El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

MEETING OF THE EL CAMINO HOSPITAL BOARD

Wednesday, January 13, 2016 5:30 p.m.

El Camino Hospital
Conference Rooms E, F & G (ground floor)
2500 Grant Road, Mountain View, CA 94040
Director Lanhee Chen will be participating via teleconference from the following address:
The Ansonborough Inn, 21 Hasell Street, Charleston, SC 29401

MISSION: To be an innovative, publicly accountable and locally controlled comprehensive healthcare organization which cares for the sick, relieves suffering, and provides quality, cost competitive services to improve the health and well-being of our community.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER / ROLL CALL**	Dennis Chiu, Board Vice Chair		5:30 – 5:32 p.m.
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dennis Chiu, Board Vice Chair		5:32
3.	**BOARD RECOGNITION** *Resolution 2016-01* The Board will recognize individual(s) who enhance the experience of the Hospital's patients and the community. **ATTACHMENT 3**	John Zoglin, Board Member and Julia Miller, Board Member	*public comment*	**motion required** 5:32 – 5:37
4.	**ADJOURN TO CLOSED SESSION**	Dennis Chiu, Board Vice Chair		5:37 – 5:38
5.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dennis Chiu, Board Vice Chair		5:38 – 5:39
6.	**CONSENT CALENDAR** Any Board Member may remove an item for discussion before a motion is made. - Meeting Minutes of the Closed Session of the Hospital Board Meeting (11-4-15 and 11-11-15). *Gov't Code Section 54957.2.*	Dennis Chiu, Board Vice Chair		**motion required** 5:39 – 5:40
7.	*Gov't Code Section 54956.8* - conference with real estate negotiator Ken King regarding property (APN 702-02-55 and 702-02-56) - Land Acquisition	Ken King, CASO		**possible motion** 5:40 – 5:53
8.	Adjourn to Open Session	Dennis Chiu, Board Vice Chair		5:53 – 5:54
9.	**RECONVENE OPEN SESSION/REPORT OUT**	Dennis Chiu, Board Vice Chair		5:54
	To report any required disclosures regarding permissible actions taken during Closed Session.			

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at 650-988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
10.	**LAND ACQUISITION (APN 702-02-55 and 702-02-56)** **ATTACHMENT 10**	Ken King, CASO	*public comment*	**possible motion** 5:54 – 6:04
11.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 11**	Dave Reeder, Chair, Quality Committee		**discussion** 6:04 – 6:19
12.	**FINANCIAL REPORT – PERIOD 5 FY16** **ATTACHMENT 12**	Iftikhar Hussain, CFO	*public comment*	**motion** 6:19 – 6:29
13.	**iCARE UPDATE** **ATTACHMENT 13**	Dave Reeder, Chair, iCare Ad Hoc Committee		**information** 6:29 – 6:39
14.	**BOARD AND COMMITTEE MINUTES CONTENT** **ATTACHMENT 14**	John Zoglin, Board Member	*public comment*	**possible motion** 6:39 – 6:49
15.	**PUBLIC COMMUNICATION** A. Oral Comments This opportunity is provided for persons in the audience to make a brief statement, not to exceed 3 minutes on issues or concerns not covered by the agenda. B. Written Correspondence	Dennis Chiu, Board Vice Chair		**information** 6:49 – 6:54
16.	**ADJOURN TO CLOSED SESSION**	Dennis Chiu, Board Vice Chair		6:54 – 6:55
17.	Report of the Medical Staff. *Health and Safety Code Section 32155.* - Deliberations concerning reports on Medical Staff quality assurance matters - Medical Staff Report	Karen Pike, MD, LG Chief of Staff Ramtin Agah, MD, MV Chief of Staff		**motion required** 6:55 – 7:05
18.	Report of the Medical Staff. *Health and Safety Code Section 32155.* - Organizational Clinical Risks	Eric Pifer, MD, CMO Joy Pao, Senior Director of Quality Improvement and Patient Safety		**discussion** 7:05 – 7:15
19.	*Gov't Code Section 54957.6* – Conference with labor negotiator Kathryn Fisk - Labor Relations Update	Kathryn Fisk, CHRO		**information** 7:15 – 7:25
20.	*Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret. - Strategic Update	Tomi Ryba, President and CEO		**discussion** 7:25 – 7:50
21.	*Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret. - Long Term Financial Forecast	Iftikhar Hussain, CFO		**information** 7:50 – 8:00

22.	*Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret. - Ad Hoc Committee Planning: Structure and Duration	Dennis Chiu, Board Member and Member, Strategy Ad Hoc Committee John Zoglin, Board Member, and Member, Strategy Ad Hoc Committee		**discussion** 8:00 – 8:15
23.	**INFORMATIONAL ITEMS:** - CEO Report. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret; *Gov't. Code Section 54956.9(d)(2)* for conference with legal counsel – pending or threatened litigation; and *Gov't Code Sections 54957* for report and discussion on personnel matters. - Urology Call Panel. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret. - Surgical Robot Purchase. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret. - Pacing Plan. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret.	Tomi Ryba, President and CEO		**information** 8:15 – 8:17
24.	Report involving *Govt. Code Section 54957* for discussion and report on personnel performance matters. - Executive Session a. CEO Talent Profile Development	Dennis Chiu, Board Vice Chair		**discussion** 8:17 – 8:22
25.	Adjourn to Open Session	Dennis Chiu, Board Vice Chair		8:22 – 8:23
26.	**RECONVENE OPEN SESSION/REPORT OUT**	Dennis Chiu, Board Vice Chair		8:23
	To report any required disclosures regarding permissible actions taken during Closed Session.			
27.	**CONSENT CALENDAR ITEMS:** Any Board Member or member of the public may remove an item for discussion before a motion is made.	Dennis Chiu, Board Vice Chair	*public comment*	**motion required** 8:23 – 8:25
	<u>Approval</u>: a. Minutes of the Open Session of the Hospital Board Meeting (<u>11-4-15</u> and <u>11-11-15</u>) b. <u>Appointment of Foundation Board Member (R. Ahuja)</u> c. <u>Report on Educational Activity (J. Miller)</u> d. <u>Draft Revised ECH Bylaws Article IV, Sections 4.5 and 4.6</u>			

e. Consent to Action Amending Silicon Valley Medical Development LLC Articles of Organization and Operating Agreement
f. Advisory Committee Appointments
Reviewed and Recommended for Approval by the Executive Compensation Committee
g. Letter of Rebuttable Presumption
Reviewed and Recommended for Approval by the Corporate Compliance, Committee
h. Policies:
Information Security Policies:
i. Information Security Management
ii. Access Control
iii. Risk Management
iv. Security Policy
Administrative Policies:
v. Leadership Policy
vi. Outside Services Providers
vii. Receipt Summons and Complaint and Legal Documents
Corporate Compliance Policies:
viii. Confidentiality
ix. Corporate Compliance Hotline
x. Code of Ethics
xi. Government Investigations
xii. Internal Investigations
xiii. Gifts and Business Courtesies From Vendors or Provided to Non Referral Sources
xiv. Gifts and Business Courtesies to Physicians
xv. Gifts from Patients and Families
xvi. Direct Patient Care Services Contractual Agreements
xvii. Use of Social Network Mediums by Employees
xviii. Confidentiality Form
xix. Conflict of Interest
xx. Charitable Donations to Outside Organizations
xxi. Identity Theft Misidentification Prevention
Reviewed and Recommended for Approval by the Quality Committee
i. Policies:
Environment of Care Policies
i. *New Policies – (0 Policies)*
ii. *Policies with Major Revisions- (1 Policy)*
1. Code Definitions- FAS Paging Codes
iii. *Policies with Minor Revisions*

(20 Policies) iv. *Policies with no Revisions – Reviewed (14 Policies)* v. *Policies to Archive (0 Policies)* ***Reviewed and Recommended for Approval by the Finance Committee*** j. Policies: i. Charge Entry Policy ii. Value Analysis Policy k. Urology Call Panel l. Surgical Robot Purchase m. Primary Care Center Approval ***Reviewed and Approved by the Medical Executive Committee*** n. Medical Staff Report **ATTACHMENT 27**			
28. AD HOC COMMITTEE PLANNING - Strategy Ad Hoc Committee	Tomi Ryba, President and CEO	*public comment*	**motion** 8:25 – 8:27
29. DRAFT RESOLUTION 2016-02 AUTHORIZING THE CEO TO EXECUTE ED ON-CALL AGREEMENT WITH PETER C. FUNG, MD **ATTACHMENT 29**	Tomi Ryba, President and CEO	*public comment*	**motion** 8:27 – 8:29
30. INFORMATIONAL ITEMS a. CEO Report b. Executive Compensation Committee Report c. Investment Committee Report d. Advisory Committees' Progress Against FY16 Goals **ATTACHMENT 30**	Tomi Ryba, President and CEO		**information** 8:29 – 8:31
31. BOARD COMMENTS	Dennis Chiu, Board Vice Chair		**information** 8:31 – 8:36
32. ADJOURNMENT	Dennis Chiu, Board Vice Chair		8:36 – 8:37 p.m.

Upcoming ECH Board Meetings in FY 2016:

- February 10, 2016
- February 20, 2016 (Board retreat)
- March 9, 2016
- March 23, 2016 (Semi-Annual Board and Committee Educational Session)

ATTACHMENT 3

RESOLUTION 2016 - 1

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE TO THE COMMUNITY

WHEREAS, the Board of Directors of El Camino Hospital values and wishes to recognize the contribution of individuals who enhance the experience of the hospital's patients, their families, the community and the staff, as well as individuals who in their efforts exemplify El Camino Hospital's mission and values.

WHEREAS, the Board wishes to honor Wes Alles, PhD, for his commitment to El Camino Hospital and El Camino Healthcare District and his longstanding service on the District Board, Hospital Board, Corporate Compliance, Privacy and Internal Audit Committee, and Community Benefit Advisory Council.

Mr. Alles was first appointed to the El Camino Healthcare District Board in 2003. During his nine years of serving on the El Camino Healthcare District Board and El Camino Hospital Board, he helped guide the organizations to their current positions as community health leaders. He is a selfless leader and served as Chair, Vice Chair and Secretary of both boards. As a Board member, Mr. Alles was committed to maintaining El Camino Hospital as a not-for-profit, locally governed public asset and sustaining financial viability of the hospital while maintaining the highest quality of care and ensuring population health.

He has continued to serve on the Corporate Compliance, Privacy and Internal Audit Committee, even after leaving the Boards in 2012, and has been instrumental in advancing the Hospital's Compliance Program. Mr. Alles helped develop standardized compliance reporting, an internal audit plan, and privacy and security oversight. He was committed to the hospital conducting business and patient care with honesty, integrity and high ethical standards.

Until recently, Mr. Alles remained an active member of the Community Benefit Advisory Council. He spearheaded discussions and provided guidance and insight on community health. His well-informed, thoughtful, and compassionate perspectives helped develop the Community Benefit Grants Program.

WHEREAS, the Board would like to publically acknowledge Wes Alles, PhD, for his dedication to improving the health and well-being of our community.

NOW THEREFORE BE IT RESOLVED that the Board does formally and unanimously pay tribute to:

Wes Alles, PhD

FOR HIS LEADERSHIP AND SERVICE.

IN WITNESS THEREOF, I have here unto set my hand this **13TH DAY OF JANUARY, 2016.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee Chen, JD, PhD	Jeffrey Davis, MD	David Reeder
Dennis Chiu, JD	Peter Fung, MD	Tomi Ryba
Neal Cohen, MD	Julia Miller	John Zoglin

PETER FUNG, MD
SECRETARY/TREASURER,
EL CAMINO HOSPITAL BOARD OF DIRECTORS

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

ATTACHMENT 10

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Land Acquisition APN's 702-02-55 and 702-02-56 Board Meeting Date: January 13, 2016
	Responsible party:	Ken King, Chief Administrative Services Officer
	Action requested:	Requesting Approval to Purchase Real Property at a cost not to exceed $24.1 Million.
	Background: To fulfill the strategic objective of expanding community based services to the broader region of Silicon Valley and to secure future growth opportunities for the El Camino Hospital Enterprise, we have secured the opportunity to purchase approximately 16 acres of undeveloped land in South San Jose. The transaction to purchase the property requires the approval of the Board of Directors.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: This request was reviewed by the Board Finance Committee as a confidential information item on November 30, 2015. The Committee was supportive but no formal recommendation was made.	
	Summary and session objectives : • To provide information regarding the size, location and attributes of the property. • To obtain the approval of the Board of Directors to complete the transaction.	
	Suggested discussion questions: 1. Where exactly is the property and were other properties considered? 2. What due diligence has been undertaken regarding this particular site? 3. What opportunities does owning this property provide?	
	Proposed board motion, if any: The Board of Directors is requested to approve the acquisition of 15.83 Acres of undeveloped land in South San Jose on Santa Teresa Blvd. between San Ignacio Ave. and Great Oaks Blvd. (APN's 702-02-55 and 702-02-56) at a cost not to exceed $24.1 million, including a 2% brokers' fee and due diligence expenses.	
	LIST OF ATTACHMENTS: Power Point Slide Presentation (Public Session)	

Att 10b - HospitalBoard_ Powerpoint_West Valley_01_13_2016

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Land Acquisition Request
ECH Board of Directors

January 13, 2016

Ken King
Chief Administrative Services Officer

The Request for Approval

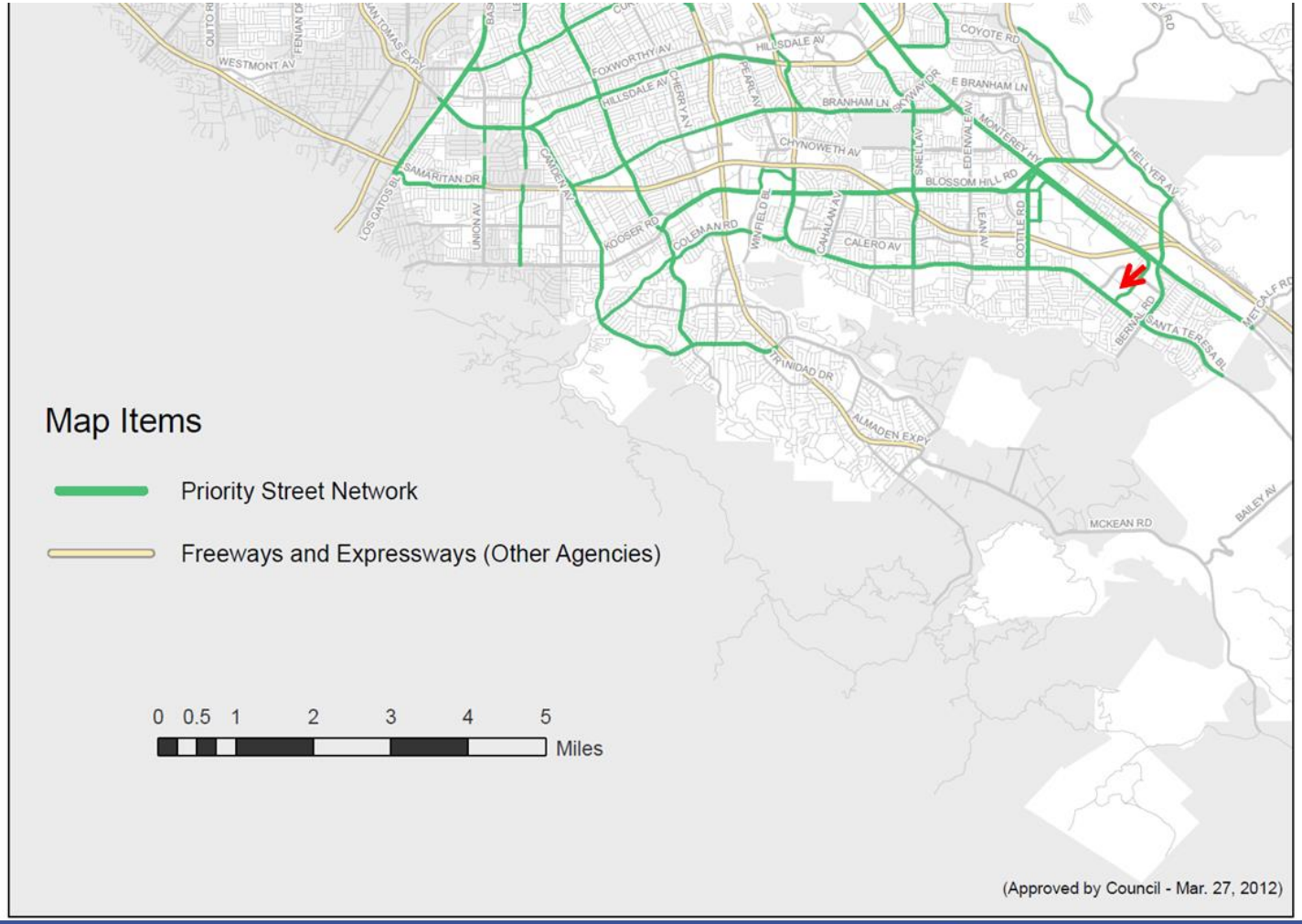
The Board of Directors is requested to approve the acquisition of 15.83 Acres of undeveloped land in South San Jose on Santa Teresa Blvd. between San Ignacio Ave. and Great Oaks Blvd. (APN's 702-02-55 and 702-02-56) at a cost not to exceed $24.1 million, including a 2% brokers' fee and due diligence expenses.

Background

- To fulfill the strategic objective of expanding our community based services to the broader Silicon Valley region we conducted a search of possible properties that would provide future growth opportunities.
- We studied the population growth projections developed by the Association of Bay Area Governments (ABAG) and the City of San Jose's Envision 2040 General Plan.
  - Santa Clara County population is projected to grow by 36% between 2010 and 2040. The city of San Jose is projected to grow by 41% over the same period.
- We successfully secured the opportunity to purchase nearly 16 acres of undeveloped land in South San Jose that provides a location for expanding our community based services to the broader region.

Key Supporting Points

Accessible Location: Santa Teresa Blvd., South San Jose



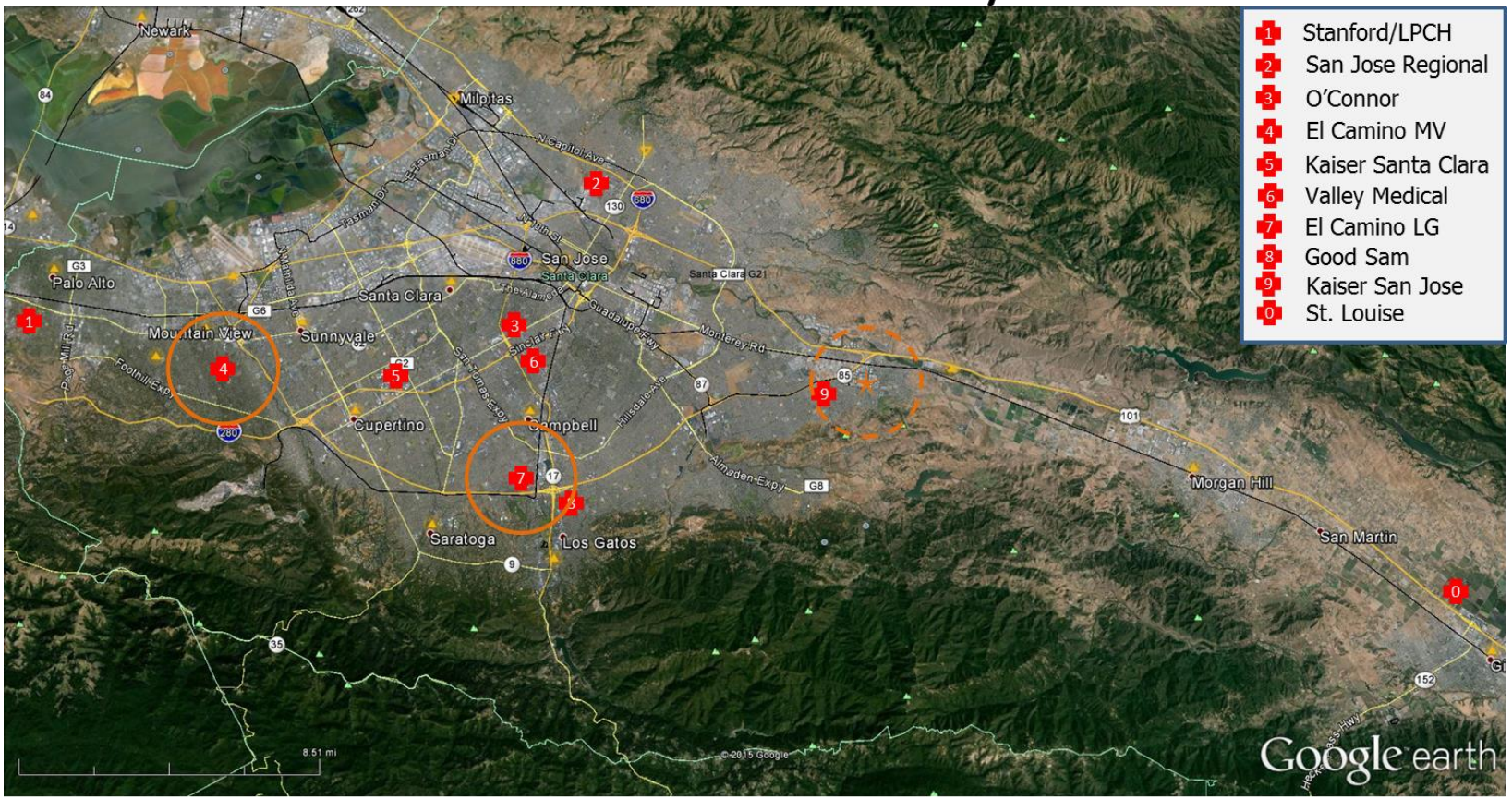
Key Supporting Points

- Greenfield site with various development opportunities.

Key Supporting Points

Potential to Extend Community Based Services to Broader Region:

Santa Clara County



○ = ECH Sites

Current Hospital Locations & New Santa Teresa Site

Final Slide

- The Board of Directors is requested to approve the acquisition of 15.83 Acres of undeveloped land in South San Jose on Santa Teresa Blvd. between San Ignacio Ave. and Great Oaks Blvd. (APN's 702-02-55 and 702-02-56) at a cost not to exceed $24.1 million, including a 2% brokers' fee and due diligence expenses.

ATTACHMENT 11

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Quality, Patient Care and Patient Experience Committee ("Quality Committee") Report El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	David Reeder, Quality Committee Chair
	Action requested:	For Discussion
	Background: The Quality Committee meets 10 times per year. The Committee last met on December 7, 2015 and meets next on February 1, 2016.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives: To update the Board on the work of the Committee. **1. Progress Against Goals:** The Committee is on track to complete its FY16 Goals. **2. Summary of December 2015 Meeting:** We continue to focus on keeping the Patient and Family Centered Care project on track even as the organization stabilizes after the iCare activation. Through the exception report and reports from the management team, we are trying to help focus on consistency in patient safety and quality. The computer system has added some excellent safety features but the change in the way that staff completes their jobs has created some very important challenges as well. These challenges and changes are resulting in some near miss events that need to be addressed. 1. Exception Report: Medication Errors: There has been an increase in the number of medication administration errors between October and November. To address this increase, the committee heard from Chris Tarver, Nursing Chair of El Camino's medication safety committee. Ms. Tarver and the rest of the management team described a weekly medication safety meeting that has been convened to address a host of issues that are causing some of the safety risks. To address the risky period in the short term, pharmacists have been added to increase staffing and vigilance related to medication errors. Some examples of medication error types: a. Adult orders entered on pediatric patients. b. Incorrectly "mapped" medicines (very few of these and all addressed). c. Delays in medicine administration related to a variety of issues. d. Complex medication orders (several issues). 2. Exception Report: Falls: Although the overall rate of falls has not increased, we are still	

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	seeing too many for comfort. Cheryl Reinking reported on falls in our December meeting. 3. Patient and Family Centered Care: The management team brought forward some options for a "model line" to be used for the PFCC program. Good discussion ensued. The committee felt that we should chose a relatively confined area (As example: Cancer Care is too broad but perhaps end of life care for cancer patients may work well) and have clearly defined goals around communication and shared decision making. iCare: The committee discussed the success of the iCare program with the management team. Massive amounts of work have been done to bring the system live and optimize it. But more work still needs to be done to reduce the likelihood of error and patient harm. **3. Important Future Activities** Review of the Medical Staff Peer Review Process and further work on the Patient and Family Centered Care Project are paced for the next several months.
	Suggested discussion questions: None
	Proposed board motion, if any: None.
	LIST OF ATTACHMENTS: None.

ATTACHMENT 12

ECH BOARD MEETING AGENDA ITEM

	Item:	ECH Financials FY16 Period 5 El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Iftikhar Hussain, CFO
	Action requested:	Approval
	Background: Typically, we bring forward Financials for approval following review and recommendation by the Finance Committee. However, since the Finance Committee does not meet until the end of January we thought it important to bring the currently available Period 5 Financials forward to the Board now. The Finance Committee will review the Period 5 Financials at its January 25th meeting.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: The Finance Committee did review and vote to recommend approval of the Period 4 Financials at its November 30, 2015 meeting.	
	Summary and session objectives : 1. To answer questions the Board may have regarding short term impact the iCare project has had on ECH's Financial Performance in Period 5. 2. To obtain approval of the FY16 Period 5 Financials.	
	Proposed board motion: To approve the ECH FY16 period 5 Financials.	
	LIST OF ATTACHMENTS: FY 16 Period 5 Financials	

Att 12b - Board and Finance Committee FY16 Period 5

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Summary of Financial Operations

Fiscal Year 2016 – Period 5

7/1/2015 to 11/30/2015

EL CAMINO HOSPITAL

(Excludes Controlled Affiliates)

EXECUTIVE FINANCIAL SUMMARY

Period Ending November 30, 2015

YTD STATEMENT OF REVENUE AND EXPENSES ($000s)

	Prior Year	Actual	Budget	Var F(U)
Gross Revenue	$1,054,048	$1,108,380	$1,113,255	($4,874)
Deductions from Revenue	(761,566)	(796,192)	(805,425)	9,233
Net Patient Revenue	292,482	312,188	307,829	4,358
Other Operating Revenue	7,825	9,690	8,437	1,253
Total Operating Revenue	**300,306**	**321,878**	**316,266**	**5,612**
Salaries & Wages	167,878	176,154	173,597	(2,558)
Supplies	44,917	48,390	46,118	(2,272)
Fees & Purchased Services	30,927	35,276	34,715	(562)
Other Operating Expense	16,060	21,899	17,908	(3,990)
Total Non Capital Operating Expense	**259,783**	**281,720**	**272,338**	**(9,382)**
OPERATING EBITDA	**40,523**	**40,159**	**43,929**	**(3,770)**
Interest, Depreciation & Amortization	21,975	21,361	20,191	(1,171)
NET OPERATING SURPLUS	**18,547**	**18,797**	**23,738**	**(4,941)**
Non Operating Income	3,695	(12,293)	9,301	(21,594)
TOTAL NET SURPLUS	**22,242**	**6,504**	**33,039**	**(26,535)**
EBITDA Margin	13.5%	12.5%	13.9%	-1.4%
Operating Margin	6.2%	5.8%	7.5%	-1.7%
Total Margin	7.4%	2.0%	10.4%	-8.4%

BALANCE SHEET ($000s)

	November 30, 2015	Jun 30, 2015
Cash and Investments	698,514	707,865
Non Cash Current Assets	141,217	143,766
Property, Plant & Equipment (Net)	689,219	686,537
Other Assets	91,650	94,707
Total Assets	**1,620,601**	**1,632,874**
Current Liabilities	93,620	107,925
Long-Term Liabilities	275,926	272,696
Fund Balance/Capital Accounts	1,251,056	1,252,254
Total Liabilities & Equity	**1,620,601**	**1,632,874**

KEY ECH STATISTICS - YTD

Balance Sheet	Actual	Target [1]
Debt Service Coverage Ratio (MADS)	7.9	1.2
Debt to Capitalization	14.5%	29.0%
Days of Cash	376	262
Net AR Days	48.5	48.0

Other	Prior Year	Actual	Budget
Acute Discharges	7,862	7,724	7,935
Acute Average Daily Census	237	232	237
Deliveries	2,200	1,967	2,188
Emergency Department Visits	24,319	24,536	24,689
Surgical Cases	4,542	4,511	4,629
Full Time Equivalent Employees	2,425	2,542	2,395
Worked Hrs/Adjusted Patient Day	29.70	31.08	29.58

[1] For Debt Service Coverage Ratio and Debt to Capitalization, Target represents Bond Convenants
For Days Cash and Net AR Days, Target represents S&P A Rated Stand-Alone Hospital Medians

[1] Hospital entity only, excludes controlled affiliates

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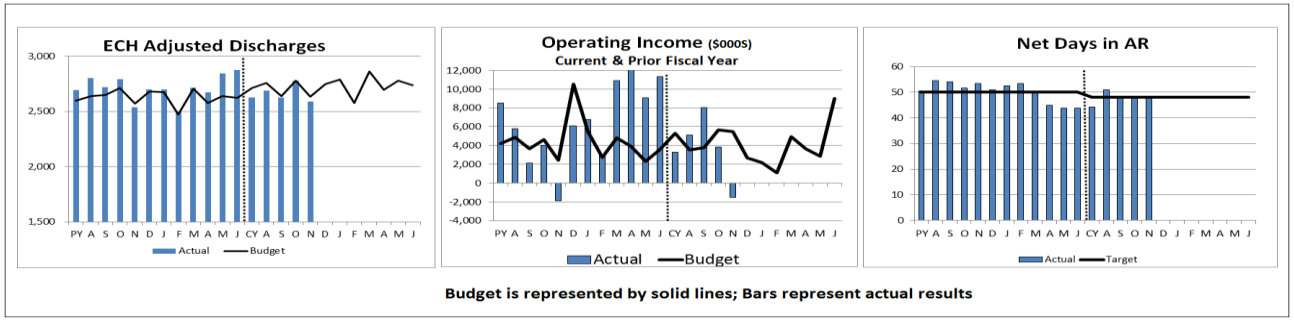
Financial Trends and Commentary

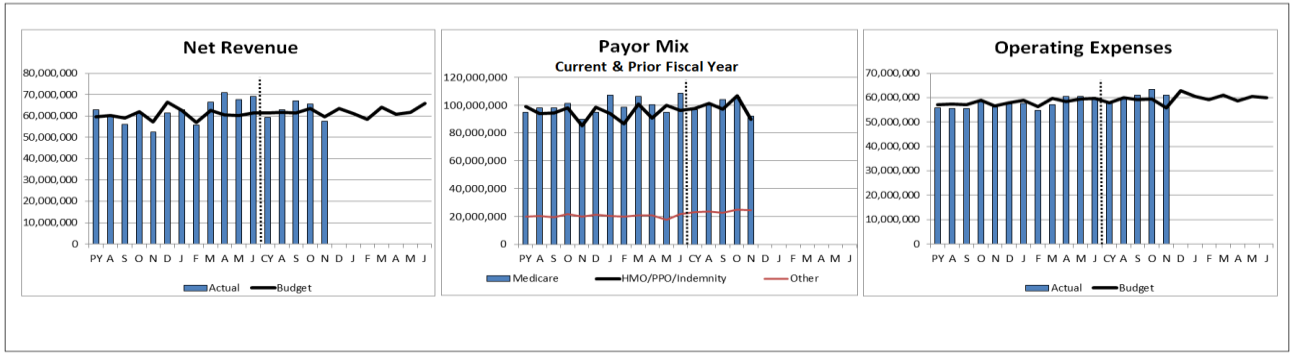
Volume:
Inpatient volume for the year is 1.8% lower than prior year primarily in OB services.

Operating Margin:
Operating margin is $7 million unfavorable for the month, $5 million unfavorable for the year primarily due to low volume and EPIC related expenses in labor and nonlabor (EPIC training). Productivity is unfavorable compared to target due to EPIC preparation.

Non-Operating Margin:
Non operating income is $21.6 million behind target primarily due to investment loss. Our cash position remains strong and allows us to keep a long term view on returns.

Net Days in AR:
In November, receivables decreased $1.1 million from October. Net days in A/R decreased slightly to 48.5 primarily due to strong collections on legacy accounts receivable

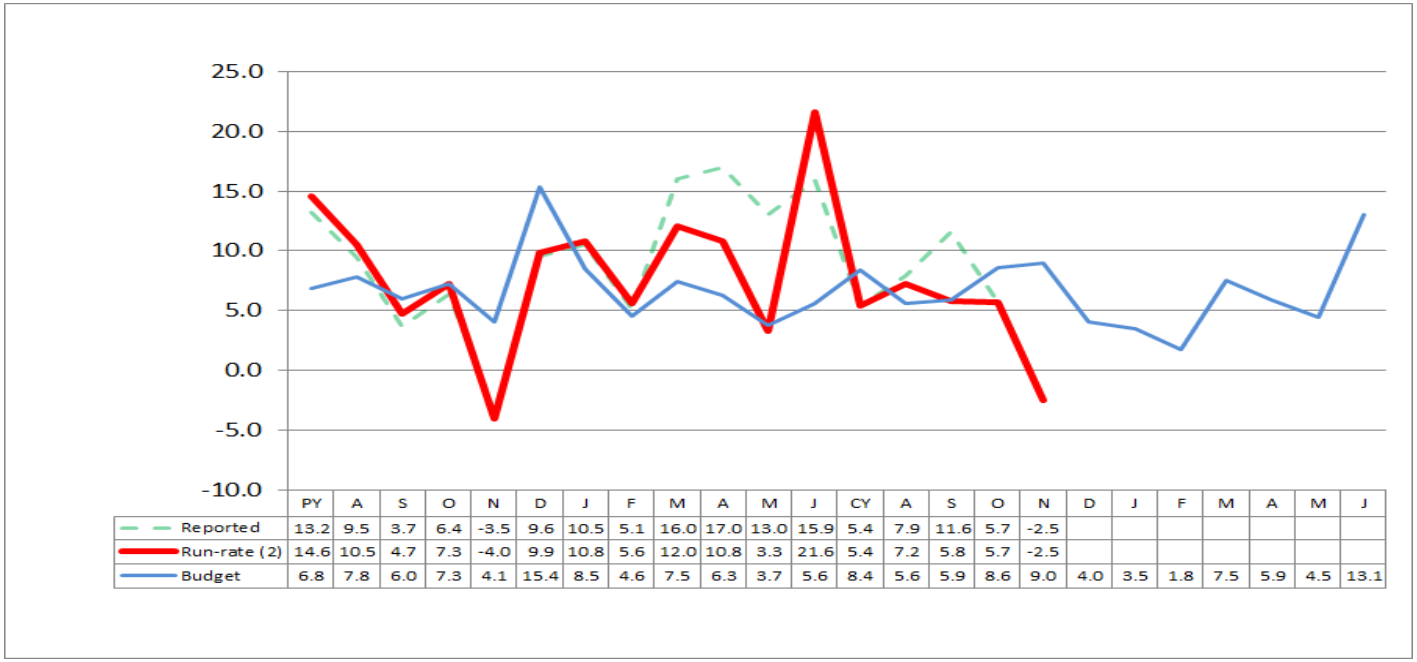




Non-Labor Expenses:
Supplies are high primarily due to pharmacy, surgical and heart valve supplies. EPIC training makes up -$2.9 year to date variance for other general and administrative expenses. Depreciation is higher due to completion of the data center project and accelerated depreciation on the old hospital that will be demolished to build the iMOB.

ECH Operating Margin

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



	PY	A	S	O	N	D	J	F	M	A	M	J	CY	A	S	O	N	D	J	F	M	A	M	J
Reported	13.2	9.5	3.7	6.4	-3.5	9.6	10.5	5.1	16.0	17.0	13.0	15.9	5.4	7.9	11.6	5.7	-2.5							
Run-rate (2)	14.6	10.5	4.7	7.3	-4.0	9.9	10.8	5.6	12.0	10.8	3.3	21.6	5.4	7.2	5.8	5.7	-2.5							
Budget	6.8	7.8	6.0	7.3	4.1	15.4	8.5	4.6	7.5	6.3	3.7	5.6	8.4	5.6	5.9	8.6	9.0	4.0	3.5	1.8	7.5	5.9	4.5	13.1

FY 2016 Actual Run Rate Adjustments (in thousands)

		J	A	S	O	N	D	J	F	M	A	M	J
Revenue Adjustments	RAC	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Cost Reports Settlements	-$49	-$569	-$616	$0	$0	$0	$0	$0	$0	$0	$0	$0
	IGT-Inter Government Transfer	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Insurance Overpayment Released	$0	$0	-$4,913	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total	**-$49**	**-$569**	**-$5,530**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Expense Adjustments	EPIC Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Pay-For-Performance Bonus	$76	$69	$1,183	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total	**$76**	**$69**	**$1,183**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

- No revenue/expense adjustments for November.

Summary of Financial Results
$ in Thousands

	Period 5 - Month			Period 5 - FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Income (Loss) from Operations						
Mountain View	(10,044)	4,928	(14,972)	5,555	19,941	(14,385)
Los Gatos	8,546	568	7,977	13,242	3,797	9,445
Sub Total - El Camino Hospital, excl. Afflilates	**(1,498)**	**5,497**	**(6,995)**	**18,797**	**23,738**	**(4,941)**
Operating Margin %	**-2.5%**	**9.0%**		**5.8%**	**7.5%**	
El Camino Hospital Non Operating Income						
Investments	(1,458)	2,298	(3,756)	(7,757)	11,488	(19,245)
Swap Adjustments	350	0	350	(1,147)	0	(1,147)
Community Benefit	(49)	(233)	184	(1,448)	(1,166)	(281)
Other	302	(204)	506	(1,941)	(1,021)	(921)
Sub Total - Non Operating Income	**(856)**	**1,860**	**(2,716)**	**(12,293)**	**9,301**	**(21,594)**
El Camino Hospital Net Income (Loss)	**(2,354)**	**7,357**	**(9,710)**	**6,504**	**33,039**	**(26,535)**
ECH Net Margin %	**-4.0%**	**12.0%**		**2.0%**	**10.4%**	
Concern	214	80	134	1,122	1	1,122
ECSC	1	0	1	11	0	11
Foundation	5	174	(170)	119	667	(548)
Silicon Valley Medical Development	(2)	0	(2)	(8)	0	(8)
Net Income Hospital Affiliates	**218**	**255**	**(37)**	**1,244**	**668**	**576**
Total Net Income Hospital & Affiliates	**(2,136)**	**7,611**	**(9,747)**	**7,748**	**33,707**	**(25,959)**

Actual to Budget Variance for hospital affiliates primarily due to drug, medical supplies, and EPIC labor/training expenses offset by unrealized gain.

ECH Volume Statistics [1]

ECH COMBINED

	Month of Nov, 2015			Year to Date			Prior Year	
	Act	Bud	Var	Act	Bud	Var	Act	Var%
Discharges [2]	1,549	1,553	-0.3%	7,724	7,935	-2.7%	7,862	-1.8%
ADC [2]	226	238	-5.0%	232	237	-2.0%	237	-2.3%
Deliveries	394	412	-4.4%	1,967	2,188	-10.1%	2,200	-10.6%
ED Visits	4,454	4,802	-7.2%	24,536	24,689	-0.6%	24,319	0.9%
Surgical Cases	850	893	-4.8%	4,511	4,629	-2.5%	4,542	-0.7%

MOUNTAIN VIEW

	Month of Nov, 2015			Year to Date			Prior Year	
	Act	Bud	Var%	Act	Bud	Var%	Act	Var%
Discharges [2]	1,270	1,272	-0.2%	6,311	6,495	-2.8%	6,460	-2.3%
ADC [2]	190	194	-2.2%	190	193	-1.5%	193	-1.7%
Deliveries	342	356	-4.0%	1,680	1,891	-11.2%	1,888	-11.0%
ED Visits	3,520	3,836	-8.2%	19,523	19,726	-1.0%	19,446	0.4%
Surgical Cases	531	555	-4.2%	2,762	2,874	-3.9%	2,746	0.6%

LOS GATOS

	Month of Nov, 2015			Year to Date			Prior Year	
	Act	Bud	Var	Act	Bud	Var	Act	Var%
Discharges [2]	279	281	-0.7%	1,413	1,440	-1.9%	1,402	0.8%
ADC [2]	37	45	-17.3%	42	44	-4.3%	44	-4.6%
Deliveries	52	56	-7.0%	287	297	-3.4%	312	-8.0%
ED Visits	934	965	-3.2%	5,013	4,963	1.0%	4,873	2.9%
Surgical Cases	319	338	-5.7%	1,749	1,754	-0.3%	1,796	-2.6%

[1] Hospital entity only, excludes controlled affiliates

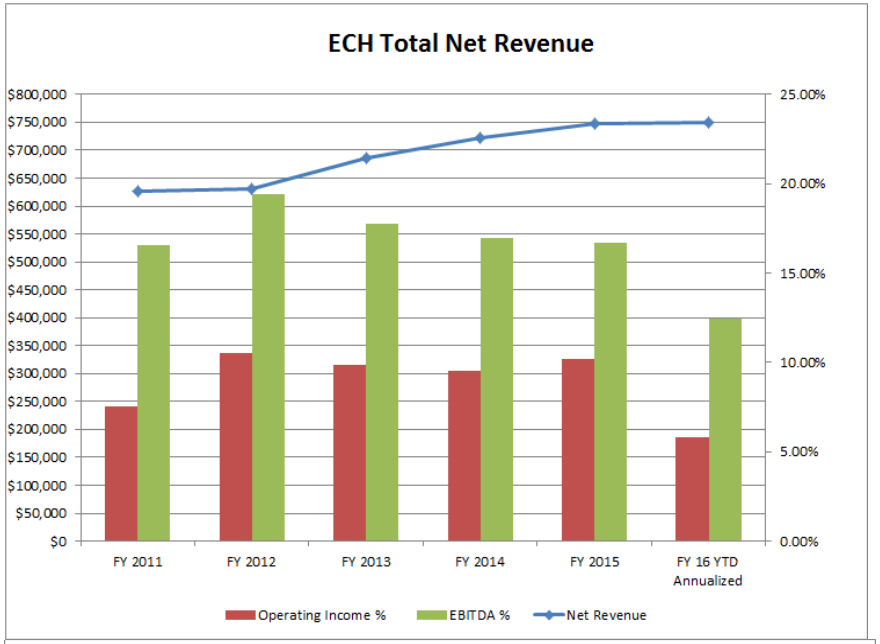
[2] Excludes normal newborns, includes discharges from L&D

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

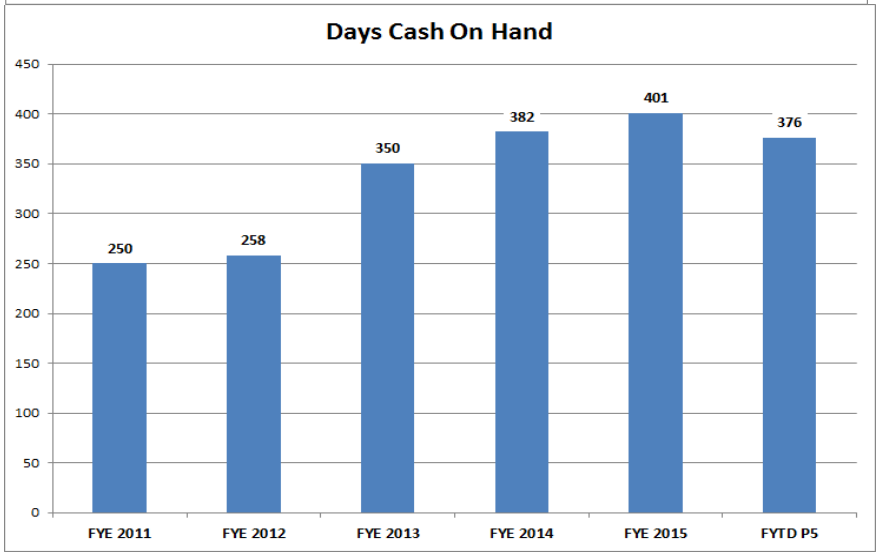
El Camino Hospital Financial Metrics Trend (1)

Profit_Loss

BAL_SHEET



Revenue growth remains strong but pharmacy drug and EPIC related costs are driving down 2016 margin



Cash position remains strong with a $7.8 million investment loss

(1) Hospital entity only, excludes controlled affiliates

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Key Hospital Indicators[1]

Statistic	FYE 2013	FYE 2014	FYE 2015	FYTD 2016	Annual Target (2)	+/-
Operating Margin	9.9%	9.5%	10.2%	5.8%	6.5%	
EBITDA Margin	17.8%	16.9%	16.7%	12.5%	13.3%	
Days of Cash	350	382	401	376	262	
Debt Service Coverage Ratio (MADS)	7.9	9.5	8.9	7.9	4.8	
Debt to Capitalization	14.0%	12.6%	13.6%	14.5%	29.4%	
Net AR Days	48.3	50.9	43.6	48.5	48.0	
In Patient Operating Margin	-1.1%	-3.2%	-4.5%	-10.0%	-1.0%	
Out Patient Operating Margin	25.9%	25.2%	28.1%	29.7%	25.0%	

(1) Hospital Only - Excludes Affiliates

(2) Due to timing of month end costing, In Patient and Out Patient Operating Margin % for FYTD 2016 are one month in arrears

(3) Target source: Annual Budget for Operating Margin and EBITDA Margin

Target source: S&P 2014 A Rated Stand-Alone Hospital Median Ratios (last published 9/9/2015)

*Prior Year numbers represent full year

Tracking Smart Growth

COMBINED				
	FY15 Year to Date	FY16 Year to Date	Change	Annual Goal
Inpatient Discharges	7,862	7,724	(138)	300
Surgical Outpatient Cases (incl Litho)	2,694	2,632	(62)	290
Endo Outpatient procedures	1,201	1,070	(131)	-
Outpatient Interventional Cases	803	778	(25)	10
Total	12,560	12,204	(356)	
Targeted Physician Total	35	113	148	
Current Physician Total	12,525	12,091	(504)	-
# New Physicians*	1	4	3	15

* New Physicians: MDs with 20% or more inpatient or procedural (above definition) cases (at least 10) and/or New PCP (OB, Internal Med, Fam Prac)

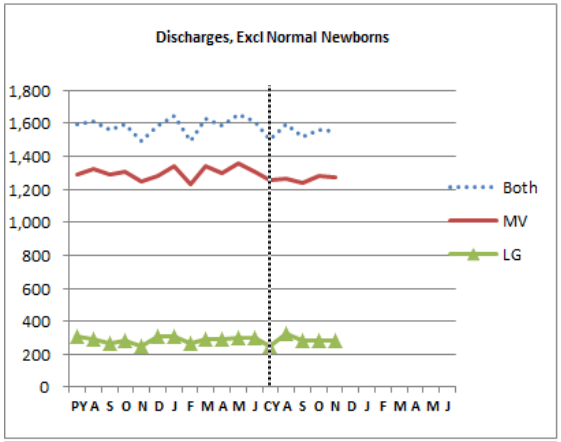
Mountain View Campus				
	FY15 Year to Date	FY16 Year to Date	Change	Goal
Inpatient Discharges	6,460	6,311	(149)	
Surgical Outpatient Cases (incl Litho)	1,368	1,396	28	
Endo Outpatient procedures	1,110	1,002	(108)	
Outpatient Interventional Cases	797	772	(25)	
# New Physicians*	1	-	(1)	

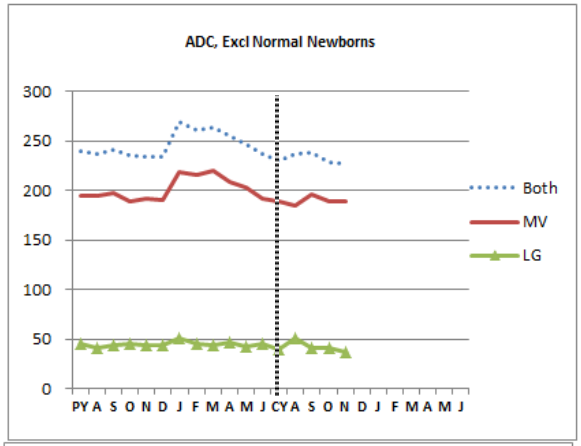
Los Gatos Campus				
	FY15 Year to Date	FY16 Year to Date	Change	Goal
Inpatient Discharges	1,402	1,413	11	
Surgical Outpatient Cases (incl Litho)	1,326	1,236	(90)	
Endo Outpatient procedures	91	68	(23)	
Outpatient Interventional Cases	6	6	-	
# New Physicians*	-	4	4	

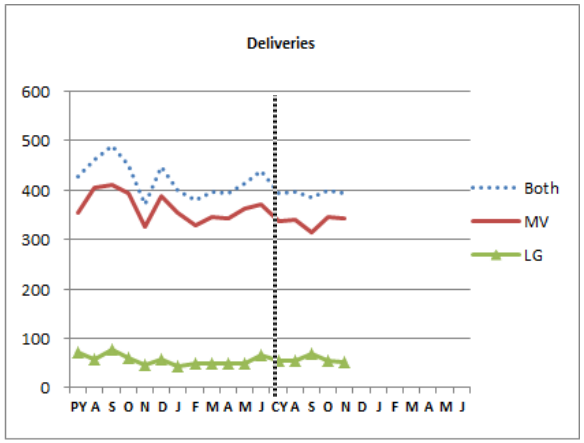
(1) Hospital entity only, excludes controlled affiliates

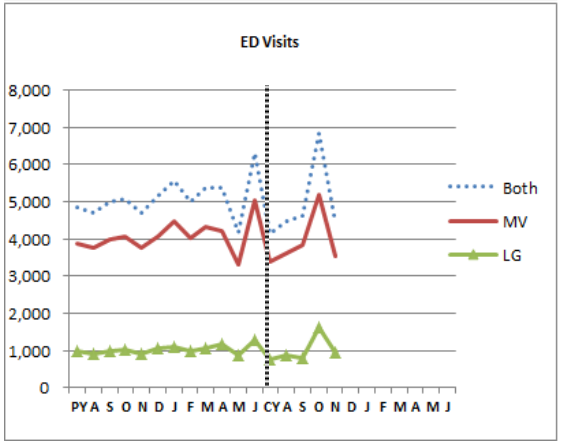
APPENDIX

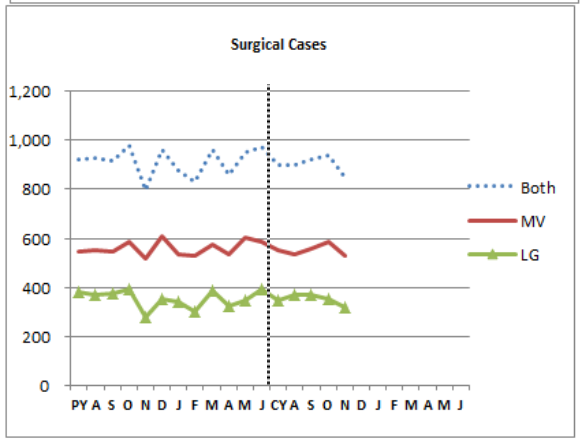
El Camino Hospital Volume Trends
Prior and Current Fiscal Years

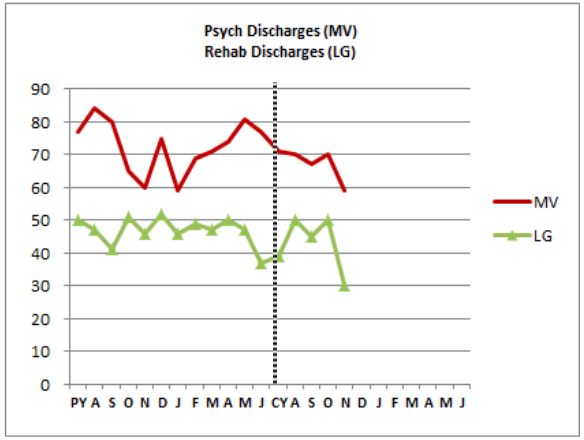




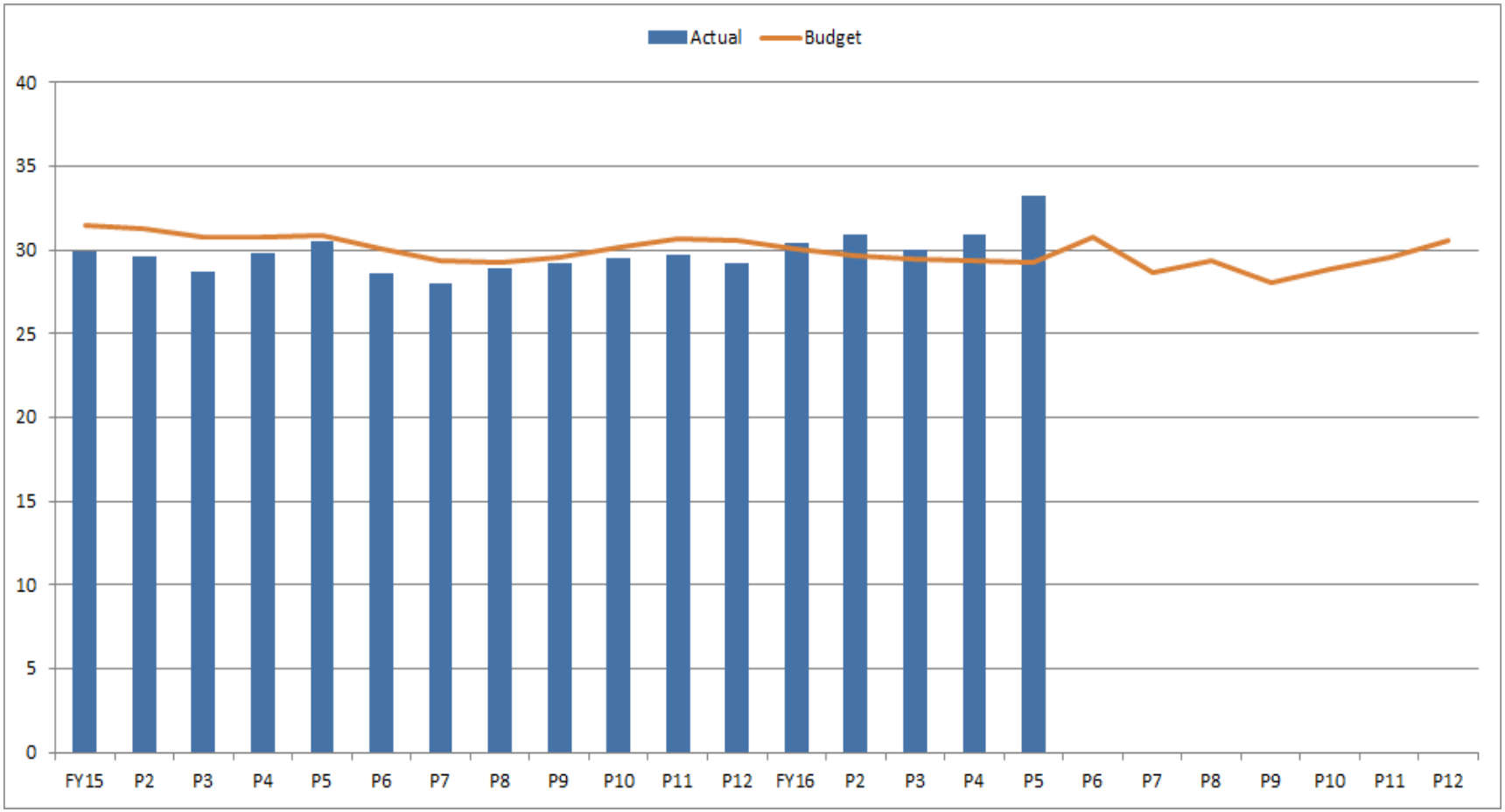








Worked Hours per Adjusted Patient Day

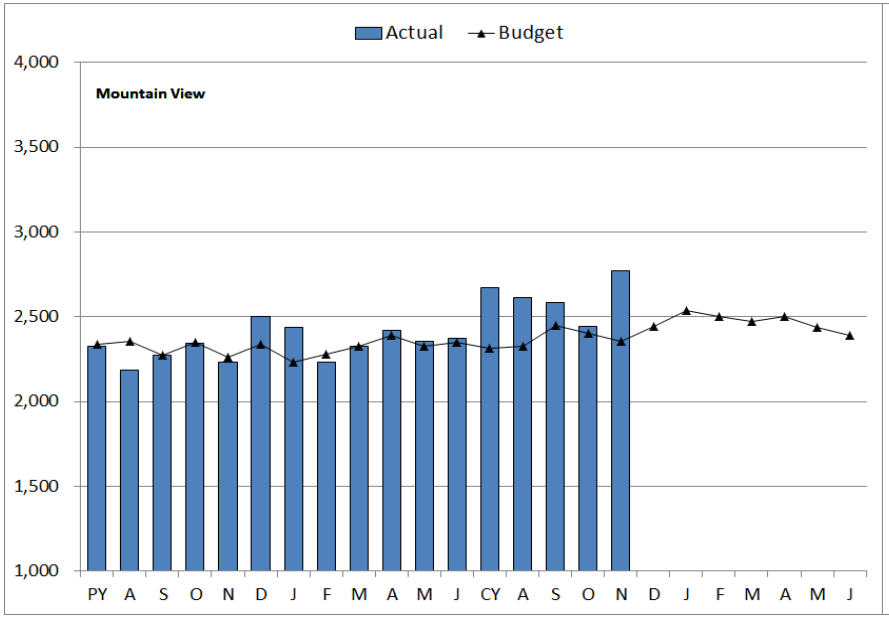


Worked Hours per Adjusted Patient Day: Worked hours are unfavorable to budget for the new fiscal year.

Supply Cost per CMI Adjusted Discharges [1]

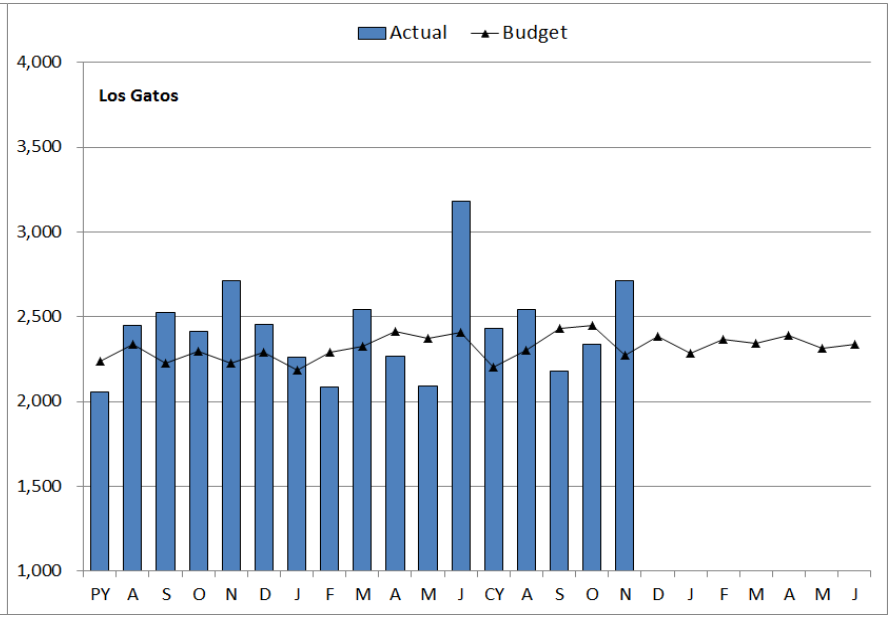
YTD: 10.3% over budget

Mountain View



YTD: 4.7% over budget

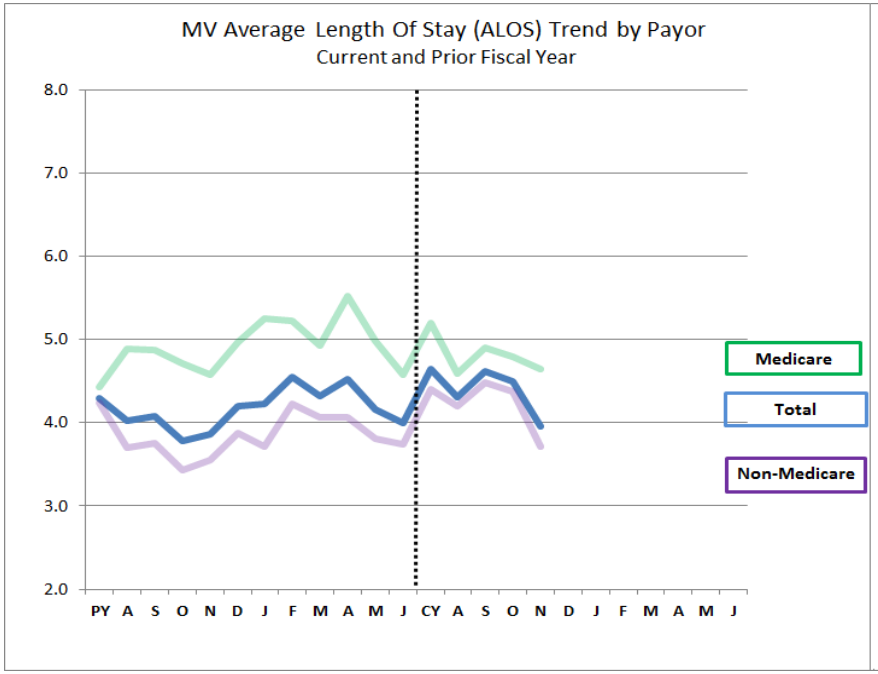
Los Gatos

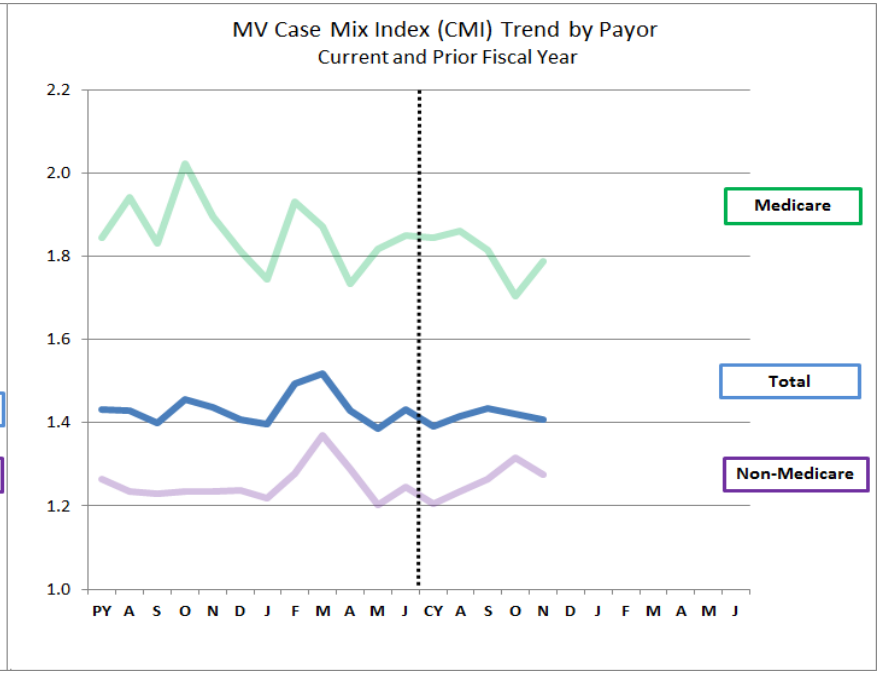


Continued high cost in November related to pharmacy, heart valve supplies and general surgery supplies.

[1] Hospital entity only, excludes controlled affiliates

Mountain View LOS & CMI Trend[1]





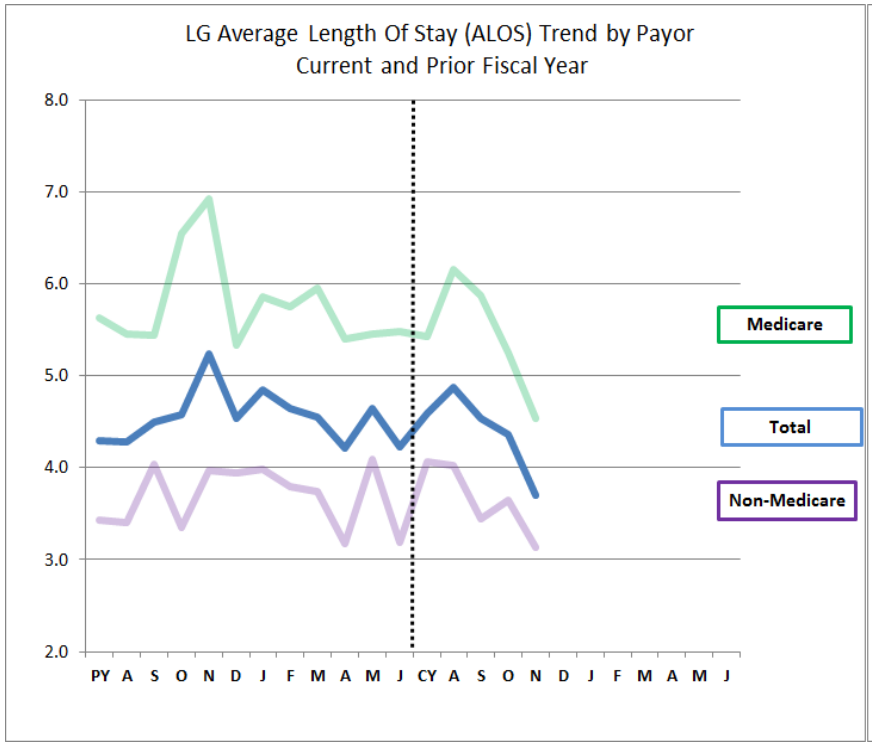
- Medicare: Due to DRG reimbursement, financial results usually improve with decreased LOS and increased CMI
- Non-Medicare: Reimbursement varies; financial results usually improve when both LOS & CMI increase

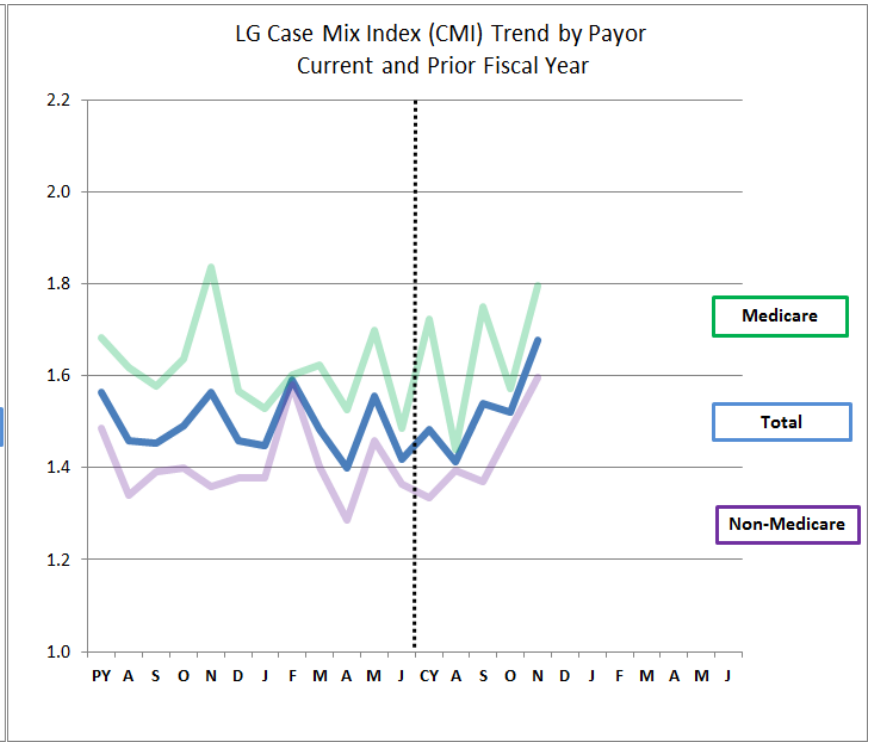
Length of stay has a sharp downward trend while CMI remains relatively flat .

[1] Hospital entity only, excludes controlled affiliates

All data excludes normal newborns (MS-DRG=795), Medicare data excludes Medicare HMOs and PPOs

Los Gatos LOS & CMI Trend [1]





- Medicare: Due to DRG reimbursement, financial results usually improve with decreased LOS and increased CMI
- Non-Medicare: Reimbursement varies; financial results usually improve when both LOS & CMI increase

The Los Gatos Medicare caseload shows a sharp decrease in length of stay and increasing case complexity while the non-Medicare caseload shows a downward trend in length of stay. The small campus is impacted by relatively slight shifts in surgical volume.

[1] Hospital entity only, excludes controlled affiliates

All data excludes normal newborns (MS-DRG=795), Medicare data excludes Medicare HMOs and PPOs

El Camino Hospital [1]

Results from Operations vs. Prior Year

5 months ending 11/30/2015

$000s	FY 2016	FY 2015	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	1,108,380	1,054,048	54,333	5.2%
Deductions	(796,192)	(761,566)	(34,626)	4.5%
Net Patient Revenue	**312,188**	**292,482**	**19,706**	**6.7%**
Other Operating Revenue	9,690	7,825	1,866	23.8%
Total Operating Revenue	**321,878**	**300,306**	**21,572**	**7.2%**
OPERATING EXPENSE:				
Salaries & Wages	176,154	167,878	(8,276)	-4.9%
Supplies	48,390	44,917	(3,473)	-7.7%
Fees & Purchased Services	35,276	30,927	(4,349)	-14.1%
Other Operating Expense	43,260	38,036	(5,224)	-13.7%
Total Operating Expense	**303,081**	**281,759**	**(21,322)**	**-7.6%**
Net Operating Income/(Loss)	**18,797**	**18,547**	**250**	**1.3%**
Non Operating Income	(12,293)	3,695	(15,988)	-432.7%
Net Income(Loss)	**6,504**	**22,242**	**(15,738)**	**-70.8%**
Collection Rate	28.2%	27.7%	0.4%	
Operating Margin	5.8%	6.2%	-0.3%	
Net Margin	2.0%	7.4%	-5.4%	

[1] Hospital entity only, excludes controlled affiliates

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital – Mountain View[1]

Results from Operations vs. Prior Year

5 months ending 11/30/2015

$000s	FY 2016	FY 2015	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	902,601	861,270	41,331	4.8%
Deductions	(658,445)	(625,045)	(33,401)	5.3%
Net Patient Revenue	**244,156**	**236,225**	**7,930**	**3.4%**
Other Operating Revenue	8,638	6,927	1,712	24.7%
Total Operating Revenue	**252,794**	**243,152**	**9,642**	**4.0%**
OPERATING EXPENSE:				
Salaries & Wages	146,552	139,292	(7,261)	-5.2%
Supplies	39,545	36,189	(3,356)	-9.3%
Fees & Purchased Services	28,462	24,766	(3,696)	-14.9%
Other Operating Expense	32,679	29,789	(2,890)	-9.7%
Total Operating Expense	**247,239**	**230,036**	**(17,202)**	**-7.5%**
Net Operating Income/(Loss)	**5,555**	**13,116**	**(7,560)**	**-57.6%**
Non Operating Income	(12,293)	3,695	(15,988)	-432.7%
Net Income(Loss)	**(6,738)**	**16,810**	**(23,548)**	**-140.1%**
Collection Rate	27.1%	27.4%	-0.4%	
Operating Margin	2.2%	5.4%	-3.2%	
Net Margin	-2.7%	6.9%	-9.6%	

[1] Hospital entity only, excludes controlled affiliates

El Camino Hospital – Los Gatos[1]

Results from Operations vs. Prior Year

5 months ending 11/30/2015

$000s	FY 2016	FY 2015	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	205,779	192,777	13,002	6.7%
Deductions	(137,747)	(136,521)	(1,226)	0.9%
Net Patient Revenue	**68,032**	**56,256**	**11,776**	**20.9%**
Other Operating Revenue	1,052	898	154	17.1%
Total Operating Revenue	**69,084**	**57,154**	**11,930**	**20.9%**
OPERATING EXPENSE:				
Salaries & Wages	29,602	28,587	(1,015)	-3.6%
Supplies	8,845	8,728	(117)	-1.3%
Fees & Purchased Services	6,814	6,161	(653)	-10.6%
Other Operating Expense	10,581	8,247	(2,334)	-28.3%
Total Operating Expense	**55,842**	**51,723**	**(4,120)**	**-8.0%**
Net Operating Income/(Loss)	**13,242**	**5,432**	**7,810**	**143.8%**
Non Operating Income	0	0	0	0.0%
Net Income(Loss)	**13,242**	**5,432**	**7,810**	**143.8%**
Collection Rate	33.1%	29.2%	3.9%	
Operating Margin	19.2%	9.5%	9.7%	
Net Margin	19.2%	9.5%	9.7%	

[1] Hospital entity only, excludes controlled affiliates

El Camino Hospital [1]

Results from Operations vs. Budget

5 months ending 11/30/2015

$000s	FY 2016	Budget 2016	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	1,108,380	1,113,255	(4,874)	-0.4%
Deductions	(796,192)	(805,425)	9,233	-1.1%
Net Patient Revenue	**312,188**	**307,829**	**4,358**	**1.4%**
Other Operating Revenue	9,690	8,437	1,253	14.9%
Total Operating Revenue	**321,878**	**316,266**	**5,612**	**1.8%**
OPERATING EXPENSE:				
Salaries & Wages	176,154	173,597	(2,558)	-1.5%
Supplies	48,390	46,118	(2,272)	-4.9%
Fees & Purchased Services	35,276	34,715	(562)	-1.6%
Other Operating Expense	43,260	38,099	(5,161)	-13.5%
Total Operating Expense	**303,081**	**292,528**	**(10,553)**	**-3.6%**
Net Operating Income/(Loss)	**18,797**	**23,738**	**(4,941)**	**-20.8%**
Non Operating Income	(12,293)	9,301	(21,594)	-232.2%
Net Income(Loss)	**6,504**	**33,039**	**(26,535)**	**-80.3%**
Collection Rate	28.2%	27.7%	0.5%	
Operating Margin	5.8%	7.5%	-1.7%	
Net Margin	2.0%	10.4%	-8.4%	

[1] Hospital entity only, excludes controlled affiliates

El Camino Hospital – Mountain View[1]

Results from Operations vs. Budget

5 months ending 11/30/2015

$000s	FY 2016	Budget 2016	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	902,601	911,362	(8,761)	-1.0%
Deductions	(658,445)	(661,792)	3,346	-0.5%
Net Patient Revenue	**244,156**	**249,570**	**(5,415)**	**-2.2%**
Other Operating Revenue	8,638	7,503	1,135	15.1%
Total Operating Revenue	**252,794**	**257,073**	**(4,280)**	**-1.7%**
OPERATING EXPENSE:				
Salaries & Wages	146,552	144,015	(2,537)	-1.8%
Supplies	39,545	37,489	(2,056)	-5.5%
Fees & Purchased Services	28,462	27,873	(589)	-2.1%
Other Operating Expense	32,679	27,756	(4,924)	-17.7%
Total Operating Expense	**247,239**	**237,133**	**(10,106)**	**-4.3%**
Net Operating Income/(Loss)	**5,555**	**19,941**	**(14,385)**	**-72.1%**
Non Operating Income	(12,293)	9,301	(21,594)	-232.2%
Net Income(Loss)	**(6,738)**	**29,242**	**(35,980)**	**-123.0%**
Collection Rate	27.1%	27.4%	-0.3%	
Operating Margin	2.2%	7.8%	-5.6%	
Net Margin	-2.7%	11.4%	-14.0%	

[1] Hospital entity only, excludes controlled affiliates

El Camino Hospital – Los Gatos [1]

Results from Operations vs. Budget

5 months ending 11/30/2015

$000s	FY 2016	Budget 2016	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	205,779	201,893	3,886	1.9%
Deductions	(137,747)	(143,634)	5,887	-4.1%
Net Patient Revenue	**68,032**	**58,259**	**9,773**	**16.8%**
Other Operating Revenue	1,052	934	118	12.7%
Total Operating Revenue	**69,084**	**59,193**	**9,891**	**16.7%**
OPERATING EXPENSE:				
Salaries & Wages	29,602	29,582	(20)	-0.1%
Supplies	8,845	8,628	(217)	-2.5%
Fees & Purchased Services	6,814	6,842	28	0.4%
Other Operating Expense	10,581	10,343	(238)	-2.3%
Total Operating Expense	**55,842**	**55,395**	**(447)**	**-0.8%**
Net Operating Income/(Loss)	**13,242**	**3,797**	**9,445**	**248.7%**
Non Operating Income	0	0	0	0.0%
Net Income(Loss)	**13,242**	**3,797**	**9,445**	**248.7%**
Collection Rate	33.1%	28.9%	4.2%	
Operating Margin	19.2%	6.4%	12.8%	
Net Margin	19.2%	6.4%	12.8%	

[1] Hospital entity only, excludes controlled affiliates

El Camino Hospital [1]

Balance Sheet ($ Thousands)

ASSETS

CURRENT ASSETS	November 30, 2015	Audited June 30, 2015
Cash	51,458	55,224
Short Term Investments	125,758	145,027
Patient Accounts Receivable, net	98,183	95,737
Other Accounts and Notes Receivable	2,706	2,378
Intercompany Receivables	1,111	1,595
Inventories and Prepaids	39,218	44,055
Total Current Assets	**318,433**	**344,016**
BOARD DESIGNATED ASSETS		
Plant & Equipment Fund	122,141	117,965
Operational Reserve Fund	100,196	100,196
Community Benefit Fund	13,047	2,085
Workers Compensation Reserve Fund	25,816	24,719
Postretirement Health/Life Reserve Fund	17,889	17,197
PTO Liability Fund	23,814	22,212
Malpractice Reserve Fund	1,800	1,800
Catastrophic Reserves Fund	13,937	14,150
Total Board Designated Assets	**318,640**	**300,324**
FUNDS HELD BY TRUSTEE	**35,419**	**37,676**
LONG TERM INVESTMENTS	**202,659**	**207,290**
INVESTMENTS IN AFFILIATES	**31,213**	**31,808**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,138,832	1,077,951
Less: Accumulated Depreciation	(491,095)	(473,920)
Construction in Progress	41,483	82,506
Property, Plant & Equipment - Net	**689,219**	**686,537**
DEFERRED OUTFLOWS	25,018	25,218
RESTRICTED ASSETS - CASH	1	5
TOTAL ASSETS	**1,620,601**	**1,632,874**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	November 30, 2015	Audited June 30, 2015
Accounts Payable	19,005	30,142
Salaries and Related Liabilities	21,028	20,812
Accrued PTO	23,814	22,212
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	14,572	20,253
Intercompany Payables	62	108
Malpractice Reserves	1,800	1,800
Bonds Payable - Current	5,475	5,475
Bond Interest Payable	2,122	1,711
Other Liabilities	3,441	3,111
Total Current Liabilities	**93,620**	**107,925**
LONG TERM LIABILITIES		
Post Retirement Benefits	17,889	17,197
Worker's Comp Reserve	23,516	22,419
Other L/T Obligation (Asbestos)	3,576	3,531
Other L/T Liabilities (IT/Medl Leases)	-	7,102
Bond Payable	230,946	222,446
Total Long Term Liabilities	**275,926**	**272,696**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	932,415	951,924
Board Designated	318,640	300,324
Restricted	1	5
Total Fund Bal & Capital Accts	**1,251,056**	**1,252,254**
TOTAL LIABILITIES AND FUND BALANCE	**1,620,601**	**1,632,874**

[1] Hospital entity only, excludes controlled affiliates

El Camino Hospital

Capital Spending (in millions)

Capital Spending
As of November 2015

Category	Detail	Approved	Total Authorized Active	Total Spent YTD	Spent from Inception	Remaining	2016 Proj Spend
CIP	EPIC Installation		73.8	12.1	48.3	25.5	35.9
IT Hardware, Software, Equipment*			6.9	2.1		4.8	6.9
Medical & Non Medical Equipment			12.6	2.5		10.1	12.6
Facility Projects							
	NPCR3 Seismic Upgrades	FY12	6.7	0.1	5.0	1.7	0.0
	LG Imaging Masterplan	FY12	3.1	0.0	2.8	0.3	0.0
	Slot Build-Out	FY13	19.0	0.1	17.5	1.5	0.0
	LG Upgrades	FY13	13.0	1.0	7.9	5.1	9.5
	LG Spine OR	FY13	4.1	0.0	0.6	3.5	4.1
	Oak Pavilion Cancer Ctr TI	FY14	5.9	0.4	5.7	0.2	0.0
	Integrated MOB	FY15	28.0	3.5	6.2	21.8	10.0
	North Drive Parking Expansion	FY15	3.0	0.7	0.9	2.1	14.5
	Behavioral Health Bldg	FY16	9.0	0.6	6.1	2.9	4.5
	LG Imaging Phase II (CT & Gen Rad)	FY16	0.0	0.0	0.0	0.0	4.8
	LG Rehab HVAC System & Structural	FY16	3.7	0.0	0.0	3.7	3.4
	Cabling & Wireless Upgrades	FY16	2.8	0.8	0.8	2.0	2.8
	IMOB Preparation Project - Old Main	FY16	0.5	0.0	0.0	0.5	2.3
	Women's Hospital Expansion	FY16	0.0	0.0	0.0	0.0	1.5
	CUP Upgrade	FY16	1.5	0.2	0.3	1.2	0.5
	Willow Pavilion Tomosynthesis	FY16	1.3	0.0	0.0	1.3	0.0
	LG Electrical Systems Upgrade	FY16	0.0	0.0	0.0	0.0	1.0
	Facilities Planning Allowance	FY16	0.0	0.0	0.0	0.0	1.0
	All Other		6.7	0.6	3.3	3.3	10.6
	Unassigned Costs		0.0	1.8	2.6	-2.6	0.0
			108.2	9.9	59.7	48.5	70.4
	GRAND TOTAL		**201.5**	**26.5**			**125.8**

2016 projected spend includes items to be presented for approval during the fiscal year

El Camino Hospital Capital Spending (in thousands) FY 2011 – FY 2015

Category	2011	2012	2013	2014	2015	Totals
IT Hardware/Software Equipment	**3,543.9**	**7,289.3**	**8,019.0**	**2,788.1**	**4,660.5**	**26,300.8**
Medical/Non Medical Equipment	**6,631.6**	**11,203.3**	**10,284.5**	**12,891.0**	**13,339.9**	**54,350.3**
Non CIP Land, Land I, BLDG, Additions	**2,518.4**	**7,310.7**	**0.0**	**22,291.5**	**0.0**	**32,120.6**
Facilities Projects CIP						
0101 - Hosp Replace	232.2	313.4	0.0	0.0	0.0	545.6
0317 - Melchor TI's	925.4	117.5	0.0	0.0	0.0	1,042.9
0701 - Cyberknife	734.8	0.0	0.0	0.0	0.0	734.8
0704 - 1 South Upgrade	0.0	1.7	0.0	0.0	0.0	1.7
0802 - Willow Pavillion Upgrades	7.2	0.0	0.0	0.0	0.0	7.2
0805 - Women's Hospital Finishes	51.5	0.0	0.0	0.0	0.0	51.5
0809 - Hosp Renovations	261.9	0.0	0.0	0.0	0.0	261.9
0815 - Orc Pav Water Heater	28.9	0.0	0.0	0.0	0.0	28.9
0816 - Hospital Signage	40.9	0.0	0.0	0.0	0.0	40.9
0904 - LG Facilities Upgrade	254.2	41.0	2.0	0.0	0.0	297.1
0907 - LG Imaging Masterplan	0.0	161.9	243.8	774.4	1,401.9	2,582.0
1000 - LG Rehab Building	258.3	0.0	0.0	0.0	0.0	258.3
1104 - New Main CDU TV's	124.1	0.0	0.0	0.0	0.0	124.1
9900 - Unassigned Costs	921.2	279.4	733.6	470.3	3,716.8	6,121.2
0803 - Park Pav Foundation	206.7	270.4	0.0	0.0	0.0	477.1
1005 - LG OR Light Upgrd	89.4	108.0	14.2	0.0	0.0	211.5
1101 - Melchor Pavilion - Genomics	15.2	0.0	0.0	0.0	0.0	15.2
1102 - LG Joint Hotel	359.0	656.8	0.0	0.0	0.0	1,015.9
1106 - SHC Project	0.0	2,245.0	0.0	0.0	0.0	2,245.0
1108 - Cooling Towers	4.1	932.3	449.5	0.0	0.0	1,386.0
1115 - Womens Hosp TI's	0.0	49.5	0.0	0.0	0.0	49.5
1118 - Park Pav Roto Care	0.0	119.3	0.0	0.0	0.0	119.3
1120 - BHS Out Patient TI's	0.0	472.0	66.1	0.0	0.0	538.0
1122 - LG Sleep Studies	0.0	147.2	7.0	0.0	0.0	154.2
1129 - Old Main Card Rehab	0.0	399.8	9.2	0.0	0.0	409.0
0817 - Womens Hosp Upgrds	132.3	1,241.8	645.3	1.3	0.0	2,020.8
0906 - Slot Build-Out	0.0	0.0	1,003.0	1,575.7	15,101.1	17,679.7
1107 - Boiler Replacement	0.0	49.1	0.0	0.0	0.0	49.1
1109 - New Main Upgrades	0.0	589.1	423.3	392.7	2.2	1,407.4
1111 - Mom/Baby Overflow	0.0	267.0	211.8	28.9	0.0	507.7
1129 - Cardic Rehab Improv	0.0	0.0	0.0	0.0	0.0	0.0
1132 - Pheumatic Tube Prj	0.0	78.4	0.0	0.0	0.0	78.4
1204 - Elevator Upgrades	0.0	23.9	25.3	30.5	0.0	79.7
1210 - Los Gatos VOIP	0.0	0.6	146.7	88.6	0.0	235.9
0800 - Womens L&D Expansion	26.8	129.3	2,103.9	1,531.1	268.6	4,059.7
1116 - LG Ortho Pavillion	0.0	44.3	176.7	24.0	21.1	266.1
1124 - LG Rehab BLDG	0.0	10.6	49.0	457.6	0.0	517.2
1128 - LG Boiler Replacement	0.0	3.3	0.0	0.0	0.0	3.3
1131 - MV Equipment Replace	0.0	190.0	216.3	0.0	0.0	406.3
1135 - Park Pavilion HVAC	0.0	47.2	0.0	0.0	0.0	47.2
1208 - Willow Pav. High Risk	0.0	0.0	110.4	0.0	0.0	110.4
1213 - LG Sterilizers	0.0	0.0	102.0	0.0	0.0	102.0
1225 - Rehab BLDG Roofing	0.0	0.0	6.7	241.3	4.0	252.0
1227 - New Main eICU	0.0	0.0	95.7	20.7	0.0	116.5
1230 - Fog Shop	0.0	0.0	339.3	79.9	0.0	419.2
1247 - LG Infant Security	0.0	0.0	133.8	0.0	0.0	133.8
1307 - LG Upgrades	0.0	0.0	376.5	2,979.5	3,282.5	6,638.4
1308 - LG Infrastructure	0.0	0.0	0.0	113.7	0.0	113.7
1315 - 205 So. Drive TI's	0.0	0.0	0.0	499.5	1.9	501.4
0908 - NPCR3 Seismic Upgrds	0.0	554.3	1,302.1	1,223.9	1,327.6	4,407.9
1125 - Will Pav Fire Sprinkler	0.0	9.4	56.5	38.7	0.0	104.6
1211 - SIS Monitor Install	0.0	0.0	215.3	0.0	0.0	215.3
1216 - New Main Process Imp Office	0.0	0.0	18.7	1.1	15.9	35.7
1217 - MV Campus MEP Upgrades FY13	0.0	0.0	0.0	180.9	273.8	454.7
1219 - LG Spine OR	0.0	0.0	0.0	214.1	323.0	537.1
1221 - LG Kitchen Refrig	0.0	0.0	0.0	84.6	0.0	84.6
1224 - Rehab Bldg HVAC Upgrades	0.0	0.0	10.5	202.3	81.1	293.9
1245 - Behavioral Health Bldg Replace	0.0	0.0	0.0	1,257.3	3,774.6	5,031.9
1248 - LG - CT Upgrades	0.0	0.0	0.0	26.1	344.6	370.8
1249 - LG Mobile Imaging	0.0	0.0	0.0	145.9	0.0	145.9
1301 - Desktop Virtual	0.0	0.0	0.0	13.3	0.0	13.3
1304 - Rehab Wander Mgmt	0.0	0.0	0.0	86.8	0.0	86.8
1310 - Melchor Cancer Center Expansion	0.0	0.0	0.0	44.2	13.2	57.4
1318 - Women's Hospital TI	0.0	0.0	0.0	48.5	47.8	96.3
1327 - Rehab Building Upgrades	0.0	0.0	0.0	0.0	15.0	15.0
1320 - 2500 Hosp Dr Roofing	0.0	0.0	0.0	74.7	80.8	155.5
1328 - LG Ortho Canopy FY14	0.0	0.0	0.0	255.2	208.8	464.0
1340 - New Main ED Exam Room TVs	0.0	0.0	0.0	7.5	193.0	200.5
1341 - New Main Admin	0.0	0.0	0.0	32.3	102.7	135.1
1344 - New Main AV Upgrd	0.0	0.0	0.0	243.2	0.0	243.2
1345 - LG Lab HVAC	0.0	0.0	0.0	112.4	0.0	112.4
1346 - LG OR 5, 6, and 7 Lights Replace	0.0	0.0	0.0	0.0	285.1	285.1
1347 - LG Central Sterile Upgrades	0.0	0.0	0.0	0.0	181.3	181.3
1400 - Oak Pav Cancer Center	0.0	0.0	0.0	0.0	5,208.2	5,208.2
1403 - Hosp Drive BLDG 11 TI's	0.0	0.0	0.0	85.8	102.7	188.5
1404 - Park Pav HVAC	0.0	0.0	0.0	64.0	7.1	71.1
1408 - New Main Accessibility Upgrades	0.0	0.0	0.0	0.0	6.6	6.6
1413 - North Drive Parking Structure Exp	0.0	0.0	0.0	0.0	166.6	166.6
1414 - Integrated MOB	0.0	0.0	0.0	0.0	2,009.1	2,009.1
1421 - LG MOB Improvements	0.0	0.0	0.0	0.0	197.6	197.6
1429 - 2500 Hospital Dr Bldg 8 TI	0.0	0.0	0.0	0.0	101.0	101.0
1432 - 205 South Dr BHS TI	0.0	0.0	0.0	0.0	8.1	8.1
1501 - Women's Hospital NPC Comp	0.0	0.0	0.0	0.0	3.7	3.7
1504 - Equipment Support Infrastructure	0.0	0.0	0.0	0.0	60.5	60.5
Subtotal Facilities Projects CIP	**4,674.1**	**9,553.4**	**9,294.2**	**13,752.7**	**38,939.6**	**76,213.8**
Grand Total	**17,368.0**	**35,356.6**	**27,597.6**	**51,723.3**	**56,940.0**	**188,985.6**

FY 2016 Facilities Projects Detail

(In 000s)

		Budgeted Commitment		Budgeted Spend
Mountain View Campus Master Plan Projects				
BHS Replacement	**	$53,500		$4,500
North Dr Parking Structure Expansion		$14,000	*	$14,500
Integrated Medical Office Building	**	$229,000		$10,000
CUP Upgrades		$500		$500
Womens Hosp Expansion	**	$2,000		$1,500
		$299,000		**$31,000**
Mountain View Capital Projects				
Womens Hosp NPC Closeout		$750		$500
IMOB Preparation Project - Old Main		$2,250		$2,250
Cabling and Wireless upgrades		$2,800		$2,800
Histology Fume Hood Upgrades		$500		$500
ED Remodel Triage / Psych Observation		$300		$100
Signage & Wayfinding		$600		$600
MV Equipment & Infrastructure Upgrades		$750		$750
Breast Imaging Tomography	**	$300		$300
Willow Pavilion FA Sys and Equip Upgrades		$800		$800
Ceiling Lifts - Imaging Dept.		$200		$200
Misc. Reconfiguration Upgrades		$600		$600
MV MOB TI Allowance		$500		$500
Facilities Planning Allowance		$1,000		$1,000
		$11,350		**$10,900**
Los Gatos Capital Projects				
LG Spine Room Expansion - OR 4	**	0	*	$4,100
LG Rehab HVAC Upgrades		0	*	$3,400
LG Imaging Phase II (CT & Gen Rad)		$4,650	*	$4,800
LG Upgrades - Major		$2,500	*	$9,500
LG Electrical Systems Upgrade		$1,000		$1,000
LG Rehab Building Upgrades		$500		$500
LG Surgical Lights OR's 5,6 & 7		$0	*	$149
LG Central Sterile Upgrades		$3,455	*	$3,600
LG MOB Improvements		$500		$150
LG IR Upgrades	**	$800		$600
LG NICU 4 Bed Expansion	**	$500		$150
LG Misc. Reconfiguration Upgrades		$600		$600
		$14,505		**$28,549**
Grand Total Facilities Projects		**$324,855**		**$70,449**

* Spending includes prior year commitments

* Incremental Revenue Producing

Capital < 250k includes exploration of ED Lobby Space Redesign

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

ATTACHMENT 13

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

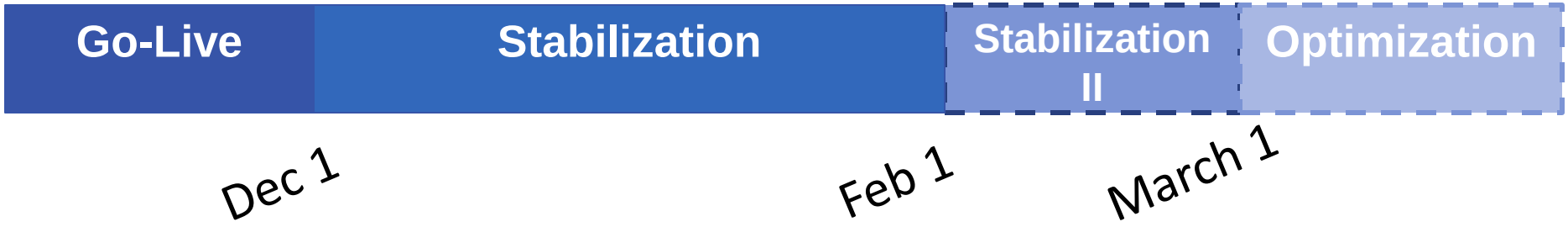
iCare Board Update
January 13, 2016

Dave Reeder
Chair, iCare Ad Hoc Committee

Highlights from 8+ weeks Post Go-Live

- Technical system for iCare continues to run smoothly
- Issues being encountered are what was expected and are primarily related to process changes
- Key Areas of Focus (remain the same from 12/18/2015):
  - Schegistration/Charge Capture (and Revenue Recognition)
  - Data Integrity (including Medication Reconciliation)
  - Physician Workflows
  - Patient Movement
- Stabilization Phase is focused on getting folks to use system as designed while dealing with issues when/if they arise related to patient safety
- Open Work Orders (as of 12/28/2015): 1258
- Operating Costs are running somewhat higher than planned with additional staff used in a variety of ways Post Go-Life
- Epic will be onsite January 18th to conduct their first Post-Go-Live Assessment
- Overall : "Things are better than they used to be before Go-Live, but not as well as they can/will be going forward"

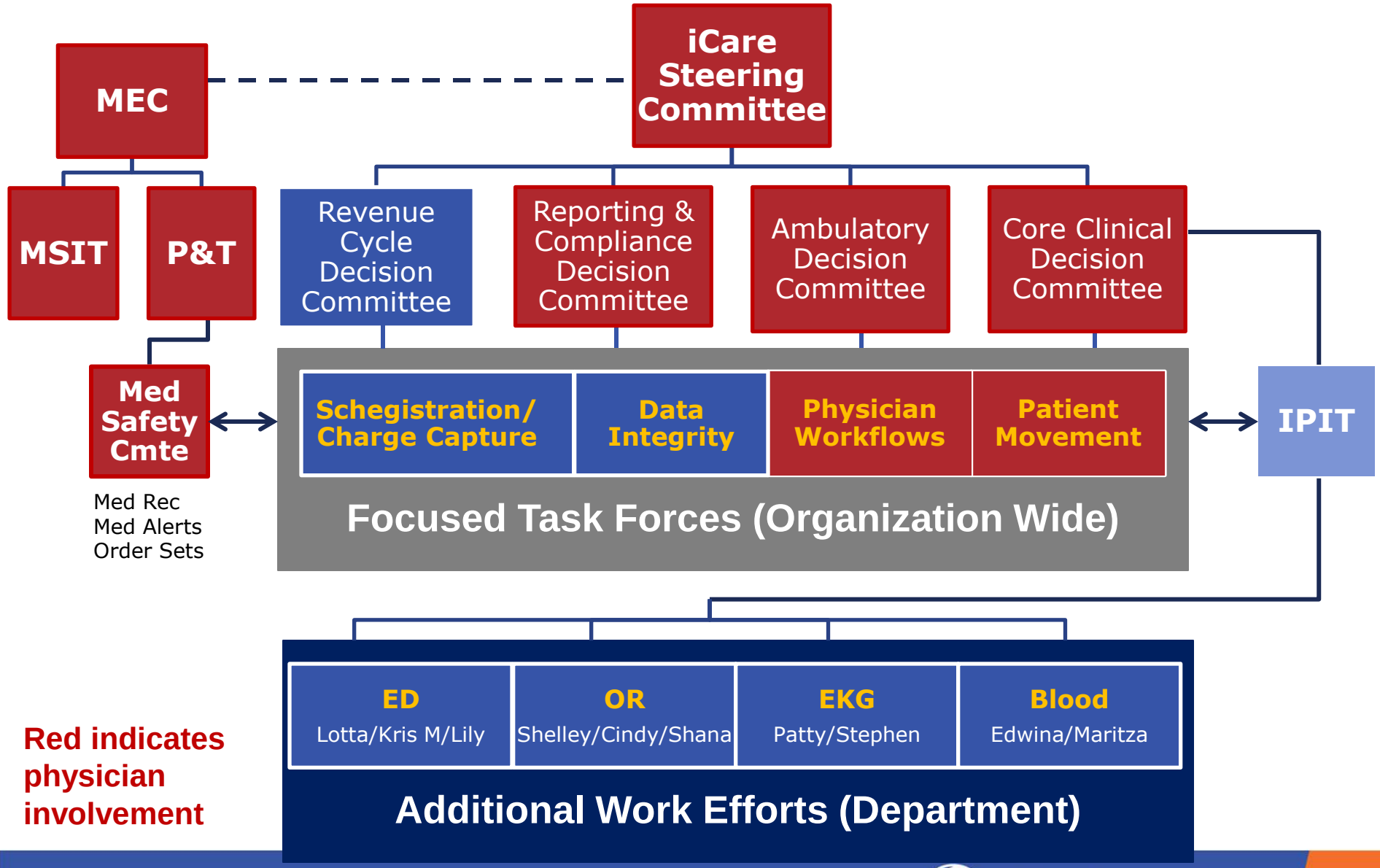
Looking Forward



Goal: Stable and Safe

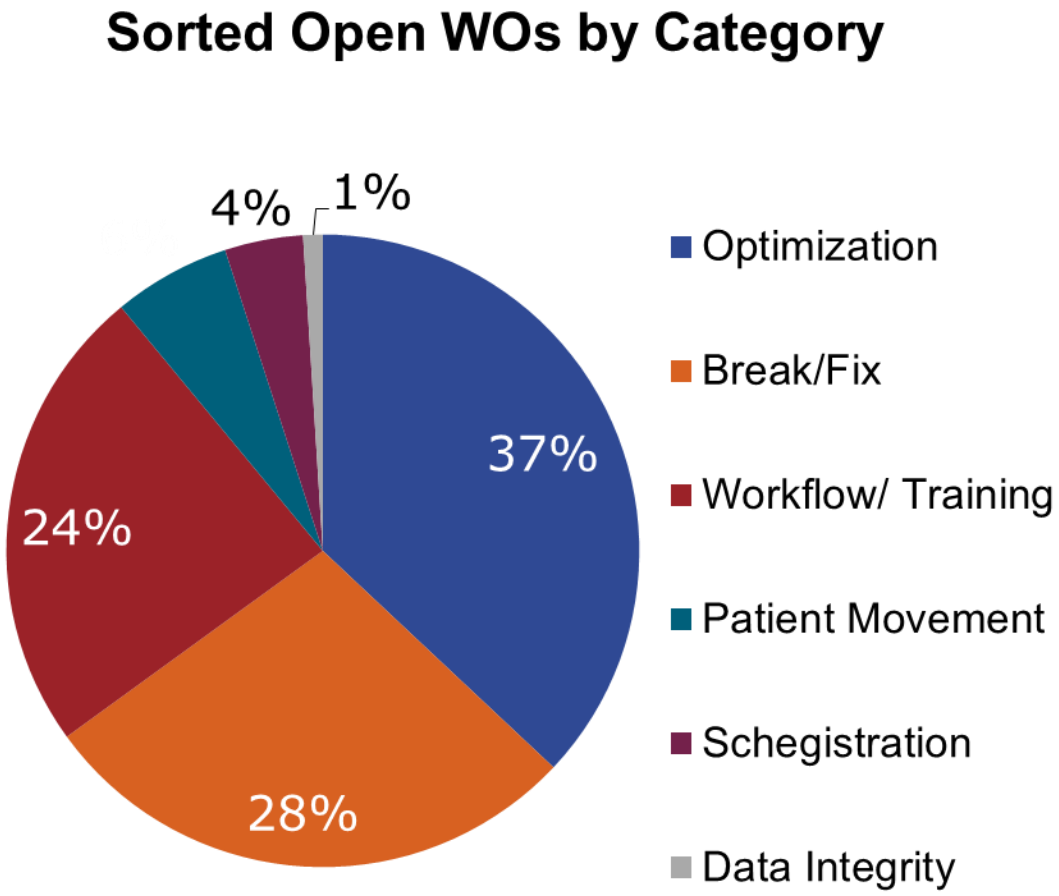
- Using system as designed
- Training & workflow adjustments
- HelpDesk process & flow

Post Go- Live Governance



Red indicates physician involvement

Open Work Orders (as of 12/28/15)



- All WOs are being addressed based on severity
- In addition, we are categorizing open WOs to identify trends
- Total Open WOs: 1258
  - 731 have been categorized and depicted in the graph on the left

Key Go-Live Metrics

Excellence in Patient Care

Medication Barcoding & Clinical Documentation

- **Medication barcoding** includes:
  - Combined patient and med barcode scanning and compliance

- **Completion of clinical documentation** includes the following:

Within 1 hour

- Pain Assessment
- Vitals, Height, and Weight

Within 8 hours

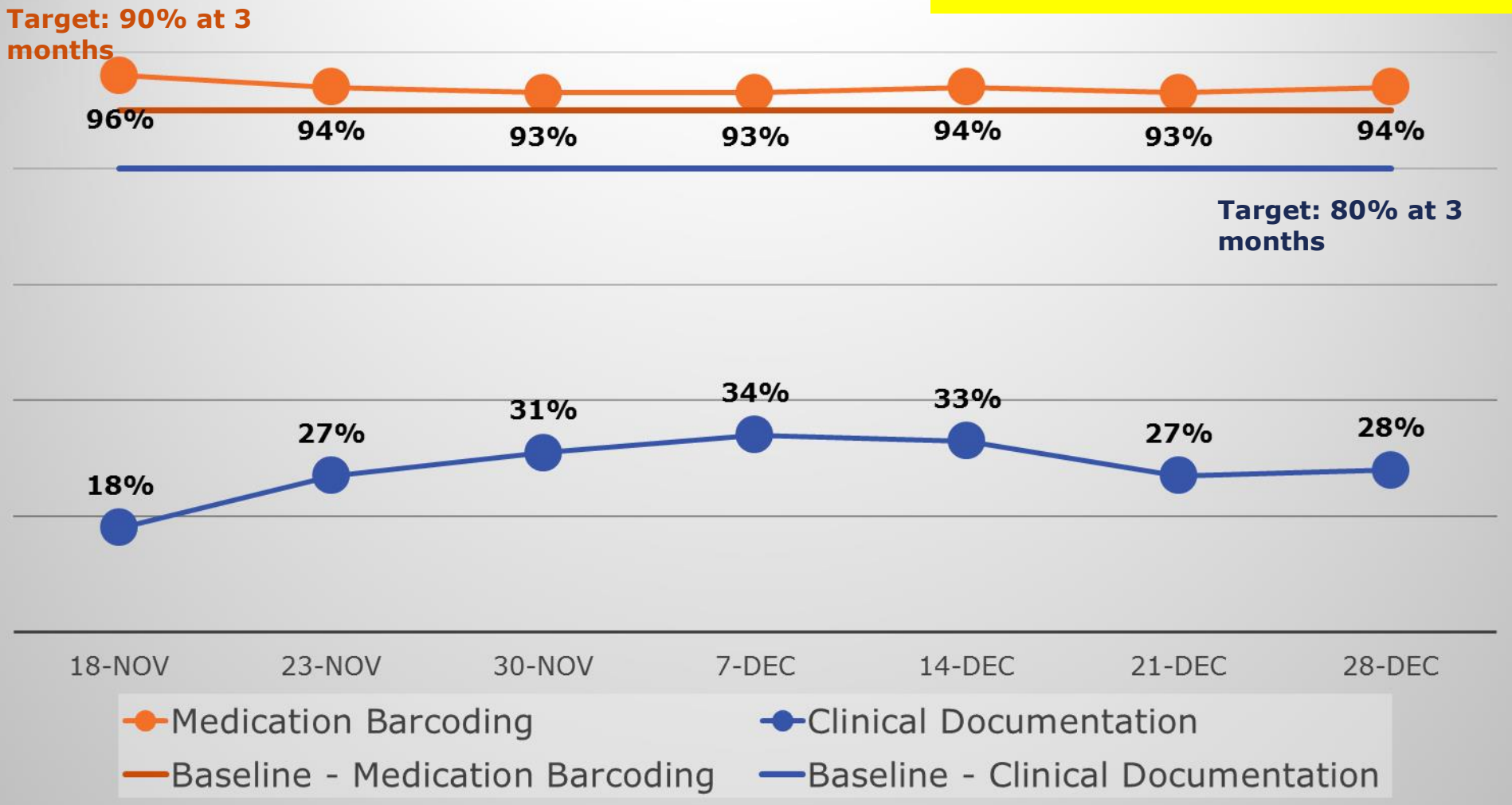
- Advance Directives Documented
- Advance Directives Reviewed
- Allergies Reviewed
- DVT Risk Assessment

Within 8 hours (continued

- Domestic Abuse Assessment
- Fall Assessment
- Functional Assessment
- Infectious Risk Assessment
- Influenza Vaccine Screen
- Learning Assessment Filed
- Medical History Reviewed
- Nutrition Assessment
- PTA Med List Complete
- Patient Belongings Assessment
- Pneumococcal Vaccine Screen
- Preferred Pharmacy Documented
- Skin/Braden Assessment
- Smoking History Documented
- Suicide Assessment
- Values Assessment

Excellence in Patient Care

Medication Barcoding is in good shape; more work needed to get clinical documentation completed in agreed to time windows



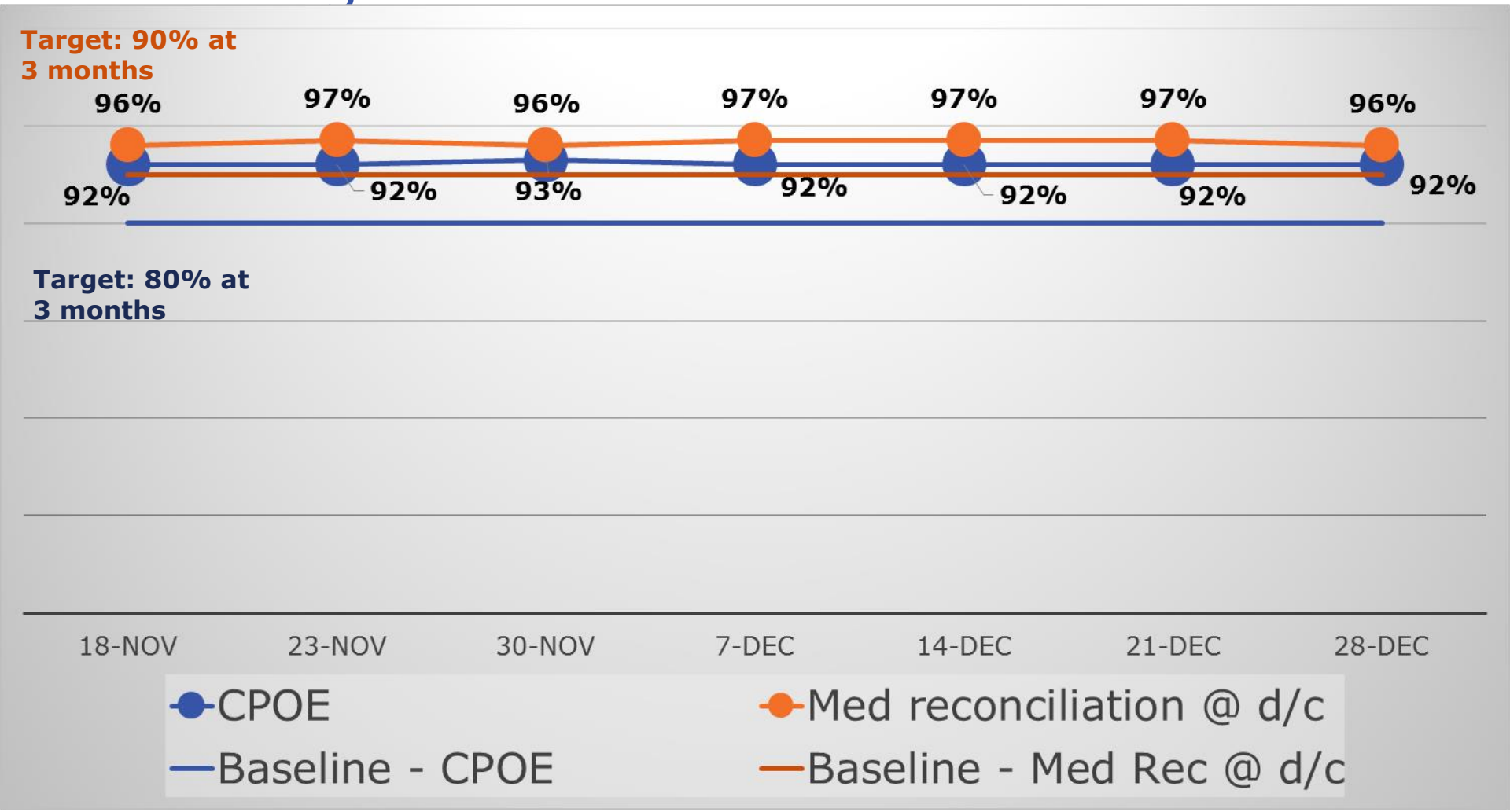
Physician Adoption

- **CPOE:** % of total orders enter by a physician or per protocol orders. Verbal or telephone orders count against CPOE.
- **Med reconciliation at discharge:** % of discharged patients that have full med rec done at time of discharge
- **Patients with problem in the problem list:** % of patients that have had problem list updated during the hospital stay
- **Use of order sets:** % of total physician orders from order sets

Physician Adoption

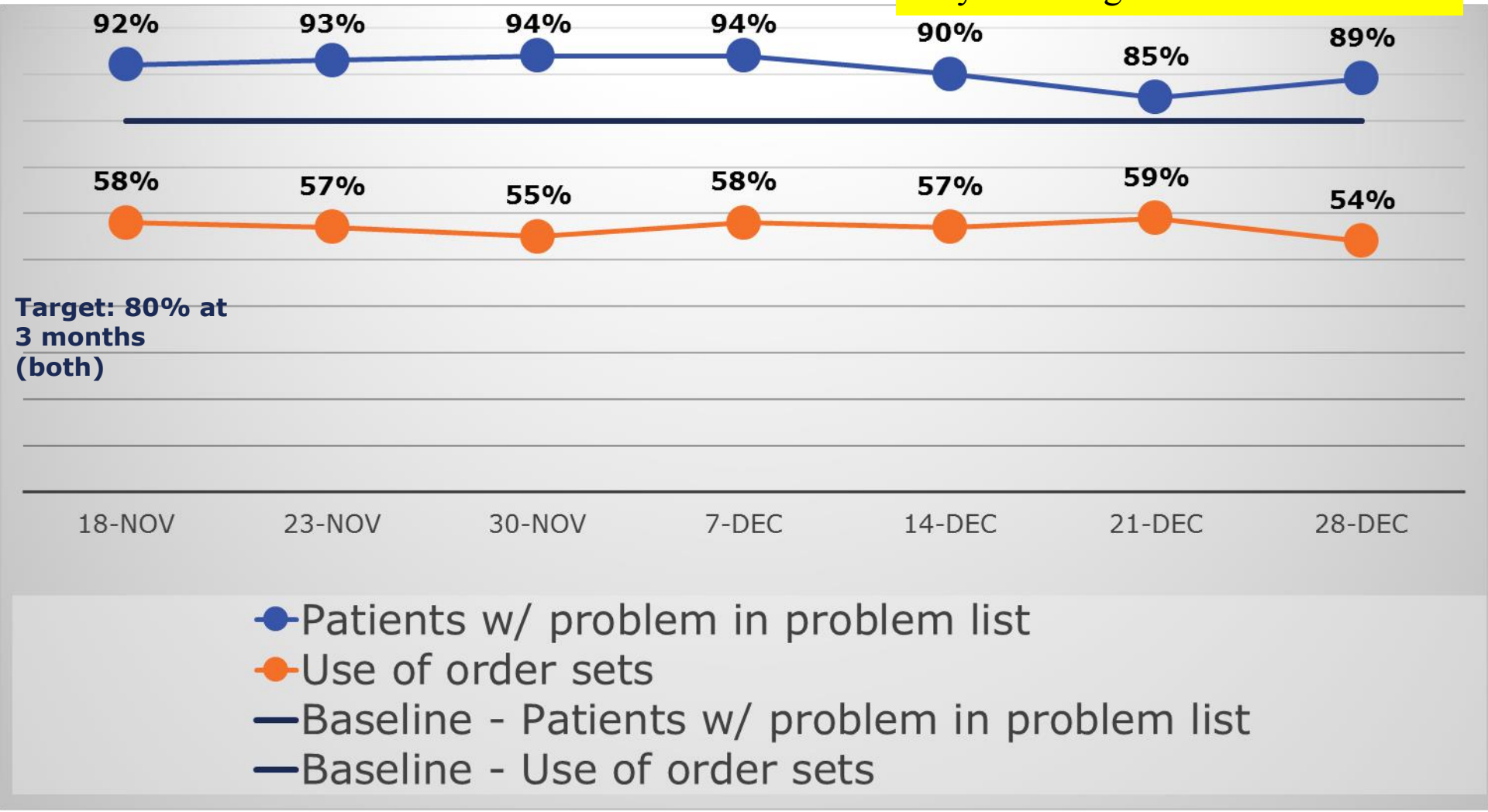
CPOE & Medication Reconciliation at Discharge

Going Well



Physician Adoption
Problem List & Order Sets

Problem lists themselves appear to be well designed; more work needed to ensure they are being used as intended



Efficiency

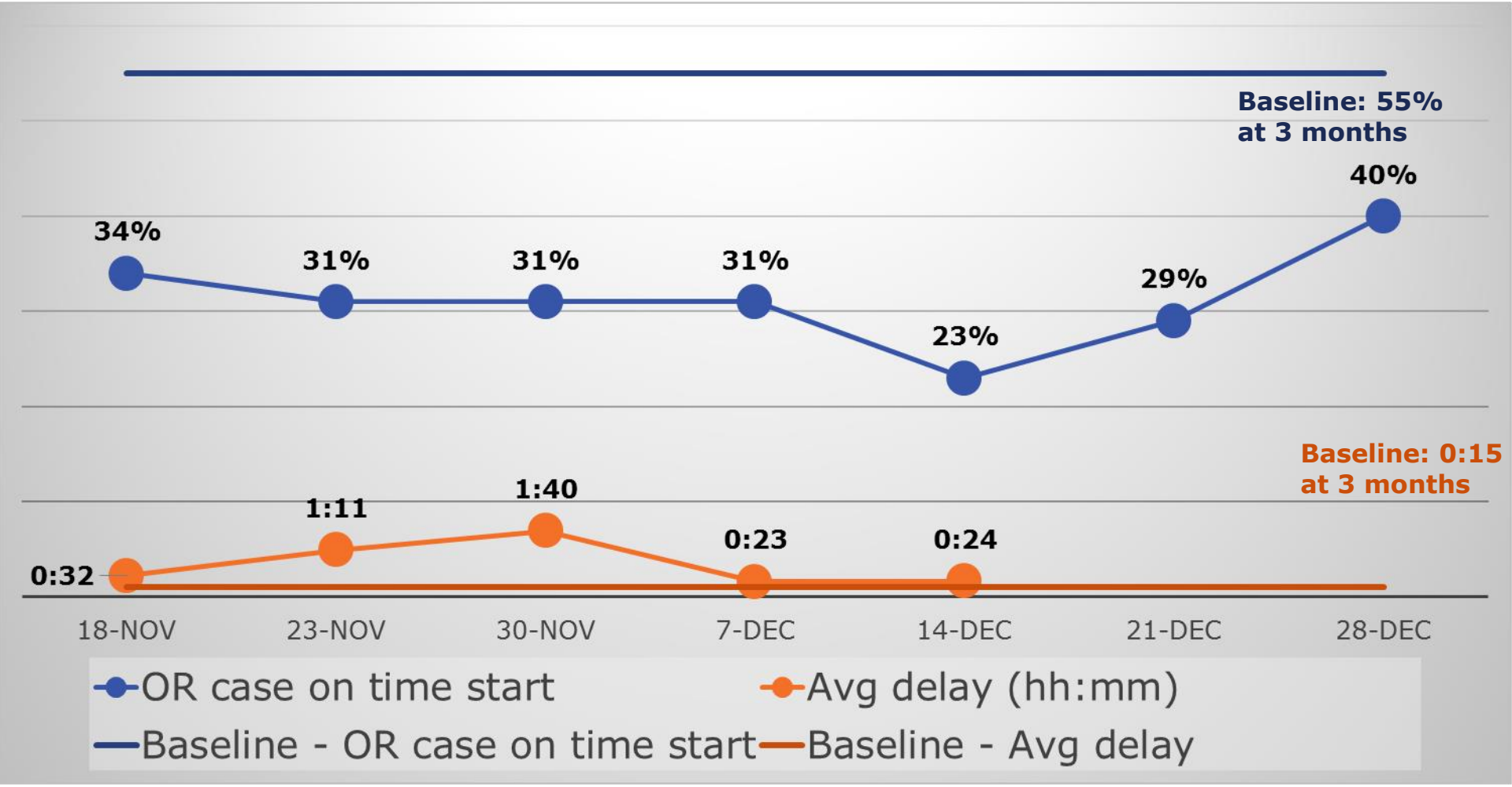
- **OR Case Starts:** % of OR cases that start within 5 minutes of scheduled time
- **Average Delay:** the average amount of time (hh:mm) delay for case starts
- **ED Door to Floor:** the average amount of time (hh:mm) it takes for an admitted patient from the point of being triaged in the ED to arriving on the inpatient unit

Efficiency

OR Case Start & Average Delay

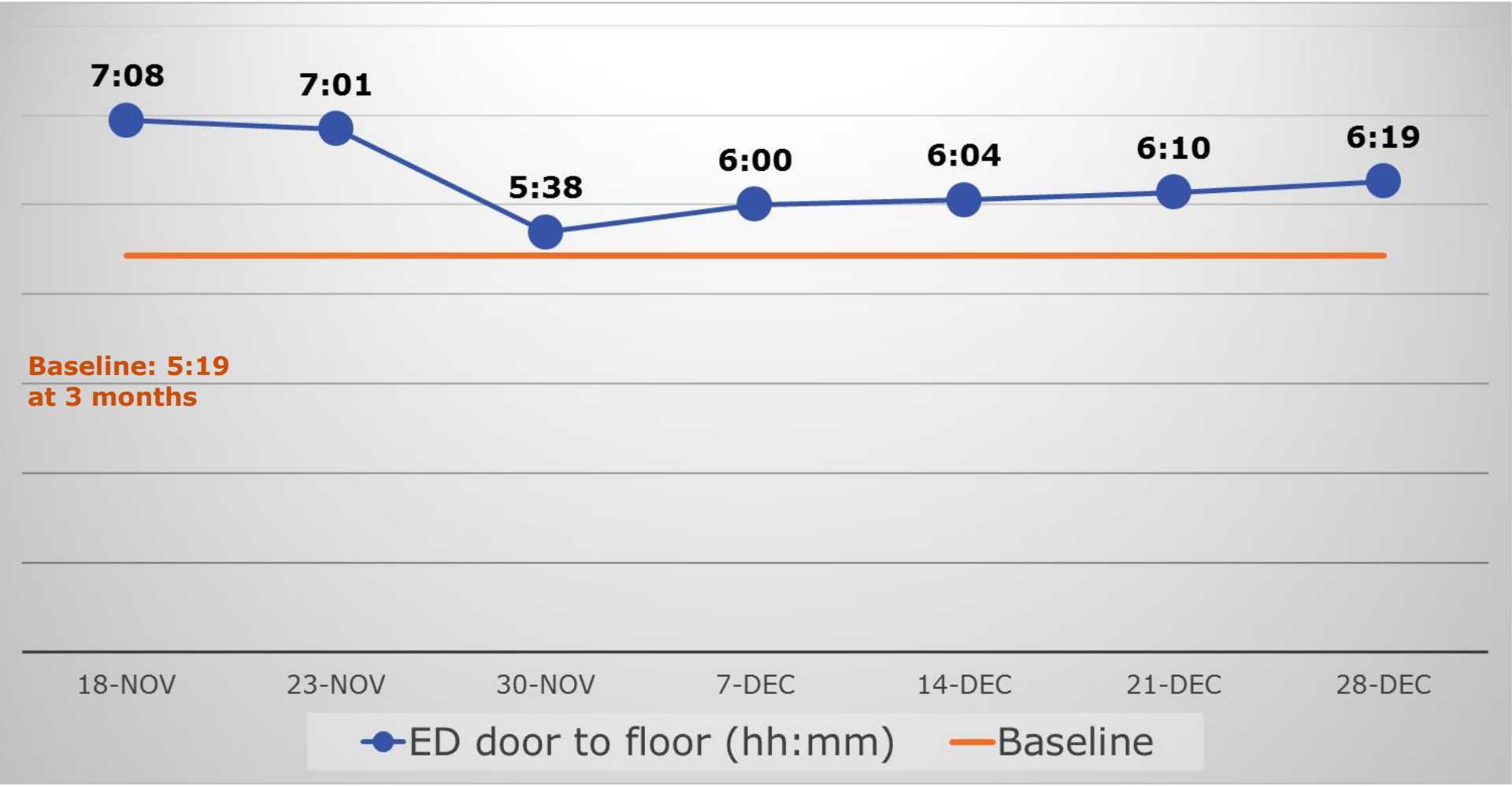
Clear improvement being seen

NOTE: Avg Delay Data Not Available At This Time



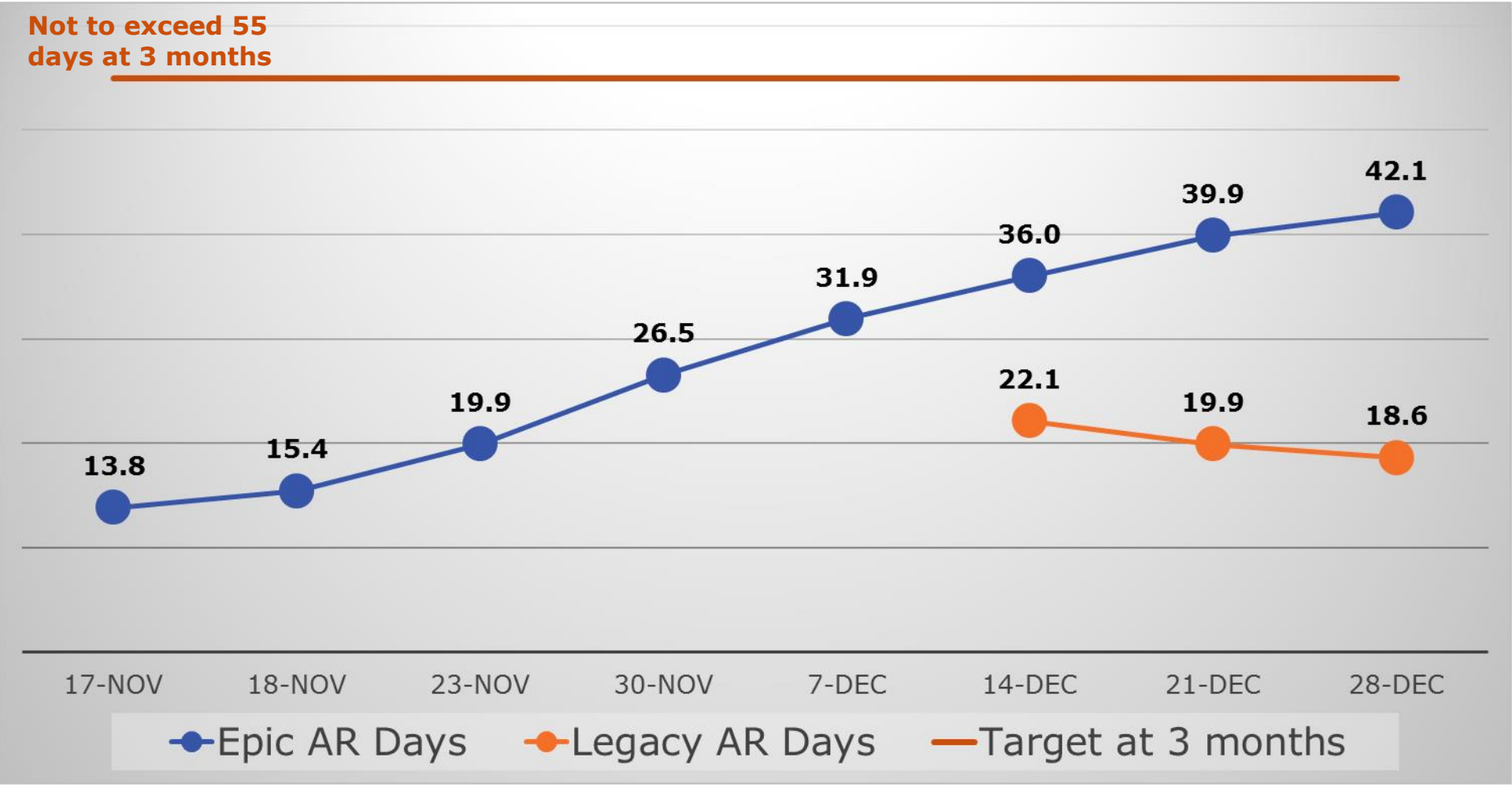
Efficiency
ED Door to Floor

More work needed to get this time down, although this was an issue prior to iCare's implementation



Revenue Cycle
Epic and Legacy AR Days (Gross)

See focused efforts in this area on next slide



Revenue Cycle Recognition

- A daily meeting is scheduled to review the Revenue Cycle Dashboard metrics and address areas which are not trending appropriately
- Daily Charges are trending over the expected baseline while the Candidate For Bill metric is not meeting the expected 3 month baseline goal
- A mitigation plan has been identified and monitored at the daily Dashboard Meeting to address Work queue challenges which are impacting this target
- More detail is being developed and will be added to the packet when available.

ATTACHMENT 14

ECH BOARD MEETING AGENDA ITEM

	Item:	Board and Committee Minutes Content El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	Discussion/Possible Motion
	Background: In May 2015 the Board adopted a number of Board Process Recommendations made by Via Healthcare Consulting. Among the recommendations was reduction of the level of detail in Board and Committee Minutes and to limit recording to what was reported, what was approved and what follow-up was requested from the Committee or the Board, as opposed to detailed reporting of the conversations that took place. Staff implemented Via's recommendations in June 2015. Director Zoglin has expressed concern about the recommendations and the implementation, in particular the possible loss of enough detail to provide historical context, and requested that this item be placed on the Board's agenda for discussion.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: The Board Processes Work Group and the Governance Committee reviewed and recommended Board approval of the Via Healthcare Consulting Recommendations in FY 2015.	
	Summary and session objectives : 1. Is the current level of detail provided in Board and Committee Minutes over the first half of Fiscal Year 16 in accord with the Board's expectations following the Via Consulting recommendations? 2. Is the current level of detail provided in Board and Committee Minutes over the first half of Fiscal Year 16 acceptable to the Board?	
	Proposed board motion: At the discretion of the Board.	
	LIST OF ATTACHMENTS: All approved Board and Committee Minutes are available on the Board portal and Open Session Minutes are available on the ECH Website. They are not presented here to avoid duplication.	

11-4-15

Minutes of the Open Session of the
Special Meeting to Conduct a Study Session of the El Camino Hospital Board
Wednesday, November 4, 2015
Los Altos Golf & Country Club
1560 Country Club Drive, Los Altos, CA 94024

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, PhD	Julia Miller	None
Neal Cohen, MD		
Dennis Chiu		
Jeffrey Davis, MD		
Peter Fung, MD		
David Reeder		
Tomi Ryba		
John Zoglin		

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The Open Session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 p.m. by Chair Neal Cohen, MD.	
2. ROLL CALL	Silent roll call was taken.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Cohen asked if any Board members may have a conflict of interest on any of the items on the agenda. No conflicts were noted.	
4. EDUCATIONAL PRESENTATION	Director Ryba introduced Robert Wachter, MD, author of *The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age.* Dr. Wachter gave an educational presentation regarding technology's influence on healthcare with an emphasis on the physician patient relationship and electronic health records.	
5. ADJOURN TO CLOSED SESSION	The Board adjourned to closed session at 7:05 pm for a report pursuant to *California Health and Safety Code Section 32106(b)*: El Camino Hospital Strategy Update	
6. AGENDA ITEM 8 – RECONVENE OPEN SESSION	Open session was reconvened at 7:15 pm. No action was taken in closed session.	

7. AGENDA ITEM 9 - ADJOURNMENT	**Motion:** To adjourn at 7:15 pm. **Movant:** Ryba **Second:** Chiu **Ayes:** Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba, and Zoglin **Noes:** None **Abstentions:** None **Absent:** Miller **Recused:** None	

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

_____
Neal Cohen, MD
Chair, ECH Board

_____
Peter C. Fung, MD
ECH Board Secretary

Prepared by: Cindy Murphy, Board Liaison

11- 11-15)

Minutes of the Open Session of the
Regular Meeting of the El Camino Hospital Board and
Wednesday, November 11, 2015
El Camino Hospital, 2500 Grant Road, Mountain View California
Conference Room A & B

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, PhD (arrived at 5:35 p.m.) Neal Cohen, MD Dennis Chiu Jeffrey Davis, MD Peter Fung, MD David Reeder Tomi Ryba John Zoglin	Julia Miller	None

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER/ROLL CALL	The Open Session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 p.m. by Chair Neal Cohen, MD. Silent roll call was taken.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Cohen asked if any Board members may have a conflict of interest on any of the items on the agenda. No conflicts were noted.	
3. BOARD RECOGNITION	**Motion:** To approve Resolution 2015-14. **Movant:** Chiu **Second:** Davis **Ayes:** Chiu, Cohen, Davis, Fung, Reeder, Ryba and Zoglin **Noes:** None **Abstentions:** None **Absent:** Chen and Miller **Recused:** None Cheryl Reinking, RN, CNO, presented the resolution to the Falls Prevention Committee for their work in fiscal year 2015 to decrease the number of patient falls. Ms. Reinking noted that due to iCare obligations, many of the Committee members were not able to attend the Board recognition ceremony. Chair Cohen acknowledged Veterans' Day honoring American Veterans.	***Resolution 2015-14 Approved***
4. QUALITY COMMITTEE REPORT	Director Reeder, Chair, Quality Committee, provided an update on the efforts of the Quality Committee. He noted that one of the committee's goals is to review the	

organizational quality objectives and ensure their fit with the strategic plan. He reported that the committee recently reviewed the medical staff credentialing process and is planning to review the peer review process in the next couple of meetings.

He noted that the committee began working on developing the patient centered care program at the beginning of the fiscal year, but took a break once it became clear the impact that iCare would have on ECH resources. The committee's goal is to have the patient centered care program developed by the end of Q3.

Director Reeder noted that at the last meeting, the committee reviewed the exception report which showed a trend toward increased medication administration errors during the months of August and September. One of the possible reasons for the increase could be the use of a higher number of traveler nurses during iCare implementation, who, it was noted, might not always have the same level of awareness of ECH policies and procedures as compared to regular nurses. Director Reeder noted that the committee has requested a full report of the medication safety committee for the December meeting to review the different categories of medication errors and ascertain how many of those errors are minor versus major.

Director Reeder reported that the committee spent a majority of time at its last meeting learning about ECH's efforts to expand its continuum of care capabilities. He noted that one of the patient advocates suggested that training for caregivers should be included in the overall continuum of care strategy. He noted that the transition to the continuum of care is already happening and that ECH is "off to a great start."

Chair Cohen noted that one of the challenges for the Quality Committee is to decipher whether increased medication errors are a result of improved tracking and identification mechanism associated with iCare or as a result of issues specific to iCare implementation.

He also noted the need for ECH to continue paying attention to the hospital's primary business which is in-patient care, as it implements the continuum of care strategy.

	Director Davis acknowledged the two patient advocates on the Quality Committee and the tremendous value that they bring to the committee.	
5. COMMUNITY BENEFIT FUNDING STRATEGY	Director Ryba presented information in response to the 4 questions that the Board asked staff to follow-up on during the September Board meeting: 1) What is the composition of the ECH Community Benefit? 2) What are national benchmarks? How are they relevant? 3) What is the composition of Community Benefit from other institutions? and 4) What percentage of the ECH budget or formula is reasonable to commit to Community Benefit? She reviewed Community Benefit funding as a percentage of expenses by ECH as compared to other local and comparable hospitals in California. She noted that the Federal and State governments have no rule as to how much nor are there any recommendations or guidelines for how much community benefit hospitals should provide. She reviewed national examples of Community Benefit threshold criteria, noting the variety of ways Community Benefit funding is established across the nation. Director Ryba pointed out that because there is no one recommended way of establishing Community Benefit funding, it is really up to the Board to make a policy decision on what is important to ECH. Director Ryba noted that ECH and ECHD have increased the amount of Community Benefit generating community grants from 3% to 5%. She commented that this level of commitment for grants exceeds that of other hospitals. Board members ensued in a discussion around the level of Community Benefit funding provided by ECH. Some members expressed their view that ECH should be spending more on Community Benefit. Iftikhar Hussain, Chief Financial Officer, restated that the $10 million endowment that the Board approved in September 2015, will provide from its interest approximately $500,000 in additional on-going support to grantees. Director Chen noted that there needs to be a model to reflect the ups and downs of ECH's margin. **Motion:** To confirm existing funding for the ECH Community Benefit Program, including the endowment.	***Financial Report Through August 31, 2015 Approved***

	Movant: Reeder **Second:** Ryba Director Chiu commented that ECH needs a mechanism for increasing Community Benefit during times of greater profit. Mr. Hussain suggested that the endowment can be revisited annually. Director Davis recommended a friendly amendment that endowment funding would be re-addressed every year during budget time. Director Reeder accepted the friendly amendment and made the motion to amend the original motion. **Second:** Davis **Ayes:** Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba and Zoglin **Noes:** None **Abstentions:** None **Absent:** Miller **Recused:** None Friendly amendment approved. A vote was taken on the original motion to confirm existing funding for the ECH Community Benefit Program. **Ayes:** Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba and Zoglin **Noes:** None **Abstentions:** None **Absent:** Miller **Recused:** None Motion approved.	
6. GOVERNANCE COMMITTEE REPORT	Director Fung, Chair, Governance Committee, reviewed the proposed agenda for the Annual Board Retreat. **Motion:** To approve proposed Annual Board Retreat Agenda **Movant:** Fung **Second:** Reeder Director Zoglin commented on the need for the retreat to	

include focus on physician strategy. Director Ryba noted that the retreat will mainly focus on integrated care and how ECH is extending care to the community. It may discuss physician networks and the importance of primary care physician as part of the integrated care work, but the main focus will be on integrated care. She also suggested using the second part of the retreat for a debrief from Dr. Thilo based on her work with the Board.

Director Davis noted that he will not be able to make the retreat the first week of February and asked to reconsider the date of the retreat.

Director Reeder commented on the need to use common terminology and differentiate between integrated care versus continuum of care.

Director Chiu asked to add an interactive time during the retreat to allow Board members to get to know each other better. Chair Cohen acknowledged the need for a social time, either at the retreat or another day.

Chair Cohen restated the motion to approve the proposed agenda based on the topic, with the date to be re-evaluated by staff.

Ayes: Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba and Zoglin
Noes: None
Abstentions: None
Absent: Miller
Recused: None

Motion approved.

Chair Cohen noted that staff will work on finding a date that would allow everyone to attend.

Director Fung commented that there is an incongruity between the District Board member's term limits on the ECH Board, which is three 4-year terms, and that of Non-District Board members, which are four 3-year terms. He reported that the Governance Committee recommended that the limit of three 4 year-terms each apply to Non-District Board members as well. The present Non-District Board members would be affected

	by this change, and therefore, their terms would be extended by one more year. He also noted that the Governance Committee recommended continuing to keep the end of the term for Non-District Board members at the end of the fiscal year, as it currently stands now. Since the District Board members' terms end at the end of the calendar year, there would not be too much disruption at the same time. **Motion:** To change Non-District Board Member term of service to three 4-year terms, including those currently serving. **Movant:** Fung **Second:** Reeder Director Zoglin noted that part of the reason a three years term was chosen is because there would be a standard process for every year a new Non-District Board member gets elected. If ECH were to move to a 4 year term, every 4th year would have a different process. He commented that there was no compelling reason to change the current term of service. He also suggested that if terms were changed, they should apply to future terms and not those currently serving in Non-District Board positions. **Ayes:** Chen, Chiu, Cohen, Davis, Fung, Reeder, and Ryba **Noes:** Zoglin **Abstentions:** None **Absent:** Miller **Recused:** None Motion approved.	
7. iCARE AD HOC COMMITTEE REPORT	Madeleine Fackler, IT Advisor to the iCare Project, took the lead in providing the Board with an update on the status of iCare implementation. She noted that this was day 5 of Go Live. She commended the entire iCare team for what it has accomplished. She reported that after only 5 days of going live, ECH is starting to see issues that are usually not seen until the middle of the second week of Go Live. This is an excellent start to a long journey of Epic implementation. She showed photographs of the command center which is made up of 14 rows of terminals, with 11 people in	

each row, dealing with impending iCare issues that need to be resolved. She noted that it is one of the most impressive command centers she has ever seen for a Go Live of this size.

She reported that there is a daily update meeting for management staff at 1:00 p.m. which provides a great mechanism to bring everyone together at one time to understand what the implementation issues are.

Mick Zdeblick, Chief Operating Officer, reviewed the key themes in the first days of Go Live: 1) making sure that front end devices such as scanners and signature pads are working, 2) ensuring that "ticket to ride", which is a process of getting transporters to the right patient or spot, were working the same on both campuses, 3) verifying how the OR charges are being entered into the system, and 4) monitoring the challenge of the Laboratory which represents a complex area. He noted that overall, the team is now working through mostly medium level tickets.

Deb Muro, RN, Associate Chief Information Officer, reviewed the tickets being tracked based on the different software applications. Cheryl Reinking, RN, Chief Nursing Officer, reported that on the first day of Go Live, the patient experience team rounded with the patients, and early feedback showed that patients did not even realize that anything unusual was going on at ECH this weekend. She noted that complaints heard were over queues and waiting time in ED, lab, and MBU discharge. There were also cardiopulmonary complaints against new information-revalidation process, as well as bar code scanning problems. There were definitely inconveniences for the patients as a result of Go Live, but staff is aware of the issues and is working on resolving them.

Greg Walton, Chief Information Officer, reported that ECH will continue to maintain 24/7 support via the command center. He noted that staff is using strategic and tactical Go Live metrics to determine the level of success for implementation until the end of the project in March.

Director Fung reported on his positive experience using the Super Users. He noted that there were some "hiccups" with the system and that it is slower and

	requires more time and effort. He also noted a need for more adequate staffing during lunch hour since that is when many of the physicians come down to ask for help. Other Board members added their impression of the Go Live success, noting the huge team effort involved. Additionally, it was noted that it will take months before the system is stable enough for staff to go back to their regular everyday duties.	
8. PUBLIC COMMUNICATION	Mr. Geoffrey Mangers spoke regarding his concerns as mentioned in his prior written communication with the Board.	
9. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn the Open Session to Closed Session at 6:38 p.m. pursuant to *Gov't Code Section 54957.2* for approval of Minutes of the Closed Session Hospital Board Meeting (10-14-15); pursuant to *Gov't Code Sections 54957* for report and discussion on personnel matters: Proposed FY16 General Counsel Incentive Goals; pursuant to *Health and Safety Code Section 32155* for a Report of the Medical Staff: Approval of Safety Report for the Environment of Care; pursuant to *Health and Safety Code Section 32155* for deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report; pursuant to *Health and Safety Code Section 32155* for deliberations concerning reports on Medical Staff quality assurance matters: Organizational Clinical Risks; pursuant to *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret and *Govt. Code Section 54957* for discussion and report on personnel performance matters: Strategy Ad Hoc Committee Report; pursuant to *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret, *Health and Safety Code Section 32155* for report of medical staff quality assurance committee; and *Gov't Code Sections 54957* for report and discussion on personnel matters: CEO Report; pursuant to *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret: Pacing Plan; and pursuant to *Govt. Code Section 54957* for discussion and report on personnel performance matters: Executive Session. **Movant:** Chiu **Second:** Fung **Ayes:** Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba and Zoglin	***Motion to Adjourn to Closed Session approved***

	Noes: None **Abstentions:** None **Absent:** Miller **Recused:** None	
10. AGENDA ITEM 18 – RECONVENE OPEN SESSION/REPORT OUT	*Agenda Items 10 – 17 were handled in closed session.* Open Session was reconvened at 9:40 p.m. Cindy Murphy, Board Liaison, reported that following actions were taken in closed session: A. The consent calendar: approval of the Minutes of the Closed Session of the Hospital Board Meeting (10-14-15); Proposed FY16 General Counsel Incentive Goals; and FY15 Safety Report for the Environment of Care by a vote of 8 Directors in favor (Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba and Zoglin) and 1 Director absent (Miller). B. The Minutes of the Medical Staff Executive Committee Meeting of September 24, 2015 and the Credentials and Privileges Report of October 22, 2015 were approved by a vote of 8 Directors in favor (Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba and Zoglin) and 1 Director absent (Miller).	***Motion Approved***
11. AGENDA ITEM 19 – CONSENT CALENDAR	Chair Cohen asked if anyone wished to remove any items from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Hospital Board Meeting (10-14-15); Proposed Annual Board and Committee Self-Assessment Tool; Environment of Care Policies: Safety Education Requirements, Training – Fit Testing Program Curriculum, Respiratory Etiquette – Exposure Control Information, Selecting and Acquiring Medical Equipment, Incoming Medical Equipment Inspection Requirement, and Environment of Care Policies with Minor Revisions (35) or No Revisions (25) or to Archive (0) (See attached Appendix 1); and Medical Staff Report. **Movant:** Ryba **Second:** Reeder **Ayes:** Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba, and Zoglin **Noes:** None **Abstentions:** None	***Consent Calendar Approved***

	Absent: Miller **Recused:** None	
12. AGENDA ITEM 20 – INFORMATIONAL ITEMS	Chair Cohen noted that the CEO Report and September Financials were for information only.	
13. AGENDA ITEM 21 – BOARD COMMENTS	No comments.	
14. AGENDA ITEM 22 – ADJOURNMENT	**Motion:** To adjourn at 9:45 pm. **Movant:** Ryba **Second:** Chiu **Ayes:** Chen, Chiu, Cohen, Davis, Fung, Reeder, Ryba, and Zoglin **Noes:** None **Abstentions:** None **Absent:** Miller **Recused:** None	***Motion Approved***

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

_____
Neal Cohen, MD
Chair, ECH Board

_____
Peter Fung, MD
ECH Board Secretary

Prepared by: Cindy Murphy, Board Liaison and Marina Kipnis, Board Services Coordinator

b. Appointment of Foundation Board Member (R. Ahuja)

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Appointment of El Camino Hospital Foundation Board Member ECH Board Meeting Date: January 13, 2016
	Responsible party:	Jodi Barnard, President, El Camino Hospital Foundation
	Action requested:	Approval
	Background: During its December 16, 2015 meeting, the El Camino Hospital Foundation Board approved one nominee to join the Foundation Board, per the approval of the Foundation Executive Committee meeting on December 12, 2015, and at the recommendation of the Foundation Governance Committee meeting on November 16, 2015. The candidate will begin her first three-year term in January 2016.	
	Summary and session objectives : The Foundation Board is seeking to appoint Romina Ahuja as a member. Below is a brief background: • An accomplished small business entrepreneur who ran her own successful business at the age of 21. • Paused her career to focus on raising three children who are now 22, 19 & 15. • Co-founder of iFynder, a startup focused on leveraging location as a service for multiple applications. • Extremely active in giving back to the community, and in the past few years has served as: o President of the JF Smith Elementary school PTA for 2 years. o Donor to the South Asian Heart Center (SAHC) and member of the Foundation's newly formed Philanthropy Council for the SAHC. o Active contributor to the Aubri Brown Club, a non-profit organization that exists to help families who have lost a child.	
	Suggested discussion questions: n/a	
	Proposed board motion, if any: To appoint Romina Ahuja to the El Camino Hospital Foundation Board of Directors	
	LIST OF ATTACHMENTS: n/a	

Report on Educational Activity (J. Miller)

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Educational Activity Report El Camino Hospital Board of Directors Board Meeting Date: January 13, 2016
	Responsible party:	Julia Miller, ECH Board Member
	Action requested:	For Information

Background:

It was my honor and pleasure to attend THE ESTES PARK INSTITUTE Conference October 25th - 28th 2015 in Half Moon Bay. There were 164 registrants from 23 states representing 50 hospitals. Seventeen individuals from Washington Hospital attended, including eleven physicians.

The program agenda was standard for the first day: registration, general session and conference reception. On the second day, the general session titled "The 9 Major Problems in Health Care Today." The presentation focused on the following:

1. Future of revenue for hospital care.
2. Availability of physician care for Medicare beneficiaries.
3. Lack of primary care for newly insured and the Affordable Care Act.
4. The movement away from fee-for-service.
5. Moving from fee-for-service to value-based care.
6. Pressures of new ACO and bundled payment systems.
7. The inevitable increasing cost and need for chronic care.
8. Coordination of care in the hospital and post-discharge.
9. Co-pays and deductibles - what can people afford?

I also attended the following sessions:

- Quality Safety and Patient Experience
- Governance: Changing Environment
- Population Health 101
- Population Health 102
- Leadership and Engagement
- Governance and the New Government Regulatory Guide

I also attended a presentation of the Blue Zones Project, a community well-being improvement initiative designed to make healthy choices easier through permanent changes in environment, policy and social networks. The community participates in making small changes to contribute to potentially huge benefits...lowered healthcare costs, improved productivity and a better quality of life.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: N/A
	Summary and session objectives: To inform fellow Board members of key learnings from conference attendance.
	Suggested discussion questions: None. This is a consent item.
	Proposed board motion, if any: None. This item is for information.
	LIST OF ATTACHMENTS: None.

d. Draft Revised ECH Bylaws Article IV, Sections 4.5 and 4.6

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Draft Revised ECH Bylaws Article IV, Sections 4.5 and 4.6 El Camino Hospital Board of Directors Board Meeting Date: January 13, 2016
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	For Approval
	Background: With the exception of the Chief Executive Officer, the term of service of non El Camino Healthcare District ("ECHD") Board Members ("NDBMs" referred to in the Bylaws as the "2012 Directors") who serve as members of the El Camino Hospital ("ECH") Board of Directors is currently three years, and the NDBMs may serve a maximum of 4 continuous terms. At its November 11, 2015 meeting, the ECH Board approved the Governance Committee's recommendation to increase the length of term to 4 years. ECHD Board members may serve a maximum of three continuous 4-year terms as members of the ECH Board. Neither the Governance Committee nor the Board specifically addressed whether the NDBM's maximum number of terms should be changed. However, because staff believes it is the Board's intent to limit both types of Directors to 12 continuous years of service on the ECH Board, the proposed revision provides for a maximum of three continuous 4-year terms for NDBMs.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: At its November 3, 2015 meeting, the Governance Committee voted to recommend changing the NDBM term of service to 4 years. Since the Governance Committee's next meeting is on March 29, 2016, it has not reviewed the proposed revisions to the Bylaws.	
	Summary and session objectives: To obtain approval of the draft Bylaws revisions. Legal counsel has reviewed and approved the draft revisions.	
	Suggested discussion questions: None. This is a consent item.	
	Proposed board motion, if any: To approve the Draft Revised ECH Bylaws Article IV, Sections 4.5 and 4.6.	
	LIST OF ATTACHMENTS: 1. Draft Revised ECH Bylaws Article IV, Section 4.5 and 4.6 (REDLINES) 2. Draft Revised ECH Bylaws Article IV, Section 4.5 and 4.6 (CLEAN)	

Att 27d.2 - Draft Revised Amended and Restated El Camino Hospital Bylaws (REDLINES)12_8_15

DRAFT REVISED: December 8, 2015~~October 9, 2014~~

AMENDED AND RESTATED BYLAWS

OF

EL CAMINO HOSPITAL

ADOPTED

DECEMBER 7, 2005

AS AMENDED AND RESTATED

October 21, 2014

TABLE OF CONTENTS

Page

ARTICLE I CORPORATE OFFICES 1

1.1 Principal Office 1
1.2 Registered Office 1

ARTICLE II PURPOSES, POWERS AND MEMBERSHIP 1

2.1 Purposes 1
2.2 Powers 1
2.3 Membership Corporation 1
2.4 Exempt Activities 1
2.5 Termination of Membership 1

ARTICLE III MEETINGS OF MEMBERS 1

3.1 Place of Meetings 1
3.2 Annual Meeting 1
3.3 Notice of Annual Meeting 2
3.4 Special Meetings 2
3.5 Notice of Special Meetings 2
3.6 Quorum 3
3.7 Adjourned Meeting and Notice 3
3.8 Voting 3
3.9 Proxies 3
3.10 Validation of Defectively Called or Noticed Meetings 3
3.11 Action Without a Meeting 4
3.12 Rights of the Member 4

ARTICLE IV BOARD OF DIRECTORS 4

4.1 Management by Board of Directors 4
4.2 Number of Voting Directors 5
4.3 Qualifications of Voting Directors 5
4.4 Appointment and Selection of Directors 5
4.5 Term 6
4.6 Term Limits 6
4.7 Vacancy 7
4.8 Resignation 7
4.9 Removal 7

ARTICLE V CERTAIN DIRECTOR ELECTION PROCEDURES 8

5.1 Nominating Committee 8
5.2 Nominations by Member 8

ARTICLE VI BOARD MEETINGS 8

6.1 Annual Meeting 8
6.2 Regular Meetings 8
6.3 Special Meetings 8
6.4 Meetings by Conference Telephone 9
6.5 Waiver of Notice 9
6.6 Unanimous Action Without Meeting 9
6.7 Quorum 9
6.8 Agenda for Meetings 9
6.9 Board Action 10
6.10 Adjournment 10
6.11 Notice of Adjournment 10

ARTICLE VII BOARD COMMITTEES AND ADVISORY COMMITTEES 10

7.1 Establishment of Committees 10
7.2 Special Committees 11
7.3 Authority to Act 11
7.4 Appointment 11
7.5 Meetings and Actions of Committees 11
7.6 Advisory Committees 11

ARTICLE VIII OFFICERS AND EMPLOYEES 12

8.1 Officers 12
8.2 Election of Board Officers 12
8.3 Term of Board Officers 12
8.4 Resignation 12
8.5 Removal 12
8.6 Vacancies 12
8.7 Compensation 12
8.8 Duties and Qualifications of Officers 12

ARTICLE IX CHIEF EXECUTIVE OFFICER 13

9.1 Selection, Authority and Term 13
9.2 Performance Review 14
9.3 Authority and Duties 14

ARTICLE X CONTRACTS AND FINANCIAL MATTERS 15

10.1 Loans 15
10.2 Deposits 15
10.3 Compensation of Directors 15

ARTICLE XI CONFLICTS OF INTEREST AND INDEMNIFICATION 15

11.1 Conflict of Interest 15
11.2 Indemnification 15

ARTICLE XII MEDICAL STAFF 18

12.1 Organization 18
12.2 Membership 18
12.3 Medical Staff Bylaws, Rules and Regulations 18
12.4 Credentialing and Clinical Privileges 18
12.5 Allied Health Professionals 19
12.6 Contract Physicians 20
12.7 Accountability 20

ARTICLE XIII EXECUTION OF CORPORATE INSTRUMENTS, AND VOTING OF STOCKS AND MEMBERSHIPS HELD BY THE CORPORATION 20

13.1 Execution of Corporate Instruments 20
13.2 Ratification by Member 21
13.3 Voting of Stocks Owned by Corporation 21

ARTICLE XIV ANNUAL REPORT 21

ARTICLE XV STANDARD OF CARE 22

ARTICLE XVI PROHIBITED TRANSACTIONS 23

16.1 Loans 23
16.2 Self-Dealing Transactions 23
16.3 Approval 23

ARTICLE XVII MISCELLANEOUS 23

17.1 Records and Reports 23
17.2 Corporate Seal 24
17.3 Construction and Definitions 24

ARTICLE XVIII AMENDMENTS 24

18.1 Amendments 24

ARTICLE I
Corporate Offices

1.1 Principal Office. The principal office of El Camino Hospital, a nonprofit public benefit corporation (the "Corporation"), is located in Mountain View, California. The Corporation may have such other offices as the Board of Directors of Corporation (the "Board") may determine from time to time.

1.2 Registered Office. The address of the registered office of the Corporation is 2500 Grant Road, Mountain View, California 94040.

ARTICLE II
Purposes, Powers and Membership

2.1 Purposes. The purposes of the Corporation are set forth in its Articles of Incorporation (the "Articles").

2.2 Powers. The Corporation may engage in any activity consistent with the Articles and these Bylaws.

2.3 Membership Corporation. The Corporation shall have one voting Member: El Camino Healthcare District, a political subdivision of the State of California (the "Member"). The Corporation shall have no other voting members.

2.4 Exempt Activities. Notwithstanding any other provision of these Bylaws, no director, officer, employee, or representative of the Corporation shall take any action or carry on any activity by or on behalf of the Corporation not permitted to be taken or carried on by an organization exempt from taxation under Section 501(c)(3) of the Internal Revenue Code and regulations promulgated thereunder as they now exist or as they hereafter may be amended, or by an organization contributions to which are deductible under Section 170(c) of such Code and Regulations as they now exist or as they hereafter may be amended.

2.5 Termination of Membership. The membership of the sole Member shall terminate upon the resignation of the sole Member.

ARTICLE III
Meetings of Members

3.1 Place of Meetings. Meetings of the sole Member shall be held at any place within or outside the State of California designated by the Board of Directors. In the absence of any such designation, meetings of the sole Member shall be held at the principal executive office of the Corporation.

3.2 Annual Meeting. There shall be an annual meeting of the sole Member held each year. The Board shall provide for the time and place of holding the annual meeting and notify the sole Member as provided in Section 3.3. At the annual meeting, directors shall be elected as

required by these Bylaws, reports of the affairs of the Corporation shall be considered, and any other business may be transacted that is within the power of the sole Member.

3.3 Notice of Annual Meeting. Written notice of each annual meeting shall be given to the sole Member entitled to vote, either personally, or by mail, or by other means of written communication, with charges prepaid, addressed to the sole Member at the sole Member's address appearing on the books of the Corporation or given by the sole Member to the Corporation for the purpose of notice.

All such notices shall be given to the sole Member entitled to the notice by mail or other means of written communication not less than ten (10) days (or, if sent by mail other than first-class, registered, or certified mail, twenty (20) days) nor more than ninety (90) days before each annual meeting. Any such notice shall be deemed to have been given at the time when delivered personally or deposited in the mail or sent by other means of written communication. An affidavit of giving of any such notice in accordance with the foregoing provisions, executed by the Secretary or any transfer agent of the Corporation, shall be *prima facie* evidence of the giving of the notice.

The notice of the meeting shall specify:

(a) the place, date, and hour of the meeting;

(b) those matters which the Board, at the time the notice is given, intends to present for action by the sole Member;

(c) if directors are to be elected, the names of all those who are nominees at the time the notice is given;

(d) the general nature of a proposal, if any, to take action when approval of the sole Member is required with respect to (i) removal of directors without cause; (ii) the filling of vacancies on the Board; (iii) amendment of the Articles or these Bylaws; (iv) voluntary merger or dissolution of the Corporation; or (v) disposition of all or substantially all of the assets of the Corporation; and

(e) such other matters, if any, as may be expressly required by law.

3.4 Special Meetings. A special meeting of the sole Member for any lawful purpose or purposes may be called at any time by the Chairperson of the Board or by the Board. In addition, a special meeting of the sole Member for the purpose of removal of directors and election of their replacements may be called by the sole Member.

3.5 Notice of Special Meetings. Upon request in writing that a special meeting of the sole Member be called, directed to the Chairperson, Vice Chairperson, or Secretary, by any person (other than the Board of Directors) entitled to call a special meeting of the sole Member, the officer forthwith shall cause notice to be given to the sole Member that a meeting will be held at a time fixed by the Board, not less than thirty-five (35) nor more than ninety (90) days after the receipt of the request. If the notice is not given within twenty (20) days after the receipt of the request, the persons entitled to call the meeting may give the notice. Notice of any special

meeting of the sole Member shall be given in the same manner as for annual meetings of the sole Member. In addition to the matters required by Section 3.3(a) and, if applicable, Section 3.3(c) of these Bylaws, notice of any special meeting shall specify the general nature of the business to be transacted, and the fact that no other business may be transacted at the meeting.

3.6 Quorum. The presence in person or by proxy of the sole Member shall constitute a quorum for the transaction of business. Any meeting of the sole Member may be adjourned from time to time by the sole Member.

3.7 Adjourned Meeting and Notice. Except as provided below, when the sole Member's meeting, either regular or special is adjourned to another time or place, notice need not be given of the adjourned meeting if the time and place are announced at the meeting at which the adjournment is taken. At the adjourned meeting the Corporation may transact any business that might have been transacted at the original meeting. However, no meeting may be adjourned for more than forty-five (45) days. If after adjournment a new record date is fixed for notice or voting, notice of the adjourned meeting shall be given to the sole Member.

3.8 Voting.

(a) Except as may be otherwise provided in the Articles or these Bylaws, the sole Member shall be entitled to one vote on each matter being considered.

(b) Voting at a meeting of the sole Member may be by voice vote or by ballot.

3.9 Proxies.

(a) The sole Member may authorize another person or persons to act by proxy with respect to such membership. "Proxy" means a written authorization signed by the sole Member giving another person or persons power to vote on behalf of the sole Member. "Signed" for the purpose of this section means the placing of the sole Member's name on the proxy (whether by manual signature, typewriting, telegraphic transmission, or otherwise) by the sole Member. Any proxy duly executed is not revoked and continues in full force and effect until (i) a written instrument revoking it is filed with the Secretary of the Corporation prior to the vote pursuant to the proxy, (ii) a subsequent proxy executed by the person executing the prior proxy is presented to the meeting, or (iii) the person executing the proxy attends the meeting and votes in person; provided that no such proxy shall be valid after the expiration of eleven (11) months from the date of its execution, unless otherwise provided in the proxy, except that the maximum term of any proxy shall be three (3) years from the date of execution. The dates contained on the forms of proxy presumptively determine the order of execution, regardless of the postmark dates on the envelopes in which they are mailed. No proxy may be irrevocable.

(b) In any election of directors, any form of proxy in which the directors to be voted upon are named as candidates and which is marked by the sole Member "withhold" or otherwise marked in a manner indicating that the authority to vote for the election of directors is withheld shall not be voted either for or against the election of a director.

3.10 Validation of Defectively Called or Noticed Meetings. The transactions of any meeting of the sole Member, however called and noticed, and wherever held, are as valid as

though had at a meeting duly held after regular call and notice, if a quorum is present either in person or by proxy. Attendance of a person at a meeting shall constitute a waiver of notice of and presence at such meeting, except when the person objects, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened and except that attendance at a meeting is not a waiver of any right to object to the consideration of matters required by these Bylaws or by the California Nonprofit Corporation Law to be included in the notice if such objection is expressly made at the meeting. Neither the business to be transacted at nor the purpose of any regular or special meeting of the sole Member need be specified in any written waiver of notice, consent to the holding of the meeting, or approval of the minutes of the meeting, unless otherwise provided in the Articles or these Bylaws, except the general nature of the proposals listed in Section 3.3(d) of these Bylaws must be specified, to the extent applicable, in any such waiver, consent, or approval.

3.11 Action Without a Meeting. Any action required or permitted to be taken by the sole Member may be taken without a meeting, if the sole Member consents in writing to the action. The written consent shall be filed with the minutes of the proceedings of the sole Member. The action by written consent shall have the same force and effect as the vote of the sole Member.

3.12 Rights of the Member. The Member shall have all rights granted to a member under the California Nonprofit Corporation Law. Without limiting the generality of the foregoing, the Member shall have the right to approve the election of directors, to approve the disposition of all or substantially all of the assets of the Corporation or to approve a merger and dissolution of the Corporation and the other rights set forth in the articles of incorporation and bylaws. In addition to the foregoing, the Member shall have the right to require the Corporation to provide to Member any financial information requested by the Member and to approve the following actions authorized by the Board of Directors of the Corporation:

1. To approve the selection of the Corporation's Chief Executive Officer;

2. To approve the annual budget of the Corporation;

3. To approve capital expenditures by the Corporation of more than $25 million dollars in a single transaction;

4. To approve any expenditures or transfers by the Corporation in a single transaction apparent or a series of related transaction (in excess of 5% of the assets of the Corporation as determined based on last annual audit of the Corporation preceding the approval date of the proposed transaction);

5. To approve the overall strategy adopted by the Corporation.

ARTICLE IV
Board of Directors

4.1 Management by Board of Directors. The business and affairs of the Corporation shall be managed by the Board, except as otherwise provided by law, the Articles, these Bylaws or a Board resolution.

4.2 Number of Voting Directors. The number of voting directors ("Directors") of the Corporation shall not be less than five (5) nor more than nine (9) until changed by amendment of the Articles or by a bylaw amending this Section 4.2 duly adopted by the sole Member. The exact number of Directors shall be fixed from time to time, within the limit specified in the Articles or in this Section 4.2, by the sole Member.

4.3 Qualifications of Voting Directors.

(a) Commitment. Directors must be committed to the furtherance of health care delivery in the communities served by the Corporation, and must be willing to devote the necessary time and energy for self-education, corporate functions and other activities necessary to fulfill this commitment.

(b) Fiduciary Duty. Directors shall have a fiduciary duty to the Corporation, and shall make all decisions in a manner that is in the best interests of the Corporation and the communities served by the Corporation. Directors shall not advocate or act in the interests of any private person, group or entity unless such action is also in the best interests of the Corporation or the communities served by the Corporation.

(c) Restriction on Interested Directors. Not more than forty-nine percent (49%) of the persons serving on the Board of Directors at any time may be interested persons. An interested person is (i) any person being compensated by the Corporation for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (ii) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law of any such person. However, any violation of the provisions of this section shall not affect the validity or enforceability of any transaction entered into by the Corporation.

(d) Financial Interest. Except as permitted by the California Nonprofit Corporation Law, the California Health and Safety Code and any other provisions of law, Directors shall not have a "financial interest" in any transactions or contracts of the Corporation.

4.4 Appointment and Selection of Directors.

(a) Ex Officio Director. The Chief Executive Officer of this Corporation shall serve as an ex officio Director, with full voting rights; the voting right of the ex officio Director shall be suspended when the number of Directors in office is less than nine (9) except to the extent that the vacant positions are entirely among the 2012 Directors. The term of such Director shall end when his or her term of office as the Chief Executive Officer of this Corporation expires or terminates.

(b) Vacancies. In the event of a vacancy on the Board because no person holds the position designated in Section 4.4(a), such position on the Board shall remain vacant until a successor is appointed to the office described in Section 4.4(a). In the event that the office described in Section 4.4(a) no longer exists, the Member shall have the exclusive power to appoint a person to serve as a Director with respect to such position.

(c) Other Directors. All Directors, other than the ex officio Director, shall be nominated and elected by the Member.

(d) Replacement Directors. A Director, if any, who fills the unexpired term of a vacant Director position shall serve until the end of that unexpired term.

4.5 Term.

(a) Years.

(i) The term of an ex officio Director described in Section 4.4 shall be the period of time such an ex officio Director holds the office described in Section 4.4.

(ii) A Director first elected by the Member pursuant to Section 4.4(c) effective September 1, 2012 shall serve a staggered term ending June 30, 2013, June 30, 2014 or June 30, 2015 as designated by a resolution of the Board. Any Director who is later appointed to replace such position or who is later appointed to a new term for such a position after the initial term expires shall serve a term of ~~three~~four (~~3~~4) years. The Directors described in this subparagraph (ii) are referred to in these Bylaws as "2012 Directors."

(iii) All ~~other~~ Directors not listed in Section 4.5(a)(i) or (ii) shall hold office as a Director for a term of four (4) years from the date of election.

(iv) Any Director, other than a Director serving ex officio, shall serve for such Director's stated term and until his or her successor is duly elected and qualified, unless the Director resigns or is removed as provided in these Bylaws.

4.6 Term Limits.

(a) New Members.

~~(i)~~ Any Director, other than a Director serving ex officio, ~~described in Section 4.5(a)(ii)~~ who first takes office during calendar year 2014, or any time thereafter, may only serve three~~four~~ (~~3~~4) complete four~~three~~ (~~4~~3) year terms as a Director.

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~~(ii) Any Director described in Section 4.5(a)(iii) who first takes office during calendar year 2014, or any time thereafter, may only serve three (3) complete four (4) year terms as a Director.~~

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(b) Current Members.

~~(i)~~ Any Director, other than a Director serving ex officio, ~~described in Section 4.5(a)(ii)~~ who is serving as a Director as of January 1, 2014 may only serve three~~four~~ (~~3~~4) complete four~~three~~ (~~4~~3) year terms as a Director beginning with such Director's next term of office that commences after January 1, 2014.

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~~(ii) Any Director described in Section 4.5(a)(iii) who is serving as a Director as of January 1, 2014 may only serve three (3) complete four (4) year terms as a Director beginning with such Director's next term of office that commences after January 1, 2014.~~

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(c) Effect of Term Limit. The office of any Director subject to the limitation set forth in Section 4.6(a) or Section 4.6(b) shall terminate on the last day of the period described in Section 4.6(a) or Section 4.6(b) that is applicable to such Director.

(d) Election Following Term Limit. Any person who has left the Board due to the application of Section 4.6(a) or (b) may be elected to serve as a Director after two (2) years from the date such Director left the Board.

(e) New Term Limits. Any Director elected, as described in Section 4.6(d), after his or her term has been limited shall be subject to Section 4.6(a) beginning on the first day of such new term.

4.7 Vacancy.

(a) A vacancy in the Board of Directors shall be deemed to exist on the occurrence of the following: (i) the death, resignation, or removal of any Director; (ii) the declaration by the Board of a vacancy in the office of a Director who has been declared of unsound mind by a final order of court, or has been convicted of a felony, or has been found by a final order or judgment of any court to have breached any duty under Sections 5230-38 of the California Corporations Code dealing with standards of conduct for directors; (iii) an increase in the authorized number of Directors; (iv) the failure of the sole Member, at any annual or other regular meeting of Member at which any Director or Directors are elected, to elect the full authorized number of Directors to be voted for at that meeting; or (v) the affirmative vote of the sole Member to remove a Director in accordance with the voting requirements of Section 5222 of the California Corporations Code as provided in Section 4.9 below.

(b) Vacancies in the Board may be filled only by the sole Member. Each Director appointed or elected to fill a vacancy shall hold office until his or her successor is elected at an annual or other regular meeting of the sole Member.

4.8 Resignation. Any Director may resign at any time by giving written notice to the Chairperson or the Secretary. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later time specified in the resignation. If the resignation is effective at a future time, the successor may be elected to take office when the resignation becomes effective. Unless the California Attorney General is first notified, no Director may resign when the Corporation would then be left without a duly elected Director or Directors in charge of its affairs.

4.9 Removal. Any elected Director may be removed, with or without cause, at any time by the Member. No reduction of the authorized number of Directors shall have the effect of removing any Director prior to the expiration of his or her term of office. Each Director appointed or elected to fill a vacancy shall hold office until his or her successor is elected by the sole Member.

ARTICLE V
Certain Director Election Procedures

5.1 Nominating Committee. The Board shall appoint a Nominating Committee, a special committee, to select qualified candidates for election to the Board at least thirty (30) days before the date of any election of Directors. The committee shall make its report at least two (2) days before the date of the election, and the Secretary of the Corporation shall forward to the Member, with the notice of meeting required by Section 3.3 of these Bylaws, a list of candidates so nominated along with the names of any persons duly nominated by the Member as of that time.

5.2 Nominations by Member. The sole Member may nominate candidates for directorships at any time before the election. The Secretary shall cause the names of such candidates to be placed on the ballot along with those candidates named by the nominating committee. If there is a meeting to elect directors, the sole Member may place names in nomination.

ARTICLE VI
Board Meetings

6.1 Annual Meeting. An annual meeting of the Board shall be held each year, at which time officers of the Board shall be elected and such other business as is appropriate shall be transacted. Annual meetings shall be held at the location designated by the Board or at the principal office of the Corporation.

6.2 Regular Meetings. Meetings of the Board shall be held as directed by the Board, but at least quarterly at any place within or outside the State of California that has been designated by the Board. In the absence of such designation, regular meetings shall be held at the principal office of the Corporation. Regular meetings may be held without notice.

6.3 Special Meetings.

(a) Authority to Call. Special meetings of the Board may be called for any purpose and at any time by the Chairperson, the Secretary, or any two (2) Directors.

(b) Manner of Notice. Notice of the time and place of special meetings shall be given to each Director by one of the following methods: by personal delivery of written notice; by first-class mail, postage paid; by telephone communication, either directly to the Director or to a person at the Director's office who would reasonably be expected to communicate such notice promptly to the Director; by facsimile; or by telegram, charges prepaid. All such notices shall be addressed to or otherwise transmitted to the Director's address, facsimile number, or telephone number shown on the records of the Corporation. The notice shall specify the time and place of the meeting.

(c) Timing of Notice. Notices sent by first-class mail shall be deposited into a United States mail box at least four (4) days before the time set for the meeting. Notices given by personal delivery, telephone, facsimile or telegram shall be given at least forty-eight (48) hours before the time set for the meeting.

6.4 Meetings by Conference Telephone. Any meeting, regular or special, may be held by conference telephone or similar communication equipment, so long as all Directors participating in the meeting can hear one another. All such Directors shall be deemed to be present in person at any such meeting.

6.5 Waiver of Notice. The transaction of business at any meeting of the Board, however called and noticed or wherever held, shall be valid as though held at a meeting that was duly held after regular call and notice, but only if a quorum is present and if, either before or after the meeting, each of the Directors not present signs and files with the Secretary a written waiver of notice or a consent to holding such meeting or an approval of the minutes thereof, or such Director attends the meeting without protesting, prior to the meeting or at its commencement, the lack of notice to such Director, provided that no Director present at the meeting objected, prior to the transaction of any business, to the holding of the meeting because of a lack of prior notice. All such waivers, consents or approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

6.6 Unanimous Action Without Meeting. Any action required or permitted to be taken by the Board under the Articles, these Bylaws or any provision of law may be taken by the Board without a meeting, if the Directors unanimously consent in writing to such action. Such unanimous written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by unanimous written consent shall have the same force and effect as the unanimous vote of the Directors at a duly called and noticed meeting. Such unanimous written consent or consents may be signed in counterpart and may be submitted to the individual Directors, and returned to the Corporation by mail or by facsimile transmission. For purposes of this section only, "all members of the Board" does not include any "interested directors" as defined in Section 5233 of the California Corporations Code.

6.7 Quorum. A majority of the number of existing Directors (excluding vacancies) shall constitute a quorum for the transaction of business, except to adjourn. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of Directors from the meeting, if any action taken is approved by at least a majority of the required quorum for that meeting, subject to any applicable requirements for approval by a greater number or a disinterested majority.

6.8 Agenda for Meetings. The agenda for Board meetings shall be developed by the Chairperson with the Chief Executive Officer acting as staff to the Chairperson for this purpose. The Chairperson shall prepare a calendar of expected agenda items that will be communicated regularly at Board meetings. Any Director may ask that a matter be added to a future Board meeting agenda by written notification to the Chairperson and the Chief Executive Officer. The Chairperson will determine, considering all other matters to be addressed by the Board, whether and when to add the matter to a Board agenda. If the matter will not be added to the Board meeting agenda at the next meeting to be held more than fourteen (14) days after the date of the request, the Chief Executive Officer will notify the Director making the request of the Chairperson's decision; the person making the request may ask that the questions of whether such matter should be considered by the Board and the timing of such consideration be addressed during the discussion of the calendar of expected agenda items during the next meeting of the Board that occurs more than ten (10) days thereafter. Notwithstanding the foregoing, any request

to add a matter to the Board agenda made by three (3) directors shall be added to the Board meeting agenda at the next meeting to be held more than fourteen (14) days after the date of the last request.

6.9 Board Action. Every act done or decision made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be regarded as the act of the Board of Directors, unless a greater number, or the same number after disqualifying one or more Directors from voting, is required by the Articles, these Bylaws, or the California Nonprofit Corporation Law. Provided however, amendments to the Articles or these Bylaws and approval of certain transactions must be approved by the vote of a majority of the Directors in office, excluding interested directors as defined in Section 5233 of the California Corporations Code.

6.10 Adjournment. A majority of the Directors present, whether or not constituting a quorum, may adjourn any meeting to another time and place.

6.11 Notice of Adjournment. Notice of the time and place of holding an adjourned meeting need not be given, unless the meeting is adjourned for more than twenty-four (24) hours, in which case notice of the time and place shall be given before the time of the adjourned meeting to the Directors who were not present at the time of the adjournment.

ARTICLE VII
Board Committees and Advisory Committees

7.1 Establishment of Committees. The Board of Directors may, by resolution adopted by a majority of the Directors then in office, provided that a quorum is present, designate one or more committees, each consisting of two (2) or more Directors, to serve at the pleasure of the Board. The Board may designate one or more Directors as alternate members of any committee, who may replace any absent member at any meeting of the committee. The provisions of Section 7.1 through 7.5 of these Bylaws do not apply to any advisory committee established under Section 7.6. The appointment of members or alternate members of a committee requires the vote of a majority of the Directors then in office, provided that a quorum is present. Any such committee, to the extent provided in the resolution of the Board of Directors or in these Bylaws, shall have all the authority of the Board of Directors, except that no committee, regardless of Board resolution, may:

(a) Approve any action that, under the California Nonprofit Corporation Law, also requires the affirmative vote of the members of a public benefit corporation.

(b) Fill vacancies on the Board or in any committee that has the authority of the Board.

(c) Fix compensation of the Directors for serving on the Board or on any committee.

(d) Amend or repeal Bylaws or adopt new bylaws.

(e) Amend or repeal any resolution of the Board that by its express terms is not so amendable or repealable.

(f) Appoint any other committees of the Board or the members of such committees.

(g) Expend corporate funds to support a nominee for Director after there are more people nominated for Director than can be elected.

(h) Approve any transaction between the Corporation and one or more of its Directors in which the Director or Directors have a material financial interest, except as provided by Section 5233 of the California Corporations Code.

7.2 Special Committees. From time to time the Board may establish special committees. Special Board committees shall exist to perform specific tasks identified by the Board, and shall cease to exist upon completion of the task. The Board may by resolution establish special committees for such purposes as the Board deems appropriate. Members of such committees shall be appointed and removed at the Board's discretion, with or without cause.

7.3 Authority to Act. The committee may take action on behalf of the Corporation only if specifically authorized to take a Board action by resolution of the Board.

7.4 Appointment. The Chairperson of the Board shall appoint committee chairperson(s) and the committee chairperson(s) shall appoint members of committee(s) subject to approval by the Board.

7.5 Meetings and Actions of Committees. Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of these Bylaws, concerning meetings and actions of Directors, with such changes in the context of those Bylaws as are necessary to substitute the committee and its members for the Board and its members, except that the time for regular meetings of committees may be determined either by resolution of the Board or by resolution of the committee. Special meetings of committees may also be called by resolution of the Board. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the committee. Minutes shall be kept of each meeting of any committee and shall be filed with the corporate records. The Board may adopt rules not inconsistent with the provisions of these Bylaws for the governance of any committee.

7.6 Advisory Committees. Notwithstanding any other provision of this Article VII or these Bylaws, the Board may by resolution establish advisory committees to the Board. No advisory committee shall have or exercise any of the authority of the Board but shall advise the Board of Directors on matters within the advisory committee's charter as adopted by the Board. An advisory committee shall be composed of at least two members of the Board and persons who are not members of the Board. The Board, by resolution, shall adopt an advisory committee charter which shall establish the committee, state whether the advisory committee is temporary (ad hoc) or standing, the total number of members of such committee, the number of Board members to be appointed to such committee, and the subject matter to be considered by such advisory committee. The time and place of meetings of the advisory committee shall be determined by the committee chair. The charter shall designate the members of the advisory

committee or designate the process by which members of the advisory committee are selected. The Chairperson may serve as chair or a member of any advisory committee except the Governance Committee. The Board may, at any time, amend the resolution establishing the advisory committee to change the members, to change the scope of delegation, or to terminate the existence of the advisory committee.

ARTICLE VIII
Officers and Employees

8.1 Officers. The officers of the Corporation shall consist of the Chairperson, the Vice Chairperson, the Secretary and the Treasurer and such other persons who are specifically designated as officers by the Board. The offices of Secretary and Treasurer shall be held by the same person.

8.2 Election of Board Officers. All officers shall be elected by a majority vote of the Board.

8.3 Term of Board Officers. Each officer shall hold office for a two (2) year term or until his or her successor is elected and qualified, subject to any employment agreement; provided that a Director may not serve more than two (2) consecutive terms as Chairperson.

8.4 Resignation. Any officer may resign at any time by giving written notice to the Board of Directors, the Chairperson or to the Secretary, without prejudice, however, to the rights, if any, of the Corporation under any contract to which such officer is a party. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later specified time.

8.5 Removal. Any officer may be removed at any time by a majority vote of the Board.

8.6 Vacancies. Upon the removal, resignation, death, or incapacity of any officer, the Board may declare such office vacant and fill such vacancy by the majority vote of the Board.

8.7 Compensation. The salary and other compensation of the officers shall be fixed from time to time by resolution of, or in the manner determined by, the Board.

8.8 Duties and Qualifications of Officers. The officers shall have such duties, in addition to those set forth below, as the Board shall specify by resolution from time to time.

(a) Chairperson. The Chairperson shall preside at all meetings of the Board. Except as provided in Section 13.1, the Chairperson shall have authority to execute in the name of the Corporation all bonds, contracts, deeds, leases, and other written instruments to be executed by the Corporation, and shall perform such other powers and duties as may be from time to time assigned to him or her by the Board or set forth in these Bylaws.

(b) Vice Chairperson. The Vice Chairperson shall assume and perform the duties of the Chairperson in the absence or disability of the Chairperson or whenever the office

of Chairperson is vacant. The Vice Chairperson shall have such titles, perform such other duties, and have such other powers as the Board or the Chairperson shall designate from time to time.

(c) Secretary. The Secretary shall record or cause to be recorded, and shall keep or cause to be kept, at the principal executive office and such other place as the Board may order, a book of minutes of actions taken at all meetings of Directors, committees, and Member, with the time and place of holding, whether regular or special, and, if special, how authorized, the notice given, the names of those present at such Directors, committees and Member meetings, and the proceedings of all such meetings.

The Secretary shall give, or cause to be given, notice of all the meetings of the members of the Board of Directors, and of the committees of this Corporation required by these Bylaws or by law to be given, shall keep the seal of the Corporation (if any) in safe custody, and shall have such other powers and perform such other duties as may be prescribed by the Board, the Chairperson or by these Bylaws.

(d) Treasurer. The Treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains, losses, capital, retained earnings, and other matters customarily included in financial statements.

The Treasurer shall deposit all moneys and other valuables in the name and to the credit of the Corporation with such depositories as may be designated by the Board. The Treasurer shall disburse the funds of the Corporation as may be ordered by the Board, shall render to the Chairperson and Directors, whenever they request it, an account of all of the Treasurer's transactions as Treasurer and of the financial condition of the Corporation, and shall have such other powers and perform such other duties as may be prescribed by the Board, the Chairperson or these Bylaws.

ARTICLE IX
Chief Executive Officer

9.1 Selection, Authority and Term. The Board may select and employ a competent, experienced Chief Executive Officer who shall be its direct executive representative in the management of the Hospital. This Chief Executive Officer shall be given the necessary authority and held responsible for the administration of the Hospital in all its activities and departments subject only to such policies as may be adopted, and such orders as may be issued by the Board or by any of its committees to which it has delegated power for such action. He or she shall act as the "duly authorized representative" of the Board in all matters in which the governing Board has not formally designated some other person for that specific purpose. However, nothing in this section is to be construed as depriving or delegating from the Board to the Chief Executive Officer any of the powers and duties imposed upon the Board by the Local Hospital District Law, Division 23, or Chapter 1 of the Health and Safety Code of the State of California, or related statutes. The Chief Executive Officer shall hold office from the date of hire until the end of his or her term in office or sooner at the sole discretion of the Board, subject to any employment agreement.

9.2 Performance Review. The Board shall continually review the performance of the Chief Executive Officer and provide counseling in areas where improvement is needed.

9.3 Authority and Duties. The authority and duties of the Chief Executive Officer shall be as follows:

(a) To perfect and submit to the Board for approval a plan of organization of the personnel and others concerned with the operation of the Hospital; and also to establish methods of procedures concerning the internal operation of the Hospital.

(b) To prepare an annual budget showing the expected receipts and expenditures of the Hospital as required by the Board of Directors.

(c) To prepare and submit capital budget of the Hospital to the Board for approval.

(d) To select, employ, and discharge all employees serving in positions as authorized by the Board of Directors.

(e) To see that all physical properties are kept in good state of repair and operating condition.

(f) To attend all meetings of the Board of Directors.

(g) To supervise all business affairs, such as the records of financial transactions, collection of accounts and purchase and issuance of supplies, and to ensure that all funds are collected and expended to the best possible advantage.

(h) To explore and develop strategic opportunities for the Hospital and propose such opportunities to the Board.

(i) To exercise his or her professional abilities in such a manner that those concerned with the rendering of professional service at the Hospital cooperate to the end that the best possible care may be rendered to all patients.

(j) To submit regularly to the Board or its authorized committees, periodic reports showing the professional service and financial activities of the Hospital and to prepare and submit such special reports as may be required by the Board and/or its functioning committees.

(k) To serve as the liaison officer and channel of communications for all official communications between the Board of Directors or any of its committees, and its adjunct organizations.

(l) To act as an ex-officio member of all Board committees.

(m) To support such volunteer services as are necessary to carry out the purpose of the Hospital.

(n) To assist in providing an orientation program for new Board members.

(o) To perform any other duty that may be necessary in the best interest of the Hospital.

ARTICLE X
Contracts and Financial Matters

10.1 Loans. No loans shall be contracted on behalf of the Corporation and no evidence of indebtedness shall be issued in its name unless authorized by a resolution of the Board. Such authority may be general or confined to specific instances.

10.2 Deposits. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depository as the Board may select.

10.3 Compensation of Directors. Directors and members of committees may receive such compensation, if any, for their services, and such reimbursement of expenses, as may be determined by resolution of the Board to be just and reasonable; provided, however, that any such compensation must be commercially reasonable.

ARTICLE XI
Conflicts of Interest and Indemnification

11.1 Conflict of Interest. The Board shall adopt, by resolution, a conflict of interest policy which shall be attached to these Bylaws.

11.2 Indemnification.

(a) For the purposes of this article, "agent" means any person who is or was a Director, officer, employee, or other agent of the Corporation, or is or was serving at the request of the Corporation as a Director, officer, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, or other enterprise, or was a Director, officer, employee, or agent of a foreign or domestic corporation that was a predecessor corporation of the Corporation or of another enterprise at the request of such predecessor corporation; "proceeding" means any threatened, pending, or completed action or proceeding, whether civil, criminal, administrative, or investigative; and "expenses" include without limitation attorneys' fees and any expenses of establishing a right to indemnification under paragraph (d) or paragraph (e)(iii) of this Section 11.2.

(b) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any proceeding (other than an action by or in the right of the Corporation to procure a judgment in its favor, an action brought under Section 5233 of the California Corporations Code, or an action brought by the Attorney General for any breach of duty relating to assets held in charitable trust) by reason of the fact that such person is or was an agent of the Corporation, against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with such proceeding if such person acted in good faith and in a manner such person reasonably believed to be in the best interests of the

Corporation and, in the case of a criminal proceeding, had no reasonable cause to believe the conduct of such person was unlawful. The termination of any proceeding by judgment, order, settlement, conviction or upon a plea of *nolo contendere* or its equivalent shall not, of itself, create a presumption that the person did not act in good faith and in a manner which the person reasonably believed to be in the best interests of the Corporation or that the person had reasonable cause to believe that the person's conduct was unlawful.

(c) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action by or in the right of the Corporation to procure a judgment in its favor, or brought under Section 5233, or brought by the Attorney General for breach of duty relating to assets held in charitable trust, by reason of the fact that such person is or was an agent of the Corporation, against expenses actually and reasonably incurred by such person in connection with the defense or settlement of such action if such person acted in good faith, in a manner such person believed to be in the best interests of the Corporation, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances. No indemnification shall be made under this paragraph (c):

(i) In respect of any claim, issue, or matter as to which such person shall have been adjudged to be liable to the Corporation in the performance of such person's duty to the Corporation, unless and only to the extent that the court in which such proceeding is or was pending shall determine upon application that, in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for the expenses that such court shall determine;

(ii) Of amounts paid in settling or otherwise disposing of a threatened or pending action, with or without court approval; or

(iii) Of expenses incurred in defending a threatened or pending action that is settled or otherwise disposed of without court approval unless it is settled with the approval of the Attorney General.

(d) To the extent that an agent of the Corporation has been successful on the merits in defense of any proceeding referred to in paragraph (b) or (c) or in defense of any claim, issue, or matter in the proceeding, the agent shall be indemnified against expenses actually and reasonably incurred by the agent in connection with the proceeding.

(e) Except as provided in paragraph (d), any indemnification under this Section 11.2 shall be made by the Corporation only if authorized in the specific case, upon a determination that indemnification of the agent is proper in the circumstances because the agent has met the applicable standard of conduct set forth in paragraph (b) or (c), by:

(i) A majority vote of a quorum consisting of Directors who are not parties to such proceeding;

(ii) Approval or ratification by the affirmative vote of a majority of the votes represented and voting at a duly held membership meeting at which a quorum is present (which affirmative votes also constitute a majority of the

required quorum); for such purpose, any membership held by the person to be indemnified shall not be considered outstanding or entitled to vote on the matter; or

(iii) The court in which such proceeding is or was pending upon application made by the Corporation, the agent, or the attorney or other person rendering services in connection with the defense, whether or not such application by the agent, attorney, or other person is opposed by the Corporation.

(f) Expenses incurred in defending any proceeding may be advanced by the Corporation prior to the final disposition of such proceeding upon receipt of an undertaking by or on behalf of the agent to repay such amount unless it shall be determined ultimately that the agent is entitled to be indemnified as authorized in this Section 11.2.

(g) Nothing contained in this article shall affect any right to indemnification to which persons other than Directors and officers of the Corporation or any subsidiary of the Corporation may be entitled by contract or otherwise.

(h) No indemnification or advance shall be made under this article, except as provided in paragraph (d) or paragraph (e)(iii), in any circumstance when it appears:

(i) That it would be inconsistent with a provision of the Articles, a resolution of the sole Member, or an agreement in effect at the time of the accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amounts were paid, which prohibits or otherwise limits indemnification; or

(ii) That it would be inconsistent with any condition expressly imposed by a court in approving a settlement.

(i) Upon and in the event of a determination by the Board of Directors of the Corporation to purchase indemnity insurance, the Corporation shall purchase and maintain insurance on behalf of any agent of the Corporation against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such whether or not the Corporation would have the power to indemnify the agent against such liability under the provisions of this Section 11.2; provided, however, that the Corporation shall have no power to purchase and maintain such insurance to indemnify any agent of the Corporation for a violation of Section 5233.

(j) This Section 11.2 does not apply to any proceeding against any trustee, investment manager, or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be an agent of the Corporation as defined in paragraph (a). The Corporation shall have the power to indemnify such trustee, investment manager, or other fiduciary to the extent permitted by subdivision (f) of Section 207 of the California Corporations Code.

ARTICLE XII
Medical Staff

12.1 Organization. A medical staff organization has been created for the acute care hospital that is owned by El Camino Hospital, and this medical staff is known as the El Camino Hospital Medical Staff (the "Medical Staff").

12.2 Membership. Membership in the Medical Staff shall be comprised of all physicians, dentists and podiatrists who are duly licensed, competent in their respective fields, worthy in character and in professional ethics and privileged to attend to patients in the Hospital. The term "physicians" shall include physicians licensed in the State of California, regardless of whether they hold an M.D. or D.O. degree. Membership in the Medical Staff shall be a prerequisite to the exercise of any clinical privileges except as otherwise expressly provided in the Medical Staff Bylaws.

12.3 Medical Staff Bylaws, Rules and Regulations.

(a) Purpose. Medical Staff Bylaws, rules and regulations shall be adopted by the Medical Staff for its internal governance, subject to the Board's approval (the "Medical Staff Bylaws"). The Medical Staff Bylaws shall create an effective administrative unit to discharge the functions and responsibilities assigned to the Medical Staff. The Medical Staff Bylaws, rules and regulations shall also state the purposes, functions and organization of the Medical Staff, and set forth the policies and procedures by which the Medical Staff exercises and accounts for its delegated authority and responsibilities.

(b) Procedure to Adopt or Amend.

(i) Preparation and Adoption. The Medical Staff shall have the initial responsibility to formulate, revise and adopt the Medical Staff Bylaws, rules and regulations.

(ii) Review and Approval. After the above action by the Medical Staff, such Medical Staff Bylaws, rules or regulations, or amendments thereto, shall be forwarded to the Board for its review and approval, which approval shall not be unreasonably withheld.

(iii) Separate Action. If the Medical Staff fails to exercise its responsibility hereunder and in a reasonable, timely and responsible manner, and after written notice from the Board to such effect, including a reasonable period of time for response, the Board may formulate or amend the Medical Staff Bylaws, rules and regulations. Any Medical Staff recommendations and views shall be carefully considered during the Board's deliberations and actions.

12.4 Credentialing and Clinical Privileges.

(a) Delegation to Medical Staff. The Board delegates to the Medical Staff responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership and clinical privileges, including appointment, reappointment and corrective action.

(b) Initial Decision. Initial action with respect to membership on the Medical Staff and clinical privileges shall be taken by the Medical Staff in accordance with the Medical Staff Bylaws, rules and regulations. Thereafter, a recommendation shall be made to the Board.

(c) Review and Approval. The Board shall review and act upon recommendations of the Medical Staff, and shall give careful consideration to the Medical Staff's expertise in peer review matters.

(d) Separate Action. If the Medical Staff fails to exercise its responsibility hereunder in a reasonable, timely and responsible manner, and after written notice from the Board to such effect, including a reasonable period of time for response, the Board may take actions regarding medical staff membership and clinical privileges. In so doing, the Board shall carefully consider any Medical Staff recommendations and views during its deliberations and actions. In situations involving corrective action, the Board shall not initiate such action unless the Medical Staff's failure to do so is contrary to the weight of the evidence under consideration.

(e) Fair Hearing Procedure. The procedural rules to be followed by the Medical Staff and the Board in acting on matters of Medical Staff membership and clinical privileges, including such matters as appointment, reappointment and corrective action, shall be as more particularly specified in the Medical Staff Bylaws. The Medical Staff Bylaws shall provide for a procedure pursuant to which disagreements between the Medical Staff and the Board may be resolved.

(f) Standards of Decision and Review. In taking the actions referred to in this Article XII, the relevant decision-making body shall consider the supporting information and the purposes, needs and capabilities of the hospital, the health and welfare of the community, and such relevant criteria as are set out in the Medical Staff Bylaws, rules and regulations. In taking such action, no aspect of Medical Staff membership or privileging shall be limited or denied on the basis of sex, age, race, creed, color, or national origin, or on the basis of any other criterion unrelated to those set out in the preceding sentence.

(g) Duration. Appointments to the Medical Staff shall be for a maximum term of two (2) years.

(h) Terms and Conditions. The terms and conditions of Medical Staff membership and of the exercise of clinical privileges shall be as specified in the Medical Staff Bylaws, rules and regulations, or as more specifically defined in the notice of an individual appointment or privileges.

12.5 Allied Health Professionals. The categories of allied health professionals eligible to hold specific practice privileges to perform services within the scope of their licensure, certification or other legal authorization, and the corresponding privileges, prerogatives, terms and conditions for each such allied health professional category or practitioner shall be determined by the Board upon recommendations received from the Medical Staff executive committee. The Medical Staff shall have the responsibility and authority to investigate and evaluate each application by an allied health professional for satisfaction of relevant eligibility requirements in accordance with the Medical Staff Bylaws, rules and regulations.

12.6 Contract Physicians. A physician engaged as an independent contractor by the Corporation to provide medical-administrative services must obtain appropriate Medical Staff membership and privileges through the procedure outlined in the Medical Staff Bylaws, rules and regulations. Restriction or termination of such physician's Medical Staff membership or clinical privileges for reasons related to professional competence shall also be accomplished through the procedures contained in the Medical Staff Bylaws, rules and regulations. All other matters, including termination of Medical Staff membership or clinical privileges on grounds not related to professional competence, shall be governed by the terms of such physician's contracts or agreements with the Corporation.

12.7 Accountability. The Medical Staff shall be accountable to the Board for conducting activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided at the Corporation. These activities shall include:

(a) Standard of Care. Ensuring that a comparable standard of care, as determined by the Medical Staff, is provided to all patients with similar needs;

(b) Monitor Quality. Ongoing monitoring and evaluation of patient care to solve problems and identify other opportunities to improve quality.

(c) Clinical Privileges. Delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment.

(d) Continuing Education. Provision of continuing professional education, guided by the needs identified through the review and evaluation activities, as well as other perceived needs and interests.

(e) Resource Allocation. Review of utilization of the Corporation's resources to provide for their allocation to patients in need of them.

(f) Medical Records. Ensuring the preparation and maintenance of adequate and accurate medical records for all patients; and

(g) Other Matters. Such other measures as the Board may, after considering the advice of the Medical Staff and the Corporation's administration, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

ARTICLE XIII
Execution of Corporate Instruments, and Voting of Stocks and Memberships Held by the Corporation

13.1 Execution of Corporate Instruments. The Board may, in its discretion, determine the method and designate the signatory officer or officers or other person or persons, to execute any corporate instrument or document, or to sign the corporate name without limitation, except when otherwise provided by law, and such execution or signature shall be binding upon the Corporation.

Unless otherwise specifically determined by the Board or otherwise required by law, formal contracts of the Corporation, promissory notes, deeds of trust, mortgages and other evidences of indebtedness of the Corporation, and other corporate instruments or documents, and certificates of shares of stock owned by the Corporation, shall be executed, signed, or endorsed by the Chairperson.

All checks and drafts drawn on banks or other depositories on funds to the credit of the Corporation, or in special accounts of the Corporation, shall be signed by such person or persons as the Board shall authorize to do so.

13.2 Ratification by Member. The Board may, in its discretion, submit any contract or act for approval or ratification of the Member at any regular meeting of Member, or at any special meeting of Member called for that purpose.

13.3 Voting of Stocks Owned by Corporation. All stock of other corporations or memberships in other corporations owned or held by the Corporation for itself, or for other parties in any capacity, shall be voted, and all proxies with respect to such stock or memberships shall be executed, by the person authorized to do so by resolution of the Board of Directors, or in the absence of such authorization, by the Chairperson of the Board, or Vice Chairperson or by any other person authorized to do so by the Chairperson or the Vice Chairperson of the Board.

ARTICLE XIV
Annual Report

Except as provided below, the Corporation shall cause to be sent to its Member and Directors no later than 120 days after the close of its fiscal year, a report containing the following information in appropriate detail:

(a) The assets and liabilities, including the trust funds, of the Corporation as of the end of the fiscal year.

(b) The principal changes in assets and liabilities, including trust funds, during the fiscal year.

(c) The revenue or receipts of the Corporation, both unrestricted and restricted to particular purposes, for the fiscal year.

(d) The expenses or disbursements of the Corporation, for both general and restricted purposes, during the fiscal year.

(e) Any information required by Section 6322 of the California Corporations Code.

The report shall be accompanied by any pertinent report of independent accountants, or, if there is no such report, the certificate of an authorized officer of the Corporation that such statements were prepared without audit from the books and records of the Corporation.

This article does not apply to the Corporation when it receives less than twenty-five thousand dollars ($25,000) in gross revenues or receipts during the fiscal year, with the exceptions that a report meeting the above requirements must be furnished annually to all Directors and to the Member who requests it in writing and that the information referred to in paragraph (e) above must be furnished to the Member and Directors within 120 days after the close of the Corporation's fiscal year.

If the Corporation solicits in writing contributions from five hundred (500) or more persons, it need not send the report described above to the Member, with the exception of the information referred to in paragraph (e) above, if it:

(i) Includes with any written material used to solicit contributions a written statement that its latest annual report will be mailed upon request and that such request may be sent to the Corporation at a name and address which is set forth in the statement;

(ii) Promptly mails a copy of its latest annual report to any person who requests a copy; and

(iii) Causes its annual report to be published not later than 120 days after the close of its fiscal year in a newspaper of general circulation in the county in which its principal office is located.

ARTICLE XV
Standard of Care

A Director shall perform the duties of a director, including duties as a member of any Board committee on which the Director may serve, in good faith, in a manner such Director believes to be in the best interest of this Corporation and with such care, including reasonable inquiry, as an ordinarily prudent person in a like situation would use under similar circumstances.

In performing the duties of a Director, a Director shall be entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, in each case prepared or presented by:

(a) one or more officers or employees of the Corporation whom the Director believes to be reliable and competent as to the matters presented;

(b) counsel, independent accountants, or other persons as to matters which the Director believes to be within such person's professional or expert competence; or

(c) a Board committee upon which the Director does not serve, as to matters within its designated authority, provided that the Director believes such committee merits confidence; so long as in any such case, the Director acts in good faith after reasonable inquiry when the need therefor is indicated by the circumstances and without knowledge that would cause such reliance to be unwarranted.

Except as provided in Article XVI below, a person who performs the duties of a Director in accordance with this Article XV shall have no liability based upon any failure or alleged failure to discharge that person's obligations as a Director, including, without limiting the generality of the foregoing, any actions or omissions which exceed or defeat a public or charitable purpose to which a corporation, or assets held by it, are dedicated.

ARTICLE XVI
Prohibited Transactions

16.1 Loans. Except as permitted by Section 5236 of the California Corporations Code, this Corporation shall not make any loan of money or property to, or guarantee the obligation of, any Director or officer; provided, however, that this Corporation may advance money to a Director or officer of this Corporation or any subsidiary for expenses reasonably anticipated to be incurred in performance of the duties of such officer or Director so long as such individual would be entitled to be reimbursed for such expenses absent that advance.

16.2 Self-Dealing Transactions. Except as provided in Section 16.3 below, the Board of Directors shall not approve or permit the Corporation to engage in any self-dealing transaction. A self-dealing transaction is a transaction to which this Corporation is a party and in which one or more of its Directors has a material financial interest, unless the transaction is described in California Corporations Code Section 5233(b).

16.3 Approval. This Corporation may engage in a self-dealing transaction if the transaction is approved by a court or by the Attorney General. This Corporation also may engage in a self-dealing transaction if the Board determines, before the transaction, that (1) this Corporation is entering into the transaction for its own benefit; (2) the transaction is fair and reasonable to this Corporation at the time; and (3) after reasonable investigation, the Board determines that it could not have obtained a more advantageous arrangement with reasonable effort under the circumstances. Such determinations must be made by the Board in good faith, with knowledge of the material facts concerning the transaction and the interest of the Director or Directors in the transaction, and by a vote of a majority of the Directors then in office, without counting the vote of the interested Director or Directors.

ARTICLE XVII
Miscellaneous

17.1 Records and Reports.

(a) Maintenance and Inspection of Articles and Bylaws. This Corporation shall keep at its principal office the original or a copy of its Articles and these Bylaws as amended from time to time which shall be open to inspection by the Directors and the Member at any reasonable time during business hours.

(b) Maintenance and Inspection of Other Corporate Documents. The accounting books, records, and minutes of proceedings of the Member, the Board and any committee of the Board shall be kept at such place or places designated by the Board or, in the absence of such designation, at the principal office of the Corporation. The minutes shall be kept in written or typed form, and the accounting books and records shall be kept either in written or

typed form or in any other form capable of being converted into written, typed or printed form. The minutes and accounting books and records shall be open to inspection on the written demand of any Member, at any reasonable time during usual business hours for a purpose reasonably related to the Member's interests as a Member. Inspection may be made in person or by an agent or any attorney, and shall include the right to copy and make abstracts.

(c) Inspection by Directors. Each Director shall have the absolute right at any reasonable time to inspect all books, records, and documents of every kind and the physical properties of the Corporation. This inspection by a Director may be made in person or by the agent or attorney. The right of inspection includes the right to copy and make abstracts of documents.

17.2 Corporate Seal. The Board shall provide a suitable seal for the Corporation.

17.3 Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the above, singular numbers include the plural, plural numbers include the singular, and the term "person" includes both corporations and natural persons. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE XVIII
Amendments

18.1 Amendments. The Articles or these Bylaws may be adopted, repealed, amended or restated or new Articles or Bylaws may be adopted upon a majority vote of the authorized number of Directors (excluding vacancies and Directors with a conflict of interest). No such adoption, repeal, amendment, restatement or new Articles or Bylaws shall be effective until approved by the Member. Moreover, the Articles and Bylaws may be adopted, repealed, amended or restated or new Bylaws adopted upon the vote of the Member.

CERTIFICATE OF SECRETARY

I, the undersigned, certify that I am the currently elected and acting Secretary of El Camino Hospital, a California nonprofit public benefit corporation, and the above Amended and Restated Bylaws, consisting of 24 pages, are the Bylaws of this Corporation as adopted pursuant to the required affirmative vote of the Board, December 7, 2005 and the Member, the El Camino Healthcare District, on December 7, 2005 pursuant to the required affirmative vote of the District Board, as amended and restated pursuant to the required affirmative vote of the Board on August 10, 2011 and the Member, the El Camino Healthcare District, on August 10, 2011 pursuant to the required affirmative vote of the District Board and as further amended and restated by the Member, El Camino Healthcare District, on March 20, 2012 pursuant to the required affirmative vote of the District Board and as further amended and restated by the Member, El Camino Healthcare District, on May 12, 2012, May 1, 2013, June 18, 2013, and March 5, 2014 pursuant to the required affirmative vote of the District Board, and as amended and restated pursuant to the required affirmative vote of the Board on May 14, 2014 (Section 6.8) and May 14, 2014 ~~(Article VII)~~ and of the Member, the El Camino Healthcare District, on June 17, 2014, and as amended and restated pursuant to the required affirmative vote of the Board on October 8, 2014 ~~(Section 7.6)~~ and of the Member, the El Camino Healthcare District, on October 21, 2014, and as amended and restated pursuant to the required affirmative vote of the Board on January 13, 2016 and of the Member, the El Camino Healthcare District, on January 19, 2016.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Secretary on January ___ ~~October ___~~, 201~~4~~6.

_____

Peter C. Fung,~~atricia A. Einarson,~~ MD
El Camino Hospital Secretary

Att 27d.3 - Draft Revised Amended and Restated El Camino Hospital Bylaws (CLEAN)12_8_15

DRAFT REVISED: December 8, 2015(CLEAN)

AMENDED AND RESTATED BYLAWS

OF

EL CAMINO HOSPITAL

ADOPTED

DECEMBER 7, 2005

AS AMENDED AND RESTATED

October 21, 2014

TABLE OF CONTENTS

Page

ARTICLE I CORPORATE OFFICES 1

1.1 Principal Office 1
1.2 Registered Office 1

ARTICLE II PURPOSES, POWERS AND MEMBERSHIP 1

2.1 Purposes 1
2.2 Powers 1
2.3 Membership Corporation 1
2.4 Exempt Activities 1
2.5 Termination of Membership 1

ARTICLE III MEETINGS OF MEMBERS 1

3.1 Place of Meetings 1
3.2 Annual Meeting 1
3.3 Notice of Annual Meeting 2
3.4 Special Meetings 2
3.5 Notice of Special Meetings 2
3.6 Quorum 3
3.7 Adjourned Meeting and Notice 3
3.8 Voting 3
3.9 Proxies 3
3.10 Validation of Defectively Called or Noticed Meetings 3
3.11 Action Without a Meeting 4
3.12 Rights of the Member 4

ARTICLE IV BOARD OF DIRECTORS 4

4.1 Management by Board of Directors 4
4.2 Number of Voting Directors 5
4.3 Qualifications of Voting Directors 5
4.4 Appointment and Selection of Directors 5
4.5 Term 6
4.6 Term Limits 6
4.7 Vacancy 7
4.8 Resignation 7
4.9 Removal 7

ARTICLE V CERTAIN DIRECTOR ELECTION PROCEDURES ..... 7~~8~~

5.1 Nominating Committee ..... 7~~8~~
5.2 Nominations by Member 8

ARTICLE VI BOARD MEETINGS 8

6.1 Annual Meeting 8
6.2 Regular Meetings 8
6.3 Special Meetings 8
6.4 Meetings by Conference Telephone ..... 8~~9~~
6.5 Waiver of Notice 9
6.6 Unanimous Action Without Meeting 9
6.7 Quorum 9
6.8 Agenda for Meetings 9
6.9 Board Action 10
6.10 Adjournment 10
6.11 Notice of Adjournment 10

ARTICLE VII BOARD COMMITTEES AND ADVISORY COMMITTEES 10

7.1 Establishment of Committees 10
7.2 Special Committees 11
7.3 Authority to Act 11
7.4 Appointment 11
7.5 Meetings and Actions of Committees 11
7.6 Advisory Committees 11

ARTICLE VIII OFFICERS AND EMPLOYEES 12

8.1 Officers 12
8.2 Election of Board Officers 12
8.3 Term of Board Officers 12
8.4 Resignation 12
8.5 Removal 12
8.6 Vacancies 12
8.7 Compensation 12
8.8 Duties and Qualifications of Officers 12

ARTICLE IX CHIEF EXECUTIVE OFFICER 13

9.1 Selection, Authority and Term 13
9.2 Performance Review ..... 13~~14~~
9.3 Authority and Duties 14

ARTICLE X CONTRACTS AND FINANCIAL MATTERS 15

10.1 Loans 15
10.2 Deposits 15
10.3 Compensation of Directors 15

ARTICLE XI CONFLICTS OF INTEREST AND INDEMNIFICATION 15

11.1 Conflict of Interest 15
11.2 Indemnification 15

ARTICLE XII MEDICAL STAFF 18

12.1 Organization 18
12.2 Membership 18
12.3 Medical Staff Bylaws, Rules and Regulations 18
12.4 Credentialing and Clinical Privileges 18
12.5 Allied Health Professionals 19
12.6 Contract Physicians 20
12.7 Accountability 20

ARTICLE XIII EXECUTION OF CORPORATE INSTRUMENTS, AND VOTING OF STOCKS AND MEMBERSHIPS HELD BY THE CORPORATION 20

13.1 Execution of Corporate Instruments 20
13.2 Ratification by Member 21
13.3 Voting of Stocks Owned by Corporation 21

ARTICLE XIV ANNUAL REPORT 21

ARTICLE XV STANDARD OF CARE 22

ARTICLE XVI PROHIBITED TRANSACTIONS 23

16.1 Loans 23
16.2 Self-Dealing Transactions 23
16.3 Approval 23

ARTICLE XVII MISCELLANEOUS 23

17.1 Records and Reports 23
17.2 Corporate Seal 24
17.3 Construction and Definitions 24

ARTICLE XVIII AMENDMENTS 24

18.1 Amendments 24

ARTICLE I
Corporate Offices

1.1 Principal Office. The principal office of El Camino Hospital, a nonprofit public benefit corporation (the "Corporation"), is located in Mountain View, California. The Corporation may have such other offices as the Board of Directors of Corporation (the "Board") may determine from time to time.

1.2 Registered Office. The address of the registered office of the Corporation is 2500 Grant Road, Mountain View, California 94040.

ARTICLE II
Purposes, Powers and Membership

2.1 Purposes. The purposes of the Corporation are set forth in its Articles of Incorporation (the "Articles").

2.2 Powers. The Corporation may engage in any activity consistent with the Articles and these Bylaws.

2.3 Membership Corporation. The Corporation shall have one voting Member: El Camino Healthcare District, a political subdivision of the State of California (the "Member"). The Corporation shall have no other voting members.

2.4 Exempt Activities. Notwithstanding any other provision of these Bylaws, no director, officer, employee, or representative of the Corporation shall take any action or carry on any activity by or on behalf of the Corporation not permitted to be taken or carried on by an organization exempt from taxation under Section 501(c)(3) of the Internal Revenue Code and regulations promulgated thereunder as they now exist or as they hereafter may be amended, or by an organization contributions to which are deductible under Section 170(c) of such Code and Regulations as they now exist or as they hereafter may be amended.

2.5 Termination of Membership. The membership of the sole Member shall terminate upon the resignation of the sole Member.

ARTICLE III
Meetings of Members

3.1 Place of Meetings. Meetings of the sole Member shall be held at any place within or outside the State of California designated by the Board of Directors. In the absence of any such designation, meetings of the sole Member shall be held at the principal executive office of the Corporation.

3.2 Annual Meeting. There shall be an annual meeting of the sole Member held each year. The Board shall provide for the time and place of holding the annual meeting and notify the sole Member as provided in Section 3.3. At the annual meeting, directors shall be elected as

required by these Bylaws, reports of the affairs of the Corporation shall be considered, and any other business may be transacted that is within the power of the sole Member.

3.3 Notice of Annual Meeting. Written notice of each annual meeting shall be given to the sole Member entitled to vote, either personally, or by mail, or by other means of written communication, with charges prepaid, addressed to the sole Member at the sole Member's address appearing on the books of the Corporation or given by the sole Member to the Corporation for the purpose of notice.

All such notices shall be given to the sole Member entitled to the notice by mail or other means of written communication not less than ten (10) days (or, if sent by mail other than first-class, registered, or certified mail, twenty (20) days) nor more than ninety (90) days before each annual meeting. Any such notice shall be deemed to have been given at the time when delivered personally or deposited in the mail or sent by other means of written communication. An affidavit of giving of any such notice in accordance with the foregoing provisions, executed by the Secretary or any transfer agent of the Corporation, shall be *prima facie* evidence of the giving of the notice.

The notice of the meeting shall specify:

(a) the place, date, and hour of the meeting;

(b) those matters which the Board, at the time the notice is given, intends to present for action by the sole Member;

(c) if directors are to be elected, the names of all those who are nominees at the time the notice is given;

(d) the general nature of a proposal, if any, to take action when approval of the sole Member is required with respect to (i) removal of directors without cause; (ii) the filling of vacancies on the Board; (iii) amendment of the Articles or these Bylaws; (iv) voluntary merger or dissolution of the Corporation; or (v) disposition of all or substantially all of the assets of the Corporation; and

(e) such other matters, if any, as may be expressly required by law.

3.4 Special Meetings. A special meeting of the sole Member for any lawful purpose or purposes may be called at any time by the Chairperson of the Board or by the Board. In addition, a special meeting of the sole Member for the purpose of removal of directors and election of their replacements may be called by the sole Member.

3.5 Notice of Special Meetings. Upon request in writing that a special meeting of the sole Member be called, directed to the Chairperson, Vice Chairperson, or Secretary, by any person (other than the Board of Directors) entitled to call a special meeting of the sole Member, the officer forthwith shall cause notice to be given to the sole Member that a meeting will be held at a time fixed by the Board, not less than thirty-five (35) nor more than ninety (90) days after the receipt of the request. If the notice is not given within twenty (20) days after the receipt of the request, the persons entitled to call the meeting may give the notice. Notice of any special

meeting of the sole Member shall be given in the same manner as for annual meetings of the sole Member. In addition to the matters required by Section 3.3(a) and, if applicable, Section 3.3(c) of these Bylaws, notice of any special meeting shall specify the general nature of the business to be transacted, and the fact that no other business may be transacted at the meeting.

3.6 Quorum. The presence in person or by proxy of the sole Member shall constitute a quorum for the transaction of business. Any meeting of the sole Member may be adjourned from time to time by the sole Member.

3.7 Adjourned Meeting and Notice. Except as provided below, when the sole Member's meeting, either regular or special is adjourned to another time or place, notice need not be given of the adjourned meeting if the time and place are announced at the meeting at which the adjournment is taken. At the adjourned meeting the Corporation may transact any business that might have been transacted at the original meeting. However, no meeting may be adjourned for more than forty-five (45) days. If after adjournment a new record date is fixed for notice or voting, notice of the adjourned meeting shall be given to the sole Member.

3.8 Voting.

(a) Except as may be otherwise provided in the Articles or these Bylaws, the sole Member shall be entitled to one vote on each matter being considered.

(b) Voting at a meeting of the sole Member may be by voice vote or by ballot.

3.9 Proxies.

(a) The sole Member may authorize another person or persons to act by proxy with respect to such membership. "Proxy" means a written authorization signed by the sole Member giving another person or persons power to vote on behalf of the sole Member. "Signed" for the purpose of this section means the placing of the sole Member's name on the proxy (whether by manual signature, typewriting, telegraphic transmission, or otherwise) by the sole Member. Any proxy duly executed is not revoked and continues in full force and effect until (i) a written instrument revoking it is filed with the Secretary of the Corporation prior to the vote pursuant to the proxy, (ii) a subsequent proxy executed by the person executing the prior proxy is presented to the meeting, or (iii) the person executing the proxy attends the meeting and votes in person; provided that no such proxy shall be valid after the expiration of eleven (11) months from the date of its execution, unless otherwise provided in the proxy, except that the maximum term of any proxy shall be three (3) years from the date of execution. The dates contained on the forms of proxy presumptively determine the order of execution, regardless of the postmark dates on the envelopes in which they are mailed. No proxy may be irrevocable.

(b) In any election of directors, any form of proxy in which the directors to be voted upon are named as candidates and which is marked by the sole Member "withhold" or otherwise marked in a manner indicating that the authority to vote for the election of directors is withheld shall not be voted either for or against the election of a director.

3.10 Validation of Defectively Called or Noticed Meetings. The transactions of any meeting of the sole Member, however called and noticed, and wherever held, are as valid as

though had at a meeting duly held after regular call and notice, if a quorum is present either in person or by proxy. Attendance of a person at a meeting shall constitute a waiver of notice of and presence at such meeting, except when the person objects, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened and except that attendance at a meeting is not a waiver of any right to object to the consideration of matters required by these Bylaws or by the California Nonprofit Corporation Law to be included in the notice if such objection is expressly made at the meeting. Neither the business to be transacted at nor the purpose of any regular or special meeting of the sole Member need be specified in any written waiver of notice, consent to the holding of the meeting, or approval of the minutes of the meeting, unless otherwise provided in the Articles or these Bylaws, except the general nature of the proposals listed in Section 3.3(d) of these Bylaws must be specified, to the extent applicable, in any such waiver, consent, or approval.

3.11 Action Without a Meeting. Any action required or permitted to be taken by the sole Member may be taken without a meeting, if the sole Member consents in writing to the action. The written consent shall be filed with the minutes of the proceedings of the sole Member. The action by written consent shall have the same force and effect as the vote of the sole Member.

3.12 Rights of the Member. The Member shall have all rights granted to a member under the California Nonprofit Corporation Law. Without limiting the generality of the foregoing, the Member shall have the right to approve the election of directors, to approve the disposition of all or substantially all of the assets of the Corporation or to approve a merger and dissolution of the Corporation and the other rights set forth in the articles of incorporation and bylaws. In addition to the foregoing, the Member shall have the right to require the Corporation to provide to Member any financial information requested by the Member and to approve the following actions authorized by the Board of Directors of the Corporation:

1. To approve the selection of the Corporation's Chief Executive Officer;

2. To approve the annual budget of the Corporation;

3. To approve capital expenditures by the Corporation of more than $25 million dollars in a single transaction;

4. To approve any expenditures or transfers by the Corporation in a single transaction apparent or a series of related transaction (in excess of 5% of the assets of the Corporation as determined based on last annual audit of the Corporation preceding the approval date of the proposed transaction);

5. To approve the overall strategy adopted by the Corporation.

ARTICLE IV
Board of Directors

4.1 Management by Board of Directors. The business and affairs of the Corporation shall be managed by the Board, except as otherwise provided by law, the Articles, these Bylaws or a Board resolution.

4.2 Number of Voting Directors. The number of voting directors ("Directors") of the Corporation shall not be less than five (5) nor more than nine (9) until changed by amendment of the Articles or by a bylaw amending this Section 4.2 duly adopted by the sole Member. The exact number of Directors shall be fixed from time to time, within the limit specified in the Articles or in this Section 4.2, by the sole Member.

4.3 Qualifications of Voting Directors.

(a) Commitment. Directors must be committed to the furtherance of health care delivery in the communities served by the Corporation, and must be willing to devote the necessary time and energy for self-education, corporate functions and other activities necessary to fulfill this commitment.

(b) Fiduciary Duty. Directors shall have a fiduciary duty to the Corporation, and shall make all decisions in a manner that is in the best interests of the Corporation and the communities served by the Corporation. Directors shall not advocate or act in the interests of any private person, group or entity unless such action is also in the best interests of the Corporation or the communities served by the Corporation.

(c) Restriction on Interested Directors. Not more than forty-nine percent (49%) of the persons serving on the Board of Directors at any time may be interested persons. An interested person is (i) any person being compensated by the Corporation for services rendered to it within the previous twelve (12) months, whether as a full-time or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a Director as Director; and (ii) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, or father-in-law of any such person. However, any violation of the provisions of this section shall not affect the validity or enforceability of any transaction entered into by the Corporation.

(d) Financial Interest. Except as permitted by the California Nonprofit Corporation Law, the California Health and Safety Code and any other provisions of law, Directors shall not have a "financial interest" in any transactions or contracts of the Corporation.

4.4 Appointment and Selection of Directors.

(a) Ex Officio Director. The Chief Executive Officer of this Corporation shall serve as an ex officio Director, with full voting rights; the voting right of the ex officio Director shall be suspended when the number of Directors in office is less than nine (9) except to the extent that the vacant positions are entirely among the 2012 Directors. The term of such Director shall end when his or her term of office as the Chief Executive Officer of this Corporation expires or terminates.

(b) Vacancies. In the event of a vacancy on the Board because no person holds the position designated in Section 4.4(a), such position on the Board shall remain vacant until a successor is appointed to the office described in Section 4.4(a). In the event that the office described in Section 4.4(a) no longer exists, the Member shall have the exclusive power to appoint a person to serve as a Director with respect to such position.

(c) Other Directors. All Directors, other than the ex officio Director, shall be nominated and elected by the Member.

(d) Replacement Directors. A Director, if any, who fills the unexpired term of a vacant Director position shall serve until the end of that unexpired term.

4.5 Term.

(a) Years.

(i) The term of an ex officio Director described in Section 4.4 shall be the period of time such an ex officio Director holds the office described in Section 4.4.

(ii) A Director first elected by the Member pursuant to Section 4.4(c) effective September 1, 2012 shall serve a staggered term ending June 30, 2013, June 30, 2014 or June 30, 2015 as designated by a resolution of the Board. Any Director who is later appointed to replace such position or who is later appointed to a new term for such a position after the initial term expires shall serve a term of four (4) years. The Directors described in this subparagraph (ii) are referred to in these Bylaws as "2012 Directors."

(iii) All Directors not listed in Section 4.5(a)(i) or (ii) shall hold office as a Director for a term of four (4) years from the date of election.

(iv) Any Director, other than a Director serving ex officio, shall serve for such Director's stated term and until his or her successor is duly elected and qualified, unless the Director resigns or is removed as provided in these Bylaws.

4.6 Term Limits.

(a) New Members.

Any Director, other than a Director serving ex officio, who first takes office during calendar year 2014, or any time thereafter, may only serve three (3) complete four (4) year terms as a Director.

(b) Current Members.

Any Director, other than a Director serving ex officio, who is serving as a Director as of January 1, 2014 may only serve three (3) complete four (4) year terms as a Director beginning with such Director's next term of office that commences after January 1, 2014.

(c) Effect of Term Limit. The office of any Director subject to the limitation set forth in Section 4.6(a) or Section 4.6(b) shall terminate on the last day of the period described in Section 4.6(a) or Section 4.6(b) that is applicable to such Director.

(d) Election Following Term Limit. Any person who has left the Board due to the application of Section 4.6(a) or (b) may be elected to serve as a Director after two (2) years from the date such Director left the Board.

(e) New Term Limits. Any Director elected, as described in Section 4.6(d), after his or her term has been limited shall be subject to Section 4.6(a) beginning on the first day of such new term.

4.7 Vacancy.

(a) A vacancy in the Board of Directors shall be deemed to exist on the occurrence of the following: (i) the death, resignation, or removal of any Director; (ii) the declaration by the Board of a vacancy in the office of a Director who has been declared of unsound mind by a final order of court, or has been convicted of a felony, or has been found by a final order or judgment of any court to have breached any duty under Sections 5230-38 of the California Corporations Code dealing with standards of conduct for directors; (iii) an increase in the authorized number of Directors; (iv) the failure of the sole Member, at any annual or other regular meeting of Member at which any Director or Directors are elected, to elect the full authorized number of Directors to be voted for at that meeting; or (v) the affirmative vote of the sole Member to remove a Director in accordance with the voting requirements of Section 5222 of the California Corporations Code as provided in Section 4.9 below.

(b) Vacancies in the Board may be filled only by the sole Member. Each Director appointed or elected to fill a vacancy shall hold office until his or her successor is elected at an annual or other regular meeting of the sole Member.

4.8 Resignation. Any Director may resign at any time by giving written notice to the Chairperson or the Secretary. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later time specified in the resignation. If the resignation is effective at a future time, the successor may be elected to take office when the resignation becomes effective. Unless the California Attorney General is first notified, no Director may resign when the Corporation would then be left without a duly elected Director or Directors in charge of its affairs.

4.9 Removal. Any elected Director may be removed, with or without cause, at any time by the Member. No reduction of the authorized number of Directors shall have the effect of removing any Director prior to the expiration of his or her term of office. Each Director appointed or elected to fill a vacancy shall hold office until his or her successor is elected by the sole Member.

ARTICLE V
Certain Director Election Procedures

5.1 Nominating Committee. The Board shall appoint a Nominating Committee, a

special committee, to select qualified candidates for election to the Board at least thirty (30) days before the date of any election of Directors. The committee shall make its report at least two (2) days before the date of the election, and the Secretary of the Corporation shall forward to the Member, with the notice of meeting required by Section 3.3 of these Bylaws, a list of candidates so nominated along with the names of any persons duly nominated by the Member as of that time.

5.2 Nominations by Member. The sole Member may nominate candidates for directorships at any time before the election. The Secretary shall cause the names of such candidates to be placed on the ballot along with those candidates named by the nominating committee. If there is a meeting to elect directors, the sole Member may place names in nomination.

ARTICLE VI
Board Meetings

6.1 Annual Meeting. An annual meeting of the Board shall be held each year, at which time officers of the Board shall be elected and such other business as is appropriate shall be transacted. Annual meetings shall be held at the location designated by the Board or at the principal office of the Corporation.

6.2 Regular Meetings. Meetings of the Board shall be held as directed by the Board, but at least quarterly at any place within or outside the State of California that has been designated by the Board. In the absence of such designation, regular meetings shall be held at the principal office of the Corporation. Regular meetings may be held without notice.

6.3 Special Meetings.

(a) Authority to Call. Special meetings of the Board may be called for any purpose and at any time by the Chairperson, the Secretary, or any two (2) Directors.

(b) Manner of Notice. Notice of the time and place of special meetings shall be given to each Director by one of the following methods: by personal delivery of written notice; by first-class mail, postage paid; by telephone communication, either directly to the Director or to a person at the Director's office who would reasonably be expected to communicate such notice promptly to the Director; by facsimile; or by telegram, charges prepaid. All such notices shall be addressed to or otherwise transmitted to the Director's address, facsimile number, or telephone number shown on the records of the Corporation. The notice shall specify the time and place of the meeting.

(c) Timing of Notice. Notices sent by first-class mail shall be deposited into a United States mail box at least four (4) days before the time set for the meeting. Notices given by personal delivery, telephone, facsimile or telegram shall be given at least forty-eight (48) hours before the time set for the meeting.

6.4 Meetings by Conference Telephone. Any meeting, regular or special, may be held by conference telephone or similar communication equipment, so long as all Directors participating in the meeting can hear one another. All such Directors shall be deemed to be

present in person at any such meeting.

6.5 Waiver of Notice. The transaction of business at any meeting of the Board, however called and noticed or wherever held, shall be valid as though held at a meeting that was duly held after regular call and notice, but only if a quorum is present and if, either before or after the meeting, each of the Directors not present signs and files with the Secretary a written waiver of notice or a consent to holding such meeting or an approval of the minutes thereof, or such Director attends the meeting without protesting, prior to the meeting or at its commencement, the lack of notice to such Director, provided that no Director present at the meeting objected, prior to the transaction of any business, to the holding of the meeting because of a lack of prior notice. All such waivers, consents or approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

6.6 Unanimous Action Without Meeting. Any action required or permitted to be taken by the Board under the Articles, these Bylaws or any provision of law may be taken by the Board without a meeting, if the Directors unanimously consent in writing to such action. Such unanimous written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by unanimous written consent shall have the same force and effect as the unanimous vote of the Directors at a duly called and noticed meeting. Such unanimous written consent or consents may be signed in counterpart and may be submitted to the individual Directors, and returned to the Corporation by mail or by facsimile transmission. For purposes of this section only, "all members of the Board" does not include any "interested directors" as defined in Section 5233 of the California Corporations Code.

6.7 Quorum. A majority of the number of existing Directors (excluding vacancies) shall constitute a quorum for the transaction of business, except to adjourn. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of Directors from the meeting, if any action taken is approved by at least a majority of the required quorum for that meeting, subject to any applicable requirements for approval by a greater number or a disinterested majority.

6.8 Agenda for Meetings. The agenda for Board meetings shall be developed by the Chairperson with the Chief Executive Officer acting as staff to the Chairperson for this purpose. The Chairperson shall prepare a calendar of expected agenda items that will be communicated regularly at Board meetings. Any Director may ask that a matter be added to a future Board meeting agenda by written notification to the Chairperson and the Chief Executive Officer. The Chairperson will determine, considering all other matters to be addressed by the Board, whether and when to add the matter to a Board agenda. If the matter will not be added to the Board meeting agenda at the next meeting to be held more than fourteen (14) days after the date of the request, the Chief Executive Officer will notify the Director making the request of the Chairperson's decision; the person making the request may ask that the questions of whether such matter should be considered by the Board and the timing of such consideration be addressed during the discussion of the calendar of expected agenda items during the next meeting of the Board that occurs more than ten (10) days thereafter. Notwithstanding the foregoing, any request to add a matter to the Board agenda made by three (3) directors shall be added to the Board meeting agenda at the next meeting to be held more than fourteen (14) days after the date of the last request.

6.9 Board Action. Every act done or decision made by a majority of the Directors present at a meeting duly held at which a quorum is present shall be regarded as the act of the Board of Directors, unless a greater number, or the same number after disqualifying one or more Directors from voting, is required by the Articles, these Bylaws, or the California Nonprofit Corporation Law. Provided however, amendments to the Articles or these Bylaws and approval of certain transactions must be approved by the vote of a majority of the Directors in office, excluding interested directors as defined in Section 5233 of the California Corporations Code.

6.10 Adjournment. A majority of the Directors present, whether or not constituting a quorum, may adjourn any meeting to another time and place.

6.11 Notice of Adjournment. Notice of the time and place of holding an adjourned meeting need not be given, unless the meeting is adjourned for more than twenty-four (24) hours, in which case notice of the time and place shall be given before the time of the adjourned meeting to the Directors who were not present at the time of the adjournment.

ARTICLE VII
Board Committees and Advisory Committees

7.1 Establishment of Committees. The Board of Directors may, by resolution adopted by a majority of the Directors then in office, provided that a quorum is present, designate one or more committees, each consisting of two (2) or more Directors, to serve at the pleasure of the Board. The Board may designate one or more Directors as alternate members of any committee, who may replace any absent member at any meeting of the committee. The provisions of Section 7.1 through 7.5 of these Bylaws do not apply to any advisory committee established under Section 7.6. The appointment of members or alternate members of a committee requires the vote of a majority of the Directors then in office, provided that a quorum is present. Any such committee, to the extent provided in the resolution of the Board of Directors or in these Bylaws, shall have all the authority of the Board of Directors, except that no committee, regardless of Board resolution, may:

(a) Approve any action that, under the California Nonprofit Corporation Law, also requires the affirmative vote of the members of a public benefit corporation.

(b) Fill vacancies on the Board or in any committee that has the authority of the Board.

(c) Fix compensation of the Directors for serving on the Board or on any committee.

(d) Amend or repeal Bylaws or adopt new bylaws.

(e) Amend or repeal any resolution of the Board that by its express terms is not so amendable or repealable.

(f) Appoint any other committees of the Board or the members of such committees.

(g) Expend corporate funds to support a nominee for Director after there are more people nominated for Director than can be elected.

(h) Approve any transaction between the Corporation and one or more of its Directors in which the Director or Directors have a material financial interest, except as provided by Section 5233 of the California Corporations Code.

7.2 Special Committees. From time to time the Board may establish special committees. Special Board committees shall exist to perform specific tasks identified by the Board, and shall cease to exist upon completion of the task. The Board may by resolution establish special committees for such purposes as the Board deems appropriate. Members of such committees shall be appointed and removed at the Board's discretion, with or without cause.

7.3 Authority to Act. The committee may take action on behalf of the Corporation only if specifically authorized to take a Board action by resolution of the Board.

7.4 Appointment. The Chairperson of the Board shall appoint committee chairperson(s) and the committee chairperson(s) shall appoint members of committee(s) subject to approval by the Board.

7.5 Meetings and Actions of Committees. Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of these Bylaws, concerning meetings and actions of Directors, with such changes in the context of those Bylaws as are necessary to substitute the committee and its members for the Board and its members, except that the time for regular meetings of committees may be determined either by resolution of the Board or by resolution of the committee. Special meetings of committees may also be called by resolution of the Board. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the committee. Minutes shall be kept of each meeting of any committee and shall be filed with the corporate records. The Board may adopt rules not inconsistent with the provisions of these Bylaws for the governance of any committee.

7.6 Advisory Committees. Notwithstanding any other provision of this Article VII or these Bylaws, the Board may by resolution establish advisory committees to the Board. No advisory committee shall have or exercise any of the authority of the Board but shall advise the Board of Directors on matters within the advisory committee's charter as adopted by the Board. An advisory committee shall be composed of at least two members of the Board and persons who are not members of the Board. The Board, by resolution, shall adopt an advisory committee charter which shall establish the committee, state whether the advisory committee is temporary (ad hoc) or standing, the total number of members of such committee, the number of Board members to be appointed to such committee, and the subject matter to be considered by such advisory committee. The time and place of meetings of the advisory committee shall be determined by the committee chair. The charter shall designate the members of the advisory committee or designate the process by which members of the advisory committee are selected. The Chairperson may serve as chair or a member of any advisory committee except the Governance Committee. The Board may, at any time, amend the resolution establishing the

advisory committee to change the members, to change the scope of delegation, or to terminate the existence of the advisory committee.

ARTICLE VIII
Officers and Employees

8.1 Officers. The officers of the Corporation shall consist of the Chairperson, the Vice Chairperson, the Secretary and the Treasurer and such other persons who are specifically designated as officers by the Board. The offices of Secretary and Treasurer shall be held by the same person.

8.2 Election of Board Officers. All officers shall be elected by a majority vote of the Board.

8.3 Term of Board Officers. Each officer shall hold office for a two (2) year term or until his or her successor is elected and qualified, subject to any employment agreement; provided that a Director may not serve more than two (2) consecutive terms as Chairperson.

8.4 Resignation. Any officer may resign at any time by giving written notice to the Board of Directors, the Chairperson or to the Secretary, without prejudice, however, to the rights, if any, of the Corporation under any contract to which such officer is a party. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later specified time.

8.5 Removal. Any officer may be removed at any time by a majority vote of the Board.

8.6 Vacancies. Upon the removal, resignation, death, or incapacity of any officer, the Board may declare such office vacant and fill such vacancy by the majority vote of the Board.

8.7 Compensation. The salary and other compensation of the officers shall be fixed from time to time by resolution of, or in the manner determined by, the Board.

8.8 Duties and Qualifications of Officers. The officers shall have such duties, in addition to those set forth below, as the Board shall specify by resolution from time to time.

(a) Chairperson. The Chairperson shall preside at all meetings of the Board. Except as provided in Section 13.1, the Chairperson shall have authority to execute in the name of the Corporation all bonds, contracts, deeds, leases, and other written instruments to be executed by the Corporation, and shall perform such other powers and duties as may be from time to time assigned to him or her by the Board or set forth in these Bylaws.

(b) Vice Chairperson. The Vice Chairperson shall assume and perform the duties of the Chairperson in the absence or disability of the Chairperson or whenever the office of Chairperson is vacant. The Vice Chairperson shall have such titles, perform such other duties, and have such other powers as the Board or the Chairperson shall designate from time to time.

(c) Secretary. The Secretary shall record or cause to be recorded, and shall keep or cause to be kept, at the principal executive office and such other place as the Board may order, a book of minutes of actions taken at all meetings of Directors, committees, and Member, with the time and place of holding, whether regular or special, and, if special, how authorized, the notice given, the names of those present at such Directors, committees and Member meetings, and the proceedings of all such meetings.

The Secretary shall give, or cause to be given, notice of all the meetings of the members of the Board of Directors, and of the committees of this Corporation required by these Bylaws or by law to be given, shall keep the seal of the Corporation (if any) in safe custody, and shall have such other powers and perform such other duties as may be prescribed by the Board, the Chairperson or by these Bylaws.

(d) Treasurer. The Treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains, losses, capital, retained earnings, and other matters customarily included in financial statements.

The Treasurer shall deposit all moneys and other valuables in the name and to the credit of the Corporation with such depositories as may be designated by the Board. The Treasurer shall disburse the funds of the Corporation as may be ordered by the Board, shall render to the Chairperson and Directors, whenever they request it, an account of all of the Treasurer's transactions as Treasurer and of the financial condition of the Corporation, and shall have such other powers and perform such other duties as may be prescribed by the Board, the Chairperson or these Bylaws.

ARTICLE IX
Chief Executive Officer

9.1 Selection, Authority and Term. The Board may select and employ a competent, experienced Chief Executive Officer who shall be its direct executive representative in the management of the Hospital. This Chief Executive Officer shall be given the necessary authority and held responsible for the administration of the Hospital in all its activities and departments subject only to such policies as may be adopted, and such orders as may be issued by the Board or by any of its committees to which it has delegated power for such action. He or she shall act as the "duly authorized representative" of the Board in all matters in which the governing Board has not formally designated some other person for that specific purpose. However, nothing in this section is to be construed as depriving or delegating from the Board to the Chief Executive Officer any of the powers and duties imposed upon the Board by the Local Hospital District Law, Division 23, or Chapter 1 of the Health and Safety Code of the State of California, or related statutes. The Chief Executive Officer shall hold office from the date of hire until the end of his or her term in office or sooner at the sole discretion of the Board, subject to any employment agreement.

9.2 Performance Review. The Board shall continually review the performance of the Chief Executive Officer and provide counseling in areas where improvement is needed.

9.3 Authority and Duties. The authority and duties of the Chief Executive Officer shall be as follows:

(a) To perfect and submit to the Board for approval a plan of organization of the personnel and others concerned with the operation of the Hospital; and also to establish methods of procedures concerning the internal operation of the Hospital.

(b) To prepare an annual budget showing the expected receipts and expenditures of the Hospital as required by the Board of Directors.

(c) To prepare and submit capital budget of the Hospital to the Board for approval.

(d) To select, employ, and discharge all employees serving in positions as authorized by the Board of Directors.

(e) To see that all physical properties are kept in good state of repair and operating condition.

(f) To attend all meetings of the Board of Directors.

(g) To supervise all business affairs, such as the records of financial transactions, collection of accounts and purchase and issuance of supplies, and to ensure that all funds are collected and expended to the best possible advantage.

(h) To explore and develop strategic opportunities for the Hospital and propose such opportunities to the Board.

(i) To exercise his or her professional abilities in such a manner that those concerned with the rendering of professional service at the Hospital cooperate to the end that the best possible care may be rendered to all patients.

(j) To submit regularly to the Board or its authorized committees, periodic reports showing the professional service and financial activities of the Hospital and to prepare and submit such special reports as may be required by the Board and/or its functioning committees.

(k) To serve as the liaison officer and channel of communications for all official communications between the Board of Directors or any of its committees, and its adjunct organizations.

(l) To act as an ex-officio member of all Board committees.

(m) To support such volunteer services as are necessary to carry out the purpose of the Hospital.

(n) To assist in providing an orientation program for new Board members.

(o) To perform any other duty that may be necessary in the best interest of the Hospital.

ARTICLE X
Contracts and Financial Matters

10.1 Loans. No loans shall be contracted on behalf of the Corporation and no evidence of indebtedness shall be issued in its name unless authorized by a resolution of the Board. Such authority may be general or confined to specific instances.

10.2 Deposits. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depository as the Board may select.

10.3 Compensation of Directors. Directors and members of committees may receive such compensation, if any, for their services, and such reimbursement of expenses, as may be determined by resolution of the Board to be just and reasonable; provided, however, that any such compensation must be commercially reasonable.

ARTICLE XI
Conflicts of Interest and Indemnification

11.1 Conflict of Interest. The Board shall adopt, by resolution, a conflict of interest policy which shall be attached to these Bylaws.

11.2 Indemnification.

(a) For the purposes of this article, "agent" means any person who is or was a Director, officer, employee, or other agent of the Corporation, or is or was serving at the request of the Corporation as a Director, officer, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, or other enterprise, or was a Director, officer, employee, or agent of a foreign or domestic corporation that was a predecessor corporation of the Corporation or of another enterprise at the request of such predecessor corporation; "proceeding" means any threatened, pending, or completed action or proceeding, whether civil, criminal, administrative, or investigative; and "expenses" include without limitation attorneys' fees and any expenses of establishing a right to indemnification under paragraph (d) or paragraph (e)(iii) of this Section 11.2.

(b) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any proceeding (other than an action by or in the right of the Corporation to procure a judgment in its favor, an action brought under Section 5233 of the California Corporations Code, or an action brought by the Attorney General for any breach of duty relating to assets held in charitable trust) by reason of the fact that such person is or was an agent of the Corporation, against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with such proceeding if such person acted in good faith and in a manner such person reasonably believed to be in the best interests of the Corporation and, in the case of a criminal proceeding, had no reasonable cause to believe the conduct of such person was unlawful. The termination of any proceeding by judgment, order,

settlement, conviction or upon a plea of *nolo contendere* or its equivalent shall not, of itself, create a presumption that the person did not act in good faith and in a manner which the person reasonably believed to be in the best interests of the Corporation or that the person had reasonable cause to believe that the person's conduct was unlawful.

(c) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action by or in the right of the Corporation to procure a judgment in its favor, or brought under Section 5233, or brought by the Attorney General for breach of duty relating to assets held in charitable trust, by reason of the fact that such person is or was an agent of the Corporation, against expenses actually and reasonably incurred by such person in connection with the defense or settlement of such action if such person acted in good faith, in a manner such person believed to be in the best interests of the Corporation, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances. No indemnification shall be made under this paragraph (c):

(i) In respect of any claim, issue, or matter as to which such person shall have been adjudged to be liable to the Corporation in the performance of such person's duty to the Corporation, unless and only to the extent that the court in which such proceeding is or was pending shall determine upon application that, in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for the expenses that such court shall determine;

(ii) Of amounts paid in settling or otherwise disposing of a threatened or pending action, with or without court approval; or

(iii) Of expenses incurred in defending a threatened or pending action that is settled or otherwise disposed of without court approval unless it is settled with the approval of the Attorney General.

(d) To the extent that an agent of the Corporation has been successful on the merits in defense of any proceeding referred to in paragraph (b) or (c) or in defense of any claim, issue, or matter in the proceeding, the agent shall be indemnified against expenses actually and reasonably incurred by the agent in connection with the proceeding.

(e) Except as provided in paragraph (d), any indemnification under this Section 11.2 shall be made by the Corporation only if authorized in the specific case, upon a determination that indemnification of the agent is proper in the circumstances because the agent has met the applicable standard of conduct set forth in paragraph (b) or (c), by:

(i) A majority vote of a quorum consisting of Directors who are not parties to such proceeding;

(ii) Approval or ratification by the affirmative vote of a majority of the votes represented and voting at a duly held membership meeting at which a quorum is present (which affirmative votes also constitute a majority of the required quorum); for such purpose, any membership held by the person to be

indemnified shall not be considered outstanding or entitled to vote on the matter; or

(iii) The court in which such proceeding is or was pending upon application made by the Corporation, the agent, or the attorney or other person rendering services in connection with the defense, whether or not such application by the agent, attorney, or other person is opposed by the Corporation.

(f) Expenses incurred in defending any proceeding may be advanced by the Corporation prior to the final disposition of such proceeding upon receipt of an undertaking by or on behalf of the agent to repay such amount unless it shall be determined ultimately that the agent is entitled to be indemnified as authorized in this Section 11.2.

(g) Nothing contained in this article shall affect any right to indemnification to which persons other than Directors and officers of the Corporation or any subsidiary of the Corporation may be entitled by contract or otherwise.

(h) No indemnification or advance shall be made under this article, except as provided in paragraph (d) or paragraph (e)(iii), in any circumstance when it appears:

(i) That it would be inconsistent with a provision of the Articles, a resolution of the sole Member, or an agreement in effect at the time of the accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amounts were paid, which prohibits or otherwise limits indemnification; or

(ii) That it would be inconsistent with any condition expressly imposed by a court in approving a settlement.

(i) Upon and in the event of a determination by the Board of Directors of the Corporation to purchase indemnity insurance, the Corporation shall purchase and maintain insurance on behalf of any agent of the Corporation against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such whether or not the Corporation would have the power to indemnify the agent against such liability under the provisions of this Section 11.2; provided, however, that the Corporation shall have no power to purchase and maintain such insurance to indemnify any agent of the Corporation for a violation of Section 5233.

(j) This Section 11.2 does not apply to any proceeding against any trustee, investment manager, or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be an agent of the Corporation as defined in paragraph (a). The Corporation shall have the power to indemnify such trustee, investment manager, or other fiduciary to the extent permitted by subdivision (f) of Section 207 of the California Corporations Code.

ARTICLE XII
Medical Staff

12.1 Organization. A medical staff organization has been created for the acute care hospital that is owned by El Camino Hospital, and this medical staff is known as the El Camino Hospital Medical Staff (the "Medical Staff").

12.2 Membership. Membership in the Medical Staff shall be comprised of all physicians, dentists and podiatrists who are duly licensed, competent in their respective fields, worthy in character and in professional ethics and privileged to attend to patients in the Hospital. The term "physicians" shall include physicians licensed in the State of California, regardless of whether they hold an M.D. or D.O. degree. Membership in the Medical Staff shall be a prerequisite to the exercise of any clinical privileges except as otherwise expressly provided in the Medical Staff Bylaws.

12.3 Medical Staff Bylaws, Rules and Regulations.

(a) Purpose. Medical Staff Bylaws, rules and regulations shall be adopted by the Medical Staff for its internal governance, subject to the Board's approval (the "Medical Staff Bylaws"). The Medical Staff Bylaws shall create an effective administrative unit to discharge the functions and responsibilities assigned to the Medical Staff. The Medical Staff Bylaws, rules and regulations shall also state the purposes, functions and organization of the Medical Staff, and set forth the policies and procedures by which the Medical Staff exercises and accounts for its delegated authority and responsibilities.

(b) Procedure to Adopt or Amend.

(i) Preparation and Adoption. The Medical Staff shall have the initial responsibility to formulate, revise and adopt the Medical Staff Bylaws, rules and regulations.

(ii) Review and Approval. After the above action by the Medical Staff, such Medical Staff Bylaws, rules or regulations, or amendments thereto, shall be forwarded to the Board for its review and approval, which approval shall not be unreasonably withheld.

(iii) Separate Action. If the Medical Staff fails to exercise its responsibility hereunder and in a reasonable, timely and responsible manner, and after written notice from the Board to such effect, including a reasonable period of time for response, the Board may formulate or amend the Medical Staff Bylaws, rules and regulations. Any Medical Staff recommendations and views shall be carefully considered during the Board's deliberations and actions.

12.4 Credentialing and Clinical Privileges.

(a) Delegation to Medical Staff. The Board delegates to the Medical Staff responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership and clinical privileges, including appointment, reappointment and corrective action.

(b) Initial Decision. Initial action with respect to membership on the Medical Staff and clinical privileges shall be taken by the Medical Staff in accordance with the Medical Staff Bylaws, rules and regulations. Thereafter, a recommendation shall be made to the Board.

(c) Review and Approval. The Board shall review and act upon recommendations of the Medical Staff, and shall give careful consideration to the Medical Staff's expertise in peer review matters.

(d) Separate Action. If the Medical Staff fails to exercise its responsibility hereunder in a reasonable, timely and responsible manner, and after written notice from the Board to such effect, including a reasonable period of time for response, the Board may take actions regarding medical staff membership and clinical privileges. In so doing, the Board shall carefully consider any Medical Staff recommendations and views during its deliberations and actions. In situations involving corrective action, the Board shall not initiate such action unless the Medical Staff's failure to do so is contrary to the weight of the evidence under consideration.

(e) Fair Hearing Procedure. The procedural rules to be followed by the Medical Staff and the Board in acting on matters of Medical Staff membership and clinical privileges, including such matters as appointment, reappointment and corrective action, shall be as more particularly specified in the Medical Staff Bylaws. The Medical Staff Bylaws shall provide for a procedure pursuant to which disagreements between the Medical Staff and the Board may be resolved.

(f) Standards of Decision and Review. In taking the actions referred to in this Article XII, the relevant decision-making body shall consider the supporting information and the purposes, needs and capabilities of the hospital, the health and welfare of the community, and such relevant criteria as are set out in the Medical Staff Bylaws, rules and regulations. In taking such action, no aspect of Medical Staff membership or privileging shall be limited or denied on the basis of sex, age, race, creed, color, or national origin, or on the basis of any other criterion unrelated to those set out in the preceding sentence.

(g) Duration. Appointments to the Medical Staff shall be for a maximum term of two (2) years.

(h) Terms and Conditions. The terms and conditions of Medical Staff membership and of the exercise of clinical privileges shall be as specified in the Medical Staff Bylaws, rules and regulations, or as more specifically defined in the notice of an individual appointment or privileges.

12.5 Allied Health Professionals. The categories of allied health professionals eligible to hold specific practice privileges to perform services within the scope of their licensure, certification or other legal authorization, and the corresponding privileges, prerogatives, terms and conditions for each such allied health professional category or practitioner shall be determined by the Board upon recommendations received from the Medical Staff executive committee. The Medical Staff shall have the responsibility and authority to investigate and evaluate each application by an allied health professional for satisfaction of relevant eligibility requirements in accordance with the Medical Staff Bylaws, rules and regulations.

12.6 Contract Physicians. A physician engaged as an independent contractor by the Corporation to provide medical-administrative services must obtain appropriate Medical Staff membership and privileges through the procedure outlined in the Medical Staff Bylaws, rules and regulations. Restriction or termination of such physician's Medical Staff membership or clinical privileges for reasons related to professional competence shall also be accomplished through the procedures contained in the Medical Staff Bylaws, rules and regulations. All other matters, including termination of Medical Staff membership or clinical privileges on grounds not related to professional competence, shall be governed by the terms of such physician's contracts or agreements with the Corporation.

12.7 Accountability. The Medical Staff shall be accountable to the Board for conducting activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided at the Corporation. These activities shall include:

(a) Standard of Care. Ensuring that a comparable standard of care, as determined by the Medical Staff, is provided to all patients with similar needs;

(b) Monitor Quality. Ongoing monitoring and evaluation of patient care to solve problems and identify other opportunities to improve quality.

(c) Clinical Privileges. Delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment.

(d) Continuing Education. Provision of continuing professional education, guided by the needs identified through the review and evaluation activities, as well as other perceived needs and interests.

(e) Resource Allocation. Review of utilization of the Corporation's resources to provide for their allocation to patients in need of them.

(f) Medical Records. Ensuring the preparation and maintenance of adequate and accurate medical records for all patients; and

(g) Other Matters. Such other measures as the Board may, after considering the advice of the Medical Staff and the Corporation's administration, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

ARTICLE XIII
Execution of Corporate Instruments, and Voting of Stocks and Memberships Held by the Corporation

13.1 Execution of Corporate Instruments. The Board may, in its discretion, determine the method and designate the signatory officer or officers or other person or persons, to execute any corporate instrument or document, or to sign the corporate name without limitation, except when otherwise provided by law, and such execution or signature shall be binding upon the Corporation.

Unless otherwise specifically determined by the Board or otherwise required by law, formal contracts of the Corporation, promissory notes, deeds of trust, mortgages and other evidences of indebtedness of the Corporation, and other corporate instruments or documents, and certificates of shares of stock owned by the Corporation, shall be executed, signed, or endorsed by the Chairperson.

All checks and drafts drawn on banks or other depositories on funds to the credit of the Corporation, or in special accounts of the Corporation, shall be signed by such person or persons as the Board shall authorize to do so.

13.2 Ratification by Member. The Board may, in its discretion, submit any contract or act for approval or ratification of the Member at any regular meeting of Member, or at any special meeting of Member called for that purpose.

13.3 Voting of Stocks Owned by Corporation. All stock of other corporations or memberships in other corporations owned or held by the Corporation for itself, or for other parties in any capacity, shall be voted, and all proxies with respect to such stock or memberships shall be executed, by the person authorized to do so by resolution of the Board of Directors, or in the absence of such authorization, by the Chairperson of the Board, or Vice Chairperson or by any other person authorized to do so by the Chairperson or the Vice Chairperson of the Board.

ARTICLE XIV
Annual Report

Except as provided below, the Corporation shall cause to be sent to its Member and Directors no later than 120 days after the close of its fiscal year, a report containing the following information in appropriate detail:

(a) The assets and liabilities, including the trust funds, of the Corporation as of the end of the fiscal year.

(b) The principal changes in assets and liabilities, including trust funds, during the fiscal year.

(c) The revenue or receipts of the Corporation, both unrestricted and restricted to particular purposes, for the fiscal year.

(d) The expenses or disbursements of the Corporation, for both general and restricted purposes, during the fiscal year.

(e) Any information required by Section 6322 of the California Corporations Code.

The report shall be accompanied by any pertinent report of independent accountants, or, if there is no such report, the certificate of an authorized officer of the Corporation that such statements were prepared without audit from the books and records of the Corporation.

This article does not apply to the Corporation when it receives less than twenty-five thousand dollars ($25,000) in gross revenues or receipts during the fiscal year, with the exceptions that a report meeting the above requirements must be furnished annually to all Directors and to the Member who requests it in writing and that the information referred to in paragraph (e) above must be furnished to the Member and Directors within 120 days after the close of the Corporation's fiscal year.

If the Corporation solicits in writing contributions from five hundred (500) or more persons, it need not send the report described above to the Member, with the exception of the information referred to in paragraph (e) above, if it:

(i) Includes with any written material used to solicit contributions a written statement that its latest annual report will be mailed upon request and that such request may be sent to the Corporation at a name and address which is set forth in the statement;

(ii) Promptly mails a copy of its latest annual report to any person who requests a copy; and

(iii) Causes its annual report to be published not later than 120 days after the close of its fiscal year in a newspaper of general circulation in the county in which its principal office is located.

ARTICLE XV
Standard of Care

A Director shall perform the duties of a director, including duties as a member of any Board committee on which the Director may serve, in good faith, in a manner such Director believes to be in the best interest of this Corporation and with such care, including reasonable inquiry, as an ordinarily prudent person in a like situation would use under similar circumstances.

In performing the duties of a Director, a Director shall be entitled to rely on information, opinions, reports, or statements, including financial statements and other financial data, in each case prepared or presented by:

(a) one or more officers or employees of the Corporation whom the Director believes to be reliable and competent as to the matters presented;

(b) counsel, independent accountants, or other persons as to matters which the Director believes to be within such person's professional or expert competence; or

(c) a Board committee upon which the Director does not serve, as to matters within its designated authority, provided that the Director believes such committee merits confidence; so long as in any such case, the Director acts in good faith after reasonable inquiry when the need therefor is indicated by the circumstances and without knowledge that would cause such reliance to be unwarranted.

Except as provided in Article XVI below, a person who performs the duties of a Director in accordance with this Article XV shall have no liability based upon any failure or alleged failure to discharge that person's obligations as a Director, including, without limiting the generality of the foregoing, any actions or omissions which exceed or defeat a public or charitable purpose to which a corporation, or assets held by it, are dedicated.

ARTICLE XVI
Prohibited Transactions

16.1 Loans. Except as permitted by Section 5236 of the California Corporations Code, this Corporation shall not make any loan of money or property to, or guarantee the obligation of, any Director or officer; provided, however, that this Corporation may advance money to a Director or officer of this Corporation or any subsidiary for expenses reasonably anticipated to be incurred in performance of the duties of such officer or Director so long as such individual would be entitled to be reimbursed for such expenses absent that advance.

16.2 Self-Dealing Transactions. Except as provided in Section 16.3 below, the Board of Directors shall not approve or permit the Corporation to engage in any self-dealing transaction. A self-dealing transaction is a transaction to which this Corporation is a party and in which one or more of its Directors has a material financial interest, unless the transaction is described in California Corporations Code Section 5233(b).

16.3 Approval. This Corporation may engage in a self-dealing transaction if the transaction is approved by a court or by the Attorney General. This Corporation also may engage in a self-dealing transaction if the Board determines, before the transaction, that (1) this Corporation is entering into the transaction for its own benefit; (2) the transaction is fair and reasonable to this Corporation at the time; and (3) after reasonable investigation, the Board determines that it could not have obtained a more advantageous arrangement with reasonable effort under the circumstances. Such determinations must be made by the Board in good faith, with knowledge of the material facts concerning the transaction and the interest of the Director or Directors in the transaction, and by a vote of a majority of the Directors then in office, without counting the vote of the interested Director or Directors.

ARTICLE XVII
Miscellaneous

17.1 Records and Reports.

(a) Maintenance and Inspection of Articles and Bylaws. This Corporation shall keep at its principal office the original or a copy of its Articles and these Bylaws as amended from time to time which shall be open to inspection by the Directors and the Member at any reasonable time during business hours.

(b) Maintenance and Inspection of Other Corporate Documents. The accounting books, records, and minutes of proceedings of the Member, the Board and any committee of the Board shall be kept at such place or places designated by the Board or, in the absence of such designation, at the principal office of the Corporation. The minutes shall be kept in written or typed form, and the accounting books and records shall be kept either in written or

typed form or in any other form capable of being converted into written, typed or printed form. The minutes and accounting books and records shall be open to inspection on the written demand of any Member, at any reasonable time during usual business hours for a purpose reasonably related to the Member's interests as a Member. Inspection may be made in person or by an agent or any attorney, and shall include the right to copy and make abstracts.

(c) Inspection by Directors. Each Director shall have the absolute right at any reasonable time to inspect all books, records, and documents of every kind and the physical properties of the Corporation. This inspection by a Director may be made in person or by the agent or attorney. The right of inspection includes the right to copy and make abstracts of documents.

17.2 Corporate Seal. The Board shall provide a suitable seal for the Corporation.

17.3 Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the above, singular numbers include the plural, plural numbers include the singular, and the term "person" includes both corporations and natural persons. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE XVIII
Amendments

18.1 Amendments. The Articles or these Bylaws may be adopted, repealed, amended or restated or new Articles or Bylaws may be adopted upon a majority vote of the authorized number of Directors (excluding vacancies and Directors with a conflict of interest). No such adoption, repeal, amendment, restatement or new Articles or Bylaws shall be effective until approved by the Member. Moreover, the Articles and Bylaws may be adopted, repealed, amended or restated or new Bylaws adopted upon the vote of the Member.

CERTIFICATE OF SECRETARY

I, the undersigned, certify that I am the currently elected and acting Secretary of El Camino Hospital, a California nonprofit public benefit corporation, and the above Amended and Restated Bylaws, consisting of 24 pages, are the Bylaws of this Corporation as adopted pursuant to the required affirmative vote of the Board, December 7, 2005 and the Member, the El Camino Healthcare District, on December 7, 2005 pursuant to the required affirmative vote of the District Board, as amended and restated pursuant to the required affirmative vote of the Board on August 10, 2011 and the Member, the El Camino Healthcare District, on August 10, 2011 pursuant to the required affirmative vote of the District Board and as further amended and restated by the Member, El Camino Healthcare District, on March 20, 2012 pursuant to the required affirmative vote of the District Board and as further amended and restated by the Member, El Camino Healthcare District, on May 12, 2012, May 1, 2013, June 18, 2013, and March 5, 2014 pursuant to the required affirmative vote of the District Board, and as amended and restated pursuant to the required affirmative vote of the Board on May 14, 2014 (Section 6.8) and May 14, 2014 and of the Member, the El Camino Healthcare District, on June 17, 2014, and as amended and restated pursuant to the required affirmative vote of the Board on October 8, 2014 and of the Member, the El Camino Healthcare District, on October 21, 2014, and as amended and restated pursuant to the required affirmative vote of the Board on January 13, 2016 and of the Member, the El Camino Healthcare District, on January 19, 2016.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Secretary on January ____, 2016.

_____

Peter C. Fung, MD
El Camino Hospital Secretary

e. Consent to Action Amending Silicon Valley Medical Development LLC Articles of Organization and Operating Agreement

ECH BOARD MEETING AGENDA ITEM

	Item:	Approval of draft Consent to Action Amending the Silicon Valley Medical Development LLC ("SVMD") Articles of Organization and Operating Agreement El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Mary Rotunno, General Counsel
	Action requested:	Approval of draft Consent to Action
	Background: SVMD was formed as an LLC in 2008 to provide ambulatory and new venture development; conduct information systems implementation related to health information exchange with community providers; and to serve as a focal point for new business development outside of the acute care setting. El Camino Hospital is the sole corporate member of SVMD and the Hospital is currently the sole source of funding. SVMD was governed initially by a Board of Managers and in 2012, the ECH Board approved the transfer of governance to a Member managed LLC with the CEO of the Hospital appointed as the sole Member Representative.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : In furtherance of Hospital's integrated care strategy and portfolio diversification efforts, SVMD will own and operate primary care and urgent care clinics as unlicensed clinics pursuant to Health and Safety Code Section 1206(g). This new activity supports a return of governance of SVMD to a Board of Managers to provide oversight of the new clinics. The activities of SVMD will be reported to the ECH Board periodically by SVMD officers and funding will be subject to ECH Policy 17.01 Signature Authority.	
	Proposed board motion: To approve the draft Consent to Action amending of the SVMD Articles of Organization and SVMD Operating Agreement to establish a Board of Managers for SVMD, appointing the Board of Managers and re-electing officers and authorizing submission of required filings to the Secretary of State and authorizing the CEO of the Hospital to execute the Consent on behalf of El Camino Hospital.	
	LIST OF ATTACHMENTS: 1. Draft Consent to Action 2. Draft Amendment No. 3 to SVMD Operating Agreement	

ECH BOARD MEETING AGENDA ITEM

	3. Restated Articles of Organization

Att 27e.2 - Consent to Amend OA SVMD

SILICON VALLEY MEDICAL DEVELOPMENT, LLC

Action of the Sole Member Taken by Written Consent

The undersigned, being the sole member of Silicon Valley Medical Development, LLC, a California limited liability company (the "Company"), pursuant to the provisions of Section 17104 of the Beverly-Killea Limited Liability Company Act of the State of California does hereby consent to and adopt the following as the action of the sole Member of the Company:

RESOLVED: That the Articles of Organization of the Company be amended as set forth in the Limited Liability Company Restated Articles of Organization in substantially the form attached hereto as Exhibit A (the "Restated Articles of Organization") in order to provide for the Company to be managed by a Managing Board;

RESOLVED: That the officers of the Member be, and each of them hereby is, authorized, empowered and directed to execute the Restated Articles of Organization on behalf of the Member and file the Restated Articles of Organization with the Secretary of State of the State of California; and

RESOLVED: That the Limited Liability Company Operating Agreement of the Company (as amended) (the "Operating Agreement") be amended in substantially the form attached hereto as Exhibit B ("Amendment No. 3 to the Operating Agreement") in order to be consistent with the Restated Articles of Organization and provide that the sole Member shall manage the business of the Company and have the sole power to bind the Company.

IN WITNESS WHEREOF, this Consent has been executed and filed with the records of the Company, and shall be treated for all purposes as votes taken at a meeting.

Dated: _____, 2016

SOLE MEMBER:

El Camino Hospital,
a California nonprofit public benefit corporation

By:_____
Name: Tomi Ryba
Title: Chief Executive Officer

Att 27e.3 - SVMD Amendment #3 FINAL

AMENDMENT NO. 3
TO THE
LIMITED LIABILITY COMPANY OPERATING AGREEMENT
OF
SILICON VALLEY MEDICAL DEVELOPMENT, LLC

This Amendment No. 3 (the "Amendment") is made as of _____, 201__ (the "Effective Date") to the Limited Liability Company Operating Agreement of Silicon Valley Medical Development, LLC dated July 17, 2008, as amended (the "Agreement").

WHEREAS, El Camino Hospital, a California nonprofit public benefit corporation (the "Member"), is the sole member of Silicon Valley Medical Development, LLC (the "Company");

WHEREAS, the Member is authorized to amend or restate the Agreement from time to time; and

WHEREAS, the Member wishes to amend the Agreement to provide for a Board of Managers to manage the business of the Company and to delegate certain authority to the Chief Executive Officer of the Company.

NOW, THEREFORE, the Member hereby amends the Agreement as follows:

1. Management

1.1. Reference is made to Section 6 of the Agreement, which provides for the management of the Company by the Member.

1.2. Section 6 of the Agreement is hereby deleted in its entirety and replaced with the following:

> 6. Management. The business of the Company shall be managed by a Board of Managers, and the persons constituting the Board of Managers, not the Member, shall be the "managers" of the Company for all purposes under the Act.
>
> The Board of Managers shall consist of four (4) voting managers (as determined by the Member), in addition to the Chief Executive Officer who shall be an ex officio voting member of the Board of Managers. The Board of Managers shall initially consist of Iftikhar Hussain, Rich Katzman, Neal Cohen, M.D., the new Integrated Care Medical Officer hired by Member, and Tomi Ryba Chief Executive Officer of the Company. The Member has the right to remove any or all managers at any time, with or without cause. If the Member removes the entire Board of Managers, the Member shall then appoint a replacement Board of Managers. The Chief Executive Officer of the Company shall have the authority to fill any individual vacancies in the Board of Managers and may remove any manager on the Board of Managers.
>
> Decisions of the Board of Managers shall be embodied in a duly adopted vote taken by a majority of the voting members of the Board of Managers at a

meeting for which at least five (5) days' written notice was duly given or waived, or in a resolution adopted by unanimous written consent of the Board of Managers. Such decisions shall be decisions of the "manager" for all purposes of the Act and shall be carried out by any member of the Board of Managers or by officers or agents of the Company designated by the Board of Managers in the vote or resolution in question or in one or more standing votes or resolutions or with the power and authority to do so. A decision of the Board of Managers may be amended, modified, or repealed in the same manner in which it was adopted, but no such amendment, modification or repeal shall affect any person who has been furnished a copy of the original vote or resolution, certified by a duly authorized agent of the Company, until such person has been notified in writing of such amendment, modification, or repeal. Members of the Board of Managers may attend meetings in person or by electronic connection that enables all members present simultaneously to hear one another.

3. Miscellaneous

3.1. *Effectiveness*. This Amendment shall become effective as of the Effective Date.

3.2. *Defined Terms.* Capitalized terms used in this Amendment and not defined herein shall have the meaning defined in the Agreement.

3.3. *Conflict.* In the event of any conflict between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control.

3.4. *Agreement in Force.* Except to the extent specifically amended hereby, the provisions of the Agreement shall remain unmodified and the Agreement is confirmed as being in full force and effect.

IN WITNESS WHEREOF, the undersigned sole member of Silicon Valley Medical Development, LLC, intending to be legally bound hereby, has duly executed this Amendment as of the date and year first above written.

El Camino Hospital,
a California nonprofit public benefit corporation

By: _____
Name: Tomi Ryba
Title: Chief Executive Officer, El Camino Hospital

Att 27e.4 - Restated Articles of Organization - Silicon Valley Medical Development

LLC-10 Restated Articles of Organization of a Limited Liability Company (LLC)

To restate the articles of organization of your California LLC, you can fill out this form, and submit for filing along with:

- A **$30** filing fee.
- A separate, non-refundable **$15** service fee also must be included, if you **drop off** the completed form or document.
- To file this form, the status of your LLC must be active on the records of the California Secretary of State. To check of the status of the LLC, go to kepler.sos.ca.gov.

Upon filing, these restated articles of organization will supersede the initial articles of organization and all amendments previously filed.

Important! To change the LLC addresses, or to change the name or address of the LLC's agent for service of process, you must file a Statement of Information (Form LLC-12). To get Form LLC-12, go to www.sos.ca.gov/business-programs/business-entities/statements.

Note: *Before submitting the completed form*, you should consult with a private attorney for advice about your specific business needs.

This Space For Office Use Only

For questions about this form, go to *www.sos.ca.gov/business-programs/business-entities/filing-tips*

① **LLC's Exact Name** (on file with CA Secretary of State)

Silicon Valley Medical Development, LLC

② **LLC File No.** (issued by CA Secretary of State)

200820010060

New LLC Name (Only complete Item 3 if you are changing the name of your LLC.)

③ _____

Proposed LLC Name

The proposed new name must include: LLC, L.L.C., Limited Liability Company, Limited Liability Co., Ltd. Liability Co. or Ltd. Liability Company; and may not include: bank, trust, trustee, incorporated, inc., corporation, or corp., insurer, or insurance company.

Purpose

④ The purpose of the limited liability company is to engage in any lawful act or activity for which a limited liability company may be organized under the California Revised Uniform Limited Liability Company Act.

Management (Check only one.)

⑤ The LLC will be managed by:

☐ One Manager ☑ More Than One Manager ☐ All Limited Liability Company Member(s)

Amendment to Text of the Articles of Organization (If needed, list both the current text, and the text as amended by this filing.)

⑥

LLC Addresses & Service of Process (If the LLC **has not filed** a Statement of Information (Form LLC-12), in an attachment to these Restated Articles of Organization list the LLC addresses and the agent for service of process information **exactly** as listed in the original articles of organization.)

Read and sign below: Unless a greater number is provided for in the Articles of Organization, this form must be signed by at least one manager, if the LLC is manager-managed or at least one member, if the LLC is member-managed. If the signing manager or member is a trust or another entity, go to www.sos.ca.gov/business-programs/business-entities/filing-tips for more information. If you need more space, attach extra pages that are 1-sided and on standard letter-sized paper (8 1/2" x 11"). All attachments are part of this document.

▶ _____	El Camino Hospital, Sole Member By: Tomi Ryba	its CEO
Sign here	*Print your name here*	*Your business title*

Make check/money order payable to: **Secretary of State**
Upon filing, we will return one (1) uncertified copy of your filed document for free, and will certify the copy upon request and payment of a $5 certification fee.

By Mail
Secretary of State
Business Entities, P.O. Box 944228
Sacramento, CA 94244-2280

Drop-Off
Secretary of State
1500 11th Street., 3rd Floor
Sacramento, CA 95814

Advisory Committee Appointments

ECH BOARD MEETING AGENDA ITEM

	Item:	Board Advisory Committee Assignments El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Neal Cohen, MD, Board Chair
	Action requested:	Approval
	Background: Despite her busy schedule as a member of the El Camino Healthcare District Board, in which capacity she serves on the Community Benefit Advisory Council, the Silicon Valley Tobacco Securitization Joint Powers Authority and as a member of the Board of the Association of California Healthcare Districts, Director Miller has expressed interest in returning to service on one or more of the ECH Board's Advisory Committees. My recommendation, with which Jeffrey Davis MD (Chair of the Committee) concurs is to appoint Director Miller to the Executive Compensation Committee.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : To appoint Director Miller as a member of the Executive Compensation Committee.	
	Proposed board motion: To appoint Director Miller as a member of the Executive Compensation Committee, effective immediately.	
	LIST OF ATTACHMENTS: None.	

Letter of Rebuttable Presumption

BuchalterNemer
A Professional Law Corporation

55 Second Street, Suite 1700, San Francisco, California 94105-3493
Telephone (415) 227-0900 / Fax (415) 227-0770

File Number: E4192-0007
Direct Dial Number: (415) 227-3603
Direct Facsimile Number: (415) 227-3617
E-Mail Address: *molejko@buchalter.com*

January 8, 2016

Neal Cohen, M.D.
Chair
El Camino Hospital
P.O. Box 7025
2500 Grant Road
Mountain View, CA 94040

Re: Reasonableness of Executive Compensation

Dear Neal:

El Camino Hospital engaged SullivanCotter and Associates, Inc. ("SullivanCotter"), an independent healthcare consulting firm, to evaluate executive compensation levels as part of its overall executive compensation process. El Camino Hospital intends to obtain the benefit of the rebuttable presumption of reasonableness pursuant to regulations implementing Section 4958 of the Internal Revenue Code. In order to invoke the presumption, the amount of compensation must be approved in advance by an authorized body; the decision must be based on appropriate data as to comparability; and the decision must be adequately documented.

El Camino Hospital's decisions to compensate executives are approved in advance by its Board of Directors ("Board") acting without the participation of any individual who has a conflict of interest with respect to the matter under consideration. The Board has created an advisory committee that undertakes certain activities with respect to executive compensation as provided in its charter. The advisory committee also acts without the participation of any individual who has a conflict of interest with respect to the matter under consideration. The Board is an authorized body as defined by Section 4958. Further, the Board has relied upon comparability data: specifically, for example, data provided by SullivanCotter analyzing the amount of compensation organizations in El Camino Hospital's peer group pay executives in similar positions.

In its two letters attached (each dated November 17, 2015) (the "Letters"), SullivanCotter concludes that the total compensation El Camino Hospital pays its executives (listed in the Letters) during fiscal year 2016 is "within the range of competitive market data and, therefore, reasonable in relation to prevailing and current market practices" within the health care industry for an organization of El Camino Hospital's size and location. The Letters constitute SullivanCotter's report of its conclusions and a summary of the information considered by the Board prior to the actions of the Board.

Finally, in order to invoke the rebuttable presumption, El Camino Hospital must adequately document the basis for its decision. El Camino Hospital maintains documentation in the form of meeting minutes, which set forth the terms of the arrangements, the date(s) of approval, and the members who were present to vote on and discuss the arrangement. El Camino Hospital also maintains documentation – including the Letters – in the form of comparability data that it obtained and relied upon to reach the compensation levels. El Camino Hospital should keep this letter and the attached Letters as further documentation of the basis of its decision and its intent to obtain (and the steps taken to obtain) the benefits of the rebuttable presumption of reasonableness.

Very truly yours,

BUCHALTER NEMER
A Professional Corporation

By 

Mitchell J. Olejko

MJO:al

Attachments

SullivanCotter
AND ASSOCIATES, INC.

CONFIDENTIAL

November 17, 2015

Dr. Jeffrey Davis
Chair, Executive Compensation Committee
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

REASONABLENESS OF THE CURRENT TOTAL COMPENSATION AND BENEFITS PROVIDED TO EXECUTIVES OF EL CAMINO HOSPITAL

Dear Dr. Davis:

This letter reviews the reasonableness of the current total compensation and benefits – in relation to competitive market practices – provided to the executives of El Camino Hospital (ECH). A separate letter has been provided for ECH's President and Chief Executive Officer.

This letter has been prepared by Sullivan, Cotter and Associates, Inc. (SullivanCotter) to provide third-party, objective advice relative to the overall reasonableness of the executives' current total compensation and benefits, as considered by the ECH Board of Directors (the "Board") in relation to the Board-approved market practices used for comparison purposes.

Overall Findings

As presented in this letter, SullivanCotter finds current total compensation and benefits provided to the executives — as agreed to by the ECH Board of Directors — as competitive and reasonable in relation to the market practices used for comparison purposes. Specifically, when considering all elements of compensation and benefits, SullivanCotter finds the current total compensation provided to the executives as competitive with the total compensation and benefits of like positions in similarly situated organizations that constitute ECH's Board-approved peer group.

Contents of Letter

Our analysis is presented in this letter and is structured as follows:

I. Provides our understanding of ECH's current operations, its executive compensation philosophy, the Board's decision-making process, and the objectives of SullivanCotter's assessment.

II. Includes a description of SullivanCotter and our experiences in conducting similar assessments.

III. Includes a description of the methodology used to assess the executives' current total compensation and benefits program.

IV. Provides the assessment of the reasonableness of current total compensation and benefits provided to the executives.

V. Provides ECH with a list of other considerations relative to executive compensation decisions.

8400 EAST CRESCENT PARKWAY
SUITE 310
GREENWOOD VILLAGE, CO 80111
303 723 4130
SULLIVANCOTTER.COM

I. Background

ECH is a not-for-profit organization with hospital campuses in Mountain View, California and Los Gatos, California. ECH hospitals have served communities in the South San Francisco Bay Area for more than 50 years. ECH strives to provide superlative care by focusing on the needs of patients and the community, rather than shareholders, and by incorporating the latest, proven medical technology and attracting the best medical staff and affiliated physicians. ECH's mission is to be an innovative, publicly-accountable and locally-controlled comprehensive health care organization that cares for the sick, relieves suffering, and provides quality, cost-competitive services to improve the health and well-being of its community. ECH is part of a public hospital district with operating revenue of approximately $776 million for FY2015.

ECH has identified its market for executive talent as national, not-for-profit, independent hospitals/health systems of comparable net revenue size and complexity to ECH, with data increased by a 20% differential to reflect the higher prevailing wage rates in Silicon Valley. We understand that ECH has identified this peer group according to its attraction and retention experiences with executive positions.

ECH strongly believes that all of its employees should be paid fairly and competitively within the marketplace. ECH's executive compensation philosophy is summarized in **Exhibit I** and is intended to provide salaries that are consistent, on average, with the median of the identified market, median incentive opportunities, and median benefits.

ECH's Executive Compensation Committee is responsible for reviewing and recommending to the Board for approval changes to the executive total compensation and benefits program, consistent with ECH's defined executive compensation philosophy. Over the years, the Committee has consistently relied on consulting firms (such as SullivanCotter) to provide independent advice on the competitiveness and reasonableness of the executive compensation and benefits program. Consistent with ECH's historical corporate governance practices, the Committee has requested SullivanCotter's assistance in determining a competitive and reasonable total compensation and benefit program for ECH's executives.

II. About SullivanCotter

SullivanCotter is a human resources consulting firm that specializes in the provision of compensation consulting services to not-for-profit health care organizations, with a primary focus on executives and physicians. Our clients include large health systems, medical schools, academic medical centers, community hospitals and physician groups. Annually, we publish a large national survey regarding health care executive compensation practices.

SullivanCotter has significant experience in conducting competitive market analyses for executive positions similar to that requested by ECH. As such, SullivanCotter understands that a competitive and reasonable compensation package for an executive requires careful review of its overall value, not just its individual components.

This analysis is submitted in accordance with the provisions of Treasury Regulations Section 53.4958-6(c)(2), and is intended to satisfy the professional advice requirement of Treasury Regulations Section 53.4958-1(d)(4)(iii). Accordingly, we certify that SullivanCotter holds itself out to the public as a compensation consulting firm that performs executive compensation valuations on a regular basis for not-for-profit health care organizations that are similar to ECH. Therefore, SullivanCotter is qualified to assess the competitiveness and reasonableness of the total compensation and benefits provided to senior executive officers in similar roles as held by the executives.

SullivanCotter is not a law firm, and therefore cannot provide legal advice. Our assessment is focused on and limited to the prevalence and levels of compensation and benefits provided to the executives in relation to appropriate current data as to comparability, and based on prevailing not-for-profit health care market practices of similarly situated organizations for positions functionally comparable to ECH's positions.

The information provided by ECH serves as the basis for the assessment of competitiveness and reasonableness of the total compensation and benefits provided to the executives, to ensure that it is compared to what is "ordinarily paid for like services by like enterprises under like circumstances," as defined in the Intermediate Sanctions regulations. In addition, our analysis assumes that the described compensation package for the executives includes all economic benefits provided by ECH and its affiliates in exchange for the performance of services, and has not been independently validated.

III. Methodology Used to Assess Compensation and Benefits

SullivanCotter used the following methodology to assess ECH's total compensation and benefits program:

- Collected background information regarding the scope and responsibilities for each position, and current total cash compensation, benefits and employment agreement provisions:
  - **Exhibit II** summarizes the benchmarks used in the analysis.
- Referenced survey sources that were current at the time of the analysis, based on ECH's peer group for executive positions and according to ECH's executive compensation philosophy. The surveys we used were:
  - SullivanCotter: *2014 Survey of Manager and Executive Compensation in Hospitals and Health Systems.*
  - Mercer: *2014 Integrated Health Networks Compensation Survey.*
  - Integrated Healthcare Strategies: *2014 Healthcare Executive Compensation Survey.*
- Validated the 20% geographic salary differential, as described in **Exhibit I**:
  - Details of the analysis were provided in the 2014 Executive Total Compensation Review provided in May of 2014.
- Compared ECH's fiscal year 2016 (FY2016) compensation for each executive (i.e., base salary, total cash compensation and total compensation) to the market data.
- Compared standard and supplemental benefits, including retirement benefits, health benefits, disability benefits, life insurance, paid-time-off benefits, supplemental benefits, perquisites and severance practices to the market.

IV. The Competitiveness and Reasonableness of Total Compensation and Benefits

Executives received the following elements of compensation and benefits for FY2015:

- **Base salaries**.
  - FY2016 base salary adjustments varied by executive ranging from 2.5% to 4.5%, with an average of 3.4% for those receiving increases[1,2]
- **Annual incentive compensation opportunities**, which are only paid for achieving defined levels of annual performance, as approved by the Board:
  - Target award level, defined as 20% of base salary.
  - Maximum award level, defined as 30% of base salary.
  - FY2015 incentive payments ranged from approximately 17.0% to 22.4% of FY2015 base salary, with an average of 20.7% of FY2015 base salary[2] (i.e., award levels slightly above target, on average).

[1] The Vice President ECH-Los Gatos (Wolfram) did not receive a salary increase for FY2016.
[2] Excludes the newly-promoted General Counsel (Rotunno).

- **Standard benefits**, similar to those available to all eligible ECH employees:
  - Includes medical, dental, vision, grandfathered retiree medical, long-term disability, paid time off and sick leave, qualified retirement plans, and employee-paid supplemental group term life insurance and spouse/dependent life insurance.

- **Executive benefits**, provided to selected executives:

Benefit	ECH Benefit
Executive Life Insurance	• Group term life insurance of 3x salary up to $1.25 million, with amounts above $350,000 subject to medical underwriting (provided in lieu of regular group term life program).
Short-Term Disability	• 100% salary continuation for up to six months on short-term disability, after paid time off and extended sick leave exhausted, and integrated with other benefits.
Supplemental Retirement	• 5% of base salary (10% of base salary for E. Pifer), with each contribution vesting after 5 years from when the contribution is made (or age 65 if earlier). • Executives can also make voluntary deferrals to a 457(b) plan.
Taxable Allowance	• 7% of base salary, which can be used for additional long-term disability or life insurance; long-term care, 457(b) retirement plan deferrals or cash, depending on the executive's preferences.
Long-Term Care	• Grandfathered for participants prior to 2008.

- Severance benefits:
  - Paid upon involuntary termination by ECH without cause or voluntary termination by employee due to a material reduction in duties or salary within six months of a change in control.
  - Continuation of base salary and medical benefits for six months following termination date.
  - Severance reduced by other earned income immediately on reemployment.

Competitiveness of Total Compensation

Current ECH total compensation (which includes FY2016 base salaries; annual incentive awards for FY2015 performance; 2015 costs for standard benefits and executive benefits updated based on FY2016 base salaries) is at the following market positioning levels:

$ in thousands

Title (Incumbent)	FY16 Actual Total Compensation	Total Compensation Data Effective January 1, 2016				Relative Market Position [1]		Mkt %ile [2]
		P25	P50	P75	P90	% of P50	% of P75	
Chief Operating Officer (Zdeblick)	$760.8	$606.2	$731.1	$893.4	$1,061.4	104%	85%	**55**
Chief Medical Officer (Pifer, M.D.)	$723.6	$558.7	$655.4	$763.2	$907.8	110%	95%	**66**
Chief Financial Officer (Hussain)	$616.5	$570.8	$665.7	$786.7	$935.4	93%	78%	**37**
Chief Information Officer (Walton)	$519.3	$421.6	$492.7	$579.4	$671.4	105%	90%	**58**
Chief Strategy Officer (Katzman)	$506.4	$394.2	$508.6	$620.6	$718.8	100%	82%	**50**
General Counsel (Rotunno)	$474.2	$434.8	$518.3	$644.9	$736.2	91%	74%	**37**
Chief Human Resources Officer (Fisk)	$472.2	$382.1	$436.5	$515.4	$618.9	108%	92%	**61**
Chief Administrative Services Officer (King)	$439.9	$320.5	$385.4	$461.9	$532.0	114%	95%	**68**
Chief Nursing Officer (Reinking)	$451.0	$358.4	$433.7	$550.8	$615.5	104%	82%	**54**
Vice President, Payor Relations (Kezic)	$400.1	$248.0	$309.0	$393.4	$451.7	129%	102%	**77**
VP, Corp./ Comm. Health Svcs & Pres., Concern:EAP (Currier)	$390.0	$270.9	$335.4	$393.3	$445.3	116%	99%	**74**
President ECH Foundation (Barnard)	$374.0	$274.1	$337.1	$415.9	$506.4	111%	90%	**62**
Vice President ECH-Los Gatos (Wolfram)	$345.2	*Non-Benchmark Position*				---	---	---
					Aggregate (Weighted Average):	**105%**	**87%**	**57**

(1) Ratio of actual total compensation to the 50th and 75th percentiles of the market data for comparable positions adjusted to reflect the higher prevailing wage rates in Silicon Valley.
(2) Approximate market positioning assumes market compensation levels are uniformly distributed between the 25th, 50th, 75th and 90th percentiles.

***Note:** Market data were aged to January 1, 2016 at an annualized rate of 3%. This is consistent with average health care executive salary increase budgets.*

Overall, actual total compensation is 5% above the 50th percentile and 13% below the 75th percentile, and at or below the estimated 77th percentile for each executive.

Base salary and target/maximum total cash and total compensation comparisons are provided in **Exhibits III, IV and V** respectively. Tally sheets showing all of the cash compensation, benefits and perquisites costs are provided in **Exhibit VI**.

Overall, the benefits provided to the executives are at the market median. Severance is conservative with respect to market practices (12 months is most common among tax-exempt health care providers).

Based on our assessment, when considering all elements of the executives' current compensation and benefits as summarized in this letter, we believe that current total compensation is within the range of competitive market data and, therefore, reasonable in relation to prevailing and current market practices.

V. Other Considerations

Please note that our conclusions are based on the data provided to us at the time this opinion letter was prepared, which SullivanCotter has not independently verified. Any compensation and/or benefits not included in this letter are not covered by our opinion.

Our opinion is in respect to the competitiveness and reasonableness of the compensation as determined in accordance with, and for purposes of, the rules governing Intermediate Sanctions under Section 4958 of the Internal Revenue Code. Therefore, we express no opinion on:

- The tax-exempt status of ECH.
- Any issues related to prohibited inurement.
- Whether the executives are "disqualified persons" within the meaning of the Intermediate Sanctions regulations.
- Whether the terms of the employer's arrangement with the executives were or will be approved in advance by an authorized body of individuals without a conflict of interest, as described in Treasury Regulations Section 53.4958-6(a)(1).
- Whether the terms of the compensation arrangement have been adequately disclosed or documented on Form 990, other tax forms, Board reports and/or financial reports.

* * * * *

We hope this letter meets the needs of ECH's Board in documenting the reasonableness of the executives' total compensation and benefits program.

Sincerely,

Andrew Lewis
Principal

Attachments

Component	ECH's Desired/Targeted Market Position
Market Definition/ Peer Groups	• Primarily national, not-for-profit, independent hospitals/health systems of comparable net revenue size and complexity to ECH. Data increased by a 20% differential to reflect the higher prevailing wage rates in Silicon Valley.
Base Salary	• Salary range midpoints are based on the 50th percentile. • The salary range will be from 20% below to 20% above the salary range midpoint. • Placement in the range is based a combination of paying competitively, rewarding performance, and recognizing competence, credentials, and experience.
Incentives	• Target incentive opportunities set at competitive levels (i.e., median). • Actual total cash compensation will reflect an executive's current salary, individual performance and contributions, and organizational performance.
Benefits	• Executive benefits and severance targeted at competitive levels (i.e., median). • Perquisites should only be provided when supported by specific business reasons. ECH's practice is to minimize the use of perquisites.

Incumbent	Position Title	Survey Job Title	Adjustments	Scope
Michael Zdeblick	Chief Operating Officer	Chief Operating Officer	None	Health Systems: $776M
Eric Pifer, M.D.	Chief Medical Officer	Chief Medical Officer	None	Health Systems: $776M
Iftikhar Hussain	Chief Financial Officer	Chief Financial Officer	None	Health Systems: $776M
Greg Walton	Chief Information Officer	Chief Information Officer	None	Health Systems: $776M
Richard Katzman	Chief Strategy Officer	Chief Strategy Officer	Offsetting adjustments; +10% for service line responsibility and -10% as incumbent does not have Marketing, Public Relations, or Communications.	Health Systems: $776M
Mary Rotunno	General Counsel	Top Legal Services Executive (General Counsel)	None	Health Systems: $776M
Kathryn Fisk	Chief Human Resources Officer	Top Human Resources Executive	None	Health Systems: $776M
Ken King	Chief Administrative Services Officer	Top Support Services Executive	10% premium for imaging	Health Systems: $776M
Cheryl Reinking	Chief Nursing Officer	Top Patient Care Executive	None	Health Systems: $776M
Joan Kezic	Vice President, Payor Relations	Top Managed Care Executive	10% premium for managed care litigation; Market data adjusted to reflect the incumbent's .9 FTE status	Health Systems: $776M
Cecile Currier	VP, Corp./ Comm. Health Svcs & Pres., Concern:EAP	Top Service Line Executive – Other	None	Health Systems: $776M
Jodi Barnard	President ECH Foundation	Top Foundation/Fund Development Executive	None	Health Systems: $776M
Pat Wolfram	Vice President ECH-Los Gatos	***Non-Benchmark Position***	None	---

$ in thousands

Title (Incumbent)	FY2016 Base Salary	Base Salary Data Effective January 1, 2016				Relative Market Position % of P50 (1)	Mkt %ile (2)
		P25	P50	P75	P90		
Chief Operating Officer (Zdeblick)	$521.0	$455.5	$535.4	$635.6	$738.3	97%	45
Chief Medical Officer (Pifer, M.D.)	$483.2	$426.4	$488.0	$555.5	$649.2	99%	48
Chief Financial Officer (Hussain)	$438.9	$425.7	$492.1	$556.8	$632.3	89%	30
Chief Information Officer (Walton)	$354.6	$318.1	$359.4	$410.5	$462.7	99%	47
Chief Strategy Officer (Katzman)	$333.8	$300.3	$363.3	$458.0	$517.7	92%	38
General Counsel (Rotunno)	$325.0	$331.2	$382.4	$449.6	$508.9	85%	<25
Chief Human Resources Officer (Fisk)	$313.8	$290.3	$325.8	$371.9	$444.5	96%	42
Chief Administrative Services Officer (King)	$284.2	$246.4	$286.2	$334.2	$382.0	99%	49
Chief Nursing Officer (Reinking)	$286.3	$262.1	$321.5	$383.4	$432.2	89%	35
Vice President, Payor Relations (Kezic)	$254.6	$190.4	$235.9	$301.2	$337.4	108%	57
VP, Corp./ Comm. Health Svcs & Pres., Concern:EAP (Currier)	$248.0	$210.1	$262.3	$289.5	$360.0	95%	43
President ECH Foundation (Barnard)	$234.5	$207.5	$249.0	$313.7	$366.8	94%	41
Vice President ECH-Los Gatos (Wolfram)	$234.6	***Non-Benchmark Position***				---	---
Aggregate (Weighted Average):						**95%**	**41**

(1) Ratio *of current base salary to the 50th percentile market data for comparable positions adjusted to reflect the higher prevailing wage rates in Silicon Valley.*

(2) *Approximate market positioning assumes market compensation levels are uniformly distributed between the 25th, 50th, 75th and 90th percentiles.*

Note: *Market data were aged to January 1, 2016 at an annualized rate of 3%. This is consistent with average health care executive salary increase budgets.*

$ in thousands

Title (Incumbent)	FY2016 Total Cash Compensation		Total Cash Compensation Data Effective January 1, 2016				Target			Maximum		
							Relative Market Position[2]		Mkt %ile [3]	Relative Market Position[2]		Mkt %ile [3]
	Target[1]	Max[1]	P25	P50	P75	P90	% of P50	% of P75		% of P50	% of P75	
Chief Operating Officer (Zdeblick)	$625.2	$677.3	$487.5	$595.8	$749.2	$898.7	105%	83%	55	114%	90%	63
Chief Medical Officer (Pifer, M.D.)	$579.8	$628.1	$458.4	$542.9	$635.2	$759.4	107%	91%	60	116%	99%	73
Chief Financial Officer (Hussain)	$526.7	$570.6	$465.5	$551.4	$658.6	$785.8	96%	80%	43	103%	87%	54
Chief Information Officer (Walton)	$425.5	$461.0	$339.0	$404.9	$481.0	$556.1	105%	88%	57	114%	96%	68
Chief Strategy Officer (Katzman)	$400.5	$433.9	$323.0	$423.2	$505.4	$594.2	95%	79%	44	103%	86%	53
General Counsel (Rotunno)	$390.0	$422.5	$351.2	$426.2	$539.5	$618.0	91%	72%	38	99%	78%	49
Chief Human Resources Officer (Fisk)	$376.6	$408.0	$307.2	$354.0	$422.9	$511.7	106%	89%	58	115%	96%	70
Chief Administrative Services Officer (King)	$341.0	$369.4	$253.9	$310.0	$374.0	$424.7	110%	91%	62	119%	99%	73
Chief Nursing Officer (Reinking)	$343.6	$372.2	$288.0	$352.3	$442.8	$500.3	98%	78%	47	106%	84%	55
Vice President, Payor Relations (Kezic)	$305.6	$331.0	$196.5	$250.2	$324.0	$378.2	122%	94%	69	132%	102%	77
VP, Corp./ Comm. Health Svcs & Pres., Concern:EAP (Currier)	$297.7	$322.5	$210.1	$265.2	$318.2	$389.4	112%	94%	65	122%	101%	76
President ECH Foundation (Barnard)	$281.4	$304.8	$220.2	$276.0	$343.3	$415.0	102%	82%	52	110%	89%	61
Vice President ECH-Los Gatos (Wolfram)	$281.5	$304.9	*Non-Benchmark Position*				---	---	---	---	---	---
Aggregate (Weighted Average):							**103%**	**84%**	**53**	**112%**	**91%**	**63**

(1) Includes FY2016 base salary plus Target and Maximum incentive of 20% / 30% for all executives.
(2) Relative market position shows the ratio of each executive's total cash compensation to the 50th and 75th percentile market data for comparable positions adjusted to reflect the higher prevailing wage rates in Silicon Valley.
(3) Approximate market positioning assumes market compensation levels are uniformly distributed between the 25th, 50th, 75th and 90th percentiles.

***Note:** Market data were aged to January 1, 2016 at an annualized rate of 3%. This is consistent with average health care executive salary increase budgets.*

$ in thousands

Title (Incumbent)	FY2016 Total Compensation		Total Compensation Data Effective January 1, 2016				Target			Maximum		
							Relative Market Position[2]		Mkt %ile [3]	Relative Market Position[2]		Mkt %ile [3]
	Target [1]	Max [1]	P25	P50	P75	P90	% of P50	% of P75		% of P50	% of P75	
Chief Operating Officer (Zdeblick)	$756.7	$808.8	$606.2	$731.1	$893.4	$1,061.4	103%	85%	54	111%	91%	62
Chief Medical Officer (Pifer, M.D.)	$718.5	$766.8	$558.7	$655.4	$763.2	$907.8	110%	94%	65	117%	100%	75
Chief Financial Officer (Hussain)	$621.0	$664.9	$570.8	$665.7	$786.7	$935.4	93%	79%	38	100%	85%	50
Chief Information Officer (Walton)	$515.8	$551.2	$421.6	$492.7	$579.4	$671.4	105%	89%	57	112%	95%	67
Chief Strategy Officer (Katzman)	$506.2	$539.6	$394.2	$508.6	$620.6	$718.8	100%	82%	49	106%	87%	57
General Counsel (Rotunno)	$494.2	$526.7	$434.8	$518.3	$644.9	$736.2	95%	77%	43	102%	82%	52
Chief Human Resources Officer (Fisk)	$467.8	$499.2	$382.1	$436.5	$515.4	$618.9	107%	91%	60	114%	97%	70
Chief Administrative Services Officer (King)	$440.8	$469.2	$320.5	$385.4	$461.9	$532.0	114%	95%	68	122%	102%	77
Chief Nursing Officer (Reinking)	$448.4	$477.0	$358.4	$433.7	$550.8	$615.5	103%	81%	53	110%	87%	59
Vice President, Payor Relations (Kezic)	$405.0	$430.5	$248.0	$309.0	$393.4	$451.7	131%	103%	78	139%	109%	85
VP, Corp./ Comm. Health Svcs & Pres., Concern:EAP (Currier)	$389.4	$414.2	$270.9	$335.4	$393.3	$445.3	116%	99%	73	123%	105%	81
President ECH Foundation (Barnard)	$370.7	$394.2	$274.1	$337.1	$415.9	$506.4	110%	89%	61	117%	95%	68
Vice President ECH-Los Gatos (Wolfram)	$352.2	$375.6	***Non-Benchmark Position***				---	---	---	---	---	---
Aggregate (Weighted Average):							**106%**	**87%**	**57**	**113%**	**93%**	**65**

(1) Total compensation includes FY2016 base salary plus Target and Maximum incentive of 20% / 30% for all executives plus benefits costs (based on FY2016 salary).

(2) Relative market position shows the ratio of each executive's total cash compensation to the 50th and 75th percentile market data for comparable positions adjusted to reflect the higher prevailing wage rates in Silicon Valley.

(3) Approximate market positioning assumes market compensation levels are uniformly distributed between the 25th, 50th, 75th and 90th percentiles.

***Note:** Market data were aged to January 1, 2016 at an annualized rate of 3%. This is consistent with average health care executive salary increase budgets.*

Name:	Zdeblick	Pifer, M.D.	Hussain	Walton	Katzman	Rotunno	Fisk
Title:	Chief Operating Officer	Chief Medical Officer	Chief Financial Officer	Chief Information Officer	Chief Strategy Officer	General Counsel	Chief Human Resources Officer
a. Cash Compensation							
♦ FY2016 Base Salary	$521,012	$483,160	$438,900	$354,618	$333,773	$325,000	$313,814
♦ Annual Incentive Award (for FY2015 Performance)	$108,368	$101,703	$83,285	$74,471	$66,934	$44,990	$67,135
Total	**$629,380**	**$584,863**	**$522,185**	**$429,089**	**$400,707**	**$369,990**	**$380,949**
b. Benefits Provided to All Employees							
♦ Social Security & Medicare	$16,473	$15,828	$14,919	$13,569	$13,157	$12,712	$12,871
♦ Medical, Prescription Drug	27,112	15,652	1,300	9,048	27,112	27,112	15,653
♦ Dental	472	321	0	191	472	472	0
♦ Vision Care	246	146	246	246	246	246	90
♦ Long-Term Disability	540	540	540	540	540	540	540
♦ Qualified Cash Balance plan	13,250	13,250	13,250	13,250	13,250	13,250	13,250
♦ Qualified 403(b) Matching Contributions	10,600	10,600	10,600	10,600	10,600	10,600	10,600
♦ Retiree Medical (a)	0	0	0	0	0	0	0
Total	**$68,692**	**$56,336**	**$40,855**	**$47,444**	**$65,377**	**$64,932**	**$53,003**
c. Executive Benefits							
♦ Executive Life and AD&D	$233	$233	$832	$233	$233	$233	$596
♦ Long-Term Care (non-elective)	0	0	0	0	0	0	0
♦ 457(f) SERP	26,051	48,316	21,945	17,731	16,689	16,250	15,691
♦ Taxable Allowance (7% of salary)	36,471	33,821	30,723	24,823	23,364	22,750	21,967
Total	**$62,754**	**$82,370**	**$53,500**	**$42,787**	**$40,286**	**$39,233**	**$38,254**
Total Benefit/Perquisite Cost	$131,447	$138,706	$94,355	$90,231	$105,663	$104,165	$91,257
Total Compensation Cost	$760,827	$723,569	$616,540	$519,320	$506,370	$474,155	$472,206
d. Other information							
♦ SERP contribution %	5%	10%	5%	5%	5%	5%	5%
♦ Possible severance payments (in months)	6 months	6 months	6 months	6 months	6 months	6 months	6 months

(a) Ken King, Cheryl Reinking, and Cecile Currier are the only ECH executives eligible for Retiree Medical. No cost available.

Note: Non-cash benefits reflect most recently reported amounts or have been estimated based on FY2016 cash compensation levels.

Name:	King	Reinking	Kezic	Currier	Wolfram	Barnard
Title:	Chief Administrative Services Officer	Chief Nursing Officer	Vice President, Payor Relations	VP, Corp./ Comm. Health Svcs & Pres., Concern:EAP	Vice President ECH-Los Gatos	President ECH Foundation
a. Cash Compensation						
♦ FY2016 Base Salary	$284,180	$286,322	$254,642	$248,047	$234,575	$234,498
♦ Annual Incentive Award (for FY2015 Performance)	$55,896	$59,856	$45,958	$50,233	$39,923	$50,167
Total	**$340,076**	**$346,178**	**$300,600**	**$298,280**	**$274,498**	**$284,665**
b. Benefits Provided to All Employees						
♦ Social Security & Medicare	$12,278	$12,367	$11,706	$11,672	$11,327	$11,475
♦ Medical, Prescription Drug	21,793	27,112	27,112	21,793	9,048	27,112
♦ Dental	321	472	472	321	191	472
♦ Vision Care	142	246	246	142	90	246
♦ Long-Term Disability	540	540	540	540	540	540
♦ Qualified Cash Balance plan	13,250	13,250	12,732	12,402	11,729	11,725
♦ Qualified 403(b) Matching Contributions	15,900	15,900	12,732	14,883	9,383	9,380
♦ Retiree Medical (a)	0*	0*	0	0*	0	0
Total	**$64,224**	**$69,886**	**$65,540**	**$61,753**	**$42,308**	**$60,949**
c. Executive Benefits						
♦ Executive Life and AD&D	$551	$550	$8	$233	$233	$233
♦ Long-Term Care (non-elective)	921	0	3,365	0	0	0
♦ 457(f) SERP	14,209	14,316	12,732	12,402	11,729	11,725
♦ Taxable Allowance (7% of salary)	19,893	20,043	17,825	17,363	16,420	16,415
Total	**$35,573**	**$34,908**	**$33,930**	**$29,998**	**$28,382**	**$28,373**
Total Benefit/Perquisite Cost	$99,798	$104,795	$99,470	$91,752	$70,690	$89,322
Total Compensation Cost	$439,874	$450,973	$400,070	$390,032	$345,188	$373,987
d. Other information						
♦ SERP contribution %	5%	5%	5%	5%	5%	5%
♦ Possible severance payments (in months)	6 months	6 months	6 months	6 months	6 months	6 months

(a) Ken King, Cheryl Reinking, and Cecile Currier are the only ECH executives eligible for Retiree Medical. No cost available.

Note: Non-cash benefits reflect most recently reported amounts or have been estimated based on FY2016 cash compensation levels.

SullivanCotter
AND ASSOCIATES, INC.

CONFIDENTIAL

November 17, 2015

Dr. Jeffrey Davis
Chair, Executive Compensation Committee
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

REASONABLENESS OF THE CURRENT TOTAL COMPENSATION AND BENEFITS PROVIDED TO MS. TOMI RYBA, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF EL CAMINO HOSPITAL

Dear Dr. Davis:

This letter reviews the reasonableness of the current total compensation and benefits – in relation to competitive market practices – provided to Ms. Tomi Ryba, President and Chief Executive Officer (CEO) of El Camino Hospital (ECH).

This letter has been prepared by Sullivan, Cotter and Associates, Inc. (SullivanCotter) to provide third-party, objective advice relative to the overall reasonableness of Ms. Ryba's current total compensation and benefits, as considered by the ECH Board of Directors (the "Board") in relation to the Board-approved market practices used for comparison purposes.

Overall Findings

As presented in this letter, SullivanCotter finds Ms. Ryba's current total compensation and benefits arrangement — as agreed to by the ECH Board of Directors — as reasonable in relation to the market practices used for comparison purposes. Specifically, when considering all elements of Ms. Ryba's compensation and benefits, SullivanCotter finds the current total compensation provided to Ms. Ryba as competitive with the total compensation and benefits of like positions in similarly situated organizations that constitute ECH's Board-approved peer group.

Contents of Letter

Our analysis is presented in this letter and is structured as follows:

I. Provides our understanding of ECH's current operations, its executive compensation philosophy, the Board's decision-making process, and the objectives of SullivanCotter's assessment.

II. Includes a description of SullivanCotter and our experiences in conducting similar assessments.

III. Includes a description of the methodology used to assess Ms. Ryba's current total compensation and benefits program.

IV. Provides the assessment of the reasonableness of current total compensation and benefits provided to Ms. Ryba.

V. Provides ECH with a list of other considerations relative to executive compensation decisions.

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I. Background

ECH is a not-for-profit organization with hospital campuses in Mountain View, California and Los Gatos, California. ECH hospitals have served communities in the South San Francisco Bay Area for more than 50 years. ECH strives to provide superlative care by focusing on the needs of patients and the community, rather than shareholders, and by incorporating the latest, proven medical technology and attracting the best medical staff and affiliated physicians. ECH's mission is to be an innovative, publicly-accountable and locally-controlled comprehensive health care organization that cares for the sick, relieves suffering, and provides quality, cost-competitive services to improve the health and well-being of its community. ECH is part of a public hospital district with operating revenue of approximately $776 million for FY2015.

ECH has identified its market for executive talent as national, not-for-profit, independent hospitals/health systems of comparable net revenue size and complexity to ECH, with data increased by a 20% differential to reflect the higher prevailing wage rates in Silicon Valley. We understand that ECH has identified this peer group according to its attraction and retention experiences with executive positions.

ECH strongly believes that all of its employees should be paid fairly and competitively within the marketplace. ECH's executive compensation philosophy is summarized in **Exhibit I** and is intended to provide salaries that are consistent, on average, with the median of the identified market, median incentive opportunities, and median benefits.

ECH's Executive Compensation Committee is responsible for reviewing and recommending to the Board for approval changes to the executive total compensation and benefits program, consistent with ECH's defined executive compensation philosophy. Over the years, the Committee has consistently relied on consulting firms (such as SullivanCotter) to provide independent advice on the competitiveness and reasonableness of the executive compensation and benefits program. Consistent with ECH's historical corporate governance practices, the Committee has requested SullivanCotter's assistance in determining a competitive and reasonable total compensation and benefit program for Ms. Ryba.

II. About SullivanCotter

SullivanCotter is a human resources consulting firm that specializes in the provision of compensation consulting services to not-for-profit health care organizations, with a primary focus on executives and physicians. Our clients include large health systems, medical schools, academic medical centers, community hospitals and physician groups. Annually, we publish a large national survey regarding health care executive compensation practices.

SullivanCotter has significant experience in conducting competitive market analyses for executive positions similar to that requested by ECH. As such, SullivanCotter understands that a competitive and reasonable compensation package for an executive requires careful review of its overall value, not just its individual components.

This analysis is submitted in accordance with the provisions of Treasury Regulations Section 53.4958-6(c)(2), and is intended to satisfy the professional advice requirement of Treasury Regulations Section 53.4958-1(d)(4)(iii). Accordingly, we certify that SullivanCotter holds itself out to the public as a compensation consulting firm that performs executive compensation valuations on a regular basis for not-for-profit health care organizations that are similar to ECH. Therefore, SullivanCotter is qualified to assess the competitiveness and reasonableness of the total compensation and benefits provided to senior executive officers in similar roles as Ms. Ryba.

SullivanCotter is not a law firm, and therefore cannot provide legal advice. Our assessment is focused on and limited to the prevalence and levels of compensation and benefits provided to Ms. Ryba in relation to appropriate current data as to comparability, and based on prevailing not-for-profit health care market practices of similarly situated organizations for positions functionally comparable to Ms. Ryba's position with ECH, including:

- Cash compensation (i.e., base salary and incentive awards).
- Retirement benefits (i.e., qualified and nonqualified).
- Standard employee benefits (i.e., health, dental and vision benefits, disability benefits, group life and AD&D insurance benefits, paid-time-off benefits).
- Supplemental executive benefits and perquisites (including special benefits and perquisites provided to executives, typically above those benefit levels provided to all other employees).
- Employment agreement provisions (including severance provisions).

The information provided by ECH serves as the basis for the assessment of competitiveness and reasonableness of the total compensation and benefits provided to Ms. Ryba, to ensure that it is compared to what is "ordinarily paid for like services by like enterprises under like circumstances," as defined in the Intermediate Sanctions regulations. In addition, our analysis assumes that the described compensation package for Ms. Ryba includes all economic benefits provided by ECH and its affiliates in exchange for the performance of services, and has not been independently validated.

III. Methodology Used to Assess Ms. Ryba's Compensation and Benefits Program

SullivanCotter used the following methodology to assess Ms. Ryba's total compensation and benefits program:

- Collected background information regarding the scope and responsibilities for each position, and current total cash compensation, benefits and employment agreement provisions.
- Referenced survey sources that were current at the time of the analysis, based on ECH's peer group for executive positions and according to ECH's executive compensation philosophy. The surveys we used were:
  - SullivanCotter: *2014 Survey of Manager and Executive Compensation in Hospitals and Health Systems.*
  - Mercer: *2014 Integrated Health Networks Compensation Survey.*
  - Integrated Healthcare Strategies: *2014 Healthcare Executive Compensation Survey.*
- Validated the 20% geographic salary differential, as described in **Exhibit I**:
  - Details of the analysis were provided in the 2014 Executive Total Compensation Review provided in May of 2014.
- Compared Ms. Ryba's current compensation (i.e., base salary, total cash compensation and total compensation) to the market data:
  - FY2016 base salary.
  - Incentive award for FY2015 performance.
  - Value of benefits (generally 2015 benefit costs, with pay-related costs updated based on the CEO's FY2016 base salary).
- Compared Ms. Ryba's standard and supplemental benefits, including retirement benefits, health benefits, disability benefits, life insurance, paid-time-off benefits, supplemental benefits, perquisites and severance practices to the market.

IV. The Competitiveness and Reasonableness of Ms. Ryba's Total Compensation and Benefits Program

Ms. Ryba received the following elements of compensation and benefits for FY2015:

- FY2015 **base salary** of $800,300.
  - The Board approved an increase for FY2016 of 3.0% to $824,300.
- **Annual incentive compensation opportunities**, which are only paid for achieving defined levels of annual performance, as approved by the Board:
  - Target award level, defined as 30% of base salary.
  - Maximum award level, defined as 45% of base salary.
  - Ms. Ryba's actual annual incentive award for FY2015 performance is $228,334 (approximately 28.5% of FY2015 base salary).
- **Standard benefits**, similar to those available to all eligible ECH employees:
  - Includes medical, dental, vision, long-term disability, paid time off and sick leave, qualified retirement plans, and employee-paid supplemental group term life insurance and spouse/dependent life insurance.
- **Executive benefits**, provided to the CEO and other selected executives:

Benefit	ECH Benefit
Executive Life Insurance	• Group term life insurance of 3x salary up to $1.25 million, with amounts above $350,000 subject to medical underwriting (provided in lieu of regular group term life program).
Short-Term Disability	• 100% salary continuation for up to six months on short-term disability, after paid time off and extended sick leave exhausted, and integrated with other benefits.
Supplemental Retirement	• CEO: 19% of base salary, with each contribution vesting after five years from when the contribution is made (or age 65 if earlier). • Executives can also make voluntary deferrals to a 457(b) plan.
Taxable Allowance	• 7% of base salary, which can be used for additional long-term disability or life insurance; long-term care, 457(b) retirement plan deferrals or cash, depending on the executive's preferences.

- Severance benefits:
  - Paid upon involuntary termination by ECH without cause, ECH not renewing the employment agreement, or voluntary termination by employee for "good reason" (as defined in Ms. Ryba's employment agreement).
  - Continuation of base salary and medical benefits for 12 months following termination date.
  - Severance reduced by other earned income after initial six months.

Competitiveness of Total Compensation

Ms. Ryba's FY2016 current base salary, total cash compensation (i.e., base salary plus annual incentive awards) and total compensation (i.e., total cash compensation plus standard and executive benefits) are at the following market positioning levels:

Compensation Component	Amount	Market Data/Relative Market Position[1]				Approx. Market Position[2]
		P25	P50	P75	P90	
FY16 Base Salary		$779.5	$885.0	$1,021.9	$1,320.8	
	$824.3	106%	93%	81%	62%	36
Total Cash Compensation[3]		$847.8	$1,046.7	$1,316.9	$1,688.6	
Actual	$1,052.6	124%	101%	80%	62%	51
Target (30%)	$1,071.6	126%	102%	81%	63%	52
Maximum (45%)	$1,195.2	141%	114%	91%	71%	64
Total Compensation		$1,071.4	$1,307.8	$1,605.9	$2,068.7	
Actual	$1,342.0	125%	103%	84%	65%	53
Target	$1,361.0	127%	104%	85%	66%	54
Maximum	$1,484.6	139%	114%	92%	72%	65

[1] Ratio of actual total compensation to the 25th, 50th, 75th, and 90th percentiles of the market data for comparable positions adjusted to reflect the higher prevailing wage rates in Silicon Valley.

[2] Approximate market positioning assumes market compensation levels are uniformly distributed between the 25th, 50th, 75th and 90th percentiles.

[3] Incentive award paid for FY2015 performance based on FY2015 base salary. Target and maximum awards based on FY2016 base salary.

As shown above, Ms. Ryba's base salary is at the estimated 36th percentile of the market, and actual and target total cash compensation and total compensation are slightly above the 50th percentile.

While SullivanCotter has validated the use of a 20% geographic salary differential, we note that actual and target total compensation would approximate the 75th percentile of the market if the geographic differential had not been applied (maximum total compensation would approximate the estimated 80th percentile).

Detailed market data are provided in **Exhibit II**. A tally sheet showing all of the cash compensation, benefits and perquisites costs are provided in **Exhibit III**.

Competitiveness of Benefits

Overall, the benefits provided to Ms. Ryba are within the range of market practices, although slightly above average. This is primarily driven by Ms. Ryba's deferred compensation contribution, which is only payable to Ms. Ryba in full if she remains employed by ECH through age 65 or, if earlier, becomes disabled, dies, or ECH terminates Ms. Ryba's employment without cause. Severance is consistent with respect to market practices.

Overall Assessment

Overall, SullivanCotter finds Ms. Ryba's current total compensation and benefits in relation to market practice as follows:

- Base salary is at the estimated 36th percentile of the competitive market data.

- Actual, target, and maximum total cash compensation fall at the estimated 51st, 52nd and 64th percentiles of the competitive market data, respectively.
- Benefits are within the range of competitive market practices.
- Actual, target, and maximum total compensation fall at the estimated 53rd, 54th and 65th percentiles of the competitive market data, respectively.
- Severance benefits are within the range of competitive market data.

Based on our assessment, when considering all elements of Ms. Ryba's current compensation and benefits as summarized in this letter, we believe that Ms. Ryba's current total compensation package is within the range of competitive market data and, therefore, reasonable in relation to prevailing and current market practices.

V. Other Considerations

Please note that our conclusions are based on the data provided to us at the time this opinion letter was prepared, which SullivanCotter has not independently verified. Any compensation and/or benefits not included in this letter are not covered by our opinion.

Our opinion of Ms. Ryba's arrangement is in respect to the competitiveness and reasonableness of the compensation as determined in accordance with, and for purposes of, the rules governing Intermediate Sanctions under Section 4958 of the Internal Revenue Code. Therefore, we express no opinion on:

- The tax-exempt status of ECH.
- Any issues related to prohibited inurement.
- Whether the executive is a "disqualified person" within the meaning of the Intermediate Sanctions regulations.
- Whether the terms of the employer's arrangement with the executive were or will be approved in advance by an authorized body of individuals without a conflict of interest, as described in Treasury Regulations Section 53.4958-6(a)(1).
- Whether the terms of the compensation arrangement have been adequately disclosed or documented on Form 990, other tax forms, Board reports and/or financial reports.

❋ ❋ ❋ ❋ ❋

We hope this letter meets the needs of ECH's Board in documenting the reasonableness of Ms. Ryba's total compensation and benefits program.

Sincerely,

Andrew Lewis
Principal

Attachments

Component	ECH's Desired/Targeted Market Position
Market Definition/ Peer Groups	• Primarily national, not-for-profit, independent hospitals/health systems of comparable net revenue size and complexity to ECH. Data increased by a 20% differential to reflect the higher prevailing wage rates in Silicon Valley.
Base Salary	• Salary range midpoints are based on the 50th percentile. • The salary range will be from 20% below to 20% above the salary range midpoint. • Placement in the range is based a combination of paying competitively, rewarding performance, and recognizing competence, credentials, and experience.
Incentives	• Target incentive opportunities set at competitive levels (i.e., median). • Actual total cash compensation will reflect an executive's current salary, individual performance and contributions, and organizational performance.
Benefits	• Executive benefits and severance targeted at competitive levels (i.e., median). • Perquisites should only be provided when supported by specific business reasons. ECH's practice is to minimize the use of perquisites.

Competitive Compensation Data

Exhibit II

Tomi Ryba

President & Chief Executive Officer

Position Match: **President and Chief Executive Officer**

Scope: **Health Systems: $776M**

Base: $824.3

Target TCC (30.0%): $1,071.6

Maximum TCC (45.0%): $1,195.2

Position Summary

Responsible for establishing and achieving short- and long-term objectives and the overall viability of the organization. Develops policies and procedures and provides guidance with their implementation. Reports to the board and is the most senior executive.

						Market Data Effective January 1, 2016 (a)							
						Base Salary				Total Cash Compensation			
Survey Source	Code	Job Title	Category	Typical Scope	n=	25th	50th	75th	90th	25th	50th	75th	90th
SCA:MEC(HS)	7000A	President and Chief Executive Officer	Rev, $400M - $900M	$640.4	93	$614.3	$689.6	$789.7	$891.2	$641.9	$778.6	$979.6	$1,188.8
IHS:Exec(HS)	050	Independent Chief Executive Officer	Rev, $500M - $1.0B	$750.0	38	$709.4	$772.8	$862.5	$995.7	$792.7	$1,024.0	$1,146.4	$1,293.9
M:IHN(HS)	4100A	President/Chief Executive Officer (CEO)	Rev, $500M < $1.0B	$727.0	12	$634.0	$690.1	$793.2	$1,643.4	$634.0	$732.8	$1,103.4	$1,880.1
SCA:MEC(HS)	7000A	President and Chief Executive Officer	Regression	$776.5	295	$629.1	$743.8	$879.5	$1,022.2	$707.2	$875.2	$1,083.1	$1,311.4
IHS:Exec(HS)	050	Independent Chief Executive Officer	Regression	$776.5	186	$612.5	$734.6	$881.0	$1,037.2	$687.0	$866.6	$1,093.0	$1,346.3
M:IHN(HS)	4100A	President/Chief Executive Officer (CEO)	Regression	$776.5	67	$698.2	$794.2	$903.5	$1,014.3	$776.1	$956.5	$1,178.9	$1,422.2
					Average:	$649.6	$737.5	$851.6	$1,100.7	$706.5	$872.3	$1,097.4	$1,407.1
					Average (plus 20% premium to reflect Northern CA geographic differential):	$779.5	$885.0	$1,021.9	$1,320.8	$847.8	$1,046.7	$1,316.9	$1,688.6

(a) Data aged to January 1, 2016 at an annualized rate of 3%. This is consistent with average health care executive salary increase budgets.

Name:	Ryba
Title:	President & Chief Executive Officer
a. Cash Compensation	
♦ FY2016 Base Salary	$824,300
♦ Annual Incentive Award (for FY2015 Performance)	$228,334
Total	**$1,052,634**
b. Benefits Provided to All Employees	
♦ Social Security & Medicare	$22,610
♦ Medical, Prescription Drug	27,112
♦ Dental	472
♦ Vision Care	246
♦ Long-Term Disability	540
♦ Qualified Cash Balance plan	13,250
♦ Qualified 403(b) Matching Contributions	10,600
Total	**$74,830**
c. Executive Benefits	
♦ Executive Life and AD&D	$233
♦ Long-Term Care (non-elective)	0
♦ 457(f) SERP	156,617
♦ Taxable Allowance (7% of salary)	57,701
Total	**$214,551**
Total Benefit/Perquisite Cost	**$289,380**
Total Compensation Cost	**$1,342,014**
d. Other information	
♦ SERP contribution %	19%
♦ Possible severance payments (in months)	18 months

Policies:

BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Policy Approval
	Responsible Party:	Cindy Murphy, Board Liaison
	Action requested:	Approval of Policies
	Background: As required by title 22 and Joint Commission the Hospital's governing body must review and approve all organizational policies and if a policy is new or revised it must be approved by the Board before the Hospital can adopt. Policies are being brought to the appropriate Board advisory committee for review and recommendation before being placed on the Hospital Board consent calendar for approval. All policies have been internal reviewed and have received appropriate approvals before being presented to a board committee.	
	Committees that reviewed the issue and recommendation, if any: 1. The Corporate Compliance, Privacy and Internal Audit Committee has reviewed and recommended approval of polices noted on the agenda as 27h.*i* - 27h.*xxi*. 2. The Quality, Patient Care and Patient Experience Committee has reviewed and recommended approval of polices noted on the agenda as 27i.*i* – 27i.*v.* 3. The Finance Committee has reviewed and recommended approval of polices noted on the agenda as 27j.*i* – 27j.*ii.*	
	Summary and session objectives : • Approval of Policies	
	Suggested discussion questions: 1. None	
	Proposed Board motion, if any: To approve Policies noted on the agenda as items 27h through 27j.	
	LIST OF ATTACHMENTS: Spreadsheet summarizing the polices with major, minor or no revisions Complete policy available on the Board portal for review.	

Att 27h.02 - Policy Summary Report Compliance Committee

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES				
Policy Number	**Policy Name**	**Department**	**Revised Date**	**Summary of Policy Changes**
0.0	Information Security Management Program	IT Security	New	
1.0	Access Control	IT Security	New	
3.0	Risk Management	IT Security	New	
4.0	Secutity Policy	IT Security	New	
POLICIES WITH MAJOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Leadership Policy	Admin	10/15	1. Removed job description summaries 2. Summarized purpose of division executives and functional (i.e., privacy) officers 3. Added reference to IT Security officer 4. Removed 10-step method 5. Added Assistant Manager and Supervisor 6. Moved management rights from back to front of policy
	Confidentiality	Corporate Compliance	10/15	Clarifying Employees Requirements and Epic Security
	Corporate Compliance Hotline	Corporate Compliance	10/15	Removed duplicated information
	Receipt of Summons and Complaint and Legal Documents	Corporate Compliance	10/15	Centralizing process and handling of documents
POLICIES WITH MINOR REVISIONS				

Policy Number	Policy Name	Department	Review or Revised Date	Summary of Policy Changes
	Outside Services Providers	Administrative	10/15	1. Some sentences reworded to improve clarity. 2. Replaced "laminated safety card" with "safety card or information sheet.
	Code of Ethics	Corporate Compliance	10/15	
	Government Investigations	Corporate Compliance	10/15	
	Internal Investigations	Corporate Compliance	10/15	
	Gifts and Business Courtesies from Vendors or Provided to Non Referral Sources	Corporate Compliance	10/15	Title change to clarify
	Gifts and Business Courtesies to Physicians	Corporate Compliance	10/15	Title change to clarify
	Gifts from Patients and Families	Corporate Compliance	10/15	
	Direct Patient Care Services Contractual Agreements	Corporate Compliance	10/15	Removed listing of specific contract in Attachment A
	Use of Social Network Mediums by Employees	Corporate Compliance	10/15	Title change to clarify
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	
	Confidentiality Form	Corporate Compliance	10/15	
	Conflict of Interest	Corporate Compliance	10/15	
	Charitable Donations to Outside Organizations	Corporate Compliance	10/15	
	Identity Theft Misidentification Prevention	Corporate Compliance	10/15	
POLICIES TO ARCHIVE				

Policy Number	Policy Name	Department	DATE ARCHIVE	

Information Security Management

POLICY/PROCEDURE TITLE: 00.00 Information Security Management Program

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SUB-CATEGORY: **Information Security Management Program**
ORIGINAL DATE: **Dec 12, 2014**

COVERAGE:

This policy applies to all personnel that access and/or use El Camino Hospital IT assets or infrastructure. The personnel maybe defined as follows:

- El Camino Hospital Employees
- Physicians
- Independent Contractors
- Contract Services Personnel
- Registry/Temporary Agency Personnel
- Students, Interns and Instructors
- Partners
- Volunteers
- Visitors

PURPOSE:

To implement and manage an Information Security Management Program (*ISMP*).

STATEMENT:

It is the policy of El Camino Hospital that the Information Security (InfoSec) department shall establish and manage an ISMP that enables the organization to define, improve and monitor the processes, technologies, and resources to appropriately implement HIPAA, PCI-DSS compliance and other state and federal regulatory security requirements.

Responsibilities:

System Owners:
Individuals or designees (must be documented) who have the authority to grant-access in writing to systems that process, store or transmit PHI, PII, PCI or sensitive data.

Technical Services, Clinical Informatics' and Business Applications:
These are the departments with responsibility for administering and maintaining documented access control procedures and processes to protect IT assets or infrastructure.

Information Security (InfoSec):

POLICY/PROCEDURE TITLE: 00.00 Information Security Management Program

The department that is responsible for writing this policy and establishing IT Security controls and processes. InfoSec is also responsible for advising and recommending information security policies to IT Leadership, assessing information security risks, identifying and implementing countermeasures to prevent, detect and mitigate risks.

Information Technology Leadership (ITL):
The leadership team responsible for signing-off on information security policies and IT procedures and processes.

Governing Laws and Standards:

This policy enforces the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, PCI-DSS compliance and other state and federal regulatory IT Security requirements. The specific areas covered are §164.308 Administrative Safeguards and §164.316 Policies and Procedures and Documentation Requirements.

- Security Management Process **-** HIPAA §164.308(a)(1)(i)
- Risk Analysis - HIPAA §164.308(a)(1)(i)
- Risk Management **-** HIPAA §164.308(a)(1)(i)
- Evaluation **-** HIPAA §164.308(a)(8)
- Documentation - HIPAA §164.316(b)(1)
- Updates - HIPAA §164.316(b)(2)(iii)

DEFINITIONS *(as applicable)*:

PROCEDURE:

Defined as a series of documented process steps that provides objective and measureable criteria to fully implement this policy. Each procedure must have a department owner and responsible person assigned to manage and maintain procedural or process changes.

Owner: Chief Information Security Officer (CISO)

Co-Owners: *None*

Policy, Procedure and Process Review

1. This procedure shall be maintained in the NAVEX Policy Tech system. Automatic workflow for reviews, approvals, and awareness shall be conducted to the NAVEX Policy Tech System.

POLICY/PROCEDURE TITLE: 00.00 Information Security Management Program

2. InfoSec in conjunction with Technical Services, Business Applications, Clinical Informatics, and Clinical Engineering will conduct annual reviews of the 13 Security Policy Groups.
3. The reviews shall be scheduled in a proactive manner and must provide sufficient resources to complete the assessment for all 13 Security Policy Groups and their associated procedures or processes.
4. The annual review will begin on the first working day in July and shall be completed during the last working week in July.
5. InfoSec shall provide a **supplementary tool** that documents the annual review process criteria.
6. InfoSec shall develop the **appropriate metric** for managing visibility and success of the annual and interim reviews.
7. IT Leadership shall coordinate sign-off thru NAVEX Policy Tech to acknowledge their awareness and involvement to ensure efforts to complete the compliance and security evaluations are conducted in accordance to this policy.
8. Technical Services, Business Applications, Clinical Informatics, and Clinical Engineering department heads are responsible for coordinating interim compliance and security evaluations with InfoSec whenever they change the operational environment or systems in a manner that impacts PHI, PII, PCI or sensitive data.
9. The NAVEX Policy Tech system and supplementary tool shall be used to support the interim compliance and security evaluation in the same manner as in the annual review.
10. IT Leadership shall coordinate sign-off to acknowledge their awareness and involvement to ensure efforts to complete the interim compliance and security evaluation are conducted in accordance to this policy.

POLICY/PROCEDURE TITLE: 00.00 Information Security Management Program

Historical Approvals:

APPROVAL DATES:
CIO:
CISO:
Corporate Compliance:
Human Resources:
Legal:
Board of Directors:

REFERENCES: (*as applicable*)

Any documents produced for process, guidelines, and metrics for measurement of this policy will be maintained on NAVEX Policy Tech.

1. Procedure/Process Title – located in folder
2. Metric Name - located in folder
3. Supplementary Tool – located in folder

ATTACHMENTS:, ADDENDUMS:, EXHIBITS:, OR APPENDICES:

Access Control

POLICY/PROCEDURE TITLE: 01.00 **Access Control**

CATEGORY: (Inserted PolicyTech field)
LAST APPROVAL DATE:

SUB-CATEGORY: Information Security
ORIGINAL DATE: Dec 12, 2014

COVERAGE:

This policy applies to all personnel that access and/or use El Camino Hospital IT assets or infrastructure. The personnel maybe defined as follows:

- El Camino Hospital Employees
- Physicians
- Independent Contractors
- Contract Services Personnel
- Registry/Temporary Agency Personnel
- Students, Interns and Instructors
- Partners
- Volunteers
- Visitors

PURPOSE:

1. To control access to information, information assets, and business processes based on business and security requirements.
2. To ensure authorized user accounts are registered, tracked and periodically validated to prevent unauthorized access to information systems.
3. To prevent unauthorized user access, and compromise or theft of information and information assets.
4. To prevent unauthorized access to networked services.
5. To prevent unauthorized access to operating systems.
6. To prevent unauthorized access to information held in application systems.
7. To ensure the security of information when using mobile computing devices and teleworking facilities.

STATEMENT:

It is the policy of El Camino that Human Resources along with IS Technical Services, Clinical Engineering, Clinical Informatics' and Business Applications shall develop, disseminate, and periodically review and update: (i) a formal, documented, access control process that addresses purpose, scope, roles, responsibilities, coordination among organizational

POLICY/PROCEDURE TITLE: 01.00 Access Control

CATEGORY: (Inserted PolicyTech field)
LAST APPROVAL DATE:

entities, and compliance; and (ii) formal, documented process to facilitate the implementation of the access control policy and associated access controls and (iii) describes how the ECH information system enforces assigned authorizations for controlling access to the system in accordance with applicable policy.

Upon request InfoSec shall provide guidance to ensure processes are compliant with the applicable laws and standards.

Responsibilities:

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System Owners:
Individuals or designees (must be documented) who have the authority to grant~~s~~ access in writing to systems that process~~es~~, store~~s~~ or transmit~~s~~ PHI, PII, PCI or sensitive data.

Technical Service, Clinical Informatics' and Business Applications:
The departments with responsibility for administering and maintaining documented access control procedures and processes to protect IT assets or infrastructure.

Information Security (InfoSec):
The department that is responsible for writing this policy and establishing access control principles. InfoSec is also responsible for advising and recommending information security policies to IT Leadership, assessing information security risks, identifying and implementing countermeasures to prevent, detect and mitigate risks.

Information Technology Leadership and Human Resources (ITL):
The IT leadership team responsible and Human Resources Divisions are accountable for signing-off on information security policies and IT procedures and processes related to this policy.

Governing Laws and Standards:

This policy enforces the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. The applicable Payment Card Industry Data Security Standard (PCI DSS) and other regulatory standards are also enforced.

Additional details regarding the specific HIPAA laws and PCI DSS standards are provided in the HITRUST Common Security Framework (CSF).

DEFINITIONS *(as applicable)*:

POLICY/PROCEDURE TITLE: 01.00 Access Control

CATEGORY: (Inserted PolicyTech field)
LAST APPROVAL DATE:

PROCEDURE:

A procedure is defined as a series of documented process steps that provides objective and measureable criteria to fully implement this policy. Each procedure must have a department owner and responsible person assigned to manage and maintain procedural or process changes.

Owner: Technical Service, Director

Co-Owners: IT Leadership, Human Resources, Clinical Engineering**,** Clinical Informatics' and Business Applications

Technical Services with the support of Clinical Engineering, Clinical Informatics and Business Applications is responsible for developing 25 procedures/processes. Each must provide objective evidence that the process exist, is managed and communicated effectively to the ECH workforce. The methods to accomplish this requirement may be administrative, technical, or physical in nature and may include supplementary documents, spreadsheets, databases or specialized application software.

1. **01.a Access Control Policy**
   - This process must describe how the access control is established, documented, and reviewed based on business and security requirements for access.
2. **01.b User Registration**
   - This process must define the formal documented and implemented user registration and de-registration procedure for granting and revoking user access.
3. **01.c Privilege Management**
   - This process must describe how the allocation and use of privileges to information systems and services are restricted and controlled. Special attention must be given to the allocation of the privileged access rights, which allow users to override system controls.
4. **01.d User Password Management**
   - This process must define how passwords are controlled through a formal management process.
5. **01.e Review of User Access Rights**
   - This process must define how all access rights are regularly reviewed by management via a formal documented process.
6. **01.f Password Use**
   - This process must describe how users are made aware of their responsibilities for maintaining effective access controls and are required to follow good security practices in the selection and use of passwords and security of equipment.
7. **01.g Unattended User Equipment**

- This process must describe how users ensure that unattended has appropriate protection.

8. **01.h Clear Desk and Clear Screen Policy**
   - This process must define the clear desk policy for papers and removable storage media and a clear screen policy for information assets.
9. **01.i Policy on Use of Network Services**
   - This process must define how users are provided with access to internal and external network services that they have been specially authorized to use. Authentication and authorization mechanisms must be applied for users and equipment,.
10. **01.j User Authentication for External Connections**
    - This process must define appropriate authentication methods used to control access by remote users.
11. **01.k Equip Identification in Networks**
    - This process must define automatic equipment identification used as a means to authenticate connections from specific locations and equipment.
12. **01.l Remote Diagnostic & Configuration Port Protection**
    This process must describe how the physical and logical access to diagnostic and configuration ports are controlled.
13. **01.m Segregation in Networks**
    - This process must define groups of information services, users, and information systems that are segregated on the networks.
14. **01.n Network Connection Control**
    - This process must describe how shared networks, especially those extending across the ECH boundaries, the capability of users to connect to the network are restricted, in line with the access control policy and requirements of the business applications.
15. **01.o Network Routing Control**
    - This process must define routing controls implemented for networks to ensure that computer connections and information flows do not breach the access control policy of the business applications.
16. **01.p Secure Log-on Procedures**
    - This process must define how accesses to operating systems are controlled by a secure log-on procedure.
17. **01.q User Identification and Authentication**
    - This process must define the user's unique identifier (user ID) for their personnel use only, and an authentication technique implemented to substantiate the claimed identity of a user.
18. **01.r Password Management System**

- This process must define how systems for managing passwords are interactive and how they ensure quality passwords.

19. 01.s Use of System Utilities

- This process must describe the use of utility programs that might be capable of overriding system and application controls that are restricted and tightly controlled.

20. 01.t Session Time-out

- This process must define how inactive sessions are shut down after a defined period of inactivity.

21. 01.u Limitation of Connection Time

- This process must define how restrictions on connection times are used to provide additional security for high-risk applications.

22. 01.v Information Access Restriction

- This process must describe how the logical and physical access to information and application systems and functions by users and support personnel are restricted in accordance with the defined access control policy.

23. 01.w Sensitive System Isolation

- This process must describe the sensitive systems dedicated and isolated computing environment.

24. 01.x Mobile Computing and Communications

- This process must define the formal policy and appropriate security measure adopted to protect against the risks of using mobile computing and communication devices.

25. 01.y Teleworking

- This process must define the policy, operational plans and procedures developed and implemented for teleworking activities.

The InfoSec department shall provide guidance to the Human Resources and IS Technical Service, Clinical Engineering, Clinical Informatics and Business Applications departments to ensure that the procedures/processes are developed in a manner that are consistent to the HITRUST framework that ECH has adopted as the standard for complying with PCI DSS standards, and HIPAA Security, Breach Notification and Privacy rules.

InfoSec will assist the Technical Service, Clinical Engineering, Clinical Informatics and Business Applications departments by validating that the security controls and the appropriate administrative, technical and physical measures are actively and effectively present.

The validation may include examination of documentation, interviewing personnel and testing the technical implementation.

InfoSec may also leverage the support of contractors or vendors to fulfill this requirement during mandatory Pen Testing, PCI check and HIPAA audits.

POLICY/PROCEDURE TITLE: **01.00 Access Control**

Historical Approvals:

APPROVAL DATES	**APPROVAL**
CIO:	
CISO:	
Corporate Compliance:	
Human Resources:	
Legal:	
Board of Directors:	

REFERENCES: (*as applicable*)

ATTACHMENTS:, ADDENDUMS:, EXHIBITS:, OR APPENDICES:

Risk Management

POLICY/PROCEDURE TITLE: **03.00 Risk Management**

SUB-CATEGORY: **Information Security**
ORIGINAL DATE: **Dec 12, 2014**

COVERAGE:

This policy applies to all personnel that access and/or use El Camino Hospital IT assets or infrastructure. The personnel maybe defined as follows:

- El Camino Hospital Employees
- Physicians
- Independent Contractors
- Contract Services Personnel
- Registry/Temporary Agency Personnel
- Students, Interns and Instructors
- Partners
- Volunteers
- Visitors

PURPOSE:

To develop and implement a Risk Management Program that addresses Risk Analysis, Risk Evaluations, Risk Mitigation, and Risk Management.

STATEMENT:

It is the policy of El Camino Hospital (ECH) that IT Leadership shall provide the strategic vision and top-level goals for developing a cost effective risk management program.

The Information Security (InfoSec) department upon request shall provide guidance to Technical Services, Clinical Engineering, Clinical Informatics, and Business Applications during their respective risk exercises to assist in the:

(i) Risk identification and categorization process

(ii) Risk evaluation;

(iii) Risk mitigation activities and

(iv) Ongoing risk management using effective organizational communication and feedback loops for continuous improvement of the HIPAA and PCI-DSS risk-related factors.

POLICY/PROCEDURE TITLE: **03.00 Risk Management**

Responsibilities:

System Owners
Individuals or designees (must be documented) who have the authority to grants access in writing to systems that processes, stores or transmits PHI, PII, PCI or sensitive data.

Technical Services, Clinical Informatics' and Business Applications
The departments with responsibilities for administering and maintaining documented access control procedures and processes to protect IT assets or infrastructure.

Information Security (InfoSec)
The department that is responsible for writing this policy and establishing access control principles. InfoSec is also responsible for advising and recommending information security policies to IT Leadership, assessing information security risks, identifying and implementing countermeasures to prevent, detect and mitigate risks.

Information Technology Leadership (ITL)
The leadership team responsible for signing-off on information security policies and IT procedures and processes.

Governing Laws and Standards:

This policy enforces the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, Data Breach Rule and Privacy Rule. The specific areas covered are §164.306 Security Standards: General Rule,§164.308 Administrative Safeguards, §164.316 Policies and Procedures and Documentation Requirement, §164.402 Definitions (Breach), §164.530 Administrative Requirements and PCI-DSS 12.0 Maintain an Information Security Policy.

- Maintenance - HIPAA § 164.306(e)
- Security Management Process - HIPAA §164.308 (a) (1) (i)
- Risk Analysis - HIPAA §164.308 (a) (1) (ii) (A)
- Risk Management - HIPAA §164.308 (a) (1) (ii) (B)
- Standard: Assigned Security Responsibility - HIPAA §164.308 (a) (2)
- Applications and Data Criticality Analysis - HIPAA §164.308 (a) (7) (ii) (E)
- Standard: Policies and Procedures - HIPAA §164.316(a)
- Definitions (Breach) - HIPAA §164.402

POLICY/PROCEDURE TITLE: **03.00 Risk Management**

- Standard: Mitigation - HIPAA §164.530(f)
- Risk-Assessment Process - PCI DSS v3 12.2

DEFINITIONS *(as applicable)*:

1. **Risk**: The potential that a given threat will exploit vulnerabilities of an IT asset or group of assets and thereby cause harm to the hospital. It is measured in terms of a combination of the probability or occurrence of an event and its consequence.
2. **Risk Category**: Categorization of risks by type or source.
3. **Probability**: The likelihood that a risk or opportunity will ~~occur over~~occur over the next 0-36 ~~months~~(months (on a scale from 0 to 10 with 10 being the highest).
4. **Impact**: The impact of the risk to the IT asset or IT infrastructure if the risk occurs (scale from 0 to 10 with 10 being the highest).
5. **Risk Score**: Determined by multiplying probability and impact (scale from 0 to 100).
6. **Risk Ranking**: A priority list which is determined by the relative ranking of the risks (by their scores) with the number one being the highest risk score.
7. **Risk Response**: Describes the action that shall be taken if a specific risk occurs.
8. **Trigger**: an incident or event which indicates that a risk is about to occur or has already happened.
9. **Risk Owner**: The person from the impacted organization assigned the responsibility to watch for triggers, and manage the risk response if the risk occurs.
10. **Interviewing** – involves interviewing stakeholders or subject matter experts to identify risk.

PROCEDURE:

Defined as a series of documented process steps that provides objective and measureable criteria to fully implement this policy. Each procedure must have a department owner and responsible person assigned to manage and maintain procedural or process changes.

Owner: Chief Information Security Officer (CISO)

Co-Owners: *None*

POLICY/PROCEDURE TITLE: **03.00 Risk Management**

Risk Analysis

1. This procedure shall be maintained in the NAVEX Policy Tech system. Automatic workflow for reviews, approvals, and awareness shall be conducted thru the NAVEX Policy Tech System.
2. InfoSec in conjunction with Technical Services, Clinical Engineering, Clinical Informatics, and Business Applications will utilize a baseline **risk register** template as the primary tool for identifying, categorizing, and tracking risk on all systems that contains or provides connectivity to PHI, PII, PCI or sensitive data.
3. The risk register template (**reference attachment-1**) contains the basic data fields for identification, category, probability, impact, risk score, risk ranking, risk response, trigger, risk owner, qualitative rating and dates. Additional fields are added as deem appropriate by the risk owner.
4. Technical Services, Business Applications, Clinical Informatics, and Clinical Engineering each are responsible for assigning the appropriate resources to complete the initial risk analysis of their respective business environments using the baseline risk register.
5. The information gathering techniques that the risk owners from Technical Services, Business Applications, Clinical Informatics, and Clinical Engineering may use to identify risk includes interviewing, brainstorming, and root cause analysis.
6. The completed baseline risk register is coordinated by the respective risk owner thru InfoSec for awareness and preparation for use in the Risk Evaluation phase.
7. The risk register shall be updated and maintained for the lifecycle of the IT asset or infrastructure.
8. A risk register shall be completed for each business area (Technical Services, Business Applications, Clinical Informatics, and Clinical Engineering) and submitted to the respective IT Leader for awareness and sign-off.
9. The reviews shall be scheduled in a proactive manner and each respective business area (Technical Services, Business Applications, Clinical Informatics, and Clinical Engineering) is responsible for providing sufficient resources to complete the annual risk analysis. The results will be documented on their respective risk register.
10. A sign-off of this phase shall be completed by the respective business area IT Leader.
11. The risk register is an input document into the Risk Evaluation phase.

Risk Evaluation

1. Each respective business area is responsible for evaluating the risks to identify probability and potential impact to their operation and to determine which risk warrants a response strategy.
2. The business areas use subject matter experts and existing documentation to determine data classification (PHI, PCI, or Sensitive). The results are documented and maintained on a Data Classification Log **(reference attachments-3).** The data classification is reviewed at least annually.

POLICY/PROCEDURE TITLE: **03.00 Risk Management**

3. A qualitative risk evaluation is performed and a short list of the previously identified risks is documented on a risk response plan (**reference attachments-4)**. This is a subjective evaluation of the identified risks. This process is repeated when new risks are discovered. The choices for risk response strategies are accept, avoid, mitigate, and transfer. Avoidance and mitigation responses are used for high-priority, high impact risks. Acceptance and transference are appropriate for medium to low-priority, medium to low impact risks.
4. The probability of each risk occurring is measured on a standard scale of low, medium and high.
5. The impact of each risk occurring is measured on a standard scale of 1 to 10, with 10 being the highest impact rating.
6. The tools that are used to perform a qualitative risk evaluation are the Probability Matrix and the Probability Impact Scale (**reference attachments-5 & 6**).
7. The output results from the qualitative risk evaluation shall become input documents into the quantitative risk evaluation process.
8. Each respective business area must numerically analyze the probability and impact (what's at stake or the consequences) of risks identified in the qualitative risk evaluation process.
9. During this process the business area determines which risks warrant a response, creates a realistic and achievable schedule based on scope, time and available resources.
10. The risk registered is updated to reflect the current decisions.
11. The updated risk register becomes an input document into the Risk Mitigation phase.

Risk Mitigation

1. During the risk mitigation process the business areas implements the appropriate risk response strategies to mitigate each risk.
2. Avoidance and mitigation response strategies are used for high-priority, high impact risks.
3. Acceptance and transference response strategies are appropriate for medium to low-priority, medium to low impact risks.
4. The business area identifies the metrics that will provide objective evidence that the risks have been mitigated. These metrics are used to monitor and control the repeat occurrences for the mitigated risks.
5. The updated risk register, risk response strategies, and mitigation documentation are artifacts that are maintained by the business areas and InfoSec. These

documents are the foundation to the ECH Risk Management program. They are used to manage risk to an level that is acceptable to IT Leadership.

Historical Approvals:

APPROVAL DATES:
CIO:
CISO:
Corporate Compliance:
Human Resources:
Legal:
Board of Directors:

REFERENCES: (*as applicable*)

ATTACHMENTS:, ADDENDUMS:, EXHIBITS:, OR APPENDICES:

Security Policy

POLICY/PROCEDURE TITLE: **04.00 Security Policy**

CATEGORY: (Inserted PolicyTech field)
LAST APPROVAL DATE:

SUB-CATEGORY: **Information Security**
ORIGINAL DATE: **Dec 12, 2014**

COVERAGE:

This policy applies to all personnel that access and/or use El Camino Hospital IT assets or infrastructure. The personnel maybe defined as follows:

- El Camino Hospital Employees
- Physicians
- Independent Contractors
- Contract Services Personnel
- Registry/Temporary Agency Personnel
- Students, Interns and Instructors
- Partners
- Volunteers
- Visitors

PURPOSE:

To provide management direction in line with business objectives and relevant laws and regulations, demonstrate support for, and commitment to information security through the issue and maintenance of an information security policy across the organization.

STATEMENT:

It is the policy of El Camino Hospital that the Information Security (InfoSec) department shall coordinate an Information Security Policy that is approved by IT Leadership, and published and communicated to all employees and relevant external parties. This policy establishes the direction of the organization and aligns to best practices, regulatory, federal and state laws where applicable. The Information Security policy shall be supported by a strategic plan and a security program with well-defined roles and responsibilities for leadership and security related roles.

El Camino Hospital shall ensure policies are documented and communicated to all parties directly involved in the support or maintenance systems that may contains PCI,

POLICY/PROCEDURE TITLE: **04.00 Security Policy**

CATEGORY: (Inserted PolicyTech field)
LAST APPROVAL DATE:

HIPAA and other sensitive data to accommodate Payment Card Industry (PCI) Data Security Standard (DSS), HIPAA and other regulatory requirements.

Responsibilities:

System Owners
Individuals or designees (must be documented) who have the authority to grants access in writing to systems that processes, stores or transmits PHI, PII, PCI or sensitive data.

Technical Services, Clinical Engineer, Clinical Informatics' and Business Applications
The departments with responsibility for administering and maintaining documented access control procedures and processes to protect IT assets or infrastructure.

Information Security (InfoSec)
The department that is responsible for writing this policy and establishing access control principles. InfoSec is also responsible for advising and recommending information security policies to IT Leadership, assessing information security risks, identifying and implementing countermeasures to prevent, detect and mitigate risks.

Information Technology Leadership (ITL)
The leadership team responsible for signing-off on information security policies and IT procedures and processes.

Governing Laws and Standards:

This policy enforces the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, Date Breach Rule and Privacy Rule. The applicable Payment Card Industry Data Security Standard (PCI DSS) standards are also enforced.

Additional details regarding the specific HIPAA laws and PCI DSS standards are provided in the HITRUST Common Security Framework (CSF).

DEFINITIONS *(as applicable)*:

PROCEDURE:

Defined as a series of documented process steps that provides objective and measureable criteria to fully implement this policy. Each procedure must have a

POLICY/PROCEDURE TITLE: **04.00 Security Policy**

CATEGORY: (Inserted PolicyTech field)
LAST APPROVAL DATE:

department owner and responsible person assigned to manage and maintain procedural or process changes.
Owner: Chief Information Security Officer (CISO)

Co-Owners: *None*

InfoSec is responsible for developing 2 procedures/processes. Each must provide objective evidence that the process exist, is managed and communicated effectively to the ECH workforce. The methods to accomplish this requirement may be administrative, technical or physical in nature and may include supplementary documents, spreadsheets, databases or specialized application software.

1. 04.a Information Security Policy Document
   - This process must define how the information security policy documents are approved by management, and published and communicated to all employees and relevant external parties. Information security policy documents establish the direction of ECH and align to best practices, regulatory, federal/state and international laws where applicable. The information security policy documents are supported by a strategic plan and a security program with well-defined roles and responsibilities for leadership and officer roles.

2. 04.b Review of the Information Security Policy
   - This process must define the information security policy documents reviewed at planned or when significant changes occur to ensure continuing adequacy and effectiveness.

The InfoSec department shall ensure that the procedures/processes are developed in a manner that are consistent to the HITRUST framework that ECH has adopted as the standard for complying with PCI DSS standards, and HIPAA Security, Breach Notification and Privacy rules.

InfoSec will validate that the security controls and the appropriate administrative, technical and physical measures are actively and effectively present.

The validation may include examination of documentation, interviewing personnel and testing the technical implementation.

InfoSec may also leverage the support of contractors or vendors to fulfill this requirement during mandatory Pen Testing, PCI DSS risk assessment and HIPAA audits.

POLICY/PROCEDURE TITLE: **04.00 Security Policy**

CATEGORY: (Inserted PolicyTech field)
LAST APPROVAL DATE:

POLICY/PROCEDURE TITLE: **04.00 Security Policy**

Historical Approvals:

REFERENCES: (*as applicable*)

APPROVAL DATES:
CIO:
CISO:
Corporate Compliance:
Human Resources:
Legal:
Board of Directors:

ATTACHMENTS:, ADDENDUMS:, EXHIBITS:, OR APPENDICES:

Leadership Policy

POLICY/PROCEDURE TITLE: 43.00 Leadership Policy

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: General Administration
ORIGINAL DATE: 11/06

COVERAGE:

All El Camino Hospital Leadership

PURPOSE:

To provide a consistent process for leadership's role and responsibility

STATEMENT:

It is the policy of the Board of Directors of El Camino Hospital that leadership's role and accountability be clearly established in writing and reviewed at least every three years.

PROCEDURE:

I. Role of Leadership

~~**LEADERSHIP:**~~

A. Leadership begins with establishing the organization's mission, then defining and communicating the organization's vision. ~~Building on the vision, leadership defines the values of the organization. The organization's leaders provide the framework for planning the health care services to be provided by the organization.~~ Leadership has the authority and responsibility to carry out the four processes of leadership: (1) planning, (2) directing, (3) implementing and coordinating, and (4) improving services. ~~These functions are inherent throughout standards that describe operations at El Camino Hospital~~.

B. Leaders help create an environment that enables the hospital to fulfill its mission and meet or exceed its goals. Within this environment, ~~the~~ leadership:

1. Supports the Board of Directors in developing, regularly updating, and implementing the strategic mission, vision, values and goals for the organization;
2. Coordinates the development and implementation of strategic plans to achieve the vision, including the annual quality improvement plan and the annual budget;
3. Nominates, screens, and selects improvement projects;
4. Assigns teams to projects;
5. Ensures that teams have the resources and support necessary to accomplish their objectives, including appropriate staff, time, materials, team leaders, training, follow up, and incentives;
6. Monitors progress against objectives, including budget monitoring;
7. Establishes organizational standards consistent with the applicable accrediting regulatory and licensing agencies;
8. Implements strategies to improve organizational performance;
9. Defines the organizational structure and facilitates effective implementation of operation standards;
10. Serves as role models and promotes shared values.

- ~~Alignment with organizational goals;~~
- ~~Optimism;~~
- ~~Consistency;~~
- ~~A sense of diligence, persistence and urgency.~~

~~Effective leadership develops other leaders to help fulfill the vision, mission, and goals of the organization. The El Camino Hospital Board of Directors (Board) supports the process for orienting, forming and developing management as committed leaders who are effective communicators, who have appropriate competencies, perform well in their positions, and whose actions reflect El Camino Hospital's leadership philosophy, vision, mission, and values to all members of the organization and the communities it serves.~~

II. Management Rights and Responsibilities

A. There are established rights and responsibilities of hospital management in fulfilling hospital objectives. Labor agreements and mandatory subjects of bargaining may necessitate negotiations to bargain the effect of management decisions. As such, El Camino Hospital leadership management staff has the right to exercise the customary functions of management including, but not limited to, the rights to:

1. Manage and control the premises and equipment;

2. Select, hire, train/develop, promote, suspend, dismiss, assign, supervise, and discipline staff;
3. Determine and change starting times, quitting times and shifts;
4. Transfer staff within departments or into other departments and other classifications;
5. Determine and change the size, composition and qualifications of the work force;
6. Adopt, establish, change, and abolish operational standards, rules and procedure;
7. Determine and modify job descriptions, job evaluations, and job classifications;
8. Determine and change methods and means of operations, as needed, for efficient and effective delivery of services;
9. Assign duties to staff in accordance with needs and requirements, as determined by hospital management;
10. Carry out all ordinary functions of management;
11. Plan, organize, staff, lead, control, train, review and budget.

~~D. **PROCEDURE**~~

~~**SECTION I: Governance**~~

~~Subject to Bylaws, the Board shall have and exercise full power and authority to perform all actions necessary and expedient in the governance, management, and control of the business and affairs of the organization, including adopting policies to guide its operation. This authority is defined in the El Camino Hospital Bylaws. The Board may appoint standing or special committees, and designate their function and responsibility, as it may deem appropriate and desirable. Other standing committees may be created at the discretion of the Board. Each committee has an established charter that outlines the scope of responsibilities, an authority to act on behalf of the Board, and delineates its reporting relationships. The power of such committees shall be limited to the extent provided by Title 22.~~

III. ~~SECTION II:~~ Executive Leadership

A. ~~1.~~ President and CEO

The Board ~~has~~ appoint~~sed~~ a President and Chief Executive Officer (CEO) who ~~is qualified for this position by education, certification, and relevant experience and~~ possesses the management and leadership skills to effectively direct the delivery

of services for the organization. The CEO has the ultimate responsibility for the management and leadership of the organization as defined in the El Camino Hospital Bylaws. ~~The President and CEO appointed an Executive Team, consisting of the various Chiefs, Officers, Presidents and Vice-Presidents to lead the organization.~~

B. **Executives**

The CEO appoints an Executive Team, consisting of the various Chiefs, Officers, Presidents and Vice-Presidents to lead the organization. Goals and compensation for leaders designated as "executives" are reviewed and approved by the El Camino Hospital Board of Directors ("Board.").

~~**2. Chief Operating Officer (COO)**~~

~~El Camino Hospital's CEO has appointed a Chief Operating Officer (C0O) who is an individual qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible~~

C. **Division Executives** ~~. The Chief Operating Officer (COO)~~ provide~~s~~ leadership, direction, and administration of specific hospital operational and functional areas. They are responsible for performance improvement and change management initiatives ~~including all clinical service lines, nursing operations, and the Performance Improvement Office (PIO). Utilizing Lean Performance Improvement methodologies, the COO leads change management initiatives~~ across the enterprise to achieve cultural and operational effectiveness in improving outcomes, reducing waste (variability), reducing costs, and increasing satisfaction. They collaborate with each other in developing strategy, setting and achieving goals, and management of resources.

In addition, they provide strategic leadership to the leaders of the departments reporting to them including setting goal and objectives, measuring and reporting goal achievement, and financial performance. Division Executives are coaches to the leaders reporting to them supporting achievement of goals and professional growth and development.
~~The COO builds and refines the Performance Improvement Office, which is comprised of all entities related to driving improvements in performance, processes, and clinical effectiveness through leveraging such functionalities as the Enterprise Data Warehouse, Utilization Management, and Data Analytics.~~

The Hospital maintains organizational charts showing reporting relationship and span of control for each division executive.

~~B.~~D. ~~C.~~ **Presidents**

A President is ~~a~~an ~~senior~~ executive position ~~-~~reporting to the CEO of El Camino Hospital who is ~~-or directly to a board whose directors include at least two members or their designees of the El Camino Hospital Board of Directors (Board).~~

~~A President is~~ the chief executive of a separate corporation ("subsidiary"). When the position is not full-time, the CEO may appoint a division executive or vice president to serve as the subsidiary's President. Presidents will have ~~organization or affiliated healthcare facility who develops, promotes, and directs all aspects of the subsidiary's policies, objectives, and initiatives approved by the parent organization. A President will have~~ profit and loss accountability, oversee operations of the subsidiary~~/healthcare facility~~, and ensure strategic alliance with strategic goals and initiatives of the El Camino Hospital. ~~A President will oversee business development, clinical operations, and ancillary and administrative activities for the subsidiary organization or facility.~~

A subsidiary organization ~~or affiliated healthcare facility~~ will typically have a separate board of directors or advisory board. A President will effectively manage and leverage relationships with the Board, advisors, medical staff, and/or community members to achieve the ~~affiliate~~subsidiary's mission and vision and position the organization for long term sustainability.

~~II. The President title is assigned to leadership positions of the Auxiliary, Concern:EAP, El Camino Hospital, El Camino Hospital Foundation, El Camino Surgery Center and Silicon Valley Medical Development.~~

~~III.~~

~~**IV. President, El Camino Hospital Foundation – The President, El Camino Hospital Foundation is responsible for planning, developing, implementing and evaluating all aspects of the El Camino Hospital Foundation to achieve its financial growth goals. The President directs the Hospital's fundraising efforts, campaigns, and programs to meet specific operational and capital needs of the Hospital as well as fund community benefit programs. The President oversees the Foundation's board of directors and committees, directs the development of Foundation policies and procedures which are consistent with overall organizational strategies and initiatives. This Hospital vice-president oversees the services provided by the Auxiliary and**~~

~~its funded programs and is responsible for external affairs that include government relations. This position may be responsible for planning, developing, implementing, and evaluating programs that are funded or potentially funded through Foundation donations or grants such as the Center for Technology Integration and Genomics initiatives.~~

~~V.~~
~~VI.~~
~~VII. President, Silicon Valley Medical Development, LLC and Chief, Strategy and Business Development~~
~~VIII.~~
~~IX. The President of Silicon Valley Medical Development, LLC (SVMD) provides~~
~~X. leadership, strategic and operational direction for planning, development,~~
~~XI. implementation and management of Hospital-sponsored ventures relating to~~
~~XII. community, physician, and ambulatory site development. The position serves as~~
~~XIII. President of a separate corporation established by El Camino Hospital for these~~
~~XIV. purposes. Duties include managing new ventures with the Independent Physicians of~~
~~XV. El Camino Hospital (IPECH), Palo Alto Medical Foundation, the Menlo Clinic, and~~
~~XVI. other community medical groups and independent practice associations; creation and~~
~~XVII. direction of management service organization (MSO) and practice management~~
~~XVIII. support for these organizations; syndication of facility ventures with community~~
~~XIX. physicians; evaluation, development and management of retail ambulatory ventures,~~
~~XX. including embedded convenience clinics and employee health centers; and physician~~
~~XXI. network development.~~
~~XXII.~~
~~XXIII.~~

~~C.~~E. ~~10.~~ **Vice Presidents**

The CEO may appoint non-executive leaders to manage complex enterprise-wide functions and operations that have a significant impact on the Hospital's current or future operations. A Vice President may report to the CEO or to a division executive. ~~Leadership for the organization is provided by Vice Presidents who are qualified by education, licensure, and relevant experience that includes management and leadership skills to effectively direct enterprise-~~

~~wide functions and operations. A The~~ Vice President~~s have, through either direct or matrix reporting relationships, the authority and responsibility to establish standards of operations and composition of the staff, and to establish minimum criteria for education, licensure, and competency. The Vice Presidents~~ is ~~are~~ accountable for comprehensive ~~management~~ leadership of their function(s) including ~~:~~

: 1) d

~~Clinical Quality and Safety;~~

~~Compliance with laws, regulations, and accreditation standards;~~

~~Compliance with Hospital policies;~~

~~D~~evelopment and implementation of ~~division~~ strategy; 2) risk assessment and management; 3) staffing and resources; and 4) a

~~A~~achiev~~e~~ement of goals. ~~patient, employee and physician satisfaction goals;~~

~~Continuity of services;~~

~~Quality, service and productivity process improvement;~~

~~Achievement of Hospital volume growth goals;~~

~~Budget compliance;~~

~~Staff development and supervision;~~

~~Communication with staff, physicians, public and business associates;~~

~~Management of human and material resources;~~

~~Support the Hospital's mission to improve the health and well-being of the communities we serve.~~

~~XXIV.~~ ~~**The Vice Presidents represent clinical and support services at Board, Medical Staff, and Hospital committees and meetings. The Vice Presidents determine important aspects of patient care and support service delivery, and outcome measurements to determine their effectiveness.**~~

~~XXV.~~

~~XXVI.~~ ~~**Vice- President, El Camino Hospital, Los Gatos**~~

~~XXVII.~~

~~XXVIII.~~ ~~**El Camino's CEO has appointed a Vice-President for the Los Gatos Campus who is qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for the Los Gatos Hospital. The vice-president sets objectives and manages a multi-disciplinary team of individuals through direct and matrix relationships and is responsible for achieving the objectives of the El Camino Hospital: Los Gatos. Vice Chief Clinical Operations at Los Gatos. The Vice-President is responsible for effectively managing the financial, service, and quality goals of the Los Gatos Division. The Vice-President establishes annual goals for areas of responsibility that support the strategic plan. The Vice-President identifies business opportunities for providing new services or enhancing existing services. The Vice-President serves as a patient care advocate and**~~

~~collaborates with Administrative Leadership, Medical Staff Leadership, and Hospital Board Leadership in meeting the care needs of Los Gatos Division and El Camino customers. The following departments or functions report to the Vice-President, Los Gatos: Inpatient and Emergency Services which includes Critical Care and Medical/Surgical/Telemetry, Maternal/Child, Pediatric, Patient Care Resources, Emergency Department, Rehabilitation, Respiratory Therapy, Operating room, Clinical Laboratory, Nutrition Services, Environmental Services, Pharmacy and Imaging Services. The Vice-President reports to the Chief Operating Officer for operational issues and reports to the Chief Clinical Operations/Chief Nursing Officer regarding nursing practice.~~

~~b. Vice President, Marketing and Corporate Communications – Responsible for overall direction and serves as the primary resource for activities related to smarketing, planning, and external communications for El Camino Hospital. The Vice President of Marketing/Communications ensures a coordinated approach to all hospital marketing, activities. This vice president is responsible for the Hospital's image, internal and external communications and media relations.~~

~~c. Vice President, Corporate and Community Health Services and President, CONCERN: Employee Assistance Program (EAP) – This Vice President is responsible for the strategic direction, program and business development, leadership, service quality and financial accountability for the Corporate and Community Health Services including but not limited to: CONCERN: EAP, Camino Counseling Services (CCS), Health Resource Center (HRC), Health Library, RotaCare Clinic, Road Runners, Retail Services, South Asian Heart Center, Healing Arts Program, community outreach and hospital-wide initiatives to enhance the patient experience. This vice president is responsible for the development, implementation and evaluation of effectiveness of the Hospital's community benefit initiatives and programs that support the mission of the Hospital to improve the health and well being of the communities served. This Vice President serves as the President of CONCERN: EAP with responsibility for business strategy, revenue growth, oversight of its board of directors and committees and maintaining compliance with all DMHC/Knox–Keene regulations.~~

~~d. Vice President, Payor Relations – Responsible for acquiring an retaining market share for El Camino Hospital under financially favorable terms through contracts with managed care payers and health plans. This~~

~~**Vice President is responsible for overseeing and evaluating contract negotiations for all payers including financial arrangements, contract language, financial and utilization data to support contracting relationships with payers, and develops effective processes to administer the hospital-wide contracts. Responsible for administering all capitated risk arrangements and managing risk for all capitated plans. This Vice President evaluates and makes recommendations to Hospital leadership regarding managed care contract issues including contract strategy and contract administration for the hospital.**~~

~~**XXXVII.**~~

IV. ~~SECTION III:~~ Service Line ~~and Division/Department~~ Leadership

~~**A. 1. Service Line Leadership**~~
~~**B.**~~
~~C.~~A. ~~**a.**~~ **Service Lines** are designated by executive leadership as a means of increasing clinical excellence, enhancing the patients' experience of care, and revenue and services growth through collaboration among physicians (different groups, different specialties), clinical and support staff.

~~D.~~B. ~~**b.**~~ ~~**Executive**~~ **Directors of Service Lines** are responsible for the effective development, program direction, marketing, revenue and expense management, clinical quality and patient experience of the service line. This is accomplished in collaboration with staff in finance, business development and clinical operations. The service line includes a Medical Advisory Committee and a Fundraising Committee of the Hospital Foundation that is dedicated to the service line and may include an optional Community Advisory Committee.

V. ~~2.~~ Department/Division Leadership

El Camino Hospital's leadership through managers and other staff implement systems, processes, integration of functions, staff performance development to enhance patient care.

~~A. **a. Vice Chief of Clinical Operations, Mountain View** Responsible for providing operational direction to implement the strategic imperatives and goals for all clinical and patient care activities on the Mountain View campus, insuring high quality, cost efficient patient care. This position is responsible for employee and patient satisfaction, promoting teamwork among and between nursing, patient care and other hospital and medical staff. Serves as a patient care advocate and collaborates with executive leadership, medical staff leadership, and the Hospital Board leadership to meet the care needs of El Camino Hospital's patients. The Vice Chief of Clinical Operations is~~

~~responsible for in-patient, critical care, emergency department, maternal-child health, behavioral health and dialysis nursing services; Respiratory Medicine, Rehabilitation Services, and oversees clinical nutrition through a matrix reporting relationship.~~

~~B.~~

A. ~~b.~~ **Directors~~--~~**

Directors are ~~Re~~ ~~sponsible~~responsible for the organization's success in achieving ~~annual organizational~~annual organizational goals. Directors either have large and/or complex and financially significant areas of operational responsibilities or responsibility for driving direction and strategy for an area of expertise across the organization. Directors may have responsibility and accountability for multiple departments and/or provide direction to outside consultants or services to achieve annual goals and objectives. Directors may have managers reporting to them based on the scope and complexity of their area of responsibility. Directors who do not have managers reporting to them also fulfill the manager responsibilities for their area of responsibility.

~~**i. Senior Directors—**Senior directors have a broad organization-wide responsibility involving a high level of accountability due to a higher level of risk for the activities s/he oversees. In addition, they may serve in the role of an operational or functional director as described in the following sections.~~

1. ~~ii.~~ **Operational Directors--** Operational Directors are responsible for insuring the link between El Camino Hospital's mission, vision, values, goals, strategic plan and organizational goals, and the department goals. They are directly accountable, either personally or through delegation, for their area(s) of responsibility to:

    a. **Accomplish organizational goals, operational expectations, and departmental growth targets in their area.** Operational Directors work collaboratively with Strategic Planning and Business Development to develop strategies and growth plans for their area of responsibility. Additionally, Operational Directors work collaboratively with functional departments for support and expertise in Quality, Human Resources, Finance, Compliance, Materials Management, etc.
    b. **Provide effective, efficient, and financially sound department operations.** This includes meeting or exceeding budget and productivity targets, and staffing their area with competent and trained staff.

c. Assure patient safety and accreditation and regulatory compliance.

d. **Assure patient, employee, and physician satisfaction.**

2. ~~iii.~~ **Functional Directors--** Functional Directors are responsible for staff functions that support the entire organization. Functional Directors have expertise in areas such as Strategic Planning, Business Development, Financial Analysis, Human Resources, Materials Management, etc. Functional Directors are responsible for providing organizational expertise and direction across the ~~organization~~ enterprise plus directing the operations of their area. They may achieve results through matrix management or outside services and providers.

3. **Senior Directors—**Senior directors have a broad organization-wide responsibility involving a high level of accountability due to a higher level of risk for the activities s/he oversees. In most cases, senior directors will oversee several departments headed by managers and directors.

~~C.~~B. ~~3.~~ **Managers**

Managers are assigned areas of responsibility more specifically defined than those of Directors but the functions are relatively similar in nature and scope. In general, Managers have a smaller scope and focus than Directors. Managers are responsible for planning, organizing, hiring, and controlling the work in assigned areas of responsibility. Managers translate overall goals set by executive leaders into individual and team goals, develop plans for accomplishing goals, and direct and review progress.

Managers are responsible for their department's results where success is measured through departmental indicators. Managers communicate goals and accomplish results through delegation to staff.

~~a.~~ ~~Operational~~**Operational Managers -**

~~1.~~

~~2.~~1. **Operational Managers are responsible and ~~a~~accountable for their area to provide:**

a. **Effective, efficient and financially sound department operations.** This includes meeting or exceeding budget and

productivity targets, and staffing their area with competent and trained staff.

b. **Assure accreditation and patient safety and regulatory compliance.**
c. **Assure patient, employee and physician satisfaction.**
d. **Assess employee competency and conduct performance evaluations.**
e. **Provide orientation, training and education to their staff.**
f. **Communicate relevant organizational information to employees.**

~~3. **b.**~~ **Functional Managers -**
~~4.~~

2. Functional Managers are responsible for functions that support the entire organization. These managers have expertise in areas that include Marketing, Training and Development, Process Improvement, Clinical Effectiveness, Finance, etc. Managers are responsible for providing organizational expertise and direction across the organization plus managing the operations of their area. Functional Managers have a more focused area of responsibility and scope than Functional Directors.

3. **Senior Managers-** Senior managers have broader and more complex management responsibilities than other operational managers. In most cases, senior managers will oversee multiple functions led by supervisors and managers.

4. **Assistant Managers** – Assistant managers may function as a first-line supervisor to staff and/or partner with a functional manager or director to help manage and large department or unit(s). Assistant Managers coordinate and supervise daily work activities supporting hospital operations. Assistant managers coach, train, assess, and review performance of team members and support process improvement and change management activities.

VI. ~~SECTION IV:~~ Functional Officers

A. Certain functions and programs require the Hospital to appoint a designated point of contact for leadership. Functional officers have enterprise-wide responsibility. Serving as a functional officer is a job assignment. Samples include: Corporate Compliance, Hospital Safety, IT Security, Patient Safety, and Privacy.

B. Responsibilities of the functional officer include:

1. Develop, implement, communicate, and monitor the effectiveness of the function/program.
2. Develop, recommend, and execute management plan for assigned function/program
3. Ensure compliance with Hospital policy, standards, and legal requirements
4. Implement actions to correct deficiencies and improve the effectiveness of the program.
5. Chair an interdepartmental committee to aid in monitoring, managing and communicating the program.
6. Make recommendations and submit reports to Executive Leadership and Board

~~XXXVIII.~~
~~XXXIX.~~
~~XL. 1. Hospital Safety Officer – The Hospital Safety Officer (HSO) develops, implements and monitors the effectiveness of El Camino Hospital's Safety Management plan. The HSO along with Hospital Leadership and members of the Central Safety Committee ensure compliance with The Joint Commission's Environment of Care, Life Safety Management and Emergency Management standards and the requirements of the Cal/OSHA Injury and Illness Prevention Program (IIPP). This is accomplished through an ongoing effort of establishing performance standards; measuring and reviewing key performance indicators in each of the components of the Safety Management Plan and implementing actions to correct deficiencies and improve the effectiveness of the program to manage the environment of care. The HSO regularly reports on findings, recommendations, actions taken and results of measurement of safety management issues to the El Camino Hospital Board, CEO and Department Managers. The HSO is also authorized to intervene whenever conditions exist that pose an immediate threat to life or health, or pose a threat of damage to equipment or buildings.~~

~~XLI.~~
~~XLII. 2. Patient Safety Officer -The Patient Safety Officer has primary oversight of the facility-wide patient safety program. This leadership role directs others within the facility towards process improvement that will support the reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes. This practitioner provides leadership for safety assessments, coordinates the activities of the patient safety committee, educates other practitioners on the system-based causes for medical error, consults with management and staff, and~~

~~communicates literature-based ideas regarding effective patient safety strategies to others within the organization.~~

~~XLIII.~~

~~XLIV.~~ ~~3. Corporate Compliance Officer - The Compliance Officer provides direction and oversight of the Compliance Programs in conjunction with the Corporate Compliance and Internal Audit Committee. The Compliance Officer is responsible for identifying and assessing areas of compliance risk for the hospital; communicating the importance of the Compliance Program to all employees, the executive management and the Hospital Board of Directors; preparing and distributing the written Code of Conduct, setting forth the ethical principles and polices which are the basis of the Compliance Program; developing and implementing education programs addressing compliance and the Code of Conduct; implementing a retaliation-free internal reporting process, including an anonymous telephone reporting system; and collaborating with executive management to effectively incorporate the Compliance Program within system operations and programs.~~

~~XLV.~~

~~VI.~~VII. ~~4. Privacy VIII.~~ **Hospital Supervisors**

The Hospital Supervisor has responsibility for the operations of the hospital during times when other leadership are not on the premises and has the authority to initiate whatever administrative or emergency measures may be necessary to preserve the safety of the hospital and individuals. As appropriate, the Hospital Supervisor notifies the "Administrator On-Call" or appropriate leader in the chain of command.

~~There are established lines of authority and accountability within the organization.~~ As "Administrator On-Call" the Hospital's executives rotate responsibility for remaining accessible to the hospital via telephone or pager in the event administrative direction or assistance is needed by on-site supervision. The Board maintains authority and responsibility for the overall operations of the organization.

~~• The President and CEO delegates authority and responsibility for all aspects of the organization including both hospital sites and all service locations.~~

~~• Leadership including Executives, Officers, Chiefs, Directors and Managers delegate responsibility for operations of their assigned areas of responsibility.~~

~~XLVI. SECTION VI: Management Rights and Responsibilities~~

A. There are established rights and responsibilities of hospital management in fulfilling hospital objectives. Labor agreements and mandatory subjects of bargaining may necessitate negotiations to bargain the effect of management decisions. As such, El Camino Hospital leadership management staff has the right to exercise the customary functions of management including, but not limited to, the rights to:

1. Manage and control the premises and equipment;
2. Select, hire, train/develop, promote, suspend, dismiss, assign, supervise, and discipline staff;
3. Determine and change starting times, quitting times and shifts;
4. Transfer staff within departments or into other departments and other classifications;
5. Determine and change the size, composition and qualifications of the work force;
6. Adopt, establish, change, and abolish operational standards, rules and procedure;
7. Determine and modify job descriptions, job evaluations, and job classifications;
8. Determine and change methods and means of operations, as needed, for efficient and effective delivery of services;
9. Assign duties to staff in accordance with needs and requirements, as determined by hospital management;
10. Carry out all ordinary functions of management;

Plan, organize, staff, lead, control, train, review and budget.

VII.

XLVII. SECTION VII: Methods of Work/Analysis

XLVIII.

XLIX. TEN-STEP PROCESS

L.

LI. El Camino Hospital leadership will use the ten-step process outlined below when submitting recommendations in writing to the El Camino Hospital Board and El Camino Hospital District Board. This is in the form of a memo or cover letter; in certain situations the request will also require a business plan. Inherent in the completion of the ten-step process is the involvement of stakeholders, including medical staff, staff, and peers. The ten steps are:

LII. Authority (who asked you to develop this?)

LIII. Problem definition (what are you trying to solve?)

LIV. Process description (how do you plan to solve the problem?)

LV. Alternative solutions that you considered and may include cost benefit/SWOT analysis (strengths, weaknesses, opportunities, threats)

~~LVI. Concurrence for recommendation (who has agreed with your information and who else needs to?)~~
~~LVII. Outcome measures/deadlines (what are the success criteria and timeline?)~~
~~LVIII. Legal Review: has this been reviewed/approved by Legal Counsel?~~
~~LIX. Compliance Review: has this been reviewed/approved by the Internal Compliance Department?~~
~~LX. Financial Review: has this been reviewed/approved by the Finance Department?~~
~~LXI. Recommendation (what do you want people to approve?)~~
~~LXII.~~

~~**A. QUALITY and PROCESS IMPROVEMENT**~~

~~El Camino Hospital's quality and process improvement methodology is based on the Plan, Do, Study, Act model. Developing outcome measures, conducting process flow, creating process redesign, and establishing continuous monitoring of outcomes are core components of this methodology.~~

~~**3. REPORTS / INFORMATION**~~

~~There are established communication channels among hospital leadership, management staff, and all hospital employees, volunteers and physicians. The availability of and access to information to assist in the task of providing leadership and decision-making is critical. Information used by leaders comes in a variety of formats ranging from written data and information to verbal information presented through formal or informal channels.~~

~~Leadership at all levels has an obligation to appropriately and routinely report on operational activities and progress of goals. Leadership also has an obligation to inform and enroll front line staff in the organization's mission, vision, values, goals and operational plans and to report the results of organizational and team efforts to them.~~

~~Examples of such data and information are:~~

~~a. Written Reports~~
- ~~Monthly financial responsibility summary~~
- ~~Monthly financial variance reports~~
- ~~Daily and bi-weekly productivity reports~~
- ~~Patient, physician and employee satisfaction survey results~~
- ~~Quality indicator reports~~
- ~~Payroll and Accounts Payable reports~~

~~b. Structured Meetings~~
- ~~Board and Board Committee meetings~~
- ~~Leadership meetings~~
- ~~Departmental staff meetings~~
- ~~Joint practice committees~~
- ~~Organizational committees~~
- ~~Medical Staff committees~~

~~c. Electronic Information~~
- ~~Voice mail~~
- ~~Email~~
- ~~Internal databases~~
- ~~External databases~~
- ~~Knowledge-based information (e.g., internal access, medical information search services, journals, etc.)~~

- ~~Leadership Rounds—Employee rounding for outcomes by leadership is the conscious effort to connect with staff at regular intervals to develop relationships, build trust, acknowledge accomplishments and address operational needs and problems.~~
-

VIII. Supervisors

Supervisors are responsible for supervising daily work activities of a defined unit(s) supporting hospital operations and functions. They are responsible for improving and maintaining efficiency and accomplishing operational objectives within established policies, procedures, and performance standards. They are involved in hiring and selecting employees and are responsible for staff training, coaching, and assessment including conducting performance appraisals. In addition to direct supervision, they build and maintain contacts and relationships to effectively accomplish work objectives, address customer needs, assess operational requirements, and improve processes,

POLICY/PROCEDURE TITLE:43.00 Leadership Policy

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee: 10/2015 ~~(Please don't remove this line)~~	
~~Pharmacy and Therapeutics (if applicable):~~ELT:	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

11/06, 06/09, 10/12

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Outside Services Providers

POLICY/PROCEDURE TITLE: Administrative: 13.00 Outside Service Providers
CATEGORY: Administrative
LAST APPROVAL DATE: 8/12

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.

SUB-CATEGORY: Administrative Policies & Procedures
ORIGINAL DATE: 5/98
COVERAGE: ~~All El Camino Hospital staff,~~ All El Camino Hospital departments that use outside service providers, including auditors, building contractors, inspectors (e.g., regulatory agency visitors / surveyors), and forensic staff (e.g. ambulance drivers, police/fire department, etc). Temporary, registry and contract personnel are covered by Human Resources policy 17.01. Physicians and Allied Health staff are covered by Medical Staff policies

PURPOSE:
To ensure the safety of patients, staff and outside service providers by requiring outside service providers to receive basic hospital orientation ~~information prior~~information prior to performing assigned ~~duites~~duties. ~~Outside service providers are required to receive basic Hospital orientation prior to performing assigned duties in order to ensure patient safety, the safety of others and the safety of the service provider.~~

~~**STATEMENT:**~~
~~It is the procedure of El Camino Hospital regarding outside service providers to ensure patient safety~~

PROCEDURE:
A. Outside service providers include, but are not limited to, building contractors, auditors, inspectors (e.g., regulatory agency visitors/surveyors), forensic staff (e.g., ambulance drivers, police/fire department, etc.) and other non-employees who are on Hospital premises on a routine basis as part of their job duties.

B. All outside service providers are required to register at one of the following designated Hospital locations, or with any Manager:
1) Administration
2) Clinical Effectiveness
3) Emergency Department
4) Facilities
5) Human Resources
6) Medical Staff Office
7) Security

C. At the time of registration:
1) A ~~laminated El Camino Hospital~~ safety reference card or handout will be made available to all outside service providers.
2) Each outside service provider will receive from Security Services an authorized

identification badge which is required to be worn at all times while on Hospital premises. See Security Policy 2.12 Access Controls.

3) Outside service providers are required to read the safety ~~reference card~~information, as part of their orientation to their patient care and safety responsibilities, as applicable, prior to performing any duties on Hospital premises, except in emergency situations where orientation is not practical prior to performing her/his duties on Hospital premises (e.g., ambulance drivers, police/fire department, etc). The department manager or designee will be available to answer questions regarding the information on the safety reference card or any other questions that the outside service provider may have.

4) Orientation for outside service providers will be provided by the department manager or designee and may include how to interact with patients; procedures for responding to unusual clinical events and incidents or communication channels for clinical, security or other incidents.

APPROVAL DATES

Originating Committee or UPC Committee: HR Leaders Meeting 10/07/15
_____Medical Committee (if applicable):
ePolicy Committee: (Please don't remove this line)
Pharmacy and Therapeutics (if applicable):
Medical Executive Committee:
Board of Directors:
Historical Approvals: 05/98, 12/00, 05/01, 11/03, 03/05, 05/09, 8/12

vii. Receipt Summons and Complaint and Legal Documents

POLICY/PROCEDURE TITLE:Corporate Compliance:10.00 Receipt of Summons and Complaint and Legal Documents

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 11/97

COVERAGE:

All El Camino Hospital staff

PURPOSE:

To ensure the hospital accepts and responds appropriately to legal documents.

STATEMENT:

Comply with regulations and respond promptly to Summons and Complaints and other legal documents ensuring a consistent method by which Summons and Complaints and other legal documents will be accepted by El Camino Hospital.

Types of Service

1. In person
2. By m~~M~~ail

PROCEDURE:

1. Procedure

   a. ~~Any Administrator~~The Receptionist in Administration or other employee ~~of~~in Administration at the Mountain View campus may accept service of a Summons and Complaint, subpoena or legal document on behalf of the Registered Agent for Service of Process. Process Servers who attempt to serve legal documents at the Los Gatos campus should be directed to the Mountain View campus.

   b. Service of a Summons and Complaint or subpoena may be accepted only if it is addressed to an acceptable party listed on the document (usually

under Notice to Defendant or Notice to the person served). An acceptable party may be one or more of the following:

(1) El Camino Hospital, ~~Camino Healthcare,~~or El Camino ~~Hospital~~Healthcare District. ~~or El Camino Healthcare System (previous name of Camino Healthcare)~~

(2) Chief Executive Officer~~,~~ or Administrator~~, Administrative Management Personnel or Mr. Ken Graham~~.

(3) Board of Directors of El Camino Hospital~~,~~ or El Camino ~~Hospital~~Healthcare District ~~or Camino Healthcare~~.

c. A Summons and Complaint or subpoena may not be received by Administration if it is addressed to a physician, ~~Custodian of Record (Medical Records Department)~~ or an employee other than ~~oneself or Mr. Ken Graham~~Tomi Ryba the Hospital Chief Executive Officer. The process server would need to serve those parties directly. It is acceptable to give the office address of the physician ~~or the location of medical records~~. For legal documents regarding an~~d~~ El Camino Hospital employee, the process server should be referred to the Human Resources Department. For legal documents addressed to the Custodian of Medical Records, the process server should be referred to the Medical Records Department. Administration is not responsible for a Summons and Complaint or legal document received by mail for which the addressee is not acceptable. ~~If possible, these~~Such documents should be forwarded immediately ~~or returned to the sender~~to the General Counsel.

d. It is the responsibility of the process server to document the date, time of service, and name and title of the recipient. Therefore, the recipient does not sign for the receipt of a Summons and Complaint or legal document. However, the recipient may date stamp the document or sign for the receipt of an acceptable addressed document without incurring any disadvantage to himself/herself or the addressee of the document.

e. Once received in Administration at the Mountain View Campus, the legal document should be date-stamped and logged into the Legal Documents Received log maintained at the reception desk in Administration, ~~a copy made for Administration~~ noting how and when ~~it~~the document was served. For patient care claims, ~~T~~the original Summons and Complaint ~~al document~~ should be forwarded to Clinical Effectiveness, attention Manager Patient Safety and Risk Management~~Quality Management Coordinator~~, who will copy and forward to ~~contact the hospital's liability carrier~~ BETA~~eta~~ Healthcare Group. For employee claims, the original Summons and Complaint should be forwarded to H~~h~~uman Resources, attention Chief Human Resources Officer, who will copy and forward to BETA~~eta~~ Healthcare Group. All other Summons and Complaints,

subpoenas or legal documents should be forwarded to the General Counsel. When a document received by mail is accompanied by an Acknowledgment of Receipt form, this needs to be left unsigned and forwarded along with the original document to ~~Quality Management Coordinator~~the General Counsel. ~~Clinical Effectiveness will copy and forward original documents to Beta Healthcare.~~

f. A copy of the Summons and Complaint is to be filed in Clinical Effectiveness or Human Resources, as applicable, in the legal file for the appropriate case.

POLICY/PROCEDURE TITLE:Corporate Compliance:10.00 Receipt of Summons and Complaint and Legal Documents

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

11/97, 06/00, 05/01, 10/03, 03/05, 07/06, 06/09, 10/12

Confidentiality

POLICY/PROCEDURE TITLE: 2.00 Confidentiality

CATEGORY: Administrative
LAST APPROVAL DATE: 4/2013

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 5/95

COVERAGE:

- El Camino Hospital staff
- Allied health professionals
- Auxilians
- Contract services personnel
- Independent contractors
- Physicians
- Registry/temporary agency personnel
- Students, interns and instructors
- Vendors
- Volunteers

PURPOSE:

To ensure El Camino Hospital complies with all State and Federal laws governing confidentiality of patient information.

STATEMENT:

El Camino Hospital complies with all State and Federal laws governing confidentiality of patient information. Access to and communication of information is limited and based on the need to carry out business or work related assigned responsibilities. Access to the electronic health record (EHR) will be granted based on employee's roles and functions within the organization. Contract service personal and other not employed by the hospital will be granted access based on business need. Internal security has been added to the EHR to monitor all access. IT Security reports ~~and~~ will specifically track activity into records designated as restricted access or ~~request~~ ~~B~~break the glass access requests. Break the glass scenarios will be monitored and reviewed daily to validate appropriate access to protected health information (PHI).

Confidentiality is required of all persons covered by this policy when transmitting sensitive data outside El Camino Hospital.

POLICY/PROCEDURE TITLE:2.00 Confidentiality

The 1982 California Confidentiality of Medical Information Act (CMIA), The 1996 Federal Health Insurance Portability and Accountability Act (HIPAA), The 2009 California Senate Bill 541 and Assembly Bill 211, all provide that a patient whose medical information has been unlawfully used or disclosed may recover punitive damages plus attorneys' fees and court costs from the person who made the disclosure. All people covered under ~~this policy that make~~this policy that makes unauthorized access or disclosures may be subject to financial and criminal liability. In addition, a person who unlawfully discloses that a patient is being treated for a psychiatric disorder, alcohol or drug abuse may expose El Camino Hospital to substantial fines, as well as liability to the patient for civil damages under California's Lanterman-Petris-Short Act and/or Code 42 of Federal Regulations.

The Department of Health and Human Services (DHHS) published a series of regulations, the Health Insurance Portability and Accountability Act (HIPAA). ~~, beginning in August, 2000. Final privacy requirements became effective April 14, 2003. Detailed privacy policies are listed in Section F below. Final transactions and code set requirements for the use of standardized formats for electronic billing are effective October 16, 2003. Final Security requirements are effective in 2005.~~ El Camino Hospital staff are expected to comply with all finalized HIPAA regulations.

PROCEDURE:

A. **Hospital Staff Requirements**

1. All persons covered by this policy:

- Are prohibited from discussing, viewing, releasing or disclosing protected health information, employee information, proprietary information, financial information, and other sensitive information in any form, except when required in the performance of their job duties.

- Are prohibited from accessing patient information or an employee's own EHR unless necessary to perform their job. Retrieving, viewing, printing or copying information (computerized or paper) on other patients such as friends, relatives, neighbors, celebrities, co-workers, or themselves is a breach of confidentiality and may subject an employee to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

- Are prohibited from removing documents from the organization that contain personal identifiable or protected health information unless required in the performance of their job duties. Printing or copying patient

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information should be limited to the extent needed to provide necessary patient care or perform job duties and should be treated as confidential. If documents containing protected health information need to be transported outside of the organization or between campuses extreme care should be taken to keep the documents secure and with an employee or patient at all times. Documents should never be left in an unattended vehicle.

- Are prohibited from revealing or discussing with other patients, friends, relatives, or anyone else outside of the Hospital environment unless with individuals who have a medical and/or business related need to know.

- Are required to use reasonable safeguards to protect patient information and make all efforts to minimize incidental disclosures. For example, close curtains between beds and lower the volume of your voice. Conversations, including telephone calls, between healthcare providers, patients and families must be held in appropriate areas to protect patient privacy.

- Apply the minimum necessary standard when communicating protected health information other than when communicating such information to the patient (or the patient's representative), as authorized by the patient, or during the course of treatment.

- Are required to check with the patient before discussing patient's condition with family and allowing the patient an opportunity to object or limit the information disclosed to family members. In the event such consent cannot be obtained, e.g., a patient is unconscious when brought to the emergency room, the hospital staff member may use his or her professional judgment to infer whether the patient would object.

- Are required to immediately report any suspected confidentiality violations, which may include loss, misuse, unauthorized access, alterations or unauthorized modifications –to their manager and/or the Privacy Officer. The privacy Officer in accordance with SB541 will file notification with the California Department of Public Health (CDPH) within 15 days of notification in the event a violation has occurred.

- Are required to shield, de-identify or "blind" information that is shared with other organizations relative to patient specific or physician specific identifiers unless it is permissible to share such information under applicable privacy laws and regulations.

- Are required to appropriately dispose of patient information and reports in

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a manner that will prevent a breach of confidentiality. Patient identifiable information should never be discarded in the trash unless it has shredded or recycled.

- Are required to sign a Confidentiality Statement upon affiliation with the hospital and annually thereafter (see attached Confidentiality Statement).

- Are required to contact the respective department relative to the information subject as follows;

Information Release Request	Department
Employee information	Human Resources
News media request	Marketing & Community Relations
Protected health information	Health Information Management
All other requests	Administration
All after hours (after 5 p.m.) requests for information	Shift Supervisor

- Will be subject to discipline up to and including termination/ dismissal for violation of the policies concerning unauthorized access, use or disclosure of protected health information.

2. All persons covered by this policy who are assigned confidential computer codes:

- Must not disclose their confidential computer code to anyone including family, friends, fellow workers, supervisors unless directed by IT Security, ~~his or her Manager,~~ nor attempt to learn the code of any other person.

- Must not attempt to access information by using a confidential computer code other than the one assigned to them.

- Must not attempt to access unauthorized information by computer.

- Must not walk away from a workstation if logged in and will sign off after every use. Make sure the system screen or paper records are not left open or unattended in areas where unauthorized people may view it.

- Must immediately contact their manager if she/he has reason to believe that the confidentiality of her/his computer access code has been broken, so the subject code may be deleted and a new code assigned.

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- Will be subject to discipline up to and including termination of employment for the misuse or unauthorized sharing of confidential computer codes.

B. Electronic Medical Record Security:

1. **The following scenarios will trigger "Break the Glass" reviews and reports will be generated to monitor those accessing records:**
   - **Employee Health Records**
   - **Medical Records of an Employee**
   - **VIP patients and celebrities**
   - **"No Info" registered patients**
   - **Legal Lock Up of an EMR**
   - **Psych and Behavioral Health patients**
   - **Psych and Behavioral Health services for Senior Health Center or Silicon Valley Primary Care patients**

2. **The EMR will hide full Social Security Numbers from end users and will only display the last four (4) digits.**

3. **Patients will have the option of creating a privacy password with registration every time they present for an admission. The hospital will only verbally disclose patient information to those who know the privacy password. The EMR will use a patient FYI flag to indicate to an end user in the system when a privacy password has been created.**

4. **Patients who request anonymity will be registered as "no-info" and will be identified as confidential in the ERM. These patients will have their name hidden from the daily patient report and census list.**

~~1.~~5. **Safe surrender infants patients will have the mother's info hidden in the infants chart and will not be available for viewing in the EMR.**

6. **If a patient is a part of an open adaption the mother/child information will be linked in the EMR. If a patient/child is part of a closed adoption the mother/child linkage will be hidden in the EMR.**

C. ~~B.~~ Protected Health Information:

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1. Definition: Information that identifies an individual (or could reasonably be used to identify an individual) that:
   - Is created or received by El Camino Hospital;
   - is transmitted or maintained by electronic or other medium;
   - Relates to the past, present, or future physical or mental health or condition of an individual;
   - Relates to the provision of health care to an individual;
   - Relates to the past, present, or future payment for the provision of health care to an individual.

   This includes demographic information (such as name, address, date of birth, sex, and race) collected from an individual.

2. The patient has the right to expect that all communication and records pertaining to his/her care will be treated as confidential. and any permitted disclosures or exceptions will be disclosed in the Notice of Privacy Practice (NPP) form that each patient receives when initially registered for services.

3. The patient may request that no information be released to the public regarding his/her stay in the hospital. If this request is made, patient registration will designate the patient as "NO INFO" in the hospital registration system and the hospital clinical information system. Although information is designated as “no info” in the systems the hospital cannot block password access to view information in the clinical information systems. (The information desk receives a list of current patients and does not release to the public the identity of those patients who are "NO INFO").

4. Any patient information that persons covered by this policy may acquire, either directly or indirectly, is absolutely confidential and is not to be disclosed outside the scope of their official job duties. This means that under no circumstances should protected health information be discussed or released to any unauthorized individual within or outside of El Camino Hospital, including co-workers, family members, and/or personal acquaintances.

5. Confidentiality for Behavioral Health patients is protected by Lanterman-Petris-Short Act (California State Law CAHHS Consent Manual, Chp. 15) and Department of Behavioral Health policies.

6. Confidential patient records should be disposed of in accordance with the “Records Retention and Destruction Policy.”

C. Use or disclosure of protected health information:

1. Additional Administrative Policies and associated forms which address requirements of HIPAA may be found following this policy:

    - Accounting of Disclosures
    - Amendment of Protected Health Information
    - Complaints
    - Confidential Communications
    - Disclosures where the opportunity to object is NOT required
    - Disclosures where the opportunity to object IS required
    - Fundraising
    - Limited Data Sets
    - Marketing
    - Minimum Necessary
    - Mitigation
    - Notice of Privacy Practices
    - Obtaining Authorization
    - Patient Access
    - Record Retention and Destruction
    - Restrict use or Disclosure
    - Worker's Compensation

2. Refer to Health Information Management Services (HIMS) policies regarding release of patient information in the following circumstances:

    - Release of patient information when a record is sealed or under litigation.
    - Faxing patient information from the Medical Record.
    - Removal of medical records from the Hospital.
    - HIV - release of information.

3. Media Information

    - The Marketing and Community Relations Department has the responsibility and authority to determine what information is to be released to the media.

    - Statements about patients and any other El Camino Hospital related matter may be made only by authorized personnel in accordance with the Release of Information to the News Media policy (ref: Marketing and Community Relations).

- The taking of films, videotape and photographs within the organization facilities for private use or public release is strictly prohibited unless done with prior authorization by the Marketing and Community Relations Department.

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D. Confidential Computer Codes:

1. Persons covered by this policy may be assigned confidential computer codes based on the need to have information to carry out assigned responsibilities.

2. Access to electronic medical records will be audited periodically by the IS staff & HIMS staff or upon request by the Compliance Department.

3. Confidential computer codes will be deleted from the system upon termination of employment or assignment with El Camino Hospital.

E. Employee Information:

Employee personnel records are maintained in the Human Resources Department and employee health records are maintained in Employee Health Service. See Human Resources Policies and Procedures Employee Records.

F. Physician Information:

1. Physician profiles of practice patterns and resource consumption will be shared only with a coded scheme that disguises the actual identity of the physician.

2. The Director of Clinical Effectiveness shall have the responsibility to assure the development of sign-on security and/or terminal security so that PHI is accessible only to those who are required, by virtue of their job responsibilities, to collect and analyze this information.

3. The Medical Director of Quality Assurance and Utilization management shall have the final authorization on physician specific information and analysis of physician profiles.

4. Access to physician credential files is limited. See Medical Staff policies.

5. Access to physician performance and quality improvement information is restricted. See Medical Staff policies.

G. External Database Information:

Information that is shared with other organizations will be disguised as to patient specific or physician specific identifiers and ~~,~~ must be authorized by the Hospital before disclosing. ~~See the policy that follows on use of Limited Data Sets.~~

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	3/13
~~Medical Committee~~ Legal Review (if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	4/13

Historical Approvals:

OPS II: 3/13
Board of Directors: 04/13

Corporate Compliance Hotline

POLICY/PROCEDURE TITLE:Corporate Compliance:24.00 Corporate Compliance Hotline

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 3/99

COVERAGE:

All El Camino Hospital staff, Medical Staff, Contracted Service Personnel, Volunteers, Independent Contractors and Vendors

PURPOSE:

To provide a mechanism for any El Camino Hospital employee, physician or contract personnel or third party to report a concern regarding policies and procedures stated in the ~~Corporate Compliance Handbook and~~ Standards of Conduct or a potential unlawful or unethical situation.

STATEMENT:

El Camino Hospital has an outstanding reputation in the health care community. The successful operation of our hospital depends on the conduct of its employees, agents and officers. In order to promote and ensure a work environment that is based on high standards and is free from criminal and unethical conduct, the Hospital ~~ECH Board of Directors established the Corporate Compliance Program on April 8, 1998. The Office of the Inspector General's Compliance Program Guidance for Hospitals (February 1998)~~ encourages the use of hotlines (including anonymous hotlines), e-mails, written memoranda, newsletters, and other forms of information exchange to maintain these open lines of communication. El Camino Hospital's Corporate Compliance Hotline is established to provide a mechanism for individuals who know or suspect that there may be situations that represent concerns regarding our organization ~~Corporate Compliance Handbook and Standards of Conduct~~ to report anonymously without reprisal to the Director of Corporate Compliance. The hospital does not tolerate threats or acts of retaliation or retribution against employee for using the Compliance Hotline or other communication channels.

PROCEDURE:

POLICY/PROCEDURE TITLE:Corporate Compliance:24.00 Corporate Compliance Hotline

1. The Corporate Compliance Hotline telephone number: **(650) 988-7733** or on the Mountain View ~~campus~~Campus, Extension **7733 directly.**~~.~~

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2. The Hotline is answered by the Corporate Compliance Officer or designee during normal business hours (*Monday-Friday 8:00 a.m. to 5:00 p.m.*). Callers may leave voice mail after-hours and weekends.

3. The caller may report concerns by name or anonymously and without fear of retribution. Calls are not traced and will only be recorded when the caller leaves a message.

4. At the callers request for anonymity, a compliance identification number will be issued; with the first two numbers signifying the year i.e., "03" followed by the number of requests to date. All cases will be logged ~~in the confidential Corporate Compliance Hotline database on~~ by the Corporate Compliance ~~Director's personal computer~~Officer and will be kept confidential.

   (a.) All callers are informed that they may call back on an established date and time to receive an update on their concern. The nature of the concern determines the type of feedback the caller may receive when calling for updates.

   (b.) The caller's concern is triaged by the Corporate Compliance Officer and referred to the appropriate department for follow-up. It is imperative that the inquiry be handled in a confidential manner so as not to identify the person who raised the concern. The individual who raised the concern can perceive this as a form of retaliation.

5. Compliance Hotline call information, intermediate updates and final resolutions are all confidentially documented ~~entered in the confidential~~ and ~~Corporate Compliance data base maintained~~ maintained by the Corporate Compliance Officer. Information contained in the documents may be shared as privileged documents if deemed appropriate by legal counsel. ~~This database has the ability to search and sort information in numerous ways and is an invaluable tool when reporting quarterly Confidential Message Line activity to the ECH Board of Directors. *(Please note that it is not uncommon to see a Hawthorne effect on call activity when training is occurring. An industry benchmark used to determine the number of employees expected to call is approximately three to four percent of the organization's total employee population per year).*~~

6. The Corporate Compliance Officer monitors all concerns through to resolution, which includes any action taken to resolve the concern and in preventing its reoccurrence, i.e., policy changes, appropriate disciplinary actions, etc. Current concerns and their status are tracked ~~through the database~~and updated monthly. Status updates are requested periodically until a concern is resolved. ~~If a concern is under Attorney/Client privilege, our legal counsel maintains all final documentation.~~

7. Annual Healthstream ECH compliance training and new employee orientation and at-risk department classes will include informing the hospital's employees of the presence and use of the Corporate Compliance Hotline. The Hotline number is also communicated through various media tools, ~~i.e., cards, posters, Corporate Compliance Handbook and Standard~~i.e. Standard of Conduct and the Intercom.~~El Camino Journal.~~

~~8. The caller may report concerns by name or anonymously and without fear of retribution. Calls are not traced and will only be recorded when the caller leaves a message.~~

~~9. At the callers request for anonymity, a compliance identification number will be issued; with the first two numbers signifying the year i.e., "03" followed by the number of requests to date. All cases will be logged in the confidential Corporate Compliance Hotline database on the Corporate Compliance Director's personal computer.~~

~~(c.) All callers are informed that they may call back on an established date and time to receive an update on their concern. The nature of the concern determines the type of feedback the caller may receive when calling for updates.~~

~~(d.) The caller's concern is triaged by the Corporate Compliance Officer and referred to the appropriate department for follow up. It is imperative that the inquiry be handled in a confidential manner so as not to identify the person who raised the concern. The individual who raised the concern can perceive this as a form of retaliation.~~

~~10. Compliance Hotline call information, intermediate updates and final resolutions are all entered in the confidential Corporate Compliance data base maintained only by the Corporate Compliance Officer. This database has the ability to search and sort information in numerous ways and is an invaluable tool when reporting quarterly Confidential Message Line activity to the ECH Board of Directors. *(Please note that it is not uncommon to see a Hawthorne effect on call*~~

~~*activity when training is occurring. An industry benchmark used to determine the number of employees expected to call is approximately three to four percent of the organization's total employee population per year).*~~

~~11. The Corporate Compliance Officer monitors all concerns through to resolution, which includes any action taken to resolve the concern and in preventing its reoccurrence, i.e., policy changes, appropriate disciplinary actions, etc. Current concerns and their status are tracked through the database. Status updates are requested periodically until a concern is resolved. If a concern is under Attorney/Client privilege, our legal counsel maintains all final documentation.~~

~~12. Annual Healthstream ECH compliance training and new employee orientation and at-risk department classes will include informing the hospital's employees of the presence and use of the Corporate Compliance Hotline. The Hotline number is also communicated through various media tools, i.e., cards, posters, Corporate Compliance Handbook and Standard of Conduct and the El Camino Journal.~~

POLICY/PROCEDURE TITLE:Corporate Compliance:24.00 Corporate Compliance Hotline

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
~~Medical Committee~~Legal Review (if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

03/99, 05/01, 06/03, 03/05, 07/06, 06/09, 10/12

Code of Ethics

POLICY/PROCEDURE TITLE:Corporate Compliance:3.00 Code of Ethics

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative ~~Polices~~Policies and Procedures
ORIGINAL DATE: 5/98

COVERAGE:

All El Camino Hospital staff, Medical Staff, Volunteers, and Governing Board

PURPOSE:

To ensure that El Camino Hospital employees, Governing Board, Medical Staff and volunteers (ECH staff) have the responsibility to conduct patient care and all other business operations within ethical practice consistent with the Hospital mission, vision and strategic plan.

STATEMENT:

Ethical practices include but are not limited to all areas of patient rights; billing practices; admission, transfer, and discharge practices; employer practices; marketing; and conflict of interest avoidance in contractual relationships.

PROCEDURE:

Statement of Organizational Ethics:

The organization (ECH) adheres to the following principles:

- ECH treats all patients, employees, physicians, volunteers, and visitors with dignity, respect and courtesy.
- ~~———~~ECH represents ECH and ECH capabilities fairly and accurately.
- ECH provides services only to those patients to whom ECH can safely provide care.
- ECH adheres to a uniform standard of quality care throughout the Hospital regardless of the setting in which that care is provided.
- ~~———~~ECH provides quality care in a cost competitive manner.

- ECH provides quality services to meet the identified needs of ECH patients and constantly seeks to avoid the provision of those services unnecessary or non-efficacious.
- ECH consistently follows well-designed standards of care based upon the needs of the patient, and without regard to his or her ability to pay in all of the various settings in which the organization provides patient services.
- ECH does not discriminate in the admission, discharge or transfer of patients or the provision of accommodations based on sex, race, color, ancestry, religious creed, national origin or disability.
- ECH emergency services are available to all without regard to the ability to pay.
- These principles apply to the relationship of ECH and its staff members to other health care providers, educational institutions and payers.

E. **Patient Care**:

1. Principles that guide ethical relationships between ECH staff and patients (and their significant others) include:
    - Patients and patient's families (or significant others) are involved in decisions regarding care delivery to the extent that such is practical and possible.
    - ECH staff will make every effort to understand and respect the objective of care for each patient.
2. Confidentiality: Patient information will not be shared in an unauthorized manner and will be maintained in the strictest confidence and utilized only by those individuals authorized to review and act upon such information. See Administrative Policies and Procedures, 2.00 Confidentiality.
3. Patient Relations: El Camino Hospital requires that patients are treated with courtesy and respect. Accordingly, employees are required to:
    - Not address patients by their first names unless specifically requested to do so by the patient.
    - Ensure that any association with patients is governed by the highest standards of professional care and conduct.
    - Realize that the patient may be worried or in pain.

- Assist patients in a comforting and responsive manner within the scope of the El Camino Hospital staff responsibilities.
- Refer all patient questions to their supervisor, unless absolutely sure of the answer.

4. ~~4.~~ Related supporting policies and procedures should be referred to as needed:

- Abuse - Child/Elder/Dependent
- Admission Criteria
- Advance Directives
- Admission of Patients
- Affiliated Providers
- Anatomical Gift
- Bioethics Committee
- Communication Assistance
- Complaint Management
- Confidentiality
- Conflict of Interest
- Consent - Informed
- Consent - Investigative Drugs and Devices
- Coroner's Case
- CPR and No CPR
- Discharge Criteria
- Identification of Patients
- Illicit Drug Use - Patients
- Informed Decision-Making
- Unusual Occurrences
- Patient Privacy
- Restraint/Seclusion
- Patient Rights
- Transfer-Discharge
- Utilization Review/ Credentialing
- Withholding of Resuscitation

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F. Organizational Conduct:

1. Professional Codes and Responsibilities: ECH respects the professional ethical

codes and responsibilities of its staff members.

2. Employer Responsibilities: ECH supports and engages in fair and equitably administered employee policies and practices.

3. Compensation and Benefits: ECH hires and, retains qualified individuals. Compensation programs are reviewed annually to ensure that established salary ranges reflect competitive rates in the local labor market. Benefits are provided to eligible employees and are designed to enhance the individual's well-being and provide opportunities for personal and professional development.

4. Proprietary Information~~Confidentiality~~: Proprietary information is generally confidential information that is developed by the Hospital as part of it business and operations and should not be disclosed except as authorized by the Hospital. Such information includes but is not limited to, the business, financial, marketing, and Hospital services or products, Employee, Governing Board, Medical Staff and volunteer information will not be shared in an unauthorized manner. Sensitive information concerning personnel and management issues will also be maintained in the strictest confidence and utilized only by those individuals authorized to review and act upon such information. See Administrative Policies and Procedures 2.00 Confidentiality.

5. Billing Practices: The following policies establish and implement mechanisms, which ensure that patients are billed only for those services and care provided to the patient:

    - All initial patient billing is itemized and includes dates of service.
    - Patients or third parties will only be invoiced for services actually provided to patients.
    - When a patient or payer has a question about a charge, that inquiry is reviewed expeditiously and related conflict or complaints are handled through mechanisms as outlined in Complaint Management policy.
    - General credit/collection procedures are conducted according to Public Law Fair Debt Collection Practices Act and the following billing policies:
        - Credit and Collection Policy
        - Time Pay Accounts
        - Self-Pay Collection
        - Billing Third Party Payers
        - Medicare Secondary Payer

6. Protection of the Integrity of Clinical Decisions: ECH shall protect the integrity of clinical decisions. All providers of care shall order tests, treatments and other interventions based on the needs of patients regardless of the compensation that the Hospital receives or how it might share financial risk with management and licensed independent practitioners.

   The criteria basis for admission to the hospital is the Inter Quel criteria, a scientifically designed system of utilization management which:

   - Identifies appropriate and inappropriate hospital utilization.
   - Applies to all patients regardless of payer source.
   - Allows concurrent monitoring of criteria for consideration of alternatives and post hospital care.
   - Contains generic criteria not dependent on diagnosis or service line.
   - Allows for physician override according to special patient needs/conditions.
   - Captures data in a manner that allows system analysis of problems and potential solutions.

7. Marketing and Community Relations Practices:

   - Marketing practices are conducted by the Marketing and Community Relations Department with accuracy, fairness and responsibility to patients, community, and the larger public, holding to the principals of the fundamental value, honesty and dignity of the individual, and the freedoms of speech, assembly, and the press.
   - In the spirit of communication, understanding, and cooperation among individuals, groups, and institutions, the Marketing and Community Relations Department adheres to the articles of the Code of Professional Standards for the practice of public relations as adopted by the Governing Assembly of the Public Relations Society of America, the AMA Code of Ethics as adopted by the American Marketing Association, and the Standards of Practice of the American Association of Advertising Agencies.
   - Marketing materials reflect only those services available, the level of

licensure and accreditation, and comply with applicable laws and regulations of truth in advertising and non-discrimination under Title VI and Title XVI of the Public Health Service Act and 45. C.F.R. implementing section 504 of the Rehabilitation Act of 1973.

8. Foundation: The El Camino Hospital Foundation follows the nine standards recommended as common measures of governance by the National Charities Information Bureau. The standards are on file in the El Camino Hospital Foundation Policy and Procedures Manual. The Foundation also uses the Donor Bill of Rights as developed by the American Association of Fund Raising Counsel (AAFRC), the Association for Healthcare Philanthropy, the Council for Advancement and Support of Education (CASE), and the National Society of Fund Raising Executives (NSFRE).

9. Conflict of Interest: The Hospital recognizes that the potential for conflict of interest exists for decision-makers at all levels within the organization. This includes members of the Governing Board, administration, the medical staff, volunteers and all other employees. It is ECH policy to request the disclosure of potential conflicts of interest so that appropriate action may be taken to ensure that such conflict does not inappropriately influence important decisions. Board members, administration, and medical staff may be requested to submit an annual disclosure form, on a case-by-case basis, to disclose potential conflicts related to decisions that arise during the course of a year. See Administrative Policies and Procedures 4.00 Conflict of Interest.

   The Governing Board, as well as senior management and the medical staff, will review all potential conflicts (when appropriate) and take appropriate action. In the event a potential conflict of interest has a direct implication for patient care, the institution may convene an ethics committee to assist in the resolution of this issue. See Administrative Policies and Procedures 4.00 Conflict of Interest.

10. Resolution of Conflicts: Conflict will arise among those who participate in hospital and patient care decisions. Whether the conflict is between patient caregivers and the ~~patient,~~patient or between medical staff and employees ECH will seek to resolve the conflict fairly through the Medical Ethics Committee. In cases where mutual satisfaction cannot be achieved, Care Coordination ~~staff are~~staff is available to assist in resolution and to provide expert consultation from the Medical Ethics Committee if requested.

11. Medical Ethics Committee:

The committee is multi-disciplinary with representatives from Medical Staff and Patient Care Services. It may also include members of other professions or the public. Duties of the committee as follows:

- Provide ~~counsel~~consults to physicians, staff, administration and patient/family in the understanding, delineations and clarification of medical ethical dilemmas.
- Provide regular educational activities on medical ethical dilemmas to the institution.
- Assist in the development of ethical guidelines where appropriate.
- Submit reports of regular activities to the Medical Staff Executive Committee.

12. Patient Care Conferences: Patient care conferences are facilitated by Social Services staff, the nurse caring for the patient or the Care Coordinator and include the multi-disciplinary team (which includes the physician), the family and when possible the patient.

13. ~~Emergency Consultation: If emergency consultation is required between 5:00 p.m. and 8:00 a.m., or on Saturday or Sunday, the Administrative Coordinator is available to assist in making arrangements.~~

~~14.~~ Spiritual Support: Spiritual support is offered by a full-time chaplain and ~~v~~volunteers of all faiths.

1~~4~~5. Use of Investigational Drug/Device and Research (to address Medical Record Review for research): Use of investigational drugs/devices for research (i.e., drugs or devices not yet approved for marketing by the Federal Food and Drug Administration) must first be approved by the Institutional Review Board (IRB). However, physicians needing to use an investigational drug/device for emergency therapeutic purposes in a life-threatening situation -- in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval-- may do so according IRB procedures.

~~16.~~ 15. Institutional Review Board: The principal responsibility of the Institutional Review Board (IRB~~),~~) is to protect the rights, safety, and welfare of the individual by making an initial ~~judgement~~judgment that proposed research is acceptable, after reviewing the risks and benefits to the individual, the knowledge to be gained, and the adequacy of informed consent. It is also the responsibility

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of the IRB to ensure than an investigation is conducted in a manner consistent with applicable law and standards of professional practice.

16~~7~~. Anatomical/Organ Donation: In accordance with Assembly Bill 531, in order to provide tissues and organs for transplantation -- to honor the wishes of the deceased, and to cooperate with the wishes of the legal next of kin of the deceased -- all deaths in the hospital of patients under the age of 70 will be considered for possible anatomical donation, with the exception of patients who have an active generalized sepsis or a transmittable disease at the time of death. This documentation is placed on the Release of Remains form. The treating physician and/or RN (after consultation with the treating physician), in collaboration with the California Transplant Donor Network (CTDN) will inform the family of the option to donate organs and tissues

G. **Reporting ~~Other Policy Listings~~**

1. ~~The following related policies and procedures provide further guidance for ethical conduct and practice at El Camino Hospital. These policies and procedures are located in the following manuals:~~

~~Administrative, Patient Care, and other Policies and Procedures Manuals~~

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- ~~Billing Practices~~
- ~~Confidentiality~~
- ~~Conflict of Interest~~
- ~~Consultants~~
- ~~Donations~~
- ~~Hot Line~~
- ~~Illicit Drug Use – Visitors~~
- ~~Reportables~~
- ~~Software License Restriction~~
- ~~Subcontractors~~
- ~~Substance Abuse Policy~~
- ~~Subpoenas – Patient and other~~

~~Hospital Records~~

- ~~Unallowable Cost~~
- ~~Vendors~~

~~Human Resources Policies and Procedures Manual~~

- ~~Employee Assistance Program~~
- ~~Equal Employment Opportunity~~
- ~~Fitness for Duty~~
- ~~Investigation and Searches~~
- ~~Sexual Harassment~~
- ~~Solicitation~~
- ~~Substance Abuse Policy~~
- ~~Subpoenas – Employee Records~~
- ~~Time Card Coding / Authorization~~

~~2. Adherence to policy is a significant indicator of an individual's judgement and competence and will be taken into consideration when evaluating performance and future assignments. Disregard of these policies will be grounds for disciplinary action, up to and including termination.~~

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~~3.~~ Each employee, medical staff member or volunteer is required to report to their supervisor, administrator, Human Resources Department or the ECH "Hot Line" at extension 7777 (or call 650-988-7777 from outside the Hospital telephone system), conduct that involves El Camino Hospital which may be illegal or which appears unethical or improper

POLICY/PROCEDURE TITLE:Corporate Compliance:3.00 Code of Ethics

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
~~Medical Committee~~Legal Review (if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

5/98, 11/00, 05/01, 01/04, 3/05, 07/06, 06/09, 10/12

Government Investigations

POLICY/PROCEDURE TITLE:Corporate Compliance:25.00 Government Investigations

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 9/99

COVERAGE:

All El Camino Hospital staff, Governing Board, Medical Staff and Contract Personnel

PURPOSE:

The purpose of this policy is to establish a mechanism for the orderly response to government investigations to enable El Camino Hospital to protect its interests as well as appropriately cooperate with the investigation.

STATEMENT:

El Camino Hospital will cooperate with any authorized government investigation or audit; however, El Camino Hospital will assert all protections afforded it by law in any such investigation or audit. Government investigators may arrive unannounced at any ~~the~~ El Camino Hospital campus~~, Evergreen and Rose Garden Dialysis sites~~, ~~,~~ or the homes of present or former employees and seek interviews and documentation. They may or may not have a Federal Search Warrant or subpoena.

PROCEDURE:

Request for Interview

1. When government investigators request an interview, there is no obligation to consent to an interview although anyone may volunteer to do so. One may require the interview be conducted during normal business hours and for legal counsel to be present at El Camino Hospital or another location.
2. The staff member should always be polite and should obtain the following information from the investigator or officer:
   (a) The name, agency affiliation, business telephone number and address of all investigators;
   (b) The investigator's business card; and
   (c) The reason for the visit.

3. When the investigator arrives, ask if there is a subpoena or warrant to be served and request a copy of the subpoena or warrant.

4. The interview may be stopped at any time, with a request that the investigator return when counsel can be present. Its corporate counsel will represent El Camino Hospital. Employees have the right to their own individual legal counsel at their own expense or request the hospital's legal counsel. Legal counsel should be present for all interviews.

4. If an employee chooses not to respond to the investigator's questions, the investigator has the authority to subpoena the employee to appear before a grand jury. El Camino Hospital will assist the employee in preparing their response by providing legal counsel. Legal counsel will be provided if potential conflicts of interest may exist between hospital departments.

5. Any staff member contacted by an investigator should immediately notify his or her supervisor and provide them with as much information and documentation about the investigation that is known. As soon as possible, the request should be reported to the Corporate Compliance Officer at (650) 988-7032~~733~~.

The Search

1. Request that the investigator on El Camino Hospital premises wait until the Chief Executive Officer, Corporate Compliance Officer, General Counsel or Administrator-On-Call arrives (each referred to as the employee-in-charge"), before starting the search.

2. El Camino Hospital employees must not alter, remove, or destroy permanent documents or records of the hospital. All records are subject to Federal and State of California recognized retention guidelines which are stated in the El Camino Hospital Health Information Management Services Policies and Procedures, 1.14 Record Retention Rules and Regulations, paragraph D.1. The policy states that Medicare/Medi-Cal patient accounts and charge slips are retained for 5 years, while the Non-Medicare/Medi-Cal accounts are retained for 4 years." The records may be disposed of only in accordance with these guidelines. Once there has been notice of an investigation, the destruction portion of any policy on record retention is suspended.

3. If the investigators present a search warrant or subpoena, the investigators have the authority to enter private premises, search for evidence of criminal activity, and seize those documents listed in the warrant. No staff member has to speak to the investigators, but must provide the documents requested in the warrant.

4. El Camino Hospital staff may request a copy of the search warrant and the affidavit providing reason for the issuance of the warrant.

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5. All staff members should request an opportunity to consult with El Camino Hospital's Administration and legal counsel before the search commences.

6. The employee-in-charge will provide legal counsel with a copy of the warrant immediately. Please call Administration at 7300/7301 to obtain home and phone numbers of legal counsel. If counsel can be reached by telephone, counsel shall be connected directly to the lead investigator.

7. Cooperate with the investigators, but state that you do not consent to the search.
    a. The employee-in-charge should instruct the lead investigator that:
        (1) El Camino Hospital objects to the search;
        (2) The search is unjustified because El Camino Hospital is willing to voluntarily cooperate with the government; and
        (3) The search will violate the rights of El Camino Hospital and its employees.
    b. Under no circumstances should staff obstruct or interfere with the search. Although they should cooperate, any staff member should clearly state that this does not constitute "consent to the search."
    c. Whenever possible, keep track of all documents and all information the documents contain that are given to the investigators.
8. If the hospital counsel is not available, the employee-in-charge should contact the U.S. Attorney, Northern District of California at (415) 436-7200 immediately and request that the search be stopped. One can negotiate alternatives to the search and seizure, including provisions to ensure that all existing evidence will be preserved undisturbed. If the U.S. Attorney refuses to stop the search, request agreement to delay the search to enable our hospital to obtain a hearing on the warrant.

9. The employee-in-charge should attempt to negotiate an acceptable methodology with the investigators to minimize disruption and allow El Camino Hospital employees to keep track of the process. Considerations include the sequence of the search; whether investigators are willing to accept copies in place of originals; and if so, who will make the copies and arrangements for access to records seized.

10. The employee-in-charge should point out limitations on the premises to be searched and on the property to be seized.
    a. Only provide what is specified in the search warrant.
    b. Never consent to an expansion of the search.

c. Disputes regarding the scope must be brought to the attention of the U.S. Attorney, Northern District of California, or the court to be settled. El Camino Hospital's staff should not prevent the investigators from searching areas they claim to have the right to search.

d. Investigators generally have the right to seize evidence of crimes that is in their plain view during a search, regardless of whether such evidence is described in the warrant.

11. The employee-in-charge should take appropriate steps to protect other El Camino Hospital staff members.

a. El Camino Hospital should send all, except essential department personnel, home or temporarily reassign them to other areas when a warrant is served.

b. Selected employees should remain along with the employee-in-charge and/or El Camino Hospital legal counsel to monitor the search.

c. Investigators should never be left alone on El Camino Hospital's premises. There should be at least two employees with the investigators at all times.

12. Object to any search of privileged documents.

a. If there is any possibility that the search will compromise privileged information, El Camino Hospital's legal counsel should object on that basis, and raise the issue with the court, if necessary.

b. Privileged information is defined as any and all knowledge of value to the institution, which cannot be divulged, except by court order.

13. The employee-in-charge should keep a record regarding the search.

a. Ask each investigator for proper identification, including their business cards.

b. List the names and positions of all the investigators with the date and time. Verify the list with the lead agent and request he or she sign it.

c. Monitor and record the manner in which the search is conducted. Note, in detail, the precise areas and files searched, the time periods when each of them was searched, the manner in which the search was conducted, the agents who participated, and which files were seized.

d. Several hospital employees will probably be needed to monitor the different areas being searched simultaneously.

e. If the monitor is ordered to leave, contact the lead investigator. A person should only be ordered to move if they are in the way, not to avoid being observed. Never provoke a confrontation with an agent.

14. If possible, do not release a document to the investigators, unless hospital legal counsel has reviewed it. However, this may not be possible under a search warrant or subpoena.

15. Keep all privileged and confidential documents separated and labeled accordingly.

16. If possible, the employee-in-charge should make a record and a copy of all records seized.

    a. If this is not possible, before the agents leave El Camino Hospital premises, request an inventory of the documents seized.

    b. Request the lead agent to note the date and time the search was completed, as well as ~~sign~~signs the inventory of seized documents with the agent's full title, address, and telephone number.

    c. Copies of the seized documents should be requested as well, especially medical records, as these records are required for patient care and this is the most efficient way to inventory the documents seized.

    d. Create a duplicate inventory of the documents seized.

    e. ~~-~~Download copies of files from hard drives and copy to diskettes, especially if ~~the material~~the material is essential to the ongoing operations of El Camino Hospital.

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POLICY/PROCEDURE TITLE:Corporate Compliance:25.00 Government Investigations

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
~~Medical Committee~~Legal Review (if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

09/99, 05/01, 03/05, 07/06, 06/09, 10/12

Internal Investigations

POLICY/PROCEDURE TITLE:Corporate Compliance:26.00 Internal Investigation

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 9/99

COVERAGE:

All El Camino Hospital staff, Medical Staff and Contract Personnel

PURPOSE:

It is El Camino Hospital's intention to establish a culture that promotes prevention, detection and resolution of instances of conduct that does not conform to federal and state law, and federal, state and private payor health care program requirements, as well as the hospital's ethical and business policies. Once an allegation of impropriety is received by the Corporate Compliance Hotline or other forms of communication, it will be written into the compliance log. ~~If it is a potentially significant allegation, then it will be reported to the Chief Executive Officer (CEO) or the Compliance Oversight Committee. The directing authority (the CEO or Compliance Oversight Committee) will direct t~~The Corporate Compliance Officer (CCO) will~~to~~ conduct an investigation to obtain sufficient evidence to determine if an allegation can be substantiated.

STATEMENT:

El Camino Hospital's Corporate Compliance Officer will report substantiated findings of internal investigations to Hospital's Chief Executive ~~Officer~~ Officer and the Hospital Board Corporate Compliance Committee. ~~after consultation with the Hospital Board of Directors will direct the Corporate Compliance Officer to conduct an internal investigation into allegations of federal and state statute violations relating to Corporate Compliance issues.~~

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PROCEDURE:

Procedure:

Duties of Investigator

1. Conduct investigations per guidance from directing authority.
2. Make or obtain conscious decisions on disposition of all allegations.

(a.) Investigator will not discard an allegation solely because it is anonymous, appears frivolous, unimportant, or not relevant to matters under investigation.
(b.) If the allegation is subsequently withdrawn by a Complainant, it will still be investigated.

3. Obtain evidence sufficient to determine that an allegation is either substantiated or not substantiated. The standard for reaching this conclusion is that the preponderance of evidence, as viewed by a reasonable person, supports it. Preponderance is defined as "superiority of weight." In the rare instance where an allegation can be neither substantiated nor refuted, will be stated.

4. Include in the report of investigation (ROI) a complete, objective and impartial presentation of all pertinent evidence gathered during the investigation.

~~(a.)~~ Never recommend adverse action against an individual. ~~Corporate Compliance investigators are fact finders.~~

(a.)
(b.) The ROI presents the facts to the directing authority. Although it will not contain recommendations for adverse actions against an individual, administrative action to correct a mistake (for example improper coding or billing) may be made part of the investigator's recommendation.

5. Report systemic/procedural problems discovered during an investigation to the appropriate authority and follow-up to ensure corrective action is taken.

6. In all investigative activities, the investigator will be sensitive to actual and potential concerns that employees have about keeping both the fact and extent of their involvement confidential.

Conduct of Investigations

1. Investigations will be limited to matters approved by the directing authority.

2. In most investigations, evidence will be developed through documents and interviews of witnesses. The investigator will always seek the best available

evidence. The best evidence is from individuals with direct knowledge. Evidence of a lesser quality, such as memoranda of conversations, handwritten notes, second-hand information (hearsay) is also acceptable.

3. To protect confidentiality of investigations and the rights, privacy, and reputations of all people involved in them, investigators, during notifications and interviews, will ask people with whom they are talking not to reveal matters under investigation or to discuss them with anyone, except their own lawyer if they consult one, without permission of the investigator.

Discussion of Rights

1. El Camino Hospital employees who are witnesses or subjects will be encouraged to answer questions properly related to an investigation, unless answering the question(s) will incriminate them. However, if an investigator suspects or reasonably suspects that an employee being questioned has committed a criminal offense, the investigator should terminate the interview and advise the employee of their constitutional rights.

2. A witness is a person who saw, heard or knows something relevant to the issues being investigated and who is not a subject or suspect. A subject is a person against whom non-criminal allegation(s) have been made. A suspect is a person against whom criminal allegations are made. A person may also become a suspect as a result of incriminating information that arises during an investigation or interview, or whenever the questioner believes, or reasonably should believe, the person has committed a criminal offense.

3. Some El Camino Hospital employees are represented by labor organizations and have the right to union representation at any investigative examination. If the employee reasonably believes that the examination may result in disciplinary action against the employee, representation may be requested by the employee. In addition, the local union contract may provide for union representation even when the employee does not request it.

4. Although subjects and suspects are the most likely sources of such requests, witnesses may also make them. If a witness is otherwise entitled to representation, the investigator should allow a union representative to be present.

5. The union representative may comment, speak or make statements; he/she may not, however, usurp or disrupt the meeting. In determining whether a given representative is being disruptive or usurping the interview, the investigator should apply a standard of "reasonableness". The union

representative's presence is in addition to any right the employee may have to a lawyer.

6. If the employee requests and is entitled to union representation, the investigator must take every reasonable step to ensure that the union has the opportunity to represent the employee at an investigative interview. Such steps should include granting extensions and if necessary, notifying the union that the employee is having difficulty obtaining a representative. Only when these steps have been taken, may the investigator proceed with the interview.

Reports of Investigation

1. The investigator will prepare a written report with findings and recommendations (Report of Investigation) for each investigation.

2. The Report of Investigation (ROI) will be submitted to the Directing Authority for review. He/she may then request that it be forwarded to El Camino Hospital legal counsel for review.

3. Once reviewed, the Directing Authority may approve or disapprove the ROI in its entirety, or approve it in part.

4. The ROI or any portion of it that requires action will be forwarded with recommendation to the appropriate department executive for implementation or correction.

5. If the ROI discovered criminal conduct or behavior, notification will be forwarded to the appropriate authorities. Human Resources will be apprised of the situation regarding possible suspension/termination action.

POLICY/PROCEDURE TITLE:: Corporate Compliance:26.00 Internal Investigation

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
~~Medical Committee~~ Legal Review (if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

09/99, 05/01, 06/03, 03/05, 07/06, 06/09, 10/12

xiii. Gifts and Business Courtesies From Vendors or Provided to Non Referral Sources

POLICY/PROCEDURE ~~TITLE:Corporate Compliance:36.00 Business Courtesies to Non-Referral Sources~~TITLE: Corporate Compliance 36.00 Gifts or Entertainment From or Provided To Vendors or Non- Referral Sources

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 03/05

COVERAGE:

All El Camino Hospital staff, Governing Board and Business Associates

PURPOSE:

To establish rules related ~~to~~to employees receiving or giving gifts or business courtesies from vendors or providers~~business courtesies involving~~ to staff or El Camino Hospital representatives or hospital providing gifts to individuals ~~and~~or vendor companies which are not potential referral sources.

STATEMENT:

Covered individuals may receive business courtesies from a current or potential vendor or business associate, ~~in~~excluding potential referral sources, provided the total value of such business courtesies does not exceed a combined value of $360 per calendar year and $100 per occurrence. Courtesies related to vendor-sponsored promotional education and training can be accepted free of charge when the organizational value outweighs the personal value of the event. It is critical to avoid the appearance of impropriety when giving or receiving gifts to individuals who do business or are seeking to do business with El Camino Hospital. Moreover, receiving and providing gifts or other incentives should never be used to influence relationships or business outcomes. Also, business courtesies with respect to any particular individual must be infrequent, which, as a general rule, means not more than four times per year. Business courtesies exceeding these amounts will require approval from the individual's immediate manager, division VP, and the Corporate Compliance Officer

DEFINITIONS:

Business courtesies include gifts and entertainment. They include items of value given to another free of cost, as well as social events sponsored or hosted by the hospital such as sporting events, theatrical events and receptions.

POLICY/PROCEDURE ~~TITLE:Corporate Compliance:36.00 Business Courtesies to Non-Referral Sources~~TITLE: Corporate Compliance 36.00 Gifts or Business Courtesies Received From or Given To Vendors or Non- Referral Sources

A *potential non-referral source* are all individuals or entities except: a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, a chiropractor, or medical groups containing these sources.

PROCEDURE:

1. **Receiving** gifts or business courtesies from non-referral sources

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a. Employees may accept business courtesy invitations from current or potential vendors or business associates provided: (1) the cost associated with such an event is reasonable and appropriate, which, as a general rule, means the cost will not exceed $100.00 per person; (2) no expense is incurred for any travel costs (other than in a vehicle owned privately or by the host entity) or overnight lodging; and (3) such events are infrequent, which, as a general rule, means not more than four times per year.
b. The limitations of this section do not apply to business meetings at which food (including meals) may be provided.
c. Employees may accept gifts with a total combined value of $360.00 or less in any one year. For purposes of this paragraph, physicians practicing at the hospital are considered to have such a referral relationship with the hospital and gifts or business courtesies should not be accepted or given.
d. Vendor-promotional training, including travel and lodging, may be accepted free of charge or at reduced rates when the business value to our organization outweighs any recreational or entertainment value of the event, provided that the appropriate approvals are obtained in advance per education and training policies and procedures.
e. Perishable or consumable gifts given to a department or group are not subject to any specific limitation.
f. Employees may accept store-specific gift certificates, but may never accept cash or financial instruments (e.g., checks, stocks).
g. Employees are prohibited from soliciting a gift.
h. This policy does not limit the hospital from accepting gifts, provided they are used and accounted for appropriately.
i. Business courtesies exceeding these amounts or that do not fall under the guidelines of this procedure will require approval from the individual's immediate manager, division VP, and the Corporate Compliance Officer.

2. **Providing** gifts or business courtesies to non-referral sources

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a. The purpose of the business courtesy must never be to induce any favorable business action. During these events, topics of a business nature must be discussed and the host must be present.
b. These events must not include expenses paid for any travel costs (other than in a vehicle owned privately or by the host entity) or overnight lodging.
c. The cost associated with such an event must be reasonable and appropriate. As a general rule, this means the cost will not exceed $100.00 per person. Moreover, such business courtesies with respect to any particular individual must be infrequent.
d. Courtesies may be given, to include gift certificates, to individuals who have made substantial, non-compensated time commitments to the hospital. Employees must obtain the approval of his/her supervisor and the Corporate Compliance Officer before giving a gift in excess of $100 to an individual in recognition of his/her ~~volunteer~~volunteer efforts on behalf of the hospital.
e. Business necessity and appropriateness of the proposed event must be established. The organization will under no circumstances sanction participation in any business courtesy that might be considered lavish. Departures from the $100.00 guideline are highly discouraged.
f. Any ECH sponsored event involving non-referral sources with a legitimate business purpose (e.g., hospital board meetings or retreats) may include reasonable and appropriate meals and entertainment. In addition, transportation and lodging can be paid for.
g. Gifts to business associates who are not government employees must not exceed $100.00 per year per recipient.
h. Any gifts to Medicare or Medi-Cal beneficiaries must not exceed $10.00 per item nor total more than $50.00 per year per recipient. Transportation may exceed these thresholds provided that the transportation is not considered to be luxurious, specialized, and the arrangement is not tied in any manner to the volume or value of referrals or lucrative treatments.
i. Employees are prohibited from providing gifts, entertainment, meals, or anything else of value to any employee of the Executive Branch of the Federal government, except for minor refreshments in connection with business discussions or promotional items with the El Camino Hospital logo valued at no more than $10.00.
j. Perishable or consumable gifts are not subject to any specific limitation.
k. An employee may give gift certificates, but may never give cash or financial instruments (e.g., checks, stocks).
l. Business courtesies exceeding these amounts or that do not fall under the guidelines of this procedure must obtain approval from the individual's immediate manager, division VP, and the Corporate Compliance Officer.

POLICY/PROCEDURE ~~**TITLE:Corporate Compliance:36.00 Business Courtesies to Non-Referral Sources**~~**TITLE: Corporate Compliance 36.00 Gifts or Business Courtesies Received From or Given To Vendors or Non- Referral Sources**

POLICY/PROCEDURE ~~TITLE:Corporate Compliance:36.00 Business Courtesies to Non-Referral Sources~~TITLE: Corporate Compliance 36.00 Gifts or Business Courtesies Received From or Given To Vendors or Non- Referral Sources

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
~~_____Medical Committee~~ Legal Review(if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

03/05, 07/06, 06/09, 10/12

REFERENCES:

Federal Register/ Vol 69, No. 100, Section F-3, page 32026: Draft OIG Supplemental Hospital Compliance Guidance Identifying Significant Compliance Risk Areas: June 8, 2004; Fair Political Practices Commission: Gifts and Honoraria (http://www.fppc.ca.gov/index.html)

xiv. Gifts and Business Courtesies to Physicians

POLICY/PROCEDURE ~~TITLE:Corporate Compliance:37.00 Business Courtesies to Potential Referral Sources~~TITLE: Corporate Compliance 37.00 Gifts or Business Courtesies to Physicians or Other Potential Referral Sources

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 03/05

COVERAGE:

All El Camino Hospital staff

PURPOSE:

To establish parameters for the extension of gifts or business courtesies to Physicians or other potential referral sources and their immediate family members.

STATEMENT:

A hospital employee, governing board member, business associate, medical staff member, or volunteer representing or acting on behalf of the hospital may not extend business courtesies to a Physician or other potential referral source and his or her immediate family members. Likewise, business courtesies are not to be extended to a potential referral source who solicits it. Exceptions may apply relating to incidental expenses, medical staff members acting in administrative roles, and certain non-monetary gifts. Any potential courtesy exceptions must be approved by the Corporate Compliance Officer.

DEFINITIONS:

Business courtesies include gifts and entertainment. They include items of value given to another free of cost, as well as social events sponsored or hosted by the hospital such as meals, sporting events, theatrical events and receptions. Examples in the Procedure Section of this Policy further elaborate on what is and is not included in this definition.

An *immediate family member* includes: husband or wife; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

POLICY/PROCEDURE TITLE:: Corporate Compliance:37.00 Business Courtesies to Potential Referral Sources

A *potential referral source* includes: a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.

PROCEDURE:

1. Business courtesies may not be extended to a Physician or other potential referral source and his or her immediate family members.

2. Gifts may only be given to potential referral sources in recognition of volunteer efforts on behalf of the hospital under the following conditions:

   a. The potential referral source must agree that he or she may receive tokens of gratitude and expense reimbursement in exchange for his or her volunteer leadership service and only after the individual has provided services pursuant to such agreement.

   ~~a.~~

   b. The value of gifts given to a potential referral source in recognition of his or her volunteer efforts may not exceed the fair market value of the volunteer efforts rendered by the potential referral source.

3. Exceptions may apply related to incidental benefits, gifts, and other courtesies extended to the general medical staff or selected medical staff operating under an administrative role, and certain non-monetary gifts. Additional exceptions may also apply based on situational circumstances that do not infer any inducement of patient referrals to El Camino Hospital.

4. **All** potential gifts or business courtesies to Physicians or other potential referral sources must be approved by the Corporate Compliance Officer prior to extension of the courtesy.

5. Acceptance of gifts and other business courtesies from potential referral sources must be approved by the Corporate Compliance Officer prior to acceptance.

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POLICY/PROCEDURE TITLE:: Corporate Compliance:37.00 Business Courtesies to Potential Referral Sources

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
~~Medical Committee~~Legal Review (if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

03/05, 07/06, 06/09, 10/12

REFERENCES:

Section 1877(a) of the Social Security Act; Phase I 66-FR863-875; §411.353 and §411.351

42CFR Parts 411 and 424: Medicare Program; Physicians' Referrals to Healthcare Entities with Which They Have Financial Relationships (Phase II); Interim Final Rule

Gifts from Patients and Families

POLICY/PROCEDURE TITLE:Corporate Compliance:40.00 Gifts from Patients and Families

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 1/06

COVERAGE:

All El Camino Hospital staff, Governing Board, Business Associates and Medical Staff

PURPOSE:

To eliminate any appearance of a~~n~~ patient's, or family's ~~or friend~~ obligation to provide ~~for~~ compensation to a~~n~~ hospital employee, physician, or El Camino Hospital representative for care given. ~~because of, or for the purpose of, direct compensation to an employee or ECH representative by a patient, family or friend of patient.~~

STATEMENT:

A hospital employee, governing board member, business associate, medical staff member, or volunteer representing or acting on behalf of the hospital may not receive individual gifts of monetary value, or redeemable gift certificates, from a patient~~s, or friends or~~ or family of a patient~~s~~, or anyone giving a gift in appreciation for the care given a patient at El Camino Hospital.

An exception may be made for items of a symbolic nature traditionally received as an expression of thanks. This would include cards, flowers, candies, coffee, and the like. Such gifts would in general be accepted on behalf of all ECH personnel and be shared accordingly.

PROCEDURE:

1. If patients, family members, or other patient representatives wish to give a gift directly to an employee, other than that allowed above, they are to be acknowledged for their appreciation and thanked. They are to be informed that gifts to individual employees cannot be accepted due to hospital policy.

2. If the patients/family, etc. is insistent about providing such a gift, they are to be directed to the department manager or hospital supervisor for further information.

3. Patients/family members can be informed that donations to the hospital foundation are of course welcome, and can be specified for a department or program. Donors may also provide a donation to the foundation in the name of an employee or other individual should they choose.

4. Should an employee or other ECH representative be in doubt regarding any aspect of this policy, he/she should discuss with the corporate compliance officer or with his/her manager.

POLICY/PROCEDURE TITLE:Corporate Compliance:40.00 Gifts from Patients and Families

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
~~Medical~~Legal Review ~~Committee~~ (if applicable): October 2015	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

01/06, 12/06, 06/09, 10/12

xvi. Direct Patient Care Services Contractual Agreements

POLICY/PROCEDURE TITLE:Corporate Compliance: 57.00 Direct Patient Care Services Contractual Agreements

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Department Policies and Procedures
ORIGINAL DATE: 11/09

COVERAGE:

This policy applies to all El Camino Hospital~~/Los Gatos~~ departments utilizing outside agencies/contractors for the provision of care, treatment, and services for the hospitalized patients.

PURPOSE:

Establish appropriate standards or safe administration and monitoring of outside agencies/contractor that provide direct patient care.

STATEMENT:

Contract service companies and independent contractors may be ~~employed~~retained to perform direct patient care services that are not performed by existing staff.

Care, treatment, and services provided through contractual agreement are to be provided safely and effectively.

Performance of contracted services reflects basic principles of risk reduction, safety, staff competence, and performance improvement.

PROCEDURE:

1. Written contracts will include the nature and scope of services.
   See Attachment A – "Direct Patient Care Provided by Contract Services"

2. The identified need for contracted services must be approved by the Chief ~~of Clinical Operations~~Nursing Officer. The C~~C~~NO will take the prepared contracts to Medical Executive Committee for ~~approval and~~ annual quality review.

3. All agreements must be presented to Legal ~~the Manager of Legal and Contracting~~

Services for review before they are signed. Review may take up to ~~one~~two ~~week~~weeks for turn-around.

4. The performance of the contracted services will be measured by successful completion of their initial competency an~~d~~ annual quality of care review.

5. Contracted Services will be evaluated through any of the following:

   a. through direct observation,
   b. medical record audits of documentation,
   c. review of QRR's,
   d. review of performance reports based on indicators required in the contractual agreement,
   e. input from staff and patients,
   f. review of information about the contractor's Joint Commission accreditation or certification status,
   g. collection of data that address the efficacy of the contracted service,
   h. review of patient satisfaction studies and
   i. Review of results of risk management activities.

6. When the hospital contracts with another accredited organization for patient care, treatment, and services ~~to be provided off site,~~ the following will be addressed:

   a. Verification that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining a copy of the list of privileges.

   b. Contracted organization(s) will ensure in writing that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.

   c. Clinical leaders and Medical Staff will provide advice about the sources of clinical services via contractual agreements

7. The providers of the contracted services will be given performance expectations in writing.

8. In the event that contracted services do not meet expectations, efforts will be made to work with the contractor to make improvements. Sometimes, renegotiation or termination of the contract may need to occur. This will be done without interruption to the care, treatment, and services rendered.

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9. Reference and contract laboratory services will meet the federal regulations for clinical laboratories and maintain the evidence of the same.

10. Contracted employee files will be kept either:
    - by their agencies and upon request will be able to provide their files, or
    - in the specific Ancillary Department utilizing contractors.

APPROVAL	APPROVAL DATES
Regulatory Compliance Committee:	10/12
~~Medical Committee~~Legal Review (if applicable): October 2014	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	11/12
Board of Directors:	12/12

Historical Approvals:

Regulatory Compliance:	11/09, 10/12
Legal & Contracting:	01/10, 10/12
Executive Council:	01/10, 11/12
Board of Directors:	02/10, 12/12

POLICY/PROCEDURE TITLE:Corporate Compliance: 57.00 Direct Patient Care Services Contractual Agreements

~~ATTACHMENT A~~

~~Direct Patient Care Provided by Contract Services Report to Medical Executive Committee~~

~~Department~~	~~Scope of Service~~	~~Vendor Name~~	~~Authorizing Manager~~	~~Medical Staff Committee Oversight~~
~~Surgery~~	~~Cell Saver Procedures~~	~~William Barber~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Department of Surgery Executive Committee~~
~~Pediatrics~~	~~Infant Hearing Screening~~	~~Pediatrix Medical Group~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Department of Pediatric Executive Committee~~
~~Pediatrics~~	~~Physical Therapy Services – Pediatric & NICU~~	~~DRG (expires 2010)~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Department of Pediatric Executive~~
~~Medicine~~	~~PICC Insertion~~	~~P&A PICC, LLC~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Department of Medicine Executive Committee~~
~~Surgery~~	~~Perfusion Services~~	~~Pacific Life Lines (expires~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Cardiovascular Surgery~~
~~Behavioral Health Services~~	~~Neuropsychological Evaluations~~	~~Institute on Aging~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Behavioral Health Executive Committee~~
~~Renal Dialysis (Los Gatos)~~	~~Renal Dialysis~~	~~Fresenius Medical Care~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Department of Medicine Executive Committee~~
~~Medicine (Los Gatos)~~	~~Electroencephalogram~~	~~Mitra Meister Cynthia Henderson~~	~~Diana Russell, Chief Clinical Operations/CNO~~	~~Department of Medicine Executive Committee~~
~~Radiology~~	~~Telemedicine Remote radiology~~	~~Nighthawks~~	~~Diana Russell, Chief Clinical~~	~~Department of Imaging Services~~

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	~~medical imaging~~		~~Operations/CNO~~	

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xvii. Use of Social Network Mediums by Employees

POLICY/PROCEDURE TITLE:Corporate Compliance:59.00 Social Network Mediums

CATEGORY: Administrative
LAST APPROVAL DATE: 12/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 4/10

COVERAGE:

All El Camino Hospital staff

PURPOSE:

This policy is to establish recommended best practices for communicating Hospital information through social network mediums.

STATEMENT:

El Camino Hospital (Hospital) is ethically and legally required to ensure organizational compliance with laws that protect patient, personnel, and other confidential information not only in its physical possession, but also in the rapidly evolving environment of social network mediums. The Hospital encourages open communication in all forms; it also relies on the competencies of its employees, and other individuals covered under this policy, in meeting the community's expectations to communicate and conduct business with the highest level of trust, integrity, and professionalism.

The Hospital recognizes the vast opportunities in innovation and collaboration presented through social network mediums. For example, social network mediums can be used to promote Hospital services; survey customer feedback on satisfaction with Hospital services; enhance medical provider skills through training; educate the community about health issues; inform and seek assistance from emergency service organizations and the public in crisis situations, etc. Furthermore, social network mediums can enable the Hospital to convey timely information accurately, and without reliance on outside entities to publish crucial updates.

The Hospital also recognizes that, while comments made through social network mediums may not be intended to defy or damage the reputation of the Hospital or its constituents, the effect of such comments may nonetheless be adverse. For example, social network mediums can be used to express dissatisfaction about the Hospital; criticize types of patients being treated by the

Hospital; violate patient privacy; offend individuals through the use of inappropriate language, etc. Furthermore, social network mediums can have a reverse effect on the commenter by damaging his or her professional or personal reputation. The purpose of these guidelines is to help participants understand how hospital policies apply to these newer technologies for communication, so that they can participate with confidence.

Requests for assistance with reviewing the issues below may be forwarded to the Hospital's community relations department

DEFINITIONS:

Social network mediums are internet-based communities used by people to share information. These communities appear on publicly accessible networking websites, and make take the form of discussion blogs, message boards, podcasts, newsgroups, chat rooms, wikis, e-mail, and any other content sharing forum (e.g., Twitter, Facebook, MySpace, YouTube, etc.). Information can be shared via computer or portable electronic devices, such as cell phones, smart phones, pagers, digital cameras, and other wireless recording devices (e.g. personal digital assistants).

PROCEDURE:

1. **Recommended Best Practices:**

    - Separate professional relationships from personal relationships in your social network mediums.

    - Present your professional profile and information in a manner that is consistent with how you wish to present yourself to colleagues and the community.

    - Be personally responsible for statements, images, or other content that you post on social network mediums or portable electronic devices, and speak for yourself, not the hospital. Write in the first person ("I", not "We" or "The hospital.") Where your connection to El Camino Hospital is apparent, make it clear that you are speaking for yourself and not on behalf of the hospital. A standard disclaimer we encourage you to use is, "The postings on this site are my own and don't represent El Camino Hospital's positions, strategies or opinions."

- If you mention El Camino Hospital or El Camino Hospital-related matters, disclose your connection with the hospital and your role here. Use good judgment and strive for accuracy in your communications; errors and omissions reflect poorly on the hospital, and may result in liability for you or the hospital.

- Use a personal email address (*not* your elcaminohospital.org address) as your primary means of identification. Just as you would not use El Camino Hospital stationery for a letter to the editor with your personal views, do not use your El Camino Hospital e-mail address for personal views.

- Abide by the Hospital's Confidentiality policy (ADM 2.00) and Confidentiality statement (ADM 2.01) whether on or off duty or Hospital premises.
- Always protect Hospital patient, personnel, and other confidential information. Note this obligation applies in the event your relationship ceases with the Hospital and is, therefore, perpetual. Remember that disclosing protected health information in an inappropriate manner (e.g., on a social media site) is a federal offense. Even if an individual is not identified by name within the information you wish to use or disclose, if there is a reasonable basis to believe that the person could still be identified from that information, then its use or disclosure could constitute a violation of the Health Insurance Portability and Accountability Act (HIPAA). Never disclose patients' names, addresses or other private information, even indirectly (for example, by provider name, date of birth, or diagnosis); do not acknowledge that any person is a patient at the hospital. Do not post pictures of patients. In short, never disclose any information about the care of any specific patient anywhere except for at work, and even then, you must have a specific, justifiable purpose for disclosing that information.

- Be respectful and professional to fellow employees, business partners, competitors and patients. Do not use profanity or abusive, harassing, hateful, sexually explicit or libelous speech, or any other content determined to be unlawful or unacceptable by the Hospital; avoid using unprofessional, misleading or anonymous online personas.

- Social networking activities are allowable only on non-work time unless your position includes providing content or oversight to official hospital social media sites.

- Report immediately to Hospital management or the Corporate Compliance Hotline (650-988-7733) if you suspect or become aware of the inappropriate receipt, sharing, and/or dissemination of Hospital patient, personnel, or other confidential information; or if you are sought for advice regarding a complaint or other Hospital matter.

- It is acceptable and even encouraged that you post short excerpts--typically, a paragraph at most--from and links to hospital news releases and other online material produced by the hospital on your website, blog or social media page. Do not repost entire news releases. (This guideline also applies to material from others' websites too.) Furthermore, do not post news about the hospital that you may have learned about through other channels until it has been posted to the El Camino Hospital website. Only those who have been officially designated by El Camino Hospital have the authorization to speak on behalf of the hospital.

- Do not cite clients, partners, or suppliers without their approval and the approval of the Community Relations department. When you do have approval to cite these sources, link back to the source of the information.

- If you see inaccurate information being posted in the media about El Camino Hospital, do not attempt to rebut the information; instead, alert the Community Relations department.

2. Other Considerations:

As discussed above, there are various legitimate situations in which Hospital-designated representatives may post Hospital-related information in social network mediums. Certain ethical and legal issues may need to be considered, such as patient consent for interviews, photographs, and videos; patient safety and quality concerns; copyright, trademark, and intellectual property rights; the discoverability of information for legal proceedings, etc.

You must abide by copyright laws by ensuring that you have express, written permission (though electronic correspondence is acceptable) to use or reproduce any copyrighted text, photos, graphics, video or other material owned by others.

- The establishment of official sites representing the hospital or any hospital organization must be approved by and coordinated through the Community Relations department. The hospital's social media team provides oversight and assistance to guide development of new social media platforms, sharing knowledge and instituting best practices for successful implementation.

- The use of external Web sites for work-related purposes (for example, photo sharing through Flickr.com) must be first approved by Community Relations.

- Hospital executives and managers should not use publicly accessible websites or social media sites to communicate official hospital policies and procedures to employees.

- Obtain pre-approval from the Community Relations department before setting up an El Camino Hospital-branded site or social media page. All El Camino-branded websites or social media sites will be monitored by the Community Relations department. Do not use El Camino Hospital logos or images unless approved by the Community Relations department.

3. Code of Ethics for Approved Hospital Representatives

As El Camino Hospital employees, contract services personnel, physicians and other health care providers, students/instructors, vendors, volunteers and other contributors engage in online conversations, the following code of ethics applies, both on hospital-sponsored sites and in comments on other sites:

- El Camino Hospital blog posts and comments will be accurate and factual.
- El Camino Hospital will acknowledge and correct mistakes promptly.
- When corrections are made, El Camino Hospital will preserve the original post, showing by strikethrough what corrections have been made, to maintain integrity.
- El Camino Hospital will delete spam and/or comments that are off-topic.
- El Camino Hospital will reply to emails and comments when appropriate.
- El Camino Hospital will link directly to online references and original source materials.
- El Camino Hospital staff will disclose conflicts of interest and will not attempt to conceal their identity or that they work for El Camino Hospital.

4. Enforcement:

Individuals covered under this policy are responsible for becoming familiar with and asking questions about this policy and the related policies listed below in Section F.

Any report of the inappropriate receipt, sharing, and/or dissemination of Hospital patient, personnel or other confidential information and/or violations of other related policies listed below will be reviewed and, if necessary, disciplinary action up to and including termination may be applied in accordance with the Hospital's Discipline and Discharge policy (HR 7.00).

Related Documents:

- Confidentiality Policy (ADM 2.00)
- Confidentiality Statement (ADM 2.01)
- Discipline and Discharge Policy (HR 7.00)
- Internet Policy (ADM 20.00)
- Responsible Use of Technology Resources and Information Policy (ADM 28.00)
- Responsible Use of Portable Technology Resources and Information Policy (ADM 47.00)

POLICY/PROCEDURE TITLE:Corporate Compliance:59.00 Social Network Mediums

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	10/12
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	10/12
Board of Directors:	12/12

Historical Approvals:

Corporate Compliance Committee:	02/10, 10/12
Executive Committee:	02/10, 10/12
Management Staff:	03/10, 11/12
Board of Directors:	04/10, 12/12

Participation Guidelines for the Public

We encourage your participation in El Camino Hospital's social media sites, and we hope you will join the discussions. Please adhere to the following guidelines when you do.

- Do not post confidential medical information, either your own or any other person's. Because social media sites are open to the public, any information you post to them could be seen by anyone. Your privacy is important to us.
- Do not provide medical advice to other online participants.
- We cannot and will not provide medical advice through these forums. Your doctor is the most qualified person to provide you with personalized medical advice. If you need a doctor, please use our Find a Doctor tool.
- Show respect to others. Discussions often reveal differences of opinion, but differences can and should be discussed civilly. Do not use profanity, abusive language, hate speech, or make personal attacks on other participants.
- Stay on topic. If you want to discuss a different topic, please post it on your own page or "wall."
- Do not use El Camino's page or "wall" to promote your product or service.

To ensure that discussions and comments adhere to these guidelines, we review all comments before they go live. If any comments violate these guidelines, they will not be posted.

For more specific rules about participation on our social media sites, consult our detailed **social media policy [below]**.

[Expanded/Legal Social Media Policy]

By accessing, viewing or posting any comments, posts or other material on El Camino Hospital websites, blogs, or social media sites, you agree to all of the terms in this document. If you do not agree to the terms of this Policy, you may not view or post any content to any El Camino Hospital websites, blogs, or social media sites. Your use of these properties is acceptance of this policy and has the same effect as if you had actually physically signed an agreement.

You expressly acknowledge that you assume all responsibility related to the security, privacy, and confidentiality risks inherent in sending any content over the Internet. By its very nature, a website and the Internet cannot be absolutely protected against intentional or malicious intrusion attempts. El Camino Hospital does not control the third-party website, the network or the Internet Service Provider over which you may choose to send information. El Camino Hospital makes no

warranty of any kind, express or implied, including but not limited to site availability, accuracy of information or any safeguard against third party interception of, or compromises to your information. Furthermore, El Camino Hospital does not endorse any product, service, views or content displayed on social media sites.

You agree that any claim or dispute relating to your posting of any content on a social media site shall be construed in accordance with the laws of the State of California without regard to its conflict of laws provisions and you agree to be bound and shall be subject to the exclusive jurisdiction of the local, state or federal courts located in Santa Clara County, California.

You may not provide any content to a social media site that contains any product or service endorsements or any content that may be construed as political lobbying, solicitations or contributions or use our social media sites to link to any sites or political candidates or parties or use the Social Media Site to discuss political campaigns, issues or for taking a position on any legislation or law.

You give El Camino Hospital the irrevocable right to reproduce, distribute, publish, display, edit, modify, create derivative works from, and otherwise use your submission for any purpose in any form and on any media.

You also agree that you will not:

- Post material that infringes on the rights of any third party, including intellectual property, privacy or publicity rights.
- Post material that is unlawful, obscene, defamatory, threatening, harassing, abusive, slanderous, hateful, or embarrassing to any other person or entity as determined by El Camino Hospital in its sole discretion.
- Post advertisements or solicitations of business.
- Impersonate another person.
- Allow any other person or entity to use your identification for posting or viewing comments.
- To send "spam" (i.e., post the same note more than once, post something that is disruptive, or make an unsolicited commercial post)

El Camino Hospital reserves the right (but is not obligated) to do any or all of the following:

- Prevent or remove communications that are abusive, illegal or disruptive, or that otherwise fail to conform to these Terms and Conditions.

- Terminate a user's access to the El Camino Hospital website or social media sites upon any breach of these Terms and Conditions.
- Edit or delete any communications posted to the El Camino Hospital website or social media sites, regardless of whether such communications violate these standards.

You agree that you will indemnify El Camino Hospital against any damages, losses, liabilities, judgments, costs or expenses (including reasonable attorneys' fees and costs) arising out of a claim by a third party relating to any material you have posted.

This policy may be updated at any time without notice, and each time a user accesses a social networking site, the new policy will govern usage, effective upon posting of the policy. By continuing to post any content after such new terms are posted, you accept and agree to any and all such modifications to this policy.

Confidentiality Form

POLICY/PROCEDURE TITLE:Corporate Compliance:2.01Confidentiality Forms

CATEGORY: Administrative
LAST APPROVAL DATE:

CONFIDENTIALITY STATEMENT (2.01)

As an El Camino Hospital employee, volunteer, student, intern, instructor, person employed through a registry/temporary agency or under contract services, or vendor or other observer, you have a legal and ethical responsibility to protect the privacy of patients and the confidentiality of their health information. All information that you see or hear regarding patients, directly or indirectly, is completely confidential and must not be discussed, viewed or released in any form, except when required in the performance of your duties.

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A patient whose medical information has been unlawfully used or released may recover actual damages as well as punitive damages, plus attorney fees and court costs. Unauthorized disclosure of medical information is also criminally punishable as a misdemeanor. The mere acknowledgement that a patient is being treated, for psychiatric disorders, drug abuse, or alcohol abuse, may expose the hospital and the person making the unauthorized disclosure to substantial fines and liability.

If you are assigned a computer code that allows access to patient information, the code gives you access to confidential information that should only be used in caring for patients. Access codes are assigned based on the need to have information in order to carry out assigned responsibilities as determined by your manager.

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All system passwords use a unique identification code that serves as a signature when entering the particular system. It is your responsibility to keep your passwords strictly confidential. Under no circumstances may you give your passwords to someone else.

If you have access to employee information, El Camino Hospital financial information or any other proprietary information, you are expected to treat the confidentiality of such information in the same manner as patient information.

Additionally, protection of confidentiality is required when transmitting sensitive data outside El Camino Hospital.

Refer requests for medical records to:	Health Information Management	650-940-7066
Refer media requests for information to:	Marketing and Community Relations	650-988-7767

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Confidentiality of Patient Information

1. I understand that access to patient information may be required for me to do my job, and that I am only permitted to access patient information to the extent necessary for me to provide patient care and perform my duties. Therefore, I will treat all patient, physician, employee and hospital business information (e.g., medical, social, financial, and emotional) acquired during the course of my work as strictly confidential.

2. I understand that "confidential" means that patient information must not be revealed or discussed with other patients, friends, relatives, or anyone else outside of the El Camino Hospital health care environment. In other words, a patient's personal and medical information can only be discussed in private with appropriate individuals who have a medical and/or business related need to know, whether on duty or off.

3. I will not view, release, or disclose patient information or access my own information, unless my job requires it, and then will disclose only minimum necessary patient information needed to carry out my responsibilities for El Camino Hospital. I will not disclose identifying information (e.g. name, date of birth, etc.) if the information can be removed and is not essential to the analysis. If I am not sure whether the information should be released, I will refer the request to the appropriate department (e.g. Health Information Management) or appropriate individual (e.g. Chief Privacy Officer or Compliance Officer).

4. I will appropriately dispose of patient information and reports in a manner that will prevent a breach of confidentiality. I will never discard confidential or patient identifiable information in the trash, unless it has been shredded or recycled.

5. I understand that I have a duty to protect El Camino Hospital patient information from loss, misuse, unauthorized access, alteration or unauthorized modification, and as soon as I become aware I have a duty to immediately disclose to El Camino Hospital any breach of patient confidentiality.

~~6.~~ I will access patient information or my own information only when needed in order to do my job, and understand that retrieving/viewing/printing or copying information (computerized or paper), on other patients such as friends, relatives, neighbors, celebrities, co-workers, or myself is a breach of confidentiality and may subject me

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to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

6.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Confidentiality of Business Information

1. I understand that information regarding the business and operations of El Camino Hospital is confidential, and that such information is owned by and belongs to El Camino Hospital.

2. I understand that I am only authorized to access business information if it is required for me to perform my duties. This information must not be revealed or discussed with others within or outside of El Camino Hospital except to the extent that this discussion is necessary to perform my duties.

3. I understand that I have a duty to protect El Camino Hospital business information from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to immediately disclose to El Camino Hospital any breach of business information confidentiality.

4. I understand that failure to follow this agreement may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Information System Security

1. I understand that El Camino Hospital's information systems are company property and are to be used only in accordance with the hospital's policies. I also understand that I may be given access codes or passwords to El Camino Hospital information systems, and that I may use my access security codes or passwords only to perform my duties.

2. I acknowledge that I am strictly prohibited from disclosing my security codes or passwords to anyone, including my family, friends, fellow workers, supervisors, and subordinates for any reason. I will keep my security codes and passwords in confidence and will not disclose them to anyone (other than the System Security Administrator) for any reason.

3. I agree that I will not breach the security of the information systems by using someone else's security codes or passwords, nor will I attempt in any way to gain access to any unauthorized system. Also, I will not allow anyone else to access the information systems using my security codes or passwords.

4. If I leave my workstation for any reason, I will initiate security measures in accordance with hospital procedures so no unauthorized person may access patient or business information, or enter information under my security codes or passwords; I will make sure the system screen or paper record is not left open and unattended in areas where unauthorized people may view it.

5. I will not misuse or attempt to alter information systems in any way. I understand that inappropriate use of any information system is strictly prohibited. "Inappropriate use" includes:
   - (a.) personal use which inhibits or interferes with the productivity of employees or others associated with El Camino Hospital, or which is intended for personal gain;
   - (b.) transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission and values of El Camino Hospital;
   - (c.) disclosure of confidential information to any individual, inside or outside the organization, who does not have a legitimate business-related need to know; and
   - (d.) the unauthorized reproduction of information system software.

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6. Only El Camino Hospital approved and officially licensed software may be added to El Camino Hospital systems.

7. I understand that I will be held accountable for all work performed or changes made to the systems or databases under my security codes, and that I am responsible for the accuracy of the information I put into the systems.

8. If my employment or association with El Camino Hospital ends, I will not access any El Camino Hospital information systems that I had access to and acknowledge that legal action may result if I do.

9. I understand that El Camino Hospital reserves the right to audit, investigate, monitor, access review and disclose information obtained through the organization's information systems at any time, with or without advance notice to me and with or without my knowledge.

10. I understand that I have a duty to protect El Camino Hospital information systems from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to immediately disclose to El Camino Hospital any breach of information system security (for example, if the confidentiality of my or another's password has been broken) or any inappropriate use of information systems.

11. I understand that a violation of computer security or any component of this agreement is considered a violation of hospital policies, and may subject me to immediate termination of employment or association with El Camino Hospital, as well as civil sanctions and/or criminal penalties.

I will ask my supervisor for clarification if there are any items I do not understand before signing this agreement. My signature below acknowledges that I have read and understand this agreement and realize it is a condition of my employment/association with El Camino Hospital. I also acknowledge that I have received a copy of this signed agreement.

Signature:_____ Date:_____

Print Name:_____

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Conflict of Interest

POLICY/PROCEDURE TITLE:Corporate Compliance:4.00 Conflict of Interest

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 5/98

COVERAGE:

This policy applies to El Camino Hospital ("ECH") employees, members of the Board of Directors, consultants, contractors who operate outsourced departments, ECH volunteers, Medical Executive Committee members, physicians who are chairs of ECH committees (but not Medical Staff committees), physicians who are Medical Directors of ECH, and physicians who receive payments from ECH. Members of ECH's Medical Staff are also subject to the conflict of interest provisions found in the El Camino Hospital Medical Staff Bylaws.

PURPOSE:

The purpose of this policy is to encourage disclosure of situations where a person subject to this policy may have an interest in a transaction which is or could be deemed to be a conflict of interest so that the situation may be appropriately reviewed and resolved.

STATEMENT:

It is the policy of El Camino Hospital to comply with all mandatory reporting requirements regarding conflict of interest. This policy requires the disclosure of interests that may be or lead to a conflict of interest. Such disclosure is not a conclusion that a conflict of interest exists or that the interest would prevent a person from participating in a decision or activity. This policy is intended to protect the interests of ECH, by identifying situations where an ECH decision-maker may have an interest so that such an interest may be fully understood and addressed before ECH enters into a transaction or other arrangement. This policy also addresses the circumstances where an interest is not identified or addressed prior to completion of the transaction. This policy states and implements, but does not expand, the requirements of state or federal laws governing conflicts of interest applicable ECH as a nonprofit, public benefit tax-exempt corporation.

PROCEDURE:

A. Overview:

This Policy and Procedure has three critical elements:

Annual Disclosure Statement (Section F). Certain individuals must file an annual disclosure statement, the purpose of which is to permit the identification of any interest so that a conflict of interest, should it arise, may be promptly and appropriately resolved. The annual disclosure statement can help avoid a situation where an interest becomes a conflict of interest by, for example, deciding not to invite a person with a large ownership interest in an equipment vendor to serve on a committee deciding which equipment to purchase.

Specific Disclosure (Section G). The purpose of specific disclosure is to ensure that disclosures of interests are made in the context of particular transactions. Should a specific conflict develop, or if the issue relates to a person not covered by the annual disclosure statement filing requirement, then a disclosure must be made. Individuals must report the potentially conflicting interest regarding a particular transaction over which the individual has influence or decision-making authority.

Resolution Process (Section H). If an actual or a potential conflict of interest arises in the context of a particular transaction, this policy contains, in Section H, provisions (which vary depending on the nature of the disclosing individual's role) to determine whether a situation involves a conflict of interest and describes methods to resolve that conflict of interest.

In general terms, all matters with respect to this policy shall be addressed by ECH forthrightly but persons involved in reviewing and investigating such matters shall treat such matters in the same manner and with the same discretion as in handling other matters involving personnel information of employees or others. Such discretion, however, shall not limit the ability to obtain information or to raise and address issues. All information relating to such matters may be disclosed to members of management with an interest in the matter, the Compliance Committee, members of the Board, and the Board.

B. Interests:

An interest exists in any situation in which the actions of a person subject to this policy (or his/her immediate family) undertaken on behalf of ECH may result in a personal gain or advantage to the member or any concomitant disadvantage to ECH. Although it is impossible to list every circumstance giving rise to an interest, the following are

examples of the kinds of activities or interests that might give rise to such a conflict and that must be reported as outlined in this policy.

1. Business Affiliations:

To serve as a director, officer, partner, employee, consultant, agent or advisor of any person, firm, or organization which is a supplier of goods or services to ECH, or conducts research at ECH.

2. Governmental Affiliations:

To hold any elected or appointed office or position in any branch of government or in any regulatory agency having authority or jurisdiction over providers of health care, generally.

3. Other Hospital Affiliations:

To serve as a volunteer or paid director, officer, partner, employee, consultant, agent, or advisor of any hospital, or health care facility not affiliated with ECH, located in Santa Clara County.

4. Outside Interests:

a) To have, directly or indirectly, an ownership or other financial interest (including a service agreement) with a value greater than $2,000 in any outside concern which the person knows or has reason to believe makes payments to or receives payments from ECH (whether on account of goods, loans or other transactions), or which provides services in competition with ECH.
b) To compete, directly or indirectly, with ECH in the purchase or sale of property or any property right, interest or service.

5. Outside Activities:

a) To render directorial, managerial or consultative services to, or to engage in any financial transaction with, any person or concern which does business with or competes with ECH.

b) To render other services in competition with ECH.

6. Gifts, Gratuities, and Entertainment:

To accept a gift, gratuity, entertainment, or other material benefit as described in ECH Administrative policy 36.00 from any person or concern that does, or is seeking to do, business with, or is a competitor of, ECH under circumstances from

which it might be inferred that such a gift, gratuity, entertainment or other material benefit was intended to influence or possibly would influence the recipient in the performance of his/her duties.

7. Use of Confidential Information for Personal Gain:

To disclose or use, for personal profit or advantage, information relating to ECH's business, including but not limited to methods of operation, and research and product development.

C. Disclosure Requirements:

1. Annual Disclosure Statement. The individuals holding the following positions must complete and file an annual disclosure statement with the Corporate Compliance Officer. The Corporate Compliance Officer shall be responsible for the process of distributing such forms on a regular basis (the Corporate Compliance Officer may determine to stagger the distribution over a period of twelve consecutive months), and to ensure the return of completed forms. The Corporate Compliance Officer will review each form and address any conflicts noted in the annual disclosure statement as described in Section H of this policy.

   Annual disclosure statements must be filed by each individual who holds any of the following offices:

   Member of the Board of Directors of ECH.

   Member of the Medical Executive Committee of ECH.

   A physician who is paid compensation of any kind by ECH.

   Member of the management of ECH which, for this purpose, shall include: the Chief Executive Officer; Chief Financial Officer; Chief Medical Informatics Officer; Chief Information Officer; each person holding the title of Vice President; the President of El Camino Hospital Foundation; each director of ECH; and each manager of ECH.

   ECH employees who are members of the purchasing staff, the finance division staff, the business development division staff, any billing employee who is not part of the finance division staff, any registration staff who is not part of the finance division staff, each employee engaged in business planning and analysis and each marketing employee who is not part of the business development division.

Members of Board and management committees who are not members of the Board.

Any other individual subject to this policy selected by the Corporate Compliance Officer, in consultation with the Chief Executive Officer.

Updating Annual Disclosure Statement. A person required to file an annual disclosure statement shall file an updated form if a material change occurs during the year. A material change would, for example, involve a change in the employer of a member of a committee concerned with the acquisition of medical devices from employment by a medical group to employment by a medical device manufacturer. Making the specific disclosure described in Section G rather than updating the annual disclosure statement is an acceptable alternative.

Review. The Corporate Compliance Officer shall review all Annual Disclosure Statements and shall regularly report to the Compliance Oversight Committee regarding such disclosures. The Corporate Compliance Officer may consult with other personnel of ECH with respect to such disclosures in order to propose changes needed to prevent conflicts and shall make all appropriate disclosures to inform persons to whom such individual reports or who need to know such information in order to properly manage any potential conflicts of interest. Moreover, information regarding physicians will be disclosed and discussed with the Medical Staff leadership as appropriate.

D. Specific Disclosure:

Any person who has a material role with respect to a decision by ECH to enter into or refuse to enter into a transaction with a third party and who also has a direct or indirect interest in the transaction shall disclose the facts and circumstances to the responsible ECH employee involved in the transaction holding the position of a manager or above. If the person making the disclosure is a member of the Board of Directors of ECH, such disclosure shall be made to the Chairperson of the Board. If the person making the disclosure is the Chairperson of the Board, such disclosure shall be made to the Vice Chairperson of the Board. Such disclosure shall be in addition to disclosure previously or concurrently made on any annual statement.

A person seeking to make a disclosure may also disclose to the Corporate Compliance Officer of ECH.

All persons are encouraged to disclose situations where they are uncertain whether a potential conflict of interest exists so that a determination can be made under the process described below.

E. Procedure for Dealing with a Potential Conflict of Interest:

1. Individual is not a Board Member

- The individual must disclose the facts giving rise to the interest to the key manager(s) in charge of the proposed transaction or arrangement. If the individual seeking to disclose is unsure as to whom to report, such person shall contact the Corporate Compliance Officer.

- If the proposed transaction or arrangement requires Board approval or if the individual is in charge of the proposed transaction or arrangement, then the interest and all material facts must be disclosed to the Chief Executive Officer, the Corporate Compliance Officer and such person's immediate supervisor.

- After disclosure, the immediate supervisor of the person making the disclosure, the key manager in charge of the transaction (assuming the key manager does not have an interest) or the Corporate Compliance Officer (the Corporate Compliance Officer can involve the Chief Executive Officer), shall determine whether the interest creates a potential conflict of interest. If a potential conflict of interest exists, they shall take appropriate steps to mitigate or eliminate the effect of the potential conflict of interest on the proposed transaction.

- The immediate supervisor, the key manager(s), and/or Corporate Compliance Officer (the Corporate Compliance Officer can involve the Chief Executive Officer), shall determine the action(s) to be taken with respect to the interest. Actions may include (but are not limited to):

    - Exclusion of person with the interest from negotiating or evaluating the transaction or arrangement

    - Exclusion of the entity or individual in which the person has an interest from the negotiation or selection process

    - Appropriate disclosure to the Board.

- The immediate supervisor of the person with the interest, the key manager in charge of the transaction, and the Corporate Compliance Officer shall prepare a memorandum describing the facts, the decision(s) and action(s) taken in addressing the interest.

- The memorandum shall be filed in the files of the Corporate Compliance Officer and in the employee's personnel record. The Corporate Compliance Officer shall report to the Compliance Committee regarding the disposition of such matters and to the Board as appropriate.

2. Individual is a Board Member

In the event a Board member has an interest in a matter to be considered by the Board, the matter shall be reported to the Chief Executive Officer and referred automatically to ECH's Ad Hoc Interests Committee (defined below) for determination as to whether a potential conflict of interest exists. A Board member may recuse himself or herself from the matter, without further action, and the Board shall take such actions that shall be necessary to mitigate any potential conflict of interest as described below.

If the affected Board member does not recuse himself or herself, the Chairperson or Vice Chairperson, as applicable, shall recommend to such Board member whether recusal or other action should be taken. If the Board member with the interest disagrees with such recommendation, then upon request, he or she shall be afforded the opportunity to discuss the issue with ECH's Ad Hoc Interests Committee, which shall have final authority in its sole discretion to determine whether a potential conflict of interest exists.

The Ad Hoc Interests Committee shall be comprised of two Board members, neither of whom have an interest in the transaction or agreement. If only two Board members do not have an interest, such two Board members shall comprise the committee; if more than two Board members do not have an interest, the committee shall be comprised of the person without an interest who is the Chair, Vice-Chair, or Secretary of ECH (in that order) and a Board member without an interest with the longest tenure who is not an officer and who does not have an interest. Such committee shall be staffed by the Corporate Compliance Officer and legal counsel to ECH.

The Corporate Compliance Officer shall, before each Board meeting, review each matter scheduled to be considered by the Board at its next Board meeting and the annual disclosure statement (and any updates) filed by each Board member. If a Board member has disclosed an interest that relates to a matter that will be considered by the Board, the Corporate Compliance Officer shall notify the Board member, with a copy to the Chief Executive Officer, the Chairperson or the Vice Chairperson as appropriate. In order to avoid a situation where Board matters are deferred, persons bringing matters before the Board shall give prompt notice to the Corporate Compliance Officer of matters that are likely to be considered by the Board at upcoming meetings so that as much time as possible is permitted to identify and resolve any potential conflicts prior to the Board Meeting.

- If a Board member is uncertain whether a conflicting interest exists and whether such interest must be disclosed, a Board member may seek advice whether a conflict exists and whether additional disclosure or action is necessary. A Board member may consult with an advisory group consisting of two or more of the following individuals: Corporate Compliance Officer, Legal Counsel, external advisor(s) as determined by the Compliance Oversight Committee, and Chief Executive Officer.

- Depending on the subject matter, the Corporate Compliance Officer will be the lead advisory member to manage the process. Should the Corporate Compliance Officer also have a potential conflict, then a prompt meeting of the Compliance Oversight Committee will be called to appoint the lead advisory group member and determine additional appropriate advisory group member(s).

- After discussing the details of the potential conflict of interest with the advisory group member(s), the advisory group member(s) will make a written recommendation.

    - If the decision is that no additional inquiry is needed and no conflict exists, then the matter will be considered closed and the Chief Compliance Officer will log the consultation in the Compliance Activity log and copy each Board member.

    - If the matter requires further fact gathering, then the advisory group member(s) will conduct further inquiries to determine whether further action by the Board is required.

    - If the decision is that a disclosable conflict exists, then the advisory group member(s) will include in the report recommendations for mitigation of the effect of the potential conflict for the Chairperson or designee to consider.

3. If, after the foregoing process, a Board member must disclose the interest to the Board, then the following must be included in the process:

    - The Board member must disclose the existence and nature of the interest and all material facts to the Board when considering the proposed transaction or arrangement. The Board member shall also respond to all questions posed by the Board regarding the potential conflict of interest.

    - If the Board member's interest is substantial enough to create a conflict of interest, then the Chairperson or Vice Chairperson

acting as the Chairperson for purposes of taking action on the actual or potential conflict of interest shall determine how to mitigate the effect of the interest on the decision being made. The affected Board member may ask that the matter be referred to the Ad Hoc Interests Committee.

- Prior to making the decision, the Chairperson or Vice Chairperson shall seek the advice of legal counsel, other Board members, and/or any of the advisory group member(s).

4. Mitigating the effects of potential conflicts:

- Since each case will have unique circumstances, the Chairperson or designee, the Ad Hoc Interests Committee or the advisory group shall apply the following criteria:

- The Chairperson or Vice Chairperson shall request that such Director: (1) leave the room during all or part of the related presentations and discussions, and (2) refrain from participating in all or part of the related presentations or discussions. In all circumstances involving an actual or potential conflict of interest, the Chairperson or designee and the Board shall require the interested person to refrain from voting on any matters related to the actual or potential conflict of interest.

- The Board shall determine whether ECH can obtain a more advantageous transaction with reasonable efforts from a person or entity that does not involve a conflicting interest. If a more advantageous transaction is not reasonably attainable under the circumstances, the Board may approve the transaction only if it determines by a majority vote of the other Board members who do not have a conflict that:

  (a) The transaction is in ECH's best interest and for its own benefit; and

  (b) The transaction is fair and reasonable to ECH.

- ECH may purchase services from any corporation, association, trust, partnership, firm, venture or other entity of which any person subject to this policy is a trustee, officer or employee or owns equity, proprietary or beneficial interest.

- Notwithstanding the foregoing, ECH shall not purchase services from any other corporation, association, trust, partnership, firm,

venture or other entity of which a Board member is a trustee or officer or in which a Board member owns more than 5 percent equity, proprietary or beneficial interest unless:

(a) The purchase decision is made pursuant to a bidding process; or

(b) The purchase involves an expenditure by ECH in the aggregate of less than $50,000; or

(c) The services are provided pursuant to a contract with a term of one year or less.

- In taking action on behalf of ECH, the Board shall include its findings as part of the motion being adopted, and record such resolution in the minutes of the meeting.

- Unless not reasonably practicable prior to entering into the transaction, any transaction involving an actual or potential conflict of interest shall be addressed by the Board and not by a committee of the Board. If, in an urgent situation, the transaction is approved by a committee, the transaction shall be submitted to the Board at its next meeting. The transaction must then be ratified by a vote of the majority of disinterested Board members.

- Transactions involving Board member(s) must follow all additional requirements under California Corporations Code § 5233 not stated in the policy as then in effect (see Appendix A).

F. Situations Disclosed by Others:

1. If any person has reasonable cause to believe that a person has failed to disclose an interest relating to a transaction (the "Individual"), the person with the information shall provide such information to the Corporate Compliance Officer or the Compliance Hotline, disclosing all related facts.

2. In the event of any such disclosure, the Corporate Compliance Officer shall conduct a factual investigation, including interviewing the Individual about whom the disclosure is made, informing the Individual of the allegations and providing a full opportunity to explain the circumstances. The Corporate Compliance Officer shall determine whether a disclosing of the identity of the Individual making the allegation is permitted by law and is warranted in the circumstances.

3. The Corporate Compliance Officer shall inform the Individual of the results of such investigation and afford the Individual an opportunity to explain any alleged failure to disclose or any other fact relating to the allegations.

4. Upon considering the Individual's response, the Corporate Compliance Officer shall make such further investigation as warranted by the circumstances.

5. If the Corporate Compliance Officer tentatively determines that the individual has failed to disclose an interest, the Corporate Compliance Officer shall recommend to the Individual's supervisor, the Vice President for Human Resources and the Vice President of the affected division appropriate corrective actions including termination of employment, contract, or privileges at ECH.

6. If the situation involves a Board member, corrective action shall follow the process as specified under California Corporations Code § 5233 as then in effect. The affected Board member shall have the opportunity to request that the Ad Hoc Interests Committee (described above) be involved in the process, as described above.

APPROVAL	**APPROVAL DATES**
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

5/13/98, 11/28/00, 05/09/01, 03/02/05, 08/08/07, 06/01/09, 10/12

Annual Disclosure Statement: _____, 20__ to _____, 20__

Return to Corporate Compliance Officer (Contact the Corporate Compliance Office with any questions regarding completing this form. Refer to ECH Administrative Policy 4.00, Section E.)

Pursuant to the Conflict of Interest Policy of El Camino Hospital ("ECH") requiring disclosure of certain interests, a copy of which has been furnished to me, and consistent with the purposes and intentions of that policy, I hereby state that I, or members of my immediate family, have the following affiliations or interests and have taken part in or are now taking part in the following transactions that, considered in conjunction with my position in relation to ECH, might now or in the future result in a conflict of interest.

Name: _____ Date: _____

Position(s) you hold (check all that apply):

- ☐ Board Member
- ☐ Executive
- ☐ Medical Executive Committee
- ☐ Medical Director
- ☐ Director/Manager
- ☐ Compensated Physician
- ☐ Employee
- ☐ Volunteer
- ☐ Contractor

I hereby disclose the following information (including information regarding members of my immediate family or household). (If none, I have written "none.") (I have attached additional pages as needed):

☐ **Business Affiliations:** Listed below are any affiliations that I, or any member of my immediate family, have as a director, officer, partner, employee, consultant, agent, or advisor of any person, firm or organization which to the best of my information and belief is a supplier of goods or services to ECH (briefly describe the types of goods and services so supplied).

_____

_____

☐ **Research Agreements:** Listed below are any agreements for research conducted at, or using any facilities of, ECH where I am a party, or any member of my immediate family is a party, or an owner or director of a party to such research agreement.

_____

☐ **Governmental Affiliations:** Listed below are any elective or appointed officer position(s) which I or any member of my immediate family holds in any branch of government or in any regulatory agency having authority or jurisdiction over providers of health care.

☐ **Volunteer Activities:** Listed below are the names and address of any hospital, other than ECH, or health care facility in Santa Clara County for which I or any member of my immediate family serve as a volunteer or a paid director, officer, partner, employee, consultant, agent, or advisor and the capacity in which I or the member of my immediate family serves.

☐ **Outside Interests:**

a. Identified below is any financial interest (including a services agreement) or investment with a value greater than $2,000 held by either me or a member of my immediate family in any outside concern which is a supplier of goods or services to ECH.

b. Identified below is any purchase or sale of property or property right, interest or service, made or proposed to be made by me or my immediate family that might be deemed to have been made in competition with ECH.

☐ **Outside Activities:** Identified below are any circumstances where I have, or a member of my immediate family has, rendered or is rendering services as a director, manager or consultant to any outside concern that does business with, or competes with the services of ECH.

☐ **Competition:** Identified below are any circumstances in which I or any member of my immediate family has rendered or may render services that may be deemed to be in competition with or to the disadvantage of ECH.

_____

_____

_____

☐ **Gifts, Gratuities and Entertainment:** Neither I, nor any member of my immediate family has accepted, or is in the process of soliciting or accepting any gift, gratuity, or entertainment from any outside concern that does, or is seeking to do business with, or is a competitor of ECH, except as listed below. I also certify that, except as listed below, I have not made or authorized any gift, gratuity, entertainment or similar donative transaction in violation of ECH Administrative policy 36.00.

_____

_____

☐ **Use of Confidential Information for Personal Gain:** I hereby certify that neither I, nor any member of my immediate family, has disclosed or used, or is disclosing or using information, relating to ECH's business for the personal profit or advantage of myself or my immediate family (except such information as has been publicly disclosed or is publicly available), except as listed below.

_____

_____

☐ **Personal Affiliations:** Listed below are any relationships (such as consulting or employment) or affiliations with an individual or an entity that I know or should know directly provides services, supplies or materials to ECH, an ECH affiliate, or to a competing organization, or with whom I entered into a financial relationship that may affect my duties and obligations as a person acting on behalf of ECH.

_____

_____

☐ **Other:** Listed below are any other activities or interests that might be regarded as creating a potential conflict of interest.

_____

_____

☐ **Spouse Employment or Self Employment:**

_____

_____

Signature: _____ **Date:** _____

Charitable Donations to Outside Organizations

POLICY/PROCEDURE TITLE:Corporate Compliance:48.00 Charitable Donations to Outside Organizations

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 12/07

COVERAGE:

All El Camino Hospital staff

PURPOSE:

It is the policy of El Camino Hospital to donate to various charitable organizations in order to carry out the Hospital's mission and/or strategic objectives, especially in the important role of providing health care to the uninsured or underserved.

STATEMENT:

While El Camino Hospital, a non-profit charitable organization, is usually the recipient of donations and not a source for other non-profit organizations to solicit donated support the hospital may donate to other organizations pending administrative approval. The donations must assist and advance organizations performing services that promote the health and well-being in our communities. This support of other charitable organizations is consistent with the mission values of El Camino Hospital.

The policy will not permit donations to individual persons or contributions to local and federal ballot measures and propositions. Contributions for public office are specifically prohibited.

Certain contributions include a component of goods and services for the Hospital and/or employees of the Hospital (i.e., dinners, entertain, golf green fees, special event passes, etc.) that are not deductible to the donor, as only the tax-deductible portion of such gifts may be treated as the true donated portion of the entire amount. Thus only that portion of a donation that would be considered tax-deductible can be recorded as a non-operating donation expense and the benefit received (golf, sporting event, dinner) must be expensed as an operating expense.

POLICY/PROCEDURE TITLE:Corporate Compliance:48.00 Charitable Donations to Outside Organizations

PROCEDURE:

A. Guidelines

1. The CEO will designate a member of the Executive Council to be the "coordinator" of the decision making in allocation of donations during a fiscal year. This person may receive input from employees, physicians, members of the auxiliary, the Community Benefit Advisory Council or the Board of Directors to this allocation process.

2. During the annual budget process, a centralized cost center and budget will be established under a unique non-operating expense account and will be administered by the appointed coordinator or manager of this cost center.

3. Within the above-referenced cost center budget the Community Benefit Advisory Council, Executive Council, or Board of Directors may make requests on behalf of not-for-profit organizations whose requests meet the criteria described in greater detail below. The Hospital may make donations in cash or in-kind donations, such as, equipment, supplies, and labor, etc.

   Authority levels are:

   * $30,000.00 Coordinator
   * $50,000.00 CEO
   * >$50,000.00 Board of Directors

4. The coordinator, in conjunction with the Community Benefits Advisory Council, will establish and periodically evaluate priorities and allocation of funds with particular emphasis on the promotion of healthy communities and community collaboration among the following categories:

   - Health education related programs (i.e., nursing and critical shortage clinical skill programs)
   - Health education, health promotion, and disease prevention
   - Community-based health related services (i.e., free clinics, dental services, case management for the frail elderly, immunizations, etc.)

- Medical research (i.e., Heart Association, Cancer Society). **Not to include the Fogarty Institute for Innovation**
- The healing arts as it contributes to the overall patient experience at El Camino Hospital
- Other social needs (i.e., disaster relief)
- Ecology initiatives related to health care of the community and environment
- Other community and civic organizations (i.e., Chambers of Commerce, community breakfasts, leadership programs of adjacent cities).

5. The coordinator will discuss periodically (but at a minimum of yearly) with the Executive Council and the Community Benefit Advisory Council the individual requests or the needs that the coordinator feels the Hospital should be donating to that will enhance the health and well-being of the community. Factors to consider in the decision to make a donation and in determining the amount of the donation should be, but not limited to:

    - Does the Hospital have a role in the governance or management in the organization or program to be supported (i.e., Pathways)?
    - Will the Hospital's reputation be enhanced by the donation and health and well-being of the community?
    - Is the recipient of donation in the District or Santa Clara County?
    - Will the donation further the mission and values of the Hospital?

6. In all cases where there exists a Hospital board member or requestor who has ties to a requesting organization, the potential conflict of interest must to disclosed and the coordinator must make known to the Executive Council and the Community Benefit Advisory Council to seek approval before the donation can be made.

7. Spending will be tracked on an on-going basis against the annual budget for this donation to outside organizations as non-operating expense under the Community Health Benefits/Health Promotions cost center of 8772.

B. <u>Procedure for Issuing a Donation</u>

1. For cash donations, the requestor must request in memo form that includes the following elements:

    - Name of Requestor
    - Name of Organization
    - Brief Description of what the organizations does/provides
    - What the funds will support (i.e. a table at a breakfast that goes to a community agency that provides immunizations and case management to the frail elderly
    - Dollar amount requested
    - Time frame that the donation would be made in
    - Key contact

8. The coordinator will authorize, given the above required authority levels, to the charitable organization by approving a check request or the provided documentation from the organization and forward to the Controller.

9. The Controller will code the donation the account of 01-**807990**-8772 (Non-Operating Donation Expense under the cost center of Community Health Benefits/Health Promotion).

    If there is any component of goods and/or services provided by the donation, that portion of donation expense to be coded to the account of 01-**807993**-8772 to differentiate between a received benefit verses the actual donation.

10. In-kind donations of equipment, supplies, labor, etc. will be handled on an individual basis and documented as appropriate.

11. The Controller's office will also maintain a file on these donations by each fiscal year.

POLICY/PROCEDURE TITLE:Corporate Compliance:48.00 Charitable Donations to Outside Organizations

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	10/15
Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

12/07, 06/09, 10/12

xxi. Identity Theft Misidentification Prevention

POLICY/PROCEDURE TITLE: 52.00 Identity Theft-Patient Misidentification Prevention

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

SUB-CATEGORY: Administrative Policies and Procedures
ORIGINAL DATE: 10/08

COVERAGE:

All El Camino Hospital staff

PURPOSE:

To provide a consistent process for identifying and protecting patients when identity theft is reported or suspected.

STATEMENT:

The identity of all patients will be protected and guidelines regarding the detection, prevention and mitigation of identity theft will be followed at all times. All staff will follow this policy when health care is obtained or suspected to have been obtained under a fictitious name or in another person's name. The Fair and Accurate Credit Transaction Act of 2003 (FACTA) revised the Fair Credit Reporting Act (FCRA) and required the Federal Trade Commission (FTC) to issue new regulations governing how organizations can protect their patients, customers, and account holders from identity theft. Under the new regulations , known as the Identity Theft Red Flag Rules (Red Flag Rules) creditors, including healthcare facilities, must identify patterns, practices and specific forms of activity that indicate the possible existence of identity theft. Identity theft is defined by cross-reference to the definition found in FTC regulations at 16 CFR 603.2(a) and means "a fraud committed or attempted using the identifying information of another person without authority."

DEFINITIONS *(as applicable)*:

1. Identity Theft means the act of knowingly obtaining, possessing, buying, or using the personal identifying information of another: (i) with the intent to commit any unlawful act including, but not limited to, obtaining or attempting to obtain credit, goods, services or medical information in the name of such other person; and (ii)(a) without the consent of such other person; or (b) without the

lawful authority to obtain, possess, buy or use such identifying information.

2. Theft of services includes: (i) intentionally obtaining services by deception, fraud, coercion, false pretense or any other means to avoid payment for the services; and (ii) having control over the disposition of services to others, knowingly diverts those services to the person's own benefit or to the benefit of another not entitled thereto.

3. Identifying information is any name or number that may be used (alone or in conjunction with other information) to identify a specific person. It includes any:
    a. Name;
    b. Date of Birth;
    c. Identifying Numbers (SSN, EIN, TIN, official state or government issued driver's license or identification number, alien registration number, passport number);
    d. Biometric data;
    e. Unique electronic identification number, address, or routing code;
    f. Insurance identification numbers; or
    g. Telecommunication identifying information or access device.

PROCEDURE:

1. Identity Red Flag Alerts. Staff will identify and detect Red Flags (a "pattern, practice, or specific activity that indicates the possible existence of identity theft") from the following categories:
    a. Alerts, notifications, and other warnings received from service providers or fraud detection services.
    b. Notices from patients, victims of identified theft, insurance company report, insurance fraud investigator for a private insurance company, law enforcement agency, or other persons.
    c. Suspicious documents and suspicious personal identifying information such as documents provided for identification appear to have been altered or forged. The photograph or physical description on the

identification is not consistent with the appearance of the patient presenting the identification.

d. Other information on the identification is not consistent with readily accessible information that is on file with the hospital.
e. Previous encounters with patients that present inconsistent information during current occurrence.

2. Detecting Red Flags at Time of Registration. All registration/intake areas should review for authentication and include when available in each patient's file a copy of the photo ID issued by a local, state, or federal government agency (e.g., a driver's license; passport; military ID, etc.).

    a. Emergency Care—NO DELAY. Providing identification is not a condition for obtaining emergency care. The process of confirming a patient's identity must never delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.

    b. Responding to Questions. If asked the reason for the identifying procedures, explain that the procedures are "for patient protection to prevent identity theft and theft of services."

Refusal to Provide or Lack of Identification. No one should be refused emergency care because they do not have acceptable identification with them. Patients should be asked to bring appropriate documents to their next visit if they present to the emergency department without identification. If the hospital services to be provided are scheduled or elective and the patient lacks appropriate identification then refer the case to an immediate supervisor or

    c. manager to discuss options with patient.

3. Signs of Possible Identity Theft. Employees should be alert for cases of possible identity theft. Potential signs of identity theft include but are not limited to: (1) a patient providing photo ID that does not match the patient. (2) a patient giving a social security number different than one used on a previous visit. (3) a patient giving information that conflicts with information in the patient's file or received from third parties, such as insurance companies, and (4) family members/friends calling the patient by a name different than that

provided by the patient at registration. If an employee reasonably believes identity theft has occurred or may be occurring, immediately notify the Registration Manager or Corporate Compliance Officer and complete the Identity Alert Reporting Form (Exhibit A). The Manager of Registration or Corporate Compliance Officer will involve Security on an as needed basis (e.g., to perform background checks, to contact the person believed to be a victim of the identity theft, and if medical circumstances allow, to interview the patient, etc.)

4. Receiving A Complaint or Notification From A Victim Of Identity Theft. Employees should immediately notify the Corporate Compliance Department or Manager of Registration upon receiving a complaint or notification from any individual reporting they are a victim of identity theft and complete Exhibit A. If employee is unable to immediately reach anyone at the Corporate Compliance office or Manager of registration, they should still complete Exhibit A and attach supporting documentation and forward to the Corporate Compliance Department. A checklist of guideline action items (Exhibit E) is provided to assist in reviewing all areas. The Corporate Compliance department will initiate an investigation that will include but not be limited to verification of victim identification, investigation, determination, notifications, and mitigation. The individual claiming identity theft will be instructed to file a police report for identity theft and provide a copy to the hospital. The individual also must complete the FTC Identity Theft Affidavit attached hereto as Exhibit C and provide a copy to the hospital including supporting documentation.

5. Notifying Victims of Identity Theft When the Victim Does Not Know Identity Theft Has Occurred. Victims of identity theft will be notified by the HIMS department as directed by the Corporate Compliance office. The letter attached to this Policy as Exhibit D may be used as a form to notify a victim of identity theft. Encourage the victim to complete the FTC Identity Theft Affidavit attached hereto as Exhibit C.

6. Actions To Be Taken When Identify Theft is Verified. If, following investigation, it appears that the individual has been a victim of identity theft, the hospital will take the following actions:

a. Cease collection on open accounts that resulted from identity theft. If the accounts have been referred to collection agencies, the collection agencies will be instructed to cease collection activity.
b. The hospital will cooperate with any law enforcement investigation relating to the identity theft.
c. If an insurance company, government program or other payer has made payment on the account, the hospital will notify the payer and refund the amount paid.
d. Letter (Exhibit D or E) will be sent to the victim to guide them on next steps.

7. Correcting Medical and Payment Records of Identity Theft Victims; Verification and Releasing Bill Hold. To ensure that (1) inaccurate health information is not inadvertently relied upon in treating a patient, (2) a patient or a third-party payer is not billed for services the patient did not receive, and (3) patient health information is protected from inappropriate disclosure, patient medical and payment records must be corrected when a case of identity theft occurs.

    a. Medical Records. After consulting with the victim and properly verifying their identity, the FTC Identity Theft Affidavit must be completed. The HIMS department will make appropriate corrections to the victim's medical record. Corrections shall be made in accordance with the hospital's medical record corrections policy 2.04 (*Amendment of Health Information)* A detailed explanation of the corrections shall be generated and verified by the patient. The HIMS department shall remove all related documents from the patient's medical record and make replacements with appropriately revised documents. The patient's verification of the corrected medical record shall be documented and included as part of the case file forwarded to the Corporate Compliance office.

    b. Payment Records. After consulting with the victim (whose identity has been properly verified and documented, including receipt of a properly completed FTC Identity Theft Affidavit), the hospital's Patients Accounts department will make appropriate corrections to the victim's billing information, inform and provide documentation to any third-party

payer affected by the adjustments, and make any necessary repayments to ensure that the patient and the payer pay only for the services actually provided to the victim. A detailed explanation of the corrections shall be generated by the hospital and verified by the victim. The victim's verification of the corrected billing records shall be documented and included as part of the case file forwarded to the Corporate Compliance office and all appropriate professional or government organizations that are involved in the case.

c. Verification; Release of Hold. The Registration Manager and/or Patient Accounts Director will verify that all demographic and insurance information is correct and that all documents relating to the victim are appropriately revised. Once all medical and billing records have been corrected, the Registration Manager and/or the Patients Accounts Director will release the bill hold and bill appropriately.

8. Assisting Identity Theft Victims.

a. Copies of Records on Written Request. Identity theft victims are entitled to obtain a copy of the business transaction records maintained by the hospital relating to the identity theft free of charge. "Business transaction records" may include billing and medical record information. Before providing such records, the hospital must ask for proof of identity which may be a government-issued ID card, a police report (regarding the identity theft) and a completed FTC Identity Theft Affidavit, attached hereto as Exhibit C. Document receipt of and copy all such information. The hospital may refuse to provide business transaction records if the facility determines in good faith that: (1) the true identity of the person asking for the information cannot be verified; (2) the request for the information is based on a misrepresentation; or (3) state or federal law prohibits the hospital from disclosing such information.

b. Mitigation. The hospital should mitigate, to the extent practicable, any harmful effect that is known to the hospital as a result of unlawful use or disclosure of protected health information in connection with a case of identity theft.

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	10/12

POLICY/PROCEDURE TITLE: 52.00 Identity Theft-Patient Misidentification Prevention

CATEGORY: Administrative
LAST APPROVAL DATE: 10/12

_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	11/12
Board of Directors:	12/12

Historical Approvals:

Corporate Compliance Officer: 10/08, 10/12
Executive Council: 10/08, 11/12
Management Staff:
Board of Directors: 11/08, 12/12
Attachments:

Exhibit A
Identity Alert Reporting Form

This form should be completed by hospital personnel when the identity of a patient is questioned either because of identity theft or patient misidentification.

Form completed by: _____ Date/Time: _____
Title: _____ Department: _____

Patient presented to the hospital using the following information:
Name: _____ Phone: _____
Address: _____ SS#: _____
_____ D.O.B. _____
Date/ Time patient presented: _____

Presenting Complaint or Services Received: _____
_____
_____

Medical Record number: _____ HBOC number: _____

Insurance Information Presented: _____

Was the health information of any other patient provided to this individual: Yes___ No: _____
If yes, list Medical Record numbers affected: _____

Other information/facts (who discovered discrepancy, who was notified, what documentation was secured, etc.)
_____

_____

_____

List all involved staff members: _____

Based on investigation, the correct patient is: Medical Record number: _____
Name: _____ Phone:_____
Address: _____ SS# _____

_____ DOB: _____

ATTACH A COPY OF THE RELEVANT PHOTO ID OR DOCUMENTATION AND SEND THE COMPLETED FORM TO MANAGER OF PATIENT REGISTRATION & COMPLIANCE DEPT.

Exhibit B
Sample Letter regarding Identity Theft Reported by Patient

(Date)

(Patient Name)
(Patient Address)
(Patient Address)

Re: Identity Theft Report Made on _____(insert date)
RESPONSE REQUIRED

Dear _____:

The letter responds to your report that a person used your name, insurance information, or other personal information to obtain health care items or services at this facility. Please follow the instructions in this letter so that we can help you address this problem.

After reading the instructions for the enclosed Identity Theft Affidavit, complete the Identity Theft Affidavit (also available at: http://www.ftc.gov/bcp/edu/microsites/idtheft/), including all details of the identity theft incident that you know. Make copies of the required documentation (e.g., photo identification; police report regarding the incident, etc.) and attach them to your affidavit. Sign the affidavit, and then have the affidavit notarized or witnessed by two people who are not members of your family. **Return the completed signed affidavit and accompanying documentation to this office within two weeks from the date of this letter so this facility can take the necessary steps to correct your medical record and patient account.**

"Medical identity theft" is very serious because, in addition to causing financial problems, identity theft can lead to inappropriate care when incorrect information is included in a patient's medical record Once we receive your properly completed and signed affidavit, and appropriate supporting documentation, our Health Information Management and Patient Accounts office will work with you to make necessary corrections to your medical record and patient accounts. **In**

the meantime, should you need to visit this facility or any other health care provider, you should let the provider know that the information in your medical record may be incorrect because your identity has been used to obtain health care items or services fraudulently.

We encourage you to alert other area hospitals and health care providers that your identifying information is being used in a fraudulent manner because identity thieves often obtain services and items from more than one health care provider. You may also want to visit the FTC's website at http://www.ftc.gov/bcp/edu/microsites/idtheft/, which has information to help individuals guard against and deal with identity theft, and you may want to review the information in the FTC's publication, "Take Charge: Fighting Back Against Identity Theft." You can call 1-877-438-4338 to request a free copy.

Sincerely,

POLICY/PROCEDURE TITLE:Corporate Compliance:52.00 Identity Theft-Patient Misidentification Prevention

INSTRUCTIONS FOR COMPLETING THE ID THEFT AFFIDAVIT

To make certain that you do not become responsible for any debts incurred by an identity thief, you must prove to each of the companies where accounts were opened in your name that you didn't create the debt. The ID Theft Affidavit was developed by a group of credit grantors, consumer advocates, and attorneys at the Federal Trade Commission (FTC) for this purpose. Importantly, this affidavit is only for use where a new account was opened in your name. If someone made unauthorized charges to an existing account, call the company for instructions.

While many companies accept this affidavit, others require that you submit more or different forms. Before you send the affidavit, contact each company to find out if they accept it. If they do not accept the ID Theft Affidavit, ask them what information and/or documentation they require.

You may not need the ID Theft Affidavit to absolve you of debt resulting from identity theft if you obtain an Identity Theft Report. We suggest you consider obtaining an Identity Theft Report where a new account was opened in your name. An Identity Theft Report can be used to (1) permanently block fraudulent information from appearing on your credit report; (2) ensure that debts do not reappear on your credit reports; (3) prevent a company from continuing to collect debts or selling the debt to others for collection; and (4) obtain an extended fraud alert.

The ID Theft Affidavit may be required by a company in order for you to obtain applications or other transaction records related to the theft of your identity. These records may help you prove that you are a victim. For example, you may be able to show that the signature on an application is not yours. These documents also may contain information about the identity thief that is valuable to law enforcement.

This affidavit has two parts:

- Part One — the ID Theft Affidavit — is where you report general information about yourself and the theft.
- Part Two — the Fraudulent Account Statement — is where you describe the fraudulent account(s) opened in your name. Use a separate Fraudulent Account Statement for each company you need to write to.

When you send the affidavit to the companies, attach copies (NOT originals) of any supporting documents (for example, driver's license or police report). Before submitting your affidavit, review the disputed account(s) with family members or friends who may have information about the account(s) or access to them.

Complete this affidavit as soon as possible. Many creditors ask that you send it within two weeks. Delays on your part could slow the investigation.

Be as accurate and complete as possible. You may choose not to provide some of the information requested. However, incorrect or incomplete information will slow the process of investigating your claim and absolving the debt. Print clearly.

Exhibit D
Sample Letter Regarding Identity Theft Identified By Hospital

(Date)

BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED
(Patient Name)
(Patient Address)
(Patient Address)

Re: Suspected Identity Theft

Dear_____:

This letter addresses the unauthorized use of your name and other personal information at _____ on_____. (Explain factual situation and describe compromise of information in detail (e.g., how it happened; information disclosed; what actions have been taken to remedy situation, etc.). Include the statement that, "We have reported this incident to _____(name law enforcement officer) at the _____(local law enforcement agency), who can be reached at _____. We also have placed an alert on your account at this facility in an effort to prevent further misuse of your identity.")

"Medical identity theft" is very serious because, in addition to causing financial problems, identity theft can lead to inappropriate care when incorrect information is included in a patient's medical record. If you believe you are the victim of medical identity theft, you should ask to review and make appropriate corrections to your medical record so that you receive appropriate care. Therefore, **for your health and safety**, it is very important that your medical records do not contain information about another person. **We request your assistance in ensuring that our records about you are correct.**

We have removed from your medical record information relating to care given on _____ because (we have determined/you have indicated) you did not receive services at this hospital on those dates. After removing that information, your medical record shows the following visits:

Date of Visit	Reason for Visit
(insert)	

If someone other than you made any of the above visits, or you do not remember one or more of these visits, please contact us immediately. **You can review your entire medical record by visiting this facility's Medical Record's Department, and we encourage you to do so.** In addition to making sure your medical record with this facility is accurate, we also encourage you to check the accuracy of your records with other health care providers and your health insurance plan(s).

(Based on the information we have received relating to the improper use of your name and other identifying information on _____, this facility will not bill you or your insurer for the services it provided on _____. We are in the process of correcting your account with your health insurer. If you receive a bill or insurance statement relating to a visit to this facility by someone other than you, please let us know as soon as possible.) We also recommend that you carefully monitor explanations of benefits (EOBs) received from your health insurer to determine if any other person has used your identity to obtain health care. If you receive an EOB or bill for health care you do not remember obtaining, immediately contact your insurer and the health care provider who furnished the services.

Given the possibility that your personal information may be further misused, we recommend that you place a fraud alert on your credit file. A fraud alert tells creditors to contact you and verify your identity before they open any new accounts or change existing accounts. You can call any one of the three major credit bureaus. As soon as one credit bureau confirms your fraud alert, the others are notified to place fraud alerts. All three credit reports will be sent to you, free of charge, for your review.

Equifax	Experian	TransUnionCorp
800-525-6285	888-397-3742	800-680-7289

Even if you do not find any suspicious activity on your initial credit reports, you should continue monitoring your credit reports carefully to be certain there have been no unauthorized transactions made or new accounts opened in your name. You are entitled under federal law to get one free comprehensive disclosure of all the information in your credit file from each of the three national credit bureaus listed about once every twelve months. You may request your free annual credit report by visiting http://AnnualCreditReport.com or by calling (877)FACTACT.

If you find suspicious activity on your credit reports or have reason to believe your information is being misused, immediately notify the credit bureaus. If you believe an unauthorized account has been opened in your name, immediately contact the financial institution that holds the account. You should also file a police report. Ask for a copy of the police report because many creditors want the information it contains to absolve you of the fraudulent debts. You should also file a complaint with the FTC at www.consumer.gov/idtheft or at 1-877-ID-THEFT (877-438-4338). Your complaint will be added to the FTC's Identity Theft Data Clearinghouse,

where it will be accessible to law enforcers for their investigations. You may want to visit the FTC's website at http://www.ftc.gov/bcp/edu/microsites/idtheft/, which has information to help individuals guard against and deal with identity theft, and you may want to review the information in the FTC's publication, "Take Charge: Fighting Back Against Identity Theft." You can call 1-877-438-4338 to request a free copy.

We encourage you to report any helpful information to _____(investigating law enforcement officer) at the _____(local law enforcement agency). We also encourage your to alert other area hospitals and health care providers that your identifying information is being used in a fraudulent manner. If we can be of further assistance, please contact me at the number listed below.

Sincerely,

_____
Corporate Compliance Officer
El Camino Hospital
(telephone number)

Exhibit E
Sample Response Letter Regarding Patient Misidentification

[Date]

[Patient Name]
[Patient Address]
[Patient Address]

Dear [Mr.___/Ms.____]:

This letter is {to inform you of / in response to your report of} an erroneous use of your name or indentifying information at [Name of entity] ("Entity") and to provide you with information to assist you in preventing this incident from affecting your medical care.

[Explain factual situation and describe how records became commingled.]

The integrity of your medical record is very important, and your record should only reflect your health and medical items services provided to you. Therefore, **for your health and safety**, it is very important that your medical records do not contain information about another person. **We request your assistance in ensuring that our records about you are correct.**

We have removed from your medical record information relating to care given on _____because [we have determined/you have indicated] you did not receive services at this hospital on those dates. After removing that information, your medical record shows the following visits:

Date of Visit	Reason for Visit
[insert]	

If someone other than you made any of the above visits, or you do not remember one or more of these visits, please contact us immediately. **You can review your entire medical record by visiting the Health Information Management Department on the ground floor of the main hospital.** In addition to making sure your medical record with this facility is accurate, we also encourage you to check the accuracy of your records with other health care providers and your health insurance plan(s).

[Based on the information we have received relating to the use of your name and other identifying information on _____, this facility will not bill you or your insurer for the services provided on _____. We are in the process of correcting your account with your health insurer. If you receive a bill or insurance statement relating to a visit to this facility by someone other than you, please let us know as soon as possible.] We also recommend that you carefully monitor explanations of benefits (EOBs) received from your health insurer. If you receive an EOB or bill for healthcare you do not remember obtaining, immediately contact your insurer and the health care provider who furnished the services.

We hope this letter is helpful. If there is any other way the entity can assist you , or should you have any questions, please do not hesitate to contact me.
Sincerely,

_____
Corporate Compliance Officer
El Camino Hospital
[Telephone number]

Exhibit F
Checklists of Guideline Action Items

When Identity Theft is Alleged

1. Advise victim or patient to report identity theft incident to law enforcement in Mountain View and indicate that paperwork will be forwarded for victim to complete.
2. Send victim report of ID theft letter (Exhibit B), with a copy of the FTC Identity Theft affidavit (Exhibit C) to be completed by the victim.
3. When victim's allegation is supported by a properly completed and signed FTC Identity Theft Affidavit, flag or note the victim's account in HBOC and ECHO so that medical personnel know the medical record may contain inaccurate information.

4. Follow remainder of the steps.

When Identity Theft is Reasonably Suspected or Known to have Occurred

5. Hospital Staff should complete Exhibit A (Identity Alert reporting form).
6. Route copies of Exhibit A with a copy of the relevant photo ID to Manager of Patient Registration and the Corporate Compliance Office.
7. Upon notification the Patient Accounts Director will put affected patient accounts on hold pending the outcome of the investigation.
8. Registration, HIMS, and the Corporate Compliance departments will review and make decisions on the investigation and make all external reporting and notification decisions. (e.g., victim notification; the Corporate Compliance Office will direct reporting of actual knowledge of Medicaid fraud to the Medicaid OIG ; for incidents involving mail theft, will direct reporting to U.S. Postal Inspection Service and if appropriate will consult with law enforcement agencies) The Corporate Compliance department will notify internally to support the investigation the Security Department, Risk Management in order to file a QRR and BATI.
9. The HIMS Department will notify victims of identity theft as directed by the Corporate Compliance Department. Use the letter regarding identity theft (Exhibit D or E) to notify a victim of identity theft and include the FTC Identity Theft Affidavit (Exhibit C).
10. The HIMS Department will correct the medical record based on current policy and verification of the corrected medical record shall be documented and included as part of the case file forwarded to the Corporate Compliance office.
11. The Patient Accounts Department will correct the patient's billing information and make all necessary payment adjustments. The corrected billing record shall be documented and included as part of the case file forwarded to the Corporate Compliance Office.
12. The Patient Accounts Director will notify all professional billing groups that provided services at the hospital to update the appropriate billing information (i.e. ED, Pathology, Radiology, and Anesthesia).
13. The Corporate Compliance Officer will determine whether accounting for disclosures to the identity theft suspect is required.
14. The Registration Manager will add appropriate Alert Flag of "Identity Issue" to each MPI record affected by the identity theft event whenever possible.
15. Once the Registration Manager and/or the Patient Accounts Director verify that all demographic and insurance information is correct after the visit is transferred to the appropriate record and all related documents are removed from the Medical Record and replaced with appropriately revised documents, the bill hold will be released so that appropriate billing occurs.
16. Identity theft suspect will be billed for services and litigation will be considered.

Policies: New Policies – (0 Policies) ii. Policies with Major Revisions- (1 Policy)

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES				
Policy Number	**Policy Name**	**Department**	**Date**	**Summary of Policy Changes**
POLICIES WITH MAJOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Code Definitions- FAS Paging Codes	Environment of Care	11/15	Reformat, removal of reference to dialysis clinics, addition of code green procedures, update policy references
POLICIES WITH MINOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Performance Improvement Plan	Environment of Care	11/15	Reform and minor word tweaks
	Work Group Responsibilities	Environment of Care	11/15	Reformat and minor reqording. Removal of redundant information
	Code Triage	Environment of Care	11/15	Reformat, reqording of sections for clarity
	Bioterrorism response preparedness	Environment of Care	11/15	reformat, update titles
	Mass Casuality Decontamination Plan	Environment of Care	11/15	Reformat, minor updates to names and rearrangement of procedures
	Administrative Authority to Activate and Terminate HICS	Environment of Care	11/15	Reformat, minor revisions to procedure to align with current terminology
	Evacuation Plan and Alternative Care	Environment of Care	11/15	Reformat, update referenced document name
	Regulatory Agency Notification	Environment of Care	11/15	Title revision, added line to contact Director of Accreditation after contacting CDPH
	Exercises	Environment of Care	11/15	Reformat, minor change to structure to better comply with TJC Standards
	Communications Plan	Environment of Care	11/15	Reformat
	Supply and Equuipment Plan	Environment of Care	11/15	Reformat and minor change to policy titles to match current
	Mergency- Utility Failure Plan	Environment of Care	11/15	Reformat and added location of documents on e-policy
	Emergency- Drinking water supplyo	Environment of Care	11/15	Reformat, updated to 96 hours, will need to review quantiites and revise as needed
	Employees' Responsibility for Emergency	Environment of Care	11/15	Reformat, minor wording change
	Disaster Staffing Needs: Off Duty emplopyees, volunteers and physician staffing	Environment of Care	11/15	Title revision, no content change
	Volunteer Credentialing Policy for Use in Major Disaster	Environment of Care	11/15	Reformat, updated refernce to medical staff policy
	Plan for Medical Staff Office	Environment of Care	11/15	Reformat, minor wording change to remove reference to hard copy binder
	Disaster Financial Recovery Tracking Plan	Environment of Care	11/15	Title revision, no content change
	Response to Anthrax	Environment of Care	11/15	Reformat; rearrange to provide better content flow, removal of references to Officer of the Day, update the location and name of the Accident, Injury and Exposure Report (AIER)

	Hazardous Material Exposure- Shelter in Place	Environment of Care	11/15	Reformat, removal of references dialysis clinics and Officer of the Day. Title change
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	
	Emergency Operations Plan	Environment of Care	11/15	
	Hospital Command Center	Environment of Care	11/15	
	Emergency Coordination Plan- Key area	Environment of Care	11/15	
	Coordination with City, County and State	Environment of Care	11/15	
	Security Plan	Environment of Care	11/15	
	National Disaster Medical System	Environment of Care	11/15	
	Food Service Plan	Environment of Care	11/15	
	Food and Supplies Storage Locations	Environment of Care	11/15	
	Dependent and Family Care Plan	Environment of Care	11/15	
	Pet Care Plan	Environment of Care	11/15	
	Plan for Auxiliary and Volunteers	Environment of Care	11/15	
	Plan for Chaplaincy Services	Environment of Care	11/15	
	Patient Discharge- Transfer Plan	Environment of Care	11/15	
	Patient Registration and Tracking	Environment of Care	11/15	
POLICIES TO ARCHIVE				
Policy Number	**Policy Name**	**Department**	**DATE ARCHIVE**	

1. Code Definitions- FAS Paging Codes

TITLE:	**Emergency Management - 1.04 Code Definitions - FAS Paging Codes**
CATEGORY:	**Emergency Disaster Management**
LAST APPROVAL:	10/2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☐ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:	Emergency Operations Plan		
OFFICE OF ORIGIN:	Emergency Management		
ORIGINAL DATE:	12/1997		

I. COVERAGE:

All El Camino Hospital staff, medical staff and volunteers

II. PURPOSE:

To notify all staff required to respond to the unanticipated event to implement the appropriate emergency response plan or procedure.

III. POLICY STATEMENT:

When an unanticipated event occurs requiring an emergency response, the Emergency Codes indicated in this policy ~~and procedure~~ will be initiated. Staff will be notified through one or more of our notification systems (e.g., ~~and paged on~~ the Fire Alarm System (FAS), Vocera, and/or the mass notification system).

IV. PROCEDURE:

A. To initiate an emergency response

1. From the Mountain View and Los Gatos campuses DIAL "55"
2. ~~In~~ For the pavilions or offices outside of the main hospital buildings, there may be special procedures for activating an emergency management code (i.e. when you call dial 55 or 9-911.) See the table below for instructions.

   ~~***Los Gatos PPI will always dial 9-911 for all emergency management codes.***~~
3. When you reach the Operator (either the hospital Call Center or 911 report the following:
   a. Your name
   b. Your location in the building, floor, room, etc.
   c. Type and severity of situation.

El Camino Hospital
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TITLE:	**Emergency Management - 1.04 Code Definitions - FAS Paging Codes**
CATEGORY:	**Emergency Disaster Management**
LAST APPROVAL:	10/2012

Code	Dial 55	Dial 9-911	Response Plan
Code Blue CPR/Medical Emergency - Adult	**Mountain View** • Main Hospital • Women's Hospital • Willow Pavilion	**Mountain View** • 125 South Drive • Cedar Pavilion (Senior Health Center) • Melchor Pavilion • Oak Pavilion • Park Pavilion	• Patient Care Services: Cardiopulmonary Resuscitation (CPR) Adult
	Los Gatos • Main Hospital	**Los Gatos** • Behavioral Health ~~• PPI~~ • ~~• Rehab~~ ~~**Clinics**~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	
Code White (Neo-natal) CPR/Medical Emergency Neonatal	**Mountain View** • Main Hospital • Women's Hospital • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion		• Patient Care Services: ▪ CPR, Neonatal LG ▪ CPR, Neonatal MV
	Los Gatos • Main Hospital	**Los Gatos** • PPI ~~• Rehab~~ ~~• **Clinics**~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	
Code White (Pediatric) CPR/Medical Emergency Pediatric	**Mountain View** • Main Hospital • Women's Hospital • Willow Pavilion	**Mountain View** • 125 South Drive • Cedar Pavilion (Senior Health Center) • Melchor Pavilion • Oak Pavilion • Park Pavilion	• Patient Care Services: ▪ CPR, Pediatric LG ▪ CPR, Pediatric MV

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Emergency Management - 1.04 Code Definitions - FAS Paging Codes**
CATEGORY:	**Emergency Disaster Management**
LAST APPROVAL:	10/2012

Code	Dial 55	Dial 9-911	Response Plan
	Los Gatos • Main Hospital	**Los Gatos** • PPI • Rehab ~~**Clinics**~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	
Code Yellow Bomb Threat	**Mountain View** • Main Hospital • Women's Hospital • 125 South Drive • Cedar Pavilion (Senior Health Center) • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion **Los Gatos** • Main Hospital • Behavioral Health • PPI • Rehab	~~**Clinics**~~ • ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~ **Mountain View** • Concern	• Security 2.10 – Code Yellow
Code Red Fire, flames, visible smoke	**Mountain View** • Main Hospital • Women's Hospital • 125 South Drive • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion **Los Gatos** • Main Hospital • Inpatient Rehab	**Mountain View** • Cedar Pavilion (Senior Health Center) • Concern **Los Gatos** • PPI • Behavioral Health • ~~**Clinics**~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	• Fire Safety 4.04 Code Red

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Emergency Management - 1.04 Code Definitions - FAS Paging Codes**
CATEGORY:	**Emergency Disaster Management**
LAST APPROVAL:	10/2012

Code	Dial 55	Dial 9-911	Response Plan
Code Orange Hazardous Material spill/leak	**Mountain View** • Main Hospital • Women's Hospital • 125 South Drive • Cedar Pavilion (Senior Health Center) • Hospital Dr. Radiology • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion	**Mountain View** • Concern	• HazMat 3.05 Code Orange
	Los Gatos • Main Hospital • Behavioral Health • PPI • Rehab	~~**Clinics**~~ ~~• Evergreen Dialysis~~ ~~• Rose Garden Dialysis~~	
Code Triage Internal/External Disaster	**Mountain View** • Main Hospital • Women's Hospital • 125 South Drive • Cedar Pavilion (Senior Health Center) • Hospital Dr. Radiology • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion		• Emergency Management - 1.05 Code Triage
	Los Gatos • Main Hospital • Behavioral Health • PPI • Rehab	~~**Clinics**~~ ~~• Evergreen Dialysis~~ ~~• Rose Garden Dialysis~~	
Code Gray Angry/Violent person	**Mountain View** • Main Hospital • Women's Hospital • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion	**Mountain View** • Concern	• Security 2.06 Code Gray

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Emergency Management - 1.04 Code Definitions - FAS Paging Codes**
CATEGORY:	**Emergency Disaster Management**
LAST APPROVAL:	10/2012

Code	Dial 55	Dial 9-911	Response Plan
	Los Gatos • Main Hospital • Behavioral Health • Rehab	**Los Gatos** ~~• PPI~~ ~~• **Clinics**~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	
Code Silver Person with weapon/ hostage situation	**Mountain View** • Main Hospital • Women's Hospital	**Mountain View** • 125 South Drive • Cedar Pavilion (Senior Health Center) • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion • Concern	• Security 2.07 Code Silver
	Los Gatos • Main Hospital • Rehab	**Los Gatos** • Behavioral Health ~~• PPI~~ ~~• **Clinics**~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	
Code Pink Infant Abduction	**Mountain View** • Main Hospital • Women's Hospital • 125 South Drive • Cedar Pavilion (Senior Health Center) • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion		• Security 2.08.1 Code Pink
	Los Gatos • Main Hospital • Rehab • Behavioral Health	**Los Gatos** ~~• PPI~~ ~~• **Clinics**~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	

TITLE:	**Emergency Management - 1.04 Code Definitions - FAS Paging Codes**
CATEGORY:	**Emergency Disaster Management**
LAST APPROVAL:	10/2012

Code	Dial 55	Dial 9-911	Response Plan
Code Purple Child Abduction	**Mountain View** • Main Hospital • Women's Hospital • 125 South Drive • Cedar Pavilion (Senior Health Center) • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion		• Security 2.09.1 Code Purple
	Los Gatos • Main Hospital • Behavioral Health • Rehab	**Los Gatos** ~~•~~ PPI ~~• Clinics~~ ~~Evergreen Dialysis~~ • ~~Rose Garden Dialysis~~	
Code Green Elopement or Missing Patient	**Mountain View** • Main Hospital • Women's Hospital	• 125 South Drive • Cedar Pavilion (Senior Health Center) • Melchor Pavilion • Oak Pavilion • Park Pavilion • Willow Pavilion • Concern	•
	Los Gatos • Main Hospital • Rehab	**Los Gatos** • PPI • Behavioral Health	

B. **Evacuation Pages**: In fire or other disaster situation requiring evacuation, pages signaling Evacuation are Situation A, B and C. The response plan for each evacuation situation ~~can~~ is located in policy~~:~~ *Emergency Management – 1.16 Evacuation Plan and Alternative Care Locations.* ~~Policy EM 1.16~~

1. **Situation A** (Immediate Area Evacuation): Remove anyone in immediate danger area. Close all doors and windows (except in earthquake) and await further instruction.
2. **Situation B** (Horizontal Evacuation): Relocate persons from an area of danger to an area of refuge on the same level. This will usually mean relocating to an adjacent wing.
3. **Situation C** (Vertical Evacuation): Evacuation of entire building. Relocate all persons from an area of danger to an area of refuge to the outside or to another building.

TITLE:	**Emergency Management - 1.04 Code Definitions - FAS Paging Codes**
CATEGORY:	**Emergency Disaster Management**
LAST APPROVAL:	10/2012

V. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Emergency Management Work Group	07/2012
(name of) Medical Committee (if applicable):	
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	10/2012
Historical Approvals:	

VI. ATTACHMENTS:

- Emergency Management - 1.04.1 Emergency Conditions - Staff Response
- Emergency Management - 1.04.2 Systems Failure - Staff Response

Policies:

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES				
Policy Number	**Policy Name**	**Department**	**Date**	**Summary of Policy Changes**
POLICIES WITH MAJOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Charge Entry	Finance	10/15	1. Updated terminology and specific procedures to reflect iCare system workflows/configuration. 2. Removed references to HBOC billing system and all procedures that are no longer applicable. 3. Eliminated redundancies among various sections The title of the policy was changed from "Revenue Recognition" to "Charge Entry" for easier identification of the content.
	Value Analysis	Purchasing	11/15	Updated to reflect today's workflow through Purchasing. Eliminated redundant wording. Included review of stem cell / biologics by Quality. Clarified process for equipment evaluations.
POLICIES WITH MINOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Cash Balance Pension Plan	Admin	10/15	1. Added summary statement 2. Title change of RPAC member

	Employee Emergency Loan Fund	Admin	10/15	1. Added Statement 2. Restated coverage to be more accurate (all employees to regular full and part-time employees) with eligibility 3. Restated procedure in more “user-friendly” language
	System Modification Testing Coordination and Review of Charge Entry	Finance	10/15	1. Updated terminology and specific procedures to reflect iCare system workflows/configuration. 2. Removed references to HBOC billing system. 3. Updated testing procedures to no longer reflect HBOC’s completely interfaced billing configuration and to instead reflect fully-integrated iCare/Epic applications (with select legacy department systems still interfaced).
	Buying and Reselling New Equipment and Furnishings	Purchasing	10/15	Inserted the word supplies where missing
	Direct Receipt of Material by Departments			
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	
	Use of Signature Stamp for Check Signing	Admin	10/15	no changes
	Construction in Progress Accounting Policy	Admin	10/15	no changes
	Business Corporate Credit Card	Admin	10/15	no changes
	Reimbursement of Business, Education, and Travel Expenses	Admin	10/15	no changes

	Mileage Reimbursement Between Sites	Admin	10/15	no changes
	Vendors for Printing Services	Purchasing	11/15	no changes
	Selection of Products for ECH Promotional Purposes	Purchasing	11/15	no changes
	Delivery of Express Letters and Packages	Purchasing	11/15	no changes
	Purchasing Department Use of Hospital Issued Purchasing Card	Purchasing	11/15	no changes
	Vendor Selection	Purchasing	11/15	no changes
	Management of Obsolete Surplus Equipment, Supplies and Furnishings	Purchasing	11/15	no changes

POLICIES TO ARCHIVE				
Policy Number	**Policy Name**	**Department**	**DATE ARCHIVE**	

Charge Entry Policy

El Camino Hospital
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EL CAMINO HOSPITAL
ADMINISTRATION
POLICIES AND PROCEDURES

70.00 ~~Revenue Recognition~~Charge Entry Policy

A. Coverage:

This policy applies to all El Camino Hospital departments ~~responsible for charge entry and charge reconciliation~~that generate charges related to services provided to patients.

B. Reviewed/Revised:

~~4/2012~~8/2015

C. Policy Summary:

The purpose of this policy is to ensure timely charge entry and accurate revenue recognition in Patient Care Departments.
~~All patient service charges (including but not limited to charges for room and board, procedures, supplies, implantable devices, and pharmaceuticals) that are considered chargeable, pursuant to CMS regulations and industry standard guidelines, should be recorded for all clinical services provided by El Camino Hospital. Patient service charges are to be entered the same day or within the next business day from the service date. Department specific reconciliation procedures will be developed for each department or clinic. Patient service charges should be entered directly in host billing system and/or an appropriate hospital charging subsystem.~~

D. General Statement:

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Patient Care Department Directors/Managers are responsible for ensuring timely entry for all patient service charges (including but not limited to charges for room and board, procedures, ancillary services, supplies, implantable devices, and pharmaceuticals) that are considered chargeable, pursuant to El Camino Hospital's Charge Description Master (CDM), as well as completion of any applicable charge-related work queues and accurate charge reconciliation. ~~Revenue Integrity team~~Revenue Integrity Department is responsible for working with Patient Care departments to establish charges and appropriate compliant ~~Charge Description Master (CDM)~~CDM coding (i.e., CPT/HCPCS and UB-04 revenue coding) that accurately reflect items and services provided. Patient Care Departments are accountable for documenting and maintaining up to date charging and coding processes. ~~Revenue Integrity team~~Revenue Integrity Department will provide periodic educational support regarding appropriate charging and coding processes.

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~~E. Procedure:~~

~~a. Clinic Services~~

~~All charges for clinic visits are to be completed the same day or within the next business day from the date the services are rendered to the patient by the clinic. These charges are entered electronically through the host billing system and/or any other charging subsystem. Each clinic will reconcile both the number of patients presenting on a given date of service to the number of charge sheets (or electronic equivalent), as applicable, at the end of that date of service, and the number of visit charges posted into the subsystem to the number of charges shown processed in host billing system, based on department's daily reconciliation report(s) generated from host billing system. The accuracy of actual services (e.g. service level acuity) charged should also be verified. The Director/Manager of the clinic is responsible to ensure charge reconciliation is processed accurately and timely.~~

~~b. Ancillary (Diagnostic) Services~~

~~All charges for ancillary (diagnostic) services are to be processed on the date the service is performed (or date that specimen is received where applicable for certain lab based charges). Each ancillary (diagnostic) department will reconcile both the number of patients presenting on a given date of service to the number of charge sheets (or electronic equivalent) at the end of that date of service, and the number of visit charges posted into the subsystem to the number of charges shown processed in host billing system, based on department's daily reconciliation report(s) generated from host billing system. The accuracy of actual services charged should also be verified. The Department Director/Manager is responsible to ensure charge reconciliation is processed accurately and timely.~~

~~c. Emergency Department~~

~~Emergency Department charges will be entered into the charge system the same day or the next business day of the date of service. The Department will reconcile both the number of patients presenting on a given date of service to the number of charge sheets (or electronic equivalent) at the end of that date of service, and the number of visit charges posted into the subsystem to the number of charges shown processed in host billing system, based on department's daily reconciliation report(s) generated from host billing system. The accuracy of actual services (e.g. service level acuity) charged should also be verified. The Director/Manager of the department is responsible to ensure charge reconciliation is processed accurately and timely.~~

~~d. Procedure Based Services~~

~~Procedure based charges will be entered into the charge system the same day or the next business day of the date of service. The Department will reconcile charges posted into the subsystem to the charges shown processed in host billing system, based on department's daily reconciliation report(s) generated from host billing system. The accuracy of actual services (e.g. service level acuity) charged should also be verified. The Department Director of each procedure based patient service area (e.g. Outpatient Surgery, Cath Lab,~~

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~~etc.) will batch all the records of services performed and submit to Health Information Management Services for coding pursuant to Department's procedures. The Department Director/Manager will be responsible for enforcing this procedure.~~

~~F~~E. ~~Expectations~~Procedure:

a. Charge Entry and Revenue Reconciliation

Patient Care Departments shall ensure timely charge entry for all billable services, supplies, and pharmaceuticals provided to patients. In addition, Patient Care Department shall ensure that charges entered are reconciled timely.

~~a. Appropriate Charges in the CDM~~

~~Patient Care Departments and Revenue Integrity team will work closely to ensure that all chargeable services are established and validated in the CDM to accurately reflect the items and services being provided.~~

~~b. Periodic Reviews of Existing CDM Line Items~~

~~Patient Care Departments and the Revenue Integrity team will review existing CDM line items including charges annually to ensure they accurately reflect the items and services being provided. A third party (external) review of all CDM line items will be completed no less than every two (2) years.~~

~~c.~~b. Timely Organizational Responses to Changes in Guidelines

Patient Care Departments and ~~Revenue Integrity team~~Revenue Integrity Department will monitor changes in guidelines surrounding the charging, coding, coverage, and billing of items and services being provided by El Camino Hospital. ~~Impacted Patient Care Departments~~Both are accountable for timely implementation of the changes in guidelines. The ~~Revenue Integrity team~~Revenue Integrity Department will assist in broad scope ~~corporate~~ educational needs regarding guideline changes.

~~d.~~c. Validation of Charging Processes in Order Entry Subsystems and Applications

Patient Care Departments utilizing department-specific applications ~~specific~~ for order entry ~~subsystems~~ are accountable for working with the Information Services Department to ensure ~~the~~ validity of ~~the~~ charging processes and linkages within the order entry ~~system~~ application to the CDM. ~~These linkages should be reviewed no later than the first quarter of each calendar year to ensure charge codes accurately reflect the items and services being provided.~~

~~e. Validation of Order Entry Procedure Files~~

~~Patient Care Departments are accountable for the validity of the charge capture processes within the Order Entry Subsystems. Patient Care Departments will work closely with the Revenue Integrity team and Information Technology Department to build, validate, and maintain all department specific CDM tables in their department subsystem.~~

~~f.~~d. Departmental Charge Entry Training

Patient Care Departments are accountable for routine ~~annual~~ staff training of department-specific charge processes. ~~Revenue Integrity team~~Revenue Integrity Department and

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Information Services Department ~~is~~ will be responsible for communicating to specific Patient Care Department the completion of Patient Care Department's request to build new charges under its respective cost center in the hospital CDM. Patient Care Department, in turn, is responsible for working with ~~Information Technology~~Information Services Department, as applicable, to ensure that such new charges are built into its subsystem files that support departmental-charging processes. Patient Care Department and Information Services Department shall ~~be responsible for communicating~~ provide communication back to the ~~Revenue Integrity team~~Revenue Integrity Department (in writing) that it has completed the build of said charges in its specific subsystem or application.

~~g.~~e. Prompt Notification of Potential Charging Issues

Patient Care Departments are accountable for promptly notifying the ~~Revenue Integrity Team~~Revenue Integrity Department and Patient Accounting Department, as well as any other affected department(s) as appropriate, of potential charging issues no later than the following business day after identification~~recognition~~ of the issue. The Patient Care Departments will provide assistance in resolution of such issues and in proper escalation relative to the magnitude of the issue. The ~~Revenue Integrity team~~Revenue Integrity Department will oversee the process to ensure appropriate actions and outcomes are being met timely.

f. Interface/Outlier Issues Communication

Patient Care Departments are ~~accountable~~ responsible for promptly notifying the ~~Revenue Integrity Team~~Revenue Integrity Department, Patient Accounting Department, and the Information ~~Technology~~ Services Department of potential charging issues related to the charge interfaces between the department ~~subsystem~~ application and the host billing system/CDM no later than the following business day after identifica~~recogni~~tion of the issue. The Patient Care Departments will provide assistance in resolution of such issues and in proper escalation relative to the magnitude of the issue. The ~~Information Technology~~Information Services Department is responsible for providing timely support, updates, and resolution of such interface issues. The ~~Revenue Integrity team~~Revenue Integrity Department will oversee the process to ensure appropriate actions and outcomes are being met timely. Patient Care Departments shall also notify the Revenue Integrity Department of any other issues that will or may result in an unusual delay in charge entry (e.g. staffing issues). Furthermore, any system upgrades to applications that involve charging functionality should be tested, pursuant to the procedures outlined in Administrative Policy 73.00 (System Modification Testing and Review of Charge Integrity).

~~h.~~

~~i. Timely Charge Entry and Outlier Communication~~

~~Patient Care Departments are accountable for adhering to the Charge Capture procedures for timely entering of charges. Revenue Integrity team will provide communication of any significant late charges to affected Departments throughout El Camino Hospital.~~

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~~(Note: Definition of a late charge is any charge that is entered by a Patient Care Department beyond four days from the date of service.)~~

~~j. Expectations and plan for corrective action, if the department fails to meet the goals are listed below:~~

~~1) 100% of charges for each day's service are required to be entered into the department's primary charge capture system on the day of service and no later than four (4) days post service date. Exceptions may be agreed upon due to department specific system limitations. All charge entry must be completed in accordance with the following table:~~

	~~Service Date~~	~~Post Service Day 1~~	~~Post Service Day 2-3~~	~~Post Service Day 4~~
~~Charge Entry Percentage~~	~~90% 100%~~	~~95% 100%~~	~~98% 100%~~	~~100%~~

~~2) A daily revenue recognition reconciliation form will be completed and verified by a designated department staff member.~~

~~3) The Revenue Integrity team will monitor the weekly late charge report and will report any significant variances to the appropriate levels of management as necessary.~~

~~4) Departments who are out of compliance for 4 consecutive weeks will complete a corrective action plan (attachment A) and submit it to the department VP and to the Revenue Cycle Committee.~~

~~5) Plan of corrective action form completion~~
~~i. Part 1 requests description and cause of deficiency~~
~~ii. Part 2 describes the corrective action to be taken~~

~~k.~~g. Charge Reconciliation

Patient Care Departments are accountable for daily charge reconciliation. ~~At a minimum, Patient Care Departments should validate the number of patients seen, the number of procedures performed and the accuracy of the data that is entered, exported, and posted each day utilizing their department specific reconciliation reports. The Patient Care Departments are ultimately responsible for promptly communicating any experience in delay in receiving daily department specific report(s) that originate from the Information Technology Department no later than the next business day.~~

~~l. Charge Error Report~~

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~~Each Patient Care Department is accountable for the daily resolution of its charge errors (both credit and debit) on the host billing system error report. Patient Care Departments are accountable for responding timely to inquiries related to charge error resolution, and the implementation of process controls to minimize the volume of charging errors.~~

~~m.~~h. Auditing

The ~~Revenue Integrity team~~Revenue Integrity Department ~~will~~ may perform random audits of key departments ~~annually~~ to ensure the charging process is performing as outlined. Department re-education and training will occur as needed.

~~n.~~i. Downtime and Recovery Procedures

Each Patient Care Department is responsible for adhering to downtime and recovery procedures as outlined in the El Camino Hospital Administrative and department-specific policies and procedures as applicable. Additionally, Patient Care Department shall immediately notify, no later than the end of current business day, the ~~Revenue Integrity team~~Revenue Integrity Department, ~~Information Technology~~Information Services Department, and specific subsystem's vendor support in the event that its department subsystem experiences any unforeseen downtime. Any planned downtime for subsystem maintenance must be first coordinated and approved by the ~~Information Technology~~Information Services Department well in advance to allow sufficient preparation and communication with all affected departments.

~~o.~~j. Reports and Dashboards

The Patient Care Department's Director/Manager will work with its designated financial analyst to review ~~monthly~~ charge summary reports/dashboards and immediately report any significant variances or errors to the ~~Revenue Integrity team~~Revenue Integrity Department, who will provide assistance in resolution of such issues and ensure proper escalation relative to the magnitude of the issue.

k. Work Queues

The Patient Care Department's Director/Manager is responsible for ensuring that designated charge review staff complete any charge review work queues, claim review work queues, or other work queues that affect revenue.

~~G~~F. Definitions

a. Charge Description Master file (CDM) – a listing of all chargeable items and services, including room and board, procedures, supplies and pharmaceuticals provided ~~within El Camino Hospital~~.

b. Patient Care Department – A hospital department that provides chargeable items and/or services to patients ~~within El Camino Hospital~~.

~~H~~G. ~~Attachments:~~

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~~Attachment A: Revenue Recognition Policy – Plan for Corrective Action~~

~~I.~~ Approvals:

Revenue Cycle Committee – March 2012
Executive Operations Committee – April 2012
Finance Committee – April 2012
Board – May 2012

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~~Attachment A – Revenue Recognition – Plan for Corrective Action~~

~~**Revenue Recognition - Plan for Corrective Action**~~

~~Part 1 – Description and Cause of Deficiency~~

~~Department~~
~~Manager~~
~~Reporting Period~~

~~Description:~~

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~~Revenue Recognition – Plan for Corrective Action~~ ~~Approvals (Initial/Date)~~

~~Part 2 – Action to be taken~~

~~Exec:~~ _____

_____ ~~Mgr:~~ _____

~~Department:~~ _____

~~Manager:~~ _____

~~Reporting Period:~~ _____

~~Identify the necessary action:~~
~~(List the steps needed to correct the variance and prevent a recurrence of the problem)~~
~~Identify necessary skills and resources:~~
~~(List any skills or resources needed to complete the actions steps)~~
~~Map a corrective action timeline:~~
~~(Consider the time needed for completing each action)~~

~~Action Steps~~	~~Resources/Skills~~	~~Person Responsible~~	~~Completion Date~~	~~Expected Results~~

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~~Revenue Recognition Policy – Attachment A~~

~~Revenue Recognition - Plan for Corrective Action~~

~~Part 1 - Description and Cause of Deficiency~~

~~Department~~ _____
~~Manager~~ _____
~~Reporting Period~~ _____

~~Description:~~

~~Revenue Recognition - Plan for Corrective Action~~ ~~Approvals (Initial/Date)~~

~~Part 2 - Action to be Taken~~

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~~Exec: _____~~

~~Mgr: _____~~

~~Department: _____~~
~~Manager: _____~~
~~Reporting Period: _____~~

~~Identify the necessary action:~~
~~(List the steps needed to correct the variance and prevent a recurrence of the problem)~~
~~Identify necessary skills and resources:~~
~~(List any skills or resources needed to complete the actions steps)~~
~~Map a corrective action timeline:~~
~~(Consider the time needed for completing each action)~~

~~Action Steps~~	~~Resources/Skills~~	~~Person Responsible~~	~~Completion Date~~	~~Expected Results~~

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Value Analysis Policy

POLICY/PROCEDURE TITLE:Finance: Value Analysis Policy

CATEGORY: Administrative
LAST APPROVAL DATE:

SUB-CATEGORY: Finance
ORIGINAL DATE: 04/11

COVERAGE:

All El Camino Hospital facilities and departments.

PURPOSE:

To identify, assess and monitor processes for acquisition of medical products/supplies and equipment for El Camino Hospital that will improve outcomes, reduce costs, and optimize utilization. An interactive, discipline specific Value Analysis Team approach will be utilized to determine technical, clinical and economic quality for new products and equipment introduction.

STATEMENT:

DEFINITIONS *(as applicable)*:

Value Analysis (VA) is the process by which every element of cost and function is studied in an organized and systematic manner to identify unnecessary cost while also supporting quality patient care. Examples include identification and elimination of redundancies, meeting contractual obligations and following strategic purchasing initiatives while ensuring the supplies and equipment meet clinical requirements.

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PROCEDURE:

All requests for acquisition of new medical products/supplies and equipment shall be forwarded to Purchasing / Value Analysis Coordinator.

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2. The Value Analysis process will be used for:
    a. Introduction of new medical products/supplies and equipment
    b. Standardization of existing medical products/supplies and equipment

c. Optimization of Group Purchasing Organization, and local contracting in support of strategic purchasing targets

d. Utilization review

e. Clinical review

~~e.~~ 1. Products related to medication, stem cells or biologics require approval from Pharmacy and Therapeutics Committee prior to purchase/use decision.

f. Regulatory review.

1. New products are to be FDA approved. If not FDA approved or product is being considered for research purposes, Risk Management is to be contacted before any decision about purchase/use is made.

~~f.~~ 2. Any medical equipment that is to be used on a patient that will not be owned by the hospital is to be approved by Clinical Engineering and Risk Management before purchase/use decision is made. If approved for use, the vendor must provide all necessary quality control paperwork required for accreditation purposes or equipment cannot be used.

g. Financial performance

h. The movement of product/contract decisions from individual preferences to decisions based on group preference, clinical outcomes and financial performance.

i. The engagement of clinical shareholders in product standards, identification of alternatives and clinical product evaluations.

3. El Camino Hospital Mountain View and Los Gatos are non solicitation campuses and vendors are required to conduct business in the Purchasing department. Department managers should not accept medical supplies / product or equipment that have not been vetted and approved through the hospitals Value Analysis program.

~~3. El Camino Hospital MV LG are non solicitation campuses~~

F: PROCEDURE:

Departments contacted by a vendor:

- Should not initiate business with the vendor. Pricing, current products used or satisfaction level of current product used should not be discussed. Direct the vendor to the Value Analysis Coordinator (VAC) located in the Purchasing department. The VAC will conduct a Business Review with the supplier to asses strategic purchasing benefit and will contact department Manager for further discussion if merited.
-

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- ~~Direct the vendor to the assigned Buyer Partner (B-P) in Purchasing (a list of B-P's will be published) or to the Purchasing Manager or Director of Material Management.~~
- ~~Buyer Partner and the Value Analysis Coordinator will assess for strategic purchasing benefit and will contact Manager for further discussion.~~

Departments interested in medical products/supplies and equipment:

- Prior to contacting or discussing any business with a vendor, contact the Value Analysis Coordinator located in the Purchasing department for initial review and strategic assessment. The requestor will be assisted in submitting a new product / supply or equipment request and presented to the appropriate Value Analysis Team (VAT) for further discovery. ~~assigned Buyer Partner in Purchasing, or the Purchasing Manager or Director of Material Management.~~
- ~~Purchasing and the Value Analysis Coordinator will assess for strategic purchasing benefit and will contact Manager for further discussion.~~
- Purchasing and the VAC ~~Value Analysis Coordinator~~ will facilitate meetings with interested departments and vendor(s)
- Clinicians attending professional meetings (seminars etc.) with an interest in new products/equipment presented should bring the product information, including contact information, back to the VAC.

4. At times an urgent need for a particular product arises. Contact the VAC, and Purchasing ~~In these situations Material Management~~ will review the ~~purchase~~ request with the appropriate expert liaison, facilitate the purchase and ~~subsequently~~ refer the item to the appropriate VA Team.
5. In procedural departments, a physician~~s~~ may ~~request~~ determine that a new product or technology is necessary for the patient~~prior to the scheduled case~~. In this situation, the department manager and/or the physician should refer the ~~manufacturer / distributor rep~~vendor to the VAC with as much advance notice as possible. Purchase orders will not be issued to the vendor, until pricing has been agreed to. ~~Purchasing prior to the scheduled case. Two weeks notice is preferred. Purchasing will discuss cost, affiliations and other pertinent information. All affected stakeholders such as Finance, Clinical Engineering or Education will be appropriately advised. Following the scheduled procedure, the new product or technology will then be referred to the next scheduled meeting with the appropriate VA team.~~ If this occurs on a holiday or weekend when Purchasing is closed, the affected department should utilize their chain of command for purpose of notification or guidance.

6. All Departments will participate in the Value Analysis process for standardization of medical products/supplies and equipment, to achieve contract compliance and for the overall reduction of product and equipment costs.
7. The Value Analysis Teams will document activities and cost reductions. The ~~Value Analysis Coordinator~~VAC is responsible for the preparation of agendas, communication of actions taken and the preparation of non-salary expense reduction~~s~~ reports~~/savings reports~~ .
8. Other teams, team members and sub-groups may be added as necessary as either permanent or ad hoc teams.
9. The requestor or designee is required to attend the appropriate VA team meeting to present the business and/or clinical case for the requested product. ~~The~~ A requestor that claims savings based on improved clinical outcomes, must present a plan for monitoring, measuring and validating the claim within a specified evaluation period. In addition, the requestor is to present a plan for training on the new equipment/product/supply for staff involved. The requestor will present the data to the VAT for final disposition.
10. The Value Analysis Teams will meet monthly or as appropriate. The dates, times and locations will be pre-determined. The Value Analysis Coordinator will send a reminder to all members at least one week prior to the meetings.
11. Decisions of the Value Analysis Teams are made by consensus. If consensus cannot be achieved a majority vote will be applied.
12. Requested products not approved by the Value Analysis Teams are not eligible to be requested again for 1 year. Exceptions may be made based on availability of current product.
13. The Value Analysis Team(s) shall determine when product/equipment evaluations are necessary. Education, or appropriate department or person will assist by providing product specific, criterion based evaluations. The Value Analysis Team determines areas within the facility for evaluation and the duration of the evaluation. Vendors are expected to provide evaluation product at no cost to the hospital. Exceptions may be made at the discretion of the Director of Material Management. Note: Equipment evaluations are subject to prior approval by IT, Legal,Risk Management, Facilities, Clinical Engineering, Finance and Purchasing. All equipment must be ordered via the hospitals purchase order system, delivered to the receiving dock and checked by Clinical Engineering prior to use. Equipment arriving without prior approvals and a purchase order will not be accepted and returned to the vendor.

~~13.~~14.

G. VALUE ANALYSIS TEAM STRUCTURE

1 The Value Analysis process, through its team structure promotes interdepartmental collaboration in understanding and solving mutual issues. It provides a mechanism whereby physicians and staff continually have access and input into the facility standardization process. The Team structure is listed below:

- Perioperative Team
- Patient Care Team
- ~~Environment of Care Team~~
- Interventional Services Team
- Ancillary Departments Team ad hoc

The work of the Value Analysis Teams is reported up to the Executive Sponsor.

A. Responsibility:

It is the responsibility of the Director of Material Management and the Value Analysis Coordinator (VAC) to implement this policy.

POLICY/PROCEDURE TITLE:Finance: Value Analysis Policy

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	10/12

Historical Approvals:

04/11, 10/12

Urology Call Panel

BOARD MEETING AGENDA ITEM COVER SHEET

Item:	Renewal of Urology ED Call Panel Agreements for Mountain View & Los Gatos El Camino Hospital Board of Directors January 13, 2016
Responsible party:	Eric Pifer, MD, Chief Medical Officer
Action requested:	Approval

Background:

The Hospital has separate Urology Panels at each campus in which urologists respond when needed for emergency evaluations and surgical interventions for patients in the emergency departments. The PAMF physicians have declined to renew their Urology ED Call agreement unless the stipend is increased to $700/day, which is over the 75th percentile according to the MD Ranger survey which the Hospital relies on to evaluate FMV. The Hospital is negotiating a rate of $700/day to include the additional responsibility of covering inpatient consults for unassigned patients.

Committees that reviewed the issue and recommendation, if any: Finance Committee reviewed the initial request of $600/day on November 15, 2015; The Finance Committee recommended that staff negotiate a per diem rate up to $700/day and bring forward a revised proposal to the January Board meeting.

Summary and session objectives :

It is requested that the Board approve delegating the authority to negotiate two-year renewals of the Mountain View and Los Gatos Urology on-call agreements to the CEO on the financial terms described in the 10-step.

Suggested discussion questions:

None.

Proposed Board motion, if any:

To approve delegating the authority to negotiate two-year renewals of the Mountain View and Los Gatos Urology on-call agreements to the CEO with an increase in the daily per diem rate to $700 per campus to include the additional responsibility of covering inpatient consults for unassigned patients.

LIST OF ATTACHMENTS: 10-Step

Att 27k.2 - 10 Step Urology Renewal - FINAL

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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

Date: January 13, 2016

To: El Camino Hospital Board of Directors

From: Eric Pifer, MD. Chief Medical Officer

Subject: **Renewal of Urology ED Call Panel Agreements for Mountain View & Los Gatos**

1. **Recommendation:** On November 30, 2015 the Finance Committee voted to recommend that the Board approve delegating the authority to negotiate two-year renewals of the Mountain View and Los Gatos Urology on-call agreements to the CEO on the financial terms described herein. It is proposed that there be an increase in the daily per diem rate to $700 per campus with the additional responsibility to cover inpatient consults for unassigned patients. We now seek Board approval.

2. **Problem Definition.** The Hospital has separate Urology Panels at each campus in which urologists respond when needed for emergency evaluations and surgical interventions for patients in the emergency departments. The Urology Panel at the Los Gatos campus started in 2010 with fourteen (14) urologists from Urological Surgeons of Northern California, Inc. (USNC) at the rate of $300/day. In December 2012, the Hospital implemented a Urology Panel at the Mountain View campus with four (4) Urologists from USNC and three (3) from PAMF at the current rate of $350/day. In January 2014, the Los Gatos urologists requested an increase to match the rate at which the Mountain View Panel urologists were paid, and at that time their rate was increased to the current rate of $350/day.

   The physicians will not renew their ED Call agreements unless the stipend is increased to $700/day, which is over the 75th percentile according to the MD Ranger survey which the Hospital relies on to evaluate FMV. The Hospital has negotiated a rate of $700/day to include the additional responsibility of covering inpatient consults for unassigned patients.

3. **Authority:** According to Administrative Policies and Procedures 51.00, Finance Committee review and Board approval is required for renewal physician agreements with a greater than 10% increase in compensation and for physician compensation that exceeds 75th percentile. Additionally, the USNC agreement for the Los Gatos campus will exceed$250,000 in annual compensation and requires Board approval.

4. **Process Description:** Approval is requested for the CEO to execute two-year renewals for separate on-call panels to provide urology coverage to the emergency department and inpatient consults for unassigned patients at each campus with a not to exceed rate of

$700.00/day per campus.

5. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** A Urology Panel is not required by Title 22 or EMTALA statutes. If the physicians are not willing to renew at a per diem rate that is within the FMV range established by Board policy, then an alternative solution would be to terminate the Urology Call Panel and implement an arrangement to compensate urologists on an as needed, appearance fee type arrangement.

6. **Concurrence for Recommendation:** All Hospital parties that play a role in physician contract development and negotiation, including the Chief Medical Officer and Chief Financial Officer are in agreement to renew the Urology panel agreements at a not to exceed per day amount of $700.00.

7. **Outcome Measures and Deadlines:** The current PAMF agreement expired November 30, 2015 and the current USNC agreement expires December 31, 2015. On-call ED coverage agreements do not have quality goals included.

8. **Legal Review:** Legal counsel has approved this proposal and will review the final agreement prior to execution.

9. **Compliance Review:** Compliance has approved this proposal and will review and approve the proposed agreement and compensation prior to execution.

10. **Financial Review**: Compensation will be constrained to a not to exceed amount of $700.00 per day per campus, which is over the 75th percentile of the MD Ranger survey amount. A renewal term of two years will be proposed.

Surgical Robot Purchase

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Surgical Robotic System El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Mick Zbedlick, COO Rich Katzman, CSO
	Action requested:	For Approval
	Background: Intuitive Surgical is the industry leader in surgical robotic technology. Their systems are present throughout the market and are considered the "gold standard" among surgeons who offer minimally invasive surgical approaches in general, GYN, urologic and other surgical specialties. In 2014, Intuitive issued its new Xi robotic platform to replace its previous generation Si system that ECH currently has deployed. The new system design offers several improvements that reduce time in the OR and offer greater precision in how the system is used. Acquisition of this new system can be viewed as more of a defensive change rather than an offensive strategy. Staff does not anticipate acquisition of this technology will generate a significant increase in new cases. Rather, this is a defensive strategy that if approved will enable ECH to remain competitive against local competitors that have recently acquired the new model and any other local hospitals that seek to build a robotic surgery program.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: Finance Committee on November 30, 2015; recommended Board approval.	
	Summary and session objectives : 1. Provide education to board on this new surgical technology and its application as part of ECH's strategy to retain market share and volume; 2. Obtain board endorsement and approval to proceed forward with system acquisition	
	Suggested discussion questions: None. This is a consent item.	
	Proposed board motion, if any: Endorsement and approval of requested robotic systems at a cost [Before Rebates] not to exceed $3.7MM.	
	LIST OF ATTACHMENTS: 10-step	

Att 27l.2 - Open 10-Step_Xi system Acquistion

El Camino Hospital®
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Date: January 13, 2016

To: El Camino Hospital Board of Directors

From: Richard Katzman, CSO and Mick Zdeblick, COO

Subject: **New Robotic System Acquisition**

1. **Recommendation**: Proceed with immediate acquisition of 2 new Xi surgical robots from Intuitive Surgical at a total cost [Before Rebates] not to exceed $3.7MM.

2. **Problem/Opportunity Definition**: El Camino Hospital [ECH] has developed a successful program that employs surgical robotic technology. In fact, it is the second largest surgical robotic program in Northern California. The robotic platform used at ECH and other hospitals across the United States and internationally is the product of Intuitive Surgical, a publically traded company located in Sunnyvale. Over the past 6 years, ECH has acquired 4 robotic units; 3 located in Mountain View and 1 in Los Gatos. Currently, all 4 units are the previous generation Intuitive ***Si model***.

   In 2014, shortly after ECH acquired its 4th robotic unit Intuitive released its new ***Xi model*** surgical robot. This new platform provides some substantial improvements compared to the previous Si model. These improvements enable reduced time in the OR, improved precision through the use of laser targeting to assist in robotic arm placement, and greater efficiency for multi-site surgery procedures.

   Utilization and outcomes data for the existing systems is reviewed at the quarterly Robotics Committee meeting. While the volume of robotic procedures has increased over the past 3 years, [e.g. FY 2013 = 706, FY 2014 = 825, FY 2015 = 828] the proposed acquisition is not driven by demand that has outpaced capacity of the available technology. During the last 6 months, the competitive market has begun to change with 2 competitors acquiring the new Xi platform.

   The proposed investment will enable ECH to remain an active participant in this growing segment of the surgical market. While we expect that having the most current robotic platform could attract additional surgeons, no immediate increase in case volume is projected as a result of the acquisition. The market is experiencing an "Arms Race" in advancing technology and this investment is the price required to remain in the market as a viable competitor.

3. **Authority:** According to Administrative Policies and Procedures, Finance Committee review and Board approval is required for capital expenditures in excess of $1,000,000.

4. **Process Description:** Board Policy requires finance committee review and endorsement along with board approval for all capital purchases in excess of $1,000,000. On November 30, 2015, the Finance Committee reviewed and approved in concept the acquisition of this technology. At that time, management had proposed acquisition of one new unit in FY

2015-16 and a second unit in FY 2016-17. The negotiation with Intuitive yielded an opportunity to save ~$400,000 if ECH were to proceed with acquiring both units before December 31, 2015. This amount included $200,000 in discounts [$100k/unit], and additional value being assigned to each SI unity being traded in. Based upon this significant opportunity for cost savings, administrative discretion was applied and we proceeded with acquisition of both units prior to December 31, 2015.

5. **Concurrence for Recommendation:** The new agreement is supported by the Chief Medical Officer, the Chief Strategy Officer, the Chief Operating Officer and the Chief Executive Officer

6. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** The alternative to what is being proposed would be to hold off on the proposed acquisition and continue using the older ***Si model***. The risk is deterioration in case volume as some of our more productive surgeons are lured away to other competitors who are offering more advanced capabilities. Feedback provided by several of our surgeons would suggest that is a very tangible risk.

7. **Outcome Measures and Deadlines:** Regarding deadlines, the only consideration is receipt of both robotic units which will be on or before 12/31/15. As it pertains to measures [e.g. Metrics], the following are proposed.

    a. Quality – Continue to track quality and outcomes measures that are presently monitored by the Robotics Committee. These would include such things as complications, time in the OR, etc.
    b. Operational and Financial – Continue to track financial and related business indicators, including: case volume by surgical specialty, expense and revenue per specialty per case

8. **Legal Review:** Legal counsel has reviewed the final Sales, License and Service Agreement prior to its execution.

9. **Compliance Review:** Compliance has reviewed and signed off on the Sales, License and Service agreement.

10. **Financial Review**: A financial assessment of the existing robotic surgery program yielded the following regarding the mix of surgical sub-specialty and payer mix.

Robotic Surgeries by Type	FY2013	FY2014	FY2015
GYN	56%	61%	49%
Men's Health/Urology	17%	18%	23%
Onc	21%	10%	11%
Bariatric	0%	2%	8%
General Surgery	4%	7%	8%
Other	2%	2%	0%

Robotic Surgeries by Payer	FY2013	FY2014	FY2015
Medicare	24.4%	22.8%	22.9%
PPO	73.2%	74.6%	75.3%
Other	2.4%	2.5%	1.8%

The information demonstrates two positive trends: (1) A growing diversity in the types of surgical specialties availing themselves of this technology, and; (2) Reimbursement per case improved with an increase in PPO cases and reduction in dependence on Medicare. From FY 2014 to FY 2015, reimbursement increased by $1,191 per case while a reduction in cost per case of $1,051 was also reported. The net result was an improvement of $2,242 in net income per case.

A 3-year summary of financial performance for robotic surgery at ECH is provided in the chart that follows:

	FY2013	FY2014		FY2015		FY2016 Budget*	
	Actual	Pro Forma	Actual	Pro Forma	Actual	Pro Forma	Budget
Volume	706	946	825	946	828	946	828
Net Revenue	16,829,868	22,723,868	21,573,529	22,840,868	20,978,606	22,961,868	20,768,820
Total Cost	10,163,362	14,223,362	15,697,741	14,593,362	11,903,507	14,825,362	12,558,200
Net Income	6,666,506	8,500,506	5,875,788	8,247,506	9,075,099	8,136,506	8,210,620

*** budgeted with no increase in caseload for FY2016**

	FY2014 Increment		FY2015 Increment		FY2016 Budget Increment	
Volume	**240**	**119**	**240**	**122**	**240**	**122**
Net Revenue	5,894,000		6,011,000		6,132,000	
Total Cost	4,060,000		4,430,000		4,662,000	
Net Income	1,834,000	**(790,718)**	1,581,000	**2,408,593**	1,470,000	**1,544,114**

As the information shows, net income has seen solid improvement from $5.9MM in FY 2014 to $9.1MM in FY 2015.

A summary of the proposed transaction is provided in the table that follows.

	Unit Price	# of Units	Total
Surgical Robot [Xi Model]	1,900,000	2	3,800,000
Less Discount	(100,000)	2	(200,000)
Other Upgrades			
- Simulation Unit	85,000	1	85,000
Net Purchase			3,685,000
Less Trade-In For Si Model	(450,000)	2	(900,000)
Net Cash Required			**2,785,000**

Primary Care Center Approval

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Primary Care Centers (PCCs) El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Richard Katzman, Chief Strategy Officer
	Action requested:	For Approval
	Background: As the healthcare market continues to pivot from fee-for-service care to population health based reimbursement, hospitals will require close alignment with groups of primary care physicians. Within ECH's primary service area 3 systems are dominant; Stanford Health, PAMF/Sutter and Kaiser. In addition, Good Samaritan benefits from being part of a larger company, HCA. Each of these organizations has already built formable networks of physicians. ECH's future success will be highly dependent on being able to also develop a network of high quality primary care physicians.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: On November 30, 2015, the Finance Committee reviewed and endorsed the plan as outlined in the attached documents. There are two differences between this request and what was provided in the documents endorsed by the Finance Committee: 1) During the completion of the Business Associates Agreement it was discovered that Argus Medical Management, the MSO company that was previously identified, manages some of its billing office through an off-shore company located in India. A different MSO, Cypress Healthcare Partners, has been identified. Cypress is based in Monterey, brings equivalent experience and our review finds a similar fee structure thus no material impact on the pro forma that was reviewed and endorsed by the Finance Committee. 2) Further specificity requesting approval of the total compensation (not just base income guarantee) including benefits and incentive compensation for the 1st physician. Again, no material impact on the pro forma that was reviewed and endorsed by the Finance Committee.	
	Summary and session objectives: Review and approve attached 10-step and business plan.	
	Suggested discussion questions: None. This is a consent item.	
	Proposed Board motion, if any: Approval to pursue development of up to 5 PCCs, each with 5 physicians located in communities throughout El Camino Hospital's service area. This would include: 1. Total annual compensation for up to 25 physicians [5 Physicians X 5 Offices] o 1st physician/Medical Director – base income guarantee in the amount of $270,000/year for up to 3 years plus incentive compensation and benefits, total compensation not to exceed $370,000 per year(below 75%). 2. Payment for capital improvements, MSO services and salary support for office staff in 5 offices in accordance with the CEO's delegated authority.	

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	LIST OF ATTACHMENTS: 1. Primary Care Center Business Plan **2.** 10-Step for Primary Care Center Development

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Att 27m.2 - PCC 10 step_FINAL

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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

Date: January 13, 2016

To: El Camino Hospital Board of Directors

From: Richard Katzman, Chief Strategy Officer

Subject: **Request to Develop Primary Care Centers [PCCs]**

1. **Recommendation**: Approval to pursue development of up to 5 PCCs, each with 5 physicians located in communities throughout El Camino Hospital's [ECH's] service area. This would include:
    a) Total annual compensation including benefits for up to 25 physicians [5 Physicians X 5 Offices]
        - 1st physician/Medical Director – base income guarantee in the amount of $270,000/year for up to 3 years plus incentive compensation and benefits, total compensation not to exceed $370,000 per year. This is below the 75 percentile on Sullivan Cotter national data.
        - Further detail on remaining 24 physicians will be brought to the Finance committee for review on January 25th and to the Board approval in February 2016.
    b) Payment for capital improvements, MSO services and salary support for office staff in 5 offices in accordance with CEO's delegated authority.
2. **Problem/Opportunity Definition:** As the healthcare market continues to pivot from fee-for-service based care to population health based reimbursement, hospitals will require close alignment with groups of primary care physicians. Within ECH's primary service area 3 systems are dominant; Stanford Health, PAMF/Sutter and Kaiser. In addition, Good Samaritan benefits from being part of a large company, HCA. Each of these organizations has already build formable networks of physicians. ECH's future success will be highly dependent on being able to also develop a network of high quality primary care physicians.

3. **Authority:** According to Administrative Policies and Procedures, Finance Committee review and Board approval is required prior to CEO signature for: (1) Capital requests that exceed $1.0MM; (2) Other service contracts greater than $1.0MM, and; (3) Compensation for physicians in excess of $250,000 per physician.

4. **Process Description:** A business plan including a financial analysis and pro forma have identified capital and operational expenses that will exceed CEO signature authority. These

potential expenses have been vetted internally and, on November 30, 2015, the Finance Committee voted to recommend that the Board approve the proposal.

5. **Concurrence for Recommendation:** The project is supported by the Chief Medical Officer, the Chief Operating Officer, the Chief Financial Officer and the entire ECH administrative team.

6. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** Short of ECH becoming part of an existing competitor, there are few alternatives that are likely to enable ECH to achieve the required strategic outcome. Since the organization is committed to remaining fully independent, development of its own network of PCCs is critical to ECH's future and remaining able to serve the needs of the health care district.

7. **Outcome Measures and Deadlines:** A schedule for introducing the proposed PCCs is provided below.

Both quality measures as well as financial metrics will be put in place to monitor performance of each PCC. Along with these quality and financial metrics the above calendar will be used to evaluate and report on the progress of each PCC [Frequency of reporting TBD]

8. **Legal Review:** Both internal and outside legal counsel have been closely involved in the development of all recommendations to-date. Any future contracts that are required to pursue this project along with any other work that involves the actions proposed will receive complete review by legal counsel.

9. **Compliance Review:** Compliance will review and approve the proposed agreements and each request for physician compensation/support prior to execution.

10. **Financial Review:** The pro forma was built using the following assumptions:

- Payer mix modeled at 10% Medi-Cal/ current practice contains less than 1% Medi-Cal
- Patients migrate to 51% "managed" the 10 year period, for which a management fee is paid
- Reimbursement increases by 2% annually, matching expense/salary increases
- Expenses & billing efficiency match projection by Argus/Pro Health turnkey operation
- Tenant improvement under $1 million for 5,000 sq feet / lease rates at fair market value
- Clinic net income shows NPV at a loss of ($5.3 million) for the "expected scenario"
    - If plans move to "shared savings" faster than modeled, losses may be less
    - If patients not follow the physicians to new site, losses may be higher

Based upon these assumptions, the following pro forma for introducing each office has been developed

1st Clinic: Existing Practices	Projected: EXPECTED SCENARIO					
	FY 2016 Start March 1 2016 1/4 yr	FY 2017 - 4 MDs	FY 2018 - 5 MDs	FY 2019 - 5 MDs	FY 2020	FY 2021
Visits	990	10,184	10,836	11,728	16,828	16,828
Total Operating Revenue	$ 104,396	$ 1,325,533	$ 1,510,626	$ 1,665,920	$ 2,220,036	$ 2,261,353
MD FTEs	0.50	4.00	5.00	5.00	5.00	5.00
MD Fees	170,000	1,120,000	1,421,500	1,443,430	1,465,799	1,488,615
Clinic Staff Salary and Benefits	61,701	635,522	810,290	826,496	843,026	859,886
Total Non Labor	205,176	531,392	540,438	555,441	655,574	672,775
Total Oper Expense	436,877	2,286,913	2,772,227	2,825,367	2,964,399	3,021,277
NET OPERATIONS OF COMMUNITY CLINIC	(332,481)	(961,380)	(1,261,601)	(1,159,447)	(744,363)	(759,924)
Loss per MD FTE	*(664,962)*	*(240,345)*	*(252,320)*	*(231,889)*	*(148,873)*	*(151,985)*
	Projected: LOW VOLUME SCENARIO					
Net with 80% Volume/No change in Staffing	*(363,800)*	*(1,359,040)*	*(1,714,789)*	*(1,659,223)*	*(1,410,374)*	*(1,438,330)*
Scenario Analysis Loss per MD FTE	*(727,600)*	*(339,760)*	*(342,958)*	*(331,845)*	*(282,075)*	*(287,666)*

The above summarizes the cost for starting each clinic and the projected operating losses based upon the assumptions provided. The spread sheet that follows will provide the 5-year cumulative impact on ECH, including a projection of potential hospital utilization as these centers become fully operational.

Primary Care Center Development Plan		**5 Year Estimate**				
November 2015	**FY 2016 Start March 2015**	**FY 2017 - 1st full year**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Clinics by End of Year	1	3	5	5	5	5
Physician/PA/NP FTE	0.50	6.00	15.50	23.00	25.00	25.00
Panel Members/Lives	2,411	13,272	26,310	38,086	43,886	52,374
Managed	0%	0%	42%	42%	52%	52%
SVMD - Legal and Oversight	(500,000)	(500,000)	(500,000)	(500,000)	(500,000)	(500,000)
Clinic Losses *	(332,481)	(1,774,994)	(4,279,719)	(5,901,960)	(6,785,656)	(5,608,880)
Clinic Losses Per Physician/PA/NP		(379,166)	(308,369)	(278,346)	(291,426)	(244,355)
Tenant Improvement Cash Outlay	(980,000)	(3,062,500)	(1,102,500)	0	0	0
Estimated Contribution to Hospital Fixed Expense	15,290	5,395,690	16,629,088	29,395,549	34,579,312	40,813,197
Estimated NPV at 5% of Clinic	(32,828,690)					
Estimated NPV at 5% of Clinic, plus potential contribution	73,823,795					

Note: Potential contribution occurs as patients use hospital services as part of an overall network of care, this is NOT all incremental to current services

Att 27m.3 - PCC Final Business Plan_Board Submission_ FINAL

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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Phone: 650-940-7000
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January 13, 2016

TO: El Camino Hospital Board of Directors
FROM: Richard Katzman, Chief Strategy Officer
RE: Physician Development Plan – Primary Care Center Development

REQUEST

Approval from the Board to develop up to 5 primary care centers [PCCs] over the next 3 years, in locations throughout ECH's primary service area. For purposes of this project and to meet market need, primary care is defined to include the following specialties: Internal Medicine, Family Practice, Pediatrics and; OB/GYN. Each of the centers will be set up for 5 physicians. The first of these clinics is planned for location in Campbell with the first physician recruit already identified to start in Q4 of FY 2016. Future potential locations include the communities of Almaden, Santa Clara, Milpitas, and Saratoga.

BACKGROUND/MARKET SITUATION

As a modest sized community hospital, El Camino Hospital [ECH] will be increasingly challenged to maintain its market relevance without a secure relationship with a base of primary care physicians. Markets throughout California and across the country are experiencing a shift from traditional fee-for-service based reimbursement, towards a risk-based payment structure that is defined by lower cost, controlled utilization and improved outcomes. Today, ECH remains highly dependent [i.e. 50% of its admissions] upon a relationship with the Palo Alto Medical Foundation [PAMF] where there is partnership on some clinical areas and direct competition in others. Beyond PAMF, the balance of ECH's inpatients comes from an unorganized collection of independent community physicians.

During the past 3 years, the local market has experienced a significant shift reflected by the growth of 3 systems; Stanford Health, PAMF/Sutter and Kaiser. Stanford Health has introduced a new cancer center in Los Gatos and it continues expanding through both acquisition and new development. Kaiser currently holds ~32% of the available market and reports its growth at ~3% annually. It already offers a full spectrum of care to complement its insurance coverage. Leveraging its relationship with Sutter, PAMF has also grown substantially over the past few years throughout ECH's primary service area by acquiring both specialty and primary physician office practices. It has already developed a significant presence on the Good Samaritan Hospital campus and reports growth in that market at a rate of 1,000 patients per month.

ECH's strong market position and financial performance has been significantly enhanced by its location in a community whose employment base is the rapidly expanding high-tech industry. However, over time market relevance and financial performance will erode due to the following factors: (1) These companies who today are more concerned with top line growth than managing expenses will eventually see the need to reduce the growing cost of benefits, and; (2) The local reimbursement market controlled by payers will shift from fee-for-service to population health based fee-for-value. Moreover, CMS has made it clear that by 2018 the vast majority of its reimbursement will be through Alternative Payment Methods [i.e. some form of risk based payment]. Without access to and partnership with an adequate network of primary care physicians, ECH will be significantly challenged to maintain its market relevance and financial position.

BUSINESS MODEL SELECTION

Location in California limits the options that hospitals have to work with physicians under anything that resembles an employment model. Universities benefit from an exception that allows for Physician employment under a faculty practice arrangement. There are also opportunities for what can be referred to as "quasi employment" through a foundation model [1206(j)] but that requires a minimum employment of 40 physicians across 10 medical specialties. It also requires time and financial resources to develop and could represent a future opportunity for ECH but not at this time. As a district hospital there are several other outpatient clinic models that can be used to create a close relationship that can provide similar benefits to the foundation or faculty practice employment model. These models are summarized in the table that follows:

CLINIC OPTIONS	1204(a) - Community Clinic	1206(b) - Government	1206(g) – Clinic Affiliation with School of Healing Arts
CORPORATION	Separate Corporation (or Operating Division)	Directly operated by US Govt OR a Community/Free Clinic directly operated by the State (incl. a District)	Separate Corporation (or Operating Division) either owned by a school of healing arts or affiliated with one
LICENSING	Separate License	No License	No License
PHYSICIANS	Contracted W-2	Contract With Group; W-2 Possible	Contract With Group; W-2 Possible with faculty/residents when employed by school
ACCREDITATION	None Required unless accrediting agency determines clinic is integrated with hospital	None Required unless accrediting agency determines clinic is integrated with hospital	None Required unless accrediting agency determines clinic is integrated with hospital or, if owned by school, as part of school's accreditation
BUILDING STANDARDS	OSHPD3 But Locally Determined	Local Building Code	Local Building Code
REIMBURSEMENT	Part B billing; similar to a medical group. Eligible for grants.	Part B billing; similar to a medical group	Part B billing; similar to a medical group
ISSUES	Cost, Licensure, Compliance	Governance, LAFCo	Reliance on Partnerships,
EXAMPLES	CHOMP, ECH	Salinas, Marin	Lucile Packard, Providence Saint John's Medical Center; Mission Community Hospital; USC; CHLA; Stanford

To determine the best option for ECH, the following criteria were considered: (1) Time to market; (2) Cost of construction; (3) Governance requirements; (4) Compliance related risks, and (5) Political Risks.

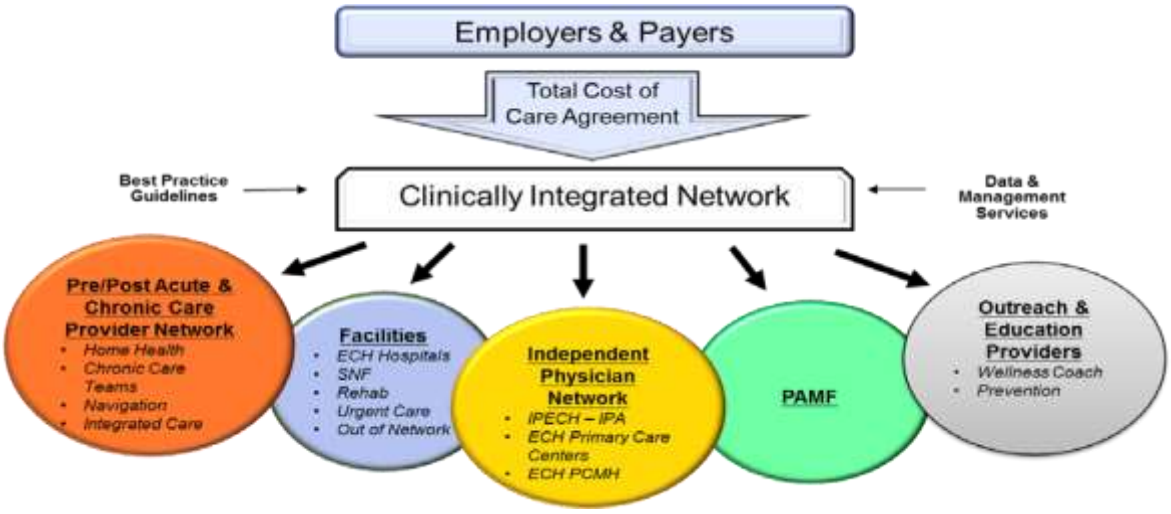
Based upon our assessment of each category of risk and with advice of outside counsel, management is recommending the 1206(g) model.

IMPLEMENTATION

ECH can reduce time to market; minimize cost of entry and other political risks through use of the 1206(g) clinic model. We believe that, to optimize the operation, expertise skilled in managing physician office practice is required. We are therefore recommending engagement of an outside Management Services Organization [MSO] to handle all front office and back office functions. Cypress Healthcare Partners, a based in Monterey, California has been identified as the MSO with whom we w o u l d partner for this effort. Cypress has 200+ physicians under management, mostly located In Monterey County. Please see Attachment 1.0, for an expanded summary of the services and current client base of Cypress Healthcare Partners. Finally, we propose to set this entire operation up through Silicon Valley Medical Development [SVMD]. This would allow us to engage Cypress and individual physicians through separate PSAs and keep operation of these centers separate from the hospital but still enable proper oversight. ***If approval is received, implementation would begin immediately and we would expect to have our first location operational with at least 2 physicians by June 30, 2016.***

STRATEGIC FIT

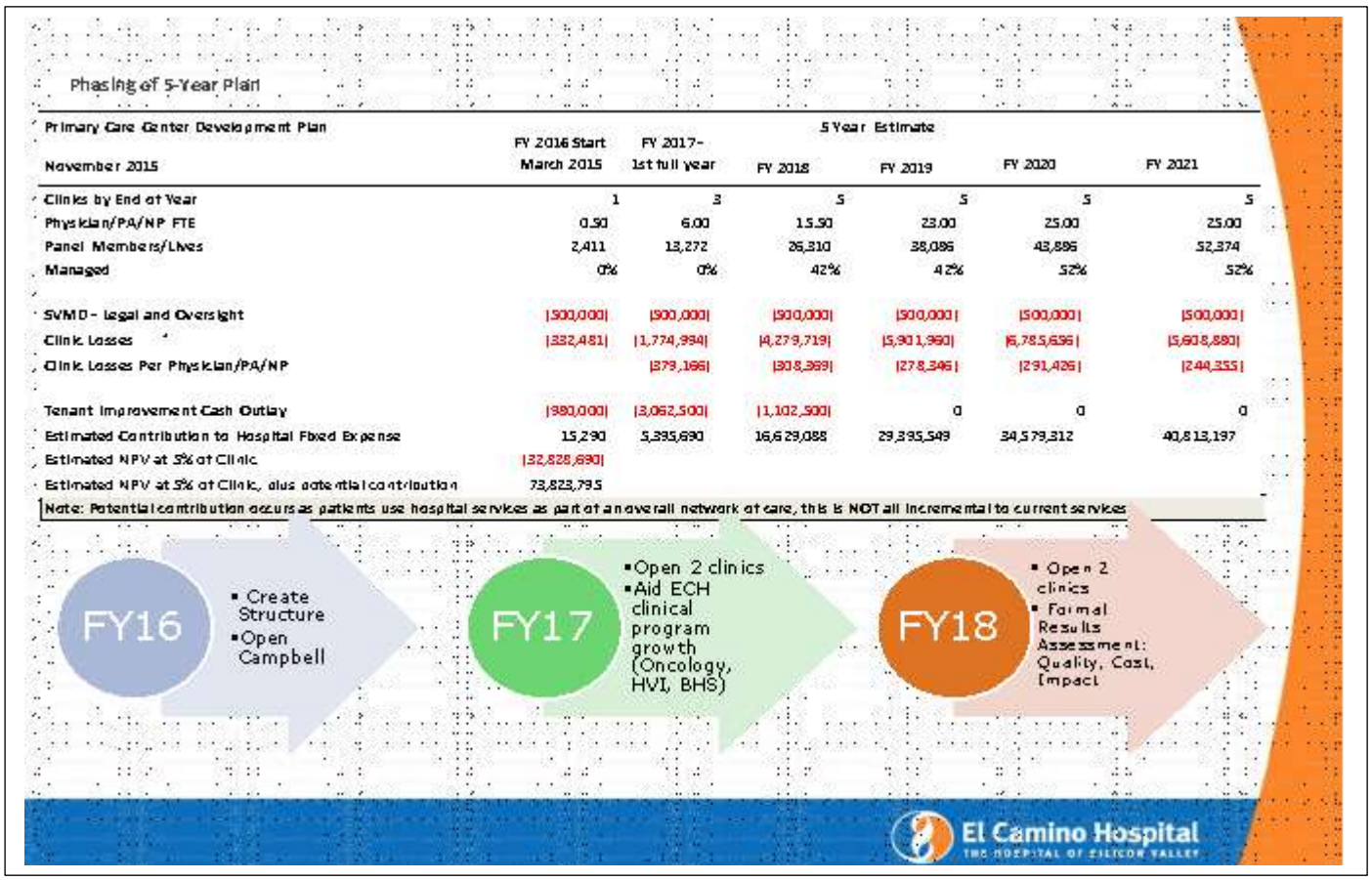
ECH is engaged in evaluating its options to develop a Clinically Integrated Network [CIN] as a larger mechanism through which to engage physicians. A CIN is a selective partnership of physicians, led by physicians, collaborating with hospitals to deliver evidence-based care to improve quality and demonstrate value to the market. We believe that development of a CIN represents one way in which ECH can retain its market relevance and financial position. A summary of how we envision a CIN would work with and relate to the market is provided in the following illustration.



Development of PCCs is only one of several important components that will be required to create a CIN. The above chart also identifies the potential inclusion of a new IPA along with the Patient Centered Medical Home as key components for a larger provider network.

FINANCIAL ANALYSIS

Attached for your consideration is a financial analysis that projects the cost associated with scaling up of the proposed network of PCCs and future operating results. Please note, we recognize that on their own, each physician is projected to produce annual net operating losses that range from as much as $252K in FY 2018, declining to $152K by 2021. Collectively, each center when fully operational will therefore produce net operating loss ranging from a high of $1.3 MM in FY 2018 declining down to $760K by FY 2012. For purposes of this analysis a worst case scenario was also created in which only 80% of maximum projected volume is achieved during the pro forma period. As a result of this reduction in patient volumes, the per clinic operating loss reaches a high of $1.7 MM in FY 2018, declining to $1.4 MM in FY 2021. [Please see attached pro forma for additional year by year per clinic detail along with a cumulative summary for all clinics.] Despite these losses, we project each center will utilize ECH in Los Gatos and Mountain View. Moreover, when the market shifts from its current fee-for-service reimbursement to at-risk or capitated payments, ECH will have a portion of the primary care physician base required to participate in these payment arrangements. The attached analysis provides the base assumptions that were used and a 5-year pro forma.



Key Assumptions:

- Payer mix modeled at 10% Medi-Cal/ current practice contains less than 1% Medi-Cal
- Patients migrate to 51% "managed" over the 10 year period, for which a management fee is paid
- Reimbursement increases by 2% annually, matching expense/salary increases
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  - If plans move to "shared savings" faster than modeled, losses may be less
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1st Clinic Existing Practice			**Projected: EXPECTED SCENARIO**			
	FY 2016 Start	**FY 2017**	**FY 2018**	**FY 2019**		
	3/1/16 .25 YR.	**4 MDs**	**5 MDs**	**5 MDs**	**FY 2020**	**FY 2021**
Visits	990	10,184	10,836	11,728	16,828	16,828
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Total Oper Expense	436,877	2,286,914	2,772,228	2,825,367	2,964,399	3,021,276
Net Ops. Of Clinic	(332,481)	(961,381)	(1,261,602)	(1,159,447)	(744,363)	(759,923)
Loss per MD FTE	(664,962)	(240,345)	(252,320)	(231,889)	(148,873)	(151,985)
Net W/80% Volume +			**Projected: LOW VOLUME SCENARIO**			
no change in staffing	(363,800)	(1,359,040)	(1,714,789)	(1,659,223)	(1,410,374)	(1,438,330)
Scenario Analysis Loss/MD FTE	(727,600)	(339,760)	(342,958)	(331,845)	(282,075)	(287,666)

Medical Staff Report

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Board of Directors Open Session – January 13, 2016

To: El Camino Hospital Board of Directors

From: Ramtin Agah, MD, Chief of Staff MV
Karen Pike, MD, Chief of Staff LG

Date: December 28, 2015

RE: REPORT FROM THE MEDICAL STAFF EXECUTIVE COMMITTEE

This report is based upon the Medical Staff Executive Committee meeting of **December 10, 2015**.

Request Approval of the Following:

A. Patient Care Policies & Procedures – Policy Summaries (pp. 3-16)

- **New Policies (attached)**
  - Utilization Management Plan (pp. 17-25)
  - Endolumenal Functional Lumen Imaging Probe Assisting MD (pp. 26-28)
  - Small Bowel Capsule (pp. 29-32)
  - Clinical Alarms Policy (pp. 33-35)
  - Description of Inpatient Services (pp. 36-44)
  - Fall Prevention Infusion Center (pp. 45-46)
  - Oncology Dietitian Referral (pp. 47-48)
  - Insulin Intravenous Administration in the Perinatal Patient (pp. 49-53)
  - Admission of Newborn to Labor and Delivery (pp.54- 57)
  - Care of the Obstetrical Patient in the OB Emergency Department (pp. 58-61)
  - Triage Orders for the Obstetric Patient in the OB Emergency Department (pp. 62-64)
- **Policies with Major Revisions (attached)**
  - Imaging Services Handoff Communication Guidelines (pp. 65-66)
  - Value Analysis (pp. 67-72)
  - Downtime and Reconciliation (pp. 73-87)
  - Triage and Assessment in the ED (pp. 88-95)
  - Radiologist Peer Review (pp. 96-97)
  - Management of Multi-Drug Resistant Gram Negative Rods (pp. 98-108)
  - Infection Control Plan (pp. 109-140)
  - Emergency Care of the Patient in the Cancer Center and Outpatient Infusion (pp. 141-144)
  - Medical Screening Exam (pp. 145-150)
  - Telemetry Cardiac Monitoring (pp.151-156)
- **Policies with Minor Revisions (See summary pp. 3-16)**
- **Policies with no Revisions (See summary pp. 3-16)**

B. Medical Staff

- **Policies and Procedures**

- Disaster Credentialing Policy (pp. 157-159)
- Impaired Physician (pp. 160-161)
- Guidelines for Supervision of Residents (pp. 162-164)
- Removal Adverse Peer Review Conclusions from Credentials Files (pp. 165-166)
- Medical Staff Credentials Files (pp. 167-169)
- Confidentiality of Peer Review (pp. 170-171)
- OPPE (pp. 172-174)
- Fluoroscopy Supervisor and Operator License (pp. 175-176)
- Electronic Submission of Application and Reappointment (pp. 177-178)
- Procedure to Assure Timely Record Keeping (pp. 179-181)

- **Privilege Lists**
  - **Ophthalmology (pp. 182-185)** – Addition of initial and reappointment criteria for all Noncore privileges
  - **Internal Medicine (pp. 186-190)** – Addition of initial and reappointment criteria for all Noncore privileges
  - **Infectious Disease, New (pp. 191-194)** – New privilege list
  - **Endocrinology (pp. 195-198)** – Addition of initial and reappointment criteria for all Noncore privileges
  - **Anesthesia (pp. 199-201)** – Adding ability to perform an H&P and updates to Core Privileging
- **Rules and Regulations**
  - **Medical Screening Exams (p. 202)** – New language as required by CMS for Emtala

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES				
Policy Number	**Policy Name**	**Department**	**Date**	**Summary of Policy Changes**
	OBED: Triage Orders for the Obstetric Patient in the OB Emergency Department	OB ED	10/15	
	Utilization Management Plan	Care Coordination	10/15	
	Endolumenal Functional Lumen Imaging Probe Assisting MD	Endoscopy	10/15	
	Small Bowel Capsule	Endoscopy	10/15	
	Clinical Alarms Policy	Patient Care	11/15	
	Description of Inpatient Services	BHS	11/15	Reflected current practice to call codes and transfer patients to ED in case of emergency, clarified admission to inpatient to include adults only (age 18 and above),changed visiting hours to begin from 5pm instead of 4pm, reflected correct title of psychiatry order sets, changes MIS to EHR, deleted psychopharmacology training requirement for staff, added nursing manager in chain of command and described the role.
	Alcohol Withdrawal Syndrome; ED	Patient Care	12/15	
	Fall Prevention Infusion Center	Cancer Center	12/15	

	Oncology Dietitian Referral	Cancer Center	12/15	
	Insulin Intravenous Administration in the Perinatal Patient	L&D	12/15	
	Admission of Newborn to Labor and Delivery	L&D	12/15	
	OBED MV: Care of the Obstetrical Patient in the OB ED	L&D	12/15	
	OBED MV: Triage orders for the Obstetric Patient in the OBED	L&D	12/15	
POLICIES WITH MAJOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Imaging Services Handoff Communication Guidelines	Imaging	10/15	Included managing pts on wall oxygen
	Value Analysis	Admin	11/15	Updated to reflect today's workflow through Purchasing. Eliminated redundant wording. Included review of stem cell / biologics by Quality. Clarified process for equipment evaluations.

	Downtime and Reconciliation Policy	Patient Care	11/115	1. Business Continuity Access (BCA) included to describe downtime system in care. 2. Additional departments added under Supportive Data: Care Coordination, Imaging, Infusion Center, Central Supply, EKG, Employee Wellness & Health Center, Oncology, Rehab Services, Respiratory Medicine, & Silicon Valley Primary Care 3. Patient Registration is now Patient Access 4. Pharmacy is requiring for new patients their height & weight status on the Physician Order Form 5. Nursing at LG will call ext. 4025 for STAT Pharmacy order 6. Nursing will initiate lab requisition on form #9350 instead of form 124 7. NIMS is now called Patient Acuity System 8. In the Appendices additional unit specific forms have been added by Behavioral Health, Critical Care, Emergency Dept., NICU, L & D, Mother Baby Unit
	Triage and Assessment in the ED	Patient Care	11/15	1. clearly identify protocol for Initial & Delayed assessment 2. Added Triage intervention process 3. Added definitions 4. Added language on Emergency Severity Index (ESI) in supportive data Added ESI Triage Algorithm & guidelines for triage in Attachment section
	Radiologist Peer Review	Imaging	11/15	Modified to reflect a less specific process in order to accommodate changes related to iCare. Tina Reuter, Director of Medical Staff also reviewed the policy for accuracy with regard to hospital reporting structure.

	Management of Multi-Drug Resistant Gram Negative Rods	Infection Control	11/15	Added: • Screen patients at admission for ESBL with a rectal swab for PCR • Screen patients at admission for both ESBL and CRE Screen patients at admission for both ESBL and CRE who have been hospitalized in India, Pakistan, SE Asia or outside the United States within the previous 6 months; • If initial result is negative, these patients, presenting for care from outside the U.S., will have a repeat rectal PCR swab obtained 35-7 days later for a repeat test for repeat ESBL/CRE testing. • Report all suspect CRE patients to the Public Health Department • Additional changes to Appendix A-Please see policy
	Infection Control Plan	Infection Control	11/15	• Added additional info to the Statement and Definitions • Updated Santa Clara Geographic Locations and Demo • Updated TB Risk Assessment info • Added CLABSI goal SIR <1.0/ NICU goal 0 CLABSI's • Updated Targeted Surveillance/Active Surveillance • Remove Flu vaccination for staff(tracked by EW&HS now) • Added Risk Assessment for FY16
	Alcohol Withdrawal Syndrome; CCU/ICU	Patient Care	12/15	1. Revised to be used with the CIWA-Ar scoring scale as the current one is no longer evidence based. 2. To bring pap in line with the most recent evidence based practice for safer, efficient patient care.

	Alcohol Withdrawal Syndrome; Med/Surg, Tele, PCU	Patient Care	12/15	1. Revised to be used with the CIWA-Ar and the Audit-C scoring tools as the current one is no longer evidence based. 2. To bring protocol/policy in line with the most recent evidence based practice for safer, efficient patient care.
	Alcohol Withdrawal Syndrome; BHS	Patient Care	12/15	1. Revised to be used with the CIWA-Ar and the Audit-C scoring tools as the current one is no longer evidence based. 2. To bring protocol/policy in line with the most recent evidence based practice for safer, efficient patient care.
	Cancer Center- Emergency Care of the Patient in the Cancer Center and Outpatient Infusion	Cancer Center	12/15	Addressing workflow in new location
	Medical Screening Exam	L&D	12/15	Replaces SP-Outpatient Admission to L&D, Management of (v.1); Removed OP-specific info including documentation; Added L&D UPC, IDPC, and OB Exec approval dates –
	Telemetry Cardiac Monitoring	Patient Care	12/15	1. Telemetry Cardiac Monitoring when off the floor – Level I with remote ECG monitoring and Level II – RN and ECG monitoring.
POLICIES WITH MINOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**

	Falls Prevention	Patient Care	10/15	1. Changed the definition of fall to include CALNOC definition (page 2) 2.Changed word to Visual Monitoring (page 4) 3. Included new policy on not moving patient with suspected neuro damage (page 5) 4. Added Fall Committee Chair when submitting post Fall Huddle sheet (page 6) 5. Added outpatient policy and procedures as an addendum (page 7): to consolidate the policies
	Special Admission Procedures for High Risk Patients	BHS	10/15	Added Clinical Manager along with Clinical Director as someone that can review the referral for SAP
	Dress Code for BHS	BHS	10/15	Corrected cross reference to HR Dress code policy
	Rounds	BHS	10/15	Added patient safety attendants as staff that occasionally does safety rounds
	Shift Report	BHS	10/15	Spelling corrections
	Patients Own Medications	Pharmacy	10/15	1. The wording of the policy was changed to reflect the process for compounded patient's own meds.
	Guidelines for Varicella Surveillance Exposure	Employee Health	10/15	1. work flow changes—updated role of Infection Control requested in previous ePolicy meeting 2. updated references
	Management of Exposure to Infectious Disease	Employee Health	10/15	1. table previously approved as "Work-Related Infectious Disease Exposures & Recommendations" 2. added general guidelines section to combine two policies 3. updated references workflow changes
	Direct Patient Care Services Contractual Agreements	Patient Care	10/15	changed verbiage and title changes within the organization
	Blanket Warming	Patient Care	11/15	Temp range per ECRI standard as we have several different manufacturers

	Consent Policy	Patient Care	11/15	1. Added language required by TJC for what is to be shared with patient 2. Added required language about patient surrogates and decision making as required by TJC 3. Added general statement about how consent for research
	Moderation Sedation	Patient Care	11/15	1. Clarification of what the policy covers 2. Delineating the policy section and the procedure section 3. Change monitoring after reversal agent from one hour to two hours 4. Updated NPO guidelines 5. Reformatting
	Patient Care Equipment Cleaning	Infection Control	11/15	1. Feeding, and Infusion pump; change to upon discharge 2. Glucometers and case; germicide agent changed to manufacture recommended disinfectant 3. COWs: added to include keyboard
	Passes	BHS	11/15	Added manager along with director to approve pass. Eligibility for pass changed to reflect only voluntary patients
	Acuity staffing	BHS	11/15	Unit bed capacity changed from 23 to 25 and included manager as the additional chain of command
	Standard of Psychiatric Nursing Care	BHS	11/15	included psychologist and interns as a part of the care team
	History and Physical	BHS	11/15	MIS changed to HER
	QI Plan	BHS	11/15	Included HBIPS as a tool to identify indicators
	Danger to others	BHS	11/15	Standard DTOP precaution monitoring requirement changed to 15 minutes instead of 30 minutes
	Cell Phones	BHS	11/15	Pay phones changed to patient phone. Cell phone no longer stored on unit, sent to security for storage
	Hypoglycemia, Emergency Management in BHS	BHS	11/15	Protocol written to reflect blood sugar level of less than 70 and not less than 60

	Management of Scabies Outbreaks	Infection Control	12/15	1. Outbreak of scabies: 2 or more patients resident, staff, and/or visitors with confirmed (positive skin scrapings) 2. Added under procedure: Dispose of multiple use equipment such as walking belts and blood pressure cuffs. Under "Equipment" replaced such as goose neck lamp with Magnifying lens and light source
	Ventilator Orders	Patient Care	12/15	1. updates of department name, grammatical edits, move to new format. 2. update attached alarm table, removed retired vent and added new vents used by ECH. Revised to be enterprise wide.
	Blood and Blood Products, Management of Patient Receiving	Patient Care	12/15	1. Removed "Including Autologous & Donor Directed Blood" from title 2. Corrected formatting of policy 3. Modified time nurse should remain at bedside after infusion is started from 5 minutes to 10 minutes (comply with AABB standards) 4. Replaced ECHO with EHR 5. Updated references
	Restraints Policy	Patient Care	12/15	Changed the order renewal statement from 24 hours to every calendar day
	Therapeutic Hypothermia, Management of	Patient Care	12/15	1. Update wording to remove all medication doses. 2. Update wording on any medication to follow physician order. 3. Remove any name brand equipment reference in favor of more generic wording.
	Bloodborne Pathogen Exposure Control Plan	Employee Health	12/15	1. work flow changes—updated names of departments 2. updated references

	Handling Sharps	Employee Health	12/15	1. work flow changes—updated names of departments 2. updated references
	Patient Needs Assessment	Cancer Center	12/15	Minor change to encompass all outpatient oncology
	CONTURA Breast High Dose Brachytherapy	Cancer Center	12/15	Added number of supplies needed and made product names generic
	Medical Physicist Duties and Support	Cancer Center	12/15	Changed contracted company name to generic
	Quality Control Program	Cancer Center	12/15	Added descriptors to two items
	Care of the Inpatient Radiation Oncology Patient	Cancer Center	12/15	Updated ECHO to EHR and changed approval date.
	Admission Discharge Transfer (ADT) for L&D Enterprise	L&D	12/15	Made Enterprise, archive previous MV and LG versions; Removed False Labor definition.
	Cervical Ripening with Prostaglandin Agents	L&D	12/15	Spelled out abbreviations, added Dinoprostone dose and administration method, add F to temp, add P&T approval date
	Fetal Demise or Neonatal Death, Management of	L&D	12/15	Changed genetic chromosomal studies to genetic microarray; OB Exec approval date added
	Hemorrhage, Postpartum, Management of the Patient	L&D	12/15	Removed AA abbreviation, PPH Cart location, medication dosages, added P&T approval date
	Hypertensive Disorders of Pregnancy, management of patient	L&D	12/15	Added grams under #4 Supportive Data, Spelled out abbreviations, Removed concentration of IV admixture on page 4 # 10, added P&T approval date
	Magnesium Sulfate Administration	L&D	12/15	Spelled out abbreviations; Added OB Exec and P&T approval dates
	Newborn Care, Management of in L&D	L&D	12/15	Streamlined content; removed items contained in other policies and cross referenced to those policies; NICU team may attend low risk deliveries upon OB Team request; Added OB Exec and P&T approval dates
	Placenta Release to Family and/or Patient and Consent Form	L&D	12/15	Most recent version submitted for approval

	Preterm Labor Suppression, Management of the Patient	L&D	12/15	Spelled out abbreviations; added P&T approval date
	Recovery of Vaginal or Cesarean Section Birth, Immediate Management of	L&D	12/15	Most recent version submitted for approval
	Trial of Labor after Cesarean Section, Management of Patient Attempting	L&D	12/15	Anesthesiologist to evaluate patient on unit; changed elimination to exclusion criteria; added P&T approval date
	Nursing Orientation	Patient Care	12/15	Removed reference to specific PBDS tool, replaced with "formal and Informal assessment tools."
	Competency and Validation	Patient Care	12/15	Removed reference to specific PBDS tool, replaced with "formal and Informal assessment tools."
	Massive Transfusion Protocol	Patient Care	12/15	made into enterprise policy, changed notification requirements
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	
	Guidelines for Patient Selection of Therapist and Prohibition Against Employee Solicitation of Patients for Personal Business	BHS	10/15	
	Definition of Grave disability for submission of LPS conservatorships	BHS	10/15	
	Denial of Patient Rights	BHS	10/15	
	Patient Placement on PICU or PACU Psychiatric Unit	BHS	10/15	
	Admission Procedures for 1 South	BHS	10/15	
	Completion of Mandatory Reporting of Firearms Documentation	BHS	10/15	

	Tarasoff/Duty to Warn Reporting Obligations	BHS	10/15	
	Patient Searches on Inpatient BHS	BHS	10/15	
	Disabled Patient access on BHU	BHS	10/15	
	Patient Prules for Admitted Patients on BHS	BHS	10/15	
	Patient and staff fraternization	BHS	10/15	
	Patient Laundry	BHS	10/15	
	Psychotropic Medication consent	BHS	10/15	
	Suicide Precautions			
	Disaster Evacuation Procedures (Inpatient and Outpatient)	BHS	10/15	
	Leadership Program	Rehab Lg	11/15	
	Continuum of Services	Rehab Lg	11/15	
	Patient safety Assessment, Monitoring, and Available Methods to assure patient safety while on the unit	Rehab Lg	11/15	
	Our Commitment to You	Rehab Lg	11/15	
	Patient Orientation Policy	Rehab Lg	11/15	
	Community Reintegration Activities	Rehab Lg	11/15	
	Therapeutic Recreation/Leisure activities	Rehab Lg	11/15	
	Weekend Therapy Program	Rehab Lg	11/15	
	Access to Spiritual Services Program	Rehab Lg	11/15	

	Post Discharge Assessment program	Rehab Lg	11/15	
	Discharge Criteria from IP Medical Rehab program at Rehab Center	Rehab Lg	11/15	
	Contracted Rehab Care Staff: Orientation and performance assessment	Rehab Lg	11/15	
	Provision of Specialized services for inpatient rehab patients	Rehab Lg	11/15	
	Psychological Neuropsychological	Rehab Lg	11/15	
	Speech Language Pathology Services	Rehab Lg	11/15	
	Use and cleaning of ADL Washer and Dryer	Rehab Lg	11/15	
	Inpatient rehab utilization review plan	Rehab Lg	11/15	
	Management of Stroke Rehab Program	Rehab Lg	11/15	
	Tuberculosis Patient in the Operating Room	Infection Control	11/15	
	Maximum Medication Dosages	BHS	11/15	
	Security	BHS	11/15	
	Patio Privileges	BHS	11/15	
	Environmental Rounds	BHS	11/15	
	Personal Protective Equipment, Engineering and Work Practice Controls	Employee Health	12/15	
	Safety Management- Work Area and Equipment	Cancer Center	12/15	

	Managing Urgent Issues Due to Equipment or Software Policies	Cancer Center	12/15	
	Cook Cervical Ripening Balloon for Dilation of Cervix, Assisting MD	L&D	12/15	
	Cord Blood Labeling	L&D	12/15	
	Epidural Analgesia and Anesthesia, Management of Obstetrical Patient Receiving	L&D	12/15	
	Fetal Fibronectin Collection Using the Blind Sweep Technique	L&D	12/15	
	Fetal Scalp Electrode, Application & Removal of in L&D and Operating Room	L&D	12/15	
	Intrauterine Pressure Catheter (IUPC) Insertion of	L&D	12/15	
	Non-Stress Test	L&D	12/15	
	Pregnant Patients Admitted Through the ED, Management of	L&D	12/15	
	Ultrasound, Limited Obstetrical by Qualified RN in L&D	L&D	12/15	
	Transfer to a Tertiary Care Center or Other Facility, Management of the Obstetrical Patient Requiring	L&D	12/15	
	Umbilical cord blood gas collection	L&D	12/15	

	Vacuum Extractor, Assisting at Delivery with Use of	L&D	12/15	
	Patient and Family Education	Patient Care	12/15	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Utilization Management Plan
CATEGORY:	Patient Care Services
LAST APPROVAL:	

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:	*Care Coordination*		
OFFICE OF ORIGIN:	*Care Coordination*		
ORIGINAL DATE:			

I. COVERAGE:

All El Camino Hospital Employees and Physicians

II. POLICY STATEMENT:

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

III. PROCEDURE:

AUTHORITY AND RESPONSIBILITY FOR THE UTILIZATION MANAGEMENT PLAN

1. Board of Directors

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

2. Senior Leadership

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

3. Medical Staff and Hospital Departments

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Utilization Management Plan
CATEGORY:	Patient Care Services
LAST APPROVAL:	

4. Professional Review Committees

   a. Committee Structure

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

   b. Composition

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

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

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

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

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

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

   c. Meetings

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

5. Physician Advisor

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Utilization Management Plan
CATEGORY:	Patient Care Services
LAST APPROVAL:	

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

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

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

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

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

UTILIZATION MANAGEMENT PLAN GOALS AND OBJECTIVES

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

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

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

3. Assess the appropriateness, efficacy and efficiency of the services and resources provided to the patient and to promote the patient's right to actively participate in treatment decisions.

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

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Utilization Management Plan
CATEGORY:	Patient Care Services
LAST APPROVAL:	

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

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

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

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

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

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

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

PROGRAM ELEMENTS

1. Criteria

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

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

   a. Pre-admission Review (when applicable)

      Pre-admission screening is performed by the Care Coordinator (CC) a member of the Care Coordination Department. Medical necessity, ability to meet the needs of the patient, appropriateness of admission, levels of care setting; pre-authorization

requirements as well as other utilization and discharge planning issues are assessed if possible. If a problem is identified, the CM contacts the attending physician to obtain the necessary information to justify admission or validate the appropriateness of the admission.

b. Admission Review and Concurrent Review

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

c. Outlier Case Review Meetings

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

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

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

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

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

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

e. Denials and Appeals

1) Denials

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

2) Appeals

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

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

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

iii. An appeal letter will be drafted by the RAAC and sent certified mailed the insurance carrier. Trends in denials and appeals status will be reported to the Utilization Management Committee on a quarterly basis.

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

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

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

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

i. Placement in alternative care facilities

ii. Referrals to home health care

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

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

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

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

RESPONSIBILITIES OF COMMITTEE

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

1. Evaluation of Utilization Data includes regular review of the following:
   a. Admissions
   b. Continued stay
   c. Professional services
   d. Length of stay
   e. Denials
   f. Medicare 1 day stays
   g. Readmission within 30 days/same diagnosis
2. There will be ad hoc monitoring for Potential Service Outliers as needs arise, such as:
   a. Length of stay
   b. Over utilization and underutilization of resources

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Utilization Management Plan
CATEGORY:	Patient Care Services
LAST APPROVAL:	

c Level of care considerations

d. Extraordinary high cost cases

e. Patient care contracted services

f. Utilization of high cost drug and biological

g. Professional services

3. Recommendations and Communication

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

REPORTING AND EXCHANGE OF INFORMATION

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

CONFLICT OF INTEREST

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

CONFIDENTIALITY

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

PLAN EVALUATION, AMENDMENT AND REVISION

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Utilization Management Plan
CATEGORY:	Patient Care Services
LAST APPROVAL:	

plan in achieving the goals and objectives.

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

IV. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	
(name of) Medical Committee (if applicable):	
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Endoscopy: Endolumenal Functional Lumen Imaging probe, Assisting MD (MV only)
CATEGORY:	Patient Care Services
LAST APPROVAL:	

TYPE:	☐ Policy ☐ Protocol ☐ Scope of Service/ADT ☑ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Patient Care Services***
OFFICE OF ORIGIN:	***Endoscopy***
ORIGINAL DATE:	August 24, 2015

I. COVERAGE:

Endoscopy RNs and Endoscopy Techs

II. PURPOSE:

EndoFLIP is intended to be used both as an aid in the diagnosis of gastro-esophageal reflux disease (GERD) and for assessment before, during, and after fundoplication surgery

The EndoFLIP balloon catheter is used in the clinical setting to dilate the gastro-esophageal junction for the purpose of treating achalasia

III. POLICY STATEMENT:

It is the policy of El Camino Hospital to use EndoFLIP safely and without harm to the patient. The Physician is present during the entire procedure giving directions to the Endo Technician assisting in operating the Endo Flip equipment.

IV. DEFINITIONS (if applicable):

EndoFLIP is a diagnostic tool for assessing the competence of the gastroesophageal junction in patients with GERD. EndoFLIP challenges the gastroesophageal junction to test its compliance.

V. REFERENCES:

1. Crospon Ltd Users Guide

VI. PROCEDURE:

1. **Using the catheter:**
   - The Endo Tech removes the catheter assembly from the packaging, remove the protective sheath from the balloon, and dispose of the sheath

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Endoscopy: Endolumenal Functional Lumen Imaging probe, Assisting MD (MV only)
CATEGORY:	Patient Care Services
LAST APPROVAL:	

- The Endo Tech places the balloon, tip first, into the EndoFLIP pre-use checkout tube, which holds the balloon in a vertical position
- The Endo Tech connects a pressure monitor with a range of at least 0-5 ATM to the balloon inflation monitor port
- The Endo Tech inserts the catheter electrical connector into the slot at the front of the unit, with the green dot on the connector aligned with the green dot ion the unit. prepare the catheter for use as described in the EndoFLIP System user manual

2. **Placing the catheter at the GEJ:**
   - Apply a lubricant to the balloon (if desired)
     NOTE: DO NOT PRE-INFLATE THE BALLOON
   - The Physician introduces the catheter orally alongside the endoscope and carefully advance it into the esophagus under direct endoscopic visualization and through the GEJ as far as the stomach so that the proximal end of the balloon sits just below the GEJ. Use the catheter markings as a guide

3. **Inflating the balloon:**
   - The Endo Tech fills the EsoFLIP balloon to 30mL with Physician's order.
   - Per Physician's order, the Endo Tech pulls back until some resistance is felt and the GEJ can be seen at the center of the measurement area on the screen of the EndoFLIP system and if cannot retract the catheter, reduce the amount of fluid in the balloon.
   - The Physician asks the Endo Tech to secure/hold the catheter once it is properly positioned in the GEJ, to reduce the risk of slippage.
   - Per Physician's order, the Endo Tech inflate the balloon to dilate the GEJ, continue checking that the balloon is correctly located within the GEJ. Note the balloon rated burst pressure limit.
   - After dilating the GEJ, you may deflate the balloon to assess the GEJ opening diameter post dilation with Physician's order.

4. **Disconnecting the catheter:**
   - Per Physician's order, the Endo Tech fully deflates the balloon and check that the plunger has stopped at the original volume of the syringe as indicated by an arrow on the syringe, and the Dest graphic and inflation status both

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Endoscopy: Endolumenal Functional Lumen Imaging probe, Assisting MD (MV only)
CATEGORY:	Patient Care Services
LAST APPROVAL:	

indicate that the balloon is empty. The catheter can then be removed slowly and carefully from the patient

- The Endo Tech, disconnects the catheter and syringe from the unit. Check the structural integrity of the catheter following removal from the patient.

VII. DOCUMENTATION:

The procedure will be documented on the applicable flowsheet in the EHR by the Physician and/or RN.
The results will be made a part of the EHR either by printing out a copy and scanning into EHR or by automatic download.

VIII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
UPC Committee	10/15
OR Committee	10/15
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

IX. AUTHOR:

S. Candel, ET, B. Marcum, RN 8/2015

REVIEW/REVISIONS:

S. Agpoon, RN, B. Marcum, RN 10/15

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Endoscopy: Small Bowel Capsule Endoscopy (MV only)**
CATEGORY:	**Patient Care Services**
LAST APPROVAL:	

TYPE:	☐ Policy ☐ Protocol ☐ Scope of Service/ADT ☑ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Endoscopy***
OFFICE OF ORIGIN:	***Endoscopy***
ORIGINAL DATE:	July 2015

I. COVERAGE:

El Camino Hospital Endoscopy RNs and Endoscopy Techs

II. PURPOSE:

Small Bowel Capsule Endoscopy is the standard care for small bowel evaluation, helping physicians detect presence of lesions and what may be the source of obscure GI bleeding, Crohn's disease and iron deficiency anemia.

III. POLICY STATEMENT:

Procedure performed without adverse effect to the patient.

IV. DEFINITIONS

Small bowel capsules - acquire pictures of the gastrointestinal tract and transmit them to the recorder.
Recorder with Sensors- receives and stores the images collected during the procedure for subsequent video creation with the RAPID software.
RAPID software- processes and transforms the raw image data stored in the recorder into a conveniently viewable RAPID video and allows review of the RAPID video.

V. REFERENCES:

Given Imaging (User Manual)
supportUS@givenimaging.com

VI. PROCEDURE:

IN PATIENT Patient Preparation

Instructions to patient:

Drink 50-100mL of water with Simethicone while ingesting capsule

- ✓ Clear liquid diet only starting at noon the day before and followed by 2 liters of Golytely.
- ✓ Do not take any medication 2 hours before having the exam.
- ✓ Wear upper garment of thin, natural fiber that is long enough to reach at least to hip level and will not rise up above the belt.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Endoscopy: Small Bowel Capsule Endoscopy (MV only)**
CATEGORY:	**Patient Care Services**
LAST APPROVAL:	

OUT PATIENT, Patient Preparation

- Clear liquid diet after lunch the day before the procedure
- 2 liters Golytely preparation the night before the procedure
- NPO four hours before ingestion of capsule
- May have water with medications 2 hours after ingestion of capsule
- May have small solid food meal 4 hours after ingestion of capsule
- May resume normal diet 8 hours after ingestion of capsule
- Patient Instructions are given after ingestion of capsule

Patient Check-IN

1. Open RAPID software. From the home screen, click on **patient Check-in.**
2. A. Click the **Recorder bar** to select recorder. Click **Check-in Patient**.
3. Enter procedure information and select SB Capsule Type. Click **Finish**.
4. Confirm data and check **Accept.** Click **Next**. Recorder DR3 is ready for procedure.

Preparation of Equipment

1. Place sensors on the patient

   For 8-lead sensor array for SB
   - ✓ Place 8-lead sensor array according to sensor location Guide for SB procedures.
   - ✓ Place DR3 pouch on patient and adjust shoulder belt straps.

   For Sensor Belt
   - ✓ Place sensor belt on patient over a single layer of clothing.
   - ✓ Place the downlink loop across the patient's left shoulder and adjust to fit.
2. Removed check-in DR3 from cradle and confirm that it is charged. If screen is OFF, use any navigation button to turn screen ON. If non-responding, push ON/OFF. Confirm match of patient and procedure data displayed on LCD screen.
3. Connect sensors to DR3 (audible click). The DR3 plays sound to confirm connection. Insert DR3 into pouch.
4. Open the Pillcam SB Box and hold it with blinking capsule close to the sensors on patient's abdominal area to perform pairing. The white capsule LED on the top of the DR3 will blink the same rate as the capsule. The red pairing Icon on the right corner of the LCD will appear. Use navigational buttons to select the capsule ID on the screen that matches the one on the back of the capsule box. Push the middle navigation button to pair it with the DR3. After pairing, the green pairing icon should replace the red pairing icon. The capsule LED on the top of the DR3 will blink blue at the same frequency as the recording rate.

During procedure

1. Instruct the patient to swallow the capsule with sip of water.
   Note: Patient should never ingest an unpaired capsule or the procedure will fail, resulting in lost data. Green paired icon must appear on the upper right corner of the LCD before ingestion.
2. Instruct the patient after capsule ingestion:
   - ✓ To keep all sensor elements in place without removing them
   - ✓ May drink colorless liquid starting 2 hours after swallowing the SB capsule
   - ✓ Be sure the Sensor Belt is tight at the waist

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Endoscopy: Small Bowel Capsule Endoscopy (MV only)**
CATEGORY:	**Patient Care Services**
LAST APPROVAL:	

Check the blue flashing Data recorder light every 15 minutes to be sure it is blinking
Note: If it stops blinking or changes color, note the time and to contact Endoscopy Staff.

- ✓ Avoid strong electromagnetic fields such as MRI devices or ham radios after swallowing the capsule and until patient pass it in a bowel movement.
- ✓ Do not disconnect the equipment or completely remove the Data Recorder at any time during the procedure.

Cleaning of Equipment for Both Inpatient and Outpatient based on manufacturer's recommendation

Video Download From DR3

1. Remove equipment from patient, disconnect sensor from recorder and place DR3 into cradle. Open RAPID and click **Recorder Download** from home screen**.** Click the **Create Video** button. The video creation bar indicates time remaining. **Video creation successful** indicates that video creation complete.

DOCUMENTATION:

The procedure will be documented on the applicable flowsheet in the EHR by the Physician and/or RN.
The results will be made a part of the EHR either by printing out a copy and scanning into EHR or by automatic download.

VII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
UPC Committee:	10/15
OR Committee	10/15
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

VIII. AUTHOR: Lilybelle Chen, RN 8/2015

REVIEW/REVISIONS:

S. Agpoon, RN, B. Marcum, RN 10/15

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Endoscopy: Small Bowel Capsule Endoscopy (MV only)**
CATEGORY:	**Patient Care Services**
LAST APPROVAL:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY TITLE: Clinical Alarms

CATEGORY: PATIENT CARE SERVICES
LAST APPROVAL DATE:

SUB-CATEGORY: ALL PATIENT CARE AREAS (INPATIENT AND OUTPATIENT)
ORIGINAL DATE: 10/2015

OUTCOME:
1. Promote safe monitoring of patients through the use and response to clinical alarms.
2. This policy applies to El Camino Hospital and to all Hospital staff and Medical Staff members.

DEFINITIONS:
1. Alarm failure includes failure to alarm in the presence of abnormal measured parameters and established set points.

CONTENT:
1. GENERAL PROVISIONS
   a. The Clinical Engineering Department is responsible for performing scheduled preventive maintenance.
   b. During scheduled preventive maintenance, the Clinical Engineering Department should ensure that testing of the alarm function, setting of alarm parameters, range and volume is performed.

2. MEDICAL EQUIPMENT / DEVICE ALARMS
   a. All Hospital staff and Medical Staff who use medical equipment should ensure alarm settings are appropriate and that audible alarms are clearly discernible relative to ambient and competing noise.
   b. All Hospital staff and Medical Staff who use medical equipment should check alarm parameters, as established by the department.
   c. Hospital staff members and/or Physician assigned to treating the patient should immediately respond to medical equipment per department guidelines.
   d. Nurses should ensure that equipment and device alarms locally at the bedside (i.e. infusion pump alarms) are monitored with special attention given to patient care areas that are remote from a nurse's station and isolation rooms.

3. ALARM FAILURE AND ALARM RELATED INCIDENTS
   a. Department managers implement department-specific procedures for response and notification of patient monitoring or clinical equipment alarm failure and procedures to identify alarms that are in disrepair or in need of assessment. Equipment that is in disrepair or in need of assessment should be taken out of service to prevent inadvertent reuse.
   b. Any patient monitoring or clinical equipment alarm failure resulting in a patient safety concern should be reported to hospital supervisor and quality department in accordance with the Quality Review Reporting Policy and equipment taken out of service.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY TITLE: Clinical Alarms

CATEGORY: PATIENT CARE SERVICES
LAST APPROVAL DATE:

c. Unexplained nuisance alarms as indicators of equipment failure should be reported to the Clinical Engineering Department and there should be a Quality Review Report completed. Clinical Engineering should assess the situation and work with the Clinical Manager of the appropriate department on corrective action plans.
d. Hospital staff members and Medical Staff members should not bypass alarm functions. Any bypass of an alarm function should be reported on a Quality Review Report.

4. ALARM MAINTENANCE AND TIMING
   a. Clinical Engineering should, as a part of the patient care equipment inventory, identify those devices and systems that include physiologic and patient care alarms at the time new equipment is put into place or checked annually.
   b. Alarms and alarm settings should be inspected and functionally tested during regularly scheduled preventative maintenance.

5. PATIENT SAFETY
   a. Based on periodic assessment of clinical equipment with alarms, guidelines will be developed for those identified as having the highest potential to adversely affect patient safety. All clinical equipment being evaluated for purchase should go through a similar process to include both clinical engineering and the appropriate clinicians. Please refer to Value Analysis Policy.
   b. Guidelines to be developed specific to patient populations served or clinical areas should address, as applicable, the following:
      i. Parameter default settings
      ii. Responsibilities for setting parameter limits for individual patients according to the patient's clinical status
      iii. Volume settings taking into consideration unit layout, competing unit noise, and presence of adjunct notification systems such as VOCERA.
      iv. Actions to minimize nuisance alarms
      v. Requirements for reviewing monitor history
      vi. Documentation requirements for settings/parameters
   c. All alarm related events and near misses reported through quality review reporting system should be evaluated to identify opportunities for improvement. That evaluation should be shared with affected departments and units. In some cases, indicators should be tracked and provided to the Quality Improvement and Patient Safety Committee.

6. RESPONSIBILITY
   a. The Directors and Managers of the patient care departments are responsible for assuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed. Instances of noncompliance with this policy should follow appropriate HR policies.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY TITLE: Clinical Alarms

CATEGORY: PATIENT CARE SERVICES
LAST APPROVAL DATE:

7. ENFORCEMENT
    a. All Hospital staff and Medical Staff are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy should be subject to appropriate performance management pursuant to all applicable policies and procedures, including the Medical Staff Bylaws, Rules and Regulations.

REFERENCES:

1. Joint Commission Sentinel Event Alert, Issue 50, April 8, 2013 and National Patient Safety Goal 2015
2. Standards of the American Society of Anesthesiologists: Standard for Basic Anesthesia Monitoring
3. Agency for Healthcare Research and Quality, A Critical Analysis of Patient Safety Practices
4. California Code of Regulation, Title 22, 70837, 70853

APPROVAL	APPROVAL DATES
Alarms Task Force	11/2015
Patient Care Leadership	11/2015
Central Partnership Council	11/2015
Professional Development Council	11/2015
Critical Care Committee	10/2015
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:BHS Ip 34.00 Description of inpatient services

CATEGORY: Patient Care Services
LAST APPROVAL DATE: 4/12

SUB-CATEGORY: BEHAVIORAL HEALTH SERVICES
ORIGINAL DATE: 01/89

COVERAGE:

El Camino Hospital Behavioral Health Services

PROCEDURE:

Policy

a. Acute Psychiatric Services, El Camino Hospital, provides a safe, superior quality continuum of mental health care to adult patients requiring acute mental health treatment. The community served will include the El Camino Hospital District and all externally referred patients assessed appropriate for acute mental health services.

b. Physical environment

BHS is physically defined by the designation of "1 South" which consists of the following patient care areas: Psychiatric Intensive Care area "PICU" which consists of 7-9 beds and 2 seclusion/restraint rooms with a separate foyer and handicapped accessible bathroom. These additional beds are used on a short-term basis, to meet the needs of patients who require additional monitoring. Psychiatric Acute Care area "PACU" which consists of up to 16 beds, and an observation bed. The outpatient program area has a separate outside entrance and includes 3 consultation rooms, Medical Directors and administrative offices, 3 group rooms, occupational therapy room, program offices, and a complete kitchen area. Included in the 1 South area are 2 outside patio areas with walking paths, basketball, volleyball, shuffleboard, and large
grass areas. There is a treatment room, laundry facilities, dining, and ample sitting space available

~~a. Criteria for Admission:~~

~~Patients may be admitted directly by a psychiatrist with El Camino Hospital privileges or through the Emergency Departments referral to an El Camino Hospital Psychiatrist, following psychiatric assessment by trained staff that are designated for this purpose by the Director of BHS.~~

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:BHS Ip 34.00 Description of inpatient services

(1) The patient must have a psychiatric disorder as defined by DSM IVR and are in need of acute psychiatric hospitalization.

(2) Priority will be given to emergencies.
(a) If patient does not meet the criteria, El Camino Hospital will facilitate transfer to the appropriate treating facility, however in any case, all patients will receive stabilization of their emergency medical condition, up to and including inpatient admission if needed for this purpose.

b. Exclusionary Criteria (These will be judged on an individual basis with the Medical Director making the decision).

(1) Those requiring a level of care which cannot be provided because of prevailing acuity. (The psychiatric department has a limited common activity area, it is not appropriate for very violent patients or for patients who could be in need of locked bed care for long term treatment).
(2) Acute medical problems requiring more than routine medical care, elaborate medical work-ups, or bedrest preventing participation in program activities.
(3) Patients, who through history, do not benefit by the type of care provided on the Department of Psychiatry.
(4) Patients who because of their age or degree of debilitation would be at risk in this environment.
(5) Patients who have behavioral or cognitive problems related to organic brain syndrome(s).

c. Obtaining an Admitting Physician

Patients must be admitted by a psychiatrist on El Camino Hospital active, provisional, or courtesy status.
(2) If a staff psychiatrist cannot be obtained, the patient can be admitted by the Medical Director. Within 24 hours he will obtain for the patient a treating physician.

(a) When the Medical Director is unavailable, staff should consult with:
i. Chief of Staff, Psychiatry
ii. Vice Chief, Psychiatry
iii. Secretary, Psychiatry

d. Physician Attendance and Support to the Department

(1) Every patient admitted to the service will have a physician from the Department of Psychiatry in charge of his care. This doctor will assume full

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responsibility for the patient, he/she must be available and willing to receive calls from the nursing staff. If he is not available, he is to obtain a member of the Department of Psychiatry as a backup on call.

(2) Patients must be seen at appropriate intervals, at a minimum every 24 hours.

(3) Every patient must have a psychiatric history and MSE and history and physical done within 24 hours of admission.

(4) Prompt response to R.N. reports of deterioration of patient status is required including appropriate orders and as needed, physician's attendance.

(5) In an urgent or emergency situation the Medical Director or Chief of Department may request immediate care from the attending physician or arrange this care with any other appropriate physician including himself. Chain of Command: Chief, Department of Psychiatry; Vice Chief, Department of Psychiatry; Secretary of the Department of Psychiatry.

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e. Orders

(1) Physicians may initiate admission orders that are maintained by the Department of Psychiatry in the MIS. On admitting a patient to the unit, he/she then instructs the nurse on the appropriate clinical path and other orders to institute.

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f. Transfer (Discharge to Another ECH Clinical Service)

(1) Medical Emergencies

(a) Both the treating psychiatrist and physician for Medical evaluation/treatment must be notified when a patient's medical condition deteriorates. If unable to reach immediately, the Charge Nurse may make the decision to call ED and have patient seen by ED Doctor until patient's own physician can be reached.

(b) The patient's physician will determine whether a patient should be discharged to a Medical Unit.

(c) When a patient is discharged to a medical floor or other specialty unit, the BHS Case Coordinator will continue to monitor the patient and include psychiatric clinical staff as needed. Purpose is to share psychiatric nursing information and develop a care plan that reflects both psychiatric and medical nursing diagnosis. The patient's psychiatrist will continue to follow the patient on the Medical floor for psychiatric needs.

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(2) Psychiatric Emergencies

(a) The treating psychiatrist is to be contacted when a patient's mental condition deteriorates. If a safer environment is needed, the patient is to be treated accordingly pending a psychiatrists order.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:BHS Ip 34.00 Description of inpatient services

(b) The treating psychiatrist and PES or charge nurse will determine whether a patient requires a more secure environment than this department can provide.

g Discharge Planning

(1) All patients are assessed by the RN on admission and by the LCSW/Discharge Planner during treatment planning regarding their discharge planning needs.
(2) Patients discharged from the department are discharged in accordance with El Camino Hospital discharge procedure.
(a) Exception - Ambulatory patients may leave the Inpatient Services unescorted.

c. Delivery of Care

BHS is staffed by qualified psychiatric registered nurses, LCSW, Licensed Therapists, OTR's, Behavioral Health Workers, administrative secretary, program manager, director, and Medical Directors. All personnel who work on the unit are specially oriented and trained in their work, performing under the supervision of the Director of Behavioral Health Services and the inpatient clinical manager.(See job descriptions)

d. Program content:

The program is highly individualized and goal-oriented. Patients care team includes psychiatrist, nurse, occupational therapist, social workers/discharge planners, psychologists and safety officers. Depending on patient's additional needs, members from other disciplines may be added. The inpatient groups and activities consists of assorted group therapies which include but are not limited to psychotherapy, art therapy, occupational therapy, recreation/fitness/ medication education, cognitive therapy, stress management and relaxation, medication education, aftercare planning and select psychoeducational therapies. Patients meet with their psychiatrists daily and a nurse is assigned 24/7. For patient safety, all patients are monitored every 15minutes while on the unit. In addition, the social workers assist with d/c planning and occupational therapists and psychologists lead groups and activities throughout the day. Within 72hrs of admission, patient and their invitees meet with the care team to establish/evaluate goals of hospitalization and to arrange for follow-up care. If the follow-up plan includes discharge to outpatient program at El Camino Hospital, patient's group assignment may be made to outpatient programs while still admitted on inpatient unit.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:BHS Ip 34.00 Description of inpatient services

e. Goals of inpatient Services:
1. Provide least restrictive, safe environment conducive for the overall recovery of the patients it serves,
2. Provide a comprehensive treatment program that includes major diagnostic, medical, psychiatric, psychosocial and occupational treatment modalities designed for patients with mental disorders in acute exacerbation
3. Provide a treatment alternative that reduces the disruption of the patient's family and social networks.
4. Provide high level intensive, comprehensive, multidisciplinary treatment with utmost dignity and respect to assist the patient in the resolution or stabilization of crisis situation that result in functional impairments.
5. Reduce inpatient recidivism
6. Provide effective referrals for subsequent treatment
7. Educate patients and families on mental health condition, medications, coping techniques and to provide a safety net for continued follow-up and recovery once discharged form inpatient services.

~~h~~f. General Regulations

(1) Visiting hours are from 12:00 Noon - 1:00 P.M. and 5~~4~~:00 P.M. - 8:00 P.M. Monday through Friday. On Saturday and Sunday visiting hours are from 12:00 Noon - 1:00 P.M. and 5~~4~~:00 P.M. - 8:00 P.M. Holidays are 12:00 Noon - 8:00 P.M. Exceptions may be made by the treating psychiatrist and/or the Charge Nurse.
(2) Smoking is not allowed ~~only outside the building in designated areas.~~ (Refer to hospital smoking policy).
(3) Patients may keep their belongings except for certain exceptions. Refer to Sharps Policy and Patient Possessions Policy.
(3) There are four phones for patient use.
(4) Patients may keep valuables in the hospital safe but should be encouraged to have those items sent home.
(6) A physicians order is required for off unit visits.
(7) All patients are assessed at the time of admission for environmental safety concerns and room placement accordingly. Patients will have access to all public areas of each ~~unit~~ treatment area unless there are special restrictions documented in MD orders.

~~i. Education~~

~~(1) Professional training and development are encouraged through in-services, mentorships, cross training etc. for personnel on a regular basis. Staff is provided ED time for mandatory educational experiences.~~

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:BHS Ip 34.00 Description of inpatient services

jg. Responsibility of Psychiatric Nurses

(1) Is familiar with ECH procedures, policies and Department of Psychiatry/Behavioral Medicine psychiatry standard orders ~~Standard Admission orders.~~

(2) Can efficiently and effectively perform in areas defined in the BHS Competency Manual.
(3) Has received CPR and crisis intervention training ~~MAB training~~. If assigned to PES (psychiatric emergency services) will have documented training in this area.
(4) As part of orientation receives focused teaching on Legal Aspects of Psychiatric Care, ~~Psychopharmacology~~, Suicide Assessment and Mental Status Exams as a professional maintains currency of information related to the above areas.
(5) Has an understanding of and commitment to Primary Nursing, and Case Management.

h. Responsibilities of Inpatient manager, Psychiatry/Behavioral Medicine Services

(1) Is directly accountable to the Director, Psychiatry/behavioral medicine Services.
(2) Maintains 24-hour responsibility and accountability for quality patient care on inpatient unit. Describes and teaches professional practice standards for Psychiatric Nurses.
(3) Coordinates and evaluates care given to patients by all department staff.
(4) Coordinates staffing, implements hospital and nursing policies.
(5) Coordinates inpatient services and patient care with other departments of the hospital.
(6) Cooperates with ECH Staff Psychiatrists and Medical Staff at large for the full and effective delivery of psychiatric care.
(7) Reports departmental Performance Improvement to staff and to Psychiatric Executive Committee.
(8) Responsible for program development, and systems design.
(9) Responsible for the financially effective running of the department.

i. Responsibilities of Director, Psychiatry/Behavioral Medicine Services

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(1) Is directly accountable to the Chief Nursing Officer ~~Vice President of Patient Care Services.~~
(2) Maintains 24-hour responsibility and accountability for quality patient care on both of the inpatient units and the outpatient services. Describes and teaches professional practice standards for Psychiatric Nurses. Responsible for providing licensed therapists to implement group therapy programs.
(3) Coordinates and evaluates care given to patients by all department staff.
(4) Coordinates staffing, implements hospital and nursing policies.
(5) Coordinates inpatients units, outpatient services and patient care with other departments of the hospital.
(6) Cooperates with ECH Staff Psychiatrists and Medical Staff at large for the full and effective delivery of psychiatric care.
(7) Reports departmental Performance Improvement to staff and to Psychiatric Executive Committee.
(8) Responsible for program development, and systems design.
(9) Responsible for the financially effective running of the department.
(10) Develops, coordinates and implements marketing plan on behalf of the department.

~~i~~j. Responsibilities of Medical Director

(1) Is directly accountable to the ~~Vice President of Patient Care Services~~Chief Medical Officer.
(2) Responsible for program development, maintenance and performance improvement of Psychiatric Services hospital wide in collaboration with Department ~~Manager~~Director.
(3) Cooperates with ECH Staff Psychiatrists and Medical Staff at large for the full and effective delivery of psychiatric care.
(4) Cooperates with other areas of ECH. Instructs in the mental health dimensions or any program development, implementation or ongoing functions.
(5) Responsive to the acute mental health needs in the Community at large using the ECH as Provider.
(6) Provides supervision to Associate Medical Directors of BHS.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:BHS Ip 34.00 Description of inpatient services

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	04/12
___Department of Pscyh__Medical Committee (if applicable):	03/15
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:
1/89, 9/90, 1/92, 5/95, 4/97, 12/97, 3/98, 5/00, 1/04, 4/07; 4/12

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:BHS Ip 34.00 Description of inpatient services

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Fall Prevention for Infusion Center**
CATEGORY:	Patient Care Services
LAST APPROVAL:	

TYPE:	☑ Policy ☑ Procedure	☐ Protocol ☐ Standardized Process/Procedure	☐ Scope of Service/ADT
SUB-CATEGORY:	Infusion Center		
OFFICE OF ORIGIN:	Infusion Center		
ORIGINAL DATE:	10/28/2015		

I. COVERAGE:

Infusion Center Staff

II. PURPOSE:

The Infusion Center takes the necessary steps to create a safe environment to prevent falls and to informa patients and families that the staff is interested in patient safety. Measures are routinely taken to prevent injury due to falls.

Evaluation

Patient fall risk will be assessed by factors such as medication effects, medical or health issues (example: arthritis, dizziness, low blood pressure, generalized weakness), gender.

Patient Education

Patient education on fall prevention is emphasized with each visit as applicable to patient assessment.

III. PROCEDURE:

A. At each patient encounter, the patient will be asked, “Are you dizzy or having difficulty walking?” If the patient answers “yes”, a nursing assessment will be done, appropriate interventions will be completed and documented in the EMR, and the patient will be considered a fall risk. Fall Risk banner will be placed on the IV pole “Fall Risk” will be documented in the EMR. Patient will be instructed to use call light and wait for assistance before attempting to get out of chair/gurney.

B. Clutter and unnecessary equipment will be removed. Equipment on wheels will be locked during patient lift/transfer/treatment. Wheelchairs will be provided for patient use.

C. Patients who are considered to be a fall risk will be accompanied by a competent adult or staff personnel while in the department.

D. Shoes and socks to be worn at all times?

Post-Fall Clinical Assessment and Documentation:

A. Assess the patient for physical injury.

B. Check blood pressure, pulse, and respiration. Assess for presence of orthostatic changes (systolic BP changes of > 20mm Hg or diastolic

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**Fall Prevention for Infusion Center**
CATEGORY:	Patient Care Services
LAST APPROVAL:	

changes BP > 10mm Hg, pulse change > 20 beats).
C. Document the patient's account of fall (symptoms, weakness, slipped, urinary urgency, etc.).
D. Notify physician of fall and patient's condition.
E. Clarify and obtain physician order if physician requires patient to have evaluation/follow-up in the emergency room.
F. Complete a Quality Review Report.
G. Document follow-up on fall in discharge communication.
H. For recurring patients: Review fall prevention risk reduction activities, as appropriate, with patient/family

IV. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	
Medical Committee (if applicable):	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Referral to Outpatient Oncology Dietitian	
Outpatient Oncology	
September 2015	

TYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Outpatient Cancer Services***
OFFICE OF ORIGIN:	***Cancer Center***
ORIGINAL DATE:	September 2015

I. COVERAGE:

Cancer Center, Infusion Center, Radiation Oncology

II. PURPOSE:

III. All newly diagnosed patients will receive basic information on Nutrition and Cancer: Before, During and After Treatment, and have the opportunity to attend a group class.

IV. POLICY STATEMENT:

1. All patients with the following diagnoses will be referred by the MD/NP for initial nutritional assessment and follow-up as needed:
   Head and Neck
   Pancreatic
   Gastric
   Lung
   Gallbladder
   Rectal
   Liver
   Enteral/parenteral supported patients.

2. Referrals accepted from:
   IFC nurse
   Clinic RN
   Nurse Practitioner
   Nurse Navigator/Coordinator
   MD
   Social Worker
   Self-referral

3. Appointments with the Oncology Dietitian can be made by the clinic Schedulers

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Referral to Outpatient Oncology Dietitian
Outpatient Oncology
September 2015

V. PROCEDURE:

1. Re-screening at return to clinic visit of all patients receiving treatment who exhibit unintentional weight loss of over 5% over three months will be referred to the oncology dietitian.

2. Re-screening at return to clinic visit of all patients receiving treatment whose oral intake is significantly decreased due to Nutrition Impact Syndrome of treatment.

3. The Oncology Dietitian will attend each Chemotherapy Teach presentation by the clinic Nurse Practitioner, clinic nurse or navigator/coordinator.

VI. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Cancer Care Committee	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Insulin Intravenous Administration in the Perinatal Patient
CATEGORY:	Patient Care Services
LAST APPROVAL:	

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:	***Pharmacy, MBU, CCU, ED***		
OFFICE OF ORIGIN:	***Labor & Delivery***		
ORIGINAL DATE:	October, 2015		

I. COVERAGE:

All ECH Nursing staff

II. PURPOSE:

To outline the procedure to be used to safely administer an intravenous insulin infusion to the perinatal patient in labor.

III. POLICY STATEMENT:

1. Maternal morbidity and mortality are increased in the presence of pre-existing diabetes.
2. Infants of women with diabetes are at risk for congenital anomalies, intrauterine fetal demise, macrosomia, hypoglycemia, polycythemia, hyperbilirubinemia, and birth trauma.
3. The diabetic mother is at risk for infections, diabetic ketoacidosis, hypoglycemia, shoulder dystocia, postpartum hemorrhage, and poor wound healing.
4. Maintaining euglycemia during the intrapartum period decreases the risk of maternal/neonatal complications.
5. Patients in active labor (dilated greater than or equal to 6 cm, or greater than or equal to 4 cm with regular uterine contractions causing cervical change of at least 1cm/hour) should receive an insulin infusion. Prior to that, insulin may be administered via patient home infusion pump (if applicable) or subcutaneously per provider order.
6. A continuous insulin infusion is titrated to the patient's blood glucose level during the intrapartum period to maintain a blood glucose level of 70-110 mg/dl.
7. Only regular insulin can be administered intravenously.
8. Insulin infusion to be mixed by Pharmacy. LG obtains insulin from MV Pharmacy after 9 PM.
9. D50 and glucagon to be readily available on the unit prior to administering the insulin infusion.
10. Insulin is a high-risk, high-alert medication and requires a 2 RN double-check when initiating infusion and for any change in rate.
11. Pregnant patients receiving IV insulin infusion to have a non-glucose containing mainline IV to be used to maintain hydration and to administer IV fluid boluses, if needed.
12. All medications i.e. oxytocin, magnesium sulfate, or antibiotics to be mixed in a non-glucose containing solution.
13. Insulin and glucose-containing solutions to be administered via infusion pump to ensure accuracy of amount administered.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Insulin Intravenous Administration in the Perinatal Patient
CATEGORY:	Patient Care Services
LAST APPROVAL:	

14. Insulin requirements decrease immediately upon delivery of the placenta, and remain decreased for 48-96 hours postpartum.

III. DEFINITIONS :

1. A-1 Gestational Diabetes is gestational diabetes controlled with diet alone
2. A-2 Gestational Diabetes is gestational diabetes requiring treatment with insulin and/or oral hypoglycemic
3. Type 2 Diabetes is pre-gestational diabetes

IV. REFERENCES:

1. American College of Obstetricians and Gynecologists. (2005, reaffirmed 2012), Pregestational Diabetes Mellitus (Practice Bulletin No. 60)
2. American College of Obstetricians and Gynecologists. (2013). Gestational Diabetes Mellitus (Practice Bulletin No. 137)
3. California Diabetes and Pregnancy Program (CDAPP) Sweet Success Guidelines for Care-2012

V. PROCEDURE:

1. Review provider orders
   a. Regarding infusions, medications, nursing assessments, blood glucose measurements, etc.
2. Assemble equipment
   a. Blood glucose meter, testing strips, finger stick device
   b. Infusion pump
   c. D50 vial (readily available on the unit)
   d. Glucagon (1 mg) (readily available on the unit)
   e. IV start kit with 18 gauge IV catheter (if no IV access)
   f. 3-way connector port
   g. For mainline non-glucose solution:
      i. Lactated Ringers (LR) 1000 ml or as ordered by provider
      ii. Regular IV primary tubing for infusion pump and multiport extension set
   h. For piggyback glucose-containing solution:
      i. D5/Lactated Ringers (D5LR)
      ii. Regular IV primary tubing for infusion pump
   i. For I.V. Insulin infusion:
      i. Infusion mixed in Pharmacy: Regular Human Insulin (Humulin, Novolin) 100 units in 100 ml of 0.9% normal saline (1 unit = 1 ml)
      ii. Regular IV primary tubing for infusion pump
3. Prepare patient
   a. Perform baseline maternal/fetal nursing assessment
   b. Obtain capillary blood glucose measurement
   c. Explain procedure to patient and support person

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Insulin Intravenous Administration in the Perinatal Patient
CATEGORY:	Patient Care Services
LAST APPROVAL:	

d. Review signs and symptoms of hypo and hyperglycemia, and instruct patient to notify nursing staff immediately for any of the following: shaking; numbness of tongue or lips; severe hunger; lightheadedness; mental confusion/anxiety, pallor, cold, clammy skin; or nausea/vomiting

4. Prepare equipment (Refer to diagram-Appendix A)
   a. Start IV with 18 gauge catheter (if IV access not already established)
   b. Attach 3-way connector to IV catheter hub
   c. Attach extension set to 3-way connector port
   d. Attach mainline IV tubing to extension set
   e. Infuse mainline 1000 ml LR via primary infusion pump tubing and extension set
      i. Connect infusion to the middle port of a 3-way connector (port #1)
      ii. Infuse via infusion pump per provider order
      iii. Use mainline IV to give IV fluid boluses prn and to piggyback any IV medications ordered i.e. antibiotics, oxytocin, magnesium sulfate
   f. Infuse a separate bag of 1000 ml D5LR with a primary infusion pump tubing
      i. Connect infusion to a 3-way connector (port #2)
      ii. Infuse via infusion pump per provider order
      iii. **DO NOT use glucose-containing solution for IV fluid boluses or IV medications**
5. Obtain Insulin infusion from pharmacy: 100 units of Regular Human Insulin (Humulin, Novolin) in 100 ml of 0.9 normal saline (1 unit=1ml)
      i. Ensure D50 and glucagon readily available on unit prior to starting insulin infusion
      ii. **Insulin requires a 2 RN double-check for correct infusion and rate when starting infusion and for any change in dose or pump settings**
      iii. Prime insulin infusion tubing with insulin to saturate insulin-binding sites on IV tubing prior to connecting to patient
      iv. Connect infusion to a 3-way connector (port #3)
      v. Infuse via infusion pump per algorithm below upon provider order:

         - If blood glucose is LESS than 70 mg/dl: Stop insulin infusion
         - If blood glucose is 70 to 90: Infuse insulin at 0.5 units/hr **in Type 1 Diabetes ONLY**
         - If blood glucose is 91to 110: Infuse insulin at 0.5 units/hr
         - If blood glucose is 111 to 130: Infuse insulin at 1 units/hr
         - If blood glucose is 131 to 150: Infuse insulin at 2 units/hr
         - If blood glucose is 151 to 170: Infuse insulin at 3 units/hr
         - If blood glucose is 171 to 190: Infuse insulin at 4 units/hr

   b. Label all infusion lines
   c. Titrate insulin and D5LR infusions to patient's blood glucose levels per provider order

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Insulin Intravenous Administration in the Perinatal Patient
CATEGORY:	Patient Care Services
LAST APPROVAL:	

d. Follow provider orders regarding nursing assessments, blood glucose measurements, treatment of hypoglycemia, etc.

6. Nursing Documentation:
   a. Document all assessments, infusions, medications, nursing care, patient education, and physician notifications

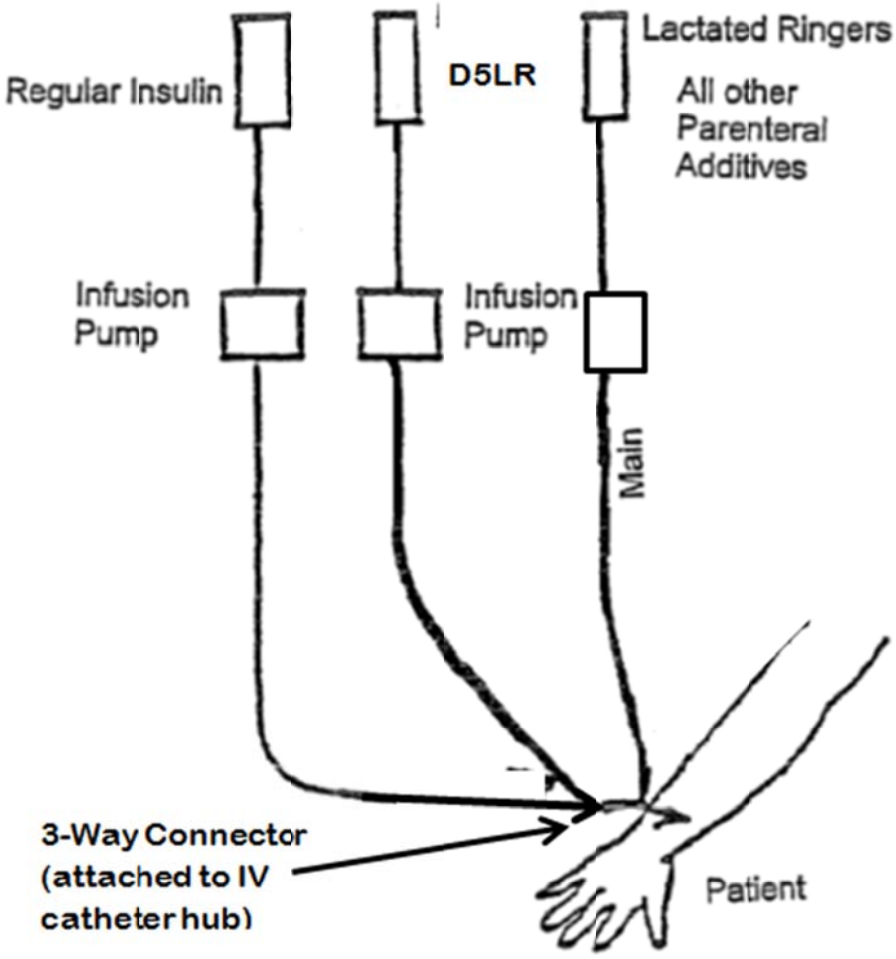
VI. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	10/15
OB Executive Committee:	11/15
ePolicy Committee:	
Pharmacy and Therapeutics:	11/15
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Insulin Intravenous Administration in the Perinatal Patient
CATEGORY:	Patient Care Services
LAST APPROVAL:	

VII. APPENDIX A:



El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**ADMISSION OF NEWBORN TO LABOR & DELIVERY**
CATEGORY:	**STANDARDIZED PROCEDURE**
LAST APPROVAL:	

TYPE:	☐ Policy ☐ Procedure	☐ Protocol ☑ Standardized Process/Procedure[1]	☐ Scope of Service/ADT
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Labor & Delivery***		
AUTHORS:	Marie Beauchemin, RN		
ORIGINAL DATE:	04/04		

I. DEFINITION AND COVERAGE:

Newborn will receive care appropriate to clinical status

II. CIRCUMSTANCES FOR THE PROCESS/PROCEDURE:

1. Upon delivery of a normal newborn, the RN will enter the appropriate newborn admission order set(s) as indicated by this procedure.
2. A neonatologist is available in-house 24 hours a day, seven days a week in Mountain View and on-call in Los Gatos.
3. The obstetrician will assign the care of the newborn to the pediatrician selected by the parents as indicated in the admission documentation. If a higher level of care is indicated, the newborn will be transferred to the NICU under the care of the neonatologist/pediatrician.

III. LOCATIONS PERMITTED FOR THE PROCESS/PROCEDURE:

1. Initial assessment will take place in Labor & Delivery, Main Operating Room, or Neonatal Intensive Care Unit.

IV. DEFINITIONS (if applicable):

V. REFERENCES:

1. American Academy of Pediatrics (2012). *Guidelines for perinatal care* (7th ed.), Washington DC: American Academy of Pediatrics/The American College of Obstetricians and Gynecologists

VI. CROSS REFERENCES:

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**ADMISSION OF NEWBORN TO LABOR & DELIVERY**
CATEGORY:	**STANDARDIZED PROCEDURE**
LAST APPROVAL:	

VII. PROCEDURE:

A. The RN assesses the newborn in Labor and Delivery by physiological parameters including:
   a. Apgar scores as assigned after the birth (as per NRP guidelines).
   b. General appearance: Skin, head & neck, eyes, ears, nose, mouth, throat, thorax & breasts, lungs, heart, abdomen, umbilicus, genitalia, trunk & spine, extremities neurological, anus & rectum, and vital signs.

B. If the newborn assessment findings indicate that the neonate is within normal limits, initiate one of the following order set(s) using the order mode of "Per protocol, cosign required".
   a. MCH Newborn Admission if newborn is greater than 37 weeks gestational age or
   b. MCH Late Preterm Infant (LPI) if newborn is 35 to 37 weeks gestational age

C. In addition, initiate one of the following order sets, when applicable, using the order mode of "Per protocol, cosign required":
   a. MCH Small for Gestational Age (SGA) according to the appropriate growth chart if meeting criteria for less than 10th percentile in birth weight.
      i. Also, initiate this order set if newborn is both an Infant of Diabetic Mother and SGA.
   b. MCH Infant of Diabetic Mother/Large for Gestational Age (LGA) according to the appropriate growth chart if meeting criteria for greater than 90th percentile in birth weight.

D. The assigned pediatrician or the pediatrician rounding for the assigned pediatrician must sign the newborn order set within 24 hours

E. The pediatrician (directly or through his or her office or exchange) will be notified of the newborn's birth by MCH Staff. Notification will be documented in the Delivery Summary.

F. The RN to document the following in the EHR:
   a. A complete Delivery Summary within 2 hours
   b. A complete initial infant assessment within 2 hours in the Infant Admission Record
   c. Medications administered to infant
   d. Infant procedures performed

VIII. TRAINING AND EDUCATION REQUIREMENTS:

RNs will maintain a Neonatal Resuscitation Program (NRP) certification and unit-specific competencies for the Mother Baby Unit and Labor & Delivery. NRP certification and unit-specific competencies can be verified through the Education Department tracker and employee professional profile folders.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**ADMISSION OF NEWBORN TO LABOR & DELIVERY**
CATEGORY:	**STANDARDIZED PROCEDURE**
LAST APPROVAL:	

IX. PHYSICIAN NOTIFICATION:

1. The pediatrician assigned will be notified if any of the following conditions are present:
    a. Temperature instability
    b. Changes in activity
    c. Abnormal cardiac/respiratory rhythm
    d. Abnormal stools or voiding
    e. Abdominal distension/bilious vomiting
    f. Unusual skin color
    g. Excessive lethargy or sleeping
    h. Low blood glucose
    i. Shaking/jitteriness
    j. Cleft palate and/or cleft lip
    k. Criteria for possible sepsis (maximum maternal temperature greater than 38 Celsius (100.4 Fahrenheit) OR any 2 of the following: 1) Late Preterm Infant (LPI), 2) Prolonged RMO greater than or equal to 18 hours, 3) Unknown GBS status or GBS positive mother (not including Cesarean birth with intact membranes) that was not adequately treated (ampicillin, penicillin, or cefazolin at least 4 hours prior to delivery, or 4) Previous child with diagnosis of GBS disease

X. STAFF COMPETENCE AND EVALUATION:

A. Initial competency for this standardized procedure is demonstrated during initial orientation.
B. Continuing evaluation for this standardized procedure is an annual review of the policy.
C. Those persons authorized to perform this standardized procedure are recorded in the Learning Management System.
D. The scope of supervision required for performance of standardized procedure functions is considered to be the ordering physician.

XI. REVIEW OF PROCESS/PROCEDURE:

This standardized process/procedure should be reviewed every three years or as practice changes, with approval by the IDPC, P&T (if applicable), MEC, and the Board of Directors.

XII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
IDPC	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**ADMISSION OF NEWBORN TO LABOR & DELIVERY**
CATEGORY:	**STANDARDIZED PROCEDURE**
LAST APPROVAL:	

ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

L&D Partnership Council: 09/08/15
DLT: 09/03/15
Pediatric Executive Department: 09/03/15
LG MCH Executive Committee: 09/10/15
IDCP: 09/09/15
P&T:
Medical Executive Committee:
Board of Directors:

XIII. ATTACHMENTS (if applicable):

OB-ED Mountain View: Care of the Obstetrical Patient in the OB Emergency Department (OB-ED)

Supportive Data:

1. Patients to be triaged by the OB-ED RN upon arrival according to the Obstetrical Emergency Severity Index (Appendix A).
2. Patients to be evaluated on the basis of acuity, otherwise they are treated on a first-come, first served basis. The nursing care assignment(s) to be based upon the complexity of the patient's condition, the assessments and management required by the patient, the dynamics of the patient's status, and the patient census.
3. Patients in labor (without provider admission orders) will be transferred to the Labor and Delivery unit after an appropriate medical screening examination (MSE) and stabilization in accordance with EMTALA regulations.
4. All non-pregnant patients presenting to the OB-ED will be quick registration to the OB-ED, vital signs obtained, any necessary code teams called (if applicable), and evaluated by the OB Hospitalist before being transferred by an RN to the Main Emergency Department for further evaluation and treatment.
5. Patients arriving for a scheduled outpatient procedure i.e. nonstress test (NST), version, or Bethamethasone injection will go directly to Labor and Delivery without being triaged in the OB-ED.
6. Patients arriving for a scheduled inpatient procedure i.e. labor induction, cesarean section, or labor patients with provider admission orders, will go directly to Labor and Delivery without being triaged in the OB-ED.

Procedure:

1. OB-ED patient presents to unit administrative support and completes a brief questionnaire on reason for visit
2. Administrative Support to quick register patient to the OB-ED, enter patient in the OB-ED log, and direct or escort patient to the OB-ED.
3. Upon arrival in the OB-ED, OB-ED RN to triage patient using the Obstetrical Emergency Severity Index (OB-ESI) (Appendix A) and patients chief complaint, gestational age and stated risk factors.

LEVEL 1: Emergent

- Patient condition is unstable and requires life saving measures
- Patient to be seen immediately
- RN:Patient ratio requirement 2:1 or 1:1
- Possible examples include:
    - Cardio-respiratory distress
    - Hemorrhage
    - Eclampsia/Seizure
    - Umbilical cord prolapse
    - Fetal parts presenting
    - Birth imminent
    - No fetal movement
    - Diabetic coma/DKA
    - Altered level of consciousness
    - Acute onset severe abdominal pain

- Other life threatening conditions to mother or fetus

LEVEL 2: Urgent

- Patient condition is stable, and unlikely to deteriorate with slight delay in care
- Patient to be seen within 15 minutes
- RN:Patient ratio requirement 1:1 or 1:2
- Possible examples include:
  - Rule out active labor/spontaneous rupture of membranes (SROM)
    - Regular contractions less than 5 minutes apart, pain scale = 7-10
  - Previous cesarean section in labor
  - Rule out preterm labor/premature rupture of membranes
  - Significant vaginal bleeding for gestational age
  - Decreased fetal movement greater than23 week/fetal heart rate decelerations
  - Rule out hypertension/preeclampsia
  - R/O deep vein thrombosis (DVT)
  - Severe depression/suicidal
  - History of recent seizure, alert on arrival
  - Asthma
  - Headache/migraine
  - Trauma, motor vehicle accident, fall
  - History diabetes; r/o hypo/hyperglycemia

LEVEL 3: Semi-urgent

- Patient condition stable, and unlikely to deteriorate with slightly longer delay in care
- Patient to be seen within 15-30 minutes
- RN:Patient ratio requirement 1:2 or 1:3
- Possible examples include:
  - Rule out labor
    - Irregular contractions greater than 37 weeks gestation, pain scale = 4-6
    - Spontaneous rupture of membranes or spotting greater than 37 weeks gestation
  - Nausea, vomiting and/or diarrhea with suspected dehydration
  - Rule out Spontaneous abortion, missed abortion, vaginal bleeding/cramping less than 20 weeks gestation
  - R/O pyelonephritis, kidney stones
  - Blood pressure check, history of high blood pressure

LEVEL 4: **Non Urgent**

- **Patient can wait to receive care with minimal risk of further injury**
- **To be seen within 30 minutes**
- RN:Patient ratio requirement 1:3
- Possible examples include:
  - Rule out latent labor
    - Mild, irregular contractions, greater than 37 weeks gestation, pain scale = 1-3
  - Vaginal discharge/vaginitis
  - Rashes

- Pregnancy discomforts
- Abdominal cramping less than 20 weeks gestation
- Rule out urinary tract infection
- Psychosocial issues, non-obstetric complaints
- Cold and flu

4. OB-ED RN to perform a medical screening exam (MSE) and evaluate patient within the OB-ESI specified time-frame
5. Notify patient's provider (per Physician Preference List) of assessment findings, and obtain orders as clinically indicated. Further assessment and treatment to be provided in collaboration with the provider.
6. OB provider to perform a bedside evaluation of patient within 30 minutes of receiving notification of patient's status from the OB-ED RN, or sooner if clinically indicated.
7. Provider to determine patient disposition in a timely manner, and patient to be transferred to the appropriate unit or discharged home undelivered per provider order.
8. If patient transferred to another unit, unit charge RN notified, SBAR report given to unit RN at patient hand-off.
9. If patient discharged home undelivered, written discharge instructions provided and reviewed with patient prior to discharge.
10. All procedures, treatments, interventions, medication administration, and physician notifications performed by the OB-ED RN including patient's response and outcomes to be documented in the electronic health record (EHR).

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Appendix A

OB-ED Obstetrical Emergency Severity Index

Level 1 **2-1:1 (RN to Pt)** **Emergent** Seen Immediately Requires Life Saving Measures	**Level 2** **1:1-2 (RN to Pts)** **Urgent** Seen within 15 min	**Level 3** **1:2-3 (RN to Pts)** **Semi-Urgent** Seen within 15-30 min	**Level 4** **1:3 (RN to Pts)** **Non-Urgent** Seen within 30 min	**Labor & Delivery Patient** Send Directly to Labor & Delivery For Registration and Care
Cardio-Respiratory Distress	R/O Active Labor/SROM Regular UCs < 5 min apart; Pain Scale = 7-10	R/O Labor Irregular UCs > 37 weeks gestation; Pain scale = 4-6	R/O Latent Labor Mild, irreg. UCs > 37 weeks gestation; Pain Scale = 1-3	**Scheduled *Outpatient* Procedures** Injection, Version, NST
Hemorrhage	Previous C/S in Labor	Nausea/Vomiting and/or Diarrhea w/ Suspected Dehydration	Vaginal Discharge/ Vaginitis	**Scheduled *Inpatient* Procedures** Inductions, Cesarean Sections, Labor Patients with Provider Admission Orders
Eclampsia Seizure	R/O Preterm Labor /PPROM	SROM or Spotting > 37 weeks gestation	Rashes	
Umbilical Cord Prolapse	Significant Vaginal Bleeding for Gestational Age	R/O Pyelonephritis/Kidney Stones	Pregnancy Discomforts	
Fetal Parts Presenting	Decreased Fetal Movement > 23 weeks gestation/ FHR Decelerations	R/O SAB/Missed Abortion; Vaginal Bleeding/Cramping <20 weeks	Abdominal Cramping <20 weeks	
Birth Imminent	R/O Hypertension/ Preeclampsia	BP Check; Hx Hypertension	R/O UTI	
No Fetal Movement	R/O DVT		Psychosocial Issues; Non-OB complaints	
Diabetic Coma/DKA	Severe Depression/ Suicidal		Cold and Flu	
Altered Level of Consciousness	Hx Recent Seizure; Alert on Arrival			
Acute Onset Severe Abdominal Pain	Asthma			
Other Life Threatening Condition for Mother or Fetus	Hx Diabetes, R/O Hypo/Hyperglycemia			
	Headache/Migraine			
	Trauma/MVA/Fall			

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**OBED: TRIAGE ORDERS FOR THE OBSTETRIC PATIENT IN THE OB EMERGENCY DEPARTMENT (OBED-MV)**
CATEGORY:	**STANDARDIZED PROCEDURE**
LAST APPROVAL:	

TYPE:	☐ Policy ☐ Procedure	☐ Protocol ☑ Standardized Process/Procedure[1]	☐ Scope of Service/ADT
SUB-CATEGORY:	***Labor & Delivery***		
OFFICE OF ORIGIN:	***OB Emergency Department***		
AUTHORS:	Marie Beauchemin, RN, CNM, WHNP, MS		
ORIGINAL DATE:	10/15/15		

I. DEFINITION AND COVERAGE:

1. All obstetric patients will be assessed by the OBED RN upon admission to the OBED according to the OBED Triage Orders.

II. CIRCUMSTANCES FOR THE PROCESS/PROCEDURE:

1. The OBED RN will enter and implement the OBED Triage Orders on all obstetrics patients admitted to the OBED.
2. An OB Hospitalist is available in-house 24 hours a day, seven days a week, if clinically indicated.

III. LOCATIONS PERMITTED FOR THE PROCESS/PROCEDURE:

1. Initial assessment will take place in the OBED.

IV. DEFINITIONS (if applicable):

V. REFERENCES:

1. American Academy of Pediatrics/American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*, 7th ed., 2012.

VI. CROSS REFERENCES:

VII. PROCEDURE:

1. Upon patient admission to the OBED, the OBED RN to initiate the OBED Triage Order Set using the order mode of “Per protocol, cosign required”.
2. The attending provider to sign the order set within 24 hours.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**OBED: TRIAGE ORDERS FOR THE OBSTETRIC PATIENT IN THE OB EMERGENCY DEPARTMENT (OBED-MV)**
CATEGORY:	**STANDARDIZED PROCEDURE**
LAST APPROVAL:	

3. The provider will be notified of the patient's arrival and OBED RN assessment findings per policy.

VI. The RN to document the following in the electronic health record (HER):
   a. Initiation of OBED Triage Orders Set
   b. Nursing assessments and care
   c. Provider notification(s)
   d. Medications administered

VIII. TRAINING AND EDUCATION REQUIREMENTS:

1. Review of all OBED Policies and Procedures
2. Completion of the OBED Healthstream Module
3. Completion of the EMTALA Healthstream Module
4. Annual Medical Screen Exam Competency Verification

IX. PHYSICIAN NOTIFICATION:

1. The physician or midwife will be notified of the following:
   a. Temperature greater than 38.5
   b. Systolic blood pressure greater than 140
   c. Systolic blood pressure less than 85
   d. Diastolic blood pressure greater than 90
   e. Diastolic blood pressure less than 60
   f. Heart rate greater than 120
   g. Heart rate less than 60
   h. Respiratory rate greater than 25
   i. Respiratory rate less than 12
   j. SpO2 less than 95
   k. Urine output less than 35 ml/hour for over 2 hours

X. STAFF COMPETENCE AND EVALUATION:

A. Initial competency for this standardized procedure is demonstrated during initial orientation.
B. Continuing evaluation for this standardized procedure is an annual review of the policy.
C. Those persons authorized to perform this standardized procedure are recorded in the Learning Management System.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	**OBED: TRIAGE ORDERS FOR THE OBSTETRIC PATIENT IN THE OB EMERGENCY DEPARTMENT (OBED-MV)**
CATEGORY:	**STANDARDIZED PROCEDURE**
LAST APPROVAL:	

D. The scope of supervision required for performance of standardized procedure functions is considered to be the ordering physician.

XI. REVIEW OF PROCESS/PROCEDURE:

This standardized process/procedure should be reviewed every three years or as practice changes, with approval by the IDPC, P&T (if applicable), MEC, and the Board of Directors.

XII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
IDPC	
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

L&D Partnership Council: 09/08/15
DLT: 09/03/15
Pediatric Executive Department: 09/03/15
LG MCH Executive Committee: 09/10/15
IDCP: 09/09/15
P&T:
Medical Executive Committee:
Board of Directors:

XIII. ATTACHMENTS (if applicable):

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: 1.31 Imaging Services Staff Handoff Communication Guidelines

CATEGORY: Clinical & Support Services
LAST APPROVAL DATE: 04/13

SUB-CATEGORY: IMAGING SERVICES

ORIGINAL DATE: 07/07

COVERAGE:
Imaging Services Staff

PURPOSE:
To provide a consistent process for patient handoff by Imaging Services staff.

STATEMENT:
It is the policy of Imaging Services to promote patient safety by providing a consistent process for patient handoff communication.

DEFINITIONS: ISBAR-
I—***Introduction***—*your name*
S—***Situation***:
B—***Background***:
A—***Assessment:***
R—***Recommendation:***

PROCEDURE:

1. Pertinent information such as code status, fall status, O2 status or isolation type must be communicated by nursing for all ED and In-house patients using the transporter ticket. Pertinent Patient information is also available in the EH ~~M~~R.

2. Direct verbal communication is required for invasive procedures requiring contrast or preparation, including but not limited to screening documents, biopsy, drainage or aspirations, or fluoroscopy exams involving contrast.

3. ~~Any patient requiring monitoring must be accompanied or overseen by a nurse. Direct communication withpatient'smust occur to facilitate patient flow and Imaging nurse availability~~. If a patient requires continuous monitoring

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: 1.31 Imaging Services Staff Handoff Communication Guidelines

(cardiac, pulse oximetry, B/P monitoring, 5150 hold, etc), there must be direct verbal **ISBAR** communication between the patient's nurse and the Imaging Services nurse to facilitate patient flow and to coordinate Imaging Services nurse availability. When Imaging Services Nurses are not available for patients, who require monitoring, either the patient's primary nurse will accompany the patient or the Nursing Supervisor will assign Nursing monitoring coverage for that patient.

4. Any change in caregiver while in Imaging, must include updated information regarding any change in patient status.

5. When sending inpatients back to their room, the technologist or nurse must complete the transport documentation, noting whether the procedure is complete, any change in patient status, the technologist's or nurse's name and phone extension. For patients requiring continuous monitoring, direct verbal ISBAR communication is required.

6. Interruptions during handoffs must be limited so that all information is communicated appropriately. Sufficient t~~T~~ime must be allowed for questions following the handoff.

7. Upon return to the ED the nurse assigned to the patient must be notified and informed of any changes to the patient's status.

8. The patient's nurse will be notified of any change in patient status.

~~7.~~9.

APPROVAL	APPROVAL DATES
Originating Committee: Imaging Services, Imtiaz Qureshi, MD	05/2015
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: 09/07, 05/09, 05/10, 07/12, 03/13

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Finance: Value Analysis Policy

CATEGORY: Administrative
LAST APPROVAL DATE:

SUB-CATEGORY: Finance
ORIGINAL DATE: 04/11

COVERAGE:

All El Camino Hospital facilities and departments.

PURPOSE:

To identify, assess and monitor processes for acquisition of medical products/supplies and equipment for El Camino Hospital that will improve outcomes, reduce costs, and optimize utilization. An interactive, discipline specific Value Analysis Team approach will be utilized to determine technical, clinical and economic quality for new products and equipment introduction.

STATEMENT:

DEFINITIONS *(as applicable)*:

Value Analysis (VA) is the process by which every element of cost and function is studied in an organized and systematic manner to identify unnecessary cost while also supporting quality patient care. Examples include identification and elimination of redundancies, meeting contractual obligations and following strategic purchasing initiatives while ensuring the supplies and equipment meet clinical requirements.

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PROCEDURE:

All requests for acquisition of new medical products/supplies and equipment shall be forwarded to Purchasing / Value Analysis Coordinator.

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2. The Value Analysis process will be used for:
    a. Introduction of new medical products/supplies and equipment
    b. Standardization of existing medical products/supplies and equipment

c. Optimization of Group Purchasing Organization, and local contracting in support of strategic purchasing targets

d. Utilization review

e. Clinical review

~~e.~~ 1. Products related to medication, stem cells or biologics require approval from Pharmacy and Therapeutics Committee prior to purchase/use decision.

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f. Regulatory review.

1. New products are to be FDA approved. If not FDA approved or product is being considered for research purposes, Risk Management is to be contacted before any decision about purchase/use is made.

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~~f.~~ 2. Any medical equipment that is to be used on a patient that will not be owned by the hospital is to be approved by Clinical Engineering and Risk Management before purchase/use decision is made. If approved for use, the vendor must provide all necessary quality control paperwork required for accreditation purposes or equipment cannot be used.

g. Financial performance

h. The movement of product/contract decisions from individual preferences to decisions based on group preference, clinical outcomes and financial performance.

i. The engagement of clinical shareholders in product standards, identification of alternatives and clinical product evaluations.

3. El Camino Hospital Mountain View and Los Gatos are non solicitation campuses and vendors are required to conduct business in the Purchasing department. Department managers should not accept medical supplies / product or equipment that have not been vetted and approved through the hospitals Value Analysis program.

~~3. El Camino Hospital MV-LG are non-solicitation campuses~~

F: PROCEDURE:

Departments contacted by a vendor:

- Should not initiate business with the vendor. Pricing, current products used or satisfaction level of current product used should not be discussed. Direct the vendor to the Value Analysis Coordinator (VAC) located in the Purchasing department. The VAC will conduct a Business Review with the supplier to asses strategic purchasing benefit and will contact department Manager for further discussion if merited.
-

- ~~Direct the vendor to the assigned Buyer-Partner (B-P) in Purchasing (a list of B-P's will be published) or to the Purchasing Manager or Director of Material Management.~~
- ~~Buyer-Partner and the Value Analysis Coordinator will assess for strategic purchasing benefit and will contact Manager for further discussion.~~

Departments interested in medical products/supplies and equipment:

- Prior to contacting or discussing any business with a vendor, contact the Value Analysis Coordinator located in the Purchasing department for initial review and strategic assessment. The requestor will be assisted in submitting a new product / supply or equipment request and presented to the appropriate Value Analysis Team (VAT) for further discovery. ~~assigned Buyer-Partner in Purchasing, or the Purchasing Manager or Director of Material Management.~~
- ~~Purchasing and the Value Analysis Coordinator will assess for strategic purchasing benefit and will contact Manager for further discussion.~~
- Purchasing and the VAC ~~Value Analysis Coordinator~~ will facilitate meetings with interested departments and vendor(s)
- Clinicians attending professional meetings (seminars etc.) with an interest in new products/equipment presented should bring the product information, including contact information, back to the VAC.

4. At times an urgent need for a particular product arises. Contact the VAC, and Purchasing ~~In these situations Material Management~~ will review the ~~purchase~~ request with the appropriate expert liaison, facilitate the purchase and ~~subsequently~~ refer the item to the appropriate VA Team.
5. In procedural departments, a physician~~s~~ may ~~request~~ determine that a new product or technology is necessary for the patient~~prior to the scheduled case~~. In this situation, the department manager and/or the physician should refer the ~~manufacturer / distributor rep~~vendor to the VAC with as much advance notice as possible. Purchase orders will not be issued to the vendor, until pricing has been agreed to. ~~Purchasing prior to the scheduled case. Two weeks notice is preferred. Purchasing will discuss cost, affiliations and other pertinent information. All affected stakeholders such as Finance, Clinical Engineering or Education will be appropriately advised. Following the scheduled procedure, the new product or technology will then be referred to the next scheduled meeting with the appropriate VA team.~~ If this occurs on a holiday or weekend when Purchasing is closed, the affected department should utilize their chain of command for purpose of notification or guidance.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Finance: Value Analysis Policy

6. All Departments will participate in the Value Analysis process for standardization of medical products/supplies and equipment, to achieve contract compliance and for the overall reduction of product and equipment costs.
7. The Value Analysis Teams will document activities and cost reductions. The ~~Value Analysis Coordinator~~VAC is responsible for the preparation of agendas, communication of actions taken and the preparation of non-salary expense reduction~~s~~ reports~~/savings reports~~ .
8. Other teams, team members and sub-groups may be added as necessary as either permanent or ad hoc teams.
9. The requestor or designee is required to attend the appropriate VA team meeting to present the business and/or clinical case for the requested product. ~~The~~ A requestor that claims savings based on improved clinical outcomes, must present a plan for monitoring, measuring and validating the claim within a specified evaluation period. In addition, the requestor is to present a plan for training on the new equipment/product/supply for staff involved. The requestor will present the data to the VAT for final disposition.
10. The Value Analysis Teams will meet monthly or as appropriate. The dates, times and locations will be pre-determined. The Value Analysis Coordinator will send a reminder to all members at least one week prior to the meetings.
11. Decisions of the Value Analysis Teams are made by consensus. If consensus cannot be achieved a majority vote will be applied.
12. Requested products not approved by the Value Analysis Teams are not eligible to be requested again for 1 year. Exceptions may be made based on availability of current product.
13. The Value Analysis Team(s) shall determine when product/equipment evaluations are necessary. Education, or appropriate department or person will assist by providing product specific, criterion based evaluations. The Value Analysis Team determines areas within the facility for evaluation and the duration of the evaluation. Vendors are expected to provide evaluation product at no cost to the hospital. Exceptions may be made at the discretion of the Director of Material Management. Note: Equipment evaluations are subject to prior approval by IT, Legal,Risk Management, Facilities, Clinical Engineering, Finance and Purchasing. All equipment must be ordered via the hospitals purchase order system, delivered to the receiving dock and checked by Clinical Engineering prior to use. Equipment arriving without prior approvals and a purchase order will not be accepted and returned to the vendor.

~~13.~~14.

G. VALUE ANALYSIS TEAM STRUCTURE

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Finance: Value Analysis Policy

1 The Value Analysis process, through its team structure promotes interdepartmental collaboration in understanding and solving mutual issues. It provides a mechanism whereby physicians and staff continually have access and input into the facility standardization process. The Team structure is listed below:

- Perioperative Team
- Patient Care Team
- ~~Environment of Care Team~~
- Interventional Services Team
- Ancillary Departments Team ad hoc

The work of the Value Analysis Teams is reported up to the Executive Sponsor.

A. Responsibility:
It is the responsibility of the Director of Material Management and the Value Analysis Coordinator (VAC) to implement this policy.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Finance: Value Analysis Policy

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	10/12

Historical Approvals:

04/11, 10/12

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

TYPE:	☑ Policy ☑ Procedure	☐ Protocol ☐ Standardized Process/Procedure	☐ Scope of Service/ADT
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Patient Care Services***		
ORIGINAL DATE:	04/2009		

I. COVERAGE:

El Camino Hospital Employees and Medical Staff.

II. PURPOSE:

Provide guidelines to be followed when Electronic Health Record (EHR) is unavailable to maintain the integrity of all required documentation and data captured in the patient medical record and ensure consistency for record keeping, medication reconciliation, and timeliness of patient care delivery.

III. POLICY STATEMENT:

Clinical information to ensure consistency of clinical care documentation and timeliness of patient care delivery will be maintained by a Downtime process when EHR is unavailable. Defined procedures and guidelines will be followed.

IV. DEFINITIONS (if applicable):

a. **Downtime**: A term commonly used to describe the situation when EHR is not available for use for at least one hour and the system completely stops responding to user requests. The term does not usually include peripheral hardware problems, such as those involving printers or terminals.

b. **Scheduled Downtime**: Scheduled downtime is a controlled event. Scheduled downtime occurs when Information Services or Computer Operations need to make hardware or software changes that require inactivation of the system. Information Services will communicate, in advance, the date and time of these scheduled events.

c. **Unscheduled downtime**: Unscheduled downtime is an unexpected event. This condition occurs when the system (without prior notice) will self-diagnoses a problem and brings the system down, or Information Services brings the system down to protect the integrity of the database.

d. **Downtime Procedures**: Instructions designed to cover the period of time during "downtime" and provide operating guidelines for users during this period.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

e. **Business Continuity Access (BCA)**: is a term to describe the downtime system. It includes functionality to ensure access to information that is most critical for patient care in the event of a downtime and minimal chart updates. It is comprised of the following elements:

i. **Supports Read-Only (SRO):** The SRO is a "read only" version of the EHR accessed through icon desktop "BCA-SRO". It can be used during downtimes where the EHR is unavailable but the network, server and power is functioning normally. Note: the read only version will only include information up until the time that the EHR system went down.

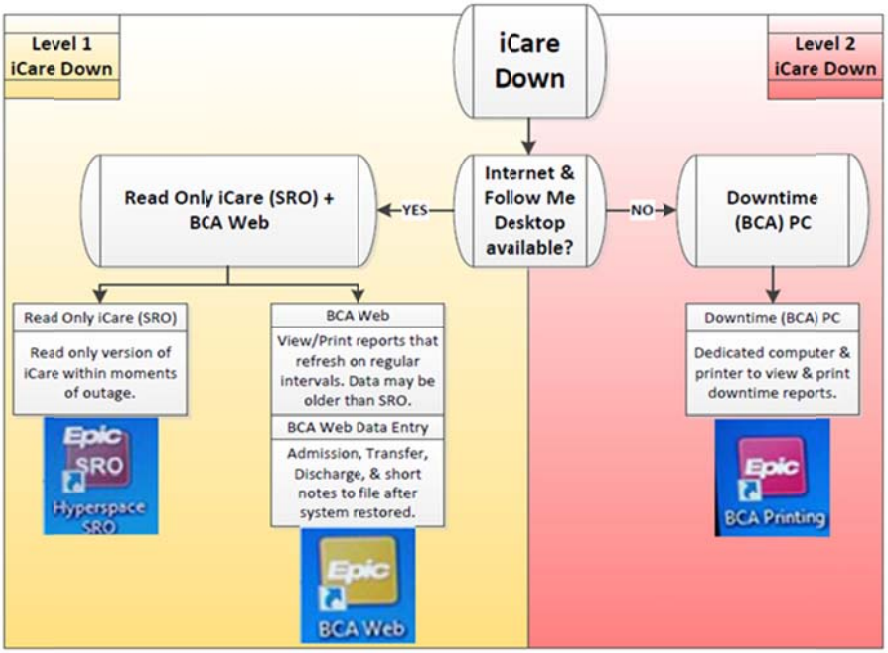
ii. **BCA Web:** Accesses through "BCA-Web" icon enables users to view and print downtime reports. BCA Web is available on "Follow Me Desktop". BCA Web also allows users to enter Admission, Transfer and Discharge (ADT) as well as a way to enter a short comment. When the EHR becomes available again, the information that was entered during downtime will be automatically filed back to the EHR.

iii. **Downtime PC:** Is a dedicated computer that is directly connected printer. If "Follow Me Desktop" is unavailable, use Downtime PC to access "BCA Printing" to view and print downtime reports. "SRO" and BCA Web are not available of the Downtime PC.

iv. **Downtime Reports:** are reports that are created at regular intervals so that during a downtime information is available to view and print via BCA printing and BCA Web. An example downtime report would be the Clinical Summary report.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012



V. REFERENCES:

1. Nelson, N. Downtime procedures for a clinical system: a critical issue. Journal of Critical Care (2007) 22: 45-50
2. Department of Clinical Research Informatics (DCRI) Clinical Center, NIH. Backup Processes for Unavailability of Electronic Clinical Systems. (2008)

CROSS REFERENCES

1. Patient Care Services Policy 08.04 Nursing Documentation
2. Patient Care Services Policy 08.05 Physician Order Entry
3. 05.09 CCU/eICU Policy

VI. PROCEDURE:

a. **Downtime Procedures**: The downtime procedures are instituted by users when EHR is unavailable. Downtime procedures may be instituted at the discretion of the nursing staff if the unit situation dictates, prior to an EHR downtime message on Vocera.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

b. **Reconciliation Procedures**: Refers to the period when EHR becomes operational after a "downtime," and data is entered that has been recorded on downtime forms.

Supportive Data:

a. **Duration**: Downtime duration is variable, depending on the amount of time Information Services requires to take the system off-line to make hardware or software changes. Scheduled downtimes for maintenance occur regularly, with occasional additional downtimes scheduled to implement changes and additions to the system.
b. Departments included in the procedure include:

i. Ambulatory clinics
ii. Care Coordination
iii. Central Supply
iv. EKG
v. Employee Wellness and Health Center
vi. EVS/Patient Transport
vii. Imaging
viii. Infusion Center
ix. Laboratory
x. Medical Staff
xi. Nursing
xii. Nutrition Services
xiii. Outpatient
xiv. Outpatient BHS
xv. Patient Access
xvi. Pharmacy
xvii. Radiology
xviii. Oncology
xviii. Rehabilitation Services
xix. Respiratory Medicine
xx. Silicon Valley Primary Care (SVPC)

a. **User Communication and Notification of Scheduled Downtime**
   i. There are multiple forms of messaging that may occur:
      1. Scheduled downtime messages appear on the message of the day screen in advance.
      2. Both scheduled and unscheduled downtimes are announced over Vocera with "EHR Status" messages.
      3. Notification of downtime can also be provided via e-mail, written, or by telephone.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

4. Reactivation of EHR will be announced over Vocera via "EHR Status".

DOWNTIME FORMS LIST (see Appendix C)

b. **PATIENT ACCESS**

i. **Downtime Procedures**:

1. The Hospital Supervisor will notify nursing units of new admissions via telephone/Vocera.
2. Upon admission to the ED or Patient Access a temporary, legibly handwritten armband containing the patient's name and date of birth will be placed on patient. The patients will arrive on the nursing unit with the temporary handwritten armband in place (Please note the patient's medical record number will not be on the temporary handwritten armband.).
3. If BCA Web Data Entry is available, Patient Access will enter all arrivals to the Emergency Department and direct admissions into EHR via BCA Web Data Entry.
4. If BCA Web Data Entry is unavailable, Patient Access will maintain a manual log of all arrivals to the Emergency Department and direct admissions. Nursing units will add the patient's name to the manual unit Patient List and into PYXIS.
5. Nursing units will notify Nutrition Services via telephone of new admissions if a tray is required.
6. Patient Access or the Emergency Department will complete the admission log and keep admissions in chronological order for the reconciliation phase.

ii. **Reconciliation Procedures:**

1. Reconciliation begins after notification via "EHR" status that EHR is fully operational.
2. If BCA Web Data Entry was used to enter arrival/admissions, no reconciliation is required; it will update the EHR automatically.
3. If BCA Web Data Entry was not available, Patient Access will enter all arrivals/admissions in chronological order when EHR is restored. Labels and armbands will be sent to the nursing unit. Nursing units currently printing their own labels and armbands may do so when the system is restored.
4. Nursing units will be responsible for banding their patients with the new barcoded armbands. Handwritten arm bands are to be cut off and disposed of.

PATIENT TRANSFERS

iii. **Downtime Procedures:**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

1. Patient Access will be notified of a patient transfer between units via telephone.
2. If BCA Web Data Entry is available, Nursing will enter all transfers into EHR via BCA Web Data Entry.
3. If BCA Web Data Entry is unavailable, Nursing will maintain a log of all transfers.
4. Nursing units will add the patient's name to the Patient List and PYXIS.
5. The complete paper chart including all printouts and written documents must be sent to the receiving unit.

iv. **Reconciliation Procedures:**

1. Reconciliation begins after notification via "EHR status" that EHR is fully operational.
2. If BCA Web Data Entry was used to enter transfers, no reconciliation is required; it will update the EHR automatically. Nursing units are to verify accurate unit census.
3. If BCA Web Data Entry was not available, Nursing will enter all transfers in chronological order.
4. Nursing staff on the receiving unit will reconcile all applicable clinical information (see nursing section below) with the exception of the Emergency Department portion of the patient's record. The Emergency Department staff will be responsible for reconciling all Emergency Department records.

c. **PATIENT DISCHARGES/EXPIRATIONS**

i. **Downtime Procedures:**

1. Nursing will notify Patient Access of patient discharge or expiration via telephone when the patient actually leaves the unit.
2. If BCA Web Data Entry is available, the nursing department will enter all discharges and expirations into EHR via BCA Web Data Entry.
3. If BCA Web Data Entry is unavailable, the nursing department will maintain a log of all discharges and expirations.
4. Nursing units will remove the patient's name to the unit Patient List and PYXIS.

ii. **Reconciliation Procedures:**

1. Reconciliation begins when EHR is fully operational.
2. If BCA Web Data Entry was used to enter discharges and expirations, no reconciliation is required; system will update the EHR automatically.
3. If BCA Web Data Entry was not available, Nursing will enter all discharges and expirations in chronological order. Nursing units are to verify accurate unit census.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

4. Nursing will complete order entry and charting of medications and IV and all applicable clinical documentation that occurred during the down before the patient is removed from EHR. (See nursing section).

d. **PHYSICIAN ORDERS**

i. **Downtime Procedures:**

1. All orders will be written on a Physician's Order form #210 form. Neatly write the patient's name, medical record number (if assigned), admitting physician, and admit date on the top right corner of the form.
2. The Physician's Order Form is a triplicate form: the original will remain at the nurses' station in the EHR Down accordion file, the middle copy will be sent to Pharmacy (if medication on order sheet), and the last copy will be given to the nurse caring for the patient.

ii. **Pharmacy Orders PYXIS Med Station on Critical Override:**

1. **New Orders**
   a. Nursing will send the middle copy of the written order sheet to Pharmacy.
   b. For new patients, include patient allergies, height, weight, pregnancy and lactation status on the Physician Order form.
   c. Nursing will call x8011 LG will call x4025 with STAT orders.
   d. Reorders: These are medications already ordered in EHR but not on the unit. Send a 124 Downtime requisition form only, listing the drug name, drug route, drug strength, and schedule. Keep the goldenrod copy for reference.
   e. IVs: Send the middle copy of the written order sheet and a 124 form, one per IV order, include solution, additive, and time scheduled to Pharmacy.
   f. In the event that the new order is for chemo, MD will be required to "write" the order and then pharmacy will enter upon reconciliation. Non chemo orders can follow the process below. Only a pharmacist or approved physician may enter chemotherapy orders.

2. **Reconciliation Procedures for Medication/IV Orders:**
   a. Reconciliation begins when EHR is fully operational.
   b. Nursing will enter all medications and IV orders into EHR.
   c. Only pharmacist or approved physician may enter chemotherapy orders into EHR.

e. **PHYSICIAN DOCUMENTATION**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

i. **Downtime Procedures:**
   1. Physician will document using the dictation system.
   2. If dictation not available, the physician will document on paper

ii. **Reconciliation Procedures**
   1. No reconciliation required; dictated notes will file into the EHR automatically when it becomes available. Paper notes will be in the physical chart while the patient is in the hospital, then scanned and available in EHR media links post discharge.

f. **LAB ORDERS:**

i. **New Orders:**
   1. Nursing will initiate the requisition on a #9350 form (Clinical Laboratory Requisition). All information must be readable on every copy. If patient labels are used, put on both pages. Fill out and send the entire form, including patient name, ordering physician, date, time, unit, room number, patient medical record number and gender.
   2. **Routine orders:** Send the entire #9350 form. Send forms in batches if possible.
   3. **STAT and Timed Orders:** STATS or timed pickups should be called to the lab. Send the entire Downtime lab requisition form. Timed pickups should be sent in batches if possible.
   4. Laboratory will date, time, and initial the Downtime lab requisition forms, and leave the goldenrod copy of the # 9350 form at the nurses' station when the specimen is drawn.

ii. **Previous Orders:**
   1. Lab will have these orders in the Laboratory Information System (LIS) and will draw as they would have if EHR had not been down. If the LIS is down, send the #9350 form.

iii. **Lab Specimens Collected by Nursing:**
   1. Nursing will fill out a #9350 form, even if the order is already in EHR. The nurse will initial, date, and note the time collected on the #9350 form and send it with the specimen to lab.

iv. **Results:**
   1. Critical results will be phoned by Lab to the nursing unit.
   2. All results will print or be tubed to the appropriate unit.
   3. STAT results will be faxed or be tubed to nursing units, if the (LIS) is unavailable.
   4. All other results- Nursing may call the lab if necessary. A phone report form will be at the desk to manually record results, if the (LIS) is unavailable.

v. **Blood Bank:**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

1. Patients admitted during the downtime without a medical record number on their armband will be banded by the phlebotomist or RN when the Type and Cross match specimen is drawn with a TypeNex pre-numbered armband that has several labels to be used for blood/patient matching purposes.
2. Blood Bank will notify the nursing unit when the blood is ready.

vi. **Reconciliation Procedures for Laboratory Orders:**
1. Reconciliation begins when EHR is fully operational
2. Lab will enter all orders sent on #9350 forms and the orders will automatically update into EHR when it becomes available.

g. **RADIOLOGY, EKG, RESPIRATORY CARE SERVICES, REHAB SERVICES**

i. Nursing will initiate the requisition on a #124 form and send it to the appropriate department.
ii. **Routine orders:** Send the entire downtime #124 requisition form. Send forms in batches if possible.
iii. **STAT and Timed Orders:** STATS or timed pickups should be called. Send the entire downtime #124 requisition form. Timed pickups should be sent in batches if possible.
iv. Pulmonary Diagnostics Laboratory will date, time, and initial the downtime #124 requisition forms, and leave the goldenrod copy of the Downtime lab requisition form at the nurses' station when the specimen is drawn.
v. Radiology and EKG orders require indications on the downtime #124 requisition form.
vi. **Results:**
1. All results will print on the appropriate unit.
2. ABG results will be called to the unit. "ABG Result" sheet.

vii. **Reconciliation Procedures:**
1. Reconciliation begins when EHR is fully operational
2. Radiology will enter all orders sent on 124 forms into the Radiology Information System (RIS) and the orders will automatically update into EHR when it becomes available.
3. Other ancillary departments will enter all orders sent on 124 forms into EHR.

h. **CENTRAL SUPPLY**

i. STAT- Nursing will order STATS on a downtime #124 requisition form and call Central Supply. The goldenrod copies will be kept on the unit for reference.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

ii. Routine Orders- Do not call. Batch the orders for certain times or send them at the end of the shift. The goldenrod copies will be kept on the unit for reference.

iii. **Reconciliation Procedures:**
1. Reconciliation begins when EHR is fully operational Nursing will enter all CS orders into EHR.

i. **NUTRITION SERVICES**
i. Nursing will manually update the diet list located at the nurses' station. An updated diet list will be sent for each meal: Send by: 0600 for breakfast; 1015 for lunch; and 1530 for dinner.
ii. Nursing will send an order for an individual patient diet on a 124 form for meals required after the diet list has been sent to Nutrition Services.
iii. Nutrition Consult orders:
1. Nursing will initiate the requisition on a downtime #124 requisition form and send it to the Diet Office.

iv. **Reconciliation Procedures:**
1. Reconciliation begins when EHR is fully operational.
2. All new nutrition services orders will be entered by the Nursing Unit.

j. **NURSING DOCUMENTATION**
i. **Downtime procedures:**
1. All units will chart manually during the down time on the appropriate down time form.
2. All medications and IVs are to be documented completely and neatly on the appropriate form during the down time. Follow directions on the form.

ii. **Reconciliation procedures:**
1. Reconciliation begins when EHR is fully operational.
2. Document medications administrations using the MAR Action "Given During Downtime" and click the "Document for Another User" (to specify which nurse actually gave the medication).
3. Documentation on paper patient note forms and flow sheets will remain in the chart as a permanent part of the record.
4. Admission Assessments, I&O shift totals, Blood Glucose values and daily weights collected during the downtime will be entered into EHR.
5. DO NOT import physiological monitor data that occurred during the down.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

k. **Patient Acuity System**
   i. **Downtime procedures:**
      1. Enter retrospective Patient Acuity System on the Patient Acuity System worksheet and send to Patient Care Resources (Staffing) Office.

   ii. **Reconciliation procedures:**
      1. Reconciliation begins when EHR is fully operational.

l. **AMBULATORY CLINICS**
   i. **Downtime Procedures:**
      1. Registration Process
         a. The patient will be given a temporary armband placed by Patient Access.
         b. In areas that issue a patient armband, the patient's name and date of birth will be legibly handwritten on the armband to identify patients without medical record numbers. In all other areas, the caregiver will ask the patient will be their first and last name, and date of birth prior to any interventions.
         c. Patient Access or Clinician will complete the intake log and keep all appointments in chronological order for the reconciliation phase.
      2. Orders
         a. All orders will be written on a Physician's Order. Neatly write the patient's name, Clinical Identification Number CIN (if assigned), physician, and date on the top right corner of the form.
         b. The Physician's Order Form is a triplicate form: the original will remain at the nurses' station in the EHR Down accordion file, the middle copy will be sent to Pharmacy (if medication on order sheet), and the last copy will be given to the nurse.
      3. Documentation
         a. Chart manually during the down time on the appropriate down time form.
         b. Cardio-Pulmonary Wellness Center will use the Telemetry documentation system.
         c. Visit and Service charges will be recorded on the appropriate down time form.

   ii. **Reconciliation Process**
      1. Reconciliation begins when EHR is fully operational.
      2. Enter all orders into EHR.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

3. Document all medications administered.
4. Enter all service charges and data elements for quality tracking.
5. Cardio-Pulmonary Wellness Center will print all documentation entered into the Telemetry documentation system; these printouts will be scanned and later available in HPF.
6. All other paper notes will be scanned and later available in HPF.

m. **RECONCILIATION PHASE**

i. At the start of the Reconciliation phase, patient location and verification of bed availability are priorities. As users begin to enter data into EHR, it is important that printouts are in the appropriate area and that new admission orders are processed as soon as possible.

ii. Entering Data During the Reconciliation Phase:
   1. To maintain continuity and to ensure accuracy, enter data on current patients and then discharged/expired patients
   2. Sort the 124 forms by patient name, date, and time (chronological order)
   3. Complete entry of new orders first
   4. Be aware that the DATE of documentation may need to be changed for accuracy.

iii. **PATIENT CENSUS**
   1. The charge nurse will verify that the unit Patient List is updated to include all admissions, transfers, discharges, and expirations.

VII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
DLT	10/15
PCMC Directors Consent	04/09, NA 12/11, 10/15
Patient Care Leadership Council	04/09, NA 12/11, 10/15
Patient Care Services Meeting (MV and LG):	12/11
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	1/2012
Board of Directors:	2/2012
Historical Approvals:	

VIII. ATTACHMENTS (if applicable):

Appendices:

A. Downtime Tip Sheet

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

B. Job Action Sheet:

- **a.** Clinical Manager
- **b.** Charge Nurse PM Shift before Scheduled Down
- **c.** Charge Nurse NOC Shift during Scheduled Down
- **d.** Primary Nurse during Scheduled Down
- **e.** Clinical Informatics Manager
- **f.** Clinical Systems Specialist (Informatics) in Command Center
- **g.** Communication Lead in Command Center
- **h.** Incident Commander
- **i.** Charge Nurse During Reconciliation

C. Escalation and Communication EHR Downtime Checklist

D. Downtime Forms List

Patient Forms

1. Form# 124: Downtime Requisition and Charge Slip
2. Form# 210: Physician Order Sheet
3. Form# 212: Graphic Chart
4. Form# 213: Intake and Output Record
5. Form# 215: Nurses' Notes
6. Form#716: Comprehensive Admission Assessment and History
7. Form# 1071A: Skilled Nursing Facility Interfacility Transport Report (page 1)
8. Form# 1071B: Skilled Nursing Facility Interfacility Transport Report (page 2)
9. Form# 2001: Medication Administration Record
10. Form# 2002: IV Administration Record
11. Form# 2003: Laboratory Telephone Report Form
12. Form #9000: Discharge Instructions
13. Form #211: Progress Notes
14. Form#9350: Clinical Laboratory Requisition

Unit Forms

15. Form# 500: Pharmacy Requisition
16. Form# 1041: Diet List
17. Form# 2005: Retrospective NIM Backup Worksheet
18. Form# 2006: Emergency Nursing Unit Floor Stock Order Sheet

Patient Specific Forms

19. Form# 271: Diabetic Management Flowsheet
20. Form# 756: Alcohol Withdrawal Scale
21. Form# 1092: Medical Restraints
22. Form# 3084: Daily Wound

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

23. Form# 1125: Rapid Response Team Form
24. Form# 3107: Adult Mechanical Ventilation Flowsheet
25. Form# 3108: Neonatal Mechanical Ventilation Flowsheet

Unit Specific Forms

26. Form# 218: Emergency Department Record (Triage & History)
27. Form# 3064: Emergency Department Adult Nursing Care Record
28. Form# 3068: Emergency Department Pediatric Nursing Care Record
29. Form #3062: Emergency Department Patient Notes
30. Form #3063: Emergency Department Medication record
31. Form #6914: Emergency Department Code Triage/EMR Downtime Physicians Order Sheet
32. Form# 278: Nursery Nurses Notes
33. Form# 278A: Infant Assessment Record Nursing Assessment
34. Form# 278B: Infant Assessment Record Nursing Assessment
35. Form# 410: Neonatal Intensive Care Unit Education Record
36. Form# 3105: Neonatal Intensive Care Nurses Notes
37. Form# 264: Neonatal Abstinence Score Sheet
38. Form# 1065: Critical Care Nursing Assessment
39. Form# 5065: Signature Log
40. Form# 1065A: Critical Care Flowsheet Addendum (yellow)
41. Form# 1065B: Vital Sign Flowsheet (pink)
42. Form# 283: EKG Mount
43. Form# 4400: CRRT
44. Form# 3912: IABP
45. Form# 2021: NIH Stroke Scale
46. Form# 763: Cancer Center: Treatment / Procedure Care Plan
47. Form# 208: Labor and Delivery Flow Sheet
48. Form# 209: Labor and Delivery Assessment and Interview
49. Form# 4057: Labor and Delivery Post-Partum Record
50. Form# 205: Labor and Delivery – Delivery Record
51. Form# 1023: OB Admission Note
52. Form# 220(A&B): Labor and Delivery Outpatient Record
53. Form#4908 Admission Nursing Database
54. Form#4905 Inter Disciplinary Treatment Plan
55. Form#4932 Evaluation of person who was restrained/secluded with violent or self-destructive behavior
56. Form#1091 Behavioral Seclusion Restraints
57. Form#4931 Patient Debriefing tool for Seclusion/Restraints
58. Form #4907 Substance Abuse/Dependency Assessment
59. Form#4900 Chemical dependency Treatment Plan
60. Form#4906 Supplemental Care Plan

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	EHR DOWNTIME AND RECONCILIATION POLICY AND PROCEDURE
CATEGORY:	PATIENT CARE/ INFORMATION SERVICES
LAST APPROVAL:	02/2012

61. Form#4901 Care Plan Update
62. Form#6888 Behavioral Health QIDS
63. Form#4903 Education/Learning Assessment and patient Strengths
64. Form#4048 Behavioral Health Voluntary Admission

E. EHR Downtime Action Checklist

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TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

TYPE:	☐ Policy ☑ Protocol ☐ Scope of Service/ADT ☐ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Emergency Department***
OFFICE OF ORIGIN:	***Emergency Department***
AUTHORS:	***Lotta Mae Alba, RN, MSN, CNS***
ORIGINAL DATE:	03/1999

I. OUTCOME:

1. Patients will be appropriately triaged (sorted) and prioritized by a registered nurse (RN) according to acuity.
2. Early recognition of life-threatening conditions at the triage desk will result in immediate treatment.
3. All legal requirements for patient assessment and treatment will be met.

II. SUPPORTIVE DATA:

1. The Emergency Medical Treatment and Active Labor Act (EMTALA) passed in 1986 requires that hospitals participating in the Medicare program provide a screening examination to each person requesting one, and patients found to be suffering from any emergency medical condition or in active labor must be stabilized.
2. The purpose of triage is to identify patients needing immediate resuscitation; to assign patient to a pre-designated patient care area, thereby prioritizing their care; and to initiate diagnostic/therapeutic measures as appropriate.
3. Triage decisions are classified into five categories using the Emergency Severity Index (ESI) levels. Level 1 is the most critical requiring immediate treatment for an unstable patient. Level 5 is the least critical, most stable with minor illness, requiring routine care. In some cases, it may be preferable to place the potentially ill or injured patient in a higher triage category to prevent delays in treatment.
4. Triage involves rapid patient assessment, interpretation of the clinical history and physiological assessment, while objectively discriminating between the ESI categories of urgency. Triage decision-making is complex, made under conditions of uncertainty and with limited or obscure information.
5. After triage, patients will receive their medical screening examinations in the order determined by their triage priority status.
6. Triage priority status may be adjusted in the event a patient's condition is determined to have changed from the time of the original triage evaluation.
7. The ESI criteria should always be used to determine triage level without regard to mode of arrival.
8. The ED tech can take and document another set of vital signs, but the RN must talk to the patient and evaluate the vital signs for changes. Assessment is a nursing function that cannot

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

be delegated to non-licensed nursing personnel.

~~7.~~9. Patients have the right to refuse a medical screening exam (MSE). Listen to the patient's concerns, and if possible, encourage them to stay. If they still refuse exam, request that they sign the Refusal of Medical Screening & Treatment Form.

~~8.~~10. Pregnancy related complaints in women 16 weeks gestation or greater are referred to OB-ED in Mountain View or Labor and Delivery in Los Gatos.

~~9.~~11. Utilize Language Line Services as needed for non-English speaking patient.

III. CONTENT:

A. ~~IMMEDIATE~~ INITIAL TRIAGE ASSESSMENT

1. Obtain chief complaint & assess ABCD's:
   a) **Airway:** Observe for patency, audible sounds
   b) **Breathing:** Respiratory rate, effort, use of ancillary muscles, ability to speak. ~~Consider having patient rate their breathlessness on a scale of 1 – 10, 10 being the most breathless.~~
   c) **Circulation:** Heart rate, quality of pulse (a strong radial pulse indicates a systolic BP of at least 80 mm Hg), skin signs.
   d) **Disability:** Mental status/changes, level of consciousness, neuromuscular function, pain level on scale of 1 – 10, 10 being the most pain.
2. Provide immediate bedding to ESI Level 1 or 2 with high risk, critically ill or injured patients requiring immediate intervention.
3. Call provider & ED RN to the bedside & give brief history to the team assuming care of the patient.
4. Continue with triage assessment if no abnormal findings, or when patient stable.

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B. ~~DELAYED~~ TRIAGE ASSESSMENT AND ~~/~~HISTORY

1. Determine patient's chief complaint & subjected assessment including:
   a) **P** - provoke (mechanism of injury)
   b) **Q** - quality
   c) **R** - region
   d) **S** – severity/associated symptoms
   e) **T** - time (onset or duration)
2. Obtain full set of vital signs
3. Determine medical history, medications, allergies and reactions.
4. Enter patient's height in inches and weight in kilograms.
5. Consider finger stick blood glucose with patients with altered level of consciousness, diabetes, or Stroke Alerts.
6. Include the date of last menses in all females of child bearing age.
7. Determine immunizations and tetanus status when indicated.
8. Screen for evidence of domestic violence and child/elder abuse.
9. Screen for respiratory illness, recent travel history, &/or hospitalization. Immediately

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

isolate and provide a face mask to any patients that are potentially infectious or any immunocompromised patient.

10. Assign an Emergency Severity Index (ESI) according to patient into priority of care classification.

C. TRIAGE INTERVENTION:

~~1.~~ Perform specific nursing interventions according to policy and standardized procedure guidelines or consult physician for additional orders.

~~2.~~1. ~~If patient's complaint is such that he/she is classified as Delayed, Minor or Fast Track, then the patient should be directed to wait and be registered in the order in which he/she arrived in the Emergency Department.~~

2. Instruct the patient to inform triage nurse if there is any change or worsening in symptoms during the wait.

3. Keep patient informed of wait times & explain tests or procedures.

4. Patients will be roomed into the Main ED in order of severity first and time of arrival.

~~4.~~ All patients should be reassessed with vital signs every two hours while in the waiting room.

5.

~~5. All patients should be reassessed or re-triaged every two hours while in the waiting room.~~

~~**GUIDELINES FOR TRIAGE:**~~

~~Use the Emergency Severity Index (ESI) triage system to assign appropriate level of care. Guidelines for Triage include but are not limited to the following:~~

~~1. Immediate: Patients requires immediate medical attention and maximum resources. Unstable VS with high probably of mortality. (ESI level 1)~~

~~a) Respiratory/Cardiovascular Arrest/Failure~~
~~b) Altered level of consciousness or unresponsive~~
~~c) Severe bradycardia or tachycardia with signs of hypoperfusion~~
~~d) Chest pain, pale, diaphoretic blood pressure 70/palpable~~
~~e) Anaphylactic shock~~
~~f) Overdose with respiratory rate of 6~~

~~2. Delayed: Requires immediate medical attention within 10 minutes and high resources, high-risk situation, or if the patient should not wait. (ESI level 2)~~

~~a) "Worst headache of my life" possibility of a subarachnoid hemorrhage~~
~~b) Active chest pain, suspicious for acute coronary syndrome, stable~~
~~c) Signs of stroke~~
~~d) Vital Signs outside accepted parameters for age~~
~~e) Rule out ectopic pregnancy, hemodynamically stable~~

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THE HOSPITAL OF SILICON VALLEY

TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

~~f) Antepartum & postpartum pre-eclampsia~~
~~g) Suicidal or homicidal patient~~
~~h) New onset confusion in an elderly patient~~
~~i) Adolescent found confused and disoriented~~
~~j) Pain scale rating of 7 or higher~~
~~k) Symptomatic abdominal pain or flank pain with history of renal colic~~
~~l) Sepsis~~
~~m) Syncope or near-syncope~~

~~3. Minor: Patient may require 2 or more resources. Continue to reassess patient ideally every 30-60 min identify any change in condition. (ESI level 3)~~
~~a) Infant fall greater than 2 feet~~
~~b) Foreign body ingestion~~
~~c)~~
~~4. Fast Track: Patients are stable and may be appropriate to wait for several hours to been by a provider. (ESI level 4 or 5)~~

IV. DEFINITIONS (if applicable):

1. Triage is the prioritization of patient care (or victims during a disaster) based on illness/injury, severity, prognosis, and resource availability.
2. Acuity is the degree to which the patient's condition is life or limb-threatening and whether immediate treatment is needed to alleviate symptoms.
3. ~~Re-triage it the process of R~~re-triage involves an assessment of the waiting patient who has not been assessed by a clinician responsible for care within the time frame allocated by the initial triage category. The purpose of re-triage is to identify and escalate the care of a patient whose condition is deteriorating, reassign an appropriate triage category and prioritize clinical resources to manage the patient.

V. CROSS REFERENCES:

1. El Camino Hospital Policy: EMTALA Refusal of Medical Screening Examination
2. El Camino Hospital Protocol: Pain, Management/Assessment and Management of
3. El Camino Hospital Protocol: Abuse, Elder/Dependent Adult, Management of
4. El Camino Hospital Protocol: Sexual Assault, Possible, Management of in the Emergency Department.
5. El Camino Hospital Protocol: Domestic Violence Victim, Management of
6. El Camino Hospital Protocol: Tissue Plasmin Activator, Alteplase (Activase®, t-PA), Utilization of in Acute Ischemic Stroke.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

VI. DOCUMENTATION:

A. Triage:
1. Patient's name, gender, date of birth, time of arrival, triage time, mode of arrival
2. Chief complaint last menstrual cycle (females of child bearing age), tetanus status (when indicated), chief complaint (in patient's own words, when possible).
3. Vital Signs on arrival & every 2 hours if in the Waiting Room
4. Clinical presentation
5. Medical history & significant events
6. Medications & allergies.
7. Respiratory screening
8. Systemic Inflammatory Response (SIRS) screening
9. Domestic Violence Abuse screenings.
10. Use of translator or language line
11. Triage ESI classification.
12. Disposition
13. If applicable, Refusal of Medical Screening Exam & Treatment or Left Without Being Seen.

B. Any change in the patient's condition prior to being seen by the treating clinician must be documented clearly. If re-triage is required; documentation should include:
1. The time of re-triage.
2. Reason for the re-triage.
3. Information about escalation of the patient's change in condition to relevant senior ED staff.

C. Left Without Being Seen: If the patient decides to leave prior to triage or the medical screening exam and does not respond to a call back to triage or the department, then the patient is considered left without being seen (LWBS) and the following steps shall be followed.
1. Attempts will be made to callback the patient for a total of three times, approximately ten minutes apart, with each attempt and time documented as "no answer" in the Left Without Being Seen flowsheet in the electronic medical record.
2. After three attempts, the patient will be documented as having left without being seen.

VII. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee of UPC Committee:	10/2015
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	See Below

Emergency Department Partnership Council: 03/08, 04/08, 3/12
REVIEW/REVISION; CPC: 1/99, 01/02, 01/05 (disbanded in 2005)
Los Gatos Rev: 06/09, 3/12

VIII. REFERENCES:

1. Emergency Severity Index (ESI): A triage tool for emergency department care, Version 4 (2012), Agency for healthcare Research and Quality.
2. Mace, S. & Mayer, T. (201X). Triage http://www.us.elsevierhealth.com/media/us/samplechapters/9781416000877/Chapter%20155.pdf
3. Zimmerman, P. (2002), Guiding principles at triage: advice for new triage nurses, Journal of Emergency Nursing, 28(1), 24-33.
4. Weaver, J. (2002), Errors at triage – don't get off on the wrong foot, ED Legal Letter, 13(1), 1-12.
5. Bracken, J. (1998), Triage in Sheehy's Emergency Nursing Principles and Practice, 4th Ed., Emergency Nurses Association, Mosby, St. Louis, 105-111.
6. Preceptor Manual: Making the Right Decision: A Triage Curriculum, 2nd Edition, (2001), Emergency Nurses Association.

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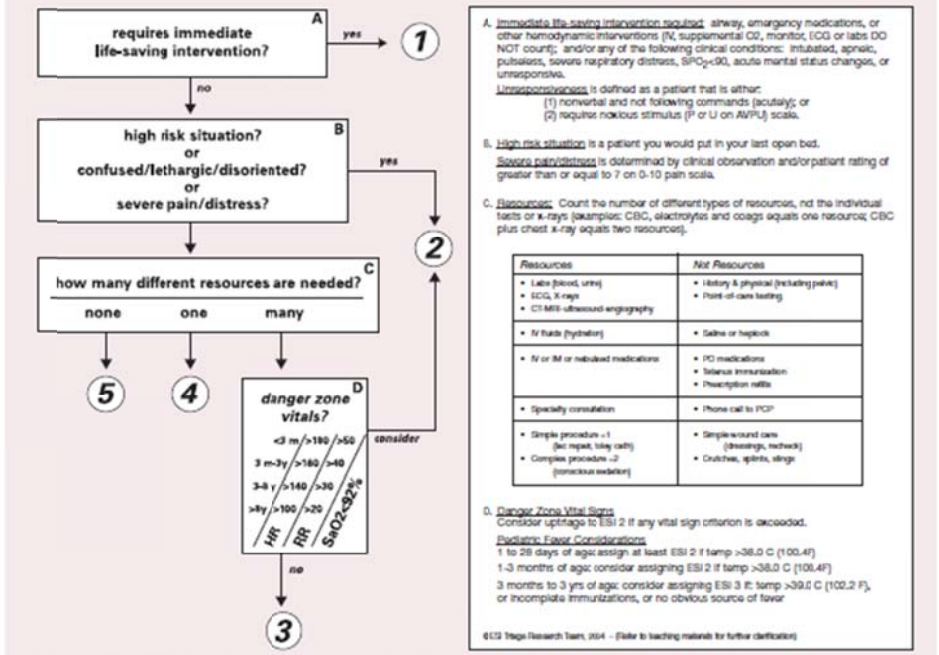
TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

IX. ATTACHMENTS (if applicable):

Note that Attachments not considered part of the actual policy and updates to the attachments do not require committee approval.

Figure 2-1a. ESI Triage Algorithm



GUIDELINES FOR TRIAGE:

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Triage & Assessment in the Emergency Department
CATEGORY:	
LAST APPROVAL:	

Use the Emergency Severity Index (ESI) triage system to assign appropriate level of care. Guidelines for Triage include but are not limited to the following:

1. Level 1: Patients requires immediate medical attention and maximum resources. .
    a) Respiratory/Cardiovascular Arrest/Failure
    b) Altered level of consciousness or unresponsive
    c) Severe bradycardia or tachycardia with signs of hypoperfusion
    d) Chest pain, pale, diaphoretic blood pressure 70/palpable
    e) Anaphylactic shock
    f) Overdose with respiratory rate of 6
2. Level 2: Requires immediate medical attention for a high-risk situation, confused/lethargic/disoriented, or severe pain/distress
    a) "Worst headache of my life" possibility of a subarachnoid hemorrhage
    b) Active chest pain, suspicious for acute coronary syndrome, stable
    c) Signs of stroke
    d) Vital Signs outside accepted parameters for age
    e) Rule out ectopic pregnancy, hemodynamically stable
    f) Antepartum & postpartum pre-eclampsia
    g) Suicidal or homicidal patient
    h) New onset confusion in an elderly patient
    i) Adolescent found confused and disoriented
    j) Pain scale rating of 7 or higher
    k) Symptomatic abdominal pain or flank pain with history of renal colic
    l) Sepsis
    m) Syncope or near-syncope
3. Level 3: Patient may require 2 or more resources.
4. Level 4 or 5: Patients are stable and require 1 or no resource.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: 2.50 Radiologist Peer Review

CATEGORY: Clinical & Support Services
LAST APPROVAL DATE: 05/13

SUB-CATEGORY: IMAGING SERVICES

ORIGINAL DATE: 05/13

COVERAGE:
Imaging Services Department

PURPOSE:
To provide quality assurance and ensure positive patient outcomes through participation in Peer Review.

STATEMENT:
It is the policy of Imaging Services to comply with the Hospital's Quality Assurance / Peer Review process, the American College of Radiology (ACR) requirements for Peer Review, the Joint Commission Medical Staff Standards, and CMS standards for Contracted and Radiologic Services.

POLICY
El Camino Hospital contracts with a Silicon Valley Diagnostic Imaging to provide comprehensive Radiologic services for the Imaging Department. In an effort to increase physician accountability and improve patient outcomes, radiologists perform Peer Review on a daily basis. This is accomplished during the radiologists' regular workflow, as part of the overall Quality Improvement Program of Imaging Services. Oversight of Peer Review is the responsibility of the Medicine Department Executive Committee as well as the Care Review Committee and Medical Executive Committee. Participation in Peer Review is a requirement of ACR Accreditation.

Examinations are systematically reviewed and evaluated at a minimum of ten reviews per week per radiologist with a target goal of 2% annually. Monitoring includes evaluation of the accuracy of the interpretation to identify opportunities to improve patient care. The Peer Review process includes a regular, random double reading of the same study by two Radiologists.

Significantly discrepant peer review findings are brought to the Radiologist Quality Assurance Committee for the purpose of achieving quality outcomes improvement and to identify opportunities to improve patient care. This information is then reported to the Medicine Department Executive Committee, as part of the hospital's quality compliance structure.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:2.50 Radiologist Peer Review

APPROVAL	APPROVAL DATES
Originating Committee: Imaging Services, Imtiaz Qureshi, MD	10/15
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: 05/13

REFERENCES:

1. 2005 ACR Guidelines and Technical Standards. ACR Position Statement on Quality Control and Improvement, Safety, Infection Control, and Patient Education (ACR Resolution 9, 1998 – revised in 2008, Resolution 1e)

2. New Accreditation Physician Peer-Review Requirements Effective April 1, 2007. (ACR)

2. CMS State of Operations Manual; Standard 482.12(e), 482.21(b), 482.26

3. The Joint Commission: Standard MS 08.01.01, .08.01.03, LD 04.03.09

4. El Camino Hospital Medical Bylaws; ECH Policy 13.5 Quality Peer Review Assessment Process

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR); ESBL, CRE, KPC and NDM1

CATEGORY: Infection Control
LAST APPROVAL DATE: 02/2015

SUB-CATEGORY: Isolation Precautions
ORIGINAL DATE: 8/05

COVERAGE:

All El Camino Hospital staff

PURPOSE:

a. There is a growing prevalence of multi-drug resistant gram negative rods (MDRGNRs) in hospitals and in outpatient facilities in the United States. In hospitals, the most important reservoirs of MDRGNRs are infected or colonized patients, but the environment may also be a critical reservoir. The main mode of transmission is via hands (especially health care worker's hands) which may become contaminated by contact with a) colonized or infected patients, b) colonized or infected body sites of the personnel themselves, or c) devices, items, or environmental surfaces contaminated with a MDRGNR. The driving force behind MDRGNR resistance is the same as for other multi-drug resistant organisms; antibiotic exposure and inadequate infection control measures.

b. MDRGNR isolates are~~tend~~ to be resistant to several classes of drugs (e.g. penicillins, cephalosporins, fluoroquinolones, aminoglycosides,etc.). Isolates of particular concern are those resistant to carbapenems, e.g.imipenem, doropenem, ~~ertapenem,~~ and/or meropenem, which are called carbapenem-resistant GNR or carbapenem-resistance Enterobacteriaceae (CRE). Some of these CRE organisms harbor resistance mutations (e.g., KPC, NDM) of particular concern to acute care facilities, which are extraordinarily difficult to treat with existing antimicrobials, and have resulted in outbreaks of serious and fatal infection within acute care facilities. Thus, identification and control of transmission of these organisms is of particular concern~~.~~

~~b.~~c. Contact IC if you are uncertain whether the isolate is considered MDR.

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STATEMENT:

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

Prevention and control of the spread of Multi-Drug Resistant Gram Negative Rods (MDRGNR) (Appendix A) shall be managed by a coordinated effort among all departments and staff at El Camino Hospital.

All visitors are required to wear gown and gloves when visiting a patient in Contact Isolation for MDRGNR.
No more than 2 visitors will be allowed at any one time
Visitors other than immediate family members will be limited to 10' visits per day
For patients with KPC/NDM resistance or MDR Acinetobacter baumanii, no visitors other than immediate family will be allowed
No children under 14-years-old are allowed in these isolation rooms.
Call Infection Control Manager for exceptions to this policy.

1. **Patient Identification and Placement**

a. Screen high risk patients at admission for CRE/ESBL with a rectal swab for PCR, including:

a. (1) Patients who have been admitted to El Camino Hospital, any long-term care facility, SNF, rehab facility or outside medical facility within the previous 30 days (the micro lab may also be prompted to screen some of these patients for CRE);

b. Screen patients at admission for both ESBL and CRE (2) Any patient presenting for care who haves been hospitalized in India, Pakistan, or SE Asia or outside the United States within the previous 6 months;

a. If initial result is negative, these patients, presenting for care from outside the U.S., will have a repeat rectal PCR swab obtained 35-7 days later for a repeat test.for repeat ESBL/CRE testing.

b. c. Screen patients at admission for CRE who are being transferred from facilities known to have had CRE.

c. The laboratory shall notify by phone or fax Infection Control (or the patient's unit when a patient's results demonstrate confirmed or suspect ESBL/CREculture is positive for MDRGNR .

d. PThe patients with suspect ESBL and/or CRE, identified based on surveillance, or the results of cultures obtained during hospitalization,, or those with a known history of ESBL/CRE at any time shall be placed on Contact Precautions and a Contact
Precaution sign shall be posted outside the patient's room.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

e. The patient shall be placed in a private room. The door may be open. Outpatients with MDRGNR, who are receiving dialysis in —the hospital, also require a private room.

2. **Use of PPE and Patient Care Equipment**

a. Gloves shall be worn when in direct contact with the patient or the patient's environment. Gloves shall be changed after each patient care task involving contact with body fluids. Hands shall be cleansed immediately after removal of gloves with a hospital-approved alcohol-based hand gel for 20 seconds or soap and water for at least 40-60 seconds.

b. A gown shall be worn when in direct contact with the patient or patient's environment.

c. If there is evidence of a MDRGNR in respiratory secretions and patient is coughing or needs suctioning, etc., personnel shall also wear a face shield mask within 3 - 6 feet of the patient

d. All personal protective equipment (PPE) shall be removed before leaving the patient's room.

e. Patient care items, such as stethoscope, thermometer, commode, etc. shall be dedicated to the room. If these items must be used on other patients, they shall be cleaned and disinfected before use.

f. Medical records and other nonessential items shall not be brought into the room.

g. All linen shall be treated the same regardless of the patient's diagnosis (Standard Precautions). Keep linen cart in room. Environmental Services must clean the linen cart whenever the room is cleaned.

3. **Patient Transport**

a. **All procedures s**hall be performed within the room whenever possible. When the patient must leave the room for treatment, etc., all aeffected departments must be informed of the patient's infection status. The patient may leave the room for ambulation, treatment or physical therapy if:

(1) Hands are cleansed thoroughly before leaving room.

(2) Patient is continent of urine and stool. If incontinent, patient shall wear a diaper or use some method of bowel/bladder control.

(3) Patient shall wear a clean patient gown.

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THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

(4) All open wounds shall be covered.
(5) Patient shall be instructed to use only his/her own bathroom facility.
(6) All equipment/environmental surfaces that come into contact with the patient during transport/treatment shall be disinfected before use with another patient.

b. P**atients and** visitors shall be instructed about:
(1) Isolation precautions
(2) Maintaining appropriate PPE
(3) Maintain good hand washing

c. Document teaching in the patient's EMR.

d. Informational handouts for patients on "Infectious Diseases" are available in the Toolbox . (Patient Education> Infectious Disease)

4. **Environmental Cleaning**

a. All surfaces must be disinfected at least once each day. Surfaces shall be kept wet for the approved dwell time recommend by the manufacturer.

b. Environmental Services personnel shall:
(1) Wear gown and gloves when cleaning the patient's room.
(2) Clean patient room daily, including all patient care items, bedside equipment and frequently touched surfaces, e.g., bed rails, door knobs, telephone, call bell, sink fixtures, etc. with disinfectant.
(3) Remove gown and gloves prior to leaving room. Hands shall be cleansed immediately after gloves are removed.

5. **Removal of isolation precautions for ESBL positive specimens~~cultures~~:** shall be reserved for Infection Control personnel only.

a. ESBL Isolation will not be removed until screening clearance conditions have been met and approved by the IC Manager, including:
1. One negative culture from all previous sites of involvement, when the patient is not on effective therapy;
2. Two negative stool surveillance tests~~PCRs~~ obtained one week apart, when the patient is not on effective therapy

7. **Patients with CRE, including those with KPC/NDM, or MDR-Acinetobacter**: are~~re~~ not cleared without approval of the IC Manager and the IC Medical Director.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

8. **Patient is discharged or removed from isolation**:
   a. Environmental services personnel shall clean the patient's room including all patient care equipment that is not sent to Central Processing for disinfection. Cubicle curtains shall be changed.

9. **Report all suspect CRE patients to the Public Health Department**
10.
~~9.~~11. **Patient transfer to another healthcare facility**:
   a. Ensure that the presence of ESBL/ CRE colonization or infection is communicated to the accepting facility.

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POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

APPROVAL	APPROVAL DATES
Infection Control Committee: ~~10/14~~	10/27/15
_____Medical Committee (if applicable):	N/A
ePolicy Committee: (Please don't remove this line)	N/A
Pharmacy and Therapeutics (if applicable):	N/A
Medical Executive Committee:	1/22/15
Board of Directors:	2/11/15

Historical Approvals:

Infection Control Committee:	9/2/05, 9/4/07, 10/10, 10/13, 10/14
Medical Executive Committee:	9/22/05, 10/25/07, 11/18/10, 1/14
Board of Directors:	10/5/05, 11/14/07, 12/8/10, 2/14

REFERENCES

1. **CDC. 2012 CRE Toolkit – Guidance for control of Carbapenem-resistant Enterobacteriaceae (CRE) (updated June 2, 2015); http//www.cdc.gov.hai/organisms/cre/cre-toolkit/index.html**
2. **CDC. Carbapenem-resistant Enterobacteriaceae (CRE) infection (updated June 1, 2015); http//www.cdc.gov/hai/organisms/cre/cre-clinicians.html**

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1. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007

2. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2006 Management of Multidrug-Resistant Organisms in Healthcare Settings, October 2006

3. CDC. New Carbapenem-Resistant Enterobacteriaceae Warrant Additional Action by Healthcare Providers. CDC Health Advisory, 2013

4. CDC. Guidance for control of infections with carbapenem-resistant or carbapenemase-producing Enterobacteriaceae in acute care facilities. MMWR 2009;58:256-60.

5. CDC. Detection of Enterobacteriaceae Isolates Carrying Metallo-Beta-Lactamase — United States, 2010. MMWR 2010;59:750.

6. CDC. Update: Detection of a Verona Integron-Encoded Metallo-Beta-Lactamase in Klebsiella pneumoniae — United States, 2010. MMWR 2010;59:1212.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

APPENDIX A

Organisms	Criteria
ESBL Current organisms affected: Eschericcia coli, Klebsiella pneumoniae, Klebsiella oxytoca	~~All isolated~~Laboratory defined
CRE Current organisms affected: Escherichia coli, Klebsiella pneumo, Klebsiella oxytoca, Enterobacter species	Laboratory defined, often contact resistant mutations (e.g., KPC, NDM, VIM, IMP, OXA-48, etc) ~~All isolated~~ (use Public Health definitions)
Pseudomonas aeruginosa	~~Imipenem~~ Meropenem Resistant
Burkholderia cepacia	All strains~~All isolated~~
Acinetobacter baumanii complex	Resistant to all aminoglycosides ~~on panel~~, (i.e. a~~i.e.,~~: ~~A~~mikacin, ~~G~~gentamicin, ~~T~~tobramycin)
Acinetobacter baumanii complex	Meropenem Resistant ~~to Imipenem~~
~~*Enterobacteriaceae:*~~ ~~*Escherichia coli,*~~ ~~Klebsiella pneumoniae~~ ~~Enterobacter species~~ ~~Proteus mirabilis~~ ~~Serratia~~ ~~Citrobacter~~	~~Resistant to (1) of the Carbpenems~~ ~~Imipenem~~ ~~Meropenem~~ ~~Ertapenem~~ ~~AND~~ ~~Resistant to all:~~ ~~Ceftriaxone~~ ~~Cefotaxamine~~ ~~Ceftazidime~~

Laboratory personnel will call the patient's unit when the patient has any of the results listed above. They will inform the unit that the patient has an organism that meets the criteria for isolation.

Laboratory personnel will also notify Infection Control.
For outpatient call MD office.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

CRE: Carbapenem-Resistant Enterobacteriaceae CDC Recommendations:

Definition: CRE are defined as Enterobacteriaceae that are:

- Not susceptible to one of the following carbapenems: doripenem, meropenem, or~~or~~ imipenem, ~~or ertapenem~~ ~~AND~~ and/or ~~OR~~
- Demonstrate~~d~~ production of a carbaepenemase enzyme (i.e. KPC, NDM, VIM, IMP, OXA-48) by a recognized test (i.e. PCR, carba-NP etc.)

While all of these isolates, or suspect isolates, require appropriate isolation precautions, isolates containing certain resistance mutations (e.g., NDM, KPC) require a higher level of precaution, as outlined below.

As newer mechanisms of resistance emerge or are recognized, definitions of MDR and CRE may change, and Public Health Authorities may require additional measures;

- ~~If organism meets Resistance pattern criteria then it actually is a "CRE"~~
- ~~Resistant to all of the following third-generation cephalosporins that were tested: Ceftriaxone, Cefotaxime, and Ceftazidime.~~
- ~~Klebsiella species, Enterobacter species, and Escherichia coli that meet the CRE definition are a priority for detection~~

Core Measures for Acute Care and Long-term Care Facilities for patients harboring suspect or documented CRE of particular concern, as defined by public health authorities:

A. Contact Precautions:

1. Place suspect or documented CRE colonized or infected patients on c~~C~~ontact precautions

* Patients at high risk (recently hospitalized in India, Pakistan or SE Asia within the previous 6 months) should be presumptively placed in contact isolation while waiting for admitting surveillance results.

2. Educate healthcare personnel about contact precautions, monitor contact precautions, and ~~CP and Monitor CP and~~ provide ongoing education and feedback

B. Hand hygiene and PPE:

1. Strict adherence to PPE and hand hygiene is required. ~~Promote hand hygiene:~~ Reinforce and ~~evaluate adherence to~~monitor hand hygiene practice and appropriate PPE.

C. Patient and Staff cohorting:

1. Dedicate rooms and staff to CRE patients at all times ~~when possible.~~
2. ~~It is preferred that staff~~Staff caring for CRE patients ~~do not also~~ should not care for non-CRE patients.

C. Additional s~~S~~urveillance screening of the Suspect CRE patient:

1. Perform additional cultures of sputum, urine and any open wound~~. For patients admitted to~~
   - Send the isolate to a reference laboratory for confirmatory susceptibility testing and test to determine the carbapenem resistance mechanism; at a minimum, this should include evaluation for KPC and NDM carbapenemases~~healthcare facilities in the United States after recently being hospitalized (within the last 6 months) in countries outside the United States, consider each of the following:~~
   - ~~Perform rectal screening cultures to detect CRE colonization.~~

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THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Infection Control- Management of Multi-Drug Resistant Gram Negative Rods (MDRGNR)

- ~~Place patients on Contact Precautions while awaiting the results of these screening cultures.~~

~~2. When a CRE is identified in a patient (infection or colonization) with a history of an overnight stay in a healthcare facility (within the last 6 months) outside the United States,~~

- ~~Send the isolate to a reference laboratory for confirmatory susceptibility testing and test to determine the carbapenem resistance mechanism; at a minimum, this should include evaluation for KPC and NDM carbapenemases~~

D. Screening of potentially epidemiologically ~~-~~linked patients:

1. If a patient with suspect or documented ~~previously unrecognized~~ CRE colonization or infection is ~~carries are~~ identified, screening of patient contacts could be conducted to identify transmission (instead of a wider point prevalence survey.)

- ~~Screen patient with stool, rectal, or perirectal cultures.~~
- Screen all roommates of the ~~unrecognized~~ CRE patient during that hospitalization~~s~~ with rectal surveillance swab and cultures of urine, sputum, and any open wound
- Screen all patients who were treated by the same healthcare personnel with rectal surveillance swab.

F. Minimal use of invasive devices:

1. Remove temporary medical devices as soon as they are no longer needed.

G. Patient transfer to another healthcare facility:

1. Ensure that the presence of CRE colonization or infection is communicated to the accepting facility.

H.

Supplemental measures:

1. Chlorhexidine bathing: bathe any suspect or documented CRE patient~~s~~ with 2% chlorhexidine daily

~~2. Screen high-risk patients at admission for CRE or patients admitted from facilities know to have CRE.~~

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POLICY/PROCEDURE TITLE: **Infection Control- Infection Control Plan**

CATEGORY: Infection Control
LAST APPROVAL DATE: 02/2015

~~10.13.15~~
SUB-CATEGORY: **Infection Control Program**
ORIGINAL DATE: **1/96**

COVERAGE:

All El Camino Hospital staff

PURPOSE:

1. To plan, coordinate and monitor policies, procedures and practices related to the identification, control and prevention of hospital associated infections.
2. To identify areas of improvement and appropriate changes in the plan that would increase the effectiveness of the infection prevention and control program.

STATEMENT:

The El Camino Hospital Infection Control and Prevention Plan is a comprehensive, dynamic document which is based on a risk assessment for acquiring and transmitting infections within the hospital environment.

The El Camino Hospital Infection Prevention & Control Program primary function is to prevent transmission of infectious agents among patients, staff and visitors. It is the goal of the Infection Prevention and Control Department to reduce infection and infectious risk through strategic plans for surveillance and control of healthcare-associated infection; to identify trends and patterns in antimicrobial resistance; to address epidemiologically important issues; and to advise hospital employees, departments and services in developing policies, procedures, and practices which reflect current infection control guidelines and standards of care.

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Goals to ~~reduce~~ reducing the possibility of transmitting infections will be set based upon the identified risks. The plan includes risk reduction strategies supported by evidence based guidelines or expert consensus. At least annually, and whenever risks significantly change, an evaluation of the effectiveness of the infection prevention and control plan will be done. This evaluation will include a review of the prioritized risks, the goals, objectives, and the infection prevention strategies. The results of the evaluation will be used to make revisions to the plan. The revised plan will be communicated to the organization.

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POLICY/PROCEDURE TITLE: Infection

DEFINITIONS *(as applicable)*:

- Evaluation of the Infection Control Plan shall be done at least annually or upon changes in the scope of the Infection Control Program or changes in the risk analysis. Assessment of the prevention strategies will be based on their effectiveness at preventing and controlling infection. The Infection Prevention Department reports all communicable diseases to the Public Health Departments to help prevent spread of certain infections within the public at large.

-The Infection Prevention and Control Plan evaluate the risk of communicable diseases transmission based on the following:

- Santa Clara County geographic location and demographics
- Mountain View demographics
- Santa Clara County Community health status assessment
- TB Risk Assessment: California and Community profiles
- Threats facing Santa Clara County
- The Infection Prevention Department reports all communicable diseases to the Public Health Departments to help prevent spread of certain infections within the public at large.

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Santa Clara County Geographic Location and Demographics:

With 1.8 million residents, Santa Clara County is the sixth most populated of California's 58 counties. More than one-third (37%) of county residents are foreign-born. The largest percentage of foreign-born residents were born in Mexico (21%), followed by Vietnam (15%), India (13%), the Philippines (9%), and China, excluding Hong Kong and Taiwan (8%). Santa Clara County encompasses 1,312 square miles and runs the entire length of the County from north to south, ringed by the rolling hills of the Diablo Range on the east, and the Santa Cruz Mountains on the west. Salt marshes and wetlands lie in the northwestern part of the county, adjacent to the waters of San Francisco Bay. Nearly 92% of the population lives in cities.

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The local industry of the County of Santa Clara is dominated by the technology sector. The County has three main interstate highways; 280, 680, and 880, one U.S. Route (101), and the following CA State Routes; 9, 17, 82, 85, 87, 130, and 237.
Airports include: Norman Y. Mineta International Airport, Moffett Federal Airfield, and three County airports: Reid Hillview, Palo Alto, and South County.

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THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

Mountain View Demographics:
(Source: US Census Bureau. State and County Quick Facts. January 2014)
The resident population of Mountain View is approximately 76,260. More than half the population is between 20 and 54, while nearly 25% is in the 25 to 34 year age bracket. The median age is 34.6 years old.

Santa Clara County Community Health Status Assessment:
(Data: 2012 Santa Clara County Community Assessment Project Survey)

Access to Care	87% of adults have health insurance
Chronic Disease	8% of adults have diabetes. Heart disease: 22% of the death among county residents.
Overweight and Obesity	Over 50% of adults and over 25% of adolescents in the county are overweight or obese
HIV/ AIDS	Over 4,500 adults in Santa Clara County are living with HIV (61% Sexual transmission; 33% unknown, 6% IV Drug use
Tobacco use	1 in 10 adults and 1 in 12 adolescents in the county smoke cigarettes

TB Risk Assessment:
California Overview

- TB has reached an all-time low in California. In 2014,a total of 2,145 cases were reported, a 1% decline from 2013 (2,166 cases)
- CA reports the most TB cases in the U.S. and has an incident case rate of 5.6 per 100,000 residents that is nearly twice the national case rate of 3 per 100,000 residents.
- Despite the overall decline of TB cases in CA, of 21 local health jurisdictions with at least 15 cases in 2014, 11 jurisdictions (52%) had an increase in cases between 2013 and 2014.
- An estimated 2.5 million Californians are infected with TB and are at risk of becoming sick with TB in the future if they are not diagnosed and treated for latent TB infection.

COMMUNITY TB PROFILE

- There were 163 cases of active tuberculosis in Santa Clara County in 2014, which is a 10% decline from 2013 (181 cases).
- This represents a case rate of 8.8 per 100,000 residents, ranking SCC fourth among all health jurisdictions in CA
- TB case rates have been consistently highest among Asians in Santa Clara County and the rate was 20.4 per 100,000 residents in 2014 (compared to overall case rate of 8.8).

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POLICY/PROCEDURE TITLE: **Infection**

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POLICY/PROCEDURE TITLE: **Infection**

Threats facing Santa Clara County:

1. Major Earthquake
The Operational Area is in the vicinity of several known active and potentially active earthquake faults including the San Andreas, Hayward, and Calaveras faults.
Two major local earthquakes that have impacted the County include:
- The San Francisco Earthquake (1906), magnitude 7.8, approximately 3000 fatalities
- The Loma Prieta Earthquake (1989), magnitude of 6.9, 63 fatalities.

Other significant local earthquakes near or within the County include:
- The Concord Earthquake (1955), magnitude 5.4, 1 fatality
- The Daly City Earthquake (1957), magnitude 5.3, 1 fatality
- The Morgan Hill Earthquake (1984), magnitude 6.2, no fatalities
- The Alum Rock Earthquake (2007), magnitude 5.6, no fatalities.

2. Wild land Urban/Interface Fire
The months of August, September and October have the greatest potential for wild land fires as vegetation dries out, humidity levels fall, and off shore winds blow.

3. Hazardous Material Incident
There are four major highways in the county that carry large quantities of hazardous materials: U.S. 101, I-880, and I-680, and I-280.. Truck, rail, and pipeline transfer facilities are concentrated in this region, and are involved in considerable handling of hazardous materials.

5. Flood
There are approximately 700 miles of creeks and rivers in the County, all of which are susceptible to flooding. An Emergency Action Plan exists for the Anderson Dam and a general Dam Plan exists which includes other dams within Santa Clara County. These plans are maintained by the Santa Clara Valley Water District.

6. Landslide
For Santa Clara, the hillside areas in the Los Gatos areas have the greatest potential for economic loss due to landslides. The winters of 1982, 1983, 1986, and 1996/1997 provided a reminder of the degree of hazard from landslides in Santa Clara County.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

PROCEDURE:

1. **Purpose**

- To plan, coordinate and monitor policies, procedures and practices related to the identification, control and prevention of hospital associated infections.
- To identify areas of improvement and appropriate changes in the plan that would increase the effectiveness of the infection prevention and control program.

2. **Objectives**

a. Maintain Enterprise Central Line Associated Bloodstream Infection (CLABSI) rate below Standardized Infection Ratio (SIR) SIR < 1.0 with a goal of "0" CLABSI's.

b. Maintain NICU CLABSI rate below SIR < 1.0 with a goal of "0" CLABSI's

~~a.~~c. Achieve 95% bundle compliance rate with CLIP organization-wide.

~~b.~~d. Maintain Enterprise hospital onset *Clostridium difficile* infection rate to ≤ 7.0 /10,000 patient days.

~~c.~~e. Maintain Enterprise hospital onset MRSA infection rate to ≤ 1.4 /10,000 patient days.

~~d.~~f. Maintain Enterprise MRSA screening compliance rate to 90% or more.

~~e.~~g. Maintain Enterprise hospital onset MDRGNR infection rate to ≤ 1.4 /10,000 patient days.

~~f.~~h. Maintain CABG SSI rate at or below NHSN Rates/Risk of SIR <1.00 (see Risk Assessment). (MV campus).

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

~~g.~~i. Maintain Total Knee Surgical Site Infection rate at or below NHSN Rates/Risk of SIR <1.00 (see Risk Assessment). (MV and LG campus).

~~h.~~j. Maintain Total Hip Surgical Site Infection rate to at or below NHSN Rates/Risk of SIR <1.0 (see Risk Assessment). (MV and LG campus).

~~i.~~k. ~~Reduce~~ Maintain laminectomy surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (see Risk Assessment) (MV and LG campus).

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~~j.~~l. Maintain spinal fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR < 1.00 (see Risk Assessment). (LG campus).

~~k.~~m. Maintain spinal re-fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (see Risk Assessment). (LG campus).

~~l.~~n. Maintain hand hygiene compliance at ≥ 95%.

~~m.~~o. Maintain PPE compliance at ≥ 95%.

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~~n.~~p. Maintain Enterprise Catheter Associated Urinary Tract Infection (CAUTI) rate at ≤ 0.25 ~~(MV) and maintain 0.00 (LG)~~ / 1000 Foley catheter days.

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3. Goals

a. Recommend methods for early identification of infections.

b. Analyze practices that have the potential to affect hospital onset infection rates and recommend changes.

c. Support Employee Wellness and Health Services, Clinical Effectiveness, Environmental Services, SPD and Safety and Case Management using epidemiological and scientific methodologies.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

d. Facilitate compliance with hospital reporting requirements to various public health agencies, National Healthcare Safety Network (NHSN), California Department of Public Health (CDPH), CMS Hospital In patient Quality (IQR), Santa Clara County Health Department and the state of California.

e. Coordinate monitoring and surveillance activities for targeted infections and microorganisms selected by Infection Control Committee based on annual Risk Assessment (Appendix A).

f. Monitor infection control practices of healthcare workers. Provide feedback and education with recommendations for improvement.

g. Provide general orientation in infection prevention and control for all employees.

h. Review and revise infection control policies every three years, or as needed. Provide input into patient care, procedure evaluation and selection, and approve written policies and procedures that describe the role and scope of participation of each department in infection control and prevention activities.

i. Recognize and maintain an awareness and working knowledge of guidelines and recommendations that are published by Centers for Disease Control, Occupational Safety and Health Administration, The Joint Commission, Association of perioperative Registered Nurses (AORN), Society for Healthcare Epidemiology of America (SHEA) and the Association of Professionals in Infection Control and Epidemiology (APIC)that impact infection control. Maintain and enhance own knowledge of infection control and epidemiology.

j. Provide documentation of recognition and compliance with appropriate regulatory and accrediting agencies. Review/revise yearly Bloodborne Pathogens and TB Exposure Control Plans to reflect changes in regulatory requirements.

k. Provide liaison activities with community health care providers that impact on our ability to control communicable diseases. Continue to expand infection control role over the continuum of care with the assistance of Public Health Department.

l. Provide input and education on infection control issues related to construction and renovation within the hospital. Perform infection control risk assessment of construction projects and monitor construction sites for compliance with infection control practices.

4. Infection Control Program and Committee

a. The responsibility for monitoring the Infection Control Program is invested in the Infection Control Committee. The Infection Control Medical Director has the authority to institute any appropriate control measures or studies when the situation is reasonably felt a danger to any patient, HCW or visitor, or in the event of an infection control crisis situation (The committee functions as the central decision and policymaking body for infection control. The Infection Control Committee shall meet not less than quarterly.

b. The Infection Control Committee shall be a multi-disciplinary committee consisting of representatives from at least the medical staff, nursing, Quality Department administration, Clinical Laboratory and the Infection Prevention Nurses. The Chairman is the Infection Control Medical Director, physician with knowledge of and special interest in infectious disease. Representatives from key hospital departments such as but not limited to Facilities Services, Environmental Services, Pharmacy, Central Services, Peri-operative services, Nutrition Services and Employee Wellness and Health shall be available on a consultative basis when necessary.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

c. The Infection Control Department will collaborate with the Infection Control Committee in developing a hospital-wide program and maintain surveillance over the program.

d. The Infection Department in collaboration with the Infection Control Committee shall develop a system for reporting, identifying and analyzing the incidence and cause of all hospital onset infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.

e. The Infection Control Department in collaboration with the Infection Control Committee shall develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating isolation precautions, and cleaning and disinfection techniques. Such techniques shall be defined in written policies and procedures.

f. The Infection Control Department ~~Committee~~ shall develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.

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g. The Infection Control Department will collaborate with the Infection Control Committee to identify new indicators and thresholds of diseases, recommend and assess corrective measures based upon the analysis of relevant data, and communicate its findings and interventions to the appropriate departments.

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h. The Infection Control Committee shall act upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, the departments, other medical staff and hospital committees.

i. The Infection Control Medical Director of the Infection Control Committee is responsible for medical direction and decisions as required for the review, analysis and presentation of data to the Medical Staff.

j. The Infection Control Medical Director of the Infection Control Committee is responsible for medical direction and decisions as required for the review, analysis and presentation of data to the Medical Staff.

k. The committee minutes shall be reviewed by the Medical Executive Committee, and the Board of Directors.

5. Infection Prevention Nurses

a. The Manager of Infection Prevention and the Infection ~~Prevention~~ Nurses are responsible for the supervision and coordination of infection control activities throughout the organization. The Manager and Infection Prevention Nurses are also responsible for the development, implementation, and evaluation of the performance improvement activities, ensuring that they are based upon accurate data collection, analysis, and interpretation.

b. Qualifications for Infection Prevention Nurse are:

1) Baccalaureate degree from an accredited college or university. A current California license as a registered nurse.

2) Certification by Certification Board of Infection Control (CBIC) is preferred or must be obtained within two years of hire date; and recertification every five years.

~~2)~~ In the absence of certification by CBIC, three to five years' general clinical nursing experience. ~~and completion of the Association for Professionals in Infection Control and Epidemiology (APIC) Beginning Infection Control Practitioners Course within one year.~~

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3) Knowledge of current infection control standards and practices and requirements, regulations and recommendations of federal and state/county regulatory bodies (Joint Commission, OSHA, and Center for Disease Control) in order to perform duties listed above.

c. Provides input and assistance in the revision, updating and formulation of policies and procedures related to infection control.

d. Identifies possible trends and risks of disease transmission through ongoing surveillance process.

e. Participates with members of Infection Control Committee to provide solutions to potential infection control problems.

f. Communicates potential infection control risks to appropriate departments either verbally or through written report.

g. Notifies the Santa Clara County Public Health Department, The Santa Clara County TB Control Department and the California Department of Public Health, either verbally or by written communication for mandatory disease reporting.

h. Provides education for all, staff, patients and families regarding infection control principles that reduce the spread of disease.

i. Acts as consultant in the management of patient's infection problem while in the hospital or upon discharge.

6. **Scope of Services**

~~h.~~ a. The infection control program is divided into functional groups of routine activities that address the integrated facets of surveillance and prevention of infections, monitoring and evaluation, epidemiological investigation, risk reduction, consultation and education.

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~~i.~~ b. Hospital Onset Infections

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1. For the purpose of surveillance, hospital onset infections shall be clinically active infections occurring in hospitalized patients in whom the infection was not present or incubating at the time of admission.
2. ~~I~~infections with endogenous organisms of the patient and those organisms transmitted either by healthcare workers or

indirectly by a contaminated environment shall be included. Some hospital onset infections are potentially preventable while others may be considered inevitable.

3. Strict criteria shall be used for assessment in regard to targeted hospital onset infections. Not all hospital onset infections in the hospital shall be counted and presented for statistical analysis. The type of data collection to be used and analyzed shall be determined by the Infection Control Committee (ICC) based upon the annual Risk Assessment.
4. The criteria written by the Center for Disease Control and Prevention (CDC) shall be used when calculating infection rates for statistical analysis. (See Infection Control Policy and Procedure 1.06, Hospital Infections.)

~~j.~~ c. **Surveillance Activities**

1) Active infection surveillance within the hospital shall be an ongoing observation of the occurrence and distribution of disease or disease potential and of the conditions that increase or decrease the risk of disease transmission.
2) The surveillance of patients, staff and environment shall ensure appropriate patient placement, initiation of appropriate isolation or special precautions, identification of patient care problems associated with hospital infection control, prevention of targeted hospital onset infections in high risk, high volume procedures, facilitation of data collection for selected quality indicators and the collection of required information for reporting to the Public Health Department.
3) Daily laboratory reports, utilization review reports and verbal communications with staff shall be reviewed routinely by the Infection Prevention Nurses. Surveillance shall be a blend of routine physical presence in all areas of the facility and the use of clinical and laboratory computer information systems.
4) The amount of time spent on infection surveillance, control and prevention activities is based upon the following:

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POLICY/PROCEDURE TITLE: Infection

5)

El Camino Hospital is a General Acute Care Community hospital with 2 campuses serving Santa Clara County, a large urban area in Northern California.

- Licensed beds:
  El Camino Hospital Mountain View:
  274 General Acute Care
  44 Perinatal Services
  24 Intensive Care
  20 Intensive Care Newborn Nursery
  7 Pediatric Services
  179 Unspecified General Acute Care
  El Camino Hospital Los Gatos:
  143 General Acute Care
  30 Rehabilitation Center14 Perinatal Services
  8 Coronary Care
  7 Intensive Care
  2 Intensive Care Newborn Nursery
  30 Unspecified General Acute Care
- FTE Staff:
- Department Resources:
  - 1.0 FTE as Manager of Infection Prevention
    2.0 FTE RNs as Infection Prevention Nurses
  - 1/2 FTE for administrative support
  - Equipment: computer, printer, fax
- Patient Population:
  - Various ages, ethnic, socio-economic backgrounds
- Risk factors of the population:
  - Infectious agents related to construction
  - Tuberculosis
  - MRSA
  - CRE (Carbapenem-resistant enterobacteriacea)

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POLICY/PROCEDURE TITLE: **Infection**

- o ESBL (Extended spectrum beta-lactamase)
- o MDRGNRs
- o *Clostridium difficile*
- o *VRE*

- Complexity of the services provided:
  - o Critical Care- adult and NICU
  - o Emergency Services
  - o Women's Services
  - o Medical / Surgical
  - o Surgery (including Bariatrics)
  - o Dialysis-inpatient
  - o Oncology – inpatient and outpatient
  - o Behavioral Health
  - o Cardiac Cath Lab
  - o Nuclear medicine, radiology, diagnostic imaging
  - o Rehab Services
  - o Community Outreach Programs
  - o Senior Center

6) The selection of clinical indicators is determined by the Infection Control Committee and is based upon the assessment of problem prone, high risk/high volume services provided. Results of these measures are reported in rates rather than raw numbers using valid epidemiological methods. Results are evaluated annually using data trend analysis generated by surveillance activities during the year and shall reflect changes in the hospital's assessed needs.

7. Surgical Site Infection Surveillance

a. Specific surgical site infection surveillance in accordance with California Department of Public Health Senate Bill 1058 requirements shall be monitored and reported to NHSN on a monthly basis. Surveillance activities include: daily census review of admission diagnosis, daily review of positive cultures and review of post discharge surveillance letters to surgeons.

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POLICY/PROCEDURE TITLE: **Infection**

b. Targeted surgical site infection surveillance selected by Infection Control Committee based on annual Risk Assessment is monitored and reported quarterly to the Infection Control Committee. Surveillance activities include: daily census review of admission diagnosis, daily review of positive cultures and review of post discharge surveillance letters to surgeons.

8. Targeted Surveillance Indicators for upcoming Calendar Year based upon the annual evaluation of the IC plan

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Monitor targeted hospital and community onset infections and specific organisms as determined by the annual risk assessment.

Targeted Surveillance for FY 2015: *(see risk assessment)*

- Surgical site infections high-risk procedures: Total knee, total hip, laminectomy, fusion, refusion and CABG procedures.
- Marker organisms: MRSA, *C. difficile* and MDR GNRs
- BSI related to central lines hospital-wide
- Foley catheter related UTIs hospital-wide

Active disease surveillance at both campuses

- Daily surveillance of MRSA, C difficile, Multi-Drug Resistant Organisms (MDRO), Tuberculosis, & other communicable diseases
- Active surveillance of Surgical Site Infections (SSI), Central Line-Associated Blood Stream Infection (CLA-BSI), Catheter-Associated UTI (CA-UTI)
- CRE surveillance (patients hospitalized outside the U.S. within 6 months
- Tracking: mold-related organisms in construction areas
- Evaluation/segregation of persons at risk
- Specialized response to exposure & outbreaks

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9. Epidemiologically significant microorganisms Cdiff

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POLICY/PROCEDURE TITLE: Infection

a. Plan: Use Clostridium rates as quality indicators to evaluate the effectiveness of compliance with transmission-based precautions and decontamination protocols. Goal is to reduce hospital onset infections of each microorganism.

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b. Do: (1) Determine number of new *C. difficile* cases per 10,000 patient days. (2) Track daily Cdiff patients by room location.

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c. Study: Review and analyze data on a quarterly basis to identify trends and potential high-risk areas.

d. Act: (Clostridium difficile) – Cleanse hands of patients with soap and water before each meal. Place patient on Contact Precautions. Provide education to patient and family on Clostridium difficile infection. Bathe patient daily. Change linens daily or when soiled. Clean/disinfect patient room with bleach product upon transfer/ discharge or clearance. Provide education to staff, physicians, patients, and families.

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POLICY/PROCEDURE TITLE: Infection

Targeted Surgical Site Infection Surveillance

a. Plan: Use NHSN definitions of SSI's -according to NHSN. Total knee, total hip, CABG, and spine surgeries are high-risk cases with potential for adverse patient outcome. Goal for all SSIs is to maintain SSI SIR rate < 1.00.

b. Do: Determine number of total knee, total hip, CABG, and spine surgery infections.

c. Study: Monitor indicator rates for SSIs over time and compare to NHSN benchmarks. Statistically analyze data to determine if appropriate interventions are needed. Review and analyze data on a quarterly basis to identify trends and potential high-risk areas.

d. **Act:**
   1. Perform MRSA nares swabs on targeted patients before surgery.
   2. Instruct targeted patients to shower with CHG on night and morning of surgery.
   3. Perform preop scrub with CHG on targeted patients upon admission to unit.
   4. Ensure appropriate pre-op antibiotics are given within recommended time prior to incision.
   5. Follow all SSI Core Measures.

Central Line Associated Bloodstream Infection (CLABSI)

a. Plan: Use NHSN definition of CLABSI. These are high-risk patients with documented additional lengths of stay due to infection. Goals are to maintain CLIP compliance at or above 95%, to maintain all ~~critical~~ patient care area CLABSI rates at 0.00/1000.

b. Do: 1) Determine number of CLABSI's in ~~critical care~~ all patients/1000 ~~CCU~~ central line days, 2) Determine number of CLABSI's in NICU patients stratified by birth weight/1000 NICU central line days.

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POLICY/PROCEDURE TITLE: Infection

c. Study: Data are reviewed and analyzed quarterly to identify trends and potential high-risk areas. In coordination with the CLABSI Prevention Taskforce, perform RCA (Root Cause Analysis) on all CLABSI cases.

d. Act: ~~Implement~~ Monitor CLIP compliance bundle outcomes for all central lines by reviewing NHSN CLIP reports. IN coordination with the CLABSI Prevention Taskforce, ~~P~~provide staff, ~~patient, and family~~ with education regarding care and maintenance of lines. ~~Implement a~~ Monitor daily necessity of central lines ~~protocol~~. Provide biopatch dressing in all Central Line kits.

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9. Data Collection Methods

All identified cases related to targeted infections and communicable diseases will be maintained in a database.
Specific methods used by infection control to obtain surveillance data include daily lab reports, patient census reports, daily serological reports, patient charts, referred cases from case managers and verbal communication with staff and physicians.

Surveillance shall be a blend of routine physical presence in all area of the facility and use of clinical and laboratory computer information systems.

~~10.~~ **Investigation of Disease Clusters (Outbreak Control)**

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The Infection Control Infection Control Medical Director in coordination with the Manager of Infection Control ~~Committee~~ shall have ultimate authority and responsibility for investigating epidemic/outbreak situations and implementing appropriate interventions in order to prevent and to control further disease and to identify factors that contributed to the outbreak. (See Infection Control Policy and Procedure ~~1.05,~~ Outbreak Investigation).

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11. Reporting to Outside Agencies

a. Specified communicable diseases (in accordance with Title 17, California Code of Regulation) identified at El Camino

Hospital shall be reported to the Santa Clara Department of Public Health (SCDPH) in the required timelines to prevent the spread of certain communicable diseases to the public at large.(See Infection Control Policy and Procedure ~~1.08~~, Communicable Diseases).

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b. El Camino Hospital shall provide follow-up management for pre-hospital caregivers who may have been exposed to a communicable disease during the performance of their duties and reporting of these exposures to the proper authorities. (See Infection Control Policy and Procedure ~~1.09,~~ Pre-hospital Communicable Disease Exposure).

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c. El Camino Hospital shall report to NHSN the following:

- Hospital Onset and community onset MRSA BSI's
- Hospital Onset and community onset VRE BSI's
- Hospital Onset and community onset CRE-Klebsiella BSI's
- All Hospital cases of *Clostridium difficile* infections
- Hospital wide CLABSI's ~~in CCU, ICU and NICU (MV campus)~~

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- Hospital Wide CAUTI's
- Number of Operative procedures identified by CDPH as consistent with meeting the requirements of Health and Safety Code (HSC) Section 1288.55 for reporting SSI's.
- All Healthcare associated Surgical Site infections of deep incisional or organ space surgical sites, healthcare associated infections of orthopedic surgical sites, cardiac surgical sites, and gastrointestinal surgical sites designated as clean and clean-contaminated as outlined in HSC 128.55.

12. Education

a. Orientation for all hospital employees shall include general information on potential infection risks, transmission routes, and infection prevention measures, proper hand hygiene, isolation precautions, and environmental cleaning and disinfection.

b. Annual review of infection control principles shall be done through a computer-based learning system (Health Stream) and tracked by the Education Department.

c. Department specific education shall be done as deemed necessary by the Infection Control Medical Director and/or the Infection Prevention Nurses, working in conjunction with department managers.

d. Training material in all areas of education shall be kept current and conform to current information pertaining to the prevention and control of infectious diseases. Infection Control Nurses shall attend annual hospital-funded continuing education programs to maintain current in principles of Infection Prevention and Control and epidemiology.

e Quarterly In-service presentations are provided to the Infection Control Resource Groups (ICRG). The ICRG is comprised of staff members from all nursing departments and ancillary departments (Lab, RT, etc.).

ECH Infection Prevention and Management
Infection Control Committee Involvement– FY 2015

- CA-UTI Reduction Task Force
- NICU CLABSI Reduction Taskforce
- CLABSI Reduction Taskforce
- SSI Reduction Task Force: Neurosurgeons and Peri-op Team
- Critical Care Committee
- Antibiotic Stewardship
- Emergency Management
- Value Analysis

13. Research

a. Research and investigate unusual cases, infections, or issues pertaining to Infection Control through ongoing literature review and web-based search activities.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Infection

b. Identify and report unusual cases, infections, or trends at scientific meetings or in the medical literature.

c. Participate in any regional or national Infection Control projects as is feasible and appropriate.

d. Participate in government- or pharmaceutically-sponsored clinical research projects pertaining to Infection Control as feasible and appropriate.

e. Identify opportunities for independent directed clinical research and focused projects within the hospital and surrounding facilities as feasible and appropriate.

f. Lend knowledge and practical support to other departments or units participating in clinical research studies including but not limited to the Microbiology Laboratory, Employee Health Services, Pharmacy Services, and Patient Care Services.

14. Liaison

a. Provide ongoing expert advice and consultation as appropriate to other departments including but not limited to Microbiology Laboratory, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.

b. Coordinate Infection Control activities with other departments or units including but not limited to Dialysis Services, Patient Care Services, Microbiology Laboratory, Pathology, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.

c. Function as a liaison to the Santa Clara Public Health Department and other agencies.

d. Function as a liaison to ~~other~~ Infection Control Programs at other hospitals and long-term care facilities.

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15. Policy Formation

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

a. Policies and procedures shall be reviewed on a regular basis with changes made as new guidelines and information become available.

b. Standard Precautions shall be practiced in all areas of the hospital and are the basic standard of care for all patients.

~~c.~~ Additional transmission-based precautions shall be used in addition to standard precautions for specific diseases or organisms to prevent their transmission. (~~See Section 5 of the Infection Control Manual.)~~

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d. Infection control departmental policies are found on the toolbox. Copies of policies are located in IC department. ~~and other specified areas.~~

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16. Quality Improvement

a. Provide ongoing evaluation and assessment of the goals and accomplishments of the Infection Control Program to ensure that it meets the needs of the hospital, employees, physicians, patient population, and visitors.

b. Evaluation of the Infection Control Plan shall be done at least annually or when a change in the scope of the Infection Control Program or in the Infection Control risk analysis occurs. Assessment of Infection Control strategies shall also be evaluated for their effectiveness at preventing infections.

17. Environmental Conditions

a. To ensure a safe environment during times of construction and or remodeling, protective measures shall be approved by the Infection Control ~~Committee~~ Staff and implemented before the project commences. All construction projects will have an Infection Control Risk Assessment (ICRA) performed by the Infection Control staff prior to start of construction.

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b. Routine microbiological surveillance of the inanimate hospital environment or of personnel, with the exception of research purposes, shall be done on an as needed basis (to be determined by the Infection Control Nurse).

c. Sterile Processing: Cleaning, disinfection and sterilization. Steam, Sterrad and ETO sterilizers shall be monitored according to current best practice guidelines. Instrument cleaning, disinfection and sterilization procedures shall be performed according to the manufacturer's recommended instructions for use.

d. Endoscopes: Instrument cleaning, disinfection and sterilization shall be monitored each cycle by Steris/ Medivators quality indicators according to current best practice guidelines and manufacturer's instructions for use.

e. All probes & TEE scopes: Instrument cleaning, disinfection and sterilization shall be monitored each use by ~~Cidex OPA~~ quality indicators according to current best practice guidelines and manufacturer's instructions for use.

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f. Water used to prepare dialysis fluid shall be tested according to current AAMI standards. Current testing includes at least once a month. It shall contain a total viable microbial count not greater than < 100 cfu/ml; Endotoxin level < 0.25 EU/MI).

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

18. Reporting Mechanisms

a. Patients admitted with a reportable or communicable disease or who develop such a disease while hospitalized shall be reported to Infection Control by admitting staff, care coordinators, case managers or direct care providers.

b. Physicians shall be encouraged to report infections that occur after discharge that could be related with a recent hospitalization.

c. Suspected exposure of pre-hospital care providers to infectious diseases shall be reported to infection control by emergency department staff or by the designated officer of the pre-hospital care giver. Each case shall be evaluated and exposure confirmation determined. The proper forms shall be sent to the designated officer and to the Public Health Department. (See Policy & Procedure ~~1.09,~~ Pre-hospital Communicable Disease Exposure.)

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d. A report regarding all infection control activities shall be made each quarter to the Infection Control Committee. The report shall include appropriate results related to routine surveillance, sentinel organisms, emerging pathogens, public health issues, employee health issues and special studies or reports. Copies of the committee meeting minutes shall be forwarded to the Medical Executive Committee. *C. diff* and MRSA Hospital Onset incidence rates and prevalence (new and old cases) shall be reported to individual departments on a quarterly basis. MRSA Screening compliance, Hand Hygiene/PPE compliance, Blood Stream infection rates are also reported to individual departments on a quarterly basis.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Infection

Defined as "Provides system specific methods and appropriate actions required to perform a specific task for effective management of patient care, clinical or non-clinical issues."

APPROVAL	APPROVAL DATES
Infection Control Committee	11/18/14
Medical Committee (if applicable):	1/22/15
ePolicy Committee:	N/A
MEC:	01/2015
Board of Directors:	2/2015

Historical Approvals:

Infection Control Committee:	5/01, 7/3/03, 1/21/05, 9/2/05, 11/22/05, 11/28/06, 9/4/07, 7/31/09, 1/29/10, 4/22/11, 12/13, 11/14
Medical Executive Committee:	5/01, 7/3/03, 2/3/05, 9/22/05, 12/22/05, 4/26/07, 10/25/07, 8/27/09, 3/25/10, 4/28/11, 11/12, 1/14, 01/15
Board of Directors:	5/01, 7/9/03, 3/2/05, 10/5/05, 1/4/06, 5/11/07, 11/14/07, 9/9/09, 4/14/10, 5/11/11, 10/12, 2/14, 2/15

REFERENCES:

1. Deborah Yokoe et al. Compendium of Strategies to Prevent Hospital Acquired Infections in Acute Care Hospitals ICHE 2008:29; S12-S21.

2. Jonas Maschall et al. Strategies to Prevent Central Line Associated Blood Stream Infections in Acute Care Hospitals ICHE 2008:29; S22-S30.

3. Susan Coffin et al. Strategies to Prevent Ventilator Acquired Pneumonia in Acute Care Hospitals ICHE 2008:29; S31-S60.

4. Deverick J. et al. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals ICHE 2008:29; S51-S61.

5. David Calfee et al. Strategies to Prevent Transmission of Methicillin Resistant *Staphylococcus aureus* in Acute Care Hospitals ICHE 2008:29; S62-S80.

6. Erik Dubberke et al. Strategies to Prevent *Clostridium difficile* Infection in Acute Care Hospitals ICHE 2008:29; S81-S92.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Infection

Appendix A

Enterprise Risk Factor/Event *Measurement* *FY15 Rate*	**FY15 Goal**	**Probability Risk Will Occur** *(1=low, 2=mod, 3=high)*	**Potential Severity if Risk Occurs** *(1=low, 2=mod, 3=high)*	**Stability of Process** *(1=high, 2=needs impvmt, 3=no process in place)*	**FY15 Outcome** *(compared to annual goal or benchmark) 1=met goal, 2=didn't meet goal*	**Priority Rank** *The higher the score the greater the risk of HAIs.*	**FY16 Goal / Benchmark**	**Comments:**
Laminectomy Surgical Site Infection *#2 New Infections/100 Procedures* *0.43/SIR ≤1*	SIR < 1.0	2	3	2	1	8	SIR < 1.0	Met goal. Post discharge surveillance monitoring for identifying SSI in place. Implemented SSI reduction taskforce with neurosurgeons, ID and periop director, established strategies to decrease spine SSI. Accomplished goal of providing CHG Scrubs, in pre-op to spine patients.
Sterile Processing	NA	2	3	2	1	8	Centralize all cleaning and disinfection of equipment to the SPD area.	Evaluate the Imaging Dept. to determine how to transport equipment requiring HLD to SPD or Endoscopy. Set-up a process for transport of equipment to SPD for cleaning/disinfection.
Total Hip Surgical Site Infection *# 3 New Infections/100 Procedures* *0.67/ SIR 1.29*	SIR ≤1.0	1	3	1	2	8	SIR < 1.0	MV (3) SSIs. Process Improvement: Partner with surgical services management to provide CHG pre-op scrubs to all joint patients'.
Operating Room *(Immediate Use Steam Sterilization)* *IUSS < 5%*	IUSS <5%	1	3	2	1	7	IUSS <5%	Follow AAMI and AORN guidelines and OR policies. Daily tracking of all IUSS cases; report quarterly to ICC.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Infection

CLABSI (ICU/non-CCU depts.) #6 *Infections/1000 Central Line Days* *0.71*	0.00	1	3	1	2	7	SIR < 1.0	Increase in CLABSI this FY. Active participant in CLABSI Task Force: provide re-education to nursing staff on best practice for: CVL line care, dressing changes, blood draws, accessing hubs and injection ports. Monitor CLIP documentation for compliance; Daily line necessity, performed by IP manager and reported at daily huddle.
CLABSI in NICU *Infections/100 Central Line Days* *≤750: 0.00* *751-1000: 0.0* *1001-1500: 0.0* *1501-2500: 0.0* *≥2500: 0.0*	≤750: 0.00 751-1000: 0.00 1001-1500: 0.00 1501-2500: 0.00 ≥2500: 0.00	1	3	1	1	6	SIR<1.0	Sustain process improvement measures to maintain zero CLABSIs. NICU collaborative taskforce in place with NICU/IC departments. No CLABSI's this FY. Continue best practice guidelines to sustain improvement in 0 CLABSI's.
CABG Surgical Site Infection *# 0 New Infections/100 Procedures* *0.00*	SIR ≤1.0	1	3	1	1	6	0.00	Met Goal of 0 SSI.
Total Knee Surgical Site Infection *# 1 New Infections/100 Procedures* *0.17/SIR ≤1*	SIR ≤1.0	1	3	1	1	6	SIR < 1.0	Maintained goal; continue to monitor and investigate SSI's
Spinal Fusion Surgical Site Infection *# 2 New Infections/100 Procedures* *0.56/ ≤1*	SIR ≤1.0	1	3	1	1	6	SIR < 1.0	Maintained goal; continue to monitor and investigate SSI's

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Infection

Spinal Re-Fusion Surgical Site Infection *#0 New Infections/100 Procedures* *0.00*	SIR ≤1.0	1	3	1	1	6	SIR < 1.0	Maintained goal; continue to monitor and investigate SSI's
Acute HO Foley Cath Urinary Tract Infection *# 6 New Infections/1000 Cath Days* *0.23*	0.25	1	2	1	1	5	0.25 or SIR ≤1	CAUTI taskforce in place with IC Manager, Medical Director of Infection Control and nursing. Daily tracking of Foley catheters for justification: report daily to clinical managers. RCA's performed on all CAUTI's by taskforce. Provided re-education to Nursing and CNA staff on daily Foley care, and reinforced best practice for insertion/ maintenance.
Rehab HO Foley Cath Urinary Tract Infections *# New Infections/1000 Cath Days* *0.00*	0.00	1	2	1	1	5	0.00	Sustained 0 CAUTI's. Continue monitoring for daily justification.
***Clostridium difficile*: Hospital Onset** *Infections/10,000 Patient Days* *5.61*	≤7	2	1	1	1	5	≤7	Decreased HO rate; work to sustain improvement with current measures. Daily tracking of all C. diff patients. Process in place for notifying clinical managers, unit staff, EVS and MD attending on all HO cases to provide education on transmission and hand hygiene compliance. Surveillance system in place to test high risk patients on admission. IC nurse member of the Antibiotic stewardship committee to present C.diff data.
MDRGNR: Hospital Onset Infections Infections/*10,000 Patient Days* *0.23*	1.40	1	2	1	1	5	1.40	Met goal. Continue to work to sustain improvement with current measures.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Infection

MRSA: Hospital Onset Infections *Infections/10,000 Patient Days* *0.40*	1.40	1	2	1	1	5	1.40	Met goal. Continue to work to sustain improvement with current measures.
Hand Hygiene *% Observed Compliance* *Entry: 97%* *Exit: 96%*	95%	1	2	1	1	5	95%	Monitoring system in place; follow up process for notification of non-compliant staff. Ongoing yearly hand hygiene campaign during IC week in Oct. Provide education/ demonstration to staff on WHO hand hygiene guidelines during general hospital orientation.
Personal Protective Equip *% Observed Compliance* *100%*	95% Delfina to update	1	2	1	1	5	95%	PPE/ Isolation education to all staff during general hospital orientation. PPE education to visitors and patients in isolation. Monitoring system in place; follow up process for notification of non-compliant staff.
MRSA Screening *% "At Risk" with Screen Ordered* *91%*	90%	1	1	1	1	4	91%	Improved screening compliance: FY14 87% to FY15 91%. Performed daily census audit for high-risk patients. Documentation of MRSA education by IC Nurses/staff nurses.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:EMERGENCY CARE OF THE PATIENT IN THE CANCER CENTER AND OUTPATIENT INFUSION CENTER

CATEGORY: Clinical Procedures Committee
LAST APPROVAL DATE: 5/08

SUB-CATEGORY: Patient Care Services
ORIGINAL DATE: 5/08

COVERAGE:
Cancer Center

PURPOSE:
~~Patient receives prompt emergency care, is stabilized, and is safely transported to a higher level of care.~~
Outline process for obtaining emergency medical services for patients demonstrating a significant change in baseline status.

~~**STATEMENT:**~~

~~**DEFINITIONS *(as applicable)*:**~~

PROCEDURE:
OUTCOME: **SUPPORTIVE DATA:**

~~1. For an anaphylactic reaction during chemotherapy administration, follow the standardized procedure outlined in Treatment of Adult Anaphylaxis (21.04).~~
~~2. For a hypersensitivity reaction during chemotherapy administration, follow the standardized procedure outlined in Adult Hypersensitivity Reaction during Chemotherapy/Biotherapy Administration (21.23).~~
~~3.~~1. There must always be two RNs and one practitioner ~~four employees (two licensed RNs)~~ present in the Cancer Center when infusions are taking place.
~~4. All Cancer Center employees will review this procedure annually at the time of their review.~~
~~5. Mock emergency drills will be conducted in the Cancer Center every six months.~~

EQUIPMENT LIST:
1. Ambu bag
2. Portable oxygen tank with nasal cannula ~~or mask~~
3. Automatic External Defibrillator (AED) located in Infusion Center Nurse Station 1.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:EMERGENCY CARE OF THE PATIENT IN THE CANCER CENTER AND OUTPATIENT INFUSION CENTER

4. ~~Stethoscope~~
5. ~~Blood pressure cuff~~
4. ~~Pulse oximeter~~
~~6.~~5. Automatic vital signs equipment

CONTENT:

STEPS	KEY POINTS
1. If patient develops respiratory distress, deteriorates hemodynamically, and/or becomes unresponsive: 2. IFC:~~,~~ 3. –RN caring for patient pulls call light cord from wall 4. –S~~s~~tays at the chairside and initiates Basic Life Support (BLS). 5. Cancer Clinic: 6. –MA/RN calls out for help ~~1.~~7. –Stays with patient and initiates Basic Life Support (BLS)	–
8. IFC and Clinic: 9. –Second staff member ~~RN~~ summons MD to chairside/exam room and calls for additional help from Cancer Center personnel. ~~2.~~10. Staff member assigned by RN or MD to call 911	• Additional staff members gather emergency equipment (including ambu bag, AED, blood pressure cuff, stethoscope or~~,~~ automatice vital signs equipment, oxygen, ~~and pulse oximeter)~~ and call 9-911, if RN or MD determines to be necessary.
3. IFC: 4. –Primary RN to assess patient and carry out MD orders (and/or standardized procedures, if appropriate). ~~3.~~5. Clinic: Clinic RN RN to assess patient and carry out MD orders	• Nursing interventions include: measuring vital signs, maintaining IV access, using the AED to analyze rhythm, applying O2, administering medications, performing CPR (if no pulse), and/or ventilating the patient using the ambu bag (if no respirations).
4. Cancer Center staff members to provide reassurance to family or friends that may have accompanied the patient to the Cancer Center as well as any other patients that are in the nearby vicinity.	
5. Cancer Center staff member to meet EMS team outside of ~~Melchor Pavilion~~ building and direct	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:EMERGENCY CARE OF THE PATIENT IN THE CANCER CENTER AND OUTPATIENT INFUSION CENTER

them to the patient.	
6. RN/MD caring for patient to give report to EMS team.	
7. If patient was unaccompanied to the Cancer Center, RN to phone patient's emergency contact and apprise them of the situation and the patient's whereabouts.	
8. RN to submit a QRR re: the incident.	

Documentation

1. Sequence of events leading up to patient emergency
2. Emergency treatment provided
3. Patient's response to treatment
4. Patient disposition post treatment

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
_____Medical Committee (if applicable):	
ePolicy Committee: (Please don't remove this line)	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals:

REFERENCES: (*as applicable*)

REFERENCES:

Sherman, M. (2003). Improving clinical emergency response in an outpatient setting. *American Academy of Ambulatory Care Nursing*. Retrieved on May 1, 2008 from http://findarticles.com.

CROSS REFERENCES

1. Standardized Procedure: Treatment of Adult Anaphylaxis (21.04)
2. Standardized Procedure: Adult Hypersensitivity Reaction during Chemotherapy/Biotherapy Administration (21.23)
3. Patient Care Policy: Emergency medical screening services for patients presenting at off-campus services operated by El Camino Hospital (Evergreen Dialysis Center and Rose Garden Dialysis Center) (04.06)

ATTACHMENTS:, ADDENDUMS:, EXHIBITS:, OR APPENDICES:

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:EMERGENCY CARE OF THE PATIENT IN THE CANCER CENTER AND OUTPATIENT INFUSION CENTER

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

~~POLICY/PROCEDURE TITLE:~~~~Standardized Proc- Outpatient Admission to L&D, Management of~~Standardized Procedure - Medical Screening Exam (MSE) for the Obstetric Patient

CATEGORY: Patient Care Services
LAST APPROVAL DATE:

SUB-CATEGORY: ED
ORIGINAL DATE: 12/90

OUTCOMES: Competent Labor & Delivery (L&D) RNs will evaluate under the direction of the attending obstetrician or midwife, obstetric (OB) patients of 16 weeks or greater gestation who present in L&D or Emergency Department (ED) for disposition as outpatient or inpatient.

SUPPORTIVE DATA:

1. Any pregnant patient without an assigned obstetrician who is being evaluated must be seen by an obstetrician, even if an evaluation of a medical condition is done by an ED physician or hospitalist.
2. ~~Level 1 patients are all patients presenting in L&D for evaluation of labor, or evaluation of OB or medical conditions which may impact mother and or fetus.~~
3. ~~Level 2 patients are patients scheduled for NSTs.~~

WHO CAN PERFORM:

The MSE may be performed by ~~OB assessments and evaluations may be done~~ obstetricians, midwives, and perinatologists or ~~by~~ RNs ~~and CNMs competent~~ competent in the medical screening exam (MSE), as established by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), El Camino Hospital Standardized Procedures and Emergency Medical Treatment and Active Labor Act (EMTALA) guidelines~~, or by an obstetrician~~.
*"Under EMTALA regulation, it is presumed that a woman having contractions is in labor, unless a physician, certified midwife or another qualified medical person, after a reasonable period of observation, certifies that the woman is in false labor. (*CA Health Association-pg. 3.19)

UNDER WHAT CIRCUMSTANCES CAN THIS PROCEDURE BE PERFORMED:

All obstetric patients of 16 weeks gestation or greater will be evaluated with an MSE ~~appropriately~~ for disposition as an inpatient~~s~~ or outpatient~~s~~ in L&D or ED. Obstetric patients less than 16 weeks will receive an MSE in the Main Emergency Department.

WHERE CAN THIS PROCEDURE BE PERFORMED:

The MSE ~~OB nursing assessment and evaluation by RNs should~~ to be performed ~~be done~~ in L&D. May also be done in the ED if clinically indicated for trauma or other indications.~~, unless the patient cannot safely leave the ED~~.

PROCEDURE:

~~1. Assess all outpatients~~

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Standardized Proc- Outpatient Admission to L&D, Management of

1.
2. Initiate OBED Triage Order Set
3. Obtain OB and medical history.

~~a.~~ Obtain vital signs including pain level~~Monitor & document vital signs and pain assessment.~~

~~b.~~ Evaluate fetal heart rate pattern~~.~~

~~c.~~4. Complete labor assessment

1. Apply tocomanometer and palpate to evaluate uterine contractions for quality, frequency and duration.
2. ~~—~~Determine if amniotic membranes are intact or ruptured with nitrazine and/or Amnisure as needed
3. ~~—~~Perform vaginal exam if needed to evaluate labor status.
4. ~~Obtain OB and medical history.~~

~~5.~~ Complete a focused physical assessment.

5. Notify provider ~~MD~~ of assessment findings and document in EHR date/time of notifications.
6. Obtain and implement additional orders as needed.~~s and observations of any abnormal findings.~~

~~2.~~7. Complete other required documentation on flowsheet.

~~3.~~8. Request MD ~~to come to~~ evaluate any patient presenting ~~who presents~~ with a non-labor related condition or when the medical screening and obstetrical evaluation are outside the scope of this standardized procedure ~~remain the MD's responsibility~~.

~~4.~~ After OB provider evaluation, obtain order for patient disposition, and provide discharge instructions for patients sent home undelivered regarding fetal kick counts, labor precautions, preterm labor precautions (if applicable) and signs and symptoms of preeclampsia in addition to other instructions that may pertain to patient's medical condition. ~~Give patient appropriate verbal and written instructions when discharged to home~~.

~~a. Any patient 37 weeks gestation or greater, without significant cervical change Early Labor discharge instruction sheet~~
~~b. Any patient less than 37 weeks gestation Preterm Labor discharge instruction sheet~~
~~c. Patient complaining of decreased or lack of fetal movement Decreased Fetal Movement discharge instruction sheet.~~
~~d. Patient being evaluated for hypertension Pregnancy induced Hypertension discharge instruction sheet.~~

~~5.~~9. ~~*"Under EMTALA regulation, it is presumed that a woman having contractions is in labor, unless a physician, certified midwife or another qualified medical person, after a reasonable period of observation, certifies that the woman is in false labor. (CA Health Association pg. 3.19)*~~

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Standardized Proc- Outpatient Admission to L&D, Management of

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TRAINING AND EDUCATION REQUIREMENTS

Qualified Labor & Delivery RNs who have completed the Healthstream EMTALA Module and demonstrated competency in performing the Medical Screening Exam annually
~~ACLS~~

SCOPE OF SUPERVISION:
The scope of supervision required for performance of standardized procedure functions is considered to be the ordering physician

~~**STAFF COMPETENCE**~~

~~a. Initial competency for this standardized procedure is OB assessment competencies.~~
~~b. Continuing Evaluation for this standardized procedure is done annually.~~
~~c. Those persons authorized to perform this standardized procedure are recorded in the Learning Management System.~~
~~d.~~a. ~~The scope of supervision required for performance of standardized procedure functions is considered to be the ordering physician~~.

PHYSICIAN NOTIFICATION:

The attending provider to be notified of assessment findings in a timely manner~~nurse will notify the Physician for the following conditions:~~
~~a. All patients assessed who are not having a scheduled NST.~~

DOCUMENTATION:

Document assessments, care, interventions, provider notifications and orders, patient education and disposition in the electronic health record (EHR).~~Enter in EMR:~~
~~1. Enter allergies.~~
~~2. Under the Patient Info tab, the patient's height and weight.~~
~~3. Under the RX writer icon, medications patient is taking at home.~~
~~4. Next enter order for OUTPATIENT MED VERIFICATION REQUEST, under orders by ME.~~
~~5. For scheduled NST patients enter orders for ONE TIME OBSERVATION L&D PATIENT, under MD's name as a protocol order.~~
~~6. For all other outpatients enter orders received by MD.~~
~~7. Chart on Worklist Manager against any meds given. KBMA not used for outpatient medication administration.~~
~~8. If patient received any medication during the outpatient visit a Medication Record Sheet must be printed out and included on the patient's chart. Use the Print Reports icon in ECHO, choose Clinical/Nursing and select Medication Records Current Visit.~~
~~Enter on Labor & Delivery Outpatient Record:~~
~~1. Have physician sign "physician order" portion of outpatient record if they are on the unit to see the patient.~~

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Standardized Proc- Outpatient Admission to L&D, Management of

~~2. For scheduled NST patients you can fax the L&D Outpatient Record to the MD's office.~~
~~3. You must also complete the MD ORDERS section of the form. You cannot write 'in EMR' in lieu of writing out the orders. Then signing, date & time the section. The billing department has no access to ECHO.~~
~~4. Complete Labor & Delivery Outpatient Record~~
~~5. Obtain patient's signature for discharge instruction. All patients must go home with written discharge instructions. If patient received written instructions on a prior visit, verify they still have the instructions, and document this on the outpatient record.~~
~~6. Complete Charge Sheet.~~

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REVIEW REQUIREMENTS:
This standardized procedure is required to be reviewed every three years, with approval by the IDPC, P&T (if applicable), MEC, and the Board of Directors.

REFERENCES:

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~~**REFERENCES:**~~

AUTHORS: M.Brogan, BSN, RNC, C-EFM (revised 7/14)

DISTRIBUTION: L&D, ED

APPROVAL DATES	**APPROVAL**
IDPC	10/6/2015
L&D Unit Partnership Council:	10/2015
OB Executive Committee:	11/2015
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	4/12
Board of Directors:	5/12

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Historical Approvals:
Patient Care Management Council: 05/04, 02/08, 2/12
OB Executive Committee: 05/02, 03/08, 1/12, 8/14, 11/15
L&D Unit Partnership Council MV: 6/09, 2/12, 7/14
L&D Unit Partnership Council LG: 6/09
MEC: 01/98, 03/00, 10/02, 03/08, 07/09, 4/12
Board of Directors: 03/00, 10/02, 04/08, 08/09, 5/12

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Standardized Proc- Outpatient Admission to L&D, Management of

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Standardized Proc- Outpatient Admission to L&D, Management of

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Telemetry Cardiac Monitoring

CATEGORY: Patient Care Services
LAST APPROVAL DATE:

SUB-CATEGORY: **Patient Care Services**
ORIGINAL DATE: **05/1995**

COVERAGE:

All Inpatient clinical areas providing telemetry cardiac monitoring.

PURPOSE:

- *To provide continuous cardiac monitoring to be used to detect alterations in heart rate and rhythm, to determine origin and conduction of ectopic impulses, as well as manifest changes due to myocardial irritability, ischemia and metabolic derangements. Patients with known and/or potential dysrhythmias are monitored for the purpose of early recognition and treatment. Continued cardiac monitoring is provided as the patient's activity is progressed.*
- *To provide guidelines for transport of patients requiring off unit procedures.*

STATEMENT:

- *Patients cared for on the telemetry units will be provided continuous cardiac monitoring by trained monitor technicians and registered nurses.*

SCOPE AND COVERAGE

1. Registered nurses and certified nursing assistants may place initial ECG electrodes on the patient and initiate continuous cardiac monitoring based on the physician's order.

2. The goals of monitoring and appropriate lead selection shall be determined according to patient clinical needs.

3. Patients requiring continuous telemetry monitoring are cared for on Los Gatos Medical Surgical, Ortho Pavilion, Labor and Delivery and Mother Baby units, and Mountain View 3B Telemetry and 3C Telemetry/Stroke units.

4. Patients will be monitored via wireless telemetry transmitters. RNs or monitor technicians will continuously monitor patients from central location. Portable monitors at bedside may be utilized based on patient condition.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Telemetry Cardiac Monitoring

CATEGORY: Patient Care Services
LAST APPROVAL DATE:

PROCEDURE:

1. Standard Work for Admission to Telemetry
    a. Verify physician order for telemetry. If no order entered in electronic medical record, contact MD for order if telemetry service requested.
    b. Notify monitor technician of pending patient admission. Obtain telemetry box of room assigned and verify room assignment and name of patient with monitor technician or RN. Only prepare one telemetry box at a time.
    c. Place telemetry box in room in preparation for patient's arrival
    d. When patient arrives, prepare skin for electrode placement and attach telemetry.
    e. Call monitor technician or RN from bedside and verify patient name, read room number from telemetry box and verify rhythm.
    f. Monitor technician or RN initials on monitor tech report sheet that new admission was verified.
    g. If rhythm change from information given in handoff, double check correct box was placed on patient, assess patient, check most recent 12 lead EKG and notify physician of changes.
    h. Verify interpretation of rhythm done by monitor technician. Sign strip and document rhythm in electronic health record.

2. Lead Placement and Skin Prep
    a. Monitor technician or RN should select a monitoring lead that has the greatest sensitivity and diagnostic accuracy. For routine monitoring, V1 will be used with a 5 lead system. V6 may be used as alternate lead choice when V1 is impractical due to dressings, incisions, etc. An exception is lead specific ST segment monitoring.
    b. Prepare skin for electrode application.
    c. If necessary shave area or cut hair close to skin where electrodes will be placed.
    d. Clean skin with an alcohol pad to remove oils then briskly dry with dry gauze which helps remove dead skin cells and improve impulse transmission.
    e. Apply only electrodes with center gel pad that is still moist.
    f. Place pads on chest by pressing center outward.
    g. Electrodes will be changed daily and as needed.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Telemetry Cardiac Monitoring

CATEGORY: Patient Care Services
LAST APPROVAL DATE:

3. Alarm Parameter Setting
    a. RNs or monitor technicians review all alarm settings at the start of each shift.
    b. Alarms for heart rate limits are adjusted from default settings based on the individual patient's condition and in consultation with the RN.
    c. Arrhythmia alarms may be adjusted or disabled based on patient condition and in consultation with the RN.

4. Alarm Notification-Monitor Technician responsibilities
    a. Monitor technician must notify RN of all changes in rhythm
    b. If monitor technician unable to notify primary RN, they must escalate to another RN, charge nurse or manager.
    c. Documentation of all notifications will be done on the rhythm strip sheet.

5. Documentation
    a. Rhythm strip will be documented in medical record every 4 hours.
    b. PR, QRS, QT, rate and rhythm should be indicated on strip.
    c. All strips interpretation should be verified by a registered nurse.

6. Transport of new admissions from Emergency Department to Telemetry
    a. All patients will be transported on a portable cardiac monitor accompanied by a RN or MD.

7. Transport and Care of patients for off unit procedures
    a. Patients will be transported off unit based on Level I and Level II criteria.
    b. With a physician order, patient may be off unit without continuous telemetry monitoring.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Telemetry Cardiac Monitoring

CATEGORY: Patient Care Services
LAST APPROVAL DATE:

	LEVEL I **Remote ECG monitoring**	**LEVEL II** **RN & ECG monitoring**
Locations of Remote Monitoring	All areas except MV endoscopy and bronchoscopy	**N/A**
Vital Signs	stable, normal routine Q4 hr or >	• unstable, requiring assessment every 2 hours or more frequently OR • vital signs within previous shift requiring nursing intervention
Neurological Status	oriented x3 (person, place, time), can follow commands, no acute change	• Altered level of consciousness within last 12 hours OR • Patient cannot follow commands and requires frequent observation to prevent harm
Respiratory Status	no potential for aspiration	• Respiratory rate less than 8 or greater than 25/minute OR • Oxygen saturation less than 90% on O2 OR • Oxygen therapy greater than or equal to 6 Liters per nasal cannula OR • continuous respiratory monitoring required
Cardiovascular Status	Stable ECG rhythm not requiring interventions	Within last 24 hours, has patient experienced any of the following: • hemodynamically unstable arrhythmia • systolic BP greater than 160 or less than 90 (if not patient's baseline blood pressure) • chest pain • symptoms of acute heart failure
IV	IV does not require constant monitoring (IV fluids only)	• IV drips or med requiring constant monitoring (including vasoactive drips)
Sedation	none	• sedation given on floor for procedure which requires oximetry and someone to monitor • RN must report to RN/MD
Equipment	none requiring immediate interventions by RN	If patient has any of the following: • external pacemakers • chest tubes • restraints
Transport Personnel	Transporter	Nurse or MD with unlicensed assistant for escort
On-going care during procedure	Tech OK	RN/MD with tech

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: Telemetry Cardiac Monitoring

CATEGORY: Patient Care Services
LAST APPROVAL DATE:

8. Discharge Process
   a. A physician's order is required to discontinue telemetry.
   b. RN should verify there are no rhythm changes prior to discontinuing telemetry.
   c. If any changes in rhythm, the physician must be notified.
   d. RN or Nursing assistant returns telemetry equipment to monitor technician for cleaning.

9. Telemetry Equipment Cleaning Guidelines
   a. Telemetry equipment must be cleaned according to manufacturer's guidelines and infection control policy.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: (Inserted PolicyTech field)

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee: Cardiovascular Services Committee: 12/97, 2/01, 09/03, 12/06, 02/09 Critical Care Committee (Special Services Committee):6/00, 08/03, 12/06, 07/07, 02/09, 01/12 Patient Care Management Council: 10/03, 02/05, 11/06, 06/07, 03/09, 03/12 Medical Executive Committee: 1/96, 4/98, 3/01, 11/06/03, 03/05, 11/06, 03/09, 04/26/2012 Board of Directors: 12/03/03, 04/05, 12/06, 04/09, 05/09/2012	
_____Medical Committee (if applicable):	
ePolicy Committee:	
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: 5/95, 8/03, 3/05, 10/06, 6/07, 2/09, 3/12

REFERENCES: (*as applicable*)

Drew BJ, Califf RM, Funk M, Kaufman ES, Krucoff MW, Laks MM, Macfarlane PW, Sommargren C, Swiryn S & Van Hare GF. Practice Standards for Electrocardiographic Monitoring in Hospital Settings: An American Heart Association Scientific Statement From the Councils on Cardiovascular Nursing, Clinical Cardiology, and Cardiovascular Disease in the Young: Endorsed by the International Society of Computerized Electrocardiology and the American Association of Critical-Care Nurses. *Circulation*. 2004;110:2721-2746. http:www.circulationaha.org

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Privileging Licensed Independent Practitioners During Disaster Events
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	June 2002		

I. COVERAGE:

El Camino Medical Staff & Allied Health Practitioners

II. PURPOSE:

To ensure that physicians and allied health practitioners (hereinafter referred to as "practitioner"), who do not possess medical staff or practice privileges, may be accepted to work at El Camino Hospital during a disaster, when Code Triage has been activated (Emergency Management Plan located in Hospital Safety Manual).

These disaster privileges are granted only when the following two conditions are present:

- The Emergency Management Plan (Code Triage) has been activated
- El Camino Hospital is unable to meet immediate patient needs

III. PROCEDURE:

A. A practitioner may present to the hospital to volunteer to provide services during a disaster. The scope of services provided must be within the practitioner's scope of practice as outlined by their state board.

B. All staff will be alerted to direct the practitioner to the hospital triage officer or the medical staff office to process disaster privileges.

C. The practitioner must produce his/her pocket license to practice medicine, a photo ID, the name of his/her malpractice insurance carrier, and the name of a hospital where he/she currently has privileges or has recently practiced. If possible, copies should be made of the license and photo ID.

D. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed with 72 hours from the time the volunteer practitioner presents to the organization. The medical staff office will keep the name, title, and license number of the volunteer practitioner on file for future reference if needed.

IN THE EVENT THESE CALLS CANNOT BE COMPLETED, DISASTER PRIVILEGES MAY STILL BE GRANTED UPON RECEIPT OF THE KEY IDENTIFICATION DOCUMENTS NOTED ABOVE.

E. The Chief of Staff (or designee) may grant these disaster privileges. If the Chief of Staff (or designee) is not available, the CEO (or designee) may grant disaster privileges.

F. The practitioner granted disaster privileges must be paired with a credentialed practitioner currently on staff who has a similar specialty. This pairing should be recorded along with the

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Privileging Licensed Independent Practitioners During Disaster Events
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

licensing information. Within 72 hours a decision will be made (based on information obtained regarding the professional practice of the volunteer) related to the continuation of the disaster privileges initially granted.

G. The practitioner will wear a temporary El Camino Hospital nametag issued by Security, while working in the facility.

H. A practitioner's privileges, granted under this situation, may be terminated at any time without reason or cause.

I. Termination of these privileges will not give rise to a hearing or review.

IV. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*June 2002, April 2003, October 2006, April 2007, September 2010, September 2012*

V. ATTACHMENTS (if applicable):

Note that Attachments not considered part of the actual policy and updates to the attachments do not require committee approval.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Privileging Licensed Independent Practitioners During Disaster Events
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

Disaster/Emergency Privileges Checklist:

Volunteer Practitioner Information:

Name: _____

Specialty: _____

License: State _____

Number _____

Items Presented:

License to practice medicine _____

Government Issued Photo ID _____

Malpractice Insurance Carrier Name _____

Name of Hospital where currently holds privileges or has recently practiced:

_____

Approval:

Chief of Staff (or designee): _____

Name Date/Time

Or

CEO (or designee): _____

Name Date/Time

ECH Credentialed Practitioner who will be paired with this volunteer practitioner:

_____

Name Specialty

Volunteer practitioner will take a copy of this document to Security to obtain a temporary El Camino Hospital Nametag.

Within 72 hours of the approval of volunteer practitioner:

Primary source verification of licensure (is accomplished as soon as the immediate situation is under control – or within 72 hours from the time the volunteer practitioner presents to the organization) – Primary source verification complete (date/time) _____

Decision made based whether to continue disaster privileges for volunteer

Continue privileges (date/time) _____

Discontinue privileges (date/time) _____

Name & Title of Person Completing this form:

_____

Name Title

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Impaired Physician
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	July 2004		

I. COVERAGE:

El Camino Hospital Medical Staff

II. PURPOSE:

Any behavior of Medical Staff members that adversely affects clinical performance resulting from physical or mental illness or addictive disorders in the hospital setting needs to be addressed. The purpose of this policy is to provide clear guidelines and procedures for responding to Licensed Independent Practitioners (LIPs) who may be impaired.

III. POLICY STATEMENT:

The Medical Staff is committed to maintaining a patient care environment where members of the Medical Staff are free of the effects of mental or physical illness or the effects of alcohol/drugs.

IV. PROCEDURE:

For standardized identification and testing of potentially impaired physicians. Anyone who has concern about an LIP, or the LIP him/herself through self-referral should address concerns with the Department Chief who will be in contact with the Physician Health & Well-Being Committee (PHWB) for evaluation.

A. Testing of Medical Staff Members:
   1. Testing of Medical Staff members for confirmation of alcohol or drug use may be conducted under the following circumstances:
      a) When there is **a reasonable suspicion** that a staff member is under the influence of drugs or alcohol. **(Reasonable suspicion** is a belief based on facts sufficient to lead a prudent person to suspect that a staff member may be under the influence of alcohol or drugs. Such behavior, as exhibited in per/patient interactions that affects performance, may include serious or repeated errors, extreme carelessness, mood swings, falling asleep, slurred speech, inability to appropriately respond to questions, the odor of alcohol on the breath or inappropriate behavior.) Reports of **reasonable suspicion** could come to the Medical Staff officers or their designee from any of the following sources: patients, visitors, auxillians, hospital employees or other staff members.
      b) When a staff member is found in possession of alcohol or illegal/unauthorized drugs on the hospital premises, or when alcohol or unauthorized drugs are found in an area controlled or used by a member of the Medical Staff (e.g. locker or desk is applicable).

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Impaired Physician
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

B. Informed Consent:
   1. After **reasonable suspicion** of a staff member has been reported, he/she will be contacted by a Medical Staff officer or his/her designee. The staff member will be asked to contact the PHWB Committee for interview and evaluation. At that time he/she will be informed of the reasons he/she is being asked to contact the PHWB Committee. The staff member will also be informed that refusal to cooperate will cause the Medical Staff to refer to the Medical Staff Executive Committee (MEC) which may result in discipline up to and including termination of staff privileges as outlined in Article VII of the bylaws.

C. Inability to Function:
   1. If the staff member disagrees with the recommendation of the PHWB, the case will be referred to the MEC for review and action. Under the Medical Staff Bylaws Section 7.2, "Summary Suspension" will be initiated if the practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or others.

THIS POLICY SHALL NOT BE INTERPRETED TO LIMIT OR WAIVE THE STAFF MEMBER'S RIGHTS UNDER ARTICLE IX HEARINGS AND APPELLATE REVIEWS OF THE MEDICAL STAFF BYLAWS.

V. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*July 2004, September 2005, October 2008, September 2010, September 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Guidelines for Supervision of Residents
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	August 2003		

I. COVERAGE:

El Camino Hospital Medical Staff – Residents

II. REFERENCES:

1. Joint Commission Standard MS.2.30

III. PROCEDURE:

A. Application:
   1. The sponsoring institution of an ACGME Accredited Training Program will notify the Medical Staff Office, in writing, of the application for a rotation by the Resident. The application shall include, but is not limited to, 1) the name of the Resident; 2) the training level; 3) the sponsoring department; 4) the dates of rotation; 5) the identity of the preceptor in the hospital; 6) the Training Program's provision for professional liability insurance covering the Resident. The Medical Staff Office will forward the signed Authorization for Resident Rotation to the appropriate personnel.
   2. Students from a non-accredited training program may not be permitted to do a rotation in the hospital.

B. Identification:
   1. All Residents shall be required to wear a photo identification badge.

C. Supervision:
   1. Residents are assigned to the hospital for the primary purpose of receiving education and training pertinent to their specialty. The Supervising Physician or preceptor ensures appropriate supervision and monitoring of the Resident. The Supervising Physician must be a member of the Medical Staff and must have clinical privileges consistent with the nature and scope of the activities to be supervised. The Supervising Physician is to ensure that the educational quality of the rotation is maintained at a high level, and that the patient care delivered by the Resident pursuant to his/her education and training is appropriate in content and of consistently high quality. The Supervising Physician is ultimately responsible for the care of the patient.
   2. For procedures, the Supervising Physician must be present and participating in all procedures.

D. Consent:

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Guidelines for Supervision of Residents
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

1. Patient consent must be obtained from patients, or their lawful surrogates, to have Residents participate in and/or provide patient care. This consent must be documented in writing through a patient consent form or in the progress notes.

E. Medical Record Documentation:
   1. The Supervising Physician must also countersign pre-operative reports or operative reports written or dictated by the Resident. The Supervising Physician must also complete or countersign the discharge summary in addition to writing daily progress notes. The Supervising Physician must document his/her continued supervision of the Resident's by making appropriate entries in the patient's medical record.
   2. Resident may write orders in the medical record. The Supervising Physician shall review all orders and document the plan of care in the progress notes.

F. Prerogatives:
   1. No resident may perform a procedure for which the Supervising Physician does not have privileges. Whether or not a Resident performs or participates in performing a procedure is up to the judgment of the Supervising Physician.

G. Communication:
   1. The Medical Staff has the overall responsibility for the quality of the patient care and professional services provided by individuals with clinical privileges or practice prerogatives within the hospital. The Medical Staff shall discharge its responsibilities relative to the Resident program through the appropriate departmental executive committee. This committee will monitor and evaluate the safety and quality of patient care provided by Residents and their related educational and supervisory needs. The Chairman shall report to the Medical Staff Executive Committee (MEC).
   2. The departmental executive committee will periodically communicate directly with members of their department who serve as Supervising Physicians regarding matters such as supervision policies, patient safety, and quality of patient care. Additionally, written descriptions of the responsibilities of Supervising Physicians, as well as role, responsibilities, and patient care activities of the Resident will be provided to the Supervising Physicians.
   3. At the conclusion of each rotation by the Resident, the Supervising Physician shall complete a performance evaluation and return it to the Resident program liaison who will compile the evaluation and share the information with the Stanford Hospital Resident Office.
   4. The departmental executive committee will report on its activities on an annual basis to the MEC, who will, in turn, report to the Board of Directors.

IV. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Guidelines for Supervision of Residents
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

Board of Directors:	
Historical Approvals:	*August 2003, February 2006, July 2009, September 2010, September 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Removal Adverse Peer Review Conclusions from Credentials File
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	March 1998		

I. COVERAGE:

El Camino Hospital Medical Staff

II. PURPOSE:

To encourage performance improvement by practitioners in areas defined by peer review. This process should reward improvement by allowing removal of adverse conclusions from the credentials' file in defined areas. The defined areas will be periodically reviewed by the Medical Staff Officers in conjunction with the Medical Staff Executive Committee. A period of at least five (5) years must have elapsed before a request may be initiated. No area which has resulted in privilege change, legal proceedings or extreme adverse outcome will be considered.

III. POLICY STATEMENT:

Procedure to remove adverse peer review conclusions from credentials' file.

IV. PROCEDURE:

A. The practitioner may petition the Department Executive Committee by writing a letter stating the area he/she has improved in and requesting consideration for removal of prior adverse conclusions in that area.
B. The Department Executive Committee will request all trend information, including any input from Department members or hospital staff regarding the area of question.
C. If the Department Executive Committee recommends removal of the peer review conclusion, they will be responsible for discussing their rationale at the Medical Staff Executive Committee meeting where a vote will be taken.
D. If the Medical Staff Executive Committee votes in favor, then the specific peer review conclusions will be removed permanently.
E. If the Department Executive Committee or Medical Staff Executive Committee decides not to honor the practitioner's request, then a letter will be sent to the practitioner outlining the reasons and a copy will be placed in the credentials' file.

V. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Removal Adverse Peer Review Conclusions from Credentials File
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*March 1998, June 1998, April 2004, November 2005, October 2006, October 2008, September 2010, September 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Medical Staff Credentials Files
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	March 2009		

I. COVERAGE:

All members of the medical staff

II. PROCEDURE:

A. Contents & Retention: The medical staff credentials file will contain the following:

1. Initial Application – This will be kept indefinitely
   a) Curriculum Vitae
   b) Peer References
   c) Hospital Verifications
   d) AMA Profile
   e) NPDB
   f) OIG Report of Sanctions
   g) Board Specialty Confirmation from ABMS
   h) ECFMG & Federation of State Medical Boards (if applicable)
   i) Government Issued ID (CA Drivers License)
   j) TB Status
   k) Malpractice Insurance Certificate and Claims History
   l) Privilege Requests
   m) Activity Log
   n) Board Approval Letter
2. Reappointment Application – Keep all reappointment applications indefinitely
   a) Peer References
   b) Hospital Verifications
   c) NPDB
   d) OIG Report of Sanctions
   e) Board Specialty Confirmation from ABMS (if changes since initial app)
   f) Malpractice Insurance Certificate and Claims History
   g) Privilege Requests
   h) Board Approval Letter
3. Licensing Information – Most current certificate will be kept on file
   a) Medical Board of California
   b) Drug Enforcement Administration
   c) Fluoroscopy
   d) NPI – no expiration

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Medical Staff Credentials Files
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

e) Medicare UPIN – no expiration
f) Moderate Sedation Certificate – no expiration
g) Proctoring – FPPE/OPPE Plans – Keep indefinitely
h) CME – Keep CME filed with initial app indefinitely. Keep most recent reappointment CME after that.
i) ECHO Access Code Agreement – Keep indefinitely
j) Reappointment Profile – Keep indefinitely
k) Peer Review Data – Keep indefinitely
l) Letters of correspondence – Keep indefinitely
m) Other – if questions arise regarding content or retention of any items not on this list, MEC will advise.

B. Confidentiality & Access:
1. It is the policy of this organization to maintain the confidentiality of all credentials files and the information contained therein. All files will be maintained under the care and custody of authorized representatives. Electronic records will have passwords and possess read/write controls protections. Authorized representatives include:
a) Officers of the practitioner's department
b) Medical staff officers, QA Medical Director, CEO, CMO
c) Regulatory agencies, Joint Commission, Federal and State agencies
d) Legal counsel for the medical staff
e) Medical staff services personnel in accordance with their job responsibilities
f) Board of Directors
2. All such reviews will take place in a confidential manner and may be reviewed for the following reasons:
a) Initial application/reappointment
b) Review trends to establish comparative histories and specific variations
c) Department-wide studies
d) Other specific projects which relate to credentialing and defined and approved by the MEC
e) Peer Review/Quality Assessment
f) Privileging issues
3. An individual physician may review his or her credentials file under the following circumstances:
a) The chief of staff, CEO, or department chair approves the request
b) A medical staff coordinator or officer of the medical staff is present during the review of the file.
c) The physician understands that he/she may add an explanatory note or other document to the file
d) The physician understand that he/she may not review confidential letters of reference or proctoring reports received during the initial appointment or any subsequent reappointment.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Medical Staff Credentials Files
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

e) The physician may not have photocopies of any items unless he/she has the permission of the Chief of Staff, Chief of Department, or Director of Medical Staff Services.

III. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*March 2009, October 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Confidentiality of Peer Review
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	October 2009		

I. COVERAGE:

El Camino Hospital Medical Staff

II. PURPOSE:

To assure confidentiality of all Medical Staff peer review.

III. POLICY STATEMENT:

Confidentiality and access to peer review records.

IV. PROCEDURE:

A. Peer review is considered confidential and privileged information. Discussions of peer review are confined to meetings and committees designated to complete this function. Discussion may include fact-finding and phone calls between officers, the practitioner and other peer review bodies. Confidentiality of the process includes protecting the identity of individuals making complaints to the department executive committee and reviewers.

1. Those individuals and entities legally permitted access to peer review include the following:
   a) Practitioner whose credential's file is being requested.
   b) Officers of the practitioner's department.
   c) Medical Staff Officers, Quality Assessment Medical Director, Medical Director of Service, Administration: CEO or designee.
   d) Regulatory Agencies, Joint Commission, Federal and State agencies.
   e) Legal Counsel for the Medical Staff.
   f) Medical Staff Services personnel.
   g) Board of Directors during appointment and reappointment period.
   h) Other Department Executive Committees only if germane to privileging process.
2. Practitioner's access to peer review records must take place in the Medical Staff Office. Access for other individuals or entities listed above must have prior approval by the Chief of Staff or Quality Assessment Medical Director. Under no circumstances should issues be discussed with non-involved individuals and at no time may copies of minutes or peer review records be given to practitioners unless there is a judicial review hearing.

V. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Confidentiality of Peer Review
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*October 2009, September 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Ongoing Professional Practice Evaluation (OPPE)
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	July 2012

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

I. COVERAGE:

All members of the medical staff.

II. PURPOSE:

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

III. POLICY STATEMENT:

OPPE is conducted on an ongoing basis and will include review of performance data for all practitioners with clinical privileges at ECH

IV. REFERENCES:

1. The Joint Commission Standards 2008- 2009 - 2010
2. The Joint Commission "Credentialing, Privileging, and Appointment" – August 13, 2008
3. Briefings on Credentialing – September 2008, Vol. 17, No. 9

V. PROCEDURE:

A. Duties and responsibilities: Each medical staff department chief (or one of the department officers, if designated by the chief) shall be responsible for:
   1. Assisting the department executive committee in establishing criteria for data to be reviewed. All practitioners will require an evaluation, not just those with performance issues. The department executive committee will determine the type of data and amount of data to be collected. MEC and the Board will review and approve or make recommendations for revision.
   2. Reviewing the data in the time frame prescribed by the MEC.
   3. Information resulting from the evaluation will be used to determine whether to continue, limit, or revoke any existing privileges at the time the information is analyzed.
      a) Continue privileges – Practitioner is performing well or within desired expectations and no further action is warranted - department chief may make this decision and the record of the decision, along with the data, will be filed in the practitioner's credentials file.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Ongoing Professional Practice Evaluation (OPPE)
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	July 2012

b) Determine that issues exist that require a focused practitioner performance evaluation (FPPE – see Medical Staff Policy 13.5.1) – department chief may make this decision.
c) Determine whether zero performance of a privilege should trigger FPPE (i.e. proctoring) – department chief may make this decision.
d) Determine that the privilege should be continued because the organization's mission is to be able to provide the privilege to its patients and there are no competence issues in the other data available for this practitioner – department chief may make this decision.
e) Limit or revoke privileges – department chief will make a recommendation to the MEC and the corrective action procedure will be invoked (Medical Staff Bylaws, Article 7).

B. Medical Staff Executive Committee (MEC) will be responsible for:
1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.
2. Determining how often the data will be reviewed.
3. 10/23/08 MEC meeting determined the frequency of review will be every 8-10 months.
4. Acting upon recommendations received from department chiefs when corrective action is deemed necessary (in compliance with Medical Staff Bylaws, Article 7).

C. Board of Directors will be responsible for:
1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.
2. Acting upon recommendations for corrective action as described in Medical Staff Bylaws Articles 7 & 8 (Corrective Action and Fair Hearing Sections).

D. Methodologies for Collecting Data
1. Quality indicators selected and approved by medical staff
2. Quality review reports
3. Periodic chart review
4. Direct observation
5. Monitoring of diagnostic and treatment techniques
6. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.
7. Peer recommendation from a peer who is in the same professional discipline and is knowledgeable about the applicant's professional performance and competence.
8. Quality data obtained from a practitioner's primary hospital (when the primary hospital is not ECH). It will be the practitioner's responsibility to obtain such data. The department chief, upon review of this data, will determine whether the data is sufficient to assess ongoing clinical competence.
9. National Practitioner DataBank Reports – the medical staff participates in the Proactive Disclosure Service.
10. Medical Board of CA Action Reports – the medical staff receives email alerts of all actions taken for licensed practitioners.

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Ongoing Professional Practice Evaluation (OPPE)
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	July 2012

VI. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*November 2008, January 2010, February 2011, July 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Fluoroscopy Supervisor and Operator License
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	March 2002		

I. COVERAGE:

All members of the medical staff.

II. PURPOSE:

To comply with California Administrative Health and Safety Code; Title 17, Chapter 5, Subchapter 4.5, Group 5, Article 1, Section 30463. This code reports that physicians must hold a Fluoroscopy Supervisor & Operator License issued by the California Department of Health Services if the physician does one or more of the following:

1. Actuates or energizes fluoroscopic equipment.
2. Directly controls the radiation exposure to the patient during the fluoroscopic procedure.
3. Supervises one or more persons who hold a Radiologic Technologist Fluoroscopy Permit.

California Health and Safety Code Section 25671.1 reports: It shall be unlawful for any person to direct, order, assist, or abet a violation of the certificate provisions. Violation constitutes a misdemeanor and any person who violates this code may be held liable for a civil penalty not to exceed $10,000 for each separate violation.

III. PROCEDURE:

A. The Medical Staff Office (MSO) will maintain the Fluoroscopy Supervisor & Operator License (Fluoro License) for physicians who possess them. The expiration date will be entered into the physician database.

B. Physicians are notified 30 days prior to the expiration of their Fluoro License. If a current Fluoro License hasn't been received prior to the expiration date, the MSO will notify the appropriate personnel via e-mail (Manager Radiology, Manager OR, Manager Endoscopy). The physician will not be allowed to perform or supervise fluoro studies until the MSO receives a current license. The physician will be notified via certified letter from the Chief of Staff or Chief of his/her Department.

C. The schedulers for Radiology, O.R., and Endoscopy will be given a list (provided by the MSO) on a monthly basis of each physician who holds a Fluoro License and the expiration date. When scheduling a fluoro study, the scheduler will check to see whether the physician holds a current Fluoro License. If not, the study will not be scheduled.

D. If a physician performs a fluoro study without a Fluoro License, a QRR will be generated and the Chief of the Department will be informed.

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Fluoroscopy Supervisor and Operator License
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	September 2012

IV. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*March 2002, April 2004, November 2005, October 2006, October 2008, September 2010, September 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Electronic Submission of Application and Reappointment
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	March 2009		

I. COVERAGE:

All members of the medical staff.

II. PURPOSE:

To provide an efficient and secure method for practitioners to apply for medical staff application and reappointment electronically.

III. PROCEDURE:

A. Initial Application – The practitioner interested in medical staff membership will request an application and provide the following information:
   1. Full Name
   2. Specialty
   3. Email address
   4. Phone number

   The information will be entered into the medical staff database and two separate emails will be sent to the practitioner. One email will contain the secure web link and the other will contain the practitioner's unique password. Practitioner will complete the application online and submit electronically.

B. Reappointment – Five months prior to the expiration of the practitioner's appointment, two emails will be sent – one containing the secure web link and the other will contain the practitioner's unique password. Practitioner will complete the application online and submit electronically.

C. Electronic Signatures – Applications will be signed electronically, through the secure, password protected link provided to the practitioner.

D. Paper copies of the applications may be obtained by request if the practitioner does not have access to the online application

IV. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

TITLE:	Electronic Submission of Application and Reappointment
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

Board of Directors:	
Historical Approvals:	*March 2009, October 2012*

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Procedure to Assure Timely Record Keeping
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT
	☑ Procedure	☐ Standardized Process/Procedure	
SUB-CATEGORY:			
OFFICE OF ORIGIN:	***Medical Staff Services***		
ORIGINAL DATE:	February 1992		

I. COVERAGE:

All members of the medical staff and allied health staff.

II. POLICY STATEMENT:

Practitioners who have not completed medical records in a timely manner will have admission privileges suspended in accordance with the procedure described below. In summary, the weekly reminder and suspension schedule will be as follows:

1. All delinquent records must be completed within fourteen (14) days after the discharge in order to avoid suspension.
2. Suspension will occur automatically on the day after the due date at 9:00 a.m. and Suspension Notification letters will be sent via email or fax at this time.
3. Suspension will remain in effect until all delinquent records have been completed.

III. DEFINITIONS (if applicable):

1.

IV. REFERENCES:

1.

V. PROCEDURE:

A. Record completion requirements:
   1. All medical records must be completed according to "El Camino Hospital Medical Staff Rules and Regulations" within fourteen (14) days of discharge of the patient from the hospital.
   2. A delinquent record is defined as any medical record which has not been completed (including signatures) within fourteen (14) days of discharge of the patient from the hospital, complying with DHS California Code of Regulations Title 22.

B. Incomplete Records Reminder Letter:
   1. If medical records are incomplete, an Incomplete Records Reminder letter will be sent to the practitioner via email or fax, according to their stated preference, on the first Wednesday seven (7) or more days after discharge from the hospital. Note: Email notifications are tracked with a read receipt/delivery status and faxes are tracked with a confirmation of receipt. This notice will inform the practitioner that if incomplete records

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Procedure to Assure Timely Record Keeping
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

are not completed by the specified due date (seven (7) days after the Reminder Notice), they will become delinquent and suspension will occur automatically at 9:00 a.m. on the day after the due date (Thursday).

2. Emailing and faxing an Incomplete Records Reminder letter to the email address or fax number supplied by the practitioner to the Medical Staff Office constitutes adequate notification to the practitioner. Refusal of a practitioner or a practitioner's office to accept such a letter does not negate notification.
3. Copies of Suspension Notification letters will also be sent to the following:
   a) The Chief of the suspended practitioner's department.
   b) The Chief of Medical Staff
   c) The Medical Staff Office for inclusion in the suspended practitioner's file.
   d) All hospital departments who are responsible for reporting violations of suspensions.

C. Vacation/Leave of Absence/Illness: It is the practitioner's responsibility to notify the Health Information Management Department in writing or by telephone before they go on a scheduled vacation/leave of absence (other than weekends or legal holidays) in order to prevent delinquencies from developing while they are away. If the practitioner is out due to illness, the deadline for completion will be extended by the amount of time the practitioner is expected to be out and depending on the circumstances, the deficiencies may be reassigned.

D. Suspension:
1. Suspension is defined as the loss of all privileges including:
   a) admission, consultation, or care of new inpatient and outpatient medical/surgical patients;
   b) care of patients in the Emergency Department, and
   c) performance of procedures on outpatients.
   d) Suspended physicians may continue to care for patients already hospitalized when the suspension period began, and patients may continue to be referred for use of outpatient labs, x-ray, and ancillary facilities.
2. A suspended physician may not serve on the ED call panel – if stipends are given for ED call, stipends will be withheld while physician is on suspension.
3. A suspended physician may not schedule a surgery or procedure while on suspension. A suspended physician must be removed from suspension before he/she can resume scheduling procedures.

E. Rescission and Deletion of Suspension: The practitioner may appeal to the Medical Staff Executive Committee if the days on suspension are deemed to be incorrect.

F. Deemed Resignation: A practitioner who has accumulated 45 days of medical record suspension in any calendar year shall be deemed to have resigned from the Medical Staff. Should the practitioner be on suspension on the last day of a calendar year, the continuing days of suspension at the start of the new calendar year shall count as part of the 45 day calculation, as well as be counted as the initial days for the calculation in the new calendar year. To assure that the physician is aware of his/her status, the following notices will be sent regarding total suspension days during a calendar year:

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Procedure to Assure Timely Record Keeping
CATEGORY:	Medical Staff Policies and Procedures
LAST APPROVAL:	October 2012

a) At 15 days of suspension, the department chief will contact the practitioner;
b) At 30 days, the chief of staff will contact the practitioner;
c) At 40 days the practitioner will be asked to come and meet with the medical staff officers.

The Medical Staff Office will send registered letters from the Chief of Staff at 15 and 30 days.

A practitioner subject to the deemed resignation of this Section D.7, shall not be eligible to reapply for Medical Staff membership for 30 days from the date of the resignation. If a practitioner has a second deemed resignation, the fee for reapplying to the medical staff will be double. If a third deemed resignation, the fee will be double and the practitioner may not reapply for two years (24 months). A practitioner may appeal the accuracy of the number of days calculation in the 45 day total to the Medical Staff Executive Committee on such terms as that Committee deems appropriate. However, no hearing rights under Article 8 shall apply unless the Medical Staff Executive Committee makes a determination under Section 7.3-5 of the Medical Staff Bylaws that the failure to complete medical records during the 45 days is reportable to the Medical Board of California. If an appeal is requested, the resignation will become effective after the appeal has been considered and upheld by the MEC at its next regularly scheduled meeting.

VI. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*February 1992, March 1998, June 1998, July 2003, August 2004, November 2005, October 2006, January 2011, October 2012*

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Practitioner Name:

CRITERIA FOR PRIVILEGES:
Physicians must demonstrate successful completion of an Accreditation Council of Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency program in ophthalmology, and/or current board certification in ophthalmology by the American Board of Ophthalmology (ABOP) or the American Osteopathic Board of Ophthalmology and Otolaryngology (AOBOO).

CORE PRIVILEGES:
Physicians with core privileges may admit patients to the hospital. These privileges are considered intrinsic to the practice of ophthalmology and routinely include the usual post-graduate training program in the specialty of ophthalmology.

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

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

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Core Privileges in Ophthalmology				
	Core privileges for ophthalmology including the ability to admit, evaluate, diagnose, treat, provide consultation to, order diagnostic studies and procedures for, and perform surgical and nonsurgical procedures on patients of all ages with ocular and visual disorders, including those of the eye and its component structures, the eyelids, the orbit, and the visual pathways including temporal artery biopsies. They may assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in ophthalmology include the following procedures and such other procedures that are extensions of the same techniques and skills: • A and B mode ultrasound examination • Anterior limbal approach or pars plana automated vitrectomy • Cataract surgery • Conjunctiva surgery, including grafts, flaps, tumors, pterygium, and pinguecula • Corneal surgery • Cryotherapy for ciliary body for uncontrolled painful glaucoma • Glaucoma surgery • Injection of intravitreal medications • Laser peripheral iridotomy, tabeculoplasty, pupilo-/gonioplasty, suture lysis, panretinal photocoagulation, macular photocoagulation, repair of retinal tears, capsulotomy, cyclophotocoagulation, sclerostomy and lysis • Lid and ocular adnexal surgery • Nasolacrimal surgery	**New applicant applying for core privileges:** Provide evidence of at least 10 ophthalmology procedures, reflective of the scope of privileges requested during the last 24 months or demonstrate successful completion of an ACGME or AOA-accredited residency or clinical fellowship within the last 24 months.	**Current medical staff applying for reappointment:** **For reappointment applicant,** Attest to at least 10 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 10.	

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
	• Removal of anterior and/or posterior segment foreign body • Removal of chalazion and other minor skin and eyelid lesions • Retrobublar or peribublar injections • Strabismus surgery			
Please list any of the above core privileges you do not wish to request:				
Special Noncore Privileges in Ophthalmology				
	Corneal transplants (penetrating keratoplasty)	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 2 corneal transplant procedures in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 2 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 2.	
	Placement of External Radiotherapeutic Source	**New applicant applying for core privileges:** Provide evidence of at least 5 cases, reflective of the scope of privileges requested during the last 24 months or demonstrate successful completion of an ACGME or AOA-accredited fellowship in Ocular Oncology or Advanced Orbital/Oculoplastics within the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 1 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 1.	
	Moderate (Conscious) sedation	**New applicant applying for privilege:** Pass the moderate sedation examination provided by ECH Medical Staff Office with 85% or higher.	**Current medical staff applying for reappointment:**. Pass the moderate sedation examination provided by ECH Medical Staff Office with 85% or higher.	

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Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Special Noncore Privileges in Ophthalmology				
	Retina and Vitreous surgery The privileges in retina and vitreous surgery include the following procedures: • Closed system vitrectomy, including peeling epiretinal or subretinal membranes • Pneumatic retinopexy • Scleral buckle procedures • Laser photocoagulation	**New applicant applying for privilege:** Provide evidence of at least 10 retina and vitreous surgery procedures, reflective of the scope of privileges requested during the last 24 months and demonstrate successful completion of an ACGME or AOA-accredited residency and clinical fellowship in vitreo retinal surgery within the last 24 months or the equivalent in training and experience.	**Current medical staff applying for reappointment:** Attest to at least 10 retina and vitreous surgery procedures over the last 24 months. *These 10 cases may also apply to core ophthalmology privileges.* **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 10.	
Please list any of the above retina and vitreous surgery privileges you do not wish to request:				

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

Applicant Signature _____ Date _____

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Practitioner Name:

CRITERIA FOR PRIVILEGES:
Physicians must demonstrate successful completion of an Accreditation Council of Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency program in internal medicine, and/or current board certification in internal medicine by the American Board of Internal Medicine (ABIM) or the American Osteopathic Board of Internal Medicine (AOBIM).

CORE PRIVILEGES:
Physicians with core privileges may admit patients to the hospital. These privileges are considered intrinsic to the practice of internal medicine and routinely include the usual post-graduate training program in the specialty of internal medicine.

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

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

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Core Privileges in Internal Medicine				
	Core privileges for internal medicine include the ability to admit, evaluate, diagnose, treat and provide consultation to adolescent and adult patients with common and complex illnesses, disease, and functional disorders of the circulator, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, and genitourinary systems. The core privileges in internal medicine include the following procedures and such other procedures that are extensions of the same techniques and skills: • Drawing of arterial blood • Management of burns, superficial and partial thickness • Excision of skin and subcutaneous tumors, nodules, and lesions • Incision and drainage of abscesses • Local anesthetic techniques • Performance of simple skin biopsy • Placement of anterior and posterior nasal hemostatic packing • Placement of a peripheral venous line • Interpretation of EKGs • Removal of non-penetrating foreign body from the eye, nose, or ear	**New applicant applying for core privileges:** **For initial applicant,** no additional/ special criteria needed for core privileges in internal medicine.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed for core privileges in internal medicine.	
Please list any of the above core privileges you do not wish to request:				
Special Noncore Privileges in Internal Medicine				
	Abdominal paracentesis	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 abdominal paracentesis procedures in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
	Arthrocentesis and joint injections	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 2 arthrocentesis and joint injection cases in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 2 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 2.	
	Endotracheal Intubation	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 endotracheal intubations in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	
	Exercise testing – treadmill	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 exercise treadmill tests in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	
	Flexible sigmoidoscopy with or without biopsy	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 flexible sigmoidoscopies (with or without biopsy) in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
	Insertion and management of central venous catheters and arterial lines	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 central venous catheters and arterial line procedures in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	
	Lumbar puncture	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 lumbar punctures in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	
	Ventilator management – Limited (uncomplicated case suitable for 12 hour Ventilator protocol, including CPAP and BIPAP)	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 mechanical ventilator cases (i.e., not complex) in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	
	Moderate (Conscious) sedation	**New applicant applying for privilege:** • Pass the moderate sedation examination provided by ECH Medical Staff Office with 85% or higher • Current ACLS certification • Provide evidence of at least 4 in the last 24 months.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed for moderate sedation privileges.	

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
	Thoracentesis	**New applicant applying for privilege:** Provide documentation of training/competence, verification from program director or evidence of at least 4 thoracentesis procedures in the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4.	

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

Practitioner Name:

Practitioner Name:

CRITERIA FOR PRIVILEGES:
Physicians must demonstrate successful completion of an Accreditation Council of Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency program in infectious disease, and/or current board certification in infectious disease by the American Board of Internal Medicine (ABIM) or the American Osteopathic Board of Internal Medicine (AOBIM).

CORE PRIVILEGES:
Physicians with core privileges may admit patients to the hospital. These privileges are considered intrinsic to the practice of infectious disease and routinely include the usual post-graduate training program in the specialty of infectious disease.

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

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

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Core Privileges in Internal Medicine				
	Core privileges for internal medicine include the ability to admit, evaluate, diagnose, treat and provide consultation to adolescent and adult patients with common and complex illnesses, disease, and functional disorders of the circulator, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, and genitourinary systems. The core privileges in internal medicine include the following procedures and such other procedures that are extensions of the same techniques and skills: • Drawing of arterial blood • Management of burns, superficial and partial thickness • Excision of skin and subcutaneous tumors, nodules, and lesions • Incision and drainage of abscesses • Local anesthetic techniques • Performance of simple skin biopsy • Placement of anterior and posterior nasal hemostatic packing • Placement of a peripheral venous line • Interpretation of EKGs • Removal of non-penetrating foreign body from the eye, nose, or ear	**New applicant applying for core privileges:** **For initial applicant,** no additional/ special criteria needed for core privileges in internal medicine.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed for core privileges in internal medicine.	
Please list any of the above core privileges you do not wish to request:				

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Special Noncore Privileges in Internal Medicine				
	Moderate (Conscious) sedation	**New applicant applying for privilege:** • Pass the moderate sedation examination provided by ECH Medical Staff Office with 85% or higher • Current ACLS certification • Provide evidence of at least 4 in the last 24 months.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed for moderate sedation privileges.	

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Core Privileges in Infectious Disease				
	Core privileges for infectious disease may admit, evaluate, diagnose consult, and provide care to patients of all ages with infectious diseases of all types and in all organ systems. This includes, but is not limited to, infection of the reproductive organs, infection in solid organ transplant patients, infectious in bone marrow transplant recipients, sexually transmitted diseases, HIV/AIDS, infections in travelers, and viral hepatitis, including hepatitis B and C. Physicians may also provide care to patients in the intensive care setting in conformance with unit policies. Further, they may assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in infectious disease include the following procedures and such other procedures that are extensions of the same techniques and skills: • Administration of antimicrobial and biological products via all routes • Application and interpretation of diagnostic tests • Aspiration of superficial abscess • Interpretation of Gram's stain • Lumbar puncture • Management, maintenance, and removal of indwelling venous access catheters	**New applicant applying for core privileges:** Provide evidence of at least 10 cases, reflective of the scope of privileges requested during the last 24 months or demonstrate successful completion of an ACGME or AOA-accredited residency or clinical fellowship within the last 24 months.	**Current medical staff applying for reappointment:** Provide evidence of at least 10 infectious disease consultations in the past 24 months. **For reappointment applicant,** documentation of 10 infectious disease consultations in the past 24 months.	
Please list any of the above core privileges you do not wish to request:				

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

Applicant Signature _____ Date _____

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Practitioner Name:

CRITERIA FOR PRIVILEGES:
Physicians must demonstrate successful completion of an Accreditation Council of Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency program in internal medicine, followed by successful completion of a postgraduate program in endocrinology, and/or current board certification in endocrinology by the American Board of Internal Medicine (ABIM) or the American Osteopathic Board of Internal Medicine (AOBIM).

CORE PRIVILEGES:
Physicians with core privileges may admit patients to the hospital. These privileges are considered intrinsic to the practice of endocrinology and routinely include the usual post-graduate training program in the specialty of endocrinology.

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

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

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Core Privileges in Internal Medicine				
	Core privileges for internal medicine include the ability to admit, evaluate, diagnose, treat and provide consultation to adolescent and adult patients with common and complex illnesses, disease, and functional disorders of the circulator, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, and genitourinary systems. The core privileges in internal medicine include the following procedures and such other procedures that are extensions of the same techniques and skills: • Abdominal paracentesis • Arthrocentesis and joint injections • Drawing of arterial blood • Management of burns, superficial and partial thickness • Excision of skin and subcutaneous tumors, nodules, and lesions • Incision and drainage of abscesses • Local anesthetic techniques • Lumbar puncture • Performance of simple skin biopsy • Placement of anterior and posterior nasal hemostatic packing • Placement of a peripheral venous line • Interpretation of EKGs • Removal of non-penetrating foreign body from the eye, nose, or ear • Thoracentesis	**New applicant applying for core privileges:** **For initial applicant,** no additional/ special criteria needed for core privileges in internal medicine.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/special criteria needed for core privileges in internal medicine.	
Please list any of the above core privileges you do not wish to request:				

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Special Noncore Privileges in Internal Medicine				
	Moderate (Conscious) sedation	**New applicant applying for privilege:** • Pass the moderate sedation examination provided by ECH Medical Staff Office with 85% or higher • Current ACLS certification • Provide evidence of at least 4 in the last 24 months.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed for moderate sedation privileges.	
Core Privileges in Endocrinology				
	Core privileges for endocrinology include the ability to admit, evaluate, diagnose, treat and provide consultation to patients of all ages with injuries or disorders of the internal (endocrine) glands, such as the thyroid and adrenal glands. Includes management of disorders such as diabetes, metabolic and nutritional disorders, obesity, pituitary diseases, and menstrual and sexual problems. The core privileges in endocrinology include the following procedures and such other procedures that are extensions of the same techniques and skills: • Interpretation of laboratory studies, including the effects of non-endocrine disorders • Interpretation of hormone assays • Interpret radiologic and other imaging studies for diagnosis and treatment of endocrine and metabolic diseases • Performance of and interpret stimulation and suppression tests • Performance of fine-needle aspiration of the thyroid • Radiologic measurement of bone density and perform other tests used in the management of osteoporosis and other metabolic bone diseases • Radionuclide localization of endocrine tissue • Ultrasonography of the soft tissues of the neck	**New applicant applying for core privileges:** Provide evidence of at least 6 cases (inpatient and/or outpatient), reflective of the scope of privileges requested during the last 24 months or demonstrate successful completion of an ACGME or AOA-accredited residency or clinical fellowship within the last 24 months.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/special criteria needed for core privileges in endocrinology.	
Please list any of the above core privileges you do not wish to request:				

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Special Noncore Privileges in Endocrinology				
	Biopsy Thyroid Nodule	**New applicant applying for core privileges:** Provide evidence of at least 6 cases (including inpatient and/or outpatient), reflective of the scope of privileges requested during the last 24 months or demonstrate successful completion of an ACGME or AOA-accredited residency or clinical fellowship within the last 24 months.	**Current medical staff applying for reappointment:** Attest to at least 4 cases (inpatient and/or outpatient) over the last 24 months. **For reappointment applicant,** the number below needs to reflect the number performed within the last 24 months and at least 4 cases (inpatient and/or outpatient).	

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

Practitioner Name:

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Practitioner Name:

CRITERIA FOR PRIVILEGES:
Physicians must demonstrate successful completion of an Accreditation Council of Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency program in Anesthesiology and current board certification in Anesthesiology by the American Board of Anesthesiology (or the osteopathic equivalents).

CORE PRIVILEGES:
Physicians with core privileges may admit patients to the hospital. These privileges are considered intrinsic to the practice of anesthesiology and routinely include the usual post-graduate training program in the specialty of anesthesiology.

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

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

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
Core Privileges in Anesthesia				
	Core privileges for Anesthesia include being able to admit, treat, and consult. The core privileges in anesthesia include the following procedures and such other procedures that are extensions of the same techniques and skills: • General anesthesia – inhalation and intravenous; • Regional anesthesia – including spinal, epidural, and caudal blocks; • Peripheral, extremity, and sympathetic nerve blocks; • Bier blocks; • Sedation and analgesia – intravenous, cutaneous, oral and rectal routes; • Acute and chronic pain therapy including patient controlled analgesia (PCA); • Insertion of intravascular monitoring devices – to include but not limited to central venous lines, arterial lines, Swan-Ganz catheters and transvenous pacemakers; • Cardiopulmonary resuscitation – basis and advanced. • Management of mechanical ventilation – Unrestricted • ***May perform medical history & physical examination and required updates***	**New applicant applying for core privileges:** **For initial applicant,** no additional/ special criteria needed for core privileges in anesthesia	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed for core privileges in anesthesia.	
Please list any of the above core privileges you do not wish to request:				
Special Noncore Privileges in Anesthesia				
	Chronic Pain Therapy Only	**New applicant applying for core privileges:** **For initial applicant,** no additional/ special criteria needed.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed.	

Requested	Privilege	Additional/Special Criteria Highlighted area shows required documentation		Dept Chief Approval
	Transesophogeal echocardiography (TEE)	**New applicant applying for privilege:** Initial applicant for intra-operative TEE examination and monitoring requires completion of an anesthesia residency program since 1995 or documented experience. Provide documentation of training/competence, verification from program director or evidence of experience during the past 5 years.	**Current medical staff applying for reappointment:** **For reappointment applicant,** no additional/ special criteria needed for core privileges in anesthesia.	

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

Practitioner Name:

a. If the ordering practitioner is not a member of the El Camino Hospital Medical Staff or Allied Health Professional Staff, verification that the practitioner is licensed and acting within his/her scope of practice in the State in which he/she sees the patient shall be obtained by the outpatient department(s) prior to performing or providing the test, study, or outpatient service. The license shall be verified via the appropriate website or by obtaining verbal verification from the appropriate licensing board by the department providing the service. In addition, a telephone number for the ordering practitioner will be verified by the outpatient department(s) prior to performing or providing the test, study, or outpatient service.

b. Orders for outpatient services must include the name of the patient, the date of the order, the test or treatment to be performed, and the reason for the test or treatment to be performed (symptoms or diagnosis). Orders for outpatient diagnostic tests (i.e., laboratory, radiology exams, EKG, etc.) may be submitted on a requisition form, a prescription/order form from the practitioner's office, or may be telephoned to the appropriate department by the practitioner's office staff with follow-up written orders.

c. Results shall be directly sent to the ordering practitioner unless otherwise requested by the ordering practitioner.

d. Practitioners who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order or refer patients for all outpatient services provided by El Camino Hospital except for chemotherapy orders.

Verbal or telephone orders must be signed/authenticated, dated and timed by the author within 48 hours. Faxed or electronic signatures may be used to authenticate a verbal or telephone order. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice. Verbal or telephone orders should be limited to those situations in which it is impossible for the prescriber to enter it into a computer.

In the case of an incorrect order, the practitioner must document in the medical information system or on the Unsigned Orders Summary, that the order was entered incorrectly.

5. A Record of Newborn must be completed for each normal newborn. The Admission Examination must be completed within twenty-four (24) hours of birth by the attending physician.

6. Medical Screening Exams (as defined under the Emergency Medical Treatment and Labor Act) shall be performed and documented in the Emergency Department and Labor and Delivery. Medical Screening Exams shall be performed by a credentialed MD, DO, certified nurse midwife, Emergency Department physician assistants under appropriate supervision and within scope of practice, or, in the case of a patient presenting with pregnancy and/or signs and symptoms of labor, RNs who have demonstrated current competence (per hospital policy) in assessing the laboring patient.

7. A discharge summary is required on all stays over forty-eight (48) hours, except for uncomplicated obstetrical cases and normal newborns. Discharge summaries are also required for patients who are transferred to another acute care facility or who die within forty eight (48) hours, and shall be written or dictated at the time of discharge, transfer or death.

A discharge summary should briefly recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the

Att 29.2 - Draft Resolution 2016-02

ECH BOARD MEETING AGENDA ITEM

	Item:	Resolution 2016-02 El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Mary Rotunno, General Counsel
	Action requested:	Approval
	Background: El Camino Hospital management wishes to renew Board Director Peter C. Fung, MD's Stroke and Neurology ED On-Call agreement which expires on January 31, 2016. Management believes that the proposed contract is in the best interest of El Camino Hospital and is fair to its patients. Moreover, the amount to be paid will be no greater than the amounts paid under the same or similar agreements. The agreement must be approved by the Board in order to comply with the California Nonprofit Corporations Act. In addition, although Director Fung's agreement is with El Camino Hospital, not with the District, I recommend that the Board approve Resolution 2016-02 in a manner that would comply with Health and Safety Code Section 32111; if it applied. California Government Code Section 1090 generally bars contracts between governmental entities and directors, among others, who are financially interested in certain agreements. California Health and Safety Code Section 32111 provides an exception to contracts involving a member of a medical staff who is subject to Section 1090, where the contract is between the district and the officer for professional services to the district's patients, employees, or medical staff members and their respective dependents, provided that similar contracts exist with other staff members and the amounts payable under the contract are no greater than the amounts payable under similar contracts covering the same or similar services if the following conditions have been satisfied: (i) the officer abstains from any board action regarding the contract; (ii) the officer's relationship to the contract is disclosed to the board and noted in its official records; and (iii) the board finds the contract is fair and in its best interest and authorizes the contract in good faith without the participation by the officer.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : For the Board to approve Resolution 2016-02 finding that Director Fung's Stroke andNeurology ED On-Call Coverage agreement is fair and in it best interests.	

ECH BOARD MEETING AGENDA ITEM

	Proposed board motion: To approve Resolution 2016-02
	LIST OF ATTACHMENTS: Resolution 2016-02

DRAFT RESOLUTION 2016 – 02
BOARD OF DIRECTORS
EL CAMINO HOSPITAL

WHEREAS, Peter Fung, M.D. ("Dr. Fung") has provided services as an Emergency Room on-call physician to El Camino Hospital, a California nonprofit corporation, since October 1, 2005;

WHEREAS, Dr. Fung became a member of the Board of Directors of El Camino Hospital on December 9, 2014;

WHEREAS, El Camino Hospital has similar contracts with other members of its Medical Staff;

WHEREAS, El Camino Hospital management has proposed renewing the Emergency Room on-call physician agreement with Dr. Fung with terms, including payments terms, that are similar to those entered into with other physicians;

WHEREAS, El Camino Hospital management has determined that renewing the Emergency Room on-call physician agreement with Dr. Fung is fair and in the interests of El Camino Hospital and El Camino Hospital could not have obtained a more advantageous arrangement; and

WHEREAS, Dr. Fung has recused himself from voting or otherwise participating in this matter;

NOW, THEREFORE, BE IT:

RESOLVED, that the Board of Directors finds that the proposed contract with Dr. Fung is fair and in the interests of El Camino Hospital and El Camino Hospital could not have obtained a more advantageous arrangement; be it further

RESOLVED, that the proposed agreement with Dr. Fung is hereby approved and the President and CEO is authorized to execute and deliver such agreement on behalf of El Camino Hospital.

CEO Report

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Date: January 13, 2015

To: El Camino Hospital Board of Directors

From: Tomi Ryba, CEO

Re: CEO Report - Open Session

Rev. 1-5-16

Performance Measurement

Organizational Goals FY16	Benchmark	2015 ECH Baseline	Minimum	Target	Maximum	Weight	Evaluation Timeframe	FY16 thru Dec
Threshold Goals								
Joint Commission Acceditation	Standard Threshhold	Full Accreditation	Full Accreditation			Threshold	FY 16	Met
Budgeted Operating Margin	90% threshold recommended by Exec Comp Consultant	Met	90% of Budgeted			Threshold	FY 16	Met
Patient Safety & iCare								
Achieve iCare Tier 1 Metric: Medication Reconciliation at Discharge	Epic Benchmark: 97% accuracy is 90%ile at stable state	May - Jun FY15 Actual	6 Months Post Go-Live: 60%	6 Months Post Go-Live: 75%	6 Months Post Go-Live: 90%	34%	May, 2016	Report starting Dec 2015
Achieve Medicare Length of Stay Reduction while Maintaining Current Readmission Rates for Same Population **(One Month Delay for Readmission)**	Internal Improvement	Jan - June FY15 Actual for LOS: 5.17 Readmission: 12.67	.10 Day Reduction, Readmission at or below FY15	.20 Day Reduction, Readmission at or below FY15	.30 Day Reduction, Readmission at or below FY15	33%	Jan - Jun FY16	LOS: N/A **Nov** Readmission: N/A
Smart Growth								
Achieve Enterprise Planned Growth (300 Discharges, 300 Outpatient Visits) **(One Month Delay)**	Internal Goal: 120 net, per each metric, is Threshold	FY15 Actual: 310 Discharges, 145 Procedures	80% (240/240)	100%	120% (360/360)	33%	FY 16	**FYTD thru Nov** (356) Discharges, (504) Procedures

Patient Quality and Safety

- Mislabeled specimens**:** 9 and 8 Specimen labeling errors in Oct and Nov, respectively (goal is ≤ 15/month). No mislabeled specimen with use of SoftID. SoftID Errors include: 1) no SoftID label used, 2) not collected [process steps not completed in SoftID], and 3) upside down labels.

Operations

- Pathways has started their Home Health and Hospice Epic project with a design build team now returning from Wisconsin. The full team is assembled with two staff from Pathways and seven others from ECH. The blended team looks balanced and well prepared with Pathways leadership excited and engaged.

- During January, we expect to continue the post iCare stabilization period and clean up some of the items cut late from scope such as credit card scanners, printing capabilities and the like. We will also continue efforts around several multi-year projects, including the need to exit the old data center, help with the relocation of all Old Main personnel and early efforts around the data archive project. We have begun Project Discovery work around the new primary care clinics. The goal is to have the first location live in the current fiscal year. Another large project to complete this fiscal year will be the lab system upgrade for Meaningful Use. The great news is that early Meaningful Use reports from Epic show ECH in great shape for Stage 2, so the lab project will seal the deal.

- CT Surgery team awarded 3 star rating for outcomes for both isolated CABG and isolated aortic valve procedures. This places ECH in the TOP 5% in the nation for outcomes for these patient populations.

- Additional physicians signed on to do electrophysiology procedures at ECH. New equipment purchased and interventional services room made available to accommodate the expected increased volumes for EP procedures.

- Primary Care Clinics Summary

	November	**YTD**
Net Operating Income	$90,889	$803,962
Budget Operating Income	$185,025	$925,019
Actual Visit Volume	304	1,901
Budget Visit Volume	427	2,176

- Fiscal Year 2015 Medical Director Quality Goals: Supporting documentation has been received for all fiscal year 2015 medical director quality goals and has been evaluated and approved by the CMO. All Medical Directors, with the exception of a few have been reviewed by Compliance, submitted to Accounts Payable for

payment, and paid. All incentive payments for FY15 quality goals are expected to be paid by the end of 2015.

- Patient Experience HCAHPS Scores – Q1FY16 to date
  Nurse Commination: 79.2 vs. FY15 score of 78.51
  Med Communication: 65.5 vs. FY15 score of 68.31
  Staff Responsiveness: 67.3 vs. FY15 score of 66.84

- CONCERN hired and trained a new Account Executive to manage our growing base of accounts. Developed a Financial Wellness offering that is a complete resource and 1:1 coaching experience to help employees overcome whatever financial challenge they may be facing and to accomplish their financial goals.

- Multi-disciplinary Discharge Rounds scheduled to begin in January on 3 nursing units – 2C, 3B and 3C with physician participation.

- Administered >3700 flu vaccines to employees, volunteers, physicians, students, and contractors & achieved 99.22% employee flu vaccine compliance by the end of November.

Community Outreach

- Community Benefit pre-diabetes awareness campaign has reached over 270,000 individuals through radio and television ads; over 1,000 individuals have taken the CDC pre-diabetes risk assessment.

- South Asian Heart Center (SAHC) **s**igned a two year ($165K) partnership with Jain Centers of North America to enroll 1000+ participants and provide lifestyle counseling.

- Continued planning meetings with the American Heart Association and MayView Community Health Center to implement an initiative addressing hypertension in the District. The District Board will be updated on the project in January.

- Attended Silicon Valley Healthy Aging Partnership meeting in San Jose to discuss their falls prevention program with a group that included prominent local organizations (Stanford, Santa Clara County and San Jose State University).

- Conducted hypertension screening and workshop on a low sodium diet at Life's Garden Senior Housing in Sunnyvale.

- Participated in the Chinese American Coalition for Compassionate Care's (CACCC) "When East Meets West" Health Professional Forum in Mountain View with over 60 medical professionals in attendance. Also participated in CACCC's fundraising event with 300 community members in attendance. ECH community benefit was a sponsor of this event.

- Partnered with the First Morning Light Church in Sunnyvale and provided 75 hypertension screenings and a workshop on a low sodium diet for 100 participants.

- Dr. Pifer spoke at the “Health & Housing Summit” for 80 members of the Silicon Valley Council of Nonprofits.

- Over 100 people attended a seminar hosted by ECH titled “Mental Illness and the Courts”. Michael Fitzgerald joined a distinguished panel of judges, public defenders, prosecutors and mental health advocates to examine how to best meet the needs of patients, their families, and the community when persons with mental illness are arrested.

- ECH presented day of programming and hospital tours for Leadership Mountain View. Five other city leadership groups will attend similar programs in the first six months of 2016.

- Staff and board attended the Abilities United Annual Authors Luncheon, the PACT Interfaith Luncheon, the Silicon Valley Fundraising Professionals Philanthropy Day, and the Los Altos Community Foundation Holiday event.

- California’s new AED law becomes effective January 1, 2016, but the new “End of Life Options” law will not take effect until 90 days after the special session on health care ends.

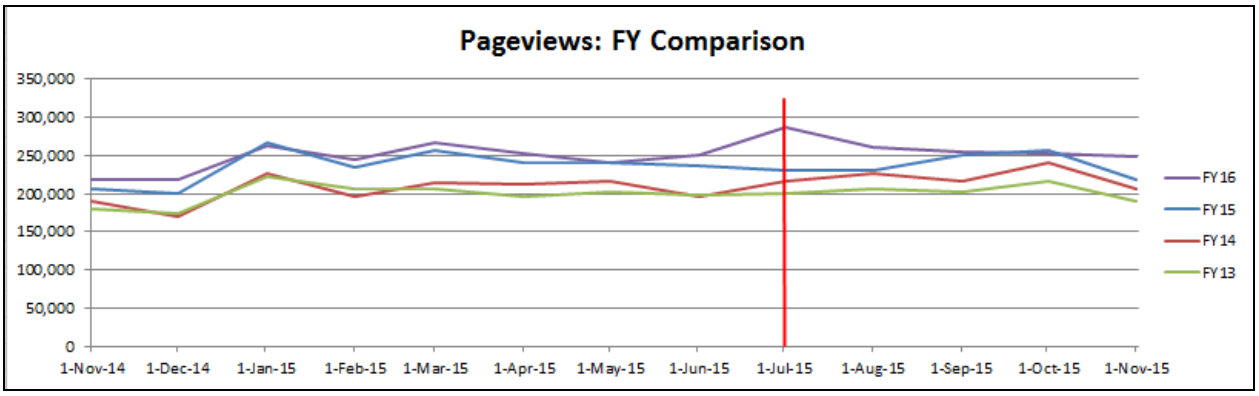
- Brenda Taussig will represent the Hospital Council on the County’s new AED Matching Fund Reserve Oversight Committee, and was sworn in as a member of the Santa Clara Family Health Plan Governing Board. She continues her work with CHA’s statewide Advocacy Communications Committee, and as co-chair of the Silicon Valley Leadership Group’s Health Committee.

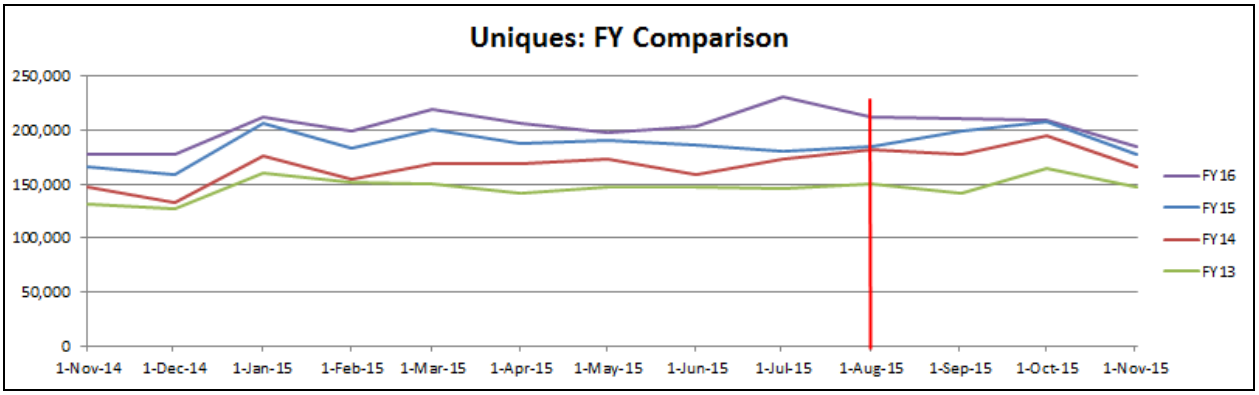
- The 2015 Community Benefit report was mailed to 100 elected officials.

Digital Engagement
Website:

- Over 248K page views and 184K unique page views in the month of November; respectively, this is a 14% and 4% increase over the same period in FY15.

November	*FY16*	*FY15*	*FY % Δ*	*Month % Δ*
Pageviews	248,398	218,239	14%	-1.83%
Uniques	184,602	177,688	4%	-11.70%



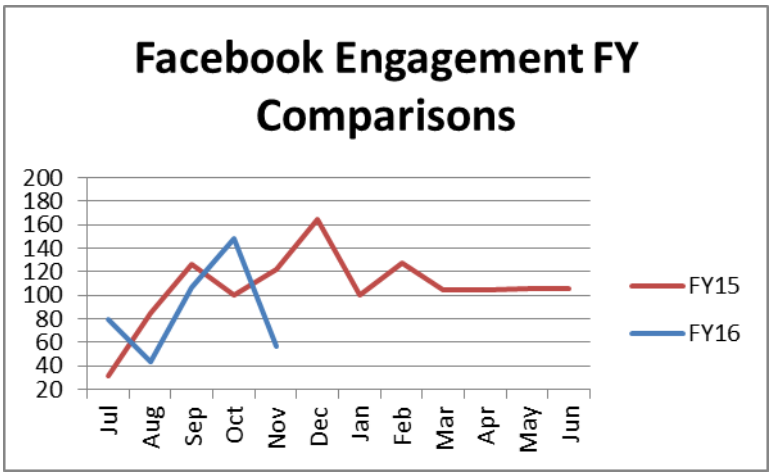


Social Media: (10/15-12/15)

- Facebook grew to over 20,700 fans, +68% compared to last year's fan-count in this time period. Facebook fan pages generally grow at a rate of 2.5% per month.

- The average engagement rate per post was 6%, which continues to outperform the rate of 1% across all industries. Top three Facebook organic posts with the highest engagement rates:
  - Veteran's Day, 12.8% (1,800 people)
  - Germ zapping robots, 11.3% (3,300 people)
  - Dynamic Healthcare video, 10.5% (8,900 people)

- The average reach per post was 1,225 people (5.9% of audience, which continues to outperform the average reach of 2.6% across all industries). Top three Facebook organic posts with the highest reach:
  - Niche award, 10.1k (48.8% of fans)
  - Dynamic Healthcare video, 8.9k (43% of fans)
  - Happy Thanksgiving, 4.9k (23.7% of fans)



Media Relations

- The Satake family was highlighted in the *Los Altos Town Crier* for their generous donation to El Camino Hospital Foundation's Fulfilling the Promise initiative.

- *RevCycle Intelligence* and *Executive Insight* wrote articles about patient experience scores and included information from RJ Salus, director of patient experience, about the hospital's patient experience improvement efforts.

- *Palo Alto Weekly* and *Mountain View Voice* recognized El Camino Hospital for its low scores in regards to the federal government's Hospital-Acquired Condition (HAC) Reduction Program. El Camino Hospital had the lowest scores out of the hospitals in the area.

- El Camino Hospital was recognized for performance excellence in the reduction of hospital acquired pressure ulcers (HAPU stage II+), injury falls, central line-associated blood stream infections, catheter-associated urinary tract infections, and methicillin-resistant staphylococcus aureus (MRSA) infections in a press release issued by CALNOC.

- *Mountain View Voice* wrote an article about the launch of iCare.

- The hospital's effort to reduce patient falls by using MDAnalytics was featured in the *Los Altos Town Crier*.

- *Urology Times* included an article by Dr. Edward Karpman which highlighted the Men's Health Program at El Camino Hospital.

- Becker's Healthcare's year-end review from 20 healthcare CEOs included responses from Tomi Ryba.

Traditional Advertising Campaigns
Television:

- A 30-second spot on KPIX-TV (CBS) featuring the hospital's creative campaign runs nightly at 6 and 11 pm. This marks the hospital's first broadcast ad as sponsors for the KPIX Countdown to Super Bowl 50.

Print:

- Ads focused on the Senior Health Program offerings ran during the Medicare open enrollment period, in the *Mountain View Voice, Los Altos Town Crier, Palo Alto Weekly*, and *Sunnyvale Sun*.

- Open enrollment ads focused on primary care and SVPC are continuing to run during general open enrollment in the *Mountain View Voice, Los Altos Town Crier, Palo Alto Weekly,* and *Sunnyvale Sun*.

- The Chinese Health Initiative Hypertension Campaign ads continue to run in the *World Journal, News for Chinese*, and *Sing Tao*.

- An ad featuring the Scrivner Challenge was included in the *Silicon Valley Business Journal* Annual Giving Guide.

- The financial audit ran in the *Mountain View Voice*. Print ads ran in the *Sunnyvale Sun* and *Los Altos Town Crier* directing readers online for the complete report.

- An ad notifying the community about the termination of the hospital's contract with Anthem Blue Cross ran in the *Mountain View Voice, Sunnyvale Sun, Cupertino Courier, Los Altos Town Crier, and Los Gatos Weekly Times*.

- El Camino Hospital and its physicians already have the largest OB program in the Silicon Valley. We are building on this success by partnering with Google and Apple to be the preferred provider of OB services for their employees. The clinical and physician leadership of the program have met with the benefits leadership of these two employers to understand their needs and how we can distinguish our program from other providers. The proposal will be presented at the Employer Focus group meeting on January 19, 2016.

Att 30a.2 - Hospital Board Report Period 5 November 2015

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Memorandum

DATE: December 23, 2015

TO: El Camino Hospital Board of Directors

FROM: Russ Satake, Chair, El Camino Hospital Foundation Board of Directors
Jodi Barnard, President, El Camino Hospital Foundation

SUBJECT: Report on Foundation Activities FY 2016 – Period 5

ACTION: For Information

During the months of October and November, the Foundation raised $871,569, bringing the total raised by the end of period 5 to $2,564,030. Year-to-date actual fundraising numbers are on par with our results in FY15 and $560,000 above where it was in FY14 at the end of November.

Planned Gifts

- The Foundation received approximately $60,000 in planned gifts. $10,000 was received as payment on a bequest from the Igna B. Long Trust. Another donor generously signed her third charitable gift annuity with the Foundation for $50,000.

Annual Giving

- In October and November, the Foundation received $141,245 in annual gifts, bringing the total year-to-date to $226,653. The majority came from contributions to the Employee Giving Campaign, which ended on December 18. The Foundation also received a number of gifts earmarked for the Cancer Center in memory of Marian Cheng, who was a nurse and dedicated Employee Giving champion from the Mother Baby unit in Mountain View. Other donations came from Hope to Health membership renewals, Circle of Caring donations made in honor of hospital caregivers, unsolicited gifts, and responses to the end of year direct mail appeal, which was sent out in early November. The Foundation is emailing appeal follow-up messages throughout the month of December.

Fundraising Events

- ***20th Annual El Camino Heritage Golf Tournament*** – The Foundation continues to collect payments for the golf tournament, which was held on October 19, 2015. At the close of November, the tournament had raised $317,205, which is in line with last year and far exceeds the results in 2014. Notably, even though the number of golfers was down because a large past sponsor did not renew, the fund-in-need appeal was the most successful on record, generating $80,000 to support the Scrivner Challenge for adolescent

mental health. Final payments for the golf tournament are expected in December and will be reflected in the period 6 fundraising report.

- ***Norma's Literary Luncheon*** – Norma's Literary Luncheon will be held on February 4, 2016 at Sharon Heights Golf & Country Club in Menlo Park. The featured speaker is Mireille Guiliano. This year's event will support the establishment of a women's heart program at the Norma Melchor Heart & Vascular Institute. Online registration opened in November and the Foundation received $20,250 in the first month from sponsorships and ticket sales. The luncheon will be at a larger venue this year, with the expectation of increased attendance. As of today, 17 tables have been committed toward a goal of 25. Invitations will be mailed after the New Year. We expect to sell out again this year.

- ***Scarlet Night*** – Scarlet Night, the South Asian Heart Center's annual gala benefit, will be held on March 19, 2016 at the Santa Clara Convention Center. Proceeds will support the Center's expansion to more sites in the Bay Area and this year's fete will also celebrate the Center's 10th anniversary. In October and November, the Foundation received an additional $16,010 in registrations and table sponsorships.

- ***Sapphire Soirée*** – In October and November, the Foundation received $10,200 toward the 2016 gala. Sponsorship packets have been mailed and follow-up is underway. Save the date cards announcing this year's entertainment, the B-52s, will be mailed at the start of the New Year.

Fundraising Initiatives

- ***Fulfilling the Promise*** – The Foundation has now raised $550,000 toward the Scrivner Challenge, Mary and Doug Scrivner's promise to match dollar for dollar all gifts up to a total of $1 million, to create an endowment for ASPIRE. Donna and John Shoemaker, chairs of the Foundation's Philanthropy Council for Mental Health and Addiction Services, were honored as Silicon Valley's Outstanding Volunteer Fundraisers at the Association of Fundraising Professionals Silicon Valley Chapter annual Philanthropy Day Luncheon on November 20, which was attended by 700 people.

Donor Stewardship

- ***Impact Reports*** – In October, breast cancer awareness month, the Foundation sent an e-blast to current and potential Cancer Center major donors, as well as an impact report letter from Tomi to all Cancer Center donors in the past year.
- ***Thanksgiving Card*** –The Foundation mailed a Thanksgiving card to all Foundation donors in November.
- ***Donor Recognition Event*** – The Foundation held a thank you reception for Legacy Society members and major donors to all fundraising initiatives on November 17 at Los Altos Golf & Country Club. Seventy five donors attended.

Att 30a.3 - Fundraising Report - November (Period 5) FY16

ECH Foundation Fundraising Report

FY16 Income figures through November 30, 2015 (Period 5)

ACTIVITY		FY16 YTD (7/1/15 - 11/30/15)	FY16 Goals	FY16 % of Goal	Difference Period 4 & 5	FY15 YTD (7/1/14 - 11/30/14)	FY14 YTD (7/1/13 - 11/30/13)
Major Gifts		$ 1,440,000	$ 3,735,000	39%		$ 171,200	$ 125,000
Planned Gifts		$ 160,178	$ 1,200,000	13%	$ 60,069	$ 1,162,015	$ 794,247
Special Events	Sapphire Soirée	$ 31,700	$ 600,000	5%	$ 5,200	$ 6,600	$ 251,150
	Golf	$ 317,205	$ 280,000	113%	$ 22,275	$ 319,150	$ 265,325
	Scarlet Night	$ 21,070	$ 250,000	8%	$ 10,500	$ 7,245	
	Norma's Literary Luncheon	$ 83,550	$ 135,000	62%	$ 20,250	$ 63,900	
Annual Giving		$ 226,653	$ 400,000	57%	$ 67,450	$ 285,528	$ 241,590
Grants		$ 26,833	$ 200,000	13%		$ 318,750	$ 81,250
Investment Income		$ 256,842	$ 500,000	51%	$ (8,959)	$ 239,243	$ 242,093
TOTALS		***$ 2,564,030***	***$ 7,300,000***	***35%***	***$ 176,785***	***$ 2,573,631***	***$ 2,000,655***

El Camino Hospital® Foundation
THE HOSPITAL OF SILICON VALLEY

Att 30a.4 - David Reeder Cover Memo Period 5 November 2015

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Memorandum

DATE: December 23, 2015

TO: El Camino Hospital Board of Directors

FROM: David Reeder, Hospital Board Liaison to the Foundation Board of Directors

SUBJECT: Report on Foundation Activities FY 2016 – Period 5

ACTION: For Information

During the months of October and November, the Foundation raised $871,569, bringing the total raised by the end of period 5 to $2,564,030. Year-to-date actual fundraising numbers are on par with our results in FY15 and $560,000 above where it was in FY14 at the end of November.

Upcoming Events

- *Norma's Literary Luncheon* – February 4, 2016 at Sharon Heights Golf & Country Club, benefiting the establishment of a women's heart program at the Norma Melchor Heart & Vascular Institute

- *Scarlet Night* – March 19, 2016 at Santa Clara Convention Center, celebrating the South Asian Heart Center's 10th anniversary and benefiting its expansion to more sites in the Bay Area

- *Sapphire Soirée* – May 21, 2016 at the Menlo Circus Club, benefiting ongoing patient-centered programs at the Cancer Center and featuring celebrity musical entertainment by the B-52s.

Att 30a.5 - ECHA Activity Report to ECH Board November 2015

El Camino Hospital Auxiliary
Activity Report to the Hospital Board
December 1, 2015

November Highlights:

- The Auxiliary proactively worked with the various Auxiliary services to ensure that their volunteers were properly trained on iCare.

- Members of the Escort Service (senior and junior) assisted the Patient Experience Team in supporting the hospital staff during the first couple of weeks of Go-Live. The Java Junction was open and operational on Go-Live Saturday to also support the staff during this transition.

- The Auxiliary "elves" completed the holiday decorating for 2015.

Att 30a.6 - ECHA Activity Report to ECH Board December 2015

El Camino Hospital Auxiliary
Activity Report to the Hospital Board
January 1, 2016

December Highlights:

- R J Salus, Director of Patient Experience attended the meeting and gave an update on the Auxiliary Task Force. He will follow up with Marc Trowbridge to resolve the training on iCare concerns brought to light by the Los Gatos volunteers.

- The major activity in which the Auxiliary participated was the decorating of the hospital for the holidays, both in Mountain View and Los Gatos.

- The Auxiliary continues to work on recruitment issues.

Att 30a.7 - Copy of ECHA membership report to ECH BOD-Meeting of January 13 2016

El Camino Hospital Auxiliary

Membership Report to the Hospital Board
Meeting of January 13, 2016

Combined Data as of November 30, 2015 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	439	-1 Relative to end of previous month
Dues Paid Inactive	93	(Includes Associates & Patrons)
Leave of Absence	19	
Subtotal	**551**	

Resigned in Month	4
Deceased in Month	1

Junior Members

Active Members	227	-1 Relative to end of previous month
Dues Paid Inactive	0	
Leave of Absence	4	
Subtotal	**231**	

Total Active Members	**666**
Total Membership	**782**

COMBINED AUXILIARY HOURS FROM INCEPTION (to November 30, 2015): 5,578,181
In Nov. 2015: 8,889
For FY 2016: 49,284

b. Executive Compensation Committee Report

ECH BOARD MEETING AGENDA ITEM COVER SHEET

Item:	Executive Compensation Committee Report El Camino Hospital Board of Directors January 13, 2016
Responsible party:	Jeffrey Davis, MD , Chair , Executive Compensation Committee
Action requested:	For Information

Background:

The Executive Compensation Committee meets 4 times per year, or more often if necessary. The Committee last met on November 17, 2015 and meets next on January 20, 2016.

Board Advisory Committee(s) that reviewed the issue and recommendation, if any:

None.

Summary and session objectives: To update the Board on the work of the Committee.

1. Progress Against Goals:

The Committee is on track to meet its goals for FY16.

2. Other FY: 16 Key Accomplishments Since Last Report To The Board:

The Committee appointed Bob Miller and Teri Eyre to serve on an Ad Hoc Committee to develop an Executive Compensation Consultant RFP. The RFP was approved by the Committee in November. Mr. Miller and Ms. Eyre will meet on January 7th to review the proposals and determine which proposals will be brought forward to the Committee for final consideration. The finalists will have an opportunity to meet with the Committee on January 20th and the Committee will make a selection.

Also in November, the Committee discussed the individual executive incentive goal setting process. That discussion will continue at its January meeting and the Committee hopes to bring forward a recommendation at a joint meeting with the Board in February or March, in time to implement for the FY17 executive incentive goals.

3. Important Future Activities

In March, the Committee will begin to address the executive performance review process and in June will bring forward annual base salary and incentive goal recommendations to the Board.

Suggested discussion questions:

None. This is a consent item.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

Proposed board motion, if any: None.
LIST OF ATTACHMENTS: None.

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Investment Committee Report

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Investment Committee Report El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	John Zoglin, Chair, Investment Committee
	Action requested:	For Information
	Background: The Investment Committee meets 4 times per year. The Committee last met on November 9, 2015 and meets next on February 8, 2016. We will also have a joint meeting with the Finance Committee on January 25, 2016 to discuss funding needs for capital projects.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives: To update the Board on the work of the Committee. **1. Progress Against Goals:** The Committee is on track to complete its FY16 Goals. **2. Other FY: 16 Key Accomplishments Since Last Report To The Board:** Completed education session on impact investing **3. Important Future Activities** At the February meeting, review current investment strategy of using active managers vs. Passive allocation. The review will include a comparison of the risk and returns under the two strategies. There is also be a joint meeting of the investment and finance committees in January to confirm align of the investment philosophy with capital and cash flow needs	
	Suggested discussion questions: None. This is a consent item.	
	Proposed board motion, if any: None.	
	LIST OF ATTACHMENTS: None.	

d. Advisory Committees' Progress Against FY16 Goals

ECH BOARD MEETING AGENDA ITEM

	Item:	Board Advisory Committees Progress Against FY16 Goals El Camino Hospital Board of Directors January 13, 2016
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	Information
	Background: In June of every year the Board approves goals set by each of its Advisory Committees for the following fiscal year, and in January the Board is provided with a status report regarding completion.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None	
	Summary and session objectives : Objective: To inform the Board regarding the Advisory Committees' progress. Summary: With only one exception, each Committee has completed or is on track to complete FY16 Goals. The Executive Compensation Committee will discuss its 3rd goal regarding Executive Performance Review and Development at its next meeting.	
	Proposed board motion: None. This item is for information.	
	LIST OF ATTACHMENTS: FY 16 Advisory Committee Goals	

Att 30d.2 - Progress_ FY2016 Goals Finance Committe_ 1 13 16

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FINANCE COMMITTEE
FY 2016 GOALS
Progress as of January 13, 2016

Purpose

The purpose of the Finance Committee is to provide oversight, information sharing and financial reviews related to budgeting, capital budgeting, long-range financial planning and forecasting, and monthly financial reporting for El Camino Hospital Board of Directors. In carrying out its review, advisory and oversight responsibilities, the Finance Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

Staff: Iftikhar Hussain, CFO

The CFO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the executive team may participate in the Committee meetings upon the recommendation of the CFO and subsequent approval from the Committee Chair. The CEO is an ex-officio of this Committee.

Goals	Planned Timeline (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	Metrics
1. Review Results of Premier Assessment	▪ Q1 – Completed in Q2	▪ *Present results to Finance Committee and Board of Directors*
2. Review Capital Projects in Progress	▪ Q3 – On Track – to be presented at January 2016 meeting	▪ *Update on capital projects in progress that exceed $2.5M*
3. Evaluate 2nd Round of Bond Issuance	▪ Q2 – On Track. Bond information presented at November 2015 meeting. Further information to be presented in January or March 2016 ▪ KPI's to be discussed at January 2016 meeting	▪ *Presentation for a possible Spring 2016 for Revenue Bonds or Fall 2016 for GO Bonds* ▪ *Develop KPIs for outpatient services*

Goals	Planned Timeline (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	Metrics
4. Provide education to Finance Committee and Board – External Trends in Healthcare Industry	▪ Q4 – On track, paced for May 2016 meeting.	▪ *Presentation to Finance Committee and Board on employer provided health insurance trends*

Submitted by:

Dennis Chiu - Chair, Finance Committee
Iftikhar Hussain - Executive Sponsor, Finance Committee

Approved by the Board of Directors August 12, 2015

Att 30d.3 - Progress_ECH Corp. Comp Cmte Goals FY16_ 1.13.16

Corporate Compliance/Privacy and Audit Committee
Goals FY 2016
Progress to Complete as of January 13, 2016

Purpose

The purpose of the Corporate Compliance/Privacy and Audit Committee ("Compliance and Audit Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its exercise of oversight by monitoring the compliance policies, controls and processes of the organization and the engagement, independence and performance of the internal auditor and external auditor. The Compliance and Audit Committee assists the Board in oversight of any regulatory audit and in assuring the organizational integrity of ECH in a manner consistent with its mission and purpose.

Staff: Diane Wigglesworth, Director of Corporate Compliance

The Director, Corporate Compliance/Privacy and Audit Committee shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chairs consideration. Additional members of the executive team or outside consultants may participate in the Committee meetings upon the recommendation of the Director, Corporate Compliance/Privacy and Internal Audit Committee and at the discretion of the Committee Chair.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics of Success Achieved
▪ Review and evaluate Hospitals audit plan for EPIC system access	▪ Q1 2016 – Complete	▪ Committee reviews and approves plan.
▪ Review Enterprise Risk Management reporting tools and plan for continuous monitoring	▪ Q3 2016 – On Track. Committee to review and make risk tolerance recommendation to Board in Q3 followed by recommendation for ERM monitoring plan in Q4.	▪ Committee reviews ERM reporting tools and monitoring plan quarterly and then recommends a final version to the Hospital Board for approval by March 2016.
▪ Review post EPIC IT security review and recommendations	▪ Q4 2016 – On Track to complete in Q4	▪ Committee reviews post EPIC IT security review and recommendations.

Submitted by:
John Zoglin, Chair, Corporate Compliance/Privacy and Compliance Committee
Diane Wigglesworth, Executive Sponsor, Corporate Compliance/Privacy and Compliance Committee

Att 30d.4 - Progress_ECH Gov Cmte Goals FY16_1.13.16

Governance Committee
Goals for FY 2016
Progress as of January 13, 2016

Purpose

The purpose of the Governance Committee ("Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition, i.e., the nomination and appointment/reappointment process. The Governance Committee ensures the Board and Committees are functioning at the highest level of governance standards.

Staff: Tomi Ryba, CEO

The CEO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the executive team or outside consultants may participate in the Committee meetings upon the recommendation of the CEO and at the discretion of the Committee Chair.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
▪ Review the governance structure of the Hospital Board, conduct research and make recommendations on preferred competencies.	▪ Q1 FY 2016 – Complete	▪ Recommendation for high-priority Board member competencies made to Hospital Board and District Board. ▪ Participate in Non-District Board Member recruitment/interview process as requested by the District Board.
▪ Promote Enhanced and Sustained Competency Based Effective Governance	▪ Q1 – Q4 FY 2016 – Ongoing: Board and Committee Self-Assessment in progress. Discussions regarding Board Processes Work and competency based effective governance paced for March 2016.	▪ FY 16 Self- Assessment Tool Recommended to the Board and Survey Completed ▪ Reports are completed and made available to the Board and the District Board – Q4 ▪ Monitor Effectiveness of Board Processes Work (Via Consulting)

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
▪ Develop Board and Committee Education Plan for FY 2016	▪ Q1 – Q2 FY 2016 - Complete	▪ Recommend Annual Retreat Agenda to the Board – Q2 ▪ Make Recommendation Regarding Conference Attendance for the Full Board – Q1
▪ Ensure Advisory Committee Composition and Member Competencies are Adequate to Support the Board.	▪ Q2 FY2016 - Complete	▪ Review Advisory Committee Composition and Make Recommendations to the Board regarding skill gaps - Q2

Submitted by:

David Reeder, Chair, Governance Committee
Tomi Ryba, Executive Sponsor, Governance Committee

Att 30d.5 - Progress_Exec Comp Cmte Goals FY16_1.13.16

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Executive Compensation Committee
Goals for FY 2016

Progress as of Janaury 13, 2016

Purpose

The purpose of the Executive Compensation Committee ("Compensation Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Compensation Committee shall advise the Board to meet all applicable legal and regulatory requirements as it relates to executive compensation.

Staff: Kathryn Fisk, Chief Human Resources Officer and Julie Johnston, Director HR Compensation and Benefits

The Chief HR Officer and Director HR Compensation and Benefits shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may attend meetings at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing his/her compensation. The CEO is an ex-officio of this Committee.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
1. Oversee the implementation of the policy changes approved by the Board ensuring strategic alignment and proper oversight of compensation-related decisions.	Q2 – October Board meeting - Complete Q3 – January Board meeting - Complete Q4 – June Board meeting – On Track Q4 – June Board meeting – On Track	• Recommend FY15 performance incentive payouts. Complete. • Recommend acceptance of the letter of rebuttable presumption of reasonableness. Complete • Review and recommend FY17 organizational and individual goals for the Executive Performance Incentive Plan • Recommend FY17 Base Salaries

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
2. Evaluate the effectiveness of the Executive Compensation and Benefit compensation and benefit plan design.	Q3 – Committee selects consultant and defines scope of work (i.e., peer group, market position, incentive plan design, base salary administration, goal-setting and performance review process) – On Track Q4 – Committee receives report from Consultant and discusses findings and recommendations. Committee develops FY17 Committee goals based on results and discussion to better align with strategies and Board's direction. On track.	• Conduct an RFP to select Executive Compensation and Benefits Consultant • Continue reviewing long-term strategy and goals and how the executive program supports their achievement. • Consultant completes comprehensive market analysis of pay and benefit practices and presents recommendations for consideration
3. Evaluate the effectiveness of the executive performance review process and the annual/biannual cycle that includes self-assessment, stakeholder feedback, talent profiling, and executive leadership development.	Q1 – Receive summary report regarding FY 15 executive performance reviews – Not Complete Q4 – Recommend changes to the annual review process to CEO/CHRO Q3 – Receive report Q4 – Receive report regarding 360 review process and/or pulse check results This will be discussed at January 20th meeting and plan for completion will be addressed.	• Executive Performance Reviews • Succession Planning and Leadership Development • 360 Review/Stakeholder feedback

Submitted by:
Nandini Tandon, PhD, Chair, Executive Compensation Committee
Kathryn Fisk and Julie Johnston, Executive Sponsors, Executive Compensation Committee

Att 30d.6 - Progress_ECH Inv Cmte Goals FY16_1.13.16

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

INVESTMENT COMMITTEE

Goals for FY 2016 - Progress as of January 13, 2016

Purpose

The purpose of the Investment Committee is to develop and recommend to El Camino Hospital Board of Director the investment policies governing the Hospital's assets, maintain current knowledge of the management and investment of the invested funds of the Hospital, and provide oversight of the allocation of the investment assets.

Staff: Iftikhar Hussain, CFO

The CFO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the hospital staff may participate in the Committee meetings upon the recommendation of the CFO and subsequent approval from the Committee Chair. The CEO is an ex-officio member of this Committee.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	Metrics
1. Review performance of consultant recommendations of managers and asset allocations.	▪ Each quarter –Ongoing	▪ Investment Committee to review selection of money managers; recommendations are made to CFO
2. Review current investment strategy of using active managers vs. passive allocation.	▪ Q3 – Committee to review at February 2016 meeting	▪ Recommend to the Board by December 2015 (Recommendation will be brought to the Board in March 2016)
3. Educate Board and Committee on trends regarding environment, social, and governance (socially responsible investing).	▪ Q1- Completed at November meeting for the Committee.	▪ To be completed by September 2015
4. Review/revise Executive Dashboard.	▪ Each quarter - Ongoing	▪ To be completed by June 2016
5. At least once a year meet with the Finance Committee to help align investment philosophy with capital and cash flow needs.	▪ No later than Q4 – On track, scheduled for January 2016.	▪ To be completed by Q4

Submitted by: Iftikhar Hussain, Executive Sponsor, Investment Committee

Board Approved – June 10, 2015

Att 30d.7 - Progress_Quality Cmte Goals FY16_ 1.13.16

Quality, Patient Care and Patient Experience Committee
Goals for FY 2016
Progress as of January 13, 2016

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Quality Committee helps to assure that exceptional patient care and patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

Staff: Eric Pifer, MD, CMO

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff, VP of Patient Care Services, physicians, nurses, and members from the Community Advisory Councils or the community-at-large. The CEO is an ex-officio of this Committee.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
1. Review the hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care and Patient Experience Committee.	▪ Q1 – Metrics for FY16 - Complete ▪ Q3 – Goals for FY17 – On Track. Paced to begin in February 2016 and Complete by April 2016.	▪ Review, complete and provide feedback given to management, the governance committee and the board.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
2. Work with the hospital management team to develop a plan for patient centered care. Plan should include the following elements: • Metrics • Standards • Vision • Best Practices • Sponsor at least one site visit to an organization very advanced in transformation of care to be more patient centric. • Review organizations quality improvement plan • Incorporate patient centered care plan into overall plan.	▪ Q3 – Will begin to develop and pace specific plan. ▪ Q4	▪ Review, complete and provide feedback given to management and the board.
3. Biannually review peer review process and medical staff credentialing process.	▪ Every other year Credentialing Process Reviewed in FY15 Peer Review Paced for February 2016	
4. Develop a plan to review exceptions for goals that are being monitored by the management team and report those exceptions to the El Camino board of directors.	▪ Q3 – Exception Report for FY16 Completed in Q1. Will review and update beginning in March for FY17	

Submitted by:
Dave Reeder, Chair, Quality Committee
Eric Pifer, MD, Executive Sponsor, Quality Committee