and programmatic needs El Camino Hospital ("ECH") must bring physicians into the ECH market. ECH's Income Guarantee Recruitment Plan supports this effort. The Board approved the budgeted amount for FY20 as part of the FY20 budget. The needed medical and surgical specialties are presented here.

2. Authority: Pursuant to ECH's Finance: Physician Recruitment Program Policy the need for physician recruitment, the recruitment plan and the recruitment budget shall be presented to the Board for its review and approval.

3. Background: ECH engaged ECG, an outside consulting firm to perform a community needs assessment to support the proposed Plan. The Board last approved a Medical Staff Development Plan in 2017 for FY18-19.

4. Assessment: The proposed Plan is necessary to meet community and programmatic needs.

5. Other Reviews: At its July 29, 2019 meeting, the Finance Committee voted to recommend Board approval of the proposed Plan.

6. Outcomes: ECH will have the ability to bring physicians into the ECH market through the use of the Income Guarantee Recruitment Plan.

List of Attachments:

1. Income Guarantee Recruitment Plan

Suggested Board Discussion Questions: None. This is a consent item.

2019 ECH Medical Staff Development Plan Report

Physician Need and Succession Risk by *Medical* Specialty:

Medical Specialty	Current Need	Succession Risk	Total Need
Allergy & Immunology	2	2.5	4.5
Cardiology	5	14.1	19.1
Dermatology	1	6.4	7.4
Endocrinology	2	2.8	4.8
Gastroenterology	4	4.4	8.4
Hematology/Oncology	4	2.0	6.0
Infectious Disease	1	3.5	4.5
Nephrology	2	4.8	6.8
Neurology	4	5.6	9.6
Obstetrics/Gynecology	6	9.4	15.4
Pain Management	3	0.6	3.6
Physical Medicine/Rehabilitation	-	4.2	4.2
Psychiatry	14	7.2	21.2
Pulmonology/Critical Care	6	3.0	9.0
Radiation Oncology	2	0.1	2.1
Rheumatology	3	1.0	4.0

2019 ECH Medical Staff Development Plan Report

Physician Need and Succession Risk by *Surgical* Specialty:

Surgical Specialty	Current Need	Succession Risk	Total Need
Cardiac/Thoracic Surgery	3	4.0	7.0
General Surgery	16	6.3	22.3
Interventional Radiology	2	2.0	4.0
Neurosurgery	3	-	3.0
Orthopedic Surgery	7	16.1	23.1
Otolaryngology	3	2.8	5.8
Plastic Surgery	1	10.2	11.2
Podiatry	-	6.8	6.8
Urogynecology	-	0.4	0.4
Urology	6	6.0	12.0
Vascular Surgery	1	2.4	3.4

Income Guarantee Recruitment Plan FY20-FY21

Based on the ECG Medical Staff Development Analysis, we request authorization for the following potential recruitments for FY 20/21

Income Guarantee Request (Specialty)	ECG Current Need	ECG Succession Risk	Max 2 Year Authorization Request	Estimated Support per Physician	Max Estimated Support
Primary Care	70	51.5	5	$300,000	$1,500,000
Obstetrics/Gynecology	6	9.4	2	$350,000	$700,000
Psychiatry	14	7.2	2	$260,000	$520,000
General Surgery	16	6.3	3	$400,000	$1,200,000
Orthopedic Surgery	7	16.1	3	$500,000	$1,500,000
Other Unspecified TBD			2	$350,000	$700,000
TOTAL	113	90.5	17		$6,120,000

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Jim Griffith, COO
Date: August 21, 2019
Subject: Approval of Capital Funding for Radiation Oncology Equipment Replacement

Recommendation(s):

To recommend approval of purchase of a Halcyon™ Adaptive System and an EDGE® Radiosurgery System, at a total cost not to exceed $6.75 million, including equipment, construction, installation and software upgrades.

Summary:

1. Situation: ECH's current equipment (Cyberknife® and Varian Trilogy®) are over 9 years old. The life expectancy of a linear accelerator is 10 years. It may take up to 24 months to replace both pieces of medical equipment. Management recommends moving forward with an expected start date of November 2020 for the Halcyon™ and May 2021 for the EDGE®. Installation will occur sooner if the timeline for construction can be shortened. Downtime in the aging devices is causing patient dissatisfaction due to cancelled treatments. The need to replace the Cyberknife® offers ECH opportunity to leap ahead of the local competition by purchasing the Halcyon™ technology. This is ground-breaking technology that combined with EDGE® is not available elsewhere in California. The need to replace the current Varian Trilogy® (a general, non-digital workhorse) with more specialized equipment offers ECH an opportunity to diversify our program to offer specialized care for lung and spine tumors.

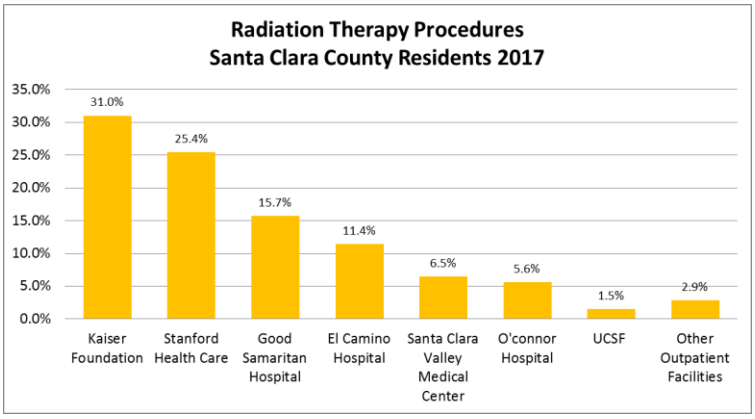
2. Authority: Capital expenditures over $5 million require both Finance Committee Review and Board approval

3. Background: This request pertains to enhanced replacement of the external radiation beams used by ECH to deliver radiation therapy to tumors. The goal is to treat the tumor while minimizing the impact on nearby tissues. Radiation therapy is usually delivered over a series of weeks during outpatient visits. ECH's customer service goal is to begin treatment as soon as possible after the treatment plan is finalized by the patient's oncologist and our market strategy is to provide a patient-centric, personalized experience. ECH's patient experience is currently threatened by machine downtime because of the need to re-schedule visits at times after the patient is on the treatment table or in the waiting room. Approximately 3 to 20 patients are displaced with each breakdown. We attempt to make up for the delayed treatments by offering weekend appointments. This mitigates some but not all of the stress patients and physicians feel when treatments are cancelled. Demand for radiation therapy is projected to increase by 20% in Santa Clara County, based on the zip code level projections from the Advisory Board. 60% of our radiation therapy services are to patients over 64 years of age and that population is expected to increase from 13% to 15% of the population over the next 5 years.

Data and Analytics | Market Scenario Planner - Outpatient Santa Clara County

Subservice Line	2017 Volume	2022 Volume	2027 Volume	5 Yr Growth	10 Yr Growth
Radiation Therapy	5,375	6,006	6,468	11.7%	20.3%

Competition for the business is strong. Kaiser – with approximately 30% market penetration on the payer side – does the most procedures. Stanford holds the highest non-Kaiser market share and, as an academic center, is generically perceived as having cutting edge technology. Good Samaritan, El Camino, O'Connor, PAMF, and Washington all offer similar radiation therapy programs.



4. Assessment: ECH's market strategy is enhanced by offering technological advancements targeting more precise treatment and more tumor sites. ECH seeks to strengthen its market distinction - in the eyes of both the consumer and referring physicians - by adopting the latest technology that adapts treatment while the patient is on the treatment table through the use of simultaneous imaging and treatment delivery. The Halcyon™ equipment offers real-time imaging. The EDGE® equipment will further expand ECH's ability to deliver precision treatments which is of particular importance in treatment for lung and spine tumors. The proposed equipment will offer greater precision while retaining integration with current purchases (Varian Aria® (information management) and Calypso® (clinical planning)). The advantages of moving to the Varian solutions are:

- **Strong integration with current systems**: A fully integrated environment is the safest way to treat patients and house/transfer patient data. This is one reason ECH migrated to ARIA®.
- **Better transferability between devices**: Transferring a patient from the EDGE® to Halcyon™ or vice versa is an option that will not exist as smoothly (if at all) in a mixed-vendor environment.
- **High volume throughput**: As bundled patients come into the market, throughput will become increasingly important to overall profitability. The EDGE® can treat approximately 30 patients a day.
- **Early Adopter Opportunities**: Varian invests over $240 million in research and development each year. Varian continually leads the radiation oncology market with a long track record of excellence. The advantage to El Camino is the ability to quickly adopt the latest technologies on a flexible, reliable platform.

Purchase of the new equipment is advised for several reasons.

A. **Alignment with Strategic Priorities:** The service line seeks to create a market differentiation based on provision of a patient-centric, personalized care. The new devices improve service line differentiation in the following ways:

B. **Consumer Alignment:** Adding **leading therapies** to ECH's treatment base is a key performance indicator for the oncology service line. The EDGE® and Halcyon™ technologies place ECH radiation therapy at the forefront of technology in a way that acknowledges the direction of this service toward increased precision. ECH currently treats all types of cancers but our top 5 sites are breast, prostate, lung, colorectal and uterine cancers. The EDGE® technology allows additional capabilities for liver, pancreas, head, neck, abdomen, bladder, pelvis, stomach, adrenal, bone, spine, pelvis and esophagus cancers. It also serves to decrease the current consumer "dissatisfiers" of increased cancellations, wait-times and delayed treatment.

C. **Physician Integration:** Another key performance indicator that this replacement will touch is **increased medical oncologists alignment with market approach**. Recruitment of new oncologists and retaining our current oncologists depend upon offering a work environment capable of offering opportunities to adjust to new delivery techniques and equipment. In conjunction with outreach (marketing, physician to physician, educational series), offering the latest technology can help primary physicians and patients who otherwise lack awareness of treatment alternatives.

D. **Unique Opportunity:** El Camino would be the first in California to offer both of the Varian advanced technologies.

E. **Strong Financial Projection:** Halcyon™ purchase has a 695% return on investment with a net present value of $14.2 million. The EDGE® purchase has as a 3064% return on investment with a net present value of $77.1 million.

5. Other Reviews: At its July 29, 2019 meeting the Finance Committee reviewed and recommended approval of this funding request. The radiation oncology Medical Director visited the prototype in Palo Alto. The findings have been positive and our Medical Staff looks forward to improving our treatment modalities with these two new devices.

6. Outcomes: The following sequence and target timeline is indicated below but management is looking at ways to shorten the time to deployment:

08/19 Board approval of funding for equipment and planning
09/19 Finalize equipment purchase agreement
10/19 Place purchase orders
12/19 Complete phased construction specifications, submit for building permit
06/20 Obtain building permit and start construction
10/20 Complete construction and installation of Halcyon™
11/20 Gain CDPH and Radiation Board approval of Halcyon™

List of Attachments:

1. None.

Suggested Board Discussion Questions: None. This is a consent item.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Jim Griffith, COO
Cheryl Reinking, RN, CNO
Ken King, CASO
Date: August 21, 2019
Subject: Capital Facilities Project Request – Emergency Room Remodel, Mountain View

Recommendation:

To approve the remodel of the emergency department on the Mountain View campus at a cost not to exceed $6.75 million.

Summary:

1. Situation: The Mountain View campus emergency room was opened in 2009 with a volume of 41,166. Emergency room volume in FY-19 was 48,718; an 18% increase over 10 years. Included in these visits are increases in patient acuity and patients with mental health and addiction illnesses. The increased volume has required us to add providers and staff and the existing environment for check-in, triage, registration and fast track services is not adequately configured to effectively manage throughput. Additionally, with the increase of mental health and addiction patients presenting in our emergency room daily, a more secure and efficient care environment is needed.

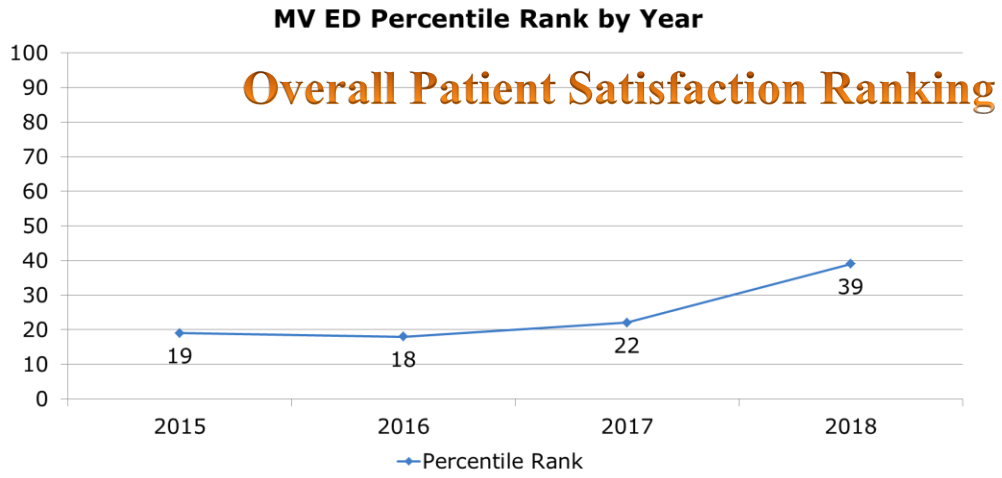
   Emergency room visits are expected to increase approximately 1% each year for the next 10 years with mental health and addiction and higher acuity cases continuing to grow faster than "come and go" emergency room visits. Without reconfiguring the space we have it will be extremely difficult, if not impossible to handle additional visits.

2. Authority: Expenditures exceeding $5 million require the approval of the Board of Directors with a recommendation from the Finance Committee.

3. Background: It has been 15 years since the emergency room was designed and two major factors have occurred since then. The first is the dramatic increase in both visits and acuity and the second is the dramatic increase in patients presenting with mental health and addiction illness. We have been able to absorb the additional volume by expanding the emergency room into the adjacent ten bed clinical decision unit. Additionally, over the past three years as the volume and acuity has increased, the emergency room providers and staff have gone through two lean assessments and work flow improvement projects and made adjustments to how patients are treated without changes to the physical environment. During that time improvements have been made, but as time goes on it is more and more evident that the physical layout is the largest constraint to improved patient flow and patient, provider and staff satisfaction.

   The other factor that continues to stress the capacity and efficiency of the emergency room is increased number of patients with mental health and addiction illness. In the past year we have had four (4) to five (5) patients per day who have long stays (recent average of 513 minutes) and often require one to one sitters in addition to the direct care nurse oversite. These patients are roomed in exam rooms that were designed for medical care and as such they pose potential safety risks to at risk patients and the staff who care for them.

All of these factors combined have resulted in higher than acceptable wait times and lower patient satisfaction. The following chart shows how our overall patient satisfaction with the emergency room ranks when compared to our peers.



The remodel construction plans for this project have been completed and reviewed by OSHPD and a building permit has been issued. A general contractor has provided a competitively bid Guaranteed Maximum Price (GMP) Proposal for the construction and upon approval the work will begin within eight weeks. The breakdown of project costs is as follows:

Construction	$5,155,769	
Soft Costs	$ 971,374	
FF&E	$ 169,805	
Contingency	$ 437,302	
Total	$6,748,000	Rounded to $6,750,000

4. Assessment: The benefits of this remodel include the following:

- Improved physician and staff morale and efficiency
- Improved patient satisfaction and safety
- Improved financial results based on allowing growth in emergency services

Every effort to improve the situation has run into the constraints of the physical environment and all other options have been exhausted.

Financially, with a current NPV of $22.7 million, the investment of $6.75 million would allow us to continue to grow emergency room services. If that growth allows us to increase market share as indicated below in Scenarios 2, the ROI is solid. If that growth only matches the Scenario 1, projected market growth of 1% a year, then the $6.75 million would not provide a complete ROI.

The investment will however provide the means to achieve the benefits stated above and ensure that we are meeting our Mission, Vision, Values, and overall Strategic Goals.

5. Other Reviews: The executive leadership, the emergency room physicians and providers along with staff have participated with architects and planners to develop a plan that addresses the short-comings of the existing environment. They along with the Executive Team members who

have reviewed and evaluated the current situation and outcomes support the recommendation to invest in this remodel. The Finance Committee reviewed and recommended this proposal for approval at its July 29, 2019 meeting.

6. Outcomes: The following sequence and target timeline for construction is indicated below:

ED Remodel Target Timeline		2019					2020					
		Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Design & Construction Documents	Complete											
OSPHD Plan Review & Permit	Complete											
Funding Approval												
Procurement & Pre-Construction												
Construction Phase 1												
Fit-Up & Licensing Approval												
Construction Phase 2												
Fit-Up & Licensing Approval												

Following the completion of the project we would expect to see higher patient satisfaction scores and improved through-put for inpatient admissions from the ER.

List of Attachments: None

Suggested Board Discussion Questions: None – Consent Calendar Item

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Cindy Murphy, Director of Governance Services
Date: August 21, 2019
Subject: Appointment of Quality, Patient Care and Patient Experience Committee Members

Recommendation(s):

To appoint Terrigal Burn, MD, Caroline Currie, Alyson Falwell and Krutica Sharma, MD to the Quality, Patient Care, and Patient Experience Committee.

Summary:

1. Situation: Due to the departure of a number of Committee members and a need for representation of additional technical competencies as well as the patient voice, the Quality Committee appointed an Ad Hoc Committee, comprised of Director Julie Kliger and then Director Jeffrey Davis, MD, tasked with recruiting new members. Mark Adams, MD, CMO, worked with Directors Davis and Kliger on the recruitment. The Ad Hoc Committee brought forward four (4) candidates for the Committee's consideration.

2. Authority: The Committee Charter as well as the Board's Advisory Committee Member Nomination and Selection Policy and Procedures allow the Committee to appoint an Ad Hoc Committee for this purpose.

3. Background: The Ad Hoc Committee sought applicants through public advertising, as well as through the Board, Committee and leadership team networks. Their search was focused on the following areas of expertise: 1) Innovation [within or outside of healthcare], 2) Customer or Patient Experience, 3) Data and Technology Expertise, or 4) Recent Patient (or Family of Patient) Experience at El Camino Hospital. They received nine (9) applications, interviewed five (5) candidates and brought four (4) candidates forward for the full Committee's consideration.

4. Assessment: The Ad Hoc Committee recommended all four (4) candidates be appointed to the Committee.

5. Other Reviews: At its August 5, 2019 meeting, the Quality, Patient Care and Patient Experience Committee voted to recommend the Board appoint all four candidates to the Committee.

6. Outcomes: Enhanced technical competencies and a new patient voice on the Committee.

List of Attachments:

1. Candidate Profile – Terrigal Burn, MD
2. Candidate Profile – Caroline Currie
3. Candidate Profile - Alyson Falwell
4. Candidate Profile – Krutica Sharma, MD

Suggested Board Discussion Questions: None. This is a consent item.

TERRIGAL BURN, MD, MS
190 Lucero Way
Portola Valley, CA 94028
650-468-1418
tburn@pamf.org

CAREER SUMMARY

Primary care internist with extensive experience in medical practice leadership and administration as well as managed care provision in community practice and academic settings. Led a 330 physician medical group through the process of evaluating and deciding in favor of merging with 2 sister groups to form 8th largest medical group in the US. Introduced managed care at two academic medical centers, and led its oversight in community practice. Twenty-five years of primary care medical practice and teaching experience. Highly effective change agent, leader, and team builder, with a strong commitment to improving quality of health care while lowering its cost.

PROFESSIONAL EXPERIENCE

PALO ALTO FOUNDATION MEDICAL GROUP

Current — Primary care internal medicine practice (50% time)

2014 to 2016 — Medical Director, Lean Promotion Office. Clinical practice, internal medicine (50% time)

2011 to 2014 — Member, Board of Directors, Palo Alto Foundation Medical Group. Board Liaison to Leadership Development Committee. Physician Champion, Lean Promotion Office. Clinical practice, internal medicine. (Currently 50% time)

2008 to 2011 — Chairman, Board of Directors, and CEO, Palo Alto Foundation Medical Group
Member, Board of Trustees, Sutter Health Peninsula Coastal Region
Internal Medicine Practice

PALO ALTO MEDICAL FOUNDATION (PAMF)

2005 to 2008 — Medical Director and Executive Board Chairman, Palo Alto Medical Clinic
Co-Chair, Pharmacy and Therapeutics Committee
Member, Board of Trustees, Palo Alto Medical Foundation
Internal Medicine Practice
Adjunct Clinical Professor of Medicine, Stanford University School of Medicine

MANAGEMENT RESPONSIBILITIES:
Provide leadership and oversight to our 330 physician medical group. Duties include:

- Oversight of physician staffing, recruitment, compensation, and quality of care
- Working with Foundation staff in planning and implementation of growth in existing and new markets
- Coordination of care delivery with sister medical groups within the Foundation
- Representing our organization at local and national levels

CLINICAL CARE RESPONSIBILITIES:
Care for a panel of 300 patients.

1998 to 2004 Medical Director, Health Plans and Utilization Management
Secretary, Executive Board, Palo Alto Medical Clinic
Chair, Quality Improvement Steering Committee
Chair, Utilization Management Committee

MANAGEMENT RESPONSIBILITIES:
Managed the provision of capitated care to 70,000 managed care enrollees for medical group. This represented 40% of the group's practice; 10% of the enrollees are Medicare HMO members. Significant accomplishments include:

- Led the organization's first chronic disease management initiative, developing bi-annual physician profiles in diabetes management, improving diabetes teaching programs.
- Improved case management, discharge planning, and utilization management functions at PAMF and Stanford to achieve and maintain low inpatient utilization in commercial and Medicare enrollments.
- Developed an early transfer program from Stanford Hospital to contracting SNFs to control inpatient costs.
- In charge of developing a resource team to evaluate and oversee quality improvement and evidence based medicine within PAMF.

1995 to 1997 Associate Medical Director, Health Plans

UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO

1993 to 1995 Associate Clinical Professor of Medicine
Medical Director for Managed Care Programs, UCSF Clinical Practice Organization

MANAGEMENT RESPONSIBILITIES IN THE UCSF CLINICAL PRACTICE ORGANIZATION:
Managed the UCSF HMO Programs office, supervised an office staff of 25. Responsibilities included distribution of over $18 million in annual capitation revenues for our 17,000 HMO members. Significant accomplishments include:

- Managed the development of capitated care at UCSF. Directed the growth of the HMO Programs office from a staff of 1 to present size, and from an enrollment of 500 to 17,000 members.
- Participated in the selection and implementation of a managed care hardware and software system to perform claims processing, utilization review, and management reporting, enabling automation of office functions in a complex academic environment.
- Supervised the incorporation of 160 community physicians based at UCSF's Mt. Zion Hospital Campus into UCSF's managed care network.
- Developed specifications, hired staff, and purchased hardware and software to create reports profiling clinical patterns of care and resource utilization by primary care physicians at UCSF for their panels of managed care patients.

CLINICAL CARE AND TEACHING RESPONSIBILITIES:
Cared for a panel of 400 patients and taught medical students and medicine residents in in- and outpatient settings.

1987 to 1992 Assistant /Associate Clinical Professor of Medicine
Director of Clinical Programs, Division of General Internal Medicine (DGIM)
Director of HMO Programs, UCSF Clinical Practice Organization

MANAGEMENT RESPONSIBILITIES IN DGIM: Managed finances, personnel, quality, utilization review, and care delivery at 4 internal medicine practices, the UCSF urgent care clinic, and the DGIM Satellite in Daly City. These 6 practice sites in combination delivered 65,000 patient visits per year, and billed over $4 million in annual revenues. Significant accomplishments included:

- Expanded DGIM's outpatient delivery sites from 3 to 5 clinics, increasing annual patient volume by 25%.
- Developed the role of clinician-educator in DGIM and recruited 10 physicians to staff these positions, doubling the size of the Division's faculty.
- Developed the physician management structure in the General Medical Practices to improve efficiency, and develop more creative and rapid problem solving.

STANFORD UNIVERSITY MEDICAL CENTER

1983 to 1987 Assistant Clinical Professor of Medicine
Associate Director, Stanford Medical Group
Medical Director of HMO Programs

EDUCATION

Fellowship	California Health Care Foundation in Healthcare Leadership, 2007
M.S.	University of Wisconsin-Madison, in Administrative Medicine, 1992
M.D.	SUNY at Buffalo, 1978
B.S.	Vassar College, 1974. Phi Beta Kappa, Thesis and Departmental Honors
Internship	University of California at San Francisco, 1978-79
Residency	University of California at San Francisco, 1979-81

HONORS AND MEMBERSHIPS

Elected, Alpha Omega Alpha, SUNY at Buffalo School of Medicine, 1978. Nominated for Kaiser Teaching Award, Stanford University School of Medicine, 1985. Diplomat, American Board of Internal Medicine.

PERSONAL INTERESTS

Fluent in Spanish and French. Accomplished jazz pianist, dogged runner, occasional ocean kayaker, and enthusiastic hiker/backpacker.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Candidate Questionnaire (T. BURN)
Quality, Patient Care and Patient Experience Committee

1. Quality, Patient Care and/or Patient Related Experience – Please describe how your professional background demonstrates your knowledge and experience with any of the following:
    a. An environment where patient or customer experience, safety and quality and process improvement were key market differentiators. As a physician practicing at PAMF and previously, UCSF and Stanford I have been responsible for providing high quality care and service. As the Medical Director of PAMF's Lean Promotion Office, and previously of PAMF's Quality Improvement Steering Committee I was responsible for overseeing and in some cases designing quality improvement programs.
    b. Establishing new patient or customer care, quality and/or safety programs and procedures.
    c. Innovation (within or outside of healthcare)
    d. Customer or Patient Experience
    e. Data and Technology Background
    f. Examples of situations where you made recommendations for change with any of the above areas. Helped bring UpToDate to PAMF. Started PAMF's Quality Improvement Steering Committee. Developed the guideline that flags all Sutter Epic Charts for patients over 65 to ask about Advance Directives.

2. In addition to candidates with the technical competencies described above, we are also hoping to recruit members with experiences at El Camino Hospital. To the extent you are comfortable disclosing, please describe any recent experience you or a close member of your family had at El Camino Hospital. I have had many patients cared for by my PAMF colleagues at ECH.

3. Why are you interested in being considered as a member of El Camino Hospital's Quality, Patient Care and Patient Experience Committee? Excellent hospital doing good work; my patients benefit from improved quality. The chair of the committee is a forward thinking leader.

4. Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check? No

5. Are you able to make the necessary time commitment? Yes

6. Would this position create a conflict of interest with any of your other commitments? No

CAROLINE R. M. CURRIE
linkedin.com/in/carolinecurrie

SUMMARY

Highly energetic professional with a hard-wired athlete's mentality and a passion for healthcare innovation. 10 years of success in program management, vendor strategy, clinical operations, and team leadership in both clinical and fast-paced tech environments.

EXPERIENCE

Apple Inc., Cupertino, CA **2015 - Present**

Engineering Manager, Health Studies Data Acquisition *(2018-present)*

Engineering Project Manager, Health Studies *(2015-2018)*

UCSF Orthopedic Institute, San Francisco, CA **2013 - 2015**

Clinical Project Manager
Managed 30+ clinical studies on Sports Medicine team, reporting to Chief of Surgery. Implemented multi-center clinical trials (both NIH and industry-sponsored), as well as investigator-initiated clinical trials. Managed a Research Assistant and oversaw intern team.

- Oversaw execution of clinical research activities, including patient screening, scheduling, physical testing, specimen collection and processing, data collection, analysis, and presentation.
- Created study protocols, standard operating procedures, databases, IRB and FDA submissions, informed consent forms, and case reports.
- Managed departmental study funds, including federal, non-federal, and foundational grants. Communicated regularly with sponsors, created and negotiated budget contracts, and drafted invoices.

EARLY EXPERIENCE

Project Wellness, *Founder and General Manager*, Palo Alto, CA **2012 - 2015**
Culminated years of formal and experiential education in medicine, nutrition, fitness, and health research, to build a consumer-facing consulting and educational program with a focus on achieving life-long, overall wellness. Transitioned to not-for-profit program in 2014; taught weekly classes at low income housing community center in Palo Alto.

Basis Science (acquired by Intel in Mar 2014), *Content Strategy Copywriter*, San Francisco, CA **2013 - 2014**
Independent Contractor on Content Strategy team with the goal of providing a voice for the brand. Published scientifically-backed content for consumer audiences on topics in health, fitness, sleep, and nutrition, as well as an eBook comparing Basis to other fitness trackers.

Children's Hospital Boston*, Research Assistant,* Boston, MA **2010 - 2011**
Designed and executed bench studies on Pediatric Oncology/Hematology team, at the direction of 4 physician scientists.

Maine Medical Center Research Institute*, Clinical Research Assistant*, Scarborough, ME **2008 - 2009**
Managed study strategy, kickoff, data collection, and all ongoing study operations for a clinical study that examined the impact of exercise and nutrition on childhood obesity.

Maine Medical Center, *Case Study Writer,* Portland, ME **2008 - 2009**
Conducted extensive literature searches, examined and analyzed patient charts, and wrote full case reports for the Division of Maternal-Fetal Medicine, one of which was selected for publication in October 2009.

EDUCATION

University of New England College of Osteopathic Medicine, *D.O. Candidate,* Biddeford, ME **2011 - 2012**

Bowdoin College, *B.A. in Biology and Pre-Medicine, 3.90 GPA,* Brunswick, ME **2004 - 2008**

- Phi Beta Kappa (Sep 2007), Magna Cum Laude (May 2008), Bowdoin Scholar award (2005-2008).
- Varsity Women's Ice Hockey, 2004-2008. Starter and impact player.

KEYNOTE PRESENTATIONS & PUBLISHED RESEARCH

Currie, Caroline. “Designing Technology for Health.” Silicon Valley Women in Engineering Conference: Emerging Technologies for Improving Health, 16 March 2019, San Jose State University, http://siliconvalleywie.org/

Currie, C., JR Wax, MG Pinette, and J Blackstone (2009) Cogan’s Syndrome complicating pregnancy. Journal of Maternal-Fetal and Neonatal Medicine. 22(10): 928-30

Jonathan W. Snow, Jonghwan Kim, Caroline R. Currie, Jcian Xu, and Stuart H. Orkin. (2010) Sumoylation regulates interaction of FOG1 with CTBP. Journal of Biological Chemistry. 285: 28064-28075

Shao, L., W Feng, Y Sun, H Bai, J Liu, C Currie, J Kim, R Gama, Z Wang, Z Qian, L Liaw, and W Wu (2009) Generation of iPS cells using defined factors linked via the self-cleaving 2A sequences in a single open reading frame. Cell Research. 19: 296–306

Candidate Questionnaire
Quality, Patient Care, and Patient Experience Committee

Applicant: Caroline Currie

Question 1 Response

As the daughter of a GYN-oncologist surgeon and an infectious disease nurse, understanding patient care is deeply-rooted in my upbringing. I remember doing rounds with my Dad on the weekends in the pre-HIPAA days and listening to his lessons before entering each room, and then watching his approach and demeanor with very sick women and their families. It was a profound experience as a child to understand empathy.

While I did not pursue medicine, my entire career has been dedicated to patient care and participant experience in health/clinical research. I have designed over 50 health-related research studies and managed research teams who have executed them. In the early years of my career, I was the one executing the studies – recruiting eligible patients, explaining the research, consenting them – I was the first face they would see before the physician came in.

a. Every experience I have had, from my first job in clinical research to my current role managing health study development at Apple, has focused on patient safety, participant experience, and process improvement.
b. I helped develop the processes and procedures for Apple's health programs, trained health teams to human ethics, safety, and risk, and currently oversee participant experience flow for health study protocol design.
c. Innovation is at the heart of the work I do at Apple. I had to think creatively to evolve my traditional clinical research approach to fit the needs of a fast-moving innovation-focused tech company, while still adhering to the principles of GCP, human rights, patient safety, and ethics.
d. In my early career, I was particularly involved with direct customer, patient, and participant experience. I have worked in restaurants in customer-focused settings, I have interned and volunteered in hospitals, and of course, I have executed clinical research studies (recruiting, consenting, and facilitating the study procedures). These experiences have helped shape the wisdom and philosophies about "people care" to which I train teams today. Aside from my professional development, I have also been a patient in a countless number of hospitals and clinics. I have been on the receiving-end of terrible patient care, as well as phenomenal, and over-time I have developed a good understanding of the nuances that tip the scale in one direction vs. another.
e. My overarching deliverable at Apple is to deliver health data to our organization for the development of technology features/products. I also appreciate that intuition, creativity, and a high EQ are essential to my work, particularly as it relates to designing technically complicated studies to have high-quality participant experience.
f. When I first came to Apple, I was tasked to build up health study knowledge and infrastructure. I created a Research Protocol and Informed Consent Form template, and

trained research teams on the key elements of protocol/study design, risk assessment, informed consent, and adverse events. This was in 2015, and these tools are still being used company-wide today.

Question 2 Response

My wife and I delivered our daughter at El Camino. I carried, and therefore experienced first-hand the anxiety and unknowns of a first-time pregnancy, as well as experienced the compassion, patience, and professionalism of the staff at El Camino. Between weeks 36 and 40, we came to El Camino A LOT, super convinced that something was either wrong, or that I was in early labor. The staff were friendly and patient as they saw my familiar face marching (back) in for a fetal stress test exam, and then would politely assure me everything was fine and to go home. Once I was finally admitted in actual labor, everyone was simply wonderful. The delivery of my daughter was one of my favorite days. She was born surrounded by strong women: my wife, my sister, my OB, 2 nurses, and me. The following 2 days in the hospital we were met with outstanding support.

As a same-sex couple, however, my wife and I acknowledged that – for a hospital in the ultra-inclusive Bay Area – El Camino (and PAMF) under-represented same sex parenting. From brochures to classroom materials, we saw appropriate representation of different races and ethnicities, but there were no same sex couples (at least in any of the OB/maternity materials). We joked about this lightly, but during the delivery it became a stronger concern, as my wife, the second parent, had to walk around with a "father" wristband and was forced to sign along the "father" line on various forms. My wife voiced her concern about this, and El Camino took it seriously and put steps in motion to change things. This was most impressive and made us feel part of the El Camino community.

Question 3 Response

I have two motivations. First, as stated in the second paragraph above, I feel like my wife and I are part of the El Camino community. We love El Camino's commitment to improvement – and to actually following through. My wife is part of a monthly group at El Camino Hospital, and I would like to give back to El Camino as well. I believe I would bring value and perspective to the group based on my professional and personal experiences. I am also a dynamic problem solver, a thoughtful listener, and am comfortable sharing my views in a room full of people.

My second motivation is for my own growth. I love to be continuously learning, and I see this as a valuable opportunity to not only share my knowledge and experience to better El Camino patient care/experience, but also to expand the breadth of my knowledge and then apply this in my profession as I continue to improve the best practices and standard of care in that arena.

Question 4 Response: No.
Question 5 Response: Yes.
Question 6 Response: No.

Alyson Falwell, MPH
1571 De Anza Way
San Jose, CA 95125
(408) 438-3061 • alysonfalwell@gmail.com

Over 15 years of experience in clinical research at top tier academic medical centers with 10 years in managerial and leadership roles. Deep expertise in Phase I-IV clinical trial startup and management in adult and pediatric populations in both the inpatient and outpatient settings. Experience with both drug and device trial feasibility assessment and implementation. Extensive experience with regulatory submissions, developing and scaling research programs, federal audits, training clinical and non-clinical stakeholders, managing large cross-functional teams, developing guidelines and SOPs, and management of up to 15 independent, concurrent clinical trials. Experienced public speaker and writer with co-authorship on 8 published articles in peer-reviewed journals.

Experience

Clinical Research Operations Manager **April 2019 -- Present**
Stanford Children's Health

- Manages and directs all clinical and programmatic aspects of clinical research operations
- Responsible for the implementation and monitoring of an effective and ongoing Clinical Research Support Office adhering to quality, compliance, and patient safety standards
- Collaborates in research planning activities, working closely with principal investigators and research teams to help develop and review potential protocols prior to study initiation, including assisting with assessing feasibility, operational needs, and budget development
- Educates clinical and research staff on established policies, processes, and procedures
- Serves as a clinical research expert resource and provides guidance and education for all aspects pertaining to implementation of research projects
- Plans protocol, develops policies, and establishes standards for the research unit
- Provides leadership in determining, recommending, and implementing improvements to policies/processes; define best practices

Clinical Research Program Lead **December 2017 – March 2019**
El Camino Hospital

- Responsible for developing and deploying an internal and external quality monitoring and assurance program
- Developed and implemented strategy and roadmap for clinical trial quality oversight and management within the Clinical Research Department
- Developed metrics and tools to track, measure, and address quality in research across the enterprise
- Generate and oversee new Standard Operating Procedures related to subject enrollment, informed consent, regulatory management and adverse event detection and management
- Train staff on tools and processes focused on consistent program compliance and proper clinical trial conduct
- Actively manage 5-10 interventional pulmonology clinical trials
- Advise leadership on standards and best practices related to clinical trial compliance and Federal regulations

Senior Associate/Director **February 2016 - December 2017**
Alvarez & Marsal, Healthcare Industry Group

- Worked with Performance Improvement and Healthcare Industry business units on health equity, hospital philanthropy and clinical service line development
- Partnered with Clinical Senior Director to lead best practices research for 4 chronic diseases and develop framework for disease management across conditions. Also led development of health equity maturity model and assessment tools
- Developed tools and processes for grants management program including: evaluation protocol for funding requests, active award reporting and tracking dashboard, and impact assessment of funded activities
- Served in interim management role for a large regional healthcare foundation where responsibilities included optimizing workflows, creating tools to improve staff efficiency, and supporting staff fundraising efforts

Manager, Multi-Specialty Cooperative Group Research **December 2013 - January 2016**
Stanford University School of Medicine, Cancer Clinical Trials Office

- Responsible for overseeing operations of the Stanford University Cooperative Group Research Program, including staff and clinical trials associated with Stanford membership in NIH NCI Cooperative Groups: SWOG, ECOG, NRG and COG
-Managed a staff of 25-35 research coordinators and data managers
-Responsible for overseeing progress towards targets required as part of NIH U10 grant award
-Responsible for all aspects of hiring, mentorship, performance management, strategic planning and resource allocation for Stanford Cooperative Group program
- Worked with Stanford IRB and Regulatory Department to improve processes for regulatory management of NCI CIRB trials
- Implemented Lean processes in work several groups including daily huddles and visible tracking boards to improve staff efficiency and reduce delays in patient enrollment
- Coordinated preparation for and management of multiple on-site NCI audits
- Participated in development of clinical trials infrastructure for Adolescent and Young Adult Cancer Program with Stanford Hospital and Lucile Packard Children's Hospital
- Partnered with local, state and Federal regulatory agencies and complying with regulatory requirements

Clinical Trials Supervisor **January 2011 - December 2013**
Stanford University School of Medicine, Department of Pediatrics, Division of Hematology/Oncology
- Responsible for operations and conduct of more than 150 clinical trials in pediatric hematology and oncology
- Managed budgets, hiring, and performance of 7 research coordinators to ensure compliance with protocols, GCP, and University practices
- Using PDSA, implemented systems to improve operational efficiency including developing standard operating procedures for managing clinical trials and implementation of a single Universal consent form for patient sample collection
- Worked with physicians, nurse practitioners and pharmacists to implement a double-check system to ensure that clinical trial patients receive the correct chemotherapy treatment plan
- Worked with physicians and nurse practitioners to expand the role of research coordinators and improve integration into clinical care team
- Managed Phase I-III clinical trials for Neuroblastoma, Ewings sarcoma and Osteosarcoma
- Deepened cross-functional relationships through organized, monthly, faculty led educational sessions for coordinators
- Ensured charts were always "audit ready" through oversight of regular, internal reviews of chart data quality
- Managed successful team completion of quarterly data deadlines for Cooperative Group studies
- Coordinated preparation for and management of NCI audit for Children's Oncology Group

Director of Operations **January 2009 - January 2011**
The Altos Group
- Responsible for managing all operations for organizational improvement and management advisory firm that works exclusively with healthcare organizations
- Managed implementation of multi-million dollar change management grant funded by the Gordon and Betty Moore Foundation at three Bay Area community hospitals
- Oversaw compliance with protocol, developed and modified project tools, participated in curriculum development and organized clinician trainings
- Worked with hospital leadership to develop and train high functioning teams of nurses, physicians and allied health professionals

Research Project Manager **May 2005 - September 2008**
Stanford University, Center for Health Policy/Primary Care and Outcomes Research
- Oversaw several federally and privately funded grants studying medical errors and patient safety in US Hospitals
- Responsible for ensuring timely and accurate achievement of all project goals
- Participated in development of new project ideas, wrote and submitted grant applications, developed project budgets, hired and trained staff, and supervised a team of research assistants and data analysts
- Prepared reports for submission to funder, managed all human subjects requirements, conducted data analyses, participated in preparation of manuscripts, and presented findings at national scientific meetings
-Responsible for managing consortium of 150 US hospitals and medical centers. Maintained communication with and prepared individual reports for all hospitals on their safety culture
- Coordinated partnerships with federal government, Joint Commission, Institute for Safe Medication Practices and other partner organizations and entities

- Planned and organized large annual meeting for all hospitals and affiliate organizations
- Worked with team of diverse investigators to ensure compliance with project protocols

Research Coordinator **June 2003 - May 2005**
University of Washington, Harborview Medical Center, End of Life Care Research Program
- Coordinated multi-faceted intervention to improve palliative care in seven distinct intensive care units at Harborview Medical Center
- Managed both pre-intervention and post-intervention data collection, coordinated intervention activities, managed IRB activities, and ensured compliance with human subjects and HIPAA regulations
- Supervised research assistant activities and coordinated meetings and communication with diverse project team

Research Coordinator **September 2002 - September 2003**
University of Washington, Department of Psychiatry and Behavioral Sciences
- Assisted with research activities in the area of stress & coping
- Extracted relevant physiological data from medical records
- Coordinated human subjects applications for University of Washington IRB and NIH
- Performed literature searches and assisted with preparation for grant submission

Research Coordinator **May 2000 - August, 2002**
University of Pennsylvania, Department of Psychiatry, Bipolar Disorders Program
- Coordinated industry sponsored clinical trials for the treatment of Bipolar Disorders
- Acted as liaison between sponsoring agencies, laboratories, patients and Bipolar Disorders Program
- Set up and ran patient clinics and ensured drug accountability
- Responsible for clinical trial regulatory compliance, CRF management, patient recruitment, patient screening, and IRB coordination
- Performed assessments using structured interviews and rating scales

Education

University of Washington - *Master of Public Health, 2004*
Skidmore College - *Bachelor of Arts, 1998*

Consulting Work

2008-2009	**Stanford University School of Medicine**
	Consulting on management and closeout of federally funded simulation grant
2009	**iAccessCare**
	Survey design and market research for healthcare startup
2009-2011	**Convergence Health Consulting**
	Authored report on Operational Efficiency for California HealthCare Foundation and Safety Net Institute
	Conduct Meta analysis of research on hospital characteristics and performance

Invited Lectures

MD Anderson Children's Cancer Hospital, Pediatric Grand Rounds, November 4, 2013. "Safety Culture and Efficiency in Clinical Research: A View From The Trenches"

Teaching

2019: Incoming Instructor for UCSD Clinical Trials Design and Management Program. Developing course on Critical Competencies for Clinical Research Professionals

Awards

Retirement Research Foundation Masters Student Research Award, American Public Health Association, 2004.
Academy of Management, Health Care Management Division, Best Paper, 2009.

Membership in Professional Organizations

American Public Health Association; since 2003; AcademyHealth; since 2005

El Camino Hospital
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Candidate Questionnaire (A. Falwell)
Quality, Patient Care and Patient Experience Committee

1. Quality, Patient Care and/or Patient Related Experience – Please describe how your professional background demonstrates your knowledge and experience with any of the following:
    a. An environment where patient or customer experience, safety and quality and process improvement were key market differentiators.
    b. Establishing new patient or customer care, quality and/or safety programs and procedures.
    c. Innovation (within or outside of healthcare)
    d. Customer or Patient Experience
    e. Data and Technology Background
    f. Examples of situations where you made recommendations for change with any of the above areas

I have extensive experience establishing and managing programs in the clinical research space within both academic medical centers and community hospitals. My experience managing large clinical research programs and developing quality and regulatory infrastructure and processes would be a good fit for the Quality, Patient Care and Patient Experience Committee. Additional relevant experience includes:

10+ years of experience as a working manager leading small and large high-functioning research teams with a focus on regulatory compliance and quality improvement;
• Experience as the Director of Operations for a healthcare consulting firm;
• Project management experience including developing complex project plans, performance dashboards, identifying potential project risks, adhering to project timelines and meeting project milestones;
• Experience working with organizational leadership to develop strategic plans and roadmaps to achieve those plans;
• Experience developing and scaling research programs including providing financial and administrative oversight;
• Experience developing SOPs, policies and workflows to improve quality and regulatory compliance
• Experience using a data-driven approach to guide programmatic decision-making;
• Experience working on cross-functional teams and collaborating with physicians, administrators, nurses, sponsors, and other key stakeholders;

2. In addition to candidates with the technical competencies described above, we are also hoping to recruit members with experiences at El Camino Hospital. To the extent you are comfortable disclosing, please describe any recent experience you or a close member of your family had at El Camino Hospital.

- As a former employee of El Camino Hospital, I am familiar with both the employee and patient culture at the hospital. I worked at El Camino Hospital for 15 months helping develop a quality program within the Clinical Research Department, and have a good understanding of some of the strengths and challenges of the organization. Personally, I have had several friends deliver babies at El Camino Hospital and have other friends that have received both emergency and ongoing care at the facility.

3. Why are you interested in being considered as a member of El Camino Hospital's Quality, Patient Care and Patient Experience Committee?

In the Bay Area, large healthcare players dominate the medical landscape. The role of a community hospital is an important one and El Camino Hospital plays a critical role for those who seek outstanding heart and vascular or pulmonary care, among others, in the context of a community hospital setting. Ensuring that patients have a good care experience while ensuring that the providers are able to provide cutting edge medical care in a culture that supports innovation and rapid cycle improvement will be critical for ECH's survival in the Bay Area healthcare marketplace. As a member of the community and a resident of the South Bay, I'm interested in helping ensure that all current and future patients continue to receive the highest quality care and an optimal care experience at the hospital.

4. Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check?

No

5. Are you able to make the necessary time commitment?

Yes

6. Would this position create a conflict of interest with any of your other commitments?

No

KRUTICA SHARMA

krutica.sharma@gmail.com

Krutica Sharma is a Healthcare Management Consultant with a combination of clinical background and experience with strong technical and analytical skills. Ms. Sharma's areas of focus include quality, compliance, performance improvement, and physician productivity and compensation.

PROFESSIONAL EXPERIENCE

Alvarez and Marsal LLC

Senior Associate, Healthcare Industry Group **2018 - Present**

Associate, Healthcare Industry Group **2014 - 2018**

Analyst, Healthcare Industry Group **2013 - 2014**

Intern, Healthcare Industry Group **2012**

- Assisted several locations of a multi-facility international faith based not for profit health system with financial turnaround and cost saving effort
- Provided operational advisory and project management support to a county health system with acquisition and integration of a private non-profit health system
- Involved with assisting a large academic medical center and public hospital with system-wide clinical and operational performance improvement and compliance with Centers for Medicare and Medicaid Services Conditions of Participation under a Systems Improvement Agreement
- Served as the Quality Review Organization and reviewed the compliance and quality programs at a large academic hospital and public hospital system in Dallas, Texas
    - Project Management
    - Perform audits on floors and clinics to ensure adherence to organizational policies and procedures and industry best practice standards
    - Work directly with client for regular meetings reviewing and analyzing adverse safety events
    - Review quality of care dashboards and analyze for trends
    - Investigate adverse safety events
    - Draft regular reports submitted to the hospital leadership and DHHS
    - Monitor progress on organization workplan
- Involved with Strategic Planning for the world's largest Organ Recovery Organization
- Performed commercial due diligence for a Private Equity client looking to invest in a specialty clinic chain
- Program review and recommendations for performance improvement around a community program of a non-profit organization
- Review and crosswalk of sanctions and deficiencies identified as part of a CMS audit of Medicare Advantage & Prescription Drug Program involving a major insurance provider
    - Research and review historical OIG reports on compliance and billing audits and identify trends with the audit score and sanctions
    - Obtain and analyze data to assist the Health Plan, and their attorneys, in responding to a decision by CMS to impose intermediate sanctions on their Medicare Advantage plans.
    - Research similar sanctions against other MA plans
    - Prepare analytical and presentation materials for the Health Plan's attorneys to use in response to CMS action
- Provided analytical support and process mapping for a Revenue Cycle Assessment and Process Improvement project at a medical device manufacturing company

- Assessed clinical quality and performance at a multi-facility Retirement system
- Provided analytical support on a project involving performance-based payments for a large non-profit health system in the mid-West
    - Create a Value Based Purchasing dashboard
    - Assist in cost center mapping
- Conducted healthcare industry research to aid in authoring of intellectual property as well as assist in formulating strategies for existing clients
- Assisted senior management in producing client-facing marketing materials, resulting in new business
- Devised internal group exercises and analyses

Tulane University, New Orleans, LA

Tutor and Teaching Assistant **2009-2011**

- Tutored graduate and undergraduate students in Biology, Genetics, Cell & Molecular Biology, Biochemistry, and General Chemistry
- Supported the professor for the course Principles of Health Systems Management

EDUCATION

Tulane School of Public Health and Tropical Medicine, New Orleans, LA **2011**

Master of Public Health Systems Management

- Received the Gaylord Cummins Outstanding Master of Public Health Student Award May 2011
- Awarded honorary membership to Delta Omega National Honorary Society in Public Health, Eta Chapter
- Research Projects:
    - "Effectiveness of Counseling Session on Knowledge of First-Aid among Primary (Elementary) School teachers of a metropolitan city in India"
    - "Study of Reimbursement Procedures for Medical Devices and In-Vitro Diagnostics" in India, Under the International Society for Pharmacoeconomics and Outcomes Research (ISPOR)

Smt. N.H.L. Municipal Medical College, Gujarat University, India **2009**

M.B.B.S (Bachelor of Medicine and Bachelor of Surgery) (M.D.)

- Graduated with distinction (Equivalent GPA 4.0 as calculated by the World Education Services International Credential Evaluation)

SKILLS

- Clinical Data Review
- Literature Review
- Truven Database
- Definitive Healthcare Product Suite
- Microsoft Office Suite
- SQL
- SAS
- SPSS

3 – 5 YEAR GOALS

- Venture into Health-tech
- Advance in Healthcare Quality and compliance

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Candidate Questionnaire (K. Sharma)
Quality, Patient Care and Patient Experience Committee

1. Quality, Patient Care and/or Patient Related Experience – Please describe how your professional background demonstrates your knowledge and experience with any of the following:
    a. An environment where patient or customer experience, safety and quality and process improvement were key market differentiators.
    b. Establishing new patient or customer care, quality and/or safety programs and procedures.
    c. Innovation (within or outside of healthcare)
    d. Customer or Patient Experience
    e. Data and Technology Background
    f. Examples of situations where you made recommendations for change with any of the above areas

ANSWER: Being trained as a physician, I have had extensive experience interacting with patients in various care settings. Additionally, working as a healthcare management consultant, I have been deeply involved with client engagements focused on patient safety and quality and advising on quality program review / redesign.

I have been part of CMS approved monitoring team at one of the largest public hospitals in the country under their Corporate Integrity Agreement (CIA). Prior to this role, I was involved with system-wide clinical and operational performance improvement, and compliance with CMS Conditions of Participation (CoP) under a Systems Improvement Agreement (SIA) for the same organization.

I also performed clinical quality review and provided recommendations for performance improvement at a multi-facility Retirement System in Texas.

In addition to experience with Patient Safety and Quality of Care, other areas that I have championed include:

- Strategic planning for the world's largest Organ Recovery Organization,
- Commercial due diligence for private equity firms looking to invest in the healthcare space,
- Program review and go-to-market plans for Silicon Valley and Boston based technology startups entering healthcare, and non-profit organizations,
- Financial turnaround and health system integration.

Data analytics is core to all of client related decision making and recommendations and I have extensive expertise using various data analysis techniques.

For additional experience, please refer to the attached bio at the end of this document.

2. In addition to candidates with the technical competencies described above, we are also hoping to recruit members with experiences at El Camino Hospital. To the extent you are comfortable disclosing, please describe any recent experience you or a close member of your family had at El Camino Hospital.

ANSWER: Prefer not to answer

3. Why are you interested in being considered as a member of El Camino Hospital's Quality, Patient Care and Patient Experience Committee?

ANSWER: Access to affordable, safe, and quality healthcare is one of the key fundamental human rights. With quality being one of El Camino Hospital's core values, I would like to get involved the hospital's leadership and board's efforts for continuous enhancement of quality of care and patient safety, thereby being able to provide my assistance and expertise toward the effort that would greatly impact my community in the South Bay.

4. Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check?

ANSWER: None

5. Are you able to make the necessary time commitment?

ANSWER: Yes

6. Would this position create a conflict of interest with any of your other commitments?

ANSWER: No

Krutica Sharma, MD

- Krutica Sharma is a Healthcare Management Consultant, with a combination of clinical background and experience with strong technical and analytical skills. Ms. Sharma's areas of focus include quality, compliance, performance improvement, and physician productivity and compensation.

- In her current role, Ms. Sharma has been involved with assisting a large academic medical center and public hospital with system-wide clinical and operational performance improvement, and compliance with Centers for Medicare and Medicaid Services Conditions of Participation under a Systems Improvement Agreement. She was later involved as the Quality Review Organization, reviewing the compliance and quality programs at the same organization.

- Most recently Ms. Sharma has been involved with turnaround and cost saving efforts at several locations of a multi-facility international faith based not for profit health system. She is currently helping a county health system with acquisition and integration of a private non-profit health system.

- Her other engagements include:
  - Strategic planning for worlds' largest Organ Recovery Organization
  - Assessment and re-engineering of the revenue cycle of a multi-state skilled nursing and assisted living facility with more than 70 centers nationwide
  - Revenue cycle assessment and process improvement at a medical device manufacturing company
  - Clinical quality and performance assessment at a multi-facility Retirement System in Texas
  - Performance based payments for a large non-profit health system in the mid-West
  - Review of sanctions and deficiencies identified as part of a CMS audit of Medicare Advantage & Prescription Drug Program of a major Health Plan and provide analytical and presentation material to the attorneys of the plan to use in response to the CMS sanctions
  - Healthcare Industry and clinical research aiding in formulating strategies for existing clients

- Ms. Sharma is a physician, trained at one of the most esteemed Medical Centers in India and has earned her Master's in Public Health Systems Management from the Tulane School of Public Health and Tropical Medicine. She is a member of the Delta Omega Honorary Society in Public Health, Eta chapter.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Imtiaz Qureshi, MD, Enterprise Chief of Staff
Linda Teagle, MD Chief of Staff Los Gatos
Date: August 21, 2019
Subject: Medical Staff Report – Open Session

Recommendation:

To approve the Medical Staff Report, including the Policies/Scopes of Service identified in the attached list, the Medical Staff Peer Review Policy, Revisions to Neurosurgery Delineation of Privileges, Revisions to Pediatrics Delineation of Privileges, the FPPE Policy, the OPPE Policy and the Policy for Allied Health Professionals.

Summary:

1. Situation: The Medical Executive Committee met on June 27, 2019 and for a Special Session on August 14, 2019.

2. Background: We received the following informational reports.

A. Quality Council – The newly consolidated Quality Council met on June 5, 2019. SSI sub-committee remains in place to address the increased number of SSIs this year over last year. Code Status Orders policy was approved which simplifies code status to Full Code or No Code and addresses patient treatment options for medications, dialysis and feeding separately. Reports were and performance dashboards were received from the following ECH Departments/Programs:

i. Information Services: Data Analytics
ii. Perioperative Services Annual Report and Dashboard –
iii. Clinical Laboratory and Pathology Services Annual Report and Dashboard
iv. Stroke Program Report and Dashboard
v. Patient and Employee Safety Committee

B. iCare Storyboard- Storyboard application in iCare pilot implemented that permits physicians to have quick view of most recent patient information without having to review slide by slide. Improves efficiency and ease of accessing vital information.

C. Medical Staff Peer Review Policy – the medical staff peer review task force presented its recommended revisions to the Medical Staff Peer Review Policy and introduction of a centralized peer review committee. Policy was approved for recommendation to the Governing Board. Behavioral issues were recommended to be separated from clinical care concerns. Triggers for peer review case selection were identified and the goal is to move away from the QRR system as the primary source for case review.

D. Credentials Committee - Pediatrics Delineation of Privileges Revisions – the MEC recommends that the Board approve the revised criteria for circumcision privileges from the Department of Pediatrics.

E. Proposed Bylaws Revisions – Medical Staff Categories- Changes were proposed to reduce the number of Medical Staff Categories from eight (8) to five (5). Medical staff members voted to recommend to the Organized Medical Staff for vote reduction of the categories of medical staff categories to Active, Provisional, Consultant, Affiliate and Emeritus/Honorary. This will be sent to the Medical Staff for approval and brought to the Board for approval at a later date.

F. Allied Health Professional Categories - The medical staff reviewed the current types of allied health professionals credentialed and privileged under direct supervision of medical staff members. Members of MEC unanimously voted to keep the current types and recommend the listed categories to the Governing Board for approval.

G. CEO Report – The CEO Report was provided by the COO and included the following updates:

i. Push notifications to families and patients providing real-time updates implemented in the ED. This is in addition to notifications used in the OR.
ii. Mako robotic precision joint replacement starting July 1, 2019 at Los Gatos.
iii. Stroke Program earned the AHA's 2019 Get with the Guidelines – Stroke Gold Plus Quality Achievement Award.
iv. $11.5 M from the Community Benefit Grant Programs will be awarded in FY20 to local programs to improve the health of our community.
v. Don Watters and Dr. Jack Po are new members of the El Camino Hospital Board of Directors.
vi. Los Gatos will celebrate their 10 year anniversary as part of the El Camino family in July.

H. CMO Report – The CMO reviewed the Quality Dashboard Updates through April 2019.

I. CNO Report – The CNO informed MEC members:

i. Capacity Command Center has had positive impact on improvement with ED throughput and demonstration of great collaboration between nursing, ED physicians and hospitalist team.
ii. Contract negotiations continue with the nurses' union.
iii. The application for the fourth Magnet Status Designation is underway and looks good for meeting the criteria.

J. <u>Chief of Staff Reports</u>:

i. Enterprise – Medical staff and hospital quality strategic plans are intricately linked and both consultants groups continue to aid in development of the medical staff's goals.
ii. Los Gatos – upcoming celebration of 10 years as ECH. Two long term members of the medical staff passed away this month Dr. Desmond Gunatilaka and Dr. Paul Dossick.

K. <u>Special Session (August 14, 2019):</u> The Medical Staff Executive Committee and Peer Review Committee Members were educated on FPPE and OPPE revised procedures as well as the STOP Surgical Safety Checklist and Procedure. The MEC approved the revisions of the FPPE and OPPE policies as well as the Policy for Allied Health Professionals and recommended provisional amendments to the Medical Staff Rules contained in the Bylaws regarding documentation of operative reports (immediate post

procedural and comprehensive operative summary). The MEC also approved Neurosurgery Delineation of Privileges Revisions.

3. Other Review**:** The MEC approved the Policies and Scopes of Service identified in the attached file.

List of Attachments:

A. Spreadsheet showing approved Policies and Scopes of Service
B. Revised Scope of Service – Patient Experience
C. Medical Staff Peer Review Policy
D. Revisions to Neurosurgery Delineation of Privileges
E. Revisions to Pediatrics Delineation of Privileges
F. FPPE Policy
G. OPPE Policy
H. Policy for Allied Health Professionals

Suggested Board Discussion Questions: None. This is a consent item.

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL - Board			
		14-Aug-19	
DOCUMENTS WITH MAJOR REVISIONS			
Document Name	**Department**	**Type of Document**	**Summary of Policy Changes**
Scope of Service Patient Experience	Patient Experience	Scope	Re-written (Guest Services) to reflect scope of Patient Experience
DOCUMENTS WITH NO REVISIONS			
Document Name	**Department**	**Type of Document**	
Scope of Service Progressive Care Unit	PCU	Scope	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

SCOPE OF SERVICE
Patient Experience

Scope and Complexity of Services Offered

The Patient Experience Department offers a variety of services to the Los Gatos and Mountain View hospital campuses.

Scope of Services includes:

- Spiritual care services
- Healing Arts
- Patient Ambassador Program
- Patient and identified support system feedback
- Patient satisfaction data
- Interpreting services
- Patient experience quality improvement efforts

Types and Ages of Clients Served

The Patient Experience Department serves all patients and their identified support systems, as well as staff when appropriate.

Assessment Methods

All Patient Experience staff members are evaluated using job specific competencies.

Appropriateness, Necessity and Timeliness of Services

The Patient Experience Department is staffed Monday through Friday during general business hours. Hours for support services such as the Auxiliary and Spiritual Care may vary.

Staffing/Skill Mix

The Patient Experience Department consists of:

- Chaplains
- Patient Experience Representatives
- Interpreter
- Project managers
- Volunteers to support a variety of work within the department
- Patient Experience Director

Level of Service Provided

The Patient Experience Department provides services under hospital and divisional policy and procedure guidelines.

Standards of Practice

Where applicable, the Patient Experience Department is governed by state and federal guidelines and The Joint Commission.

I. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
ePolicy Committee:	6/2019
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

TYPE:	☑ Policy ☐Protocol ☐Practice Guideline ☐Standardized ☑Procedure ☐Plan ☐Scope of Service/ADT Procedure
SUB-CATEGORY:	Medical Staff
OFFICE OF ORIGIN:	Medical Staff Services
ORIGINAL DATE:	February 2013

I. COVERAGE:

All members of the medical staff and allied health practitioners

II. PURPOSE:

~~To assure standards of care are maintained at El Camino Hospital and to provide a process for peer review of the medical staff~~. 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 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, (4) when necessary, uses the results of such assessments, 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.

III. 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.

IV. REFERENCES:

A. Medical Staff: Focused Professional Practice Policy (FPPE)
B. Medical Staff: Ongoing Professional Practice Policy (OPPE)
C. Medical Staff Bylaws
D. Comprehensive Accreditation Manual for Hospitals, ~~January 1, 2017~~July 1, 2019, Medical Staff Chapter: MS.05.01.03; MS.8.01.03.
E. CMS Medicare Conditions of Participation, § 482.22 (a)1

V. DEFINITIONS:

A. **Practitioner-** The word Practitioner used throughout this policy means both licensed independent practitioner and allied health practitioner.

~~B. **Care Appropriate:** The Practitioner care provided was consistent or compliant with either:~~

~~▪ best clinical practices (including evidenced based medicine when available),~~
~~▪ common practices for the majority of Practitioner in those circumstances, defined medical staff expectations for all general competencies (e.g. medical staff bylaws, rules, regulations or medical staff of hospitals policies), or generally accepted medical ethics~~

~~C. **Opportunity for Improvement-Minor**: The Practitioner's care varied from the appropriate rating either because:~~
- ~~a majority of physicians on the committee (but not all) would not have provided care in that manner under those circumstances;~~
- ~~the care was **not** definitely a major opportunity for improvement but an alternative approach was viewed as consistently better practice.~~
- ~~while the care was not appropriate, the level of significance of issue was relatively low as part of the overall care provided in that case.~~

~~D. **Opportunity for Improvement, Major:** The physician care varied from the appropriate rating either because the majority of physicians on the committee would not have provided care in that manner under those circumstances and the level of significance of issue was relatively high.~~

~~E. **Care Exemplary:** The practitioner's care was rated appropriate and all or some significant component of the care was performed exceptionally well despite difficult circumstances.~~

~~F. **Complex Issue**: For the purposes of this policy, a complex issue is one which involves any of the following and results in referral to Leadership Council: requires immediate or expedited review, involves practitioners from two or more departments Involves practitioners from two or more departments or specialties, involves the department chief, involves professional conduct/disruptive physician behavior, involves possible practitioner impairment, involves pattern despite prior interventions, prior performance improvement plan with recurrence of issues, EMTALA violations or Serious Safety Event identified.~~

B. **Focused professional practice evaluation (FPPE):**
The establishment and confirmation of an individual practitioner's current 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 which are raised through the OPPE or other processes. These activities include, but are not limited to, what is typically called proctoring or focused review, depending on the nature of the circumstances.

C. **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.

1. **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

2. **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

3. **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care

4. **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

5. **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

6. **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

D. **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.

E. **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: 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the medical staff and clinical standards, and 3) use of rate measures in comparison with established medical staff goals using benchmarks or norms as guidelines.

F. **Peer review body:**
The peer review body designated to perform the initial review by the 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 peer review body will be the Practitioner Excellence Committee (PEC) unless otherwise designated for specific circumstances by the Medical Executive Committee.

G. **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.

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.

VI. 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.
   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

VII. PROCEDURE:

~~A. Case Selection and Referral for Peer Review~~

1. ~~The peer review process will evaluate any occurrence or practice pattern that may contribute to an adverse patient outcome. The process shall be applied in an objective, uniform and consistent fashion to the entire Medical Staff.~~
2. ~~Case selection for peer review may be initiated by the Clinical Effectiveness Department, Chief of Staff, Chief Medical Officer, Medical Staff Department Chairs, medical staff members, or other clinical staff members. Sources for identifying cases for review include but are not limited to direct referrals, chart reviews, quality indicators, data from hospital data collection systems, referrals from medical staff committees, patient or family complaints and incident reports (QRRs). These screens are applied objectively and uniformly to the entire Medical Staff.~~
3. ~~Case referrals are reviewed by clinical staff in Clinical Effectiveness and the Medical Directors for Quality and Safety for suitability for peer review. Cases may be closed, trended for practitioner performance, referred to Department peer review committees, or referred to Leadership Council for complex issues as defined above. Decisions shall be documented in the appropriate database used by Clinical Effectiveness for quality monitoring.~~
4. ~~Clinical Effectiveness staff shall enter referrals for peer review and complete required documentation on the Peer Review Assessment form.~~

~~B. Peer Review Procedure~~

1. The Executive Committee of the Department of the Practitioner or the designated peer review committee will conduct the peer review in accordance with the Medical Staff Bylaws.
    - **A.** The Department Executive Committee may, from time to time, appoint an ad hoc subcommittee to deliberate a specific peer review issue if other expertise is necessary to adequately assess a peer.
    - **B.** Cases referred to the Leadership Council shall be reviewed by members to identify appropriate venue for review of case. Appropriate venues include departmental peer review, review by Care Review Committee or need for external review. Cases shall be referred as requested by the Leadership Council.
    - **C.** In instances where the Department Executive Committee or the practitioner is concerned that an unbiased review cannot be satisfied, the Care Review Committee may review or an external review may be requested by either party.
    - **D.** External Reviews may be initiated by either the Care Review Committee or the MEC. External Peer Review is an impartial evaluation of a practitioner's clinical performance or professional conduct which, for whatever reason, cannot be resolved internally. Situations which may require external peer review include:
        - i. Conflicting conclusions by peer review bodies that affect a practitioner's membership or privileges (when internal reviewers submit conflicting or vague recommendations or fail to agree).
        - ii. Lack of internal expertise – when the only practitioners on the medical staff with expertise to review the specialty are associates, partners, or direct competitors of the practitioner under review.
        - iii. Conflict of interest – i.e. one practitioner reviewing a partner's performance would trigger a conflict of interest.
        - iv. New technology – When the medical staff does not have the necessary tools to assess whether a practitioner requesting privileges possesses the required skills and competence.
        - v. Miscellaneous issues – The MEC may use external peer reviewers whenever it is deemed appropriate.

2. Customarily, a Deparment Executive Committee will complete the peer review process within 90 days of receipt of a case.
3. The Peer Review Assessment form shall be forwarded to the Peer Review Practitioner assigned to review the case.
4. The involved practitioner shall be notified that the case will be reviewed and the involved practitioner shall be given an opportunity to respond to the inquiry or specific questions by presence at the committee (virtually or in person), or in writing (email communication or written response letter). If the practitioner does

not respond to inquiry of committee within reasonable time frame, the case shall be reviewed without the practitioner's input.

5. The Department Peer Review Committee or designated peer review committee shall review the case and complete the Peer Review Assessment form in its entirety, including final case evaluation using definitions to rate care. Decisions of the Department Peer Review Committee will be determined by majority vote.
6. The Practitioner shall be notified of the conclusions of the committee and expected actions if necessary. Information shall also be documented in the practitioner's credentials file as appropriate. Available action items include but are not limited to:no action warranted, educational opportunity identified and letter sent to practitioner, trend monitor practice over time, discussion with Department chairman, referral to physician well-being committee, formal letter in practitioner's credentials file, formal counseling by Department Chair with formal improvement plan or proctoring, recommendation of FPPE.
7. Documentation of the peer review shall be maintained in the appropriate databases and available for use for ongoing monitoring of medical staff.
8. Peer review is considered confidential and privileged information. Discussions of peer review are confined to meetings and committees designated to complete this function. Discussion may include fact-finding and phone calls between officers, the practitioner and other peer review bodies. Confidentiality of the process includes protecting the identity of individuals making complaints to the department executive committee and reviewers.
    a. Those individuals and entities legally permitted access to peer review include the following but are not limited to:
        1) Practitioner whose credential's file is being requested.
        2) Officers of the practitioner's department.
        3) Medical Staff Officers, Quality Assessment Medical Director, Medical Director of
        Service, Administration: CEO or designee.
        4) Regulatory Agencies, Joint Commission, Federal and State agencies.
        5) Legal Counsel for the Medical Staff.
        6) Medical Staff Services personnel.
        7) Clinical Effectiveness staff
        8) Board of Directors during appointment and reappointment period.
        9) Other Department Executive Committees only if germane to privileging process.
    b. Practitioner's access to peer review records must take place in the Medical Staff Office. Access for other individuals or entities listed above must have prior approval by the Chief of Staff or Quality Assessment Medical Director. Under no circumstances should issues be discussed with non-involved individuals and at no time may copies of minutes or peer review records be given to practitioners unless there is a judicial review hearing.

~~9. Cases rated as Opportunity for Improvement Major will automatically be forwarded to the Care Review Committee for review of findings and action plan. Summaries of all cases determined to be appropriate shall also be periodically reviewed by designated members of the Care Review Committee to ensure that reviews are being conducted fairly and consistently~~.

A. 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 Code ….
2. The medical staff will use the provider-specific OPPE/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 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 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 review data will be retained for ten years after the most recent reappointment of the provider. 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.

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, Credentials Committee, 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.
    i. No copies of peer review documents will be created and distributed unless authorized by medical staff or hospital policy.

B. <u>Circumstances requiring peer review</u>:

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 are described in Attachments 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, 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 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.

C. 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.

D. Individual case review and timeframe

1. Peer review will be conducted by the medical staff in a timely manner. The cases for review will 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 is reviewed by the quality department staff and complex cases to be completed within one hundred and twenty (120) days. Exceptions may occur based on case complexity or reviewer availability. The timelines for this process are described in Case Review Process (**Attachment B)**. 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.

E. **Rate and rule indicator data evaluation**

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**

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
    a) At least annually review all the 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 timeframe.
    b) Data from sub-specialty databases supported by the hospital shall be shared with the PEC based on MEC approved indicators.
    c) 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.
    d) Design and approve focused studies when necessary to further analyze practitioner performance.
    e) 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 initial practitioner review of all cases identified based on approved Case Review indicators. If initial 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.
    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 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.

3. 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.

4. Improvement Opportunity Accountability

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.

5. Oversight of Other Medical Staff Physician Excellence Committees

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:

a) **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.

b) **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.

c) **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.

d) **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.

e) **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.

f) **Interdisciplinary Practice Committee:** Perform routine review of cases related allied health professionals based on medical staff criteria.

H. Department (or Specialty) Peer Review Responsibilities

a) 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.

b) Aggregate Rate data shall be the responsibility of the Department as well.

c) 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.

I. Membership

The PEC will be comprised of 9 to 11 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.

The CMO, the Chief of Staff, and the quality support staff as determined by the Chair are ex-officio members of the PEC.

J. 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.

4. *Chair selection*

5. The PEC Chair will be appointed by the Chief of Staff, and approved by the MEC.

6. 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.

K. Member Responsibilities

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.

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.

L. Meetings

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.

Statutory Authority

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 State Codes…….. 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.

VIII. APPROVALS

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Peer Review Task Force:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	2/2013, 10/2014, 7/2017

IX. ATTACHMENTS:

Attachment A: Review Indicator Definitions and Response
Attachment B: Case Review Process Flow
Attachment C: Indicators and Targets Listing
Attachment D: Indicators-Rule-Rate
Attachment E: Quality Review Worksheet and Outcomes Definitions

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Attachment A
El Camino Health
Peer Review Indicator Definitions and Responses

1. Review indicators

Definition:
This type of indicator identifies a significant event that would ordinarily require analysis by physician peers to determine cause, effect, and severity.

Response:
Analysis by appropriate peer review committee. Documentation of these communications is to be maintained in a secure medical staff file for immediate action or for such future reference as may be necessary.

2. Rule indicators

Definition:
This type of indicator represents a general rule, standard, generally recognized professional guideline, or accepted practice of medicine where individual variation does not directly cause adverse patient outcomes. Ideally, there should always be compliance. Rare or isolated deviations usually represent only a minor problem.

Response:
Occurrence of a rule event generates an automatic report of findings to the physician sent directly by support personnel, a copy of which is maintained in a secure medical staff file for such future reference as may be necessary. A target number of events should be set for each indicator based on the criticality of the rule to determine whether further follow-up is needed. If a pattern of rules, events, or a potentially serious isolated event is identified, it is reported to the medical staff quality improvement committee as well as to the appropriate department chairperson and the chief of staff, who shall decide how to proceed.

3. Rate indicators

Definition:
This type of indicator identifies cases or events that are aggregated for statistical analysis prior to review by the appropriate committee or administrative function. This type of indicator may be expressed as a percentage, average, percentile rank, or ratio. A target range should be

established for each rate indicator. It may be based on best practice from benchmark data, statistical variation from the average, or internal targets.

Response:
Feedback to individual physician rates would be provided on a regular and timely basis. If the rate for a particular physician falls outside of the target range, the leadership of the appropriate medical service would determine what, if any, action is warranted.

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Attachment B
El Camino Health
Case Review Process Flow

Action	Procedure	Time
Case Gathering and Screening	Potential cases shall be gathered from the hospital information management system, from generic screens and from individual reports (incident and informal). The Quality Department (QD) will screen the cases against the Case Review Indicators. If they contain a potential Case Review issue, the case 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 PEC. The subcommittees will be encouraged to use a mirror review process to the one elaborated below.	3 working days of case receipt.
Case Summary and Reviewer Assignment	QD 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. Cases will be typically assigned to committee members on a rotating basis. 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	5 working days of receiving the chart.

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Action	Procedure	Time
	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.
Completed Case Review	Completed reviews will be submitted to the QD by the physician review immediately upon completion to enter into the case review tracking system. Only cases with completed case rated forms will be place on the PEC agenda.	3 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.
Initial Reviews Rated Quality 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 are reported to the PEC in summary form. Any concerns raised results in presentation of the case to the entire PEC.	
Initial Reviews Rated Opportunity for Improvement Minor or Major	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	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 QD department will contact

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Action	Procedure	Time
	signature receipt. 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.	the physician by phone to determine if physician is unavailable due to special circumstances.
Communicating Findings to Physicians	For final case reviews indicating appropriate 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 sent to the Department Chief and peer review file.	All completed case review findings will be communicated by letter to the involved physician within 5 days of the Committee meeting.
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.	
Tracking Review Findings	The QD department will enter the results of all final review findings into the database for tracking.	Results will be entered in the database within 1 week of the Committee meeting finalizing the rating.

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Action	Procedure	Time
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 30 days of the Committee decision.
Medical 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 30 days of the Committee decision.
Referrals to the Hospital 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.
High-risk 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 (3) working days of sentinel

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Action	Procedure	Time
	designee. Additional information (such as a literature search, second opinion, or external peer review) may be necessary before making a decision on action.	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. 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.

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Attachment C
El Camino Health
Indicators and Targets Listing

Dept	Competency	Indicator	Indicator description	Type	Excellence Target	Competence Target
All Depts	Pt. Care	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 paliative care or severe trauma; **Medical:** Deaths of medical inpatients excluding admissions for palliative care, end stage disease, or medical conditions with known expected death rates (e.g. CHF, acute AMI, pneumonia) or deaths in the ED of patients presenting in stable condition; **OB/Peds:** maternal death within 30 days, newborn or intrapartum fetal death with gestational age greater than 25 weeks excluding infants with severe congenital anomalies;	Review	NA	NA
All Depts	Pt. Care	Transfer to another facility for significant/unanticipated change in clinical condition.	Exclusion: transfers for higher level of services not available or transfers not based on potential physician care issues	Review	NA	NA

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

All Depts	Pt. Care	Missed/ misdiagnosis resulting in significant change in patient treatment plan.	Includes transfer to ICU or invasive procedure interventions	Review	NA	NA
All Depts	Pt. Care	Unanticipated Cardiac or Respiratory arrest		Review	NA	NA
All Depts	Pt. Care	Unplanned return to ICU at same admission		Review	NA	NA
All Depts	Pt. Care	Patient admitted for medical condition (non-surgical) with complication resulting in additional interventions	Additional intervention: Unanticipated ICU transfer or need for unanticipated surgical procedures.	Review	NA	NA
All Depts	Pt. Care	Autopsy with unexpected findings potentially affecting patient care.	Findings of autopsy that were not known prior to death and could potential impact clinical course and treatment.	Review	NA	NA
All Depts	Pt. Care	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)	Review	NA	NA
All Depts	Pt. Care	Delay in treatment/consultation resulting in significant deterioration in patient condition		Review	NA	NA

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

All Depts.	Pt. Care	Risk management referral for significant clinical concern not otherwise classified.	Risk Mgt referral not otherwise covered by specific review indicators	Review	NA	NA
All Med	Pt. Care	Unanticipated readmission of patient 7 days after discharge for problems related to initial condition		Review	NA	NA
All Surg, Anesthesia	Pt. Care	Major perioperative complication of patient undergoing anesthesia	Inclusion: Perioperative cardiac/resp arrest, acute MI, and central neurological deficit.	Review	NA	NA
All Surg	Pt. Care	Unanticipated removal of an organ during surgical procedure		Review	NA	NA
All Surg	Pt. Care	Significant complication of surgical 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.	Review	NA	NA
All Surg	Pt. Care	Unanticipated return to surgery for significant complication.	Inclusion: Evisceration, repair of organ or obstruction Exclusion: Failed dialysis access, unrelated procedures, planned returns or a specific complications monitored by rule and rate indicators, (e.g bleeding or hematoma)	Review	NA	NA
All Surg	Pt. Care	Significant intra or post procedural complications	Inclusion: Additional procedures required due to medical or surgical complications of the original procedure or as defined by ICD-9 coding.	Review	NA	NA

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

All Surg	Pt. Care	Unplanned readmission within 30 days of procedure for problems related to initial procedure	Exclusion: Complications monitored by rates; e.g. surgical infection	Review	NA	NA
All Surg	Pt. Care	Unscheduled admission following outpatient procedure requiring inpatient admission to critical care		Review	NA	NA
All Surg	Pt. Care	Removal of iatrogenic foreign body		Review	NA	NA
Cardiol	Pt. Care	Emergent CABG due to Cardiology procedure complication		Review	NA	NA
GI	Pt. Care	Significant Complications of endoscopy, colonoscopy or ERCP	Includes: Any prolonged length of stay (greater than 48 hours) or critical care admission.	Review	NA	NA
Invasive Card	Pt. Care	Acute coronary artery closures related to interventional cardiology procedure		Review		
OB/Gyn	Pt. Care	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.	Review	NA	NA

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

OB/Gyn	Pt. Care	Post delivery maternal readmission within 7 days		Review	NA	NA
OB/Gyn	Pt. Care	Eclampsia	Exlusion: patients presenting with full eclampsia with no prenatal care provided by medical staff.	Review	NA	NA
OB/Gyn	Pt. Care	Mother transferred to ICU post-delivery	Exclusion: Patients in ICU pre delivery	Review	NA	NA
OB/Gyn	Pt. Care	Excessive maternal intra or peripartum blood loss	Inclusion: Transfusion of greater than three units	Review	NA	NA

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Attachment D
El Camino Health
Indicators –Rule-Rate Listing

Dept	Area of Competency	Indicator	Indicator description	Type	Excellence Target	Competence Target
All Depts	Pt. Care	# of case reviews deemed care questionable	# of peer review cases with a determination of care questionable over last 12 months	Rule	0/yr	4/yr
All Depts	Pt. Care	# of case reviews deemed care questionable or inappropriate.	# of peer review cases with a determination of care questionable or inappropriate over past 12 months	Rule	0/yr	4/yr
All Depts	Pt. Care	Blood component use not meeting appropriateness criteria excluding autologous units	Based on MS approved criteria for PRBC's, Platelets, FFP, cryoprecipitate	Rule	0/yr	4/yr
All Depts	Inter Pers	Patient complaints for general medical staff physicians regarding non clinical issues.	Validation as described in medical staff validation policy. Inclusion: complaints for communication, responsiveness and behavior. Exclusion: complaints regarding specific diagnostic or treatment issues; ED physicians and hospitalists (see separate indicator).	Rule	1/yr	4/yr
All Depts	Prof	Validated incidents of physician non-availability to nursing requests for modification of patient treatment		Rule	0/yr	2/yr
All Depts	Prof	Validated incidents of nonavailability for ED call by physician on call list or covering physician		Rule	0/yr	1/yr
All Depts	System	Avoidable patient days due to physician decisions or practice	Avoidable days as defined by organizational case management criteria and validated through MS guidelines.	Rule	0/yr	6/yr

El Camino Health

TITLE:	Medical Staff – Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	09/2017

All Depts	Prof	Validated incidents of inappropriate physician behavior		Rule	0/yr	1/yr
All Depts	System	Adherence to standard precautions for infection control		Rule	2/yr	6/yr
All Depts	Pt. Care	Validated incidents of patient not seen and/or documented every 24 hours by a physician		Rule	0/yr	2/yr
All Depts	Inter Pers	Illegible medication order	Medication order illegible as validated by two licensed staff at the time order is needed	Rule	2/yr	6/yr
All Depts	System	Physician orders containing "do not use" abbreviations	As determined by concurrent review (e.g pharmacy or case management) or retrospective audit.	Rule	3/yr	6/yr
All Depts	Inter Pers	Physician documentation lacking essential elements per regulatory guidelines.	As determined by concurrent or retrospective audits of documention for specific components of the H&P, Op report, Progress notes, Pre-post OP notes, patient consents, etc.	Rule	1/yr	4/yr
All Depts	System	Validated incidents of physician non-compliance with Presurgical/invasive procedure safety policies and procedures		Rule	0/yr	1/yr
All Depts	Inter Pers	Orders for restraint not in compliance with Medical Staff/Hospital guidelines	Inclusions: order not signed, timed, dated, specified type of restraint or lack of clinical justification	Rule	0/yr	2/yr
All Depts	Inter Pers	Suspensions for delinquent medical records	Inclusion: Any suspension communicated to clinical services (e.g. surgery, admissions)	Rule	0/yr	3/yr
All Depts	Prac. Learn	Physician improvement in next data report for patient care indicators rated below excellent		Rule		
All Med	System	Medicare patients in selected medical DRGs with 1 day LOS	Inclusion: specific medicare DRGs where medicare is concerned with use of 1 day LOS vs. observation status.	Rule	2/yr	6/yr

All Medical	Inter Pers	Patient complaints for hospitalist physicians regarding non clinical issues.		Rule	2/yr	8/yr
All Medical	Inter Pers	Important medical physician documentation not completed in required timeframe	Per Bylaws, Rules and Regulations and policies	Rule	2/yr	6/yr
All Surg	System	Procedure room delays for first case starts due to physician	Inclusions: either physician performing procedure or anesthesiologist; Delay defined by policy.	Rule	1/yr	5/yr
Anesth	Pt. Care	Patients having routine procedures under general anesthesia being discharged from PACU beyond 4 hours	Due to patient's clinical issue, Excludes: Delays due to non-clinical issues such as bed availablity	Rule	2/yr	6/yr
Emerg	Pt. Care	Significant discrepancy of Cardiology EKG overreads of ED physician reading requiring an acute patient intervention.		Rule	0/yr	3/yr
Emerg	Pt. Care	Significant discrepancy of Radiology overreads of ED physician reading requiring an acute patient intervention.	Inclusion: radiology plain films	Rule	2/yr	8/yr
Emerg	Inter Pers	Patient complaints for ED physicians regarding non clinical issues.		Rule	2/yr	8/yr
OB/Gyn	Pt. Care	Lack of patient examination by an attending or appropriately qualified physician within 2 hours.	For patients with no prenatal care only.	Rule	0/yr	4/yr
Peds	Med Know	Non use of systemic Corticosteroids for pediatric inpatients admitted for asthma		Rule	0/yr	2/yr
Peds	Pt. Care	Infants undergoing circumcision without pain manangement provided per guidelines.		Rule	0/yr	2/yr

All Med	Pt. Care	Unplanned readmission within 72 hours of medical patients/post procedural patient	Exclude: patients previously discharged AMA, substance abuse, dialysis dependent CKD with missed dialysis treatment, hospice or comfort care patients, patients with frequent readmission d/t social/compliance reason affecting clinical issues)	Rate		
All Depts	Pt. Care	Patient receiving reversal agent for conscious sedation		Rate		
All Depts	Med Know	Use of Relievers for Inpatient Asthma	National Measure	Rate	>98%	>95%
All Depts	Med Know	Use of Corticosteroids in Inpatient Asthma	National Measure	Rate	>98%	>95%
All Depts	Pt. Care	% Post Procedural DVT		Rate		
All Med	Pt. Care	Risk adjusted mortality index for medical DRGs	Index=actual complications divided by expected complications as determined by risk adjusted software. Option: either all medical DRGs combined, or top DRGs, individually or as a group, with some degree of expected frequency of mortality.	Rate	<0.9	>1.3
All Med	Pt. Care	% CHF Readmissions <31 days within the same DRG Major Disease Category (MDC)	Inclusion: patients with initial DRG of CHF whose principle reason for readmission is for a DRG within the heart major disease category	Rate		
All Med	Pt. Care	Risk adjusted complications index for medical DRGs	Index=actual complications divided by expected complications as determined by risk adjusted software. Option: either all medical DRGs combined, or top DRGs individually or as a group.	Rate	<0.9	>1.3
All Med	Pt. Care	Cross match to transfusion ratio		Rate		
All Med	Med Know	% AMI patients receiving aspirin within 24 hours of arrival	National Measure: Option as rule indicator as Medical bundle	Rate	100%	95%

All Med	Med Know	% AMI patients who are prescribed aspirin at discharge (publicly reported)	National Measure: Option as rule indicator as Medical bundle	Rate	100%	95%
All Med	Med Know	% AMI patients receiving a beta blocker within 24 hours of arrival	National Measure: Option as rule indicator as Medical bundle	Rate	100%	95%
All Med	Med Know	% AMI patients who are prescribed a beta blocker at discharge	National Measure: Option as rule indicator as Medical bundle	Rate	100%	95%
All Med	Med Know	% meeting Time to PTCA for AMI patients	National Measure Time<90 minutes	Rate	>98%	>95%
All Med	Med Know	% Heart failure patients prescribed ACE/ARBs inhibitors at discharge	National Measure: Option as rule indicator as Medical bundle	Rate	>98%	>95%
All Med	Med Know	% Heart failure patients with LVEF assessment documented.	National Measure: Option as rule indicator as Medical bundle	Rate	>98%	>95%
All Med	System	Severity Adjusted LOS index by medical DRG	Index=actual LOS divided by expected LOS as determined by severity adjusted software. Option: either all medical DRGs combined, or top DRGs individually or as a group.	Rate	<0.25/days	>1.0 day
All Medical	Med Know	PN- Initial antibiotic dose within 6 hours	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Medical	Med Know	PN- Initial antibiotic selection for ICU patients	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Medical	Med Know	PN- Initial antibiotic selection for non- ICU patients	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Surg	System	Severity Adjusted LOS index by surgical DRG	Index=actual LOS divided by expected LOS as determined by severity adjusted software. Option: either all surgical DRGs combined, or top DRGs individually or as a group.	Rate	<0.25/days	>1.0 day
All Surg	Pt. Care	Unscheduled admission following outpatient procedure with >48 hour inpatient stay		Rate		

All Surg	Pt. Care	Risk adjusted mortality index for surgical DRGs	Index=actual complications divided by expected complications as determined by risk adjusted software. Option: either all surgical DRGs combined, or top DRGs, individually or as a group, with some degree of expected frequency of mortality.	Rate	<0.9	>1.3
All Surg	Pt. Care	Risk adjusted complications index for surgical DRGs	Index=actual complications divided by expected complications as determined by risk adjusted software. Option: either all surgical DRGs combined, or top DRGs individually or as a group.	Rate	<0.9	>1.3
All Surg	Pt. Care	% unplanned repair of an organ during operative procedure including laceration, puncture, tear or perforation	Based on ICD-9 injury codes	Rate		
All Surg	Pt. Care	% perforations of colonoscopy procedures		Rate		
All Surg	Pt. Care	% Unanticipated return to surgery for hematoma, or hemorrhage		Rate		
All Surg	Pt. Care	% Arterial vascular complications following surgical procedure		Rate		
All Surg	Pt. Care	% of Appendectomies with no pathologic findings	Inclusion: Minimal serosal inflammation should not be considered a pathological finding. Exclusion: appendenctomies removed incidentally as part of a principle procedure.	Rate	<5%	<10%
All Surg	Pt. Care	% Surgical site infections by selected surgical procedures	Rate of surgical site infections subcategorized by procedure type	Rate	>98%	>95%
All Surg	Med Know	% Prophylactic antibiotic received within one hour prior to surgical incision	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%

All Surg	Pt. Care	% Prophylactic antibiotic selection for surgical patients	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Surg	Med Know	% Prophylactic antibiotic discontinued within 24 hrs after surgery end time	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Surg	Med Know	SCIP- Prophylaxis timing	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Surg	Med Know	SCIP- Venous thromboembolism prophylaxis	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Surg	Med Know	SCIP- Beta blocker prior to admission and periop	National Measure: Option as rule indicator as surgical bundle	Rate	>98%	>95%
All Surg/Anesthesia	Pt. Care	Reintubation within 12 hours of post procedure extubation	Inclusion: Inpatients reintubated within 12 hour of post op extubation. Exclusion: Reintubation for patients on being weened from respirators.	Rate		
Anesth	Pt. Care	Failed epdural rate		Rate		
Anesth	Pt. Care	Patient safety related events for patients undergoing anesthesia	Events include: aspiration, awareness under anesthesia, broken, chipped tooth, eye trauma, corneal abrasions, spinal/general hypothermia, prolonged muscle paralysis	Rate		
OB/Gyn	Pt. Care	% Birth trauma as defined by ICD9 codes		Rate		
Path	Pt. Care	% discrepancies between frozen section and final diagnosis		Rate		
Path	Pt. Care	% discrepancies in findings between initial pathology report and final diagnosis		Rate		
Peds	Pt. Care	% neonatal mortality		Rate		
Peds	Pt. Care	% asthma patients readmitted within 7 days		Rate		
Psychiatry	Pt. Care	Readmission within 7 days for related condition		Rate		
Rad	Pt. Care	% Random case radiology interpretation correlation		Rate		

Rad	Pt. Care	% Amendment in findings in radiology reports		Rate		
Rad Onc	Pt. Care	% Amendment of original radiation treatment plan		Rate		
ED	Pt. Care	Unplanned returns to ED within 72 hours		Rate		
ED	Pt. Care	Transfers		Rate		
OB/Gyn	Pt. Care	Maternal readmissions in <7 days		Rate		
Perinatal	Pt. Care	5 Minute Apgar <7		Rate		
Peds	Pt. Care	NICU readmissions in <7 days		Rate		
Peds	Pt. Care	Neonatal jaundice readmissions <10d		Rate		

El Camino Hospital Peer Review Case Rating Form

MR#	Admit Date: Event Date:	Referral Date: Referral Cmte:	Physician ID#:

Referral Source: Check the corresponding box

	QRR		Dept Quality Indicator		Guest Services		Other	
	PSI/HAC		Medical Director Referral		Other Medical Staff			

Reason for Review/Quality Indicator

Case Summary of Reason for review

Key Issues for Practitioner reviewer

To be completed by Practitioner Reviewer

Practitioner Reviewer: _____ Cmte Review Date: _____

Outcome: Please check one					**Documentation:** Check all that apply
	1.	No Adverse Outcome		1.	No issue with documentation
	2.	Temporary Adverse Outcome (complete recovery expected)		2.	Documentation exemplary
	3.	Permanent Adverse Outcome (complete recovery NOT expected)		3.	Documentation does not substantiate clinical course and treatment
	4.	Death		4.	Documentation not timely to communicate with other caregivers
		Please describe anything checked		5.	Failure to use electronic health record
				6.	Documentation not appropriate in medical record

Issue Identification: Check all that apply					**Overall Practitioner Care: Check one**
	1.	No issues with Practitioner care identified		1.	Practitioner care exemplary
	2.	Issue with Practitioner diagnosis		2.	Practitioner care appropriate
	3.	Issue with Practitioner judgment		3.	Practitioner care Opportunity for Improvement, Minor
	4.	Issue with Practitioner technique/skills		4.	Practitioner care Opportunity for Improvement, Major
	5.	Issue with Practitioner communication		5.	Further Review Required
	6.	Issue with Practitioner policy compliance			Does case need further review? Yes No
	7.	Issue with Practitioner delay in response/on call availability			
	8.	Issue with Practitioner supervision of AHP or house staff			
	9.	Issue with plan of care/discharge planning			~~Overall Vote Tally:~~
	10.	Issue with Practitioner Behavior			~~___# Agree ___# Dissent~~
	11.	Issue with Impaired Physician			
	12.	Issue with Utilization Management			
	13.	Please describe item checked above:			

If Overall Practitioner Care rated Further Review Required or Opportunity for Improvement, provide brief description of the basis for reviewer findings:

Privileged and Confidential, Protected by Evidence Code 1157. Return to Peer Review Coordinator at fax number 650 966-9275 or by email to designated peer review coordinator or Director Risk Management at sheetal_sh@elcaminohealth.org

Rev. ~~5/18~~; 06/27/19

El Camino Hospital Peer Review Case Rating Form

MR#	Admit Date: Event Date:	Referral Date: Referral Cmte:	Physician ID#:

If Overall Practitioner Care rated Further Review Required or Opportunity for Improvement, what questions are to be addressed by the Practitioner?

COMMITTEE REVIEW:
Is physician response needed? _____ Yes _____ No

Physician Response Received: _____ Date of Appearance at Cmte ___ Written Response Received

COMMITTEE FINAL SCORING _____

Committee ~~Action~~ Recommendation (check one)		Date Completed
	No further action needed	
	Discussion with Practitioner of Improvement Opportunity (e.g., verbal coaching, feedback during/after peer review meeting)	
	Educational Letter to Practitioner of Improvement Opportunity	
	Written counseling letter to practitioner ~~(e.g., behavioral concern/bylaws violation, usually a consequence if behavior/concern not rectified or repeats)~~	
	~~Departmental~~ Performance Improvement Plan (developed by Department or Committee)	
	Focused Professional Practice Evaluation (formal process with timeframe, metrics and measurement, *requires referral to PEC)	
	Practitioner no longer on medical staff	
	Referral to PEC for determination	
	Referral to MEC for further action (e.g., suspension of privileges)	

~~Notification of Practitioner of Findings: Date _____~~
All practitioners will be notified of results in writing with copy in Quality file.

System Concerns:
☐ None
☐ Educational opportunity identified for all practitioners- Referral for General CME / Dept. M&M, Date sent: _____
☐ System Problem Identified: Forward to Clinical Effectiveness or other Committee _____: Date _____

Describe system issue: _____

☐ Referral to Nursing Administration, refer to CNO Date sent: _____
Describe nursing concern: _____

Department ~~Chair~~ Chief/ Committee Chair Signature: _____ Date: _____

Privileged and Confidential, Protected by Evidence Code 1157. Return to Peer Review Coordinator at fax number 650 966-9275 or by email to designated peer review coordinator or Director Risk Management at sheetal_sh@elcaminohealth.org
Rev. ~~5/18~~; 06/27/19

Attachment E: El Camino Hospital Peer Review Case Rating Form

MR#	Admit Date: Event Date:	Referral Date: Referral Cmte:	Physician ID#:

Department ~~Chair~~ Chief/ Committee Chair Signature: _____ Date: _____

** Overall Practitioner Care Assessment Definitions

1. **Care Appropriate:** The Practitioner care provided was consistent or compliant with either:
   - best clinical practices (including evidenced based medicine when available),
   - common practices for the majority of Practitioner in those circumstances, defined medical staff expectations for all general competencies (e.g. medical staff bylaws, rules, regulations or medical staff of hospitals policies), or generally accepted medical ethics

2. **Opportunity for Improvement-Minor**: The Practitioner's care varied from the appropriate rating either because:
   - a majority of physicians on the committee (but not all) would not have provided care in that manner under those circumstances;
   - the care was **not** definitely a major opportunity for improvement but an alternative approach was viewed as consistently better practice.
   - while the care was not appropriate, the level of significance of issue was relatively low as part of the overall care provided in that case.

3. **Opportunity for Improvement, Major:** The physician care varied from the appropriate rating either because the majority of physicians on the committee would not have provided care in that manner under those circumstances and the level of significance of issue was relatively high.

4. **Care Exemplary:** The practitioner's care was rated appropriate and all or some significant component of the care was performed exceptionally well despite difficult circumstances.

Practitioner Name:

INSTRUCTIONS:

Indicate Request Type: ☐ Initial Appointment ☐ Renewal of Privileges ☐ Additional Privileges

Applicant: Check off the "Requested" box for each privilege requested. Please note: Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications, and for resolving any doubts related to qualifications for requested privileges.

Department Chief: Check the appropriate box for recommendation on the last page of this form and include your recommendation for focused professional practice evaluation (FPPE). If recommended with conditions or not recommended, provide conditions or explanation on the last page of this form.

Other conditions:

If any privileges are covered by an exclusive contract or an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience.

REQUIRED QUALIFICATIONS ***Initial applicants:*** To be eligible to apply for privileges in Neurological Surgery, the applicant must meet the following criteria:	
Education/Training	Basic Education: MD or DO Minimal Formal Training: Successful completion of residency program in Neurological Surgery, accredited by ACGME, AOA or Royal College of Physicians and Surgeons of Canada
Certification	Currently certified or eligible in Neurological Surgery by the American Board of Neurological Surgery or the Osteopathic Board of Surgery in Neurological Surgery with achievement of certification within five (5) years of completion of residency/fellowship. **Once certified members must maintain board certification as required by the same board or association.**
Current Experience	Applicants must provide evidence of a sufficient volume (at least 50 cases) of neurological surgical procedures, reflective of the scope of privileges requested during the last 24 months or demonstrate successful completion of an ACGME or AOA-accredited residency or clinical fellowship within the last 12 months (case logs required).
Licensure	Current active, unrestricted physician license by the Medical Board of California or the Board of Osteopathic Examiners of the State of California.
DEA	Have an active, individual federal, registered DEA number for prescribing of controlled substances.
Additional Requirements	Board certification in primary specialty must be maintained. Medical Staff members whose board certificates bear an expiration date shall be afforded a grace period of two (2) years following such date or maintenance of certification requirements must be met, with a lapse in continuous maintenance of no greater than two (2) years.
FPPE (Proctoring)	It is the responsibility of the Department Chief to establish proctoring requirements for the members of the Department. Minimum proctoring requirements are delineated in the table of the privilege form.
Renewal of Privileges	The applicant must have current demonstrated competence and an adequate volume of experience ([n] neurological surgical procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. **Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.**
Special Non-Core Privileges (See Specific Criteria below)	Non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria as applicable to the applicant or reapplicant.

Requested	Privilege	Additional/Special Criteria
☐	**CORE PRIVILEGES NEUROLOGICAL SURGERY** Physicians may admit, evaluate, diagnose, provide consultation, non- operative, pre-, intra- and postoperative care to all patients of all ages presenting with injuries or disorders of the central, peripheral, and autonomic nervous systems, including their supporting structure and vascular supply. Physician may provide evaluation and treatment of pathological processes that modify function or activity of the nervous system, including the hypophysis, and provide operative and nonoperative management of pain. These privileges include but are not limited to care of patients with disorders of the nervous system (i.e. the brain, meninges, skull, skull base, and their blood supplies), including the surgical and endovascular treatment of disorders of the intracranial and extracranial vasculature supplying the brain and spinal cord; the pituitary gland; the spinal cord; meninges and vertebral column; and the cranial and spinal nerves throughout their distribution. Participate in short-term and long-term post-procedure follow-up care, including neurointensive care. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. **Core Procedures List** The core procedures in Neurological Surgery include the following procedures and such other procedures that are extensions of the same techniques and skills. It defines the types of activities/procedures/privileges that the majority of practitioners meeting the core educational, certification and experience requirements are competently able to perform. ▪ Perform history and physical exam ▪ Ablative surgery for epilepsy ▪ All types of craniotomies, craniectomies and reconstructive procedures (including microscopic) on the skull, including surgery on the brain, meninges, pituitary gland, cranial nerves and including surgery for cranial trauma and intracranial vascular lesions ▪ Artificial disc replacement (cervical/lumbar) ▪ Cordotomy, rhizotomy and dorsal column stimulators for the relief of pain ▪ Endoscopic minimally invasive surgery ▪ Epidural steroid injections for pain ▪ Insertion and management of programmable infusion pump ▪ Insertion and management of programmable shunt ▪ Insertion of subarachnoid or epidural catheter with reservoir or pump for drug infusion or CSF withdrawal ▪ Laminectomies, laminotomies, and fixation and reconstructive procedures of the spine and its contents including instrumentation ▪ Lumbar puncture, cisternal puncture, ventricular tap, subdural tap ▪ Management of congenital anomalies, such as encephalocele, meningocele, myelomeningocele ▪ Muscle biopsy; Myelography ▪ Nerve biopsy; Nerve blocks ▪ Peripheral nerve procedures, including decompressive procedures and reconstructive procedures on the peripheral nerves ▪ Posterior fossa-microvascular decompression procedures ▪ Radiofrequency ablation ▪ Selective blocks for Pain Medicine, stellate ganglion blocks ▪ Shunts: ventriculoperitoneal, ventriculoatrial, ventriculopleural, subdural peritoneal, lumbar subarachnoid/peritoneal (or other cavity)	**New applicant applying for core privileges:** Provide evidence of a sufficient volume (at least 50 cases) of neurological surgical procedures, reflective of the scope of privileges requested during the last 24 months or demonstrate successful completion of an ACGME or AOA-accredited residency or clinical fellowship within the last 12 months (case logs required). **FPPE:** Direct proctoring of first five (5) cases reflective of the core. **For reappointment requirements:** Current demonstrated competence and a sufficient volume of experience (neurological surgical procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Requested	Privilege	Additional/Special Criteria
	▪ Stereotactic surgery ▪ Surgery for intervertebral disc disease ▪ Surgery on the sympathetic nervous system ▪ Transsphenoidal procedures for lesions of the sellar or parasellar region, fluid leak or fracture ▪ Ultrasonic surgery procedures ▪ Ventricular shunt operation for hydrocephalus, revision of shunt operation, ventriculocisternostomy ▪ Ventriculography	
NON – CORE (SPECIAL) PRIVILEGES		
☐	**ENDOVASCULAR SURGICAL NEURORADIOLOGY PRIVILEGES (NON_CORE)** The physician may diagnose and treat patients of all ages with diseases of the central nervous system by use of catheter technology, radiologic imaging, and clinical expertise to include integration of endovascular therapy into the clinical management of patients with neurological diseases (or diseases of the central nervous system) when performing diagnostic and therapeutic procedures. Participate in short-term and long-term post-procedure follow-up care, including neurointensive care. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. **Endovascular Surgical Neuroradiology Procedures List** ▪ Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord); coil occlusion of aneurysm ▪ Mechanical retriever	**New applicant applying for non- core privileges:** 1. Must meet criteria and acquire core privileges above and 2. Successful completion of a one year fellowship in endovascular surgical neuroradiology and 3. Prior experience in catheter techniques and diagnostic angiography (minimum 25 cases) during the last 24 months or completion of an ACGME or AOA-accredited residency or clinical fellowship within the last 12 months (case logs required) **For reappointment requirements:** 1. Case log documenting the performance of at least 25 procedures with acceptable results for the past 24 months based on results of ongoing professional practice evaluation and outcomes
☐	**CAROTID ENDARTERECTOMY (NON_CORE)**	**New applicant applying for non- core privileges:** 1. Successful completion of an ACGME or AOA accredited post graduate training program that included training in CE procedures. 2. If the program did not include CE procedures, applicant must have completed an approved hands-on training program under the supervision of a qualified surgeon instructor. 3. Minimum of at least 10 cases during the last 24 months **For reappointment requirements:** 1. Case log documenting the performance of at least 10 procedures with acceptable results for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Requested	Privilege	Additional/Special Criteria
☐	**USE OF LASER (NON_CORE)**	**New applicant applying for non- core privileges:** 1. Successful completion of an approved residency in a specialty or subspecialty which included training in lasers; **OR** 2. Successful completion of a hands-on CME course which included training in laser principles and observation and hands-on experience with lasers; **OR** 3. Evidence of sufficient volume of procedures performed utilizing lasers (with acceptable outcomes) within the past 24 month **For reappointment requirements:** 1. Case log documenting the performance of at least 10 procedures with acceptable results for the past 24 months based on results of ongoing professional practice evaluation and outcomes
☐	**MODERATE SEDATION (NON_CORE)**	**New applicant applying for non- core privileges:** 1. Successful completion of residency or fellowship within the past 12 months that included training in moderate sedation; **OR** 2. Demonstration of prior clinical privileges to perform procedural sedation along with performance of least 20 procedures which required administration of moderate sedation performed during the previous year **AND** 3. Pass the moderate sedation examination provided by ECH Medical Staff Office with 85% or higher **For reappointment requirements:** 1. Case log documenting the performance of at least 20 procedures with acceptable results for the past 24 months based on results of ongoing professional practice evaluation and outcomes **AND** 2. Pass moderation sedation examination provided by ECH Medical Staff Office with 85% or higher

Requested	Privilege	Additional/Special Criteria
☐	**FLUOROSCOPY USE (NON_CORE)** ▪ Includes supervision of other staff using the equipment	**New applicant applying for non- core privileges:** 1. California CDPH Valid Radiology Supervisor and Operator Certificate or Fluoroscopy Supervisor and Operator Permit Required **For reappointment requirements:** 1. Maintenance of California CDPH Valid Radiology Supervisor and Operator Certificate or Fluoroscopy Supervisor and Operator Permit Required

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at **El Camino Hospital**, and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Applicant Signature: _____ **Date:** _____

DEPARTMENT CHIEF RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ **Recommend all requested privileges**

☐ **Recommend privileges with the following conditions/modifications:**

☐ **Do not recommend the following requested privileges:**

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
Notes:	

_____ _____ _____

Division Chief Signature (if applicable) ***Print Name*** ***Date***

_____ _____ _____

Department Chief Signature ***Print Name*** ***Date***

Practitioner Name:

CRITERIA FOR PRIVILEGES:
Physicians may apply/reapply for Core Privileges in the Department of Pediatrics if they are Board Certified or have completed an accredited residency training program in Pediatrics.

CONSULTATIONS:
Consultation(s) shall be obtained by all Medical Staff members whenever the patient appears to be developing unexpected complications or untoward results which threaten life or serious harm, either from the failure of the patient to appropriately respond to the therapy being given and/or substantial medical uncertainty in diagnosis and management.

INSTRUCTIONS:

- Please check the box in the "Requested" column for each privilege requested.
- Indicate the number you have performed in the "#Done" column.
  - **For new applicants**, this number needs to reflect your total experience with that procedure.
  - **For current medical staff applying for reappointment**, this will reflect the number performed within the last 24 months.
- Provide documentation where applicable – see yellow highlighted items.

GENERAL PEDIATRICS				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Core Privileges Nursery: Those privileges considered to be intrinsic to the discipline and routinely included in the usual postgraduate training program in the specialty of Pediatrics. Physicians with Core Privileges may admit patients to Pediatric Ward and Newborn Nursery, render routine care, and treat illness and provide consultation in children and adolescents from the newborn to young adult period. Some routine procedures, which are basic to everyday pediatric practice, are not specifically privileged. Examples include but are not limited to: IV placement, venipuncture, arterial puncture, laceration repair, I&D, lumbar puncture, suprapubic bladder aspiration, etc. ***FPPE:*** Initial Applicant, 3 cases proctored.		
Please list here any of the above Core privileges you do not wish to request:				
		Core Privileges Ward: Those privileges considered to be intrinsic to the discipline and routinely included in the usual postgraduate training program in the specialty of Pediatrics. Physicians with Core Privileges may admit patients to Pediatric Ward, render routine care, and treat illness and provide consultation in children and adolescents from the newborn to young adult period. Some routine procedures, which are basic to everyday pediatric practice, are not specifically privileged. Examples include but are not limited to: IV placement, venipuncture, arterial puncture, laceration repair, I&D, lumbar puncture, suprapubic bladder aspiration, etc.		
Please list here any of the above Core privileges you do not wish to request:				
		LPCH Physician – ECH Emergency Room consultations for pediatric patients who may be admitted to the LPCH (Lucile Packard Children's Hospital) Unit at El Camino Hospital Mountain View campus. May provide co-management services for post-surgical pediatric patients at the request of the ECH surgeon.	**Criteria for granting privilege (initial and reappointment):** Must be on staff at Lucile Packard Children's Hospital, credentialed to work in the LPCH Unit at El Camino Hospital MV campus. ***FPPE:*** After 30 days on ECH medical staff, professional reference provided by LPCH physician who is knowledgeable about the applicant's professional performance and competence.	

GENERAL PEDIATRICS - continued				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Circumcision	***Initial Applicant or New Privilege for Practitioner Criteria*:** **1. Meets ~~Minimum~~ #activity required of ~~5~~ 10 circumcisions performed (from residency and/or from outside institutions) performed in past two years ~~inpatient and outpatient)~~** ~~The applicant attests to activity during the past two years in the left-hand column marked " #Done".~~ ***FPPE:*** ~~Initial applicant, 5 cases proctored.~~ In-person proctoring (by practitioner with active ECH circumcision privileges) of **2 circumcisions at El Camino** within 6 months, with extension to 12 months at discretion of Department Chief **2. Does not meet activity requirement (from residency and/or outside institutions) of 10 circumcisions performed in last 2 years** ***FPPE*** – within 12 months, both of the following must be completed: a. First, observation of 5 circumcisions, including observation of **at least 2 at El Camino**, with sign off from performing practitioner who has active circumcision privileges at El Camino b. Followed by, in-person proctoring by practitioner with active ECH circumcision privileges of 5 circumcisions, including **at least 2 proctored at El Camino** **3. Failure to complete FPPE will result in relinquishment of circumcision privilege; practitioner would have to re-apply for new privilege if still desired**	

Revisions circumcision criteria (CC 06192019: MEC 06272019; GB

			Reappointment Criteria: ~~Minimum # required - 10 circumcisions performed during the past two years (inpatient and outpatient). If 10 cases are not performed, practitioner may maintain the privilege but will need to be proctored for the next 2 cases.~~ ~~The applicant attests to activity during the past two years in the left-hand column marked " #Done".~~ 1. Meets activity requirement (from ECH and outside institutions) of 10 circumcisions performed in last 2 years *with demonstrated competence based on results of quality assessment activities and outcomes* 2. Does not meet activity requirement (from ECH and outside institutions) of 10 circumcisions in last 2 year ***FPPE***: In-person proctoring (by practitioner with active ECH circumcision privileges) of **2 circumcisions at El Camino** within 6 months, with extension to 12 months at discretion of Department Chief Failure to complete FPPE will result in relinquishment of circumcision privilege; practitioner would have to re-apply for new privilege if still desired	
		Frenotomy	***Initial Applicant and Reappointment Criteria:*** Minimum # required – 2 performed during the past two years (inpatient and outpatient). The applicant attests to activity during the past two years in the left-hand column marked " #Done".	
		Consultation: Provide consultation to medical staff member of El Camino Hospital**.**		
		Arthrocentesis		
		Endotracheal intubation		
		Thoracentesis / Chest tube placement		

Revisions circumcision criteria (CC 06192019: MEC 06272019; GB

		Umbilical arterial / venous cannulation		
		MODERATE (CONSCIOUS) SEDATION	Initial Applicant: Requires passing the Moderate Sedation Examination with 85% or higher. • Initial applicant must take the exam provided by ECH Medical Staff Office – 650-940-7058.	
NEONATOLOGY				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Level 3 Nursery Care Pediatric Hospitalist - Intensive care of newborn infants including ventilatory care and advanced life support requiring skills usually achieved during neonatology fellowship. This would include conditions such as: 1. Prematurity over 31 weeks gestation 2. Respiratory diseases requiring conventional ventilation or NCPAP 3. Cardiac failure 4. Spontaneous pneumothorax with no chest tube 5. Hyperbilirubinemia requiring exchange transfusion		
Please list here any of the above Core privileges you do not wish to request:				
		Level 3 Nursery Care - Neonatologist - Intensive care of newborn infants including ventilatory care and advanced life support requiring skills usually achieved during neonatology fellowship. This would include conditions such as: 1. Prematurity less than 31 weeks gestation 2. Respiratory diseases requiring high frequency ventilation 3. Cardiac failure – requiring multiple pressors 4. Spontaneous pneumothorax – requiring chest tube 5. Fluid/electrolyte imbalance 6. Hyperbilirubinemia requiring exchange transfusion		
Please list here any of the above Core privileges you do not wish to request:				
		Exchange Transfusion		
		Endotracheal intubation	***Initial Applicant and Reappointment Criteria:*** Minimum # required – 5 performed during the past two years (inpatient and outpatient). The applicant attests to activity during the past two years in the left-hand column marked " #Done".	

		Thoracentesis/needle aspiration of chest	
		Umbilical arterial / venous cannulation	***Initial Applicant and Reappointment Criteria:*** Minimum # required – 5 performed during the past two years (inpatient and outpatient). The applicant attests to activity during the past two years in the left-hand column marked " #Done".	

NEONATOLOGY - continued				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Central line placement		
		Peripheral arterial line placement		
		~~Circumcision (Level 3 Nursery)~~	~~***Initial Applicant*** Criteria: Minimum # required – 5 circumcisions performed (inpatient and outpatient)~~ ~~The applicant attests to activity during the past two years in the left-hand column marked " #Done".~~ ~~***FPPE:*** Initial applicant, 5 cases proctored.~~ ~~***Reappointment Criteria:*** Minimum # required – 10 circumcisions performed during the past two years (inpatient and outpatient). If 10 cases are not performed, practitioner may maintain the privilege but will need to be proctored for the next 2 cases.~~ ~~The applicant attests to activity during the past two years in the left-hand column marked " #Done".~~	

PEDIATRIC ALLERGY AND IMMUNOLOGY				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**

Revisions circumcision criteria (CC 06192019: MEC 06272019; GB

		Core Privileges Pediatric Allergy/Immunology: Admit, workup, and provide nonsurgical therapy to patients presenting with allergic or immunologic conditions including consultation.	
Please list here any of the above Core privileges you do not wish to request:			

PEDIATRIC CARDIOLOGY				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Core Privileges Pediatric Cardiology: Admit, workup, and provide nonsurgical therapy to patients presented with cardiovascular conditions including consultation.		
Please list here any of the above Core privileges you do not wish to request:				
		EKG interpretation		
		Treadmill/stress test interpretation		
		Holter monitor interpretation		
		Echocardiogram performance and interpretation		
		Fetal echocardiogram performance and interpretation		
		Cardioversion		
		Pericardiocentesis		
		Transesophageal pacing		

PEDIATRIC GASTROENTEROLOGY				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Core Privileges Pediatric Gastroenterology: Admit, workup, and provide nonsurgical therapy to patients presented with gastrointestinal conditions including consultation.		
Please list here any of the above Core privileges you do not wish to request:				
		Esophagoscopy		
		Duodenoscopy		
		Gastroscopy		

PEDIATRIC GASTROENTEROLOGY				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Percutaneous gastrostomy		
		Colonoscopy		
		Colonoscopy with biopsy/polypectomy		
		Small bowel biopsy or drainage		
		Liver biopsy-percutaneous		
		Sclerotherapy of esophageal varices		
		Esophageal motility		
		Heater probe control of GI bleeding		
		Esophageal pneumatic dilatation		
		Esophageal bouginage (mechanical)		

PEDIATRIC PULMONOLOGY				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		Bronchoscopy		
		Thoracentesis		
		Chest tube placement		
		Endotracheal intubation		
		Central line placement		
		pH probe placement and interpretation		
		Pulmonary function interpretation		

PEDIATRIC NEUROLOGY				
Requested	**#Done** **New App:** Total # **Reapp:** # Last 2 yrs	**Privilege Description**	**Additional/Special Criteria (if applicable) Highlighted areas show required documentation**	**Dept Chief Approved**
		EEG Interpretation		
		Lumbar puncture		

Acknowledgement of Practitioner: I attest that I am competent to perform the procedures as requested and have attached supporting documentation where needed and agree to provide additional documentation if requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____ _____

Applicant Signature Date

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Medical Staff- Focused Professional Practice Evaluation (FPPE)
CATEGORY:	Administration
LAST APPROVAL:	2/2017

TYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Medical Staff***
OFFICE OF ORIGIN:	***Medical Staff Services***
ORIGINAL DATE:	November 2008

I. COVERAGE:

All members of the medical staff and allied health practitioners with clinical privileges at El Camino Hospital.

II. PURPOSE:

To define the process for focused professional practice evaluation (FPPE) of medical staff members and allied health practitioners at El Camino Hospital. The primary goal is to use FPPE as a tool to assess practitioners' professional performance and ensure competence as part of El Camino Hospital's commitment to quality.

III. POLICY STATEMENT:

A. FPPE is conducted to assist the medical staff in assessing current clinical competence of medical staff members and allied health practitioners at El Camino Hospital under the following circumstances:

1. Upon the granting of new privileges for initial applicants ~~Initially requested privileges of all new medical staff members~~
2. Upon the granting of new, additional privileges for ~~C~~current medical staff members ~~seeking additional privileges~~ and allied health practitioners
3. When questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care
4. ~~3.~~ For renewal of privileges performed so infrequently that assessment of current competence is not feasible

B. 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 California Peer Review Statutes.

C. The medical staff will use the provider-specific OPPE/FPPE and peer review results in making its recommendations to the Credentials Committee and/or MEC regarding the credentialing an privileging process and, as appropriate, in its performance improvement activities.

IV. REFERENCES:

A. Comprehensive Accreditation Manual for Hospitals, The Joint Commission, ~~January 2017~~July 1, 2019

~~A.~~B. Update The FPPE Toolbox – HCPro, Inc, ~~2008~~2015

~~B.~~C. Briefings on Credentialing – September 2008, Vol. 17, No. 9

V. DEFINITIONS

A. **Practitioner-** The word Practitioner used throughout this policy means both licensed independent practitioner and allied health practitioner.

B. **Focused Professional Practice Evaluation (FPPE)**: The establishment and confirmation of an individual practitioner's current 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 which are raised through the Ongoing Professional Practice Evaluation (OPPE) or other processes. These activities include, but are not limited to, what is typically called proctoring or focused review, depending on the nature of the circumstances.

C. **Ongoing Professional Practice Evaluation (OPPE):** The routine, ongoing monitoring and evaluation of competency for medical staff members and allied health clinicians under medical staff supervision, as defined by the six Joint Commission/ACGME general competencies.

D. **Six General Competencies (basis for FPPE and OPPE)**

1. **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

2. **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

3. **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care

4. **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

5. **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
6. **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

TITLE:	Medical Staff- Focused Professional Practice Evaluation (FPPE)
CATEGORY:	Administration
LAST APPROVAL:	2/2017

~~V.~~VI. PROCEDURE:

A. FPPE Methods and Data Sources

1. A combination of the following methods may be used to determine a practitioner's competency:
   a. **Prospective evaluation**: Presentation of cases with planned treatment outlined for the proctor's treatment concurrence, review of case documentation for treatment concurrence, or completion of a written or oral examination or case simulation.
   b. **Concurrent proctoring:** Direct observation of the procedure being performed or medical management either through observation of practitioner interactions with patients and staff members or review of clinical history and physical and review of treatment orders during the patient's hospital stay.
   c. **Retrospective evaluation**: Review of the case record after care has been completed. May also involve discussions with personnel directly involved in the care of the patient.
   d. **External evaluation**: Evaluation by an external proctor brought in may be used in situations where a proctor is unavailable (for example, when no one on the medical staff or allied health staff holds the privileges under review; or when practitioners on the medical staff with those privileges are determined to have a conflict of interest regarding the practitioner under review). Utilization of an outside proctor must be recommended by the Credentials Committee and approved by the MEC.

2. FPPE sources of data may include:
   a. Direct observation of practitioner
   b. Discussion with other individuals involved in the care of each patient (e.g. consulting physician, assistants in surgery, nursing or administrative personnel)
   c. Detailed medical record/chart review
   d. Review of OPPE (rate and rule data) and review of malpractice claims
   e. Monitoring of clinical practice patterns (audits by non-medical staff personnel for important clinical functions
   f. Incident reports
   g. Finding of cases identified for review by medical staff peer review committees
   h. Patient satisfaction data

B. The FPPE Period

1. All practitioners granted clinical privileges shall complete a period of FPPE and undergo proctoring. Members of the medical staff are placed into the Provisional Staff Category until satisfactory completion of the FPPE requirements.
2. The FPPE period begins when the practitioner is granted the initial privileges or new additional privileges and will conclude when the prescribed number of cases has been evaluated to meet the FPPE plan to determine competence.

3. FPPE should be completed within 12 months; however, may be extended by the Department Chief with approval by the Credentials Committee. FPPE may be extended when there is insufficient data due to lack of clinical activity during the initial period of if concerns are raised that require further evaluation.
4. If at the end of the extension(s), there is still insufficient activity, the practitioner may be deemed to have voluntarily resigned the privileges. In such circumstances, the practitioner has no right to a hearing pursuant to Medical Staff Bylaws.

C. Development of the FPPE Plan for Each Practitioner

1. The Department Chief (or Division Chief or designee) shall be responsible for overseeing the evaluation process for all applicants or staff members assigned to his/her department or division.
2. Each medical staff department chief (or one of the department officers, if designated by the chief) shall be responsible for establishing minimum criteria in developing an FPPE plan and selecting proctors.
3. The Interdisciplinary Practice Committee Chair (or designee) shall be responsible for establishing minimum criteria in developing an FPPE plan and selecting proctors of allied health practitioners.
4. Proctors must be Active or Consulting members of the medical staff in good standing, ideally in the same specialty or department and must have unrestricted privileges to perform the same privileges or procedures to be observed.
5. The Department Chief will report any significant concerns to the PEC, MEC and Credentials Committee as indicated when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care.
   a. If the results of an OPPE indicate a potential significant issue with physician performance, the Department Chief will refer the matter to the PEC or MEC who may initiate a FPPE to determine whether there is problem with current competency of the physician for either specific privileges or for more global dimensions of performance.
   b. When focused review is required, the Practitioner Excellence Committee, or the Medical Executive Committee will refer the case to the appropriate reviewer or committee who will conduct the focused review. Focused review findings, conclusions and recommendations to improve practitioner performance will be communicated as appropriate so that action can be taken as needed.

D. FPPE Procedure (Initially granted privileges, new additional privileges, recredentialing when volume is insufficient to determine competency)

1. The Department Chief will review the information gathered in the credentials file in order to determine the approach and extent of FPPE needed.

2. The Department Chief will recommend a practitioner-specific FPPE plan to the Credentials Committee with his/her recommendation for privileges. The plan will include types of cases/procedures to be evaluated, number of cases, the evaluation methods, time frame and proctor requirements.
3.
4. The Credentials Committee has the responsibility for reviewing and approving FPPE plans for initial applicants, newly added privileges, and FPPE when insufficient performance of a privilege to determine competency has occurred and forwarding recommendations to the MEC.

5. The MEC will forward recommendations of the Department Chief and Credentials Committee to the Governing Board with the credentialing and privileging recommendations.

~~1.~~6. Upon approval and granting of the initial privileges, additional privileges or recredentialing with FPPE for insufficient volume, the Medical Staff Services shall send a letter to the practitioner and proctor informing them of the FPPE plan and containing the contact information, and a copy of this policy and attachments.

7. The MSSD shall provide the practitioner and proctor with copies of the privileges granted.

8. The MSSD shall place copies of all documentation in the quality section of the credentials database.

9. At least monthly, the MSSD shall provide a status report to the Credentials Committee of FPPE activity for all practitioners.

10. **Responsibilities of the Proctored Practitioner**:

   a. The practitioner must provide the necessary cases to the proctor for review in a timely manner; if applicable, must obtain agreement from the proctor to attend and observe the procedure and/or the practitioner must provide the proctor with access to all information regarding the patient's clinical history and care, pertinent physical findings, lab and x-ray results; the course of treatment or management including a copy of the H&P, operative reports, consultations, and discharge summaries.
   b. The practitioner shall notify the proctor of each case in which care is to be evaluated and, when concurrent proctoring is required, do so in sufficient time to enable the proctor to conduct.
   c. For surgical or invasive procedures where concurrent proctoring is required, the practitioner must secure agreement from the ~~proctor~~patient for the proctor to attend and observe the procedure.

d. The practitioner has the option of requesting from the Chief of Service, a change of proctor if disagreements with the current proctor may adversely affect his/her ability to complete the proctorship timely and satisfactorily.
e. Inform the proctor of any unusual incidents associated with his/her patients.
f. It is the responsibility of the practitioner to ensure documentation of the satisfactory completion of his/her proctorship, including the completion and delivery of proctorship forms to the MSSD.
g. If the summary proctor report is not completed and submitted to the MSSD when due, or if the practitioner fails to complete the proctoring requirements prior to the expiration of the proctoring period, the additional or new privileges that are the subject of proctoring shall be deemed to be voluntarily relinquished by the practitioner and the practitioner shall immediately stop performing these privileges.

11. Responsibilities of the Proctor:

a. The proctor shall evaluate the care of the practitioner per the established FPPE plan. The proctor's role is to review and observe cases, not supervise or consult except when evaluating allied health practitioners.
b. Proctors should be available for the start of the procedure and will monitor those portions of the medical care rendered by the practitioner that are sufficient to be able to judge the quality of care provided in relationship to the privilege(s) requested.
c. The performance of a specific procedure shall be reviewed, or in the situation that the privilege encompasses cognitive care, then the relative components of the patients chart must also be reviewed for that aspect of care.
d. Proctors will ensure the confidentiality of the proctoring results and forms. The proctor will deliver the completed proctoring form(s) to the Department Chief ~~and~~ or MSSD.
e. If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor should promptly notify the respective Department Chief.
    i. One of the following may be recommended:
        (a) The Department Chief will intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for the patient.
        ~~2.~~(b) The Department Chief of designee will review the case for possible peer review at the next department meeting.
        (c) Additional or revised proctoring requirements may be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored.
    ii. If during the initial period of proctoring the proctor feels there may be imminent danger to the health and safety of any individual, the continuation of the privilege(s)

requested and proctoring are subject to being discontinued by the Department Chief or Chief of Staff.

iii. All members of the medical staff with relevant privileges, within each department, are expected as part of medical staff membership to serve as proctors when asked to do so.

iv. In addition to specialty and privilege specific issues, proctoring also will address the general competencies.

12. FPPE Results and Recommendations:

a. The MSSD will provide the proctor forms to the Department Chief for review.

b. The Department Chief will provide the Credentials Committee with a recommendation as to whether the practitioner has satisfactorily completed the FPPE plan, is in need of further evaluation, or care is unacceptable.

c. The Credentials Committee based upon the Department Chief's recommendation will forward its recommendation to the MEC for one of the following

i. conclusion of the FPPE period, and advancement from the provisional staff category

ii. an additional period of time or number of cases for FPPE; or

iii. modification of some of the requested clinical privileges.

d. If there is a recommendation of the MEC to terminate the practitioner's clinical privileges due to concerns about behavior or clinical competence, the practitioner shall be entitled to the hearing and appeal process outlined in the medical staff bylaws.

~~B. FPPE For Initially Requested Privileges And For New Or Additional Privileges:~~

~~1. Evaluation period: The evaluation period for initially requested procedures/admissions of new appointees shall be twelve (12) months. If a practitioner fails to complete the assigned proctoring within 12 months, the privileges that still require proctoring will be relinquished (after 30 days written notice to practitioner).~~

~~2. Terms of evaluation: Approved evaluation methods may include chart review (both concurrent and retrospective), monitoring clinical practice patterns, direct observation, review of quality indicators, external peer review, discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel), practitioner's clinical care provided in the office or in another hospital or healthcare institution. The terms of evaluation may vary from one department to another (as predetermined by each department); however, procedures crossing specialty lines will have uniform evaluation requirements.~~

~~3. ED/On Call: Practitioners who are initially appointed to the medical staff may not serve alone – that is, without his/her proctor – in the emergency department or on call until all required proctoring (either concurrent or retrospective, as determined by the departments) has been completed and the practitioner has been removed from proctoring by the department chief.~~

~~4. Duties and responsibilities of department chiefs: Each medical staff department chief shall be responsible for:~~

~~a) Assisting the department in establishing a minimum number of cases/procedures to be evaluated and determining when a proctor must be present. When there are privileges that cross specialty lines, the Care Review Committee will advise with regard to the minimum number of cases/procedures to be reviewed.~~

~~b) If at any time during a proctoring period, the proctor notifies the department chief that he or she has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendations of the proctor, the department chief shall then review the medical records of the patient(s) treated by the practitioner being proctored and shall take one of the following actions:~~

~~1) Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient~~

~~2) Develop an action plan for the practitioner which may include~~

~~(a) Require practitioner to complete additional educational activities~~

~~(b) Concurrent consultation~~

~~(c) Impose additional or revised proctoring requirements~~

~~(d) Coadmitting privileges~~

~~(e) Other (at department chief's discretion)~~

~~3) Recommend corrective action be taken pursuant to Medical Staff Bylaws, Article 7.~~

~~5. Duties and responsibilities of the medical staff office (MSO): The MSO shall:~~

~~a) Notify the practitioner being evaluated and any assigned proctor of the following information:~~

~~1) Evaluation requirements as predetermined by the department~~

~~2) The name and telephone numbers of the practitioner being proctored and the proctor, as well as the proctoring forms to be completed~~

~~3) A copy of the FPPE policy and procedure~~

~~b) Develop a mechanism (in coordination with health information department and clinical effectiveness department) to track admissions, procedures, and clinical practice patterns of the practitioner being evaluated~~

~~c) Periodically contact both the proctor and practitioner being proctored to ensure that proctoring and chart reviews are being conducted as required~~

~~d) Periodically submit a report to the appropriate departments of evaluation activity for all practitioners being evaluated~~

~~e)1.~~ ~~At the conclusion of the evaluation period, submit a summary report on each practitioner being evaluated to the department chief or his/her designee.~~

~~6. Circumstances under which monitoring by an external source is required: When the situation exists in which no other physician is qualified or credentialed to serve as a proctor or a conflict of interest has been declared, an outside proctor may be retained. An outside proctor may be granted temporary privileges to serve in a proctoring capacity.~~

~~In addition to the specialty- and privilege- specific issues, proctoring will also address the six general competencies of practitioner performance: Medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; systems-based practice; patient care. .~~

~~7. Duties and responsibilities of practitioners being proctored: Practitioners being proctored shall:~~

~~a) Notify the proctor of each case where care is to be evaluated and, when required, do so in sufficient time to allow the proctor to observe or review concurrently. For elective surgical or invasive procedures for which direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may arrange for proctoring by another member of the medical staff with appropriate independent privileges or admit and treat the patient; however, the practitioner must notify the proctor as soon as reasonably possible.~~

~~b) Have the prerogative of requesting from the department chief a change of proctor if disagreements with or incomplete proctoring duties by the current proctor may adversely affect his or her ability to satisfactorily complete the proctorship.~~

~~c) Inform the proctor of any unusual incident(s) associated with his or her patients.~~

~~d) Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of proctorship forms and the summary proctor report to the MSO.~~

~~e) If the proctorship forms and summary proctor report are not completed and submitted to the MSO by the end of a proctoring period, the privileges of a provisional appointee subject to proctoring, or the additional or new privileges which are the subject of proctoring for any other member of the medical staff, shall be automatically suspended. Failure to obtain submission of completed proctorship forms prior to the time for submission of the physician's next reappointment application shall be treated as a voluntary relinquishment of the privileges that were subject to proctoring.~~

~~8. Duties and responsibilities of the proctor: The proctor shall:~~

~~a) As predetermined by the department:~~

~~1) Directly observe the procedure being performed~~

~~2) Concurrently observe medical management for the medical admission~~

~~3) Retrospectively review the completed medical record following discharge~~

~~b) Complete proctoring forms and ensure their confidentiality and delivery to the MSO~~

~~c) If at any time during the proctoring period the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the department chief and may recommend that:~~

~~1) The department chief intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient~~

~~2) The department chief review the case for possible peer review, pursuant to the Medical Staff Peer Review policy~~

~~3) Additional or revised proctoring requirements be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored~~

~~4) The appointee's continued appointment and clinical privileges be referred to the MEC.~~

~~9.~~2. Liability of proctor: A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the medical staff. The proctor shall receive no compensation directly or indirectly from any patient for this service, and he or she shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor, or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner.

~~10.~~3. Completion of proctorship: At the end of the proctoring period, the department chief or his/her designee shall determine one or more of the following:

a) Whether a sufficient number of cases done at El Camino Hospital have been presented for review to properly evaluate the clinical privileges requested

b) If a sufficient number of cases have not been presented for review, whether the proctoring period or provisional appointment should be extended

c) For provisional appointees, make a recommendation for permanent membership and continued clinical privileges as requested, recommend an additional proctoring period or continued provisional staff status not to exceed an additional year, or not recommend permanent membership and continued clinical privileges as requested

d) For new or additional privileges, make a recommendation to independently perform the requested privileges, recommend an additional proctoring period, or not recommend continued clinical privileges as requested

~~d)~~e)

~~C.~~A. FPPE For Physician Performance Issues:

FPPE shall be conducted when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care that have been identified through the peer review process, ongoing feedback reports, or pursuant to the corrective action plan. Any such issues identified by a Department or Division must be reported to the ~~Care Review Committee.~~ Professional Excellence Committee (PEC);

Thresholds for FPPE

If the results of an OPPE indicate a potential significant issue with physician performance, the MEC or PEC may initiate a FPPE to determine whether there is problem with current competency of the physician for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or data from rule or rate indicators. When focused review is required, the Practitioner Excellence Committee, or the Medical Executive Committee will refer the case to the appropriate reviewer or committee who will conduct the focused review.

Focused review findings, conclusions and recommendations to improve practitioner performance will be communicated as appropriate so that action can be taken as needed.

Triggers can be single events or evidence of practice trends that may initiate this process and include but are not limited to:

- ~~Significant deviation from accepted standards of practice~~
- ~~Sentinel Events or Near Misses~~
- ~~Adverse or negative performance trends~~
- ~~Notification of a significant NPDB report~~
- ~~Notification of a significant Medical Board of CA licensing report~~
- ~~Repeated failure to follow medical staff/hospital policy~~
- ~~Significant staff or patient complaint(s)~~
- ~~Low- or no- volume practitioner~~
- ~~Upon recommendation of the department chief~~

1. infection rates,
2. sentinel events,
3. ~~perhaps~~patient complaints, and
4. other events that are not sentinel.
5. small number of admissions or procedures over an extended period of time that raise the concern of continued competence,
6. a growing number of longer lengths of stay than other practitioners,
7. returns to surgery,
8. frequent or repeat readmission suggesting possibly poor or inadequate initial management/treatment,
9. patterns of unnecessary diagnostic testing/treatments,
10. failure to follow approved clinical practice guidelines (This may or may not indicate care problems, but why is there a variance?)

~~frequent or repeat readmission suggesting possibly poor or inadequate initial management/treatment,~~

~~patterns of unnecessary diagnostic testing/treatments, and~~

~~failure to follow approved clinical practice guidelines (This may or may not indicate care problems, but why is there a variance?)~~

The determination to assign a period of FPPE should be based on the practitioner's current clinical competence, practice behavior, and ability to perform the privileges at issue. Other existing privileges in good standing should not be affected by this decision.

The terms, methods, and duration of the evaluation period shall be determined by Department or Division Chief, Department or Division Executive Committee, or the ~~Care Review Committee~~ Professional Excellence Committee (PEC). FPPEs shall be subject to ongoing review by the ~~Care Review Committee~~ (PEC)

~~. Fill out an FPPE form (revise the Credenti\FPPE Forms as appropriate) and report to MEC.~~ Follow the FPPE on the Department Executive Committee ~~Cmte~~ agenda and the ~~Care Review~~PEC Tracking Tool until the FPPE has been completed – report completion to MEC and the Governing Board~~.~~

Statutory Authority

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 State Codes…….. 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.

~~VI.~~VII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
~~Medical Staff Planning~~ Credentials Committee:	January 17, 2017
ePolicy Committee:	
Medical Executive Committee:	January 26, 2017
Board of Directors:	February 8, 2017
Historical Approvals:	*November 2008, January 2010, July 2012, October 2015*

El Camino Health

TITLE:	Medical Staff – Focused Professional Practice Evaluation (FPPE)
CATEGORY:	Administration
LAST APPROVAL:	09/2017

Attachment B
El Camino Health
FPPE Checklist

Task	Activity	Time frame	Responsibility
Development of Minimum FPPE proctoring requirements – Department Chief	The Department recommends the minimum number of cases/procedures to be monitored and/or proctored for each Delineation of Privileges Form to the Credentials Committee at least every two (2) years. Recommends if and when the monitor must be present during procedures	Every two years	Department Chief
Plan Development – FPPE period/volume and methods	The Department Chief submits the FPPE plan and identifies potential proctors, for initial privileges or newly added privileges or when competence for recredentialing cannot be established, to the Credentials Committee along with his/her credentialing and privileging recommendation ➢ Recommends the minimum number of cases/procedures to be monitored and/or proctored ➢ Recommends if and when the monitor must be present during procedures ➢ Recommends the method and duration of monitoring, which may be altered if initial concerns are raised that indicate further evaluation is required or if there is insufficient activity during the initial period ➢ Recommends potential monitors ➢ Determines whether evidence of monitoring from a healthcare facility other than [Hospital name] may be used to supplement in-house monitoring if the following criteria are met: ➢ The practitioner being monitored must consent to authorize the other facility to release copies of the	One week prior to the Credentials Committee and Submitted to the Credential Committee and MEC with department chief recommendations for privileges	Department Chief Medical Staff Coordinator places in the packet

	proctoring reports or to provide a summary of proctoring activities ➢ Considers the practitioner's previous experience in developing the FPPE plan ➢ Selects an outside proctor if a conflict is declared		
Evaluator (proctor) assignments	Practitioners from appropriate specialty contacted and confirmed	Submitted with department chief recommendations for privileges	Department Chief MSSD
Initiation of FPPE	Evaluator and practitioner informed of FPPE plan	Immediately with activation of privileges following the Governing Board decision	MSSD
Distribution of FPPE forms	Policies, FPPE Plan and evaluation forms for FPPE sent to evaluator and practitioner	Within one week following privilege activation	MSSD
Scheduling of FPPE	Proctor and practitioner determine schedule if concurrent methods used and inform Medical Staff Office	When cases are scheduled for direct proctoring. Proctoring should be completed on first cases performed at ECH	Proctor, practitioner
Completion of FPPE forms	Evaluator submits completed forms to MSSD and Department Chief	As completed	Proctor/Practitioner
FPPE chart audits	Clinical Effectiveness teams performs audits required by FPPE plan (for cause) and submits data to MSSD Clinical Effectiveness ensures monitoring forms are completed to include cases monitored, criteria met or not met; recommendations of meeting criteria, comments if not meeting criteria and concerns to PEC	Monthly for duration of FPPE plan	Clinical Effectiveness
Department Chief recommendation for advancement of medical staff status and final privileges	Department Chief reviews evaluator findings, peer review, and other performance data and provides Credentials Committee or PEC with overall assessment of FPPE data and recommendation regarding competence or need for further evaluation	Monthly for duration of FPPE plan unless substantial concerns are raised earlier requiring immediate action	Department Chief, Medical Staff Office, or Clinical Effectiveness
Final recommendation	Credentials Committee reviews department chair recommendation and approves or modifies accordingly and sends recommendation to MEC for approval	At the next scheduled Credentials Committee meeting OR PEC	Medical Staff Office, Credentials Committee; PEC
Documentation of Actions	Clinical Effectiveness or MSSD staff will ensure documentation in the	At each meeting of the Department Executive	Clinical Effectiveness

	committee minutes and inclusion of monitoring forms in the meeting packets	Committee, Credentials Committee, PEC or MEC	MSSD
Notification to Practitioner	Following Governing Board, practitioner informed of GB decision	Based upon recommendation of CC, PEC or MEC	Clinical Effectiveness, MSSD support to Medical Staff Leaders

El Camino Health

FOCUSED PROFESSIONAL PRACTITIONER EVALUATION (FPPE)

FPPE in Response to Concerns Form (TEMPLATE)

POLICY: FPPE shall be conducted when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care that have been identified through the peer review process, ongoing professional practice evaluation or pursuant to identified triggers. FPPE may be recommended by a Department or Division and subject PEC approval. FPPE may be initiated by the MEC or PEC.

INDICATION FOR FPPE:		Result of peer review determined to be related to practitioner performance (sentinel or never event)
		Significant deviation from acceptable standards of care
		Repeated failure to follow medical staff or hospital policies
		Validated staff or patient complaints
METHOD OF EVALUATION:		Concurrent medical record review
		Targeted medical record review
		Retrospective medical record review
		Direct observation of procedures: Types _____
		Discussion with other practitioners
		External peer review
		Data collected via quality review
MINIMUM NO OF CASES:		_____ Cases
PERIOD OF EVALUATION:		Time period: _____ months
MEASURE OF SUCCESS:		Rate or rule: no or percentage of charts reviewed with all areas satisfactory
		Performance of the required number of proctored procedures with no issues identified
		Satisfactory adherence to Bylaws, Rules and Regulations and Policies with no issues noted in _____ time frame
FPPE PLAN APPROVAL		Department Plan Submitted to PEC _____
		Submitted by: _____ _____ Department Chief (date)
		PEC Approval _____ (date)
		MEC Approval _____(date)
		Included in GB Summary Report _____ (date)

PEC Approval _____ (date)
PEC Summary Report Tool Updated _____ (date)
MEC Approval _____(date)
Included in GB Summary Report _____ (date)
Filed in medical staff quality file of practitioner _____ (date)

El Camino Health

FOCUSED PROFESSIONAL PRACTITIONER EVALUATION (FPPE)

FPPE in Response to Concerns Form (TEMPLATE)

Examples for establishing plan:

Additional Education/CME	1. Type required 2. PEC Approval before practitioner enrolls 3. Practitioner must enroll by: 4. CME must be completed by: 5. CME will be paid for by: practitioner, med staff, jointly 6. Documentation of completion must be submitted to: Department Chief, PEC or MEC 7. Voluntarily refrain from exercising privileges until completion of additional education? _____ Yes or No 8. Any additional monitoring required after CME has been completed?
Medical Record Case Review	1. How many cases are subject to review? 2. What types of cases are subject to review? 3. Estimated time for completion of monitoring? 4. Review to be completed by: Department Chief or designated proctor, Quality Department Staff, CMO 5. Reviewer tool to be used: general surgery, general medical, specific form developed for this review 6. Who will review the results of monitoring with the practitioner? 7. How often will the results of monitoring be reviewed with practitioner? After each case, weekly, monthly 8. How often reporting to PEC, MEC and GB via Care Review Tool?
Concurrent/Direct Proctoring	1. How many cases are subject to direct proctoring requirement? 2. What types of cases are subject to proctoring requirement? 3. Estimated time for completion of proctoring requirement? *Consider practitioners current practice patterns and hold practitioner to deadline.* 4. Is practitioner allowed to take call during FPPE proctoring period? 5. Responsibilities of the Practitioner a. Notify proctor of scheduled admission or procedure date. b. Notify proctor at least x no of days prior to scheduled, elective procedure. c. Notify patient that a proctor will be present and include name of proctor on informed consent form. d. Does proctor have authority to intervene, if necessary? 6. The Department Chief will determine who will proctor the cases. Determine who may proctor? Must the proctor hold the exact clinical privileges or may other physicians proctor the case depending on what is being monitored? 7. Proctor Responsibilities: a. Be present at the start of the case and remain throughout the procedure. b. Review chart for medical complications to determine if post-

	op complications arise. c. Document review on reviewer worksheet form: surgical procedure or specific form developed for this review. d. Complete documentation and forward to Clinical Effectiveness for review by Department Chief, PEC or MEC. 8. Who will review the results of monitoring with the practitioner? 9. How often will the results of monitoring be reviewed with practitioner? After each case, weekly, monthly? 10. Voluntarily refrain from exercising privileges until completion of additional education? _____ Yes or No
Other	***Examples:*** 1. Participate in an educational session at section or department meeting and assess colleagues' approach to case. 2. Study issue and present grand rounds. 3. Limit number of procedures in any one day/block schedule. 4. No elective procedures to be performed after ___ p.m. 5. All patient rounds done by certain time of day – timely orders, tests, length of stay concerns. 6. Personally see each patient prior to procedure (rather than using PA, NP, or APRN). 7. Personally round on patients – cannot rely solely on PA, NP 8. Utilize individuals from other specialties to assist in PIPs (e.g., cardiologist experiencing difficulties with TEE technical complications mentored by anesthesiologists).

El Camino Health

CONFIDENTIAL PEER REVIEW

Physician ID (Physician Initials), FPPE/Department Improvement Plan: Data Tracking Date Range

Description of FPPE/Improvement Plan

Case #	MRN	Clinical metrics	Clinical metrics	Clinical metrics	Clinical metrics	PERFORMANCE SATISFACTORY YES/NO	Date of Review	Name of Case Reviewer
1								
2								
3								
4								

Reviewer to Complete: Based on the results above, the provider's is/has:

☐ Meeting Criteria: Continue FPPE per plan

☐ Not Meeting Criteria: Needs Improvement in the following areas _____

☐ Met all Criteria per FPPE Plan: Conclude FPPE Plan

Reviewer Signature _____ Date _____

Department Chief/Peer Review Committee Chair to Complete: Based on the results above and the reviewer's recommendation, the provider is/has:

☐ Meeting desired expectations: FPPE to continue per initial plan

☐ Not meeting desired expectations: Needs improvement; see comments below for areas of concern

☐ Not meeting desired expectations: Needs improvement; possibility of risk to patient safety exists. Refer to PEC/MEC _____ (date)

☐ Completed FPPE successfully and the current privileges should be continued

☐ Continued for another _____ (period of time) to further evaluate the performance relative to the areas assessed as needing improvement

☐ Continued for another _____ (period of time) as there is not sufficient activity to evaluate at this time

Comments:

Department Chief/Peer Review Chair Signature _____ Date _____

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

MEDICAL STAFF - ANESTHESIA
FOCUSED PROFESSIONAL PRACTITIONER EVALUATION (FPPE)

Date on Staff:

Practitioner Name: **ID #:**

- ☒ **New Applicant**
- ☐ **Request Additional Privilege(s)**
- ☐ **For Ongoing Professional Practice Evaluation**

Proctoring Required:

Name of Privilege/Procedure	Type of Observation/Review	Number of Cases Proctored
General Anesthesia Cases	Direct observation, proctor present at start of case	3
Name(s) of Proctors: Any ECH anesthesiologist with Active Staff Privileges.		

Evaluation period: Up to 12 months - ***proctoring that is not completed within 12 months will result in relinquishment of the privileges where proctoring is incomplete.*** After the practitioner has completed the proctoring requirements and a minimum of 6 months (maximum 12 months) have elapsed, practitioner will be promoted to the appropriate category based on patient contacts. A patient contact is defined as an admission, discharge, surgical assist, ED short stay, ED discharge, consultation, or procedure.

Terms of evaluation (one or more of the following):

- ☐ Chart Review Concurrent
- ☐ Chart Review Retrospective
- ☐ Clinical Practice Patterns
- ☐ Direct Observation
- ☐ External Peer Review
- ☐ Discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).

Advancement to Active Staff: The Provisional Staff member may be promoted to the appropriate staff category after the following:

1. Proctoring requirements have been completed.
2. The Provisional Staff member has been a member of the medical staff for at least 6 months.

ED/On Call: Practitioners who are initially appointed to the medical staff may not serve alone – that is, without his/her proctor – in the emergency department or on call until all required proctoring (either concurrent or retrospective, as determined by the departments) has been completed and the practitioner has been removed from proctoring by the department chief.

Department Chief: Proctor forms submitted to the Department Chief when the required number of forms has been submitted by the proctor.

☐ A sufficient number of cases done at El Camino Hospital have been presented for review to properly evaluate the clinical privileges requested.

☐ Proctoring not completed in the timeframe prescribed by FPPE Policy #13.5.1. Privileges shall be relinquished as noted below:

_____
_____
_____

Recommendation:

New Applicant (select one)

☐ Recommend removal of proctoring and continued clinical privileges as requested. Transfer to _____ status after 6 months on Provisional Staff (based on # patient contacts during the provisional period).

☐ Recommend limited removal of proctoring as noted:

_____
_____
_____

☐ Do not recommend permanent membership and continued clinical privileges as requested – follow Bylaws with regard to adverse action (Article 7).

New or Additional Privileges (select one)

☐ Recommend that the practitioner be granted privileges to independently perform the requested privileges.

☐ Recommend an additional proctoring period.

☐ Do not recommend granting of the new privilege as requested – follow Bylaws with regard to adverse action (Article 7).

_____ _____

Department Chief Signature **Date**

Office Use Only:

Computer Updated: _____ (date)
Practitioner Informed: _____ (date)
Credentials Report, transfer to _____ Staff on _____
(date of Board Approval)
Documents scanned and uploaded to MSOW: _____ (date)
Menu - Images – Scan Image – FPPE Complete

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Medical Staff- Ongoing Professional Practice Evaluation (OPPE)
CATEGORY:	Administration
LAST APPROVAL:	10/2017

TYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT ☐ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Medical Staff***
OFFICE OF ORIGIN:	***Medical Staff Services***
ORIGINAL DATE:	November 2008

I. COVERAGE:

All members of the medical staff and allied health practitioners with clinical privileges at ECH.

II. PURPOSE:

To define the process for ongoing professional practice evaluation (OPPE) of medical staff members at El Camino Hospital. ~~The primary goal is to use OPPE as a tool to identify professional practice trends that impact the quality and safety of patient care and to ensure current clinical competence of medical staff members as part of El Camino Hospital's commitment to quality.~~

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 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, (4) when necessary, uses the results of such assessments, 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.

III. POLICY STATEMENT:

1. OPPE is conducted on an ongoing basis and will include the collection and review of performance data for all practitioners with clinical privileges at ECH.
2. 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 California Peer Review Statutes.
3. The medical staff will use the provider-specific OPPE/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.

IV. REFERENCES:

A. Comprehensive Accreditation Manual for Hospitals, ~~January 1, 2017~~ July 1, 2019, Medical Staff Chapter.

B. CMS Medicare Conditions of Participation, § 482.22 (a)1
C. Medical Staff FPPE Policy
~~A.~~D. Medical Staff Peer Review Policy

V. DEFINITIONS

A. **Practitioner-** The word Practitioner used throughout this policy means both licensed independent practitioner and allied health practitioner.

B. **Focused Professional Practice Evaluation (FPPE)**: The establishment and confirmation of an individual practitioner's current 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 which are raised through the Ongoing Professional Practice Evaluation (OPPE) or other processes. These activities include, but are not limited to, what is typically called proctoring or focused review, depending on the nature of the circumstances.

C. **Ongoing Professional Practice Evaluation (OPPE):** The routine, ongoing monitoring and evaluation of competency for medical staff members and allied health clinicians under medical staff supervision, as defined by the six Joint Commission/ACGME general competencies.

1. **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

2. **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

3. **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care

4. **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

5. **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

6. **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

~~V.~~VI. PROCEDURE:

A. OPPE will be conducted every eight (8) months for all practitioners with clinical privileges and measures of performance will be selected to reflect the six general competencies.
~~A.~~

B. Each medical staff department chief (or one of the department officers, if designated by the chief) shall be responsible for establishing criteria for the specialty that will be included in the ongoing evaluation and gaining approval from the department executive committee and Practitioner Excellence Committee (PEC).
   1. 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, patterns of blood and medication usage, resource use data such as length of stay, morbidity and mortality data.
   2. Methods of obtaining data for OPPE may include medical record review, direct observation, monitoring of diagnostic and treatment techniques and outcomes, and discussion with other care providers.
   3. The Department Chief in collaboration with the PEC evaluates and recommends specialty based OPPE indicators to MEC and Governing Board at least every three (3) years.
   4. The Medical Staff Executive Committee (MEC) will make recommendations for approval of OPPE indicators or revisions to the Governing Board.

C. The quality department staff will aggregate the data based upon the current department OPPE metrics and provide OPPE reports to Medical Staff Services Department electronically or in print form per policy.

D. The Medical Staff Services Department will provide the practitioner OPPE reports to the Department Chief for evaluation.

E. The Department Chief will review, investigate, and address any concerns regarding the information in each department practitioner's OPPE report.

   1. The Department Chief will discuss OPPE results with the individual member and provide performance feedback as necessary (i.e. low volume, opportunities for improvement).

2. The Department Chief will provide final evaluation and, if necessary, determine whether issues exist that require an improvement plan - department chief may make this decision.

3. The Department Chief will report any significant concerns to the PEC, MEC and Credentials Committee as indicated.

   a. If the results of an OPPE indicate a potential significant issue with physician performance, the Department Chief will refer the matter to the PEC or MEC who may initiate a FPPE to determine whether there is problem with current competency of the physician for either specific privileges or for more global dimensions of performance.
   b. When focused review is required, the Practitioner Excellence Committee, or the Medical Executive Committee will refer the case to the appropriate reviewer or committee who will conduct the focused review. Focused review findings, conclusions and recommendations to improve practitioner performance will be communicated as appropriate so that action can be taken as needed.

F. The department chief will sign off each report in a timely manner.

G. The Department Chief will provide signed copies of each OPPE report to the Medical Staff Services Department to be filed in each practitioner's credential file.

H. The Medical Staff Services Department will provide copies of practitioners personalized OPPE reports to each member within 30 days of receipt from the Department Chief.

I. The Medical Staff Services Department will file a copy of the OPPE report in each practitioner's credentials file.

J. Information resulting from the evaluation will be used to determine whether to continue, limit, or revoke any existing privileges at the time the information is analyzed by the Department Chief, PEC, Credentials Committee, MEC and Governing Board.

K. The Medical Staff Services will provide a written summary of all OPPE actions and compliance with this policy to the PEC, MEC and Governing Board annually.

~~B.~~L. ~~The Medical Executive Committee (MEC) will establish criteria for the ongoing professional practice evaluation which may include mortality and complication data, blood and medication usage data, length of stay, use of tests and procedures, use of consultants and other pertinent data. All practitioners will be part of this ongoing evaluation, not only those with performance issues.~~

~~C. Duties and responsibilities: Each medical staff department chief (or one of the department officers, if designated by the chief) shall be responsible for:~~

~~1. Establishing additional criteria for the specialty that will be included in the ongoing evaluation and is approved by the department executive committee. MEC and the Board will review and approve or make recommendations for revision.~~

~~2. Review, investigate, and address any concerns regarding the information in each department practitioner's OPPE report. The department chief will sign off each report in a timely manner.~~

~~3. Information resulting from the evaluation will be used to determine whether to continue, limit, or revoke any existing privileges at the time the information is analyzed.~~2.

~~a) Continue privileges – Practitioner is performing well or within desired expectations and no further action is warranted – department chief may make this decision and the record of the decision, along with the data, will be filed in the practitioner's credentials file.~~

~~b) Determine that issues exist that require a focused practitioner performance evaluation (see Medical Staff Policy on FPPE) – department chief may make this decision.~~

~~c) Determine whether zero performance of a privilege should trigger FPPE (i.e. proctoring) – department chief may make this decision.~~

~~d) Determine that the privilege should be continued because the organization's mission is to be able to provide the privilege to its patients and there are no competence issues in the other data available for this practitioner – department chief may make this decision.~~

~~e) Limit or revoke privileges – department chief will make a recommendation to the MEC and the corrective action procedure will be invoked (Medical Staff Bylaws, Article 7).~~

2.

~~D.~~ L. Medical Staff Executive Committee (MEC) will be responsible for:

~~1.~~a. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.

~~2.~~b. Determining how often the data will be reviewed.

~~3.~~c. Acting upon recommendations for corrective action as described in Medical Staff Bylaws, Article 7&8 (Corrective Action and Hearings and Appellate Reviews Section)

~~E.~~B. Board of Directors will be responsible for:

1. Reviewing and approving recommendations from ~~each department~~ MEC with regard to the ~~type of data and amount of data that will be reviewed~~ OPPE process.

2. Acting upon recommendations for corrective action as described in Medical Staff Bylaws Articles 7 & 8 (Corrective Action and Fair Hearing Sections).

~~F. Methodologies for Collecting Data~~

~~1. Quality indicators selected and approved by medical staff~~
~~2. Quality review reports~~
~~3. Periodic chart review~~
~~4. Direct observation~~
~~5. Monitoring of diagnostic and treatment techniques~~
~~6. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.~~
~~7. Peer recommendation from a peer who is in the same professional discipline and is knowledgeable about the applicant's professional performance and competence.~~
~~8. Quality data obtained from a practitioner's primary hospital (when the primary hospital is not ECH). It will be the practitioner's responsibility to obtain such data. The department chief, upon review of this data, will determine whether the data is sufficient to assess ongoing clinical competence.~~
~~9. National Practitioner DataBank (NPDB) ECH obtains reports from NPDB at the time of initial appointment, reappointment, and addition of privileges and ongoing via the NPDB Continuous Query Service.~~

~~Medical Board of CA Disciplinary Action Reports – ECH reviews actions taken regarding all licensed practitioners.~~

Statutory Authority

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 State Codes…….. 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.

~~10.~~

~~VI.~~VII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
~~Medical Staff Planning:~~	6/2017
ePolicy Committee:	8/2017
Medical Executive Committee:	9/2017
Board of Directors:	10/2017
Historical Approvals:	*November 2008, January 2010, February 2011, July 2012, January 2016*

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Medical Staff - Policy for Allied Health Professionals
CATEGORY:	Administration
LAST APPROVAL:	7/10

TYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT ☑ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Medical Staff***
OFFICE OF ORIGIN:	***Medical Staff Services***
ORIGINAL DATE:	12/97

I. COVERAGE:

All members of the medical staff and allied health professionals

II. PURPOSE:

To define the categories of individuals who are authorized to provide care as an Allied Health Professional and describe the processes by which they will be credentialed and privileged in accordance with the appointment and reappointment processes outlined in the Medical Staff Bylaws.

III. POLICY:

It is the policy of El Camino Health to ensure that privileges granted to allied health professionals are in accordance with State law, regulations and scope of practice. The qualification process for allied health professionals is set forth in this document and the Medical Staff has delegated the responsibility of credentialing and competency review of allied health professionals to the Interdisciplinary Practice Committee (IDPC). The Medical staff will exercise oversight of the allied health professionals, just as it does practitioners who are appointed to the medical staff. Only the Governing Board shall grant privileges to allied health professionals. AHPs are not eligible for Medical Staff membership.

III. DEFINITION

A. ALLIED HEALTH PROFESSIONAL or AHP means an individual, other than a licensed physician, dentist or podiatrist, who ~~exercises~~ is qualified to render direct or indirect medical, dental, or podiatric care ~~independent judgment~~ within the areas of his/her professional competence and the limits established by the Governing Board ~~of Directors~~, the Medical Staff and the applicable State Practice Acts. ~~An AHP is qualified to render direct or indirect medical, dental, or podiatric care~~ AHPs must be qualified by academic and clinical or other training to provide services under the supervision or direction of an Active, Courtesy or Provisional member of the Medical Staff and may be eligible to exercise practice prerogatives in conformity with the

standards adopted under this policy. ~~AHPs are not eligible for Medical Staff membership.~~

There are two types of AHPs: advanced practice providers (APPs) and clinical assistants/technicians. The following categories of allied health professionals are authorized to provide clinical services at El Camino Hospital.

1. Advanced Practice Providers (APP) – These individuals are required to have a standardized practice protocol evaluated and approved by the IDPC.
   a) Certified Nurse Midwife (CNM)
   b) Nurse Practitioner
   c) Physician Assistant
   d) Psychologist or Psychologist Assistant (standardized practice protocol not required)

2. Clinical Assistants/Technicians
   a) Acupuncturists
   b) Audiologists
   c) Cell Saver Technician
   d) Clinical Perfusionist
   e) Clinical Research Assistant
   f) Genetic Counselor
   g) Neurological Intraoperative Monitoring Technologist
   h) Orthopedic Technician
   i) Registered Dental Assistant
   j) RN First Assistant
   k) Surgical Technician
   l) Urology Surgical Technician

B. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE):

The establishment and confirmation of an individual practitioner's current competency at the time when he/she requests new privileges, either at initial appointment or as a current member of the medical or allied health professional staff, and is also used to evaluate and monitor clinical practice when concerns based on a medical disciplinary cause or reason which are raised through the OPPE or other processes. These activities include, but are not limited to, what is typically called proctoring or focused review, depending on the nature of the circumstances.

C. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE):

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

1. **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
2. **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
3. **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care
4. **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
5. **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
6. **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

II. QUALIFICATIONS

Allied Health Professionals holding a license, certificate or such other legal credential, if any, as required by California law, which authorizes the AHP to provide certain professional services are eligible for ~~practice prerogatives~~ clinical privileges in this Hospital only if they:

(a) ~~Hold a license, certificate or other legal credential in a category of AHPs which has been approved under this Policy as eligible to apply for practice prerogatives.~~

(b) Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to ~~exercise~~ provide ~~practice prerogatives~~ clinical services to patients within the Hospital; and

(c) Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

(d) Provide additional information as may be required by individual Allied Health Policy/Scope of Practice.

III. DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR ~~PRACTICE PREROGATIVES.~~CLINICAL PRIVILEGES

The Board of Directors shall, as reasonably necessary, review and identify the categories of AHPs, based upon occupation or profession, which shall be eligible to apply for ~~practice prerogatives~~privileges in the Hospital. For each eligible AHP category, the Board of Directors shall identify the ~~practice prerogatives and prerogatives~~ privileges and scope of practice that may be granted to qualified AHPs in this category. The Board of Directors shall secure recommendations from the Medical Staff Executive Committee as to the categories of AHPs which should be eligible to apply for ~~practice prerogatives~~ clinical privileges and as to ~~practice prerogatives~~, terms and conditions which may apply to AHPs in each category. ~~The delineation of categories of AHPs eligible to apply for practice prerogatives and the corresponding practice prerogatives, terms, and conditions for each such AHP category, shall be contained in a separate policy applicable to each approved category of AHPs.~~

IV. PROCEDURE FOR GRANTING PRACTICE PREROGATIVES

An AHP in an approved category must apply and meet specific criteria to qualify for ~~practice prerogatives~~clinical privileges. ~~and P~~practitioners ~~Physicians~~ who desire to supervise or direct AHPs must be an Active, Courtesy or Provisional member of the ECH Medical Staff. Applications for initial granting of practice prerogatives, and renewal every two years thereof, shall be submitted and processed in accordance with Section V. In addition, ~~when applicable~~, scope of practice/privileging delineation will be submitted to the supervising physician's department ~~executive committee~~ chief for review and approval. ~~For AHP's with privileges (Certified Nurse Midwives, Nurse Practitioners, Physician Assistants, RNFAs), a copy of their profile and privilege request will be presented to the department executive committees for review and comment as appropriate.~~

V. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

The Medical Staff through its designated departments, committees, and officers shall consider each application for appointment or reappointment to the Allied Health Professional Staff, before adopting and transmitting its recommendations to the Board of Directors. Initial appointment and reappointments shall be for a maximum of two years.

- No individual requesting Allied Health privileges ~~aspect of Allied Health Professional Staff membership or particular practice prerogatives~~ shall be denied on the basis of sex, race, age, creed, color or national origin, or on the basis of any other criterion, unrelated to the delivery of quality patient care in the Hospital setting, to the professional qualifications, the Hospital's purposes, needs and capabilities, or community needs.

5.2 APPLICATION FOR APPOINTMENT

5.2-1 CONTENT

All applications for appointment to the Allied Health Professional Staff shall be in writing, signed by the applicant and submitted on a form or electronic format prescribed by the Medical Staff Executive Committee. The applicant shall also identify the category for which he/she wishes to be considered and the name of his/her supervising physician. Each applicant ~~for membership~~ shall pay a non-refundable application fee in the amount established by the Medical Staff Executive Committee. The application shall require the applicant to provide:

(a) Detailed information concerning the applicant's current professional qualifications, continuing education, competency and California licensure, if applicable.

(b) The names of at least three (3) persons who can provide adequate references based on their current knowledge of the applicant's qualifications, professional competency, and ethical character. At least one reference must be from a physician, dentist or podiatrist as applicable to the privileges/scope of practice requested.

(c) Information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's ~~membership~~ allied health status ~~and/or prerogatives~~, or clinical ~~or admitting practice prerogative~~privileges at any other Hospital or Institution; membership ~~or fellowship~~ in any local, state regional, national or international professional organization for cause; license or certificate to practice any profession in any jurisdiction;

(d) Information pertaining to the applicant's professional liability insurance coverage~~.~~ And maintain in force professional liability insurance covering the exercise of all requested privileges, in not less than one million per occurrence and three million annual aggregate or such other amount as may be determined and approved by the Governing Board and Medical Staff Executive Committee from time to time.

(e) Information as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations), or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent, or willful omission in rendering services.

(f) Information as to details of any prior or pending government agency or third party payer proceeding, or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medi-Cal fraud and abuse proceedings and convictions.

(g) Information pertaining to the condition of the applicant's physical and mental health necessary to determine the applicant'~~=~~s current ability to perform the ~~practice prerogatives~~ clinical privileges requested.

(h) Certification of the applicant's agreement to terms and conditions set forth in Section 5.2-2 regarding the effect of the application.

(i) An acknowledgment that the applicant has received a copy of the Allied Health Professional Policy and has been given access to the Medical Staff Bylaws and Rules and Regulations; received an explanation of the requirements set forth therein and of the appointment process; agrees to be bound by the terms thereof, as they may be amended from time to time, if he/she is ~~granted membership or practice prerogatives~~approval to the allied health staff with clinical privileges; and agrees to be bound by the terms thereof, without regard to whether or not he/she is granted ~~membership and/or practice prerogatives~~approval in all matters relating to consideration of this application.

(j) At the time of application, the applicant shall sign a confidentiality agreement, professional code of conduct and comply with all orientation process requirements such as, but not limited to, fire/safety and occupational health.

5.2-2 EFFECT OF APPLICATION

By applying for appointment to the Allied Health Professional Staff**,** each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application; authorizes the Hospital's Medical Staff or its designee to consult with other hospitals, employers with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications, and authorizes such persons to provide all such information; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications, personality, ability to cooperate with others, moral and ethical qualifications for membership, and physical, mental and professional competence to carry out the privileges he/she requests, and directs individuals who have custody of such records and documents to permit inspection and/or copying; certifies that he/she will report any changes in the information submitted on the application form, which may subsequently occur, to the Medical Staff Services Office; and releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the Medical Staff and the Hospital concerning the applicant and all Hospital representatives for their acts performed in connection with evaluating the applicant and his/her credentials. Each applicant also agrees that so long as he/she is an applicant or member, he/she shall promptly advise the Medical Staff Services Office of changes in the information identified in Section 5.2-1.

5.3 PROCESSING THE APPLICATION

5.3-1 APPLICANT'S BURDEN

The applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, physical and mental health status, and all other qualifications specified in the Allied Health Professional Policy and for resolving any doubts about these matters. The provision of information containing significant misrepresentations or omissions, and/or a failure to sustain the burden of producing adequate information, shall be grounds for denial of his/her application.

5.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Medical Staff Services Office, which shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Services Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. The Hospital's authorized representative shall query the

National Practitioner Data Bank regarding the applicant, if applicable, and shall include any resulting information in the AHP's credentials file. Resulting adverse information will be forwarded to the Interdisciplinary Practice Committee Chair for review. An applicant whose application is not completed within six (6) months after it was received by the Medical Staff Services Office shall be automatically removed from consideration for staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, has been resubmitted.

When collection and verification is completed, the Medical Staff Services Office shall transmit the application and all supporting materials to the Chairman of the Interdisciplinary Practice Committee for review.

5.3-3 INTERDISCIPLINARY PRACTICE COMMITTEE ACTION

Upon receipt, the Chairman of the Interdisciplinary Practice Committee shall review the application, and supporting documentation. The applicant may be requested to appear for an interview with the Interdisciplinary Practice Committee. Following successful completion of the application and interview with the Interdisciplinary Practice Committee, the Chairman shall transmit to the Medical Staff Executive Committee his/her written report and recommendations. If applicable, as determined by the Interdisciplinary Practice Committee, a Medical Staff Department Chief and/or any other appropriate staff committee may ask the applicant to appear for an interview or request further documentation.

5.3-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

The Medical Staff Executive Committee shall consider the Committee Chair's recommendation and such other relevant information as may be available. The committee shall then forward to the Administrator/CEO, for transmittal to the Board of Directors, its written report and recommendations, prepared in accordance with Section 5.3-5. The Committee may also defer action on the application pursuant to Section 5.3-7(a).

5.3-5 APPOINTMENT REPORTS

The Interdisciplinary Practice Committee Chair and Medical Staff Executive Committee reports and recommendations shall be submitted in the form prescribed by the Medical Staff Executive Committee. Each report and recommendation shall specify whether the Allied Health Professional Staff appointment ~~and practice prerogatives~~clinical privileges are recommended, and, if so, the ~~membership~~ allied

health category, and ~~practice prerogatives~~ clinical privileges ~~to be granted and any special conditions to be attached to the appointment~~shall be included in the report. The reasons for each recommendation shall be stated.~~, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report. If the recommendation of the Interdisciplinary Practice Committee is to deny membership or requested practice prerogatives, the applicant shall be offered the right to review afforded in Section VIII (d) prior to final review by the Medical Staff Executive Committee.~~

5.3-6 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant for Allied Health Professional Staff membership and ~~practice prerogatives~~ clinical privileges shall be based upon:

(a)If the applicant meets the qualifications and standards, and can carry out the responsibilities specified in all sections of the Allied Health Professional Staff Policy/Scope of Practice.

(b)Compliance with legal requirements applicable to the practice of his/her profession, and other Hospitals' Allied Health Professional/Medical Staff Bylaws, Rules and Regulations, and policies, rendition of services to his/her patients. Also taken into consideration would be the applicant's experience in other healthcare settings.

(c)Consideration of any physical or mental impairment which might interfere with the applicant's ability to perform his/her duties with reasonable skill and safety.

(d)His/her provision of accurate and adequate information to allow the Medical Staff to evaluate his/her competency and qualifications.

5.3-7 EFFECT OF EXECUTIVE ACTION

(a) Interview, Further Documentation, Deferral:

After all outstanding documentation has been received, action by the Medical Staff Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within seventy (70) days with a subsequent recommendation for appointment with specified ~~practice prerogatives~~clinical privileges, or for denial of the request for Allied Health Professional Staff ~~membership/practice prerogatives~~appointment/privileges.

(b) Finalized Recommendation: After the Medical Staff Executive Committee's

recommendation is finalized, the Administrator shall promptly forward it, ~~together with all supporting documentation,~~ to the Board of Directors. ~~For the purposes of this Section 5.3-7(b), "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the Interdisciplinary Practice Committee Chairman and the Medical Staff Executive Committee. The decision of the Board of Directors shall be final with respect to an applicant's appointment to the Allied Health Professional Staff.~~

5.-8 TIME PERIODS FOR PROCESSING

Applications shall be considered in a timely and good faith manner. The Medical Staff Services Office shall transmit a completed application to the Chairman of the Interdisciplinary Practice Committee within thirty (30) days. In the event the relevant materials are not received within ninety (90) days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Medical Staff Services Office or the expiration of six (6) months. After that time, an incomplete application shall automatically be removed from consideration as specified in Section 5.3-2. The Chairman of the Interdisciplinary Practice Committee shall act on an application within thirty (30) days after receiving it from the Medical Staff Office. The Medical Staff Executive Committee shall review the application and make its recommendation to the Board of Directors within forty-five (45) days after receiving the department report. The Board of Directors shall then take final action on the application within forty-five (45) days after receiving the committee report. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his/her application processed within those periods.

5.4 REAPPOINTMENTS

5.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

At least one hundred eighty (180) days prior to the expiration of each member's current staff appointment, the Medical Staff Services Office shall ~~mail~~ send an electronic notification for reappointment application to the ~~staff member~~allied health professional.

At least one hundred twenty (120) days prior to the expiration date of his/her Staff appointment, each Allied Health Professional Staff member shall submit to the Medical Staff Services Office a completed reappointment application form. The

reappointment application shall be in writing, on a form or electronic format prescribed by the Medical Staff, and it shall require detailed information concerning the changes in the applicant's qualifications since his/her last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the appointment application form, as described in Section 5.2, except for that information which cannot change over time, such as information regarding the member's education, date of birth, and so forth. The form shall also require information as to continuing education activities during the past two (2) years. The results of peer review at this Hospital and others will be considered as a part of the reappointment review. Voluntary or involuntary termination of Allied Health Professional Staff membership at another hospital or healthcare facility must also be reported at this time in addition to information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, or voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's allied health membership status ~~and/or prerogatives,~~ or clinical or privileges ~~admitting practice prerogatives~~ at any other Hospital or Institution; membership or fellowship in any local, state regional, national or international professional organization for cause; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

5.4-2 VERIFICATION OF INFORMATION

The Medical Staff Services Office shall, in timely fashion, seek to collect and to verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent. The Medical Staff Services Office shall transmit the completed reappointment application form and supporting materials to the Chairman of the Interdisciplinary Practice Committee.

5.4-3 INTERDISCIPLINARY PRACTICE COMMITTEE ACTION

The Interdisciplinary Practice Committee shall review the application and the ~~staff~~ allied ~~healrh~~health member's file and the Chair shall transmit to the Medical Staff Executive Committee its written report and recommendations, which are prepared in accordance with Section 5.4-5. This may include a recommendation for reappointment for one or two years, based on Interdisciplinary Practice Committee ~~Guidelines~~~~decision~~ evaluation.

5.4-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

The Medical Staff Executive Committee shall consider the Interdisciplinary Practice Committee Chair's recommendation, all other relevant information available to it, and shall forward to the Board of Directors, through the CEO/Administrator, its reports and recommendations, prepared in accordance with Section 5.4-5.

When the Medical Staff Executive Committee recommends adverse action, as defined in Section VIII, a report shall be made to the appropriate State Board or agency and to the National Practitioner Data Bank, if applicable, after final action by the Board of Directors.

5.4-5 REAPPOINTMENT REPORTS

The Interdisciplinary Practice Committee Chairman and Medical Staff Executive Committee reports and recommendations shall be written and shall be submitted in the form prescribed by the Medical Staff Executive Committee Where nonreappointment, is recommended, the reason for such recommendation shall be stated and documented, and the applicant shall be offered the right to the review afforded by Section VIII-(d) prior to review by the Medical Staff Executive Committee.

5.4-6 BASIS FOR REAPPOINTMENT

Each recommendation concerning the reappointment of an Allied Health Professional Staff member and the ~~practice prerogatives~~clinical privileges to be granted upon reappointment shall be based upon whether such ~~member~~ individual has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.5, and met all of the standards and requirements set forth in all sections of this policy Specifically, recommendations shall also be based upon the practitioner's ongoing professional practice evaluations, compliance with legal requirements applicable to the practice of his/her profession, with the Hospital policies, rendition of services, any physical or mental impairment which might interfere with the applicant's ability to perform services with reasonable skill and safety, and his/her competency and qualifications.

5.4-7 DURATION OF APPOINTMENT

Initial appointments and reappointments to the Allied Health Professional Staff shall be for a period up to 24 months.

5.4-8 FAILURE TO FILE REAPPOINTMENT APPLICATION

If the ~~member~~ allied health professional fails to submit an application for reappointment completed as required, he/she shall be deemed to have resigned his/her membership and ~~practice prerogatives~~c in the Allied Health Professional Staff, effective on the expiration date of his/her appointment.

VI. PREROGATIVES

The prerogatives~~clinical privileges~~ which may be extended to an AHP shall be defined in the ~~applicable policy~~this policy and the Medical Staff Bylaws, Rules and Policies and Procedures of the Hospital. Such prerogatives may include:

(a) Provision of specified patient care services under the supervision or direction of a physician member of the Medical Staff and consistent with the ~~practice prerogatives~~ patient care privileges granted to the AHP, and within the scope of the AHP's licensure or certification.

(b) Service on Medical Staff and Hospital committees.

(c) Attendance at the meetings of the department to which he/she is assigned, as permitted by the department guidelines, and attendance at Hospital education programs in his/her field of practice.

VII. RESPONSIBILITIES

Each AHP shall:

(a) Meet those responsibilities required by ~~the~~ this policy applicable to his/her AHP category and meet those responsibilities specified in Section 3.6 of the Medical Staff Bylaws as are generally applicable to the more limited practice of the AHP.

(b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services.

(c) Participate, whenever requested by the Chairman of the Interdisciplinary Practice Committee or a Medical Staff Department Chair, in quality review and evaluation and monitoring activities required of AHPs in supervising initial appointees of his/her same occupation or profession, or of a lessor included occupation or profession, and in discharging such other functions as may be required from time to time.

(d) Follow the procedure for reappointment as delineated in 5.4-1.

VIII. TERMINATION OF PRACTICE PREROGATIVES

1. Automatic Termination

An AHP's practice prerogatives shall automatically be terminated without the right to hearing or review in the event:

(a) The Medical Staff membership of the supervising physician is terminated, whether such termination is voluntary or involuntary.

(b) The supervising physician no longer agrees to act as the supervising physician for any reason, or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore.

(c) The AHP's certificate/license or malpractice insurance expires, is revoked, or is suspended.

2. Hearing Rights

(a) An AHP's ~~practice prerogatives~~appointment and clinical privileges may also be terminated by the Chairman of the Interdisciplinary Practice Committee, Chief of the Department to which he/she is assigned, the Chief of Staff, or the CEO/Administrator. The AHP shall have the right to challenge any action that would constitute grounds for a hearing under Section 9.2 of the Medical Staff Bylaws, by filing a written grievance with the Chairman of the Interdisciplinary Practice Committee within 15 days of such action. Upon receipt of such a grievance, the Chairman of the Interdisciplinary Practice Committee will review the matter and afford the affected AHP an opportunity for an interview. The interview will either be before the Interdisciplinary Practice Committee or if the adverse action was initiated by the Interdisciplinary Practice Committee, before a committee of no less than three individuals who did not participate in the action under review and who will be appointed by the Interdisciplinary Practice Committee. The reviewing committee shall include, when indicated**,** for the purpose of this interview, at least one AHP holding the same or similar license or certificates as the affected AHP, if any. Such AHPs shall be appointed to the committee for this purpose by the Chairman of the Interdisciplinary Practice Committee. Before the interview, the AHP shall be informed of the general nature of the circumstances giving rise to the proposed action, and at the interview, the AHP may present information relevant thereto. A record of the findings of such

interview shall be made. A report of the findings and recommendations shall be made by the reviewing committee to the Medical Staff Executive Committee which shall act thereon.

b. After the Interdisciplinary Practice Committee (IDPC) makes a final recommendation to the Medical Staff Executive Committee, the AHP may then request reconsideration by the Medical Staff Executive Committee of an adverse IDPC recommendation. In that reconsideration, the AHP may present to the Medical Staff Executive Committee additional written arguments relevant to the IDPC recommendation. There is no right for the AHP to personally appear before the Medical Staff Executive Committee unless permitted by the Medical Staff Executive Committee. After considering the AHPs additional arguments, if any, the Medical Staff Executive Committee shall make a final decision on the IDPC's recommendation**.** The action of the Medical Staff Executive Committee shall be final.

c. The hearing rights afforded by this Section VIII.2 are the exclusive hearing rights afforded to AHPs unless otherwise required by law.

IX. TEMPORARY ~~PRACTICE PREROGATIVES~~ PRIVILEGES

9.1 CIRCUMSTANCES

Board of Directors' designee upon the recommendation of the Chairman of the Interdisciplinary Practice Committee, when available, or the Chief of Staff in all other circumstances, may grant temporary practice prerogatives to an AHP, subject to the conditions set forth in Section 6.5-2 below, in the following circumstances:

(a) Verification: Good standing of licensure, current and previous malpractice coverage, if applicable, must be established. Hospital's authorized representative shall query the national Practitioner Data Bank regarding the applicant, if applicable. The burden rests on the applicant to ensure that all information is received by the Medical Staff Services Office in a timely manner.

(b) Pendency of Application: Upon completion of an application for appointment, and Committee Chair recommendation, an applicant may be granted temporary practice prerogatives for up to 120 days pending review of the application by the Medical Staff Executive Committee and decision by the Hospital ~~Board of Directors.~~Governing Board

~~(c) Care of Specific Patients: Upon receipt of an application for specific temporary practice prerogatives, an AHP who is not an applicant for membership may be~~

~~granted temporary practice prerogatives for the care of one or more specific patients. Such practice prerogatives shall be restricted to the treatment of not more than two (2) patients in any one calendar year by any AHP. AHPs requesting temporary practice prerogatives more than two (2) times in any one (1) year shall be required to apply for membership in the Allied Health Professional Staff before being granted the requested practice prerogatives.~~

~~(d) Locum Tenens: AHPs seeking locum tenens practice prerogatives for less than two weeks per year must provide verification as listed above.~~

9.2 CONDITIONS

Temporary ~~practice prerogatives~~ privileges may be granted only when the AHP has submitted a written application for appointment ~~or~~ and the Supervising Physician has submitted a written ~~or telephone~~ request for temporary ~~practice prerogatives~~ clinical privileges for the AHP and the information reasonably supports a favorable determination regarding the requesting AHPs licensure, if applicable, qualifications, ability and judgment to exercise the ~~practice prerogatives~~clinical privileges requested, and only after the practitioner has satisfied the requirement regarding professional liability insurance and the National Practitioner Data Bank, if applicable. The supervising physician shall be responsible for supervising the performance of the AHP granted temporary ~~practice prerogatives~~ clinical privileges. Before temporary ~~practice prerogatives~~privileges are granted, the AHP must acknowledge in writing that he/she has received a summary of or has been given access to, and read the Allied Health Practitioners Policy and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary ~~practice prerogatives~~ privileges.

X. FEES

An applicant to the Allied Health Professional Staff shall be required to pay a processing fee as determined by the Medical Staff Executive Committee. In addition, members of the Allied Health Professional Staff shall be charged a processing fee as determined by the Medical Staff Executive Committee at the time of reappointment. Allied Health Professionals shall be required to pay dues as set by the Medical Staff Executive Committee.

XI. FPPE/OPPE – Focused Practitioner Practice Evaluation (FPPE) and Ongoing Practitioner Practice Evaluation (OPPE) will be performed for all AHPs with privileges

~~(Certified Nurse Midwives, Nurse Practitioners, Physician Assistants, RNFAs)~~ in accordance with the Medical Staff FPPE and OPPE Policies.

XII. Competency Evaluations will be performed for AHPs with Scopes of Practice at their initial appointment and annually thereafter. These competency evaluations will be performed by the supervising MD and/or his/her peer in the same specialty area.

I. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
~~Originating Committee or UPC Committee~~ IDPC	~~6/10~~; 8/19
(name of) Medical Committee (if applicable):	
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	~~6/10~~ 8/19
Board of Directors:	~~7/10~~8/19
Historical Approvals:	

Approved by: IDPC: 9/97, 04/99 2/03, 5/05, 9/07, 6/10
MEC: 11/97, 06/99. 2/03, 5/05, 10/07, 6/10
BOD: 12/97, 07/99, 3/03, 6/05, 11/07, 7/10

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

NOTICE OF PROPOSED REVISIONS TO THE MEDICAL STAFF BYLAWS

To: **Governing Board**

From: **Medical Staff Executive Committee**

Date: **August 21, 2019**

Re: **Proposed Rules Changes – Immediate Post-Operative Note**

15.2 PROCEDURE FOR AMENDMENTS/ADOPTION MEDICAL STAFF DOCUMENTS

(c) The Medical Staff Executive Committee and Board of Directors may adopt such provisional amendments to these Rules and Regulations that are in the Medical Staff Executive Committee's and Board's judgments necessary for legal or regulatory compliance without first communication to the OMS. After adoption, these provisional amendments to the Rules and Regulations will be communicated to the OMS for their review. If the OMS does not approve of the provisional amendment, this will be resolved using the conflict resolution mechanism noted in Article 15.2-1. If a substitute amendment is then proposed, it will follow the usual approval process.

In accordance with Article 15.2 (c) of the Medical Staff Bylaws, the Medical Staff Executive Committee hereby recommends provisional adoption of the revisions below to the Governing Board in response to citations received from the Centers for Medicare & Medicaid Services (CMS) as a result of their visit concluded on June 21, 2019. After adoption, the usual process for communication and review by the Organized Medical Staff will be followed.

PROPOSED AMENDMENTS
Rules and Regulations – Appendix I

B. Records

Other Medical Record Documentation:

1. Pre-Anesthetic and Post-Anesthetic Notes
   There shall be pre-anesthetic and post-anesthetic notes documented in the medical record which include the anesthesiologist's pre-anesthetic evaluation, the patient's condition upon admission to the Post Anesthesia Care Unit, a description of the post-operative course, a description of any anesthesia complications, and a description of the patient's condition upon discharge from the Post Anesthesia Care Unit.

2. Operative Reports

   The immediate post-~~operative note~~procedure note must be entered in the medical record immediately after the procedure and before the patient is transferred to the next level of care for inpatients. This documentation includes the name(s) of the primary surgeon(s), co-surgeon(s) and assistant(s), name of procedure~~s~~ performed, findings, ~~and a description of each procedure finding~~, estimated blood loss, specimens removed, and complications, if any;

~~condition at the end of the case,~~ and postoperative diagnosis. This documentation must be documented in the electronic medical record on the 'post procedure note'. Downtime paper forms may be used when the EMR is not functional.

The comprehensive operative summary (report)~~-~~describing techniques, findings, and tissues removed or altered must be entered into the electronic medical record or dictated immediately after the procedure and is considered delinquent if not completed ~~written or dictated~~ within 24 hours of surgery and signed by the surgeon**.** The following are to be included in the operative summary:

- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.
- All discrepancies in surgical counts and efforts taken to reconcile such discrepancies shall be documented in the operative summary.

El Camino Health

OPEN SESSION CEO Report
August 21, 2019
Dan Woods, CEO

Quality and Patient Safety

El Camino Hospital Mountain View received Get With the Guidelines Gold Plus with Honor Roll Elite Plus American Heart Association (AHA) National Stroke Award this year. This award recognizes 24 straight months of compliance with a set of treatment metrics involving time to treatment with IVrt-PA, administration of antithrombotic and anticoagulant therapy, prescribing of statins and anticoagulation therapy at discharge and smoking cessation education. The "Plus" Award is added for compliance with at least five quality metrics.

Information Services

Four of the five San Jose Medical Group clinics have converted to the Epic platform and ECH technology. We expect the fifth clinic to go live on August 19, 2019. This transition included network, PC's, printers, phones, Laboratory and PACS systems with large volumes of imaging studies migrated from the Verity PACS system. A Command Center is in place at the SVMD University Offices with a team including physicians and Epic vendor staff providing at the elbow support at each Clinic location. The go-lives are progressing well with daily status meetings monitoring activation metrics. There have been a low number of issues and tickets and minimal impact to patient throughput at the clinics

MyChart enrollment continues to focus upon the 50% patient enrollment goal. MyChart Bedside is live on 5 units (MCH, NICU, 3W, L/D) with 5th Unit (4A) implemented in June 2019. Adoption continues to meet or exceed benchmark of 40%.

Government and Community Relations

Staff met with Assemblymembers Evan Low and Kansen Chu, staff from other legislative offices, and hospital coalition partners to discuss bills on emergency department "surprise billing", rate regulation, nurse staffing ratios and penalties, 2030 seismic standards, and mental health. Brenda Taussig spoke to the Santa Clara Special Districts Association about ECH/ECHD structure, services, community benefit, and growth. El Camino Health and Stanford Healthcare were chosen by the Silicon Valley Leadership Group to host a group of state legislators for a November tour focusing on hospital innovation.

Staff, board, elected officials and school superintendents joined ECH's table at the June 7 "State of the Cities" luncheon for Los Altos and Los Altos Hills. Brenda Taussig was part of an invited community leader focus group for the day-long inaugural "Mountain View Police Department 101" program led by Chief Max Bosel and his department heads. On June 14, ECH held an LGBTQ Healthcare Symposium featuring Dr. Kristie Overstreet, former County Supervisor Ken Yeager, and community nonprofits. We are recruiting ECH staff to participate in civic leadership programs in seven cities.

Corporate and Community Health Services

CONCERN released Concern's Luma 2.0 with features including quality of life survey, a personal dashboard, nudges to complete pre-post surveys and expanded counselor search capability. Luma's level of personalization and integration with digital therapeutics makes this engagement platform a real differentiator for CONCERN.

The South Asian Heart Center conducted workshops on Meditation, Exercise, Diet, and Sleep at Xoriant Corporation's Sunnyvale location with 40+ employees attending each workshop. We also presented Health 3.0 workshop at Apple Inc. in Cupertino attended by 80 employees and at the Indian Institute of Science Annual Nation Alumni conference to 100 attendees.

The Chinese Health Initiative served a total of 1781 individuals, with 3371 services provided at 70 events in FY19.

Philanthropy

As of June 30, 2019, El Camino Health Foundation secured $19,564,060 in donations, the highest annual yield in the Foundation's history.

Auxiliary

The Auxiliary contributed 5828 volunteer hours in June 2019 and 5972 in July 2019.

EL CAMINO HOSPITAL
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: John Conover, Chair, El Camino Health Foundation Board of Directors
Darcie Kiyan, Interim President, El Camino Health Foundation
Date: August 7, 2019
Subject: Report on El Camino Health Foundation Activities FY19 Period 12

Purpose: For information.

Summary:

1. Situation: As of June 30, 2019, El Camino Health Foundation secured $19,564,060 in donations, the highest annual yield in the Foundation's history.

2. Authority: N/A

3. Background:

Major & Planned Gifts

In June, El Camino Health Foundation received $123,607 in major and planned gifts, bringing the total raised by the end of the fiscal year to $15,797,080. The June donations include a $23,507 distribution from a pooled income fund (a planned gift), a major gift in memory of Barbara Sonsini, and a gift from a grateful patient of Dr. Sari Levine. The grateful patient's contribution will provide the seed money to launch a new outpatient mental health program to support patients living with a chronic illness.

Special Events – Year-End Overview

- *Spring Gala*

  Spring Forward, the Foundation's annual gala, was held on May 18, 2019 at Los Altos Golf & Country Club. The Foundation received $248,700 in sponsorships, ticket sales, fund-in-need appeal paddle raises, and donations for the gala, with net proceeds of $153,970 going to mental health & addiction services. That evening, honorary chairs Tad and Dianne Taube and Mary and Doug Scrivner were honored for their transformational gifts to mental health & addiction services, Chief Administrative Officer Ken King gave a Taube Pavilion update, and addiction medicine expert Dr. Omar Manejwala gave a futurist's perspective on addiction. In June, the Foundation continued to receive payments on outstanding commitments for the gala, which are reflected on this fundraising report.

- *Golf Tournament*

  The 23rd annual El Camino Heritage Golf Tournament was held on Monday, October 29, 2018 at Sharon Heights Golf & Country Club and benefited the Norma Melchor Heart & Vascular Institute. The event raised $342,080. The cost of fundraising, 39% of gross revenue, is well below the industry standard for events. Net proceeds of more than $200,000 are being transferred to HVI.

- *South Asian Heart Center Gala*
  A Night on the Scarlet Express, the annual gala benefiting the South Asian Heart Center, was held on March 23, 2019 at the Computer History Museum. The event raised $277,526. In June the Foundation received $3,100 as it continued to collect on commitments from the event.

- *Norma's Literary Luncheon*
  The annual tribute to Norma Melchor was held on February 7, 2019 at Sharon Heights Golf & Country Club. The event raised $160,000 for the Breast Health Center's Free Mammogram Program. The Melchor Family generously covers the cost of the event each year. Their support for the 2019 luncheon was received in FY18, so is not reflected in the event's total revenue on the attached fundraising report.

Annual Giving

In June, the Foundation raised $19,010 in annual gifts from direct mail, H2H membership renewals and event registrations, Circle of Caring, Healthy Giving newsletter, and online donations. This brings total annual giving for FY19 to $639,592.

Other

- In order to best support El Camino Health, the foundation has changed its name to El Camino Health Foundation and, with assistance from the marketing department, is rebranding accordingly.
- The search for a new foundation president continues. Three finalists returned for second interviews the first week of August.
- The foundation is currently working on plans for the Taube and Sobrato Pavilion opening celebrations, the golf tournament, a Hope to Health event, and the foundation leadership reception, which are all scheduled for the fall.
- Please save the date for the 24th annual El Camino Heritage Golf Tournament, which will take place at Sharon Heights Golf & Country Club on Monday, October 28, 2019,

El Camino Health Foundation

FOUNDATION PERFORMANCE

FY19 Fundraising Report through 6/30/19

ACTIVITY		FY19 YTD (7/1/18 - 6/30/19)	FY19 Goals	FY19 % of Goal	Difference Period 11 & 12	FY18 YTD (7/1/17 - 6/30/18)
Major & Planned Gifts		$15,797,080	$3,750,000	421%	$123,607	$3,232,425
Special Events	Spring Event	$248,700	$450,000	55%	$2,500	$360,650
	Golf	$342,080	$350,000	98%	$0	$353,650
	South Asian Heart Center Event	$227,526	$325,000	70%	$3,100	$349,209
	Norma's Literary Luncheon	$136,605	$200,000	68%	$0	$284,380
Annual Gifts		$639,592	$600,000	107%	$19,010	$658,005
Investment Income		$2,172,477	$500,000	434%	$163,330	$911,273
TOTALS		***$19,564,060***	***$6,175,000***	***317%***	***$311,547***	***$6,149,592***

Highlighted Assets through 6/30/19

Board Designated Allocations	$787,178
Donor Endowments	$6,812,226
Operational Endowments	$16,093,235
Pledge Receivables	$4,156,607
Restricted Donations	$12,670,843
Unrestricted Donations	$1,070,506

El Camino Hospital Auxiliary

Membership Report to the Hospital Board

Combined Data as of June 30, 2019 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	333	-1 Net change compared to previous month
Dues Paid Inactive	5	(Includes Associates & Patrons)
Leave of Absence	7	
Subtotal	**345**	
Resigned in Month	31	
Deceased in Month	0	

Junior Members

Active Members	245	+5 Net Change compared to previous month
Dues Paid Inactive	0	
Leave of Absence	0	
Subtotal	**245**	

Total Active Members	**578**
Total Membership	**590**

Combined Auxiliary Hours from Inception (to June 30, 2019): 5,985,195
Combined Auxiliary Hours for FY2018 (to June 30, 2019): 77,528
Combined Auxiliary Hours for June 30, 2019: 5,828

El Camino Hospital Auxiliary

Membership Report to the Hospital Board

Combined Data as of July 31, 2019 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	335	+2 Net change compared to previous month
Dues Paid Inactive	5	(Includes Associates & Patrons)
Leave of Absence	9	
Subtotal	**349**	

Resigned in Month	8
Deceased in Month	2

Junior Members

Active Members	249	+4 Net Change compared to previous month
Dues Paid Inactive	0	
Leave of Absence	2	
Subtotal	**251**	

Total Active Members	**584**
Total Membership	**600**

Combined Auxiliary Hours from Inception (to July 31, 2019): 5,991,167

Combined Auxiliary Hours for FY2019 (to July 31, 2019): 5,972

Combined Auxiliary Hours for July 31, 2019: 5,972