AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, August 18, 2021 – 5:30 pm
El Camino Hospital | 2500 Grant Road | Mountain View, CA 94040

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.

In observance of the Americans with Disabilities Act, please notify us at (650) 988-8254 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

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

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>PRESENTED BY</th>
<th>ESTIMATED TIMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CALL TO ORDER/ROLL CALL</td>
<td>Lanhee Chen, Board Chair</td>
<td>5:30 – 5:31 pm</td>
</tr>
<tr>
<td>2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Lanhee Chen, Board Chair</td>
<td>information 5:31 – 5:32</td>
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<td>3. PUBLIC COMMUNICATION</td>
<td>Lanhee Chen, Board Chair</td>
<td>information 5:32 – 5:34</td>
</tr>
<tr>
<td>a. Oral Comments</td>
<td>Julie Kliger, Chair of Quality Committee</td>
<td>public comment motion required 5:34 – 5:44</td>
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<tr>
<td>b. Written Correspondence</td>
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<tr>
<td>4. QUALITY COMMITTEE REPORT</td>
<td>Julie Kliger, Chair of Quality Committee</td>
<td>information 5:44 – 5:5</td>
</tr>
<tr>
<td>a. Quality Improvement Patient Safety Plan (QAPI)</td>
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<tr>
<td>5. FY21 PERIOD 12 FINANCIALS</td>
<td>Carlos Bohorquez, Chief Financial Officer</td>
<td>information 5:54 – 6:09</td>
</tr>
<tr>
<td>6. GOVERNANCE BEST PRACTICES</td>
<td>Dan Woods, Chief Executive Officer; George M. Anderson, Consultant</td>
<td>information 5:54 – 6:09</td>
</tr>
<tr>
<td>7. ADJOURN TO CLOSED SESSION</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment motion required 6:09 – 6:10</td>
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<tr>
<td>8. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Lanhee Chen, Board Chair</td>
<td>information 6:10 – 6:11</td>
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<tr>
<td>9. CONSENT CALENDAR</td>
<td>Lanhee Chen, Board Chair</td>
<td>motion required 6:11 – 6:14</td>
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A livestream of the meeting is available at www.elcaminohealth.org/about-us/leadership/board-meeting-stream. To watch the meeting Livestream, please visit the website. Please note that the Livestream is for meeting viewing only, and there is a slight delay. To provide public comment, please use the phone number listed above.

PERSOA O SÄ O CORIA E O ECO RER O ARCH 18 2020 El CA OHE WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING. ISSEAHe PÉRINIC IS IRE OOIHE OEP SESSION IA ECO FERENCE AC.
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<tr>
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<tr>
<td>Health &amp; Safety Code Section 32155 for a report of the Medical Staff deliberations concerning reports on Medical Staff quality assurance matters:</td>
<td>Apurva Arfatia, MD, Mountain View Chief of Staff; Michael Kan, MD, Los Gatos Chief of Staff</td>
<td>information 6:14 – 6:24</td>
</tr>
<tr>
<td>(i) Medical Staff Credentials and Privileges Report</td>
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<tr>
<td>b. Quality Committee Report</td>
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<tr>
<td>a. Medical Staff Report</td>
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<tr>
<td>c. Pediatric PPE Plan – Revised</td>
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<tr>
<td>10. Health &amp; Safety Code Section 32155 for a report of the Medical Staff deliberations concerning reports on Medical Staff quality assurance matters:</td>
<td>Jim Griffith, Chief Operating Officer; Mary Rotunno, General Counsel; Diane Wigglesworth, Sr. Director of Compliance</td>
<td>discussion 6:24 – 6:39</td>
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<tr>
<td>b. Pediatric PPE Plan – Revised</td>
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<tr>
<td>c. Medical Staff Bylaws Amendments</td>
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<tr>
<td>11. Gov’t Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</td>
<td>Lanhee Chen, Board Chair</td>
<td>discussion 6:39 – 6:59</td>
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<tr>
<td>- Enterprise Risk Management</td>
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<tr>
<td>12. Health and Safety Code Section 32106(b) for a report and discussion involving health care facility trade secrets:</td>
<td>Dan Woods, Chief Executive Officer</td>
<td>discussion 6:59 – 7:09</td>
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<tr>
<td>- Strategic Plan Update</td>
<td></td>
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<tr>
<td>13. Gov’t Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:</td>
<td>Lanhee Chen, Board Chair</td>
<td>discussion 7:09 – 7:14</td>
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<tr>
<td>- CEO Report</td>
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<tr>
<td>a. Pacing Plan</td>
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<tr>
<td>- Executive Session</td>
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<tr>
<td>15. ADJOURN TO OPEN SESSION</td>
<td>Lanhee Chen, Board Chair</td>
<td>motion required 7:15 – 7:16</td>
</tr>
<tr>
<td>16. RECONVENE OPEN SESSION/REPORT OUT</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment 7:16 – 7:18</td>
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<td>17. CONSENT CALENDAR ITEMS:</td>
<td>Lanhee Chen, Board Chair</td>
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<td>Any Board Member or member of the public may remove an item for discussion before a motion is made.</td>
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<td>ESTIMATED TIMES</td>
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<tr>
<td><strong>Approval</strong></td>
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<tr>
<td>a. Hospital Board Minutes (06/23/21) Open Session Minutes</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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<tr>
<td>b. 2021 Period 11 Financials</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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<tr>
<td>c. Mountain View Time Intensivist Professional Services Renewal Agreement</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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<tr>
<td>d. Investment in Joint Venture with Satellite Healthcare</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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<tr>
<td><strong>Reviewed and Recommended for Approval by the Finance Committee</strong></td>
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<tr>
<td>e. Medical Staff Report</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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<td>f. Pediatric PPE Plan – Revised</td>
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<td>g. Medical Staff Bylaws Amendments</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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<tr>
<td>17. AMENDMENT TO CEO EMPLOYMENT AGREEMENT</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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<tr>
<td>18. CEO REPORT</td>
<td>Dan Woods, Chief Executive Officer</td>
<td>information</td>
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<td>19. BOARD COMMENTS</td>
<td>Lanhee Chen, Board Chair</td>
<td>information</td>
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<tr>
<td>20. ADJOURNMENT</td>
<td>Lanhee Chen, Board Chair</td>
<td>public comment</td>
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**Upcoming Regular Meetings:**
- September 15, 2021
- October 13, 2021
- November 10, 2021
- December 8, 2021
- February 9, 2022
- March 9, 2022
- April 13, 2022
- May 11, 2022
- May 23, 2022 (Joint with Finance Committee)
- June 8, 2022

**Upcoming Special Meetings - Education/Retreat:**
- October 27, 2021 (Joint Board and Committee Education)
- February 23, 2022 (Retreat)
- April 27, 2022 (Board Education)
To: El Camino Hospital Board of Directors
From: George Ting, Quality Committee Vice Chair
Mark Adams, MD, CMO
Date: August 18, 2021
Subject: Quality, Patient Care and Patient Experience Committee Report

Purpose: To inform the Board of the work of the Quality Committee and recommend the Quality Improvement Patient Safety Plan (QAPI) for approval.

Summary:

1. The acting committee chair, Dr. Ting, facilitated a discussion regarding the committee pacing plan. Traditionally, the pacing plan has expanded to include an increasing number of rote reports which tend to consume committee time at the expense of discussion time. Since many of the standard quality metrics don’t appreciably change from month to month, it might make sense to decrease the frequency of such reports or move some of these items to the consent calendar. Various committee members suggested discussion topics for future meetings. This included health equity, drilling down on the factors contributing to likelihood to recommend (LTR), population health, our participation in the QIP program (formerly the PRIME program for Medi-Cal patients), and selection of metrics/measures.

2. Dr. Adams reviewed the most recent patient story which came from the newly instituted post discharge phone call program. The patient praised the nursing care and the food but complained about the difficulty navigating the new Get Well Network TV system. This provided an illustration that patient experience is more than just medical care but many other factors that must be considered.

3. Vince Manoogian and Ute Burness presented the quarterly quality update for the El Camino Health Medical Network. ECHMN has established true north pillars, one of which is quality and service. For quality, the goals are: achieve top decile HEQS composite score by 2023 and achieve MIPS composite exceptional rating annually. While there are many more HEQS measures, 8 key metrics have been selected based on importance to patient care, impact on financial reimbursement, and concordance with MIPS measures. The latest quarterly results in the composite score is 3.4, which is up from the previous quarter of 3.2. The overall FY21 score is 3.75 compared to a target of 3.0. The FY22 target is 3.6 based on the same key metrics. A detailed drill down was provided on the efforts being made to improve each of the eight select metrics. This was received favorably by the committee.

4. Dr. Adams reviewed the Q4 Board quarterly quality dashboard:
   a. Safe Care:
      i. Mortality index has decreased to .79 for the quarter and .86 for the year. This is lower than target which was set as .76. This is the most recent top performers score. However, it is significantly less than 1.0, which is desirable.
      ii. Sepsis mortality index has decreased this quarter but will end at 1.08 for the year. There has been an upward shift nationally as the current top tier performers are now at 1.05. There is some contribution from COVID-19 cases but that’s not the only explanation. Some
Experts are indicating the hesitation to seek care may be contributing to more advanced sepsis cases where salvage is more difficult.

iii. **CLABSI:** 0 this quarter and FYTD is 0.5 based on a few instances in Q2 and Q3. Efforts have been made to reinforce the application of the central line bundle for placement and the ongoing care of the lines.

iv. C. diff. will end slightly above target (1.46) at 1.78.

c. **Timely:**
   i. All three ED measures continue above target. Identification of COVId-19 patients including testing continue to slow throughout as well as a resurgence of more ED visits approaching pre-pandemic levels.

d. **Effective Care:**
   i. Readmission Index has returned to a level just below target which is a very positive trend.
   ii. **CMS SEP-1 Compliance rate:** decreased in Q4 to 58.0% (target is 86%) (CMS median rate is 60% across all hospitals) FYTD rate: 72.0%
   iii. **PCP-02 C/S rate:** this has remained steady but above target of 23.5%. There is a wide variation among practitioners with some well below target and some approaching 50%. Efforts are being made to counsel those above the target.

e. **Efficient Care:** No issues

f. **Equitable Care:** No issues

g. **Patient-Centered Care:**
   i. IP enterprise LTR and ED LTR remain below target at FYTD 80.3% and 75.3% respectively. MCH LTR is also below target with FYTD 80.8%. (As a reminder the IBM Watson Health Top 100 hospitals median IP LTR was 77%.)

**Recommendation:**

To approve the Quality Improvement Patient Safety Plan (QAPI).

**Attachments:**

1. Board Quality Dashboard Q4
2. Quality Improvement Patient Safety Plan (QAPI) – FOR APPROVAL
### Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 21, Q4 (unless otherwise specified by *)

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Metric</th>
<th>Baseline</th>
<th>Target</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Care</td>
<td>Risk Adjusted Mortality Index</td>
<td>0.74</td>
<td>0.76</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Sepsis Mortality Index</td>
<td>0.96</td>
<td>0.90</td>
<td>0.76</td>
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<tr>
<td></td>
<td>Serious Safety Events Rate (SSER) (baseline Dec'19 to Jun'20)</td>
<td>4.28</td>
<td>4.00</td>
<td>3.98</td>
</tr>
<tr>
<td></td>
<td>Surgical Site Infections (SSI)</td>
<td>0.36</td>
<td>1.0 (SIR)</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td>Catheter Associated Urinary Tract Infection (CAUTI) - HAI</td>
<td>0.47</td>
<td>&lt;= 0.48</td>
<td>0.51</td>
</tr>
<tr>
<td></td>
<td>Central Line Associated Blood Stream Infection (CLABSI) - HAI</td>
<td>0.15</td>
<td>&lt;= 0.20</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Clostridium Difficile Infection (CDI) - HAI</td>
<td>1.46</td>
<td>&lt;= 1.46</td>
<td>1.6</td>
</tr>
<tr>
<td></td>
<td>Modified PSI-90 CMS HAC Reduction Program</td>
<td>0.919</td>
<td>0.90</td>
<td>0.898</td>
</tr>
<tr>
<td>Timely</td>
<td>Patient Throughput - ED Door to Admit Order</td>
<td>190 min</td>
<td>181 min</td>
<td>188 min</td>
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<tr>
<td></td>
<td>Patient Throughput - Median Time Arrival to ED Departure</td>
<td>284 min</td>
<td>245 min</td>
<td>255 min</td>
</tr>
<tr>
<td></td>
<td>ED Arrival to Direct Discharge for ED Patients</td>
<td>151 min</td>
<td>145 min</td>
<td>154 min</td>
</tr>
<tr>
<td>Effective</td>
<td>Risk Adjusted Readmissions Index</td>
<td>0.96</td>
<td>0.93</td>
<td>0.88</td>
</tr>
<tr>
<td></td>
<td>CMS SEP-1 Compliance Rate</td>
<td>70.9%</td>
<td>86%</td>
<td>67.6%</td>
</tr>
<tr>
<td></td>
<td>PC-01 Elective Delivery Prior to 39 Weeks Gestation</td>
<td>ENT: 1.3%</td>
<td>1.3%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>PC-02 NTSV C-Section</td>
<td>ENT: 24.0%</td>
<td>23.5%</td>
<td>27.6% (125/434)</td>
</tr>
<tr>
<td>Efficient</td>
<td>ECMN: CMS 165 Controlling High Blood Pressure</td>
<td>51.20%</td>
<td>&lt;= 63%</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control</td>
<td>43.30%</td>
<td>&lt;= 45</td>
<td>27.0%</td>
</tr>
<tr>
<td></td>
<td>HEDIS: Composite</td>
<td>NA</td>
<td>3.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Efficient</td>
<td>Arithmetic Observed LOS/ Geometric Expected LOS</td>
<td>1.32</td>
<td>1.30</td>
<td>1.32</td>
</tr>
<tr>
<td>Efficient</td>
<td>MSPB-1 Medicare Spending per Beneficiary (CMS)</td>
<td>0.99 (CY 18)</td>
<td>0.99</td>
<td>0.99</td>
</tr>
<tr>
<td>Equitable</td>
<td>Hospital Charity Care Support</td>
<td>$20.5 mil</td>
<td>NA</td>
<td>$6.6 mil</td>
</tr>
<tr>
<td>Equitable</td>
<td>Clinic Charity Care Support</td>
<td>$44.3k</td>
<td>NA</td>
<td>$8.4k</td>
</tr>
<tr>
<td>Equitable</td>
<td>Language Line Unmet Requests (data collection started Q2)</td>
<td>0.34%</td>
<td>&lt;= 1%</td>
<td>0.39%</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>Length of Stay Disparity (Top 3 races)</td>
<td>Black: 4.05</td>
<td>NA</td>
<td>3.98</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>40% patients did not report their race</td>
<td>White: 3.79</td>
<td>NA</td>
<td>3.81</td>
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<tr>
<td>Patient-centered</td>
<td>White: 3.79</td>
<td>NA</td>
<td>3.81</td>
<td>3.97</td>
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<tr>
<td>Patient-centered</td>
<td>Asian: 3.64</td>
<td>NA</td>
<td>3.54</td>
<td>3.38</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>IP Enterprise - HCAHPS Likelihood to Recommend</td>
<td>83.1</td>
<td>83.6</td>
<td>80.7</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>ED - Likelihood to Recommend (PG)</td>
<td>75.7</td>
<td>78.2</td>
<td>73.9</td>
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<tr>
<td>Patient-centered</td>
<td>ECHMD - Likelihood to Recommend Care Provider (NPS)</td>
<td>73.2</td>
<td>75.7</td>
<td>76.2</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>MCH - HCAHPS Likelihood to Recommend</td>
<td>84.1</td>
<td>84.6</td>
<td>82.9</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>OAS - HCAHPS Likelihood to Recommend</td>
<td>84.7</td>
<td>86.4</td>
<td>83.5</td>
</tr>
</tbody>
</table>

**Report updated 7/26/21**
* data available up to FYTD 21 May only
** data available FYTD 21 April only, displaying rolling 12 month data (December 2019 to April 2021)

STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered
Quality Improvement & Patient Safety Plan (QAPI)

PURPOSE

The quality improvement & Patient Safety Plan (QAPI) describes the multidisciplinary, systematic quality improvement framework utilized by El Camino Hospital (ECH) to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of ECH.

ORGANIZATION OVERVIEW

El Camino Health is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View, California and a 143-bed acute hospital in Los Gatos, California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip and Knee, Hip Fracture and Spinal Fusion for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center and “baby friendly hospital” by WHO/UNICEF.

The ECH Medical Staff includes 1217 active, provisional and consultant, and 228 affiliate physicians/independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

EI CAMINO HEALTH MISSION

Our Mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner.

EI CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

EI CAMINO HOSPITAL VALUES

Quality: We pursue excellence to deliver evidence based care in partnership with our patients and families.

Compassion: We care for each individual uniquely with kindness, respect and empathy.
Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

Collaboration: We partner for the best interests for our patients, their families and our community using a team approach.

Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

Innovation: We embrace solutions and forward thinking approaches that lead to better health.

Accountability: We take responsibility for the impact of our actions has on the community and each other.

HIGH RELIABILITY

El Camino’s 2021 vision for quality includes a continuation of the high reliability journey initiated in 2020 leading to zero preventable harm. Safety is a well-defined science and can be improved through attention to reliability culture (expectations, behaviors, teamwork, etc.) and processes (intuitive design, mistake proofing, etc.). A High Reliability Steering Committee provides guidance and direction toward the implementation of high reliability practices. Implementation includes training and case-based learning, multi-disciplinary interactions to improve communication, tools, job aids and newsletters. The HRO brand, SAFETY FIRST MISSION ZERO has been adopted and will be used to enhance communication and understanding of high reliability. Real-time change management will include simulations, moments for safety before meetings, red “no interruption zones,” and a cascade of safety huddles that focus on patient and team member risk assessment and mitigation. Additional support for cultural transformation will include leader rounding, safety coaches on each unit, policy changes, tools, on-line resources, and rewards/recognition.

El Camino will develop a tool kit for all executive and medical staff leaders, provide training, and monitor use. The toolkit will include techniques to lead the safety journey (e.g., how to encourage reporting, educating for safety, having a moment for safety in each meeting, sharing lessons learned), build accountability (e.g., rounding to influence, 5:1 feedback, red rules, fair and just culture), and finding and fixing problems (e.g., stop the line, top 10 work list, action planning). Leader performance evaluations will incorporate measures of safety leadership.

El Camino physician and executive leaders will work to decrease power gradients and improve interpersonal communication. In addition to the daily Safety Huddle, El Camino will develop a series of communication tools to allow for immediate frontline communication and education to decrease the risk of preventable harm. This will include internal dashboards that show the SSER (including Faces of Safety) to better personalize otherwise impersonal data.

Using the newly implemented iSAFE incident reporting system data, all safety events are now classified by a team of experts trained in the HPI classification system. The classified events are then subjected to a Pareto analysis. This allows for identification of recurrent safety events so that interdisciplinary teams can be formed to address the gaps in generally accepted performance standards.

DEFINITIONS:

El Camino Hospital has adopted the Institute of Medicine’s (IOM) Quality Framework – STEEEP – as its definition of quality. These six aims for a healthcare system comprise ECH’s approach to quality:

- **Safe**: Avoiding harm to patients from the care that is intended to help them
• **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

• **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

• **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

• **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

• **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

## SERVICES/PROGRAMS

ECH provides a full continuum of inpatient and outpatient care including:

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<th>Acute Inpatient Services:</th>
<th>Emergency Services:</th>
<th>Outpatient Services:</th>
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<tbody>
<tr>
<td>Intensive &amp; Critical Care Unit</td>
<td>Basic Emergency</td>
<td>Behavioral Services – Outpatient</td>
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<tr>
<td>Cardiovascular Surgery</td>
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## OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.

3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.

4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.

5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.

6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.

7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.


9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating or accrediting bodies.

10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.

11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

A. Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility for implementing the quality improvement & Patient Safety Plan to the medical staff and hospital administration.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its chairman or designee, cause the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting The Joint Commission and College of American Pathology accreditation standards, California Code of Regulations including Title 22, CMS Conditions of Participation and complying with applicable laws and regulations.
B. Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.5, the Medical Executive Committee is responsible for the quality and effectiveness of patient care and competent clinical performance rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

1. Fulfill the Medical Staff's responsibility of accountability to the Governing Board for medical care rendered to patients in the hospital;
2. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members and make recommendations to the governing board regarding appointments/reappointments, clinical privileges, and corrective action; and
3. Assisting in obtaining and maintenance of accreditation.

C. Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of three Enterprise departments which are those with constituency is at both campuses (including MV & LG). All departments report to an Enterprise Medical Staff Executive Committee. The current departments are; (a complete list of all sub-specialties in each department is available from the Medical Staff Office.)

- Medicine to include Radiology, Emergency Medicine, Hospitalists, Psychiatry, Neurology and Family Medicine
- Surgery to include Pathology, Anesthesia, Orthopedics, Gynecologic Oncology, Otolaryngology, Ophthalmology, Plastic Surgery, Neurosurgery, General Surgery, Urology, Cardio-thoracic surgery, and Vascular Surgery
- Maternal Child Health to include Obstetrics/Gynecology, Pediatrics and Neonatology

Each of these three departments has monthly meetings of their Executive Committees where ongoing quality improvement projects are initiated and progress reported routinely to the Quality Council.

Other specific responsibilities with regard to quality improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A for a graphic depiction of the flow of quality information through committees and to the governing board.

D. Leadership and Support

The hospital and medical staff leaders have the responsibility to create an environment that promotes quality improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the hospital's patient safety program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. The leaders perform the following key functions:

1. Adopt an approach to quality improvement, set expectations, plan, and manage processes to measure,
assess, and improve the hospital's governance, management, clinical, and support activities

2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization

3. Establish priorities for quality improvement and safety giving priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and re-prioritize these activities in response to changes in the internal and external environment

4. Participate in interdisciplinary and interdepartmental quality and safety improvement activities in collaboration with the medical staff

5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's quality performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities

6. Assure that staff are trained in quality and safety improvement approaches and methods and receives education that focuses on safety, quality, and high reliability

7. Continuously measure and assess the effectiveness of quality and safety improvement activities, and implement improvements for these activities

E. Medical Staff, Employees, and Contracted Services

Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, reporting adverse events, and implementing actions to sustain improvements.

F. Enterprise Quality & Patient Safety Committees: 
Enterprise Quality Council and Patient and Employee Safety Committees

The Medical Staff Bylaws describe the composition and duties of the Enterprise Quality Council as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. The Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY 21 Quality Council report schedule.

The Enterprise Patient and Employee Safety Committee receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Injuries, Hospital-acquired Infection Teams (CAUTI, CLABSI, C. Diff), National Patient Safety Goals, Safety/Security, Antibiotic Stewardship, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Medication Errors, Employee Injures, and the Grievance Committee. (See Attachment C: Patient and Employee Safety Dashboard). The Committee also reviews reports from Culture of Safety Surveys and works with the medical staff and hospital
administration to develop action plans in response to the results. The Director of Risk Management also conducts risk assessments regarding the safety of patient care including Failure Mode Effects Analysis (FMEA) for new or changed hospital services. The Director of Risk Management/Patient Safety Officer provides data on incident reports (iSafe – ECH’s Online System for– adverse event reporting) the adequacy of the reporting process, including updates on the number and type of iSafe reports, serious safety events and RCAs (root cause analyses). Updates are also provided on the performance improvement teams that are chartered through this committee and as a result of RCAs or Intensive Analyses. This Committee uses the Management of Adverse Events/Sentinel Events Procedure to outline the process for categorizing patient safety events, including serious safety events, performance of a root cause analysis for sentinel events, compliance with regulatory requirements for mandated reporting of adverse events and process of notification of ECH leadership of sentinel and adverse events.

The Enterprise Patient Safety Oversight Committee (PSOC) is also a subcommittee of the Quality Council Committee and is described in the Management of Adverse Events/Sentinel Events Procedure (Administrative). The Patient Safety Oversight Committee is a committee that meets weekly to review and categorize iSafe Reports, serious patient safety events, behavior, safety and operational issues. The Committee is comprised of the Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, Medical Director for Quality Assurance, Associate Chief Medical Officer, Sr. Director Quality, Director of Risk Management/Patient Safety Officer, Director of Accreditation/Public Reporting, Director of Medical Staff Services and a representative of the Medical Staff. These leaders provide direction to the organization and the medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

The Root Cause Analysis (RCA) Steering Committee is a subcommittee and reports to the Enterprise Patient Safety Oversight Committee (PSOC). The RCA Steering Committee focuses on events that an RCA has completed and thus has the senior leadership with the involved departments reporting on actions taken and the continuous improvement until the process change has been sustained. This process also includes the SSE’s and investigation process.

G. Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Quality Department staff serves as internal resources for the development and evaluation of quality improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including the teams addressing the organizational quality, ERAS Team and the HAP (hospital-acquired pneumonia)Team. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
2. Produces and maintains two quality dashboards for the organization and the board of directors: Enterprise Quality, Safety, and Experience Dashboard, and Quarterly Board Quality Dashboard (STEEEP). See Attachments D and E
3. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
4. Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment F for Data Registries in use)

5. Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities

6. Collaborates with the Director of Risk Management on efforts to manage and reduce risk through Root Cause Analyses and Intense Analyses as responses to adverse events and near misses

7. Collaborates to facilitate failure mode and effectiveness analysis (FMEA) at least every 18 months through the leadership of both the Director of Risk Management & Patient Safety and the Director of Accreditation & Public Reporting

8. Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"

9. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital – acquired infections and conditions

10. Managing data collection and reporting as required by regulatory agencies and the hospital’s strategic plan

11. Providing data as requested to external organizations, see data provided in Appendix B

12. Providing oversight for the hospital's participation in Clinical Registries, see Appendix C for current list

13. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, the MBSAQIP, and all Transfusion review and data

14. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health to improve the quality of care and safety of care provided to our patients

H. Improving Organizational Performance

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. quality improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained. quality improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(s) to quality improvement. These leaders set priorities for improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities.

Priorities are based on the organization's mission, vision and values, services provided, and populations served. Prioritization of performance improvement initiatives is based upon the following criteria:

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system

2. Results of quality improvement, patient safety and risk reduction activities

3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)
4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.

5. Low volume, high risk processes and procedures

6. Meeting the needs of the patients, staff and others

7. Resources required and/or available

8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.

I. Performance Processes

Design
The design of processes is in conjunction with the organization’s Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

1. Patient Safety
ECH strives to prevent errors and adverse effects to patients that are associated with complex patient care. While patient safety events may not be completely eliminated, harm to patients can be reduced and our goal is always zero harm. To promote the goal of zero harm, ECH adopted a new logo and phrase: “Safety First Mission Zero” in 2020. To learn from and to make changes to reduce harm, all hospital-acquired conditions, infections and complications of care are reviewed and results shared with involved departments and providers. Root cause analyses and intense analyses are conducted to more clearly understand the factors involved in a near miss or untoward event. The purpose is to develop and sustain a culture of safety. The leadership, risk management and quality staff work to promote a “just culture” that focuses on the systems involved in care and to create a trust-report-improve cycle to promote reporting of all event and near misses.

   a. iSafe reports, surgical site infections, MRSA infections, evidenced-based bundle failures and other events that result in patient harm are reported and evaluated weekly by the Safety Event Classification Team. This team determines if there were defects in care or deviations from generally
accepted performance standards (GACPS) and the level and type of patient harm. This information is translated and reported as the Serious Safety Event Rate.
2. **Measurement**

ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and finance. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.

Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/redesigned well and are consistent with sound business practices. They are:

- a. Consistent with the organization's mission, vision, goals, objectives, and plans;
- b. Meeting the needs of individuals served, staff and others;
- c. Clinically sound and current;
- d. Incorporating information from within the organization and from other organizations about potential/actual risks to patients;
- e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
- f. Incorporated into the results of performance improvement activities.

Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data
collection is systematic and is used to:

a. Establish a performance baseline;
b. Describe process performance or stability;
c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
d. Identify areas for more focused data collection to achieve and sustain improvement.

3. **Analysis**

Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.

When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.

ECH requires an intense analysis of undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

a. Performance varies significantly and undesirably from that of other organizations;
b. Performance varies significantly and undesirably from recognized standards;
c. When a sentinel event occurs;
d. Blood Utilization to include confirmed transfusion reactions;
e. Significant adverse events and drug reactions;
f. Significant medication errors, close calls, and hazardous conditions;
g. Significant adverse events related to using moderate or deep sedation or anesthesia;

**J. Improvement Model And Methodology**

MODEL FOR IMPROVEMENT: This is a simple yet powerful tool designed to accelerate improvement efforts and provide better focus on what it is we are trying to improve. The model is promoted by the Institute of Healthcare Improvement as a proven improvement model, and builds on theory developed by Juran and W. Edward Deming.

Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Model for Improvement. Multidisciplinary Performance Improvement (PI) Teams are commissioned and use the Model for Improvement to make improvements in a specific process. Unit based PI Teams and other The Plan-Do-Study-Act (PDSA) Teams are utilized and can form on their own to address unit or department specific needs. Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

The model has two parts:

1. **Three fundamental questions, which can be addressed in any order.**
   - What are we trying to accomplish?
How will we know that a change is an improvement?
What changes can we make that will result in improvement?

This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The (PDSA) Cycle provides an effective framework for developing tests and implementing changes as described next.

2. **The Plan-Do-Study-Act (PDSA) Cycle**

The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.

**Step 1: Plan**
Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?

**Step 2: Do**
Try out the test on a small scale. What did we observe that was not a part of our plan?

**Step 3: Study**
Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?

Summarize and reflect on what was learned.

**Step 4: Act**
Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary.

The cycle is ongoing and continuous.

In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:

3. **Goal Setting and Auditing Methodology**

a. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part
of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.

The acronym stands for:

**S** – **Specific**
When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn’t a detailed list of how you’re going to meet a goal, but it should include an answer to the popular ‘w’ questions:

- **Who** – Consider who needs to be involved to achieve the goal (this is especially important when you’re working on a group project).
- **What** – Think about exactly what you are trying to accomplish and don’t be afraid to get very detailed.
- **When** – You’ll get more specific about this question under the “time-bound” section of defining S.M.A.R.T. goals, but you should at least set a time frame.
- **Where** – This question may not always apply, especially if you’re setting personal goals, but if there’s a location or relevant event, identify it here.
- **Which** – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you’ve never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be “Learn how to bake in order to open a baking business.”
- **Why** – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

**M** – **Measurable**
What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it’s a project that’s going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.

**A** – **Achievable**
This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don’t currently possess those tools/skills, consider what it would take to attain them.

**R** – **Relevant**
Relevance refers focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that’s in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn’t be relevant.

**T** – **Time-Bound**
Anyone can set goals, but if it lacks realistic timing, chances are you’re not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it’s useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

b. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample
size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.

Measure of Success (MOS) auditing process has specified the following minimums:

- Sample all cases for a population size of fewer than 30 cases
- Sample 30 cases for a population size of 30–100 cases
- Sample 50 cases for a population size of 101–500 cases
- Sample 70 cases for a population size of more than 500 cases
- Sample 100 cases for a population greater than 500 cases

To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

**K. Performance Improvement and the El Camino Health Operating System**

The Performance Improvement department has adopted the use of Lean methodology and principles as the foundation for interventions used. Tools from Six Sigma, Change Management, and PDCA are used to support the journey to a High Reliability Organization. This is accomplished through a focus on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the base.

The Performance Improvement department provides resources to the organization for problem solving, as well as deploying ECHOS, our El Camino Health Operating System. The dedicated team is comprised of Program Managers with both clinical and industry expertise. The work is aligned to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and collaborating with all levels of the organization.

Systems critical to the success of Performance Improvement include reward and recognition, education and training, idea generation, communication, and engagement. These behaviors encourage and support everyone to be a problem-solver, and to engage in continuous improvement. The process makes visible the abnormal conditions and areas for improvement, while celebrating the incremental wins and positive changes.

**ECHOS: El Camino Health Operating System**

The ECH Operating System is the way that we lead and conduct performance improvement at EL Camino Health. It is the processes and tools that are used to run the various functions of our work. At the top is our True North; our mission, vision and values, as well as our True North pillars. The foundation represents our Operating system, which consists of all the process improvement concepts, methods and tools.

The Management System, with our patients as the focus, has three components which define how ECH:

1. **Aligns** the goals of the organization from the Executives to the Front Line with annual **Strategy Deployment**
2. **Engages** our people in daily front line problem solving daily through the **Daily Management System** using Tiered Huddles, Linked Visual Systems, Gemba, Standard Calendar, and Leader Standard Work
3. **Continuously Improve** our processes across departments, using structure and tools that enable both
local and large cross-functional processes to be improved and even transformed

L. Quality improvement Link With Organizational Goals

ECH’s quality improvement & Patient Safety Plan focuses on specific quality measures in three areas: quality/safety, service and finance. See below for the Fiscal Year 2021 Organizational Performance Goals.

The organization’s Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the Quality goal Readmission Index, ECH formed five new teams to address issues with Readmissions at the beginning of the fiscal year and who meet bi-weekly: Cancer team, Post-Acute Care Management team, Weekly Readmission Review team, Social Determinants of Health team, and the Surgical Complications team. Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal. (Attachment H.)

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<th>OBJECTIVES/OUTCOMES</th>
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M. Commitment to Patient Experience

ECH has embraced the concept of an excellent Patient Experience as foundational and believes that our goal is to create partnerships among health care practitioners, patients and families that will lead to the best outcomes and enhance the quality, safety and experience of patients and the health care team. As a result, ECH collects feedback from a myriad of sources to ensure that the Patient/Family voice is embedded in all that we do. In addition, a Patient and Family Advisory Council has been established as a mechanism for involving patients and families in performance improvement efforts, policy and program decision-making. The patient and family advisors act as champions of the ideal patient experience, and ensure its implementation across ECH. They are involved in reviewing communication to patients and families to ensure that it builds on patient and family strengths, engages them in a partnership with health care services, and serve as members of some hospital committees. They act as advisors with a focus on collaborating and co-designing and will often make recommendations for improvements in service and quality.

N. Allocation of Resources

The CEO and the Senior Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee,
Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities will be provided through monies allocated in expense budgets. Budgetary planning shall include resources for effective information systems, when appropriate.

O. Confidentiality

The quality improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the quality improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care quality improvement Act of 1986 and when applicable, California's Evidence Code 1157.

Data, reports, and minutes of the quality improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality Services Department, the Medical Staff Services Department and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Sr. Director, Quality Services Department or the Compliance Officer.

P. Annual Evaluation

The Sr. Director of Quality Services shall coordinate the annual evaluation of the program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address the program's effectiveness in improving patient care, patient safety, and clinical performance, resolving problems, and achieving program objectives. The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program will also be addressed.

Modifications will be implemented as needed to assure that the program is effective and efficient in monitoring patient care and clinical performance. The written plan may be modified at any time with the approval of the Quality Council, Medical Executive Committee, and the Governing Board.

Cross References:

1. Management of Adverse Events and Sentinel Events Procedure
2. Medical Staff Peer Review Policy

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

Attachments

Attachment G: External Regulatory Complicance Indicators 2021
Attachment F: Registries List for PI-PS
El Camino Health

Summary of Financial Operations

Fiscal Year 2021 – Period 12
7/1/2020 to 06/30/2021
Executive Summary - Overall Commentary for Period 12

- Strong operating / financial results for Period 12 were attributed to the following:
  - Despite being out-of-network with Anthem, June gross charges were 15.0% higher than the prior 11 month average
  - Strong volume / patient activity was attributed to the start of the new OB group at our Mountain View Campus, significant rebound in ER volumes and continued strong procedural volumes at both campuses
    - ER visits were 33.1% higher than the prior 11 month average
    - Adjusted discharges were 14.8% higher than the prior 11 month average
  - Recognition of one-time revenue for supplemental programs of $8.56M
- Total gross charges, a surrogate for volume, were favorable to budget by $93.5M / 29.7% and $99.7M / 32.3% higher than the same period last year
- Net patient revenue was favorable to budget by $30.2M / 36.8% and $11.5M / 11.4% higher than the same period last year
- Operating expenses were $13.4M / 16.2% unfavorable to budget, which is primarily attributed to higher than expected volume versus budget and significant number of procedural cases performed in June
- Operating margin was favorable to budget by $17.0M / 468.5% and $11.0M / 34.8% below the same period last year
- Operating EBIDA was favorable to budget by $17.7M / 176.3% and $9.8M / 26.1% below the same period last year
# Operational / Financial Results: Period 12 – June 2021 (as of 6/30/2021)

## PERIOD 12 - RESULTS

<table>
<thead>
<tr>
<th>Activity / Volume</th>
<th>Current Year</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>Performance to Budget</th>
<th>Prior Year</th>
<th>Variance to Prior Year</th>
<th>Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADC</td>
<td>269</td>
<td>234</td>
<td>35</td>
<td>15.0%</td>
<td>212</td>
<td>57</td>
<td>26.9%</td>
</tr>
<tr>
<td>Total Discharges</td>
<td>1,789</td>
<td>1,586</td>
<td>203</td>
<td>12.8%</td>
<td>1,425</td>
<td>364</td>
<td>25.5%</td>
</tr>
<tr>
<td>Adjusted Discharges</td>
<td>3,415</td>
<td>2,924</td>
<td>491</td>
<td>16.8%</td>
<td>2,791</td>
<td>624</td>
<td>22.4%</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>5,620</td>
<td>4,440</td>
<td>1,180</td>
<td>26.6%</td>
<td>4,006</td>
<td>1,614</td>
<td>40.3%</td>
</tr>
<tr>
<td>OP Procedural Cases</td>
<td>12,733</td>
<td>8,353</td>
<td>4,380</td>
<td>52.4%</td>
<td>10,289</td>
<td>2,444</td>
<td>23.8%</td>
</tr>
<tr>
<td>Gross Charges ($)</td>
<td>408,078</td>
<td>314,599</td>
<td>93,479</td>
<td>29.7%</td>
<td>308,375</td>
<td>99,703</td>
<td>32.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operations</th>
<th>Current Year</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>Performance to Budget</th>
<th>Prior Year</th>
<th>Variance to Prior Year</th>
<th>Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FTEs</td>
<td>2,924</td>
<td>2,744</td>
<td>180</td>
<td>6.6%</td>
<td>2,668</td>
<td>256</td>
<td>9.6%</td>
</tr>
<tr>
<td>Productive Hrs. / APD</td>
<td>28.4</td>
<td>31.9</td>
<td>(3.5)</td>
<td>(11.0%)</td>
<td>32.2</td>
<td>(3.8)</td>
<td>(11.8%)</td>
</tr>
<tr>
<td>Cost Per CMI Adjusted Discharge</td>
<td>16,225</td>
<td>17,111</td>
<td>(886)</td>
<td>(5.2%)</td>
<td>15,743</td>
<td>482</td>
<td>3.1%</td>
</tr>
<tr>
<td>Net Days in A/R</td>
<td>50.0</td>
<td>49.0</td>
<td>1.0</td>
<td>2.0%</td>
<td>51.9</td>
<td>(1.9)</td>
<td>(3.6%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Performance</th>
<th>Current Year</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>Performance to Budget</th>
<th>Prior Year</th>
<th>Variance to Prior Year</th>
<th>Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Patient Revenue ($)</td>
<td>112,238</td>
<td>82,074</td>
<td>30,165</td>
<td>36.8%</td>
<td>100,746</td>
<td>11,493</td>
<td>11.4%</td>
</tr>
<tr>
<td>Total Operating Revenue ($)</td>
<td>116,945</td>
<td>86,512</td>
<td>30,432</td>
<td>35.2%</td>
<td>108,768</td>
<td>8,177</td>
<td>7.5%</td>
</tr>
<tr>
<td>Operating Income ($)</td>
<td>20,664</td>
<td>3,635</td>
<td>17,029</td>
<td>468.5%</td>
<td>31,695</td>
<td>(11,032)</td>
<td>(34.8%)</td>
</tr>
<tr>
<td>Operating EBIDA ($)</td>
<td>27,771</td>
<td>10,052</td>
<td>17,719</td>
<td>176.3%</td>
<td>37,522</td>
<td>(8,751)</td>
<td>(26.0%)</td>
</tr>
<tr>
<td>Net Income ($)</td>
<td>40,705</td>
<td>6,968</td>
<td>33,737</td>
<td>484.2%</td>
<td>50,672</td>
<td>(9,967)</td>
<td>(19.7%)</td>
</tr>
<tr>
<td>Operating Margin (%)</td>
<td>17.7%</td>
<td>4.2%</td>
<td>13.5%</td>
<td>320.6%</td>
<td>29.1%</td>
<td>(11.5%)</td>
<td>(39.4%)</td>
</tr>
<tr>
<td>Operating EBIDA (%)</td>
<td>23.7%</td>
<td>11.6%</td>
<td>12.1%</td>
<td>104.4%</td>
<td>34.5%</td>
<td>(10.8%)</td>
<td>(31.2%)</td>
</tr>
<tr>
<td>DCOH (days)</td>
<td>388</td>
<td>264</td>
<td>124</td>
<td>47.0%</td>
<td>313</td>
<td>75</td>
<td>24.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moody's Medians</th>
<th>Performance to 'A1' Medians</th>
</tr>
</thead>
<tbody>
<tr>
<td>'A1'</td>
<td>'Aa3'</td>
</tr>
<tr>
<td>Current Year</td>
<td>Budget</td>
</tr>
<tr>
<td>Variance to</td>
<td>Performance to</td>
</tr>
<tr>
<td>Prior Year</td>
<td>Budget</td>
</tr>
</tbody>
</table>

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect monthly averages. DCOH total includes cash, short-term and long-term investments.
# Operational / Financial Results: Pre-Audit YTD FY2021 (as of 6/30/2021)

## Activity / Volume

- **Total Discharges**: 19,157 (17,351) (1,806) 10.4%
- **Adjusted Discharges**: 36,226 (32,156) (4,070) 12.7%
- **Emergency Room Visits**: 52,059 (45,202) (6,857) 15.2%
- **OP Procedural Cases**: 160,728 (95,074) (65,654) 69.1%
- **Gross Charges ($)**: 4,309,257 (3,427,558) (881,699) 25.7%

## Operations

- **Total FTEs**: 2,841 (2,620) (221) 8.4%
- **Productive Hrs. / APD**: 31.0 (33.7) (-2.8) 8.2%
- **Cost Per CMI Adjusted Discharge**: 16,815 (18,201) (-1,385) 7.6%
- **Net Days in A/R**: 50.0 (49.0) (1.0) 2.0%

## Financial Performance

- **Net Patient Revenue ($)**: 1,107,911 (893,139) (214,772) 24.0%
- **Total Operating Revenue ($)**: 1,156,342 (947,971) (208,371) 22.0%
- **Operating Income ($)**: 87,244 (23,735) (110,979) 467.6%
- **Operating EBIDA ($)**: 170,690 (55,823) (114,867) 205.8%
- **Net Income ($)**: 328,083 (11,770) (316,313) 2687.4%
- **Operating Margin (%)**: 7.5% (2.5%) 10.0% 401.3%
- **Operating EBIDA (%)**: 14.8% 5.9% 8.9% 150.7%
- **DCOH (days)**: 388 (264) (124) 47.0%

## Moody's Medians

<table>
<thead>
<tr>
<th>Performance</th>
<th>'A1'</th>
<th>'Aa3'</th>
<th>Medians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variance to Prior Year</td>
<td>7.9%</td>
<td>1.0%</td>
<td>---</td>
</tr>
<tr>
<td>Variance to Budget</td>
<td>16.2%</td>
<td>10.4%</td>
<td>---</td>
</tr>
</tbody>
</table>

YTD FY2021 Financial KPIs – Monthly Trends

Consolidated Operating Margin ($000s)
Current & Prior Fiscal Year

Hospital Adjusted Discharges

Hospital Payor Mix

Consolidated Net Days in AR

El Camino Health
**Period 12 and Pre-Audit YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 6/30/2021) ($000s)**

<table>
<thead>
<tr>
<th>Period 12- Month</th>
<th>Period 12- FYTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
</tr>
<tr>
<td>El Camino Hospital Operating Margin</td>
<td></td>
</tr>
<tr>
<td>Mountain View</td>
<td>19,736</td>
</tr>
<tr>
<td>Los Gatos</td>
<td>3,963</td>
</tr>
<tr>
<td><strong>Sub Total - El Camino Hospital, excl. Affiliates</strong></td>
<td><strong>23,698</strong></td>
</tr>
<tr>
<td>Operating Margin %</td>
<td>21.4%</td>
</tr>
<tr>
<td>El Camino Hospital Non Operating Income</td>
<td></td>
</tr>
<tr>
<td><strong>Sub Total - Non Operating Income</strong></td>
<td><strong>18,886</strong></td>
</tr>
<tr>
<td>El Camino Hospital Net Margin</td>
<td>42,584</td>
</tr>
<tr>
<td>ECH Net Margin %</td>
<td>38.4%</td>
</tr>
<tr>
<td>Concern</td>
<td>90</td>
</tr>
<tr>
<td>ECSC</td>
<td>0</td>
</tr>
<tr>
<td>Foundation</td>
<td>829</td>
</tr>
<tr>
<td>El Camino Health Medical Network</td>
<td>(2,798)</td>
</tr>
<tr>
<td>Net Margin Hospital Affiliates</td>
<td>(1,879)</td>
</tr>
<tr>
<td><strong>Total Net Margin Hospital &amp; Affiliates</strong></td>
<td><strong>40,705</strong></td>
</tr>
</tbody>
</table>
## Pre-Audit Consolidated Balance Sheet (as of 06/30/2021)

<table>
<thead>
<tr>
<th>ASSETS</th>
<th></th>
<th>LIABILITIES AND FUND BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT ASSETS</td>
<td></td>
<td>CURRENT LIABILITIES</td>
</tr>
<tr>
<td>Cash</td>
<td></td>
<td>Accounts Payable</td>
</tr>
<tr>
<td>Short Term Investments</td>
<td></td>
<td>Salaries and Related Liabilities</td>
</tr>
<tr>
<td>Patient Accounts Receivable, net</td>
<td></td>
<td>Accrued PTO</td>
</tr>
<tr>
<td>Other Accounts and Notes Receivable</td>
<td></td>
<td>Worker's Comp Reserve</td>
</tr>
<tr>
<td>Intercompany Receivables</td>
<td></td>
<td>Third Party Settlements</td>
</tr>
<tr>
<td>Inventories and Prepaids</td>
<td></td>
<td>Intercompany Payables</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td></td>
<td>Malpractice Reserves</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bonds Payable - Current</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bond Interest Payable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Liabilities</td>
</tr>
<tr>
<td>BOARD DESIGNATED ASSETS</td>
<td></td>
<td><strong>Total Current Liabilities</strong></td>
</tr>
<tr>
<td>Foundation Board Designated</td>
<td></td>
<td>LONG TERM LIABILITIES</td>
</tr>
<tr>
<td>Plant &amp; Equipment Fund</td>
<td></td>
<td>Post Retirement Benefits</td>
</tr>
<tr>
<td>Women's Hospital Expansion</td>
<td></td>
<td>Worker's Comp Reserve</td>
</tr>
<tr>
<td>Operational Reserve Fund</td>
<td></td>
<td>Other L/T Obligation (Asbestos)</td>
</tr>
<tr>
<td>Community Benefit Fund</td>
<td></td>
<td>Bond Payable</td>
</tr>
<tr>
<td>Workers Compensation Reserve Fund</td>
<td></td>
<td><strong>Total Long Term Liabilities</strong></td>
</tr>
<tr>
<td>Postretirement Health/Life Reserve Fund</td>
<td></td>
<td>DEFERRED REVENUE-UNRESTRICTED</td>
</tr>
<tr>
<td>PTO Liability Fund</td>
<td></td>
<td>DEFERRED INFLOW OF RESOURCES</td>
</tr>
<tr>
<td>Malpractice Reserve Fund</td>
<td></td>
<td><strong>FUND BALANCE/CAPITAL ACCOUNTS</strong></td>
</tr>
<tr>
<td>Catastrophic Reserves Fund</td>
<td></td>
<td>Unrestricted</td>
</tr>
<tr>
<td><strong>Total Board Designated Assets</strong></td>
<td></td>
<td>Board Designated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Restricted</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Total Fund Bal &amp; Capital Accts</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>TOTAL LIABILITIES AND FUND BALANCE</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>TOTAL ASSETS</strong></td>
</tr>
<tr>
<td>PROPERTY AND EQUIPMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Assets at Cost</td>
<td></td>
<td>Property, Plant &amp; Equipment - Net</td>
</tr>
<tr>
<td>Less: Accumulated Depreciation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Construction in Progress</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Deferred Outflows</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Restricted Assets</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Other Assets</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>TOTAL ASSETS</strong></td>
</tr>
</tbody>
</table>
Purpose:

Introduce Spencer Stuart—an outside consulting firm—to clarify objectives, expected outcomes/approach and outline the process/timeline of the governance assessment to be conducted for Fiscal Year 2021-2022.

Summary:

1. **Situation:** The Hospital Board of Directors will utilize the services of an independent consulting firm to conduct a governance assessment to promote optimal processes and practices.

2. **Authority:** Per its Charter, the Hospital Board of Directors will conduct a review of all Board and Committee processes to gauge effective governance.

3. **Background:** The governance assessment will review the actions taken by the El Camino Hospital Board of Directors to address Strategic Planning, Operational Topics, Corporate Governance Matters, Administrative Matters and Written Reports. The assessment will include, but not be limited to, Director and Management interviews.

4. **Assessment:** For discussion by the Committee.

5. **Other Reviews:** N/A

6. **Outcomes:** N/A

List of Attachments:

1. El Camino Hospital Board Review—1st Year Milestones

Suggested Committee Discussion Questions:

1. **none**
## El Camino Hospital Board Review – 1st Year Milestones

<table>
<thead>
<tr>
<th></th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Align on board review approach and plan</td>
<td></td>
<td>Discuss board review process</td>
<td>Conduct conversations with directors and select executives</td>
<td>Provide individual feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Write report, provide to board</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td></td>
<td></td>
<td></td>
<td>Discuss report</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aug 18 Board Meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oct 13 Board Meeting</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, June 23, 2021

Pursuant to State of California Executive Order N-29-20 dated March 18, 2020, El Camino Health did not provide a physical location for this meeting. Instead, the public was invited to join the open session meeting via teleconference.

<table>
<thead>
<tr>
<th>Board Members Present</th>
<th>Board Members Absent</th>
<th>Members Excused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanhee Chen, Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter C. Fung, MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julie Kliger, MPA, BS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julia E. Miller, Secretary/Treasurer</td>
<td></td>
<td>**via teleconference</td>
</tr>
<tr>
<td>Jack Po, MD, Ph.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bob Rebitzer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>George O. Ting, MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carol A. Somersille, MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don Watters**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Zoglin**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Comments/Discussion</th>
<th>Approvals/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CALL TO ORDER/ ROLL CALL</td>
<td>The open session meeting of the Board of Directors of El Camino Hospital (the “Board”) was called to order at 5:30 pm by Chair Chen. A verbal roll call was taken. Director Watters joined the meeting at 5:39 pm during Public Communication and Director Po joined the meeting at 5:44 pm during the Quality Committee Report. All other Board members were present at roll call. Chair Chen reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.</td>
<td></td>
</tr>
<tr>
<td>2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES</td>
<td>Chair Chen asked if any Board members have a conflict of interest with any of the items on the agenda. No conflicts were noted.</td>
<td></td>
</tr>
<tr>
<td>3. PUBLIC COMMUNICATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. QUALITY COMMITTEE REPORT</td>
<td>George O. Ting opens by sharing a patient story from the Quality Committee in which the patient shared some problems they had experienced while awaiting surgery on the Mountain View campus which included waiting more than tolerable and difficulty convincing the nurse about her dosing amounts (given she is a type one diabetic). However, she also shared that aside from those two areas of friction she had an overall positive experience and that she would not hesitate to recommend the hospital. He also discusses the readmission data collected over the past five years which has been categorized into seven different areas that CMS uses to score the HRRP (hospital readmission reduction penalty program). He noted three items that were observed more than expected but also noted there is no pattern between them and had nothing to do with the care being received. Director Ting discusses the highlights the patient safety indicators for the third quarter as presented by Dr. Mark Adams, CMO during the quality committee meeting:</td>
<td></td>
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</tbody>
</table>

**He draws attention to the six cases involving pressure ulcers in the...**
quarter. Each one has reviewed for root cause and several of them involved COVID patients: the way the oxygen mask is inserted and the pressure from it that is placed on to them which is causing the ulcers.

- He speaks about the five cases of hemorrhage and hematoma and mentions that no pattern could be observed at the moment and that more occurrences could be followed closely.
- Director Ding also touched on the two cases of acrogenic pneumothorax which derived from the same patient. The patient ended up doing okay.
- He discussed the vaginal injury due to trauma during childbirth so there is an ongoing discussion with maternal child health medical leadership. The instances put the hospital over the normal threshold and there are various hypotheses as to why this occurred but none definitive.

He also touches on the quality assurance and performance improvement plan which describes the structure, functions, and peer review processes that go into the quality concerns. He states that there is a joint commission that reviews this every three years and that they are due this year so a lot of time has been spent looking at this.

Dr. Shreyas Mallur opens the discussion for questions that he could address given that Dr. Adams was not present at the meeting.

Director Miller asked for further comment on the increase in the mortality and readmission rates.

In response to Director Miller’s question, Dr. Mallur states that the readmission has been trending downwards overall throughout the year and the increase is attributed to the COVD patients that came in between January and March. He also discusses the mortality index and that some of it was attributed to COVID patients but that there was also an increase in the sepsis index which is a big driver of the index.

Director Somersille inquired if there has been a specific population that has been experiencing this and whether any thought or initiative to doing a project or study of some sort in regards to the vaginal trauma during childbirth.

Dr. Mallur addresses that in addition to the Asian population experiencing vaginal trauma the South Asian population also has huge increases and that the Department of Maternal Child Health is looking at this very closely. He also mentions that there is no specific case study or project being conducted and instead trends were being identified among different hospitals but that they could bring this idea across to the Department of Maternal Child Health.

Director Zoglin inquired if there is an ECHMN equivalent of the research.

Director Ding states that there is no one right no out that it is in the orient and the information surrounding it is extremely minimal.

Director Kliger also adds that there is minimal information surrounding this as well and hasn’t seen this item being driven but that it could be added to the agenda to at least create a plan.

Dan Woods, CEO, agrees that with Director Kliger and that the same
structure as the enterprise quality plan could be used to develop this.

Director Fung asks about whether inpatient data could become available in the quality committee reports and why are only reviewing outpatient data.

Mr. Woods, comments that Director Fung brings up a really valid concern, and that the best place to start with this could be to emphasize focus on the service lines and start building data from there.

Director Somersille made a correction to the quality improvement of patient safety plan in the medical staff and department’s division surgery. She addresses that it should read gynecologic surgery instead of gynecologic oncology.

5. FY21 PERIOD 10 FINANCIALS

Carlos Bohorquez, CFO, starts a brief discussion by sharing results from the month of April in which he notes that it was an overall strong month from a volume and activity standpoint which is attributed to the rate of vaccination and the increase in volume of procedural cases as restrictions ease up. He also noted a strong operating margin which indicates a very strong recovery and stability for the months to come. He additionally touches on the quality mortality rate indicating that the CMI has increased meaning that less patients are coming in to the organization but that they are receiving care a little bit later. He mentions that the one item that is not fully recovered yet is the ED with strong activity in the month of May and June however patients are still skeptical about receiving care in general. He notes that despite the challenges and costs associated with COVID, the organization is on a stable and strong path to recovery.

Movant: Watters
Second: Zoglin
Ayes: Chen, Fung, Kliger, Miller, Po, Reitzer, Somersille, Ting, Watters, Zoglin
Noes: None
Abstentions: None
Absent: None
Recused: None

6. ADJOURN TO CLOSED SESSION

Motion: To adjourn to closed session at 5:57 pm pursuant to Gov’t Code Section 54957.2 for approval of the minutes of the Closed Session of the Hospital Board Meeting (05/12/2021) and 05/22 Individual Executive Performance 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: Quality Committee Report (Medical Staff Credentials and Privileges Report, Quality Council minutes); pursuant to Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters; Quality Committee Report (Medical Staff Credentials and Privileges Report, Quality Council minutes); pursuant to Gov’t Code Section 54957.6 for a report and discussion on personnel matters: Potential Amendment to CEO Employment Agreement pursuant to Gov’t Code Section 54956.9 for a report and discussion on personnel matters: Executive Performance Incentive Benefit Plan Design pursuant to Gov’t Code Section 54957.6 for a report and discussion on personnel matters: Proposed CQO Salary Range pursuant to Health and Safety Code Section 32106(b) for a

Adjourned to closed session at 5:57 pm
## AGENDA ITEM 15/16: RECONVENE OPEN SESSION/REPORT OUT

Open session was reconvened at 8:35 pm by Chair Chen. Agenda Items 7-14 were addressed in closed session.

During the closed session the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (05/12/21 & 5/22/21) FY 22 Individual Executive Performance Incentive Goals, Quality Committee Report, including the Medical Staff Credentials and Privileges Report, and the Annual Summary of Physician Finances by unanimous vote in favor of all members present and participating in the meeting (Directors Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, and Watters).

## AGENDA ITEM 17: 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 (05/22/21 & 5/22/21) FY 22 Committee Goals, FY 22 Committee and Liaisons Appointments FY 22 Community Benefit Plan, Anesthesia Professional Services Agreement, Reviewed and Recommended for Approval by the Finance Committee FY 21 Period 9 Finances, Infection Control Medical Director Agreement, Reviewed and Recommended for Approval by the Medical Executive Committee, Medical Staff Report Information, MV Major Projects Update

**Movant:** Chen
**Second:** Watters
**Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin
**Noes:** None
**Abstentions:** None
**Absent:** None
**Recused:** None

## AGENDA ITEM 18: CONSIDERATION OF BENEFITS COVERAGE FOR

Agenda Item will be deferred to a later date.
<table>
<thead>
<tr>
<th>BOARD MEMBERS RECLASSIFIED AS W-2 EMPLOYEES FOR IRS PURPOSES</th>
</tr>
</thead>
</table>

10. AGENDA ITEM 19: CEO REPORT

Dan Woods, CEO, reported on participation in Magnet4Europe research project, achieving Healthgrades 2021 Outstanding Patient Experience Award, COVID-19 vaccination partnership with Google, launch of Employee Voice Survey, and the holding of Taking Wing celebration.

11. AGENDA ITEM 20: BOARD COMMENTS

None.

12. AGENDA ITEM 21: ADJOURNMENT

Motion: To adjourn at 8:43pm.

Movant: Chen
Second: Watters
Ayes: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Watters, Zoglin
Noes: None
Abstentions: None
Absent: None
Recused: None

Meeting adjourned at 8:43pm

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

Shiraz Ali, Director

Prepared by: Shiraz Ali, Director
Summary of Financial Operations

Fiscal Year 2021 – Period 11
7/1/2020 to 05/31/2021
Executive Summary - Overall Commentary for Period 11

- Total gross charges, a surrogate for volume, were favorable to budget by $72.5M / 23.4% and $128.4M / 50.6% lower than the same period last year.
- Net patient revenue was favorable to budget by $14.8M / 18.4% and $24.6M / 34.7% higher than the same period last year.
- Operating expenses were $5.5M / 6.5% unfavorable to budget, which is primarily attributed to higher than expected volume versus budget and significant number of procedural cases performed in May.
- Operating margin was favorable to budget by $10.3M / 623.5% and $13.9M / 700.6% higher than the same period last year.
- Operating EBIDA was favorable to budget by $10.0M / 124.3% and $15.6M / 609.4% higher than the same period last year.
## Operational / Financial Results: Period 11 – May 2021 (as of 5/31/2021)

### Activity / Volume

<table>
<thead>
<tr>
<th></th>
<th>Current Year $</th>
<th>Budget $</th>
<th>Variance to Budget</th>
<th>Performance to Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADC</td>
<td>254</td>
<td>223</td>
<td>31</td>
<td>13.7%</td>
</tr>
<tr>
<td>Total Discharges</td>
<td>1,724</td>
<td>1,562</td>
<td>162</td>
<td>10.4%</td>
</tr>
<tr>
<td>Adjusted Discharges</td>
<td>3,270</td>
<td>2,883</td>
<td>387</td>
<td>13.4%</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>4,601</td>
<td>4,319</td>
<td>282</td>
<td>6.5%</td>
</tr>
<tr>
<td>OP Procedural Cases</td>
<td>13,397</td>
<td>8,282</td>
<td>5,115</td>
<td>61.8%</td>
</tr>
<tr>
<td>Gross Charges ($)</td>
<td>381,888</td>
<td>309,389</td>
<td>72,498</td>
<td>23.4%</td>
</tr>
</tbody>
</table>

### Operations

<table>
<thead>
<tr>
<th></th>
<th>Current Year $</th>
<th>Budget $</th>
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<th>Performance to Budget</th>
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</thead>
<tbody>
<tr>
<td>Total FTEs</td>
<td>2,919</td>
<td>2,692</td>
<td>227</td>
<td>8.4%</td>
</tr>
<tr>
<td>Productive Hrs. / APD</td>
<td>30.9</td>
<td>32.8</td>
<td>(1.9)</td>
<td>(5.7%)</td>
</tr>
<tr>
<td>Cost Per CMI Adjusted Discharge</td>
<td>15,165</td>
<td>17,507</td>
<td>(2,343)</td>
<td>(13.4%)</td>
</tr>
<tr>
<td>Net Days in A/R</td>
<td>51.7</td>
<td>49.0</td>
<td>2.7</td>
<td>5.6%</td>
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</table>

### Financial Performance

<table>
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<tr>
<th></th>
<th>Current Year $</th>
<th>Budget $</th>
<th>Variance to Budget</th>
<th>Performance to Budget</th>
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<tbody>
<tr>
<td>Net Patient Revenue ($)</td>
<td>95,542</td>
<td>80,704</td>
<td>14,838</td>
<td>18.4%</td>
</tr>
<tr>
<td>Total Operating Revenue ($)</td>
<td>100,927</td>
<td>85,201</td>
<td>15,726</td>
<td>18.5%</td>
</tr>
<tr>
<td>Operating Income ($)</td>
<td>11, 21</td>
<td>1, 4</td>
<td>12.3</td>
<td>623.5%</td>
</tr>
<tr>
<td>Operating EBIDA ($)</td>
<td>1, 13</td>
<td>1, 2</td>
<td>1, 4</td>
<td>124.3%</td>
</tr>
<tr>
<td>Net Income ($)</td>
<td>28,588</td>
<td>4,981</td>
<td>23,606</td>
<td>473.9%</td>
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<tr>
<td>Operating Margin (%)</td>
<td>11, 1</td>
<td>1, 1</td>
<td>10.7%</td>
<td>510.7%</td>
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<tr>
<td>Operating EBIDA (%)</td>
<td>1, 1</td>
<td>1, 1</td>
<td>14.1</td>
<td>543.2%</td>
</tr>
<tr>
<td>DCOH (days)</td>
<td>580</td>
<td>435</td>
<td>144</td>
<td>33.1%</td>
</tr>
</tbody>
</table>

### Performance to Moody’s Medians

<table>
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<tr>
<th></th>
<th>A1</th>
<th>Aa3</th>
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</thead>
<tbody>
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Moody’s Medians: Not-for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect monthly averages.

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%
### Operational / Financial Results: YTD FY21 (as of 5/31/21)

**Moody’s Medians:** Not for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect 11 month totals.

<table>
<thead>
<tr>
<th>Activity / Volume</th>
<th>Current Year</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>Performance to Budget</th>
<th>Prior Year</th>
<th>Variance to Prior Year</th>
<th>Variance to Prior Year</th>
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<tbody>
<tr>
<td>ADC</td>
<td>242</td>
<td>209</td>
<td>34</td>
<td>16.3%</td>
<td>228</td>
<td>14</td>
<td>6.4%</td>
</tr>
<tr>
<td>Total Discharges</td>
<td>17,368</td>
<td>15,765</td>
<td>1,603</td>
<td>10.2%</td>
<td>17,541</td>
<td>(173)</td>
<td>11.0%</td>
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<tr>
<td>Adjusted Discharges</td>
<td>32,789</td>
<td>29,232</td>
<td>3,557</td>
<td>12.2%</td>
<td>32,535</td>
<td>254</td>
<td>0.8%</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>46,439</td>
<td>40,762</td>
<td>5,677</td>
<td>13.9%</td>
<td>52,328</td>
<td>(5,869)</td>
<td>11.3%</td>
</tr>
<tr>
<td>OP Procedural Cases</td>
<td>147,978</td>
<td>95,074</td>
<td>52,904</td>
<td>55.6%</td>
<td>106,245</td>
<td>41,733</td>
<td>39.3%</td>
</tr>
<tr>
<td>Gross Charges ($)</td>
<td>3,901,178</td>
<td>3,112,958</td>
<td>788,220</td>
<td>25.3%</td>
<td>3,339,949</td>
<td>561,230</td>
<td>16.8%</td>
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<tr>
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<td>Total FTEs</td>
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<td>2,609</td>
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<td>8.6%</td>
<td>2,771</td>
<td>63</td>
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<td>Productive Hrs. / APD</td>
<td>31.2</td>
<td>33.9</td>
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<tr>
<td>Cost Per CMI Adjusted Discharge</td>
<td>16,876</td>
<td>18,300</td>
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<td>17,379</td>
<td>(503)</td>
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<td>Net Days in A/R</td>
<td>51.7</td>
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<td>5.6%</td>
<td>51.1</td>
<td>0.6</td>
<td>1.2%</td>
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<table>
<thead>
<tr>
<th>Financial Performance</th>
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<tbody>
<tr>
<td>Net Patient Revenue ($)</td>
<td>995,673</td>
<td>811,065</td>
<td>184,608</td>
<td>22.8%</td>
<td>881,951</td>
<td>113,722</td>
<td>12.9%</td>
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<tr>
<td>Total Operating Revenue ($)</td>
<td>1,039,398</td>
<td>861,459</td>
<td>177,939</td>
<td>20.7%</td>
<td>929,721</td>
<td>109,677</td>
<td>11.8%</td>
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<td>Operating Income ($)</td>
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<td>4,211</td>
<td>(6,525)</td>
<td>(163.3%)</td>
<td>2,321</td>
<td>41,2</td>
<td>162.9%</td>
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<td>Operating EBIDA ($)</td>
<td>142, 152.1</td>
<td>12, 122</td>
<td>(1,140)</td>
<td>-212.2%</td>
<td>2, -2</td>
<td>3</td>
<td>92.3%</td>
</tr>
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<td>Net Income ($)</td>
<td>287,378</td>
<td>4,802</td>
<td>282,577</td>
<td>5884.6%</td>
<td>58,603</td>
<td>228,776</td>
<td>390.4%</td>
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<tr>
<td>Operating Margin ($)</td>
<td>4.4</td>
<td>(3.2)</td>
<td>4.1</td>
<td>158.8%</td>
<td>2.4</td>
<td>3.0</td>
<td>135.2%</td>
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<tr>
<td>Operating EBIDA ($)</td>
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<th>Moody’s Medians</th>
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</table>

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%
APPENDIX
YTD FY21 Financial KPIs – Monthly Trends

Consolidated Operating Margin ($000s) Current & Prior Fiscal Year

Hospital Adjusted Discharges

Hospital Payor Mix

Consolidated Net Days in AR
### Period 11 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 5/31/2021)

($000s)

<table>
<thead>
<tr>
<th></th>
<th>Period 11- Month</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
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<tr>
<td>El Camino Hospital Operating Margin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mountain View</td>
<td>13,283</td>
<td>3,125</td>
<td>10,158</td>
<td>71,298</td>
<td>(9,770)</td>
<td>81,068</td>
</tr>
<tr>
<td>Los Gatos</td>
<td>1,410</td>
<td>1,427</td>
<td>(17)</td>
<td>29,950</td>
<td>16,177</td>
<td>13,773</td>
</tr>
<tr>
<td>Sub Total - El Camino Hospital, excl. Affiliates</td>
<td>14,694</td>
<td>4,552</td>
<td>10,142</td>
<td>101,248</td>
<td>6,407</td>
<td>94,841</td>
</tr>
<tr>
<td>Operating Margin %</td>
<td>15.4%</td>
<td>5.7%</td>
<td>10.3%</td>
<td></td>
<td>0.8%</td>
<td></td>
</tr>
<tr>
<td>El Camino Hospital Non Operating Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Total - Non Operating Income</td>
<td>15,649</td>
<td>3,028</td>
<td>12,621</td>
<td>212,390</td>
<td>28,829</td>
<td>183,560</td>
</tr>
<tr>
<td>El Camino Hospital Net Margin</td>
<td>30,343</td>
<td>7,580</td>
<td>22,763</td>
<td>313,637</td>
<td>35,236</td>
<td>278,401</td>
</tr>
<tr>
<td>ECH Net Margin %</td>
<td>31.7%</td>
<td>9.6%</td>
<td>31.9%</td>
<td></td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Concern</td>
<td>(79)</td>
<td>26</td>
<td>(104)</td>
<td>395</td>
<td>333</td>
<td>62</td>
</tr>
<tr>
<td>ECSC</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(3)</td>
<td>0</td>
<td>(3)</td>
</tr>
<tr>
<td>Foundation</td>
<td>808</td>
<td>(104)</td>
<td>911</td>
<td>6,157</td>
<td>(189)</td>
<td>6,346</td>
</tr>
<tr>
<td>El Camino Health Medical Network</td>
<td>(2,484)</td>
<td>(2,521)</td>
<td>36</td>
<td>(32,808)</td>
<td>(30,578)</td>
<td>(2,231)</td>
</tr>
<tr>
<td>Net Margin Hospital Affiliates</td>
<td>(1,755)</td>
<td>(2,599)</td>
<td>843</td>
<td>(26,259)</td>
<td>(30,434)</td>
<td>4,175</td>
</tr>
<tr>
<td>Total Net Margin Hospital &amp; Affiliates</td>
<td>28,588</td>
<td>4,981</td>
<td>23,606</td>
<td>287,378</td>
<td>4,802</td>
<td>282,577</td>
</tr>
</tbody>
</table>
### Consolidated Balance Sheet (as of May 31/2021)

($000s)

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>Audited</th>
<th>LIABILITIES AND FUND BALANCE</th>
<th>Audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>124,049</td>
<td>228,464</td>
<td>Accounts Payable</td>
</tr>
<tr>
<td>Short Term Investments</td>
<td>296,066</td>
<td>121,604</td>
<td>Salaries and Related Liabilities</td>
</tr>
<tr>
<td>Patient Accounts Receivable, net</td>
<td>161,773</td>
<td>128,564</td>
<td>Accrued PTO</td>
</tr>
<tr>
<td>Other Accounts and Notes Receivable</td>
<td>3,744</td>
<td>13,811</td>
<td>Worker’s Comp Reserve</td>
</tr>
<tr>
<td>Intercompany Receivables</td>
<td>20,565</td>
<td>72,592</td>
<td>Third Party Settlements</td>
</tr>
<tr>
<td>Inventories and Prepaids</td>
<td>23,528</td>
<td>101,267</td>
<td>Intercompany Payables</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>629,725</td>
<td>766,303</td>
<td>Malpractice Reserves</td>
</tr>
<tr>
<td><strong>BOARD DESIGNATED ASSETS</strong></td>
<td></td>
<td></td>
<td>Bonds Payable - Current</td>
</tr>
<tr>
<td>Foundation Board Designated</td>
<td>19,868</td>
<td>15,364</td>
<td>Bond Interest Payable</td>
</tr>
<tr>
<td>Plant &amp; Equipment Fund</td>
<td>245,596</td>
<td>166,859</td>
<td>Other Liabilities</td>
</tr>
<tr>
<td>Women’s Hospital Expansion</td>
<td>30,401</td>
<td>22,563</td>
<td></td>
</tr>
<tr>
<td>Operational Reserve Fund</td>
<td>123,838</td>
<td>148,917</td>
<td></td>
</tr>
<tr>
<td>Community Benefit Fund</td>
<td>19,683</td>
<td>17,916</td>
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</tr>
<tr>
<td>Workers Compensation Reserve Fund</td>
<td>16,482</td>
<td>16,482</td>
<td></td>
</tr>
<tr>
<td>Postretirement Health/Life Reserve Fund</td>
<td>31,728</td>
<td>30,731</td>
<td></td>
</tr>
<tr>
<td>PTO Liability Fund</td>
<td>32,007</td>
<td>27,515</td>
<td></td>
</tr>
<tr>
<td>Malpractice Reserve Fund</td>
<td>1,964</td>
<td>1,919</td>
<td></td>
</tr>
<tr>
<td>Catastrophic Reserves Fund</td>
<td>25,249</td>
<td>17,667</td>
<td></td>
</tr>
<tr>
<td><strong>Total Board Designated Assets</strong></td>
<td>546,815</td>
<td>465,933</td>
<td></td>
</tr>
<tr>
<td><strong>LONG TERM LIABILITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund Balance/Capital Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>2,059,433</td>
<td>1,771,854</td>
<td></td>
</tr>
<tr>
<td>Board Designated</td>
<td>193,881</td>
<td>188,457</td>
<td></td>
</tr>
<tr>
<td>Restricted</td>
<td>31,027</td>
<td>28,631</td>
<td></td>
</tr>
<tr>
<td><strong>Total Long Term Liabilities</strong></td>
<td>2,284,342</td>
<td>1,988,942</td>
<td></td>
</tr>
<tr>
<td><strong>PROPERTY AND EQUIPMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Assets at Cost</td>
<td>1,785,242</td>
<td>1,342,012</td>
<td></td>
</tr>
<tr>
<td>Less: Accumulated Depreciation</td>
<td>(737,181)</td>
<td>(676,535)</td>
<td></td>
</tr>
<tr>
<td>Construction in Progress</td>
<td>101,904</td>
<td>489,848</td>
<td></td>
</tr>
<tr>
<td><strong>Property, Plant &amp; Equipment - Net</strong></td>
<td>1,149,965</td>
<td>1,155,326</td>
<td></td>
</tr>
<tr>
<td><strong>DEFERRED OUTFLOWS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Assets at Cost</td>
<td>21,175</td>
<td>21,416</td>
<td></td>
</tr>
<tr>
<td>Less: Accumulated Depreciation</td>
<td>(46,700)</td>
<td>(46,700)</td>
<td></td>
</tr>
<tr>
<td>Construction in Progress</td>
<td>101,904</td>
<td>489,848</td>
<td></td>
</tr>
<tr>
<td><strong>Property, Plant &amp; Equipment - Net</strong></td>
<td>1,149,965</td>
<td>1,155,326</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>3,091,517</td>
<td>2,866,153</td>
<td></td>
</tr>
</tbody>
</table>
To:       El Camino Hospital Board of Directors
From:    Mark Adams, MD FACS, Chief Medical Officer
Date:    August 18, 2021
Subject: Mountain View Daytime Intensivist On-Call Professional Services Renewal Agreement

Recommendation: Finance Committee to recommend that the Board of Directors approve delegating to the Chief Executive Officer the authority to execute a three-year renewal agreement for daytime intensivist on-call professional services at the Mountain View campus at the existing rate of $1,980 per 12-hour shift to be effective September 1, 2021.

Summary:
1. Situation:
   - Palo Alto Medical Foundation ("PAMF") provides 12-hour on-site daytime (7:00 am to 7:00 pm) intensivist on-call professional services plus on-call surge physician coverage 365 days per year at the rate of $1,980 per 12-hour shift not to exceed $722,700 per year. In addition, ECH pays for the costs of each physician providing services to obtain EICU training and certification in neurocritical care not to exceed $1,200 per physician. The physicians under this arrangement have consistently provided excellent intensivist services with fifteen physicians participating on the panel. The current agreement expires August 31, 2021.
   - Nighttime intensivist services (7:00 pm to 7:00 am) will continue to be provided by the same physicians who recently formed a group called El Camino Anesthesia. ECH is contracted with El Camino Anesthesia for nighttime intensivist services effective August 1, 2021, as approved by the ECH Board of Directors on June 23, 2021.

2. Authority: According to Administrative Policies and Procedures 51.00, Finance Committee recommendation and Board approval are required prior to the Chief Executive Officer's execution of physician agreements that exceed $250,000 in annual compensation and exceed the 75th percentile for fair market value.

3. Background: PAMF has provided on-site daytime intensivist on-call professional services at the Mountain View campus since September 2012.

4. Fair Market Value Assessment: The Hospital has obtained a fair market value opinion from a third party consultant confirming that $1,980 per 12-hour shift not to exceed $722,700 per year plus $1,200 per physician to obtain EICU certification is at the 82nd percentile for fair market value.

5. Other Reviews: Legal and Compliance will review the final amendment and compensation terms prior to CEO execution.

6. Outcomes: Physicians will participate in the peer review process for consultations related to intensivist on-site services.

List of Attachments: None

Suggested Committee Discussion Questions: None
To: El Camino Hospital Board of Directors
From: Carlos Bohorquez, Chief Financial Officer, Jim Griffith, Chief Operating Officer
Date: August 18, 2021
Subject: Satellite Healthcare Joint Venture Funding Request

Purpose:

At the August 9th Finance Committee meeting, management presented an overview of the performance of the Joint Venture (‘JV’) with Satellite Healthcare and reviewed the business case for an investment in a new Dialysis center located in North Sunnyvale.

1. Recommendation:

The Finance Committee is recommending that the Board of Directors approve funding not to exceed $1.98 million for 30% ownership in the new center and authorize the CEO to execute the operating and other agreements required to enter into this new JV with Satellite Healthcare.

2. Summary:

   a. Situation:

   • The following is an overview of the JV with Satellite Healthcare

   i. ECH entered into a JV with Satellite Healthcare to operate outpatient dialysis facilities in the community. The transaction was completed in February 2015.

   ii. Both organizations meet quarterly to review operating, quality, and financial metrics.

   iii. Satellite Healthcare’s quality and patient satisfaction star ratings as reported by CMS compare favorably to national averages.

   iv. The quality and financial performance of the JV have been at or close to performance targets. Management continues to work with Satellite Healthcare to ensure any measure(s) which are below target are an area of focus.

   □ Authority: Policy requires that capital expenditures exceeding $1 million need Finance Committee and Board of Directors approval.

   c. Background: Management has been in discussion with Satellite Healthcare on an investment of $1.98 million for a 30% ownership of a new center located in North Sunnyvale.

3. List of Attachments:

   a. One

4. Suggested Board Discussion Questions:

   a. Does the request to invest in a new center align with our strategy?

   □ When is the new center expected to begin operations?
EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Apurva Marfatia, MD, Enterprise Chief of Staff
       Michael Kan, MD Chief of Staff Los Gatos
Date: August 18, 2021
Subject: Medical Staff Report – Open Session

Recommendation:

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

Summary:

1. Situation: The Medical Executive Committee met on June 24, 2021

2. Background: EC received the following informational reports.

   A. Quality Council – The Quality Council met on June 2, 2021. Reports and performance dashboards were reviewed and approved from the following ECH departments/service lines:
      i. Annual PI Report
      ii. PC and OP Perioperative dashboard
      iii. Annual PI Report Stroke Program 2021
      iv. Stroke Program dashboard 2021
      v. 2021 Annual Performance Improvement Report
      vi. Palliative Care Dashboard 2021

   B. Leadership Council – The Leadership Council met on June 8, 2021 and discussed the following:
      i. Bylaws/Rules and Regulations/Committees (excluding Leadership Council)
      ii. ER to ICU Handoff Policy
      iii. Maternal Child Health Update
      iv. Finances
      v. Felicitation of Retirees 2020-2021
      vi. Bylaws Committees/Leadership Council
      vii. Medical Staff Committee Chairs
      viii. Ethics & Wellness Committee

   C. The COO Report was provided and included the following updates:
      i. Employees of ECH are 92% vaccinated
      ii. Visitor Policy update
      iii. Update on vaccination site
      iv. Santa Clara County is the most vaccinated county with larger than 1 million population
      v. Chief Human Resources Office is on LOA. Greg Souza has been brought on board
      vi. Los Olivos group transition is going well

   D. The CMO Report was provided and included the following updates:
      i. DEB presentation given by Carol Somersille, Diego Rodriguez, Beth Shafran

List of Attachments: None

Suggested Board Discussion Questions: None
MEDICAL STAFF - PEDIATRICS
FOCUSED PROFESSIONAL PRACTITIONER EVALUATION (FPPE)

Date:

Practitioner Name:  ID #:
- New Applicant
- Request Additional Privilege(s)
- For Ongoing Professional Practice Evaluation

Proctoring Required:

<table>
<thead>
<tr>
<th>Name of Privilege/Procedure</th>
<th>Type of Observation/Review</th>
<th>Number of Cases Proctored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Admissions/Consults</td>
<td>Concurrent and/or Retrospective Review</td>
<td>3</td>
</tr>
<tr>
<td>Pediatric Circumcision (initial applicant)</td>
<td>Direct Observation – proctor must be present at start of case</td>
<td>5</td>
</tr>
<tr>
<td>Pediatric Circumcision (reappointment: 10 cases not performed)</td>
<td>Direct Observation – proctor must be present at start of case</td>
<td>2</td>
</tr>
<tr>
<td>Frenotomy</td>
<td>Direct Observation – proctor must be present at start of case</td>
<td>2</td>
</tr>
</tbody>
</table>

Name(s) of Proctors: Any ECH pediatrician with Active Staff Privileges (roster attached). At least one case should be proctored by someone who is not an associate.

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 have 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 PPE 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
ARTICLE 3
MEMBERSHIP

3.1 NATURE OF MEMBERSHIP
Membership in the Medical Staff and/or clinical privileges shall be extended only to professionally
competent practitioners who continuously meet the qualifications, standards and requirements set
forth in these Bylaws. Appointment to and membership in the Medical Staff shall confer on the
member only such clinical privileges and prerogatives as have been granted by the Board of Directors
in accordance with these Bylaws. Except as otherwise specified herein, no practitioner shall admit or
provide services to patients in the Hospital unless he/she is a member of the Medical Staff or has been
granted temporary privileges in accordance with the procedures set forth in these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP
3.2-1 GENERAL QUALIFICATIONS
In order to receive an application for appointment to the medical staff or clinical privileges, applicants
must first complete a pre-application questionnaire and meet the following general qualifications:

(a) Be a graduate from a school of medicine, osteopathy, dentistry or podiatry recognized or
approved by the Medical Board of California.

(b) Hold Education Commission of Foreign Medical Graduate (ECFMG) certification; if
applicable.

(c) Demonstrate completion of residency program, approved by the Accreditation Council for
Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of
Canada, or American Osteopathic Association.

1. Podiatrists must have successfully completed a two (2) or three (3) year residency
program in podiatric medicine and surgery approved by Council on Podiatric Medical
Education of the American Podiatric Medical Association.

2. Dentists must have successfully completed a post graduate program in hospital
dentistry approved by American Dental Association and accredited by the
Commission on Dental Accreditation.

3. Oral Maxillofacial Surgeons must have successfully completed a post-graduate
program in oral and maxillofacial surgery approved by the American Board of Oral
and Maxillofacial Surgery.

(d) Have active board certification in his/her primary specialty (or if recently completed
residency/fellowship, will become board certified within five (5) years of completion of
residency/fellowship). **Honorary/Emeritus Exempt from Board Certification.** Boards
accepted include the following (or verifiable equivalent*):

1. American Board of Medical Specialties or American Board of Osteopathic
Specialties

2. American Board of Foot and Ankle Surgery for DPMs or American Board of
Podiatric Medicine

3. American Board of Oral & Maxillofacial Surgery for Oral Maxillofacial Surgeons

4. American Board of General Dentistry or American Board of Pediatric Dentistry

*Verifiable Equivalency: Equivalency shall include, but not be limited to board certification
from another certifying body, as evaluated and determined by the Department Chief and
presented in writing, for consideration by the Credentials Committee for recommendation to
the MEC and Governing Board.

(c) Have a current and active license to practice medicine in the state of California.

(f) Have a current DEA certificate or furnishing number to prescribe controlled substances as applicable.

(g) Provide documented practice of clinical medicine within the past 24 months.

(h) During the past seven (7) years, the practitioner may not:
   1. Have had medical staff membership or any clinical privileges denied or terminated by the medical staff of another hospital, ambulatory surgery center (ASC), or healthcare facility;
   2. Have had adverse action taken by any state licensing board (for example the Medical Board of California) to include letters of reprimand, probation or any more significant adverse action;
   3. Been convicted of a felony or misdemeanor (other than a minor traffic violation); or taken a plea in exchange for not taking a felony conviction;
   4. Been sanctioned by Medicare/Medicaid or placed on the Office of Inspector General’s (OIG) list of excluded individuals/entities.

(i) Once the applicant qualifies as noted above and an application has been received, additional qualifications to meet include:
   1. Documentation of adequate experience, education, and training, current professional competence, good judgment, and current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to fulfill the responsibilities of the Medical Staff membership and/or specific privileges requested and that patients treated by them can reasonably expect to receive quality medical care.
   2. Applicant agrees to:
      1. adhere to the ethics of their respective profession;
      2. work cooperatively with others so as not to adversely affect patient care;
      3. keep as confidential, as required by law, all information or records received in the physician-patient relationship;
      4. participate in and properly discharge those responsibilities determined by the Medical Staff; and
      5. 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 Board of Directors and Medical Staff Executive Committee from time to time.
ARTICLE 4
CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES
The categories of the Medical Staff shall include the following: Active, Provisional, Consultant, Affiliate and Emeritus.

4.2 ACTIVE STAFF
4.2-1 QUALIFICATIONS
The Active Staff shall consist of practitioners who meet the qualifications set forth in Section 3.2. It is recognized that even though physicians may not admit patients to the hospital, they may wish to remain involved in the hospital and medical staff's functions.

There are two (2) ways to satisfy the activity requirements for Active Staff membership:
(a) 11+ patient contacts per year (defined below *)
(b) A practitioner who wishes to serve on the ER call panel or otherwise participate in medical staff functions may request that the Medical Staff Executive Committee appoint him/her to the Active Staff for this purpose. Active Staff membership may be granted by the Medical Staff Executive Committee for as long as the practitioner is involved in medical staff functions.

*Patient contact is defined as an admission, attending (including inpatient visit with progress note), discharge, surgical assist, ED short stay, ED discharge, consultation or an inpatient or outpatient surgical procedure at the hospital.

4.2-2 PREROGATIVES
The prerogatives of an Active Medical Staff member shall be to:
(a) Provide patient care consistent with his/her privileges unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.
(b) Exercise such clinical privileges as are granted to him/her pursuant to Article 6.
(c) Hold office in the Medical Staff and in the department and committees of which he/she is a member, and serve on committees, unless otherwise provided in the Medical Staff Bylaws.
(d) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.2-3 RESPONSIBILITIES
Each Active Medical Staff member shall:
(a) Meet the basic responsibilities set forth in Section 3.5.
(b) Actively participate in and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of his/her professional competence, including, but not limited to, emergency service and backup function **, peer review, utilization management, case management, quality evaluation and related monitoring activities required of the Medical Staff in supervising and proctoring initial appointees and allied health practitioners, and in discharging such other functions as may be required by the Medical Staff Executive Committee from time to time.
(c) Participate in such emergency service coverage or consultation panels as may be determined by the Medical Staff.

** Emergency Service and backup function – practitioners will be responsible for providing continuous care for his/her patients at the campus they have designated as their “primary” campus
improve and optimize health care.

(d) 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 membership status and/or prerogatives, or clinical or admitting privileges 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.

(e) Information pertaining to the applicant's professional liability insurance coverage, any professional liability claims that have been lodged against him/her, the status or outcome of such matters, and final judgments or settlements.

(f) 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.

(g) Information as to details of any prior or pending government agency or third party payor 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, not to include usual and customary withhold denials from insurance payors.

(h) Information pertaining to the condition of the applicant's physical and mental health necessary to determine the applicant’s current ability to perform the clinical privileges requested.

(i) Certification of the applicant's agreement to terms and conditions set forth in Section 5.2-2 regarding the effect of the application.

(j) An acknowledgment that the applicant has received (or has been given access to) the Medical Staff Bylaws and Rules and Regulations, that he/she has received an explanation of the requirements set forth therein and of the appointment process, and that he/she agrees to be bound by their terms thereof, as they may be amended from time to time, if he/she is granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of this application.

(k) The applicant shall also identify the clinical Department, and clinical privileges for which the applicant wishes to be considered. Each applicant for membership shall pay a non-refundable application fee in the amount established by the Medical Staff Executive Committee pursuant to Section 14.3.

5.2-2 EFFECT OF APPLICATION
By applying for appointment to the Medical Staff each applicant:
(a) signifies willingness to appear for interviews in regard to the application;
(b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
(c) consents to inspection and copying of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
(d) releases from any liability, to the fullest extent provided by law, all persons for their acts
performed in connection with investigating and evaluating the applicant;

(e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or Medical Staff may have, and releases the Medical Staff and hospital from liability for so doing to the fullest extent permitted by law;

(g) consents to have a background check performed at initial and reappointment. The background check will include County criminal records search, Statewide criminal search, National criminal file search, Federal criminal records search, Federal Bankruptcy Court search and Sexual Offender Registry search;

(h) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;

(i) agrees to provide for continuous professional care for patients;

(j) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to nonqualified or inadequately supervised practitioners; and

(k) pledges to be bound by the Medical Staff bylaws, rules and regulations, and policies.

(l) agrees that so long as he/she is an applicant/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 Medical Staff Bylaws and Rules and Regulations, and of his/her compliance with standards and criteria set forth in the Medical Staff Bylaws and Rules and Regulations, and for resolving any doubts about these matters. The application will not be considered complete until all information requested of the applicant or other sources has been received and the verifications under Section 5.3-2 have been completed. The provision of information containing misrepresentations or omissions, and/or a failure to sustain the burden of producing adequate information, shall be grounds for ineligibility for Medical Staff membership and 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 (or member). The resulting report shall be placed in the applicant’s/member’s credential file. 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 accomplished, the Medical Staff Services Office shall transmit
information as to continuing education activities during the past two (2) years and whether the applicant requests any change in his/her staff status and/or in his/her clinical privileges, including any reduction, deletion, or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same. 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 Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital 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 membership status and/or prerogatives, or clinical or admitting privileges 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 including information regarding the practitioner’s experience, ability, and current competence with regard to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice (see 5.2 (c) for details regarding these competencies). The Medical Staff Services Office shall transmit the completed reappointment application form and supporting materials to the chief of each department in which the staff member has or requests privileges.

5.4-3 DEPARTMENT ACTION
(a) The department Vice-Chairs, or designee chief shall review the application and the staff member’s file and shall convey transmit his/her recommendations to the Credentials Committee Medical Staff Executive Committee his/her written report and recommendations, which are prepared in accordance with Section 5.4-5. Concerns if any can be discussed and reviewed with the appropriate Medical Directors or with the Department Executive Committees. This may include a recommendation for change in staff category, change or no change in clinical privileges, or reappointment for one year, based on departmental guidelines.
(b) The following applies to the review of information in the Medical Staff member’s credentials file at the time of reappraisal or reappointment.
1. Prior to recommendation on reappointment the Department Chief, as part of the reappraisal function, shall review information in the credentials file pertaining to a member.
2. Following this review, the Department Chief, after consultation with the Department Executive Committee, shall determine whether documentation in the file warrants further action.
3. With respect to adverse information, if it does not appear that an investigation and/or adverse recommendation on reappointment is warranted, the Department Chief shall so inform the Medical Staff Executive Committee.
4. However, if an investigation and/or adverse recommendation on reappointment is warranted, the Department Executive Committee shall so inform the Medical Staff Executive Committee and shall proceed appropriately with such investigation as part of the reappointment process.
5.4-4 CREDENTIALS COMMITTEE ACTION
The Credentials Committee shall review recommendations of the department Vice-Chair or designee and any relevant supporting information in the reapplication. Any outstanding issues shall be resolved. The Credentials Committee shall make their recommendations to the Medical Executive Committee.

5.4-5 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION
The Medical Staff Executive Committee shall review the Credentials Committee recommendations and any other relevant information available to it, and shall forward to the Board of Directors, through the Administrator/Chief Executive Officer, its favorable reports and recommendations, prepared in accordance with Section 5.4-5.

If the Medical Staff Executive Committee recommends adverse action, as defined in Section 8.2, either in respect to reappointment or clinical privileges, the Chief of Staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2, and the applicant shall be entitled to the procedural rights as provided in Article 8.

The Board of Directors shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his/her procedural rights.

Thereafter, the procedures specified in Sections 5.3-8 (Action by the Board of Directors), 5.3-9 (Notice of Final Decision) and 5.3-10 (Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action) shall be followed. The Committee may also defer action; however, any such deferral must be followed up within seventy (70) days with a subsequent recommendation. In the case of adverse decision regarding appointment to the Medical Staff and after exhaustion or waiver of the applicant's procedural rights, a report shall be made to the Medical Board of California and to the National Practitioner Data Bank.

5.4-6 REAPPOINTMENT REPORTS
The department Vice-Chairs 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. If reappointment request is accompanied by request for additional privileges, then this request must be reviewed by the specific department/division/committee monitoring such privileges who will specify in writing whether the request for additional privileges should be granted. Each report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, department affiliation, and/or clinical privileges, or terminated. Where non-reappointment, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

5.4-6 BASIS FOR REAPPOINTMENT
Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member 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 these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession, with
6.3 PROFESSIONAL PRACTICE

6.3-1 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE), for additional information regarding FPPE process, see Medical Staff Policy 13.5.1

(a) FOR INITIAL APPOINTMENTS
Except as otherwise determined by the Medical Staff Executive Committee, all practitioners initially appointed to the Medical Staff shall complete a period of proctoring. Proctoring may include concurrent or retrospective review of a practitioner’s competence depending upon the nature of the privileges requested. Each initial appointee shall be assigned to a department where his/her performance shall be proctored by the chief of the department, or his/her designee, during the term of proctoring required by that department, to determine the initial appointee’s eligibility for continued Medical Staff membership in the category to which he/she was appointed and to exercise the clinical privileges initially granted in that department. If Hospital utilization is insufficient to permit necessary evaluation of a practitioner’s performance, a Department may review the practitioner’s clinical care provided in the office or in another hospital or healthcare institution. His/her exercise of clinical privileges in any other department shall also be subject to proctoring by that department's chief, or his/her designee, for the term of proctoring required by that department.

(b) MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT
On its own, upon recommendation of the Department Chief, or pursuant to a request from the member, the Medical Staff Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The executive committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to performance monitoring.

(c) TERM OF PROCTORING PERIOD
Each department will establish terms for proctoring with a minimum number of cases, and/or a specific number of cases applicable to particular clinical privileges, whenever such requirements are appropriate in view of the clinical privileges which are involved. The period of proctoring may be extended in increments of not more than six (6) months each, for a total proctoring period of not more than (12) twelve months. If an initial appointee fails within that period to complete the applicable minimum number of cases and/or to furnish the certifications required in Section 6.3-1, his/her Medical Staff particular clinical privileges, as applicable, shall be relinquished. If a Medical Staff member requesting modification fails within that period to complete the minimum number of cases and/or furnish the certifications required in Section 6.3-1, the change in Medical Staff category or Department assignment or the additional privileges, as applicable, shall be relinquished. The practitioner will be given written notice at least 30 days in advance that his/her Medical Staff clinical privileges will be relinquished because he/she failed to satisfactorily complete the proctoring requirements. In such circumstances, the affected practitioner has no right to a hearing pursuant to Section 8.3-2.

(d) 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.
6.3-2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE), for additional information regarding OPPE process see Medical Staff Policy 13.5.2
(a) 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 assess and ensure current clinical competence of medical staff members as part of El Camino Hospital’s commitment to quality.
(b) Policy: OPPE is conducted on an ongoing basis and will include review of performance data for all practitioners with clinical privileges at ECH.

6.3-3 Corrective Actions (Refer to Article 7 of the Bylaws) and Medical Staff Corrective Action Policy (Policy # 8802752)

6.3-4 Behavioral Policy – Refer to Medical Staff Code of Conduct and Professional Behavior Policy (Policy # 8425638)

SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES AS DIRECTED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE
(a) Requests for clinical privileges from dentists and podiatrists shall be processed in the same manner as specified in Section 6.2. Surgical procedures performed by dentists and podiatrists shall be under the supervision of the chief of their respective departments. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services.
(b) Admission history and physical examination on dental and podiatric patients must be performed and recorded in the hospital record in accordance with Rules and Regulations B – History & Physicals (included at the end of these Bylaws).
(c) The treating dentist or podiatrist must, when indicated, request consultation and medical management from the admitting staff physician or any physician staff member.

6.5 TEMPORARY PRIVILEGES
6.5-1 CIRCUMSTANCES
The Chief Executive Officer, or his/her designee, upon the recommendation of the Department Chief, when available, or the Chief of Staff in all other circumstances, may grant temporary privileges with or without medical staff membership to a practitioner, subject to the conditions set forth in Section 6.5-2 below, in the following circumstances:
(a) Pendency of Application: Temporary privileges may be granted upon the recommendation of the department chief for a period not to exceed 120 days when a new applicant with a complete application that raises no significant concerns is awaiting review and approval of the Medical Staff Executive Committee and Board of Directors. The minimum processing time is expected to be 72 business hours after submission of all the documents. The following items must be verified:
- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- NPDB report
- Complete application with paid application fee
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

(b) Non-applicants for Medical Staff Membership: Temporary privileges may be granted to a non-applicant for medical staff membership to meet an important patient care need (as determined by the Chief of Staff and applicable Department Chair) not met by current medical staff members. Such privileges require verification of licensure without limitation or probation, professional
ARTICLE 11
COMMITTEES

11.1 GENERAL

There will be enterprise committees (those serving all campuses, including MV and LG campuses) and campus-specific committees. The enterprise committees are designated as such – all others are campus-specific. Enterprise committees will have appropriate representation from members of both campuses. All other Medical Staff Committees are listed in Appendix 2 to the Rules and Regulations.

11.1-1 DESIGNATION AND SUBSTITUTION

The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the members of such committees and the chairman of such committees shall be appointed by the MV or LG Chief of Staff if the committee is a campus-specific committee; by the Enterprise Chief of Staff if an enterprise committee and is subject to Medical Staff Executive Committee approval. Unless specified, non-Medical Staff committee members shall be appointed by the Chief Executive Officer or his/her designee, subject to approval by the Medical Staff Executive Committee. Medical staff committees shall be responsible to the Medical Staff Executive Committee. In addition, special committees may be created by the Medical Staff Executive Committee on an ad hoc basis to perform specified tasks. The members of special committees shall also be appointed by the Enterprise, MV, or LG Chief of Staff as appropriate, and is subject to the Medical Staff Executive Committee's approval.

11.1-2 TERMS of APPOINTMENT AND REMOVAL OF CHAIRS AND COMMITTEE MEMBERS

Unless otherwise specified, a chair or any committee member shall be appointed for a term of one (1) year and shall serve until the end of this period and until his/her successor is appointed, unless he/she shall sooner resign or be removed from the committee. A Chair must be an active member of the medical staff in good standing and will be appointed by the Enterprise Chief of Staff with unlimited extensions as long as the chair remains eligible and is approved by the MEC. Committee members will be appointed by the Enterprise Chief of Staff in consultation with the Chair with unlimited extensions as long as the member remains eligible and approved by the MEC. Any chair or committee member who is appointed by the Enterprise, MV, or LG Chief of Staff as appropriate may be removed by a majority vote of the Medical Staff Executive Committee. Any committee member who is appointed by the Department Chief may be removed by a majority vote of the Department Executive Committee or the Medical Staff Executive Committee. The removal of any committee member who is automatically assigned to a committee because he/she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official pursuant to Article 10, Section 10.1-7. There will be up to four (4) at-large members elected by the Medical Staff for the MEC to ensure balanced representation of both campuses. Two (2) at-large members will be elected from the Mountain View campus and two (2) from the Los Gatos campus. All the at-large members shall be elected for three (3) year terms.

11.1-3 VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made. Vacancies resulting from resignations or retirements between election periods will be filled by the Enterprise Chief of Staff in consultation with leadership Council members and to be approved by the MEC.
11.1-4 CONDUCT AND RECORDS OF MEETINGS
Committee meetings shall be conducted and documented in the manner specified for such meetings in Article 12.

11.1-5 VOTING
Practitioners in all categories may vote on committees to which they have been appointed.

11.2 PRACTITIONER'S EXCELLENCE COMMITTEE

11.2-1 COMPOSITION OF COMMITTEE
The committee shall be a multidisciplinary peer review committee and shall include voting and non-voting members. This is further described in the PEC Policy and Procedures document. The Physician members including chair will be appointed per Article 11.1-2 of the bylaws.

11.2-2 DUTIES
(a) The duties of the PEC are described in the PEC Policy and Procedures document.
(b) The Chair of the PEC shall be an ex-officio member of the MEC. The other members of the PEC cannot hold any other position that gives membership to the MEC.

11.2-3 MEETINGS
(a) The meetings and requirements are described in the PEC Policy and Procedures document.

11.3 CREDENTIALS COMMITTEE

11.3-1 COMPOSITION
(a) The Credentials Committee shall consist of all Department Vice Chairs appointed at-large members and the Chair of the Interdisciplinary practice Committee (IDPC) and a number of sufficient members at-large as needed to ensure with balanced representation from all departments. The Physician members including chair will be appointed per Article 11.1-2 of the bylaws.
(b) Further details shall be found in the Credentials Policy and Procedure document and Appendix B of the Rules and regulations.

11.3-2 DUTIES
(a) The duties of the credentials committee are described in the Credentials Policy and Procedure document.
(b) The Chair of the Credentials Committee shall be an ex-officio member of the MEC.

11.3-3 MEETINGS
The meetings and requirements are described in the Credentials Policy and Procedure document.
11.4 LEADERSHIP COUNCIL – Enterprise Committee

11.4-1 COMPOSITION
The Leadership Council shall be comprised of the Chiefs of Staff from MV and LG campuses, Vice Chiefs of Staff from MV and LG campuses, and Immediate Past Chiefs of Staff from MV and LG campuses. The Chief Medical Officer and Director of Medical staff services or designee shall be an ex-officio member (no vote). Support personnel will include the Director of the Medical Staff Services (ex-officio, no vote).

11.4-2 CHAIR
The committee will be chaired by the Enterprise Chief of Staff (Chief of Staff MV).

11.4-3 DUTIES
(a) Serve as the Nominating Committee for the Medical Staff Officer Elections. Submit nominations for both MV and LG Chiefs of Staff and LG Vice-Chiefs of Staff as required by the Bylaws.
(b) Review the Bylaws and the rules, regulations, procedures, and forms promulgated in connection therewith as necessary.
(c) Submit recommendations to the Medical Staff Executive Committee and to the Board of Directors for changes in these documents as necessary to reflect current medical staff practices.
(d) Receive and consider all matters referred to this body as may be referred by the Board of Directors, the Medical Staff Executive Committee, the Departments, the Chiefs of Staff and the Chief Executive Officer or designee.
(e) Investigate and resolve level 2 and above breach in code of conduct and behavioral issues of medical staff with recommendations to the MEC.
(f) Review and Recommend Chairs and committee membership to MEC.
(g) Wellness, CME and Ethics Chairs will report directly to leadership Council and MEC.
(h) To review any patient care quality related issues.

11.4-4 MEETINGS
Leadership Council will meet as needed which could be as often as monthly (determined by the Chair).

11.4-5 REPORTING REQUIREMENTS
Leadership Council reports directly to the Medical Staff Executive Committee with regard to activity/reviews performed, recommendations made, actions taken.

11.5 MEDICAL STAFF EXECUTIVE COMMITTEE (MEC) – Enterprise Committee

11.5-1 COMPOSITION
The Medical Staff Executive Committee members shall consist of:
(a) The general officers of the Medical Staff as listed in Section 10.1-1; The Chair of Medical Staff Executive Committee will be the MV Chief of Staff. The Chair of Medical Staff Executive Committee will act as the Enterprise Chief of Staff.
(b) The department chairs of the three Medical Staff Departments. If the department chair is unable to attend a Medical Staff Executive Committee, a Department Vice Chair may attend and vote in both General and Executive sessions.
(c) There will be up to four (4) at-large members elected by the Medical Staff to ensure balanced representation of both campuses. Two (2) at-large members will be elected from the
Mountain View campus and two (2) from the Los Gatos campus. Two of the at-large members shall be elected for a two (2) year term for the first term. This term shall last from July 1, 2020 till June 30, 2022. The other two-at- large shall be elected for a three (3) year term. Subsequently, after the completion of the first terms all the at-large members shall be elected for three (3) year terms.

The following shall be ex-officio non-voting members of the MEC:
(a) The Chief Executive Officer (CEO);
(b) The Chief Medical Officer (CMO);
(c) The Chair of the Practitioner Excellence Committee;
(d) The Chair of the Credentials Committee;
(e) The Chief Operating Officer (COO);
(f) The Chief Nursing Officer (CNO);
(g) The Chief Quality Officer (CQO) and;
(h) The Chair of Quality Council

All members of the Active Medical Staff, of any discipline or specialty, are eligible for membership on the Medical Staff Executive Committee.

11.5-2 DUTIES
The duties of the Medical Staff Executive Committee (MEC) shall be to:
(a) Represent and to act on behalf of the organized medical staff in the absence of a general staff meeting subject to such limitations as may be imposed by these Bylaws.
(b) The Medical Staff Executive Committee shall recommend Bylaws amendments to the organized medical staff for approval in accordance with Article 15 of these Bylaws.
(c) The Medical Staff Executive Committee shall formulate, review, and propose to the Board of Directors any medical staff rule, regulations, policies/procedures, and amendments as needed and in accordance with Article 15 of these Bylaws.
(d) Coordinate the activities and general policies of the Medical Staff not otherwise established as the responsibility of the Departments.
(e) Receive and act upon Department, Division, and committee reports and requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant’s ability to perform the privileges requested.
(f) Implement policies of the Medical Staff not otherwise the responsibility of the Departments.
(g) Provide liaison between the Medical Staff and the Administrator/Chief Executive Officer and the Board of Directors.
(h) Recommend action to the Administrator/Chief Executive Officer/Board of Directors on matters of a medico-administrative nature.
(i) Make recommendations on Hospital management matters, such as long-range planning, to the Board of Directors through the Administrator/Chief Executive Officer.
(j) Fulfill the Medical Staff's responsibility of accountability to the Board of Directors for the medical care rendered to patients in the Hospital.
(k) Assure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.
(l) Review the credentials of applicants through Department Chief reports and make recommendations to the Board of Directors for staff membership, assignments to departments, delineation of clinical privileges, disciplinary actions, and terminations.
(m) Review periodically all information available regarding the performance and clinical competence of staff members, other practitioners, and allied health practitioners with practice privileges, and as a result of such review, make recommendations for reappointments and renewals or changes in clinical or practice privileges.
Take all reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and allied health practitioners including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

Review and appoint Hospital's authorized representative for reporting purposes to the National Practitioner Data Bank.

Perform such other functions as may be assigned to it consistent with these Bylaws, by the Medical Staff, or by the Board of Directors.

Establish a mechanism for dispute resolution between Medical Staff members (including limited license practitioners) involving the care of a patient.

Makes recommendations directly to the Board of Directors with regard to the organized medical staff's structure.

Provide oversight in the process of analyzing and improving patient, physician, and employee satisfaction.

Monitors the quality of medical histories and physical examinations.

11.5-3 MEETINGS
Monthly or at the discretion of the chair.

11.6 PHYSICIAN HEALTH & WELL-BEING COMMITTEE – Enterprise Committee

11.6-1 COMPOSITION
The committee will at least be composed of licensed independent practitioners members of the medical staff. There will be a Chair and four (4) multiple at-large members as deemed necessary by the chair. Further details may be found in the Medical Staff Committee and Policy and Procedures. The Physician members including chair will be appointed per Article 11.1-2 of the bylaws.

11.6-2 DUTIES
The duties of the Physician Health and Well-Being Committee may be found in the Medical Staff Committees Policy and Procedures.

11.6-3 RECORDS/REPORTING
The details of records and reporting may be found in the Medical Staff Committees Policy and Procedure.

11.6-4 MEETINGS
At least quarterly, or more often if necessary.

11.7 QUALITY COUNCIL – Enterprise Committee

11.7-1 COMPOSITION
The committee shall be composed of the Chair, the Enterprise Department Chairs, and the appropriate Service Line Leaders as determined by the Committee and the Enterprise Chief of Staff. The Enterprise Chief of Staff will appoint at large members to ensure balanced representation of campuses. Ex officio members shall include the Chief Medical Officer and the Chief Quality Officer, and Chief Nursing Officer. The committee will be co-chaired by the Chief Medical Officer and an active member of the Medical Staff appointed by the Enterprise Chief of Staff. The Physician members including chair will be appointed per Article 11.1-2 of the bylaws. Additional details per appendix 2 of the Rules and Regulations.
11.7-2 DUTIES
The details regarding duties of the Quality Council may be found in the Medical Staff Committees Policy and Procedure.

11.8 THE INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC) – Enterprise Committee

11.8-1 COMPOSITION
The details may be found in the Medical Committee Policy and Procedures. The Physician members including chair will be appointed per Article 11.1-2 of the bylaws

11.8-2 DUTIES
The details may be found in the Medical Committee Policy and Procedures.

11.9 DEPARTMENT EXECUTIVE COMMITTEES – Enterprise Committee

11.9-1 COMPOSITION
Each department designated in Article 9 shall have a Department Executive Committee. The committee shall be composed of the Department Chair, Department Vice-Chairs and Medical Directors pertaining to each Department. The Department Vice-Chair will select other members that are representative of the specialties and sub-specialties within the department whenever possible.

11.9-2 DUTIES
Each Department Executive Committee shall assist the Chief of the Department to carry out the functions described in Article 9.

11.9-3 MEETINGS
As often as necessary but at least quarterly.

11.10 CAMPUS SPECIFIC OPERATIONS COMMITTEES – (MVOC & LGOC)

11.10-1 COMPOSITION
The Chair shall be the campus specific Chief of Staff (MVCOS, LGCOS). The members shall include the campus specific vice-chief of staff (MVVCOS, LGCOS), the campus department Vice-Chairs and any members at large deemed necessary by the Chair. The COO and CMO shall be ex-officio on both campus operations committees.

11.10-2 DUTIES
Assist El Camino Health with appropriate operation decisions, implementations and quality improvement activities as is appropriate to the specific campus.

Other Medical Staff Committees are identified and detailed in the Medical Staff Committees and Policy and Procedure.
Operations

July patient volumes continued last month’s positive growth trend. Many areas saw increased volumes as more patients chose El Camino Health (ECH) for care including areas such as ED visits and deliveries.

ECH initiated two major operational improvement projects. The first focuses the effective use of observation patient hours. The second one focuses on enhancing the efficiencies within the surgical services at both hospitals.

Finance

We finalized our 2021 fiscal year end close process and will begin the annual audit process with our external auditors Moss Adams, LLP.

Human Resources

In support of the Inclusion-Diversity-Equity and Belonging (I-DEB) committee’s initiative to educate the organization to help foster a shared understanding, 95 percent of supervisory/management staff modeled the way by completing unconscious bias training. Frontline staff have also been assigned to complete this training by December 31, 2021.

Marketing and Communications

To improve heart health awareness, a targeted three month nurture campaign launched to invite consumers to take care of their heart health by completing a heart risk assessment (HRA) and make an online appointment with a primary care physician (PCP). The campaign has had good early engagement for open rates and completed HRAs.

A primary care SEM (search engine marketing) campaign was launched with call to action to make an online appointment with a primary care doctor.

Information Services

COVID Vaccination appointment scheduling is now available in the outpatient pharmacy using a custom scheduling application to promote access for patients, families and the community.

A new infant formula and breast milk tracking system is live in the MV NICU using barcode technology and integration to the electronic health record to promote accurate administration and safety with infant feedings.

California’s prescription drug monitoring program, known as CURES (Controlled Substance Utilization Review and Evaluation System), is now integrated with Epic to reduce prescription drug abuse and diversion by tracking controlled substance patient prescriptions across healthcare organizations and locations.

Radiology and cardiology PAC’s images are available for viewing by patients within the MyChart portal and PAC’s images are accessible to physicians using their mobile phone.

A new physician credentialing system provides an enhanced provider record management system and ongoing professional practice evaluation capabilities for the medical staff office, including integration with the Epic electronic medical record system.
Philanthropy

The foundation received a total of $3,493,307 in donations in FY21, which is 43 percent of goal for the year. This includes $513,250 in major gifts of which the two most notable donations were a $400,000 gift from the estate of former Auxiliary President Mariana Latham and a $50,000 gift from Google for the mobile COVID-19 vaccination clinic.

Donations to the COVID-19 Emergency Response Fund were allocated to purchase more prescription safety goggles for clinical staff and support immunization training for pharmacy staff. In addition, the foundation received $88,400 from Taking Wing, the virtual spring event that launched the fundraising effort for the Orchard Pavilion renovation and expansion. The event will exceed its modified goal of raising $100,000. Planning for the 25th annual El Camino Heritage Golf Tournament, which will be held in October, is underway and 64 golfers have already signed up.

Our inability to meet with donors in person and stage in-person events limited our exposure to new donors and significantly impacted the fundraising targets. Despite these limitations, our annual giving program completed FY21 at 109 percent of goal. We raised 47 more total donations of any amount than the previous year and 17 new major donors were added with gifts of $10,000 or more.

Corporate & Community Health Services

The South Asian Heart Center enrolled 109 new and re-engaged 275 prior participants in the AIM to Prevent program. In addition, two other education events occurred with 110 attendees. The Chinese Health Initiative hosted an educational event conducted by Dr. Andy Yu (Gastroenterology) on hepatitis B and liver cancer prevention and partnered with Mountain View Public Library for a bilingual webinar by a registered dietitian about diet for diabetes prevention.

Currently, there is a search underway for a new Pathways Director. The present leader fulfilled his 3-year obligation and led a turnaround by instituting a viable operating model resulting in a significant improvement in financial performance.

Government Relations & Community Benefit

Government Relations
ECH is the recipient of the 2021 Outstanding Community Impact Award because of the pop-up COVID-19 testing and COVID-19 community vaccination site which were set-up in Sunnyvale. GCR partnered with operations to site 13 mobile vaccine clinic days in partnership with three community service agencies and four school districts in order to help vaccinate underserved individuals. Santa Clara County Supervisor Joe Simitian and Los Altos Mayor Neysa Fligor visited the mobile vaccination clinic at CSA of Mountain View and Los Altos' back-to-school event on July 24.

Community Benefit
49 El Camino Health Community Benefit (CB) grant programs provided quantitative and qualitative reports about the impact of their FY21 funding informing year-end reporting underway along with data collection for Total Hospital CB investment. CB also launched 44 health improvement program grants approved for FY22. CB continued outreach to grant partners about ECH COVID-19 vaccination options.

Auxiliary

The Auxiliary donated 1,618 volunteer hours for the month of June.