El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS
Wednesday, April 12, 2017 – 5:30 pm
Conference Rooms E, F & G (ground floor)
2500 Grant Road, Mountain View, CA 94040

Lanhee Chen will be participating via videoconference from 10326 Strathmore Dr. Los Angeles, CA 90024.

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**	Neal Cohen, MD, Board Chair		**5:30 – 5:32 pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Neal Cohen, Board Chair		**5:32 – 5:33**
3.	**BOARD RECOGNITION** *Resolution 2017-04* The Board will recognize individual(s) who enhance the experience of the Hospital's patients and the community. **ATTACHMENT 3**	Lane Melchor, Chair, ECH Foundation Board of Directors	*public comment*	**motion required** **5:33 – 5:38**
4.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 4**	David Reeder, Quality Committee Chair		**information** **5:38 – 5:43**
5.	**FY17 PERIOD 8 FINANCIALS** **ATTACHMENT 5**	Iftikhar Hussain, CFO	*public comment*	**motion required** **5:43 – 5:53**
6.	**EMERGENCY PREPAREDNESS** **ATTACHMENT 6**	Ken King, CASO		**information** **5:53 – 6:13**
7.	**GOVERNANCE COMMITTEE REPORT** a. Biennial Board Officer Election Procedure b. Board Director Compensation Policy **ATTACHMENT 7**	Peter Fung, MD, Governance Committee Chair	*public comment*	**possible motion(s)** **6:13 – 6:33**
8.	**INVESTMENT COMMITTEE REPORT** **ATTACHMENT 8**	John Zoglin, Investment Committee Chair		**information** **6:33 – 6:38**
9.	**COMPLIANCE COMMITTEE REPORT** **ATTACHMENT 9**	John Zoglin, Compliance Committee Chair		**information** **6:38 – 6:42**
10.	**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	Neal Cohen, MD, Board Chair		**information** **6:42 – 6:45**
11.	**ADJOURN TO CLOSED SESSION**	Neal Cohen, MD, Board Chair		**motion required** **6:45 – 6:46**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Neal Cohen, MD, Board Chair		**6:46 – 6:47**

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
13.	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Special Meeting to Conduct a Study Session (March 3, 2017) b. Minutes of the Closed Session of the Special Meeting to Conduct a Study Session (March 4, 2017) c. Minutes of the Closed Session of the Hospital Board Meeting (March 8, 2017) ***Reviewed and Approved by the Executive Compensation Committee*** d. Minutes of the Closed Session of the Executive Compensation Committee Meeting (February 16, 2017) ***Information*** *Health & Safety Code 32106(b)* for a report involving health care facility trade secrets*:* e. FY18 Budget Assumptions	Neal Cohen, MD, Board Chair		**motion required** **6:47 – 6:50**
14.	*Health and Safety Code Section 32155*, Report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Report	Rebecca Fazilat, MD, Mountain View Chief of Staff; J. Augusto Bastidas, MD, Los Gatos Chief of Staff		**motion required** **6:50 – 7:00**
15.	Discussion involving *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets: - Primary Care Physician Replacement for Silicon Valley Primary Care Clinic	William Faber, MD, CMO		**discussion** **7:00 – 7:10**
16.	Discussion involving *Gov't Code Section 54956(d)(2)* – conference with legal counsel – pending or threatened litigation: - Compliance Committee Report	John Zoglin, Compliance Committee Chair		**information** **7:10 – 7:15**
17.	Discussion involving *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets: - Semi-Annual Marketing KPI Report	Kelsey Martinez, Director, Marketing & Communications		**discussion** **7:15 – 7:30**
18.	Discussion involving *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets: - Strategic Planning Update	Jonah Frohlich, Managing Director, Manatt		**discussion** **7:30 – 7:55**
19.	Discussion involving *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets: - Annual Board Self-Assessment and Board Chair Assessment	Peter C. Fung, MD, Governance Committee Chair		**discussion** **7:55 – 8:10**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
20.	Discussion involving *Health and Safety Code 32106(b)* for report involving health care facility trade secrets: - Pacing Plan	Neal Cohen, MD, Board Chair		**information** **8:10 – 8:15**
21.	Discussion involving *Gov't Code Section 54957* and *54957.6* for report and discussion on personnel matters and *Health and Safety Code 32106(b)* for report involving health care facility trade secrets: - CEO Search Committee Report	Lanhee Chen, CEO Search Committee Chair		**discussion** **8:15 – 8:25**
22.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters: - Executive Session	Neal Cohen, MD, Board Chair		**discussion** **8:25 – 8:30**
23.	**ADJOURN TO OPEN SESSION**	Neal Cohen, MD, Board Chair		**motion required** **8:30 – 8:31**
24.	**RECONVENE OPEN SESSION / REPORT OUT**	Neal Cohen, MD, Board Chair		**8:31 – 8:32**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
25.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Neal Cohen, MD, Board Chair	*public comment*	**motion required** **8:32 – 8:34**
	Approval a. Minutes of the Open Session of the Special Meeting to Conduct a Study Session (March 3, 2017) b. Minutes of the Open Session of the Special Meeting to Conduct a Study Session (March 4, 2017) c. Minutes of the Open Session of the Hospital Board Meeting (March 8, 2017) ***Reviewed and Approved by the Executive Compensation Committee*** d. Minutes of the Open Session of the Executive Compensation Committee Meeting (February 16, 2017) e. Appointment of Committee Member ***Reviewed and Approved by the Finance Committee*** f. SVPMG Physician Recruitment – Medical Oncology g. General Surgery ED Call Panel (MV) h. Medical Director, Quality & Physician Services i. Capital Funding Request – Women's Hospital Expansion Incremental Funding j. Capital Funding Request – LG Facility Improvement Project k. FY17 Period 7 Financials ***Reviewed and Approved by the Medical Executive Committee*** l. Medical Staff Report			

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	Reviewed and Approved by the Quality, Patient Care, and Patient Experience Committee			
m.	Policies with Minor Revisions			
	Information			
n.	Capital Project Status Update			
26.	**APPROVAL OF PRIMARY CARE PHYSICIAN REPLACEMENT FOR SILICON VALLEY PRIMARY CARE CLINIC**	William Faber, MD, CMO	*public comment*	**possible motion 8:34 – 8:36**
27.	**INFORMATIONAL ITEMS** a. CEO Report	Neal Cohen, MD, Board Chair		**information 8:36 – 8:37**
28.	**BOARD COMMENTS**	Neal Cohen, MD, Board Chair		**information 8:37 – 8:39**
29.	**ADJOURNMENT**	Neal Cohen, MD, Board Chair		**motion required 8:39 – 8:40 pm**

Upcoming Regular Meetings

- May 10, 2017
- June 14, 2017
- June 28, 2017

Upcoming Joint Meetings

- May 30, 2017 (*Joint with Finance Committee*)
- June 14, 2017 (*Joint with Compliance Committee*)

EL CAMINO HOSPITAL BOARD

RESOLUTION 2017 - 04

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 and acknowledge Priyanka Rana and Simran Thadani for co-chairing the Scarlet Masquerade, the annual gala for the South Asian Heart Center at El Camino Hospital.

Last fall, key stakeholders from the South Asian Heart Center and El Camino Hospital Foundation engaged in a strategic planning session to discuss the Center's annual gala, the case for support, and the role of the newly created Philanthropy Council. One of the more significant outcomes was the decision to change the gala's format. The event had always been held at a convention center with upwards of 600 attendees paying $200 to $500 per person. There was now a desire to provide an event for those dedicated to raising their paddles in support of the South Asian Heart Center, and to also change the pricing structure.

Priyanka and Simran, leading an energetic gala committee, implemented a new tiered pricing plan with tickets ranging from $350 to $550 per person. The event sold out immediately. On March 18, 2017, 304 attendees gathered at The Mountain Winery to hear about the Center's life-changing mission and plans to leverage the world's largest research cohort of young, healthy South Asians. Guests bid on live auction items, raised paddles for the Top Hearts fund-in-need appeal, and celebrated with a performance by Violinder, which was followed by dancing.

The event raised more than $304,000, which is the highest yield on record. The most significant financial impact came from the live auction and Top Hearts paddle raise. Last year, the gala secured $117,000 from 97 attendees, a 17 percent participation rate. This year, it secured $136,000 from 57 attendees, a19 percent participation rate from event attendees. Best practice in participation at a gala is typically in the range of 10 percent.

WHEREAS, the Board would like to publically acknowledge Priyanka and Simran for their dedication and commitment as loyal volunteers of El Camino Hospital Foundation and the South Asian Heart Center.

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

Priyanka Rana and Simran Thadani

FOR THEIR COMMITMENT TO ENSURE COMPASSIONATE CARE CONTINUES FOR ALL PARTICIPANTS WHO TURN TO THE SOUTH ASIAN HEART CENTER AT EL CAMINO HOSPITAL.

IN WITNESS THEREOF, I have here unto set my hand this **12TH DAY OF APRIL, 2017.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

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

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

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Quality, Patient Care and Patient Experience Committee ("Quality Committee") Report El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	David Reeder, Quality Committee Chair
	Action requested:	For Information
	Background: The Quality Committee meets 10 times per year. The Committee last met on April 3, 2017 and meets next on May 1, 2017.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None.	

Summary and session objectives:

1. **Progress Against Goals:** The Committee is on track to achieve its FY17 targets.
2. **Summary of February 27, 2017 Meeting:**
   a. Clinical Program Presentation: Terry Rutledge, Executive Director of Ortho/Neuro/Spine, introduced Pamela Coye, RN and Debbie Smyth, RN to the Committee and updated the Committee on the accomplishments, programs, and initiatives of the Service Line. El Camino provides state-of-the-art anterior hip replacement and excellent post-operative pain control. The team highlighted the program's quality metrics (which are better than national norms on hip and knee replacement) and the Joint Commission's recent recertification of ECH's disease-specific programs in Total Joint Replacement in Mountain View and Los Gatos, Hip Fracture in Mountain View, and Spinal Fusion in Los Gatos.
   b. FY17 Quality Dashboard: Catherine Carson, Senior Director of Patient Safety and Quality Assurance reviewed the newly annotated FY17 quality dashboard with the Committee. She reported that eight metrics remain stable. Surgical Site Infections, Communication with Nurses, and Responsiveness of Staff show room for improvement. Ms. Carson discussed improvement plans for these areas. The Committee engaged in a robust conversation about the opioid epidemic and recognized that inpatient responsiveness to acute, self-limiting pain is a different matter than outpatient management of chronic pain with opioids. Measures to protect ECH inpatients from over-dosage were reviewed.
   c. Proposed FY18 Committee Dates/Goals: The Committee voted to recommend approval of the proposed FY18 Committee Dates and Goals.
   d. Proposed FY 18 Organizational Goals: William Faber, MD, CMO, presented the Draft FY18 Organizational Goals to the Committee and reviewed each goal along with the benchmark, 2017 ECH baseline, minimum, target, and maximum metrics. The proposed efficiency goal is reduction of the ratio of average length of stay over mean length of

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	stay, which takes the acuity of patients into account. The proposed patient experience goal reinstitutes HCAHPs metrics, and the quality goal will be focused on improving the institutional culture of safety, measured by a monthly focused survey. Recommendations for FY18 Organizational Goals will be finalized at the May 1st meeting. e. Red or Orange Alerts/Serious Safety Event (Red Alert) Policy: There was no new serious safety events or applicable updates. A preliminary draft of an updated Serious Safety Event Policy was discussed. The Committee feedback will be incorporated and reviewed at the May 1st meeting.
	Suggested discussion questions: None.
	Proposed Board motion, if any: None.
	LIST OF ATTACHMENTS: 1. FY17 Quality Dashboard

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Quality and Safety Dashboard (Monthly)

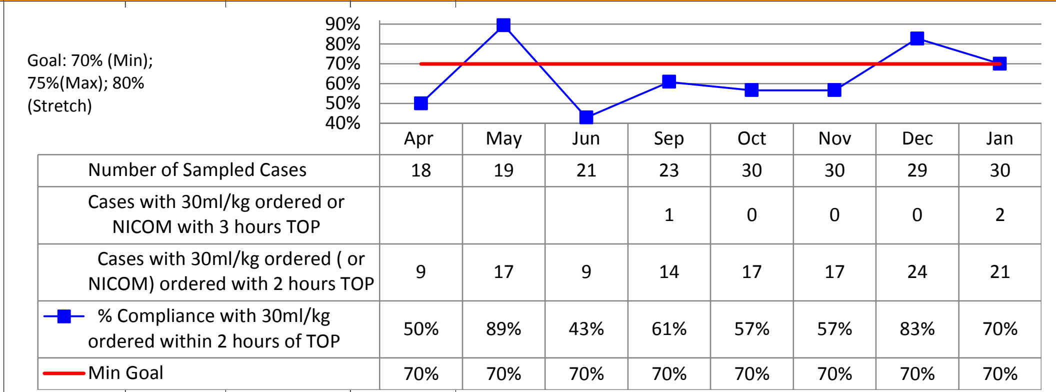
Date Reports Run: 3/12/2017				Baseline	FY17 Goal	Trend	Comments
SAFETY EVENTS		Performance		FY2016	FY2017		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: January 2017*	9/6157	1.46	1.51	1.39 (goal for FY 16)		Rate of falls dropped in January with increased census. Still a volatile measure.
2	★Organizational Goal **Pain reassessment within 60 mins after pain med administration** *Date Period: February 2017*	8136/9636	84.4%	56.3% (Jan-Jun 2016)	75% (min) 80% (mid) stretch goal=90%		Changes made in ED iCare documentation with improved compliance. Trend of continued improvement since October with weekly reporting and feedback.
3	**Medication Errors (Overall: reached to patients and near miss)** *Errors / 1000 Adj Total Patient Days* *Date Period: January 2016*	29/13269	2.19	2.68	0.00		6 data points below the mean indicates a positive trend in the reduction of medication errors.
EFFICIENCY		Performance		Jan-Jun 2016 (6-month avg)	FY 2017		
4	★Organizational Goal **Average Length of Stay (days)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Date Period: February 2017*	FYTD 3420 / Feb 2017 437	FYTD 4.58 / Feb 2017 4.65	4.78	4.87		The increase in inpatient volume in Dec/Jan contributes to a reduction in average LOS
5	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: January 2017*	FYTD 329/2944 / Jan 2017 60/516	FYTD 11.18 / Jan 2017 11.63	11.53	At or below 12.24		The readmission rate continues near the target of 12.24, and ECH is noted to have the lowest 30 readmit rate among local hospitals.

Date Reports Run: 3/12/2017		Baseline	FY17 Goal	Trend	Comments

6 ★Organizational Goal

IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock (Patients lacking initial hypotension or lactate <3 excluded)

Date Period: January 2017

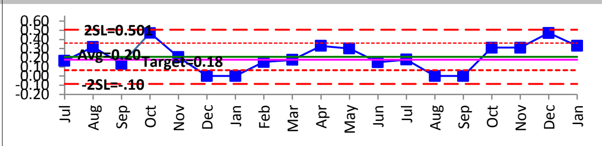


Goal: 70% (Min); 75%(Max); 80% (Stretch)

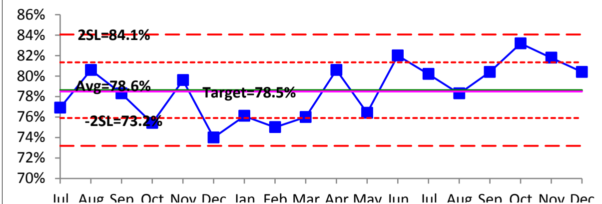
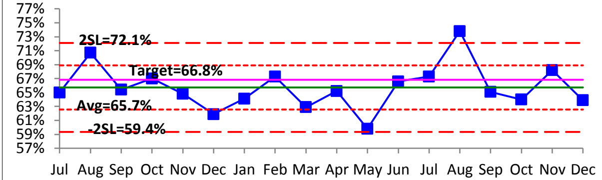
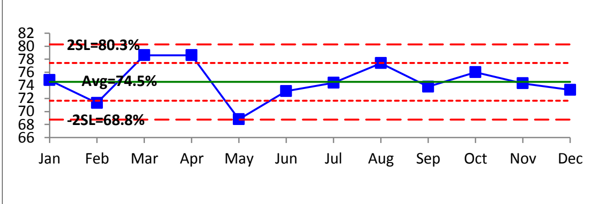
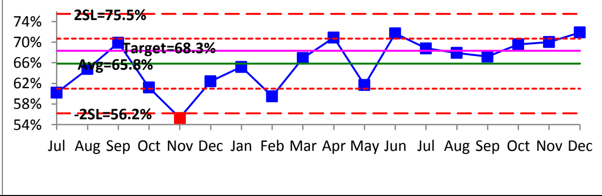
	Apr	May	Jun	Sep	Oct	Nov	Dec	Jan
Number of Sampled Cases	18	19	21	23	30	30	29	30
Cases with 30ml/kg ordered or NICOM with 3 hours TOP				1	0	0	0	2
Cases with 30ml/kg ordered (or NICOM) ordered with 2 hours TOP	9	17	9	14	17	17	24	21
% Compliance with 30ml/kg ordered within 2 hours of TOP	50%	89%	43%	61%	57%	57%	83%	70%
Min Goal	70%	70%	70%	70%	70%	70%	70%	70%

Number of Sepsis cases in January all time high of 167 due to Flu cases. Decrease in this metric due to 2 cases in which adequate fluid was ordered within 3 hrs of TOP - not the required 2 hrs. The use of NICOM device to measure suseptibility to fluid resuscitation increased to 30%. The Sepsis Core measure data result was up to 71% - top 10% in the U.S according to S.Townsend, MD (Surving Sepsis)

COMPLICATIONS

#	Measure	Performance		FY 2016	FY 2017	Trend	Comments
7	**Surgical Site Infection (SSI)** *SSI per 100 Surgical Procedures* *Date Period: January 2017*	3/606	0.33	0.20	0.18 (goal for FY 16)		2 SSI in Jan: 1 total knee and one lumbar fusion both at Los Gatos. SSI Task Force working w/surgeons and OR staff to address infections.

SERVICE

#	Measure	Performance		FY 2016	FY 2017	Trend	Comments
8	**Communication with Nurses** *(HCAHPS composite score, top box)* *Date Period: Dec 2016*	240/299	80.4%	78.0%	78.5%		Results are beginning to trend down, and a continued focus on bedside handoff, manager rounding, and hourly rounding by nursing staff. Increased use of travel and registry nurses.
9	**Responsiveness of Hospital Staff** *(HCAHPS composite score, top box)* *Date Period: Dec 2016*	178/279	63.9%	64.9%	66.8%		Hourly rounding and nurse managaer rounding continues. Flu season was ramping up during the month of December, and we lost some group in January. High census and boarding some pts. in the ED. Expect to the HCAHPS to follow.
10	★Organizational Goal **Pain management** (HCAHPS composite score, top box) *Date Period: Dec 2016*	122/166	73.3%	72.5%	73% min 74% max 76% stretch		Focus on pain management continues for ECH, and the reassessmenet compliance continues to improve. We expect HCAHPS to follow.
11	**Communication About Medicines** *(HCAHPS composite score, top box)* *Date Period: Dec 2016*	142/198	71.9%	64.7%	68.3%		We continue to support the M3 visual cue program on all th eunits which prompts the nurse and patient to discuss the purpose and side effects of medications. Nurses also are discussing pain management medications more frequently with the reassessment which is also helping to improve this score.

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Summary of Financial Operations

Fiscal Year 2017 – Period 8
7/1/2016 to 2/28/2017

Dashboard - ECH combined as of February 28, 2017[2]

	Annual					Month			YTD		
	2014	2015	2016	2017 Proj.	2017 Bud/Target	PY	CY	Bud/Target	PY	CY	Bud/Target
Volume											
Licenced Beds	443	443	443	443	443	443	443	443	443	443	443
ADC	238	246	242	236	245	268	245	262	241	236	244
Adjusted Discharges	22,206	22,342	22,499	22,980	22,992	1,692	1,915	1,824	14,699	15,320	15,346
Total Discharges	19,427	19,637	19,367	19,422	19,781	1,543	1,565	1,587	12,787	12,948	13,199
Inpatient Cases											
MS Discharges	12,883	13,114	13,344	13,359	13,499	1,058	1,106	1,083	8,706	8,906	9,003
Deliveries	5,140	5,067	4,717	4,664	4,810	376	356	386	3,128	3,109	3,208
BHS	857	901	806	924	901	67	68	73	623	616	607
Rehab	547	555	500	476	570	42	35	46	330	317	380
Outpatient											
ED	46,056	49,130	49,927	47,702	51,258	4,234	3,917	4,110	32,446	31,801	34,186
Procedural Cases											
OP Surg	6,444	6,479	6,053	6,552	6,427	436	546	515	4,082	4,368	4,287
Endo	2,492	2,520	2,322	2,150	2,479	167	184	199	1,534	1,433	1,653
Interventional	1,706	1,878	1,970	1,988	2,323	138	142	186	1,348	1,325	1,549
All Other	69,458	68,052	79,656	80,867	84,566	6,706	6,657	6,782	52,820	53,912	56,400
Financial Performance ($000s)											
Net Revenues	721,123	746,645	772,020	804,790	789,585	57,800	63,665	63,167	499,606	536,527	518,133
Operating Expenses	669,680	689,631	743,044	731,293	764,828	60,668	61,657	61,515	490,791	487,529	502,106
Operating Income $	70,305	78,120	52,613	99,343	49,817	-795	3,803	3,738	24,888	66,229	32,726
Operating Margin	*9.5%*	*10.2%*	*6.6%*	*12.0%*	*6.1%*	*-1.3%*	*5.8%*	*5.7%*	*4.8%*	*12.0%*	*6.1%*
EBITDA $	125,254	128,002	108,554	152,823	109,890	4,046	8,192	8,809	60,294	101,882	71,030
EBITDA %	*16.9%*	*16.7%*	*13.6%*	*18.4%*	*13.5%*	*6.8%*	*12.5%*	*13.5%*	*11.7%*	*18.4%*	*13.3%*
IP Margin [1]	*-3.2%*	*-3.9%*	*-8.7%*	*-6.9%*	*-6.1%*	*-15.9%*	*-15.4%*	*-6.1%*	*-11.6%*	*-6.9%*	*-6.1%*
OP Margin [1]	*25.2%*	*26.7%*	*26.7%*	*32.8%*	*26.4%*	*17.7%*	*29.0%*	*26.4%*	*25.0%*	*32.8%*	*26.4%*
Payor Mix											
Medicare	44.6%	46.2%	46.6%	47.6%	46.4%	49.2%	51.2%	46.4%	45.4%	47.6%	46.4%
Medi-Cal	6.0%	6.6%	7.4%	7.3%	6.5%	7.2%	7.5%	6.5%	7.7%	7.3%	6.5%
Commercial IP	25.4%	24.2%	23.2%	22.5%	24.0%	22.2%	20.6%	24.0%	24.1%	22.5%	24.0%
Commercial OP	18.6%	18.7%	18.7%	20.1%	19.0%	19.1%	18.2%	19.0%	19.9%	20.1%	19.1%
Total Commercial	44.0%	42.9%	41.9%	42.6%	43.0%	41.3%	38.8%	43.0%	44.0%	42.6%	43.1%
Other	5.4%	4.3%	4.1%	2.5%	4.1%	2.3%	2.5%	4.1%	2.9%	2.5%	4.1%
Cost											
Employees	2,435.6	2,452.4	2,542.8	2,484.0	2,556.4	2,559.7	2,515.0	2,623.5	2,609.8	2,484.0	2,556.4
Hrs/APD	29.31	30.45	30.35	30.23	30.82	30.62	29.17	29.33	30.79	30.23	30.82
Balance Sheet											
Net Days in AR	50.9	43.6	53.7	49.0	48.0	53.7	49.0	48.0	53.7	49.0	48.0
Days Cash	382	401	361	408	266	361	408	266	361	408	266
Debt to Capitalization	12.6%	13.6%	13.8%	12.8%	17.3%	13.8%	12.8%	17.3%	13.8%	12.8%	17.3%
MADS	9.5	8.9	6.1	15.5	9.3	6.1	15.5	9.3	6.1	15.5	9.3
Affiliates - Net Income ($000s)											
Hosp	118,906	94,787	43,043	143,102	67,032	(4,881)	8,479	4,467	(12,196)	95,401	38,557
Concern	1,862	1,202	1,823	1,504	2,604	215	274	257	1,588	1,003	1,697
ECSC	**(5)**	**(41)**	**(282)**	(90)	0	(4)	(6)	0	13	(60)	0
Foundation	3,264	710	982	3,068	(450)	14	371	(47)	(320)	2,046	(314)
SVMD	32	106	156	241	0	(1)	(30)	7	(13)	160	1,097

(1) Due to timing of month end costing, In Patient and Out Patient Operating Margin % for FYTD 2017 are one month in arrears

(2) Green - Equal to or better than budget

Yellow - Unfav vs budget by up to 5%

Red - Greater than 5% unfav variance from budget

***Inpatient Volume*:**

- February inpatient discharges exceed budget and PY; YTD discharge budget gap is 1.9%
- YTD General Medicine is higher than budget by 2.6%, as well as Cardiovascular by 2.3% and Spine Surgery 7.9%. Deliveries are down by 3.1% and rehab cases are also down by 16.7% due to total cost of care effort to reduce the lower acuity cases.

Outpatient Volume:

- Overall YTD outpatient volume is 5.3% below budget but higher than PY.
- Total ED visits including admission are flat with prior year even though OP ED cases are down.
- The OP Surgery is 1.9% higher than budget and 7% higher than last year.
- OP Oncology remains strong with 8.6% higher than budget.

***Operating Income*:**

- Operating Income was ahead of budget by $65k for the month and $33.5M YTD.
- February results are at budget despite lower volume due to higher mix of surgical volume.
- Payor Mix slightly improved from January from 38.8% to 40.4%, but still under budget due to higher Medicare general medicine cases during flu season.
- Feb Unusual Items we include $947k in Mcare settlement for FY16 and $143K in RAC Release
- Net days in AR remained the same for February at 49 days.
- Total cash on hand is still at an all time high of 408 days in Feb.
- February results for MV and LG include a $3 million correction to move net revenue to LG. No impact on combined net revenue

El Camino Hospital
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Budget Variances

$ in Thousands		Month to Date (MTD)			Year to Date (YTD)		
		Detail	Net Income Impact	% Net Revenue	Detail	Net Income Impact	% Net Revenue
	Net Revenue (FY2017 Budget/FY2017 Actual)	65,253	65,460		534,832	553,757	
Budgeted Hospital Operations FY2017			**3,738**	**5.7%**		**32,726**	**6.1%**
Net Revenue			207	0.3%		18,926	3.4%
*	Rev cycle improvements	(1,123)			12,608		
*	Medi-Cal Supplemental	240			1,366		
*	Mcare Settlement	947			1,264		
*	Prime Medi-Cal	0			3,510		
*	RAC Release	143			178		
Labor and Benefit Expense Change			(892)	-1.4%		8,902	1.6%
*	Improve Productivity & flexing down staffing during holidays	(892)			14,341		
*	Pay-for-Performance Bonus Accrual	0			(2,447)		
*	Repricing of PTO Bank	0			404		
*	Old employee WC settlement	0			(432)		
*	Ratification Bonus to PRN	0			(2,600)		
*	Severance Pay	0			(365)		
*	One time UH expense reduction	0			0		
Professional Fees & Purchased Services			275	0.4%		417	0.1%
*	Physician Fees	200			1,057		
*	Consulting Fee including LG Surgery Intrim Director, LG Rehab purchase sercice expense.	(69)			(1,484)		
*	Purchased Services mainly due to backfill for vacant IT positions	14			(2,181)		
*	Repairs and Maintenance Fees	130			3,024		
Supplies			(221)	-0.3%		2,940	0.5%
*	Drug Exp (due to higher Infusion Center volume; but offset by higher gross revenue)	(9)			(1,476)		
*	Medical Supplies	(250)			2,895		
*	Misc Net Supplies (Food/Volumes)	38			1,521		
Other Expenses			13	0.0%		(332)	-0.1%
*	Leases & Rental Fees (Rental Lease Costs)	42			(265)		
*	Utilities & Telephone (continue on routine PG&E accrual but no payment yet)	128			443		
*	Other G&A	(158)			(402)		
*	MD Income Guarantee forgiveness	0			(109)		
Depreciation & Interest			683	1.0%		2,651	0.5%
*	Depreciation (Ongoing depreciation on the Old 2nd & 3rd Fl & GL improvement projects)	679			2,488		
*	Interest Expense	4			163		
Actual Hospital Operations FY2017			**3,803**	**5.8%**		**66,229**	**12.0%**

El Camino Hospital ($000s)

8 month ending 2/28/2017

PERIOD 8 FY 2016	PERIOD 8 FY 2017	PERIOD 8 Budget 2017	Variance Fav (Unfav)	Var%	$000s	YTD FY 2016	YTD FY 2017	YTD Budget 2017	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
226,918	238,237	234,268	3,969	1.7%	Gross Revenue	1,805,926	1,957,450	1,921,399	36,051	1.9%
(169,118)	(174,572)	(171,101)	(3,471)	1.0%	Deductions	(1,306,320)	(1,420,923)	(1,403,266)	(17,658)	1.3%
57,800	**63,665**	**63,167**	**498**	**0.8%**	Net Patient Revenue	**499,606**	**536,527**	**518,133**	**18,393**	**3.5%**
2,073	1,795	2,086	(291)	-14.0%	Other Operating Revenue	16,073	17,231	16,698	533	3.2%
59,873	**65,460**	**65,253**	**207**	**0.3%**	Total Operating Revenue	**515,679**	**553,757**	**534,832**	**18,926**	**3.5%**
					OPERATING EXPENSE					
35,733	37,928	37,036	(892)	-2.4%	Salaries & Wages	287,822	296,101	305,003	8,902	2.9%
9,063	9,777	9,556	(221)	-2.3%	Supplies	75,754	75,133	78,073	2,940	3.8%
8,225	7,485	7,760	275	3.5%	Fees & Purchased Services	65,415	62,144	62,561	417	0.7%
2,805	2,079	2,092	13	0.6%	Other Operating Expense	26,393	18,497	18,165	(332)	-1.8%
602	444	448	4	0.9%	Interest	3,746	3,423	3,586	163	4.5%
4,239	3,944	4,623	679	14.7%	Depreciation	31,661	32,230	34,718	2,488	7.2%
60,668	**61,657**	**61,515**	**(142)**	**-0.2%**	Total Operating Expense	**490,791**	**487,529**	**502,106**	**14,577**	**2.9%**
(795)	**3,803**	**3,738**	**65**	**1.7%**	Net Operating Income/(Loss)	**24,888**	**66,229**	**32,726**	**33,503**	**102.4%**
(4,086)	4,675	729	3,946	541.4%	Non Operating Income	(37,083)	29,173	5,831	23,341	400.3%
(4,881)	**8,479**	**4,467**	**4,011**	**89.8%**	Net Income(Loss)	**(12,196)**	**95,401**	**38,557**	**56,844**	**147.4%**
6.8%	12.5%	13.5%	-1.0%		EBITDA	11.7%	18.4%	13.3%	5.1%	
-1.3%	5.8%	5.7%	0.1%		Operating Margin	4.8%	12.0%	6.1%	5.8%	
-8.2%	13.0%	6.8%	6.1%		Net Margin	-2.4%	17.2%	7.2%	10.0%	

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Non Operating Items and Net Income by Affiliate

$ in thousands

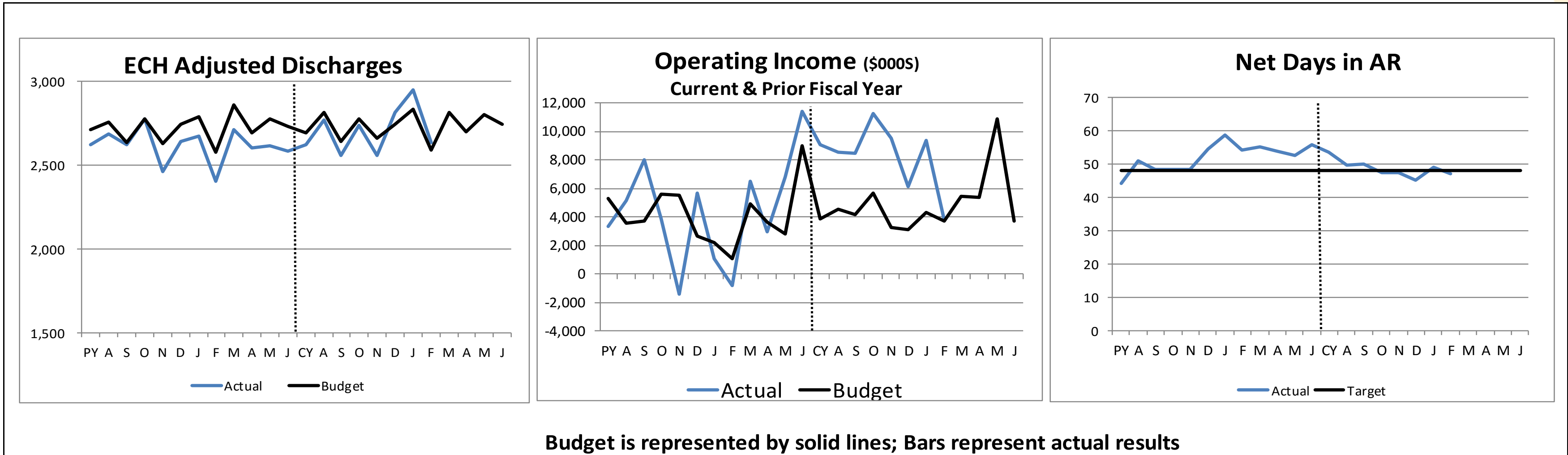
	Period 8 - Month			Period 8 - FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Income (Loss) from Operations						
Mountain View	862	3,024	(2,162)	61,929	25,252	36,678
Los Gatos	2,941	714	2,227	4,299	7,474	(3,175)
Sub Total - El Camino Hospital, excl. Afflilates	**3,803**	**3,738**	**65**	**66,229**	**32,726**	**33,503**
Operating Margin %	**5.8%**	**5.7%**		**12.0%**	**6.1%**	
El Camino Hospital Non Operating Income						
Investments	5,342	1,512	3,830	31,500	12,093	19,406
Swap Adjustments	(57)	0	(57)	3,342	0	3,342
Community Benefit	(653)	(283)	(369)	(2,769)	(2,267)	(502)
Other	43	(499)	542	(2,901)	(3,995)	1,095
Sub Total - Non Operating Income	**4,675**	**729**	**3,946**	**29,173**	**5,831**	**23,341**
El Camino Hospital Net Income (Loss)	**8,479**	**4,467**	**4,011**	**95,401**	**38,557**	**56,844**
ECH Net Margin %	**13.0%**	**6.8%**		**17.2%**	**7.2%**	
Concern	274	257	17	1,003	1,697	(694)
ECSC	(6)	0	(6)	(60)	0	(60)
Foundation	371	(47)	418	2,046	(314)	2,359
Silicon Valley Medical Development	(30)	7	(37)	160	(0)	161
Net Income Hospital Affiliates	**609**	**217**	**392**	**3,149**	**1,382**	**1,766**
Total Net Income Hospital & Affiliates	**9,088**	**4,684**	**4,404**	**98,550**	**39,940**	**58,610**

Swap gain due to rise in interest rates
Favorable variance in Other due to lower losses at SVMD

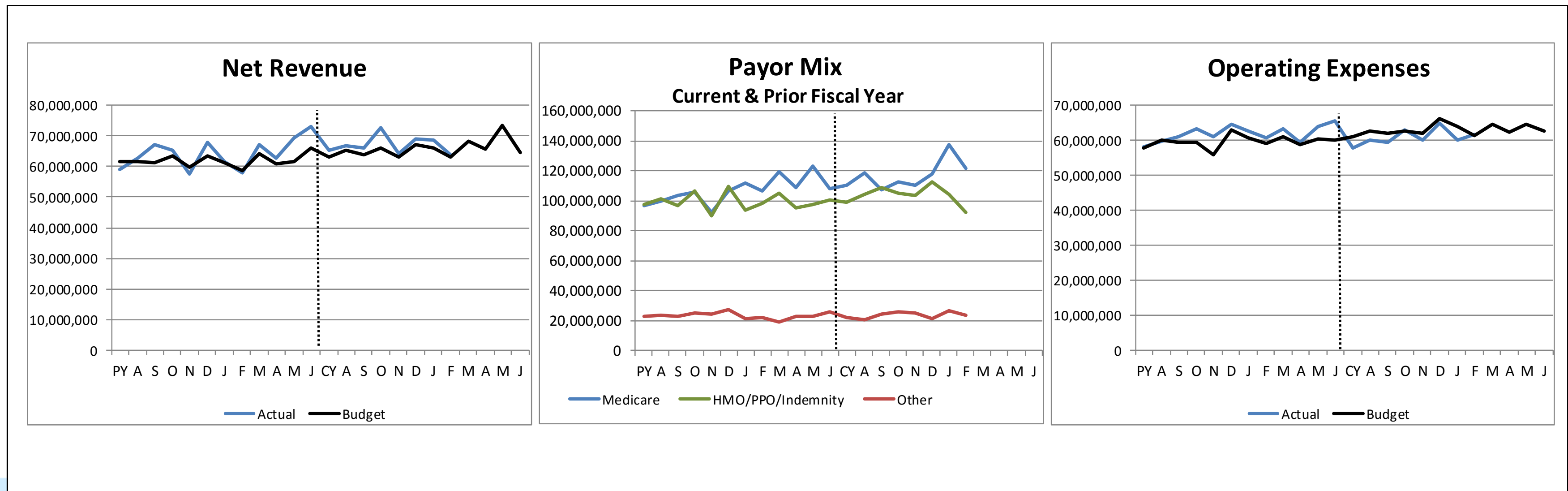
Higher Foundation income due to high unrestricted donations and investment income

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

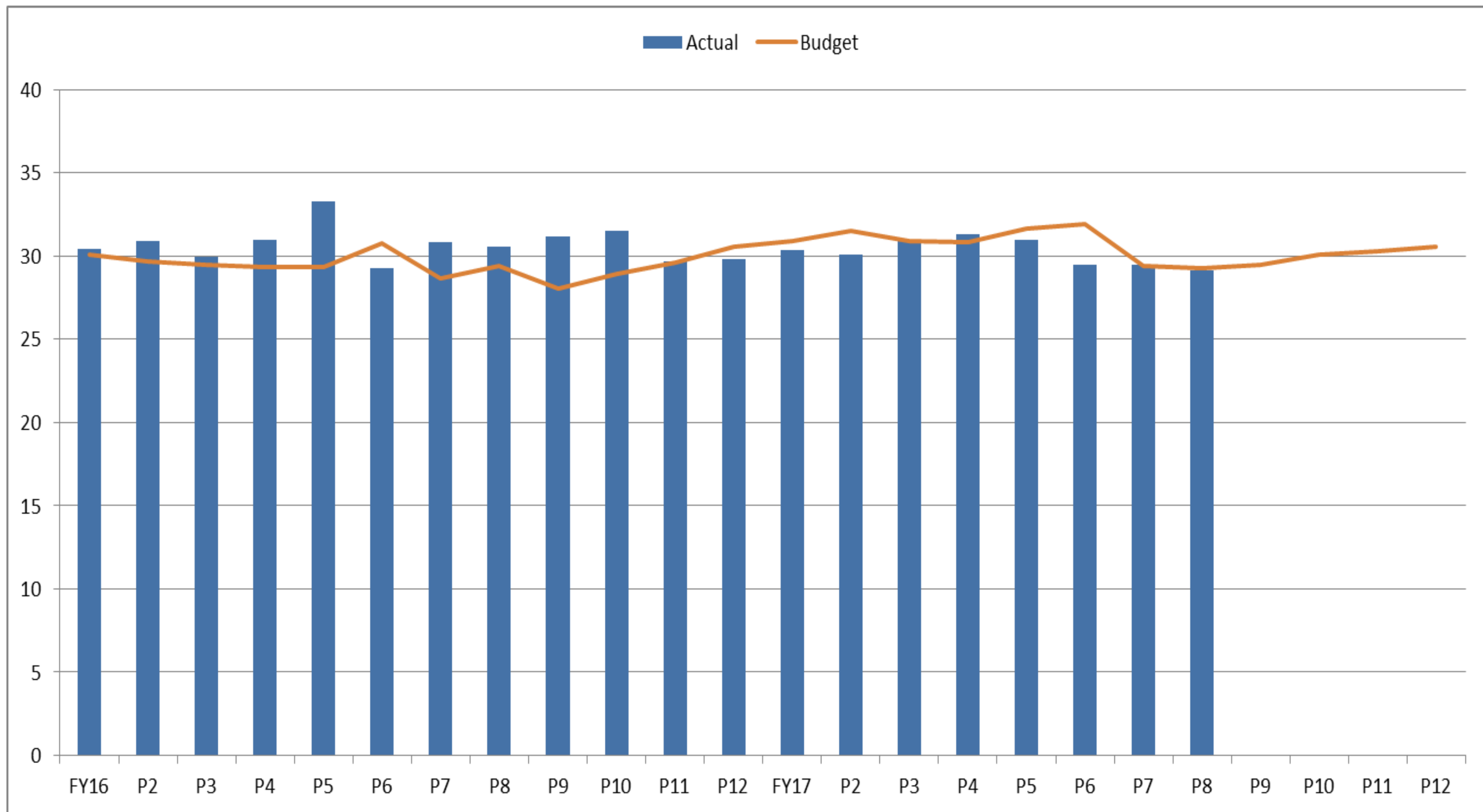
Monthly Financial Trends



February volume is lower than previous month, where January's volume spike was due to flu season.
Operating expenses slightly higher than budgeted in February, but is $14.5M under budget YTD

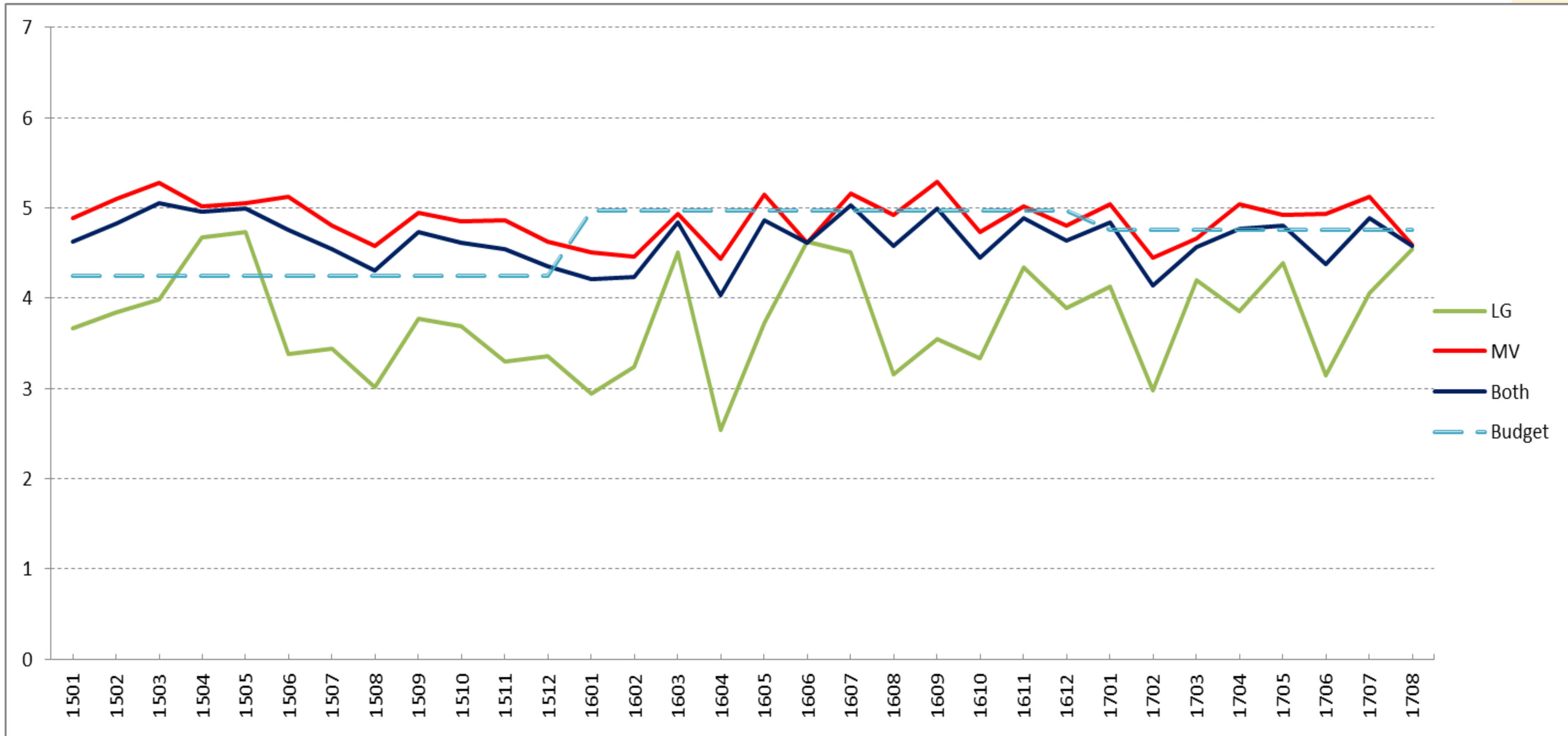


Worked Hours per Adjusted Patient Day



Productivity has improved after EPIC go-live and is favorable compared to budget.

Medicare ALOS



- ALOS decreased slightly in February due to short month.

Medicare data excludes Medicare HMOs

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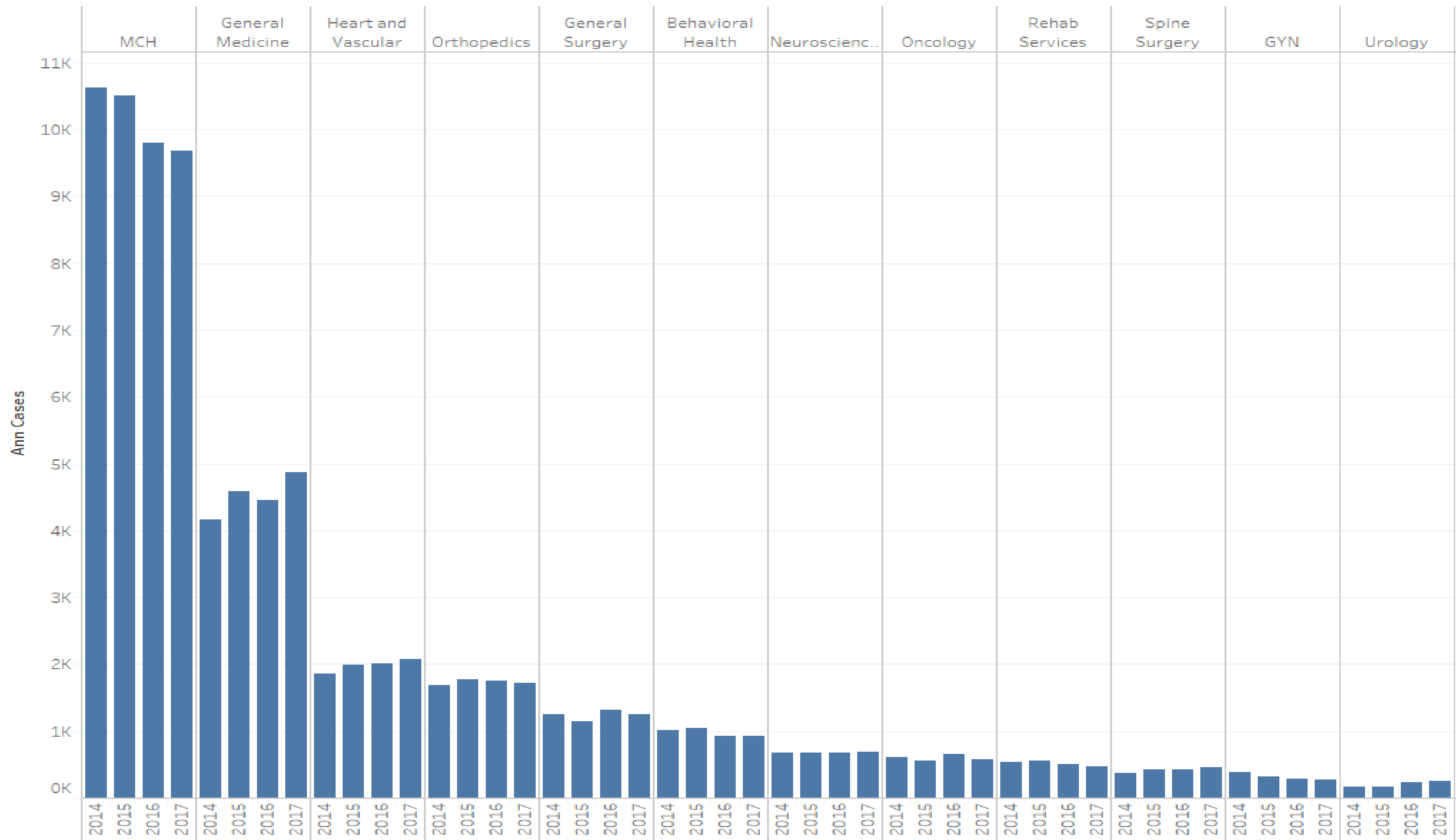
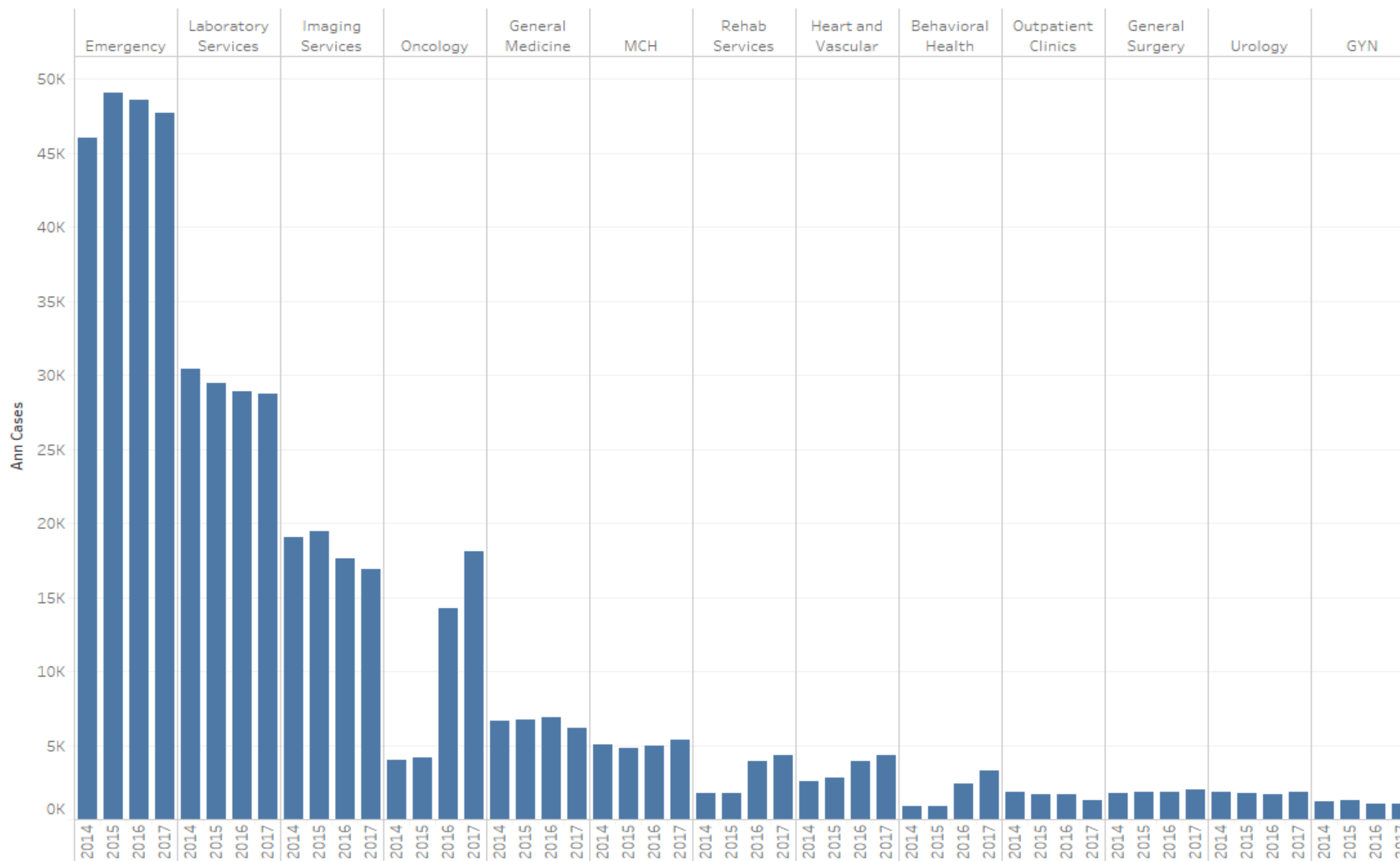
El Camino Hospital Volume Annual Trends – Inpatient
FY 2017 is annualized



- General Medicine experienced a volume decrease from January to February
- MCH volume decreased in February with decreases in both vaginal & C-section deliveries

El Camino Hospital Volume Annual Trends – Outpatient
FY 2017 is annualized



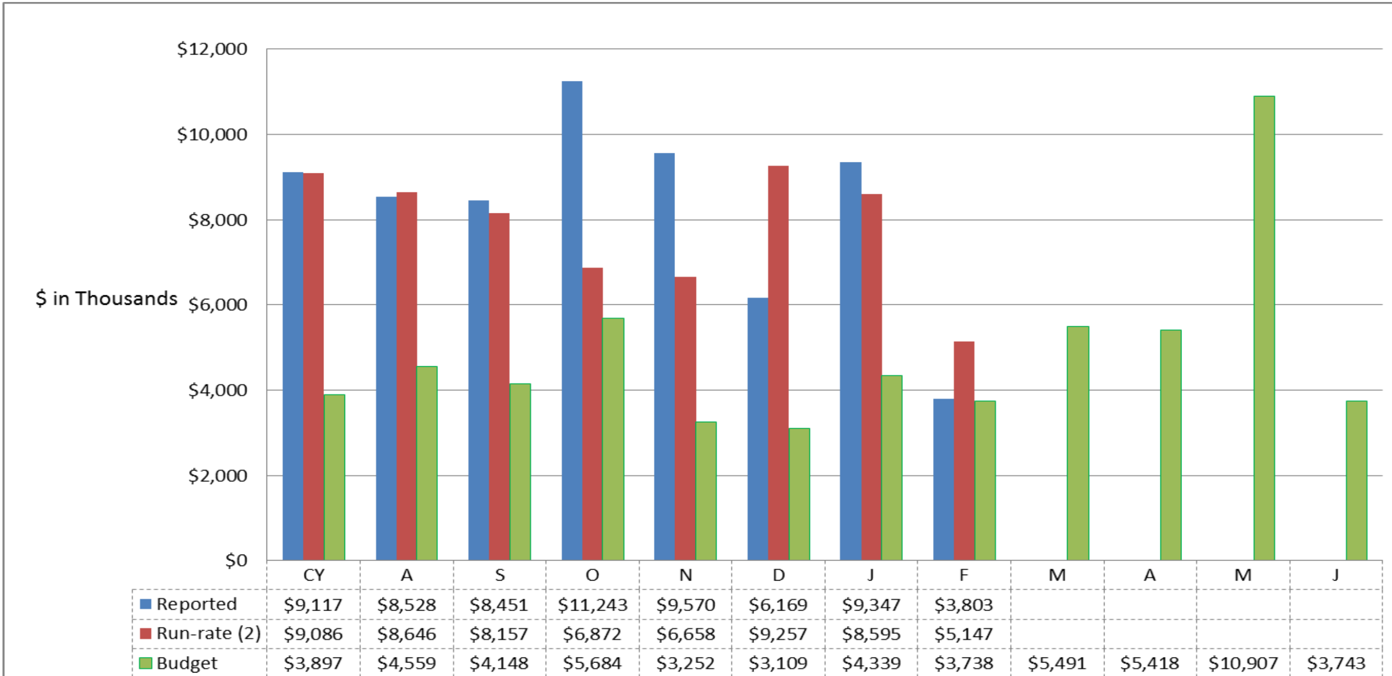
- General Surgery is 90.9% favorable budget for February, budgeted 55 cases where actual is 105.

Medicare data excludes Medicare HMOs

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

ECH Operating Margin

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



FY 2017 Actual Run Rate Adjustments (in thousands)

		J	A	S	O	N	D	J	F	M	A	M	J
Revenue Adjustments	RAC Release	$76	$1	$0	$0	$0	$0	-$112	-$143	$0	$0	$0	$0
	Insurance Overpayment Release Spine	-$335	$0	-$61	-$145	-$36	$0	$0	$0	$0	$0	$0	$0
	Mcare Settlmt/Appeal/Tent Settlmt/PIP	-$100	$158	-$74	-$67	-$67	-$100	-$67	-$947	$0	$0	$0	$0
	LPCH Adjstmt	-$8	-$41	-$19	-$25	-$12	-$9	-$19	-$14	$0	$0	$0	$0
	BPCI Settlement	$0	$0	$0	$0	$0	$0	$2,167	$0	$0	$0	$0	$0
	Medi-Cal Supplemental	$0	$0	$0	$0	$0	-$312	-$814.29	-$240	$0	$0	$0	$0
	Tricare	$0	$0	-$144	$0	$0	$0	$0	$0	$0	$0	$0	$0
	SVPMG Quarterly Payment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	IGT Supplemental	$0	$0	$0	-$6,535	$0	$0	$0	$0	$0	$0	$0	$0
	Total	**-$366**	**$118**	**-$299**	**-$6,771**	**-$115**	**-$421**	**$1,155**	**-$1,344**	**$0**	**$0**	**$0**	**$0**
Expense Adjustments	Pay-For-Performance Bonus	$0	$0	$0	$0	$0	$2,400	$403	$401	$0	$0	$0	$0
	Ratification Bonus	$0	$0	$0	$2,400	$0	$0	$0	$0	$0	$0	$0	$0
	Inst & Minor Med Equipment	$0	$0	$0	$0	$598	$0	$0	$0	$0	$0	$0	$0
	Worker's Comp Settlement	$0	$0	$0	$0	$0	$700	$0	$0	$0	$0	$0	$0
	Other Purchased Services	$0	$0	$0	$0	$0	$500	$0	$0	$0	$0	$0	$0
	Total	**$0**	**$0**	**$0**	**$2,400**	**$598**	**$3,600**	**$403**	**$401**	**$0**	**$0**	**$0**	**$0**

Medicare data excludes Medicare HOs

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital Investment Committee Scorecard

December 31, 2016

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY17 Year-end Budget	Expectation Per Asset Allocation
Investment Performance		4Q 2016		Fiscal Year-to-date		4y 2m Since Inception (annualized)			May 2016
Surplus cash balance & op. cash (millions)		$801.9	–	–	–	–	–	$657.2	–
Surplus cash return	Green	0.0%	0.3%	2.9%	3.1%	4.6%	4.6%	4.0%	5.2%
Cash balance plan balance (millions)		$227.9	–	–	–	–	–	$220.6	–
Cash balance plan return	Green	-0.2%	0.6%	3.4%	3.8%	7.0%	6.6%	6.0%	5.8%
403(b) plan balance (millions)		$362.4	–	–	–	–	–	–	–
Risk vs. Return		3-year				4y 2m Since Inception (annualized)			May 2016
Surplus cash Sharpe ratio	Green	0.67	0.76	–	–	1.06	1.05	–	0.55
Net of fee return	Green	3.1%	3.6%	–	–	4.6%	4.6%	–	5.2%
Standard deviation	Green	4.5%	4.6%	–	–	4.3%	4.3%	–	8.6%
Cash balance Sharpe ratio	Green	0.65	0.69	–	–	1.18	1.15	–	0.49
Net of fee return	Green	3.8%	4.0%	–	–	7.0%	6.6%	–	5.8%
Standard deviation	Green	6.0%	5.8%	–	–	5.8%	5.6%	–	10.7%
Asset Allocation		4Q 2016							
Surplus cash absolute variances to target	Green	7.5%	< 10%	–	–	–	–	–	–
Cash balance absolute variances to target	Green	5.7%	< 10%	–	–	–	–	–	–
Manager Compliance		4Q 2016							
Surplus cash manager flags	Green	18	< 19 Green < 23 Yellow	–	–	–	–	–	–
Cash balance plan manager flags	Yellow	21	< 20 Green < 25 Yellow	–	–	–	–	–	–

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital

Capital Spending (in millions)

Category	Detail	Approved	Total Estimated Cost of Project	Total Authorized Active	Spent from Inception	FY 17 Proj Spend	FY 17 YTD Spent
CIP	EPIC Upgrade			6.1	2.0	6.1	2.0
IT Hardware, Software, Equipment*				5.4	0.3	5.4	0.3
Medical & Non Medical Equipment FY 16**				4.3	0.0	4.3	0.0
Medical & Non Medical Equipment FY 17				10.3	1.1	10.3	1.1
Facility Projects							
	1307 LG Upgrades	FY13	17.3	17.3	12.0	3.3	2.0
	1219 LG Spine OR	FY13	4.1	4.1	2.6	2.7	1.3
	1414 Integrated MOB	FY15	275.0	247.0	30.0	58.2	16.2
	1413 North Drive Parking Expansion	FY15	24.5	24.5	6.9	19.7	5.3
	1245 Behavioral Health Bldg	FY16	91.5	72.5	10.8	17.9	3.5
	1248 LG Imaging Phase II (CT & Gen Rad)	FY16	8.8	8.8	2.8	8.1	3.1
	1313/1224 LG Rehab HVAC System & Structural	FY16	3.7	3.7	3.0	1.6	1.2
	1502 Cabling & Wireless Upgrades	FY16	2.8	2.8	2.4	1.0	0.3
	1425 IMOB Preparation Project - Old Main	FY16	3.0	3.0	2.5	2.5	1.8
	1430 Women's Hospital Expansion	FY16	91.0	0.0	0.0	0.8	0.0
	1422 CUP Upgrade	FY16	9.0	7.5	1.5	4.0	0.5
	1503 Willow Pavilion Tomosynthesis	FY16	1.3	1.3	0.2	1.2	0.1
	1519/1314 LG Electrical Systems Upgrade	FY16	1.2	0.0	0.0	0.0	0.0
	1347 LG Central Sterile Upgrades	FY15	3.7	0.2	0.3	0.4	0.0
	1508 LG NICU 4 Bed Expansion	FY16	7.0	0.5	0.2	0.2	0.2
	1520 Facilities Planning Allowance	FY16	0.6	0.0	0.0	0.0	0.0
New to FP 3	1525 New Main Lab Upgrades		1.6	0.4	0.3	2.6	0.3
New to FP 3	1515 ED Remodel Triage/Psych Observation	FY16	1.6	0.0	0.0	0.6	0.0
New to FP 3	Site Signage and Other Improvements		1.0	0.0	0.0	0.1	0.0
New to FP 3	IR Room #6 Development		2.6	0.0	0.0	0.2	0.0
New to FP 3	1602 JW House (Patient Family Residence)		2.5	0.0	0.0	0.0	0.0
New to FP 3	1507 LG IR Upgrades		1.1	0.0	0.0	0.0	0.0
New to FP 3	LG Building Infrastructure Upgrades		1.5	0.0	0.0	0.0	0.0
New to FP 3	1421 LG MOB Improvements (17)		5.0	0.9	0.7	1.7	0.1
	All Other Projects under $1M		8.6	6.7	4.6	4.1	1.7
			569.9	401.2	80.7	131.0	37.7
GRAND TOTAL				**427.3**		**157.0**	**41.1**

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital

Capital Spending – Facility Projects (in millions)

	($ in ,000)	Approved	A - FY17 Budgeted (Board packet)	D - FY17 Projected Spent	Variance from Budget
	Mountain View Campus Master Plan Projects				
1245	BHS Replacement	FY16	30,000	17,890	12,110
1413	North Dr Parking Structure Expansion	FY15	20,500	19,651	849
1414	Integrated Medical Office Building	FY15	101,500	58,230	43,270
1422	CUP Upgrades	FY16	5,000	4,025	975
1430	Womens Hosp Expansion	FY16	5,500	800	4,700
	Sub-Total		**162,500**	**100,596**	**61,904**
					0
	Other Capital Facilities Projects (Active/Budgeted)				0
1501	Womens Hosp NPC Closeout [1]	FY16	327	595	(268)
1425	IMOB Preparation Project - Old Main		1,000	2,466	(1,466)
1502	Cabling and Wireless upgrades [1]	FY16	400	1,010	(610)
1525	New Main Lab Upgrades		1,200	2,575	(1,375)
1515	ED Remodel Triage / Psych Observation		1,400	600	800
1415	Signage & Wayfinding		300	425	(125)
1416	Digital Directories [1]	FY15	-	108	(108)
1503	Breast Imaging Tomography (Excludes $1M Equip) [1]	FY16	300	1,228	(928)
1316	Willow Pavilion FA Sys and Equip Upgrades		800	100	700
1423	MV MOB TI Allowance [1]	FY16	-	419	(419)
1520	Facilities Planning Allowance		300	-	300
1523	MV Melchor Suite 309 TI's [1]	FY16	-	76	(76)
	Furniture Systems Inventory		250	250	0
	Site Signage & Other Improvements		200	100	100
	MV Equipment & Infrastructure Upgrades (17)		300	-	300
	IR Room #6 Development		500	200	300
1602	JW House (Patient Family Residence)		500	-	500
	MV Capital Projects Sub-Total		**7,777**	**10,153**	**(2,376)**
					0
1219	LG Spine Room Expansion - OR 4	FY13	3,100	2,717	383
1313	LG Rehab HVAC Upgrades (CIP# 1313 / 1224)	FY15	400	1,643	(1,243)
1248	LG Imaging & Sterile Processing		7,250	8,100	(850)
1307	LG Upgrades - Major	FY13	7,300	3,266	4,034
1327	LG Rehab Building Upgrades		500	100	400
1346	LG Surgical Lights OR's 5,6 & 7 [1]	FY15	-	154	(154)
1347	LG Central Sterile Upgrades		-	40	(40)
1421	LG MOB Improvements		150	219	(69)
1507	LG IR Upgrades		800	-	800
1508	LG NICU 4 Bed Expansion		5,000	247	4,753
1600	LG 825 Pollard - Aspire Phase 2 [1]	FY16	-	500	(500)
1519	LG Electrical Systems Upgrade	FY16			
	LG Building Infrastructure Improvements		1,200	-	1,200
	LG Facilities Planning		500	-	500
	LG MOB Improvements (17)		4,000	1,500	2,500
	LG Capital Projects Sub-Total		**30,200**	**18,487**	**11,713**
					0
	Primary Care Clinic (TI's Only)		1,600	1,400	200
	Urgent Care Clinics (TI's Only)		2,400	-	2,400
	Other Strategic Capital Project Sub-Total		**4,000**	**1,400**	**2,600**
					0
	Grand Total Facilities Projects		**204,477**	**130,636**	**73,841**

[1] **Approved Spending prior to FY17**

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Balance Sheet (in thousands)

ASSETS

		February 28, 2017	Audited June 30, 2016
	CURRENT ASSETS		
(1)	Cash	93,700	59,169
	Short Term Investments	122,486	105,284
(2)	Patient Accounts Receivable, net	105,816	120,960
	Other Accounts and Notes Receivable	2,122	4,369
(3)	Intercompany Receivables	1,493	2,200
(4)	Inventories and Prepaids	44,277	39,678
	Total Current Assets	**369,894**	**331,660**
	BOARD DESIGNATED ASSETS		
	Plant & Equipment Fund	123,178	119,650
(5)	Women's Hospital Expansion	9,298	-
	Operational Reserve Fund	100,196	100,196
	Community Benefit Fund	12,189	13,037
	Workers Compensation Reserve Fund	23,258	22,309
	Postretirement Health/Life Reserve Fund	19,339	18,256
	PTO Liability Fund	22,054	22,984
	Malpractice Reserve Fund	1,800	1,800
	Catastrophic Reserves Fund	16,185	14,125
	Total Board Designated Assets	**327,497**	**312,358**
(6)	**FUNDS HELD BY TRUSTEE**	**25,415**	**30,841**
	LONG TERM INVESTMENTS	**222,582**	**207,597**
	INVESTMENTS IN AFFILIATES	**32,412**	**31,627**
	PROPERTY AND EQUIPMENT		
	Fixed Assets at Cost	1,182,056	1,171,372
	Less: Accumulated Depreciation	(516,439)	(485,856)
	Construction in Progress	88,453	46,009
	Property, Plant & Equipment - Net	**754,070**	**731,525**
	DEFERRED OUTFLOWS	29,414	29,814
	RESTRICTED ASSETS - CASH	0	-
	TOTAL ASSETS	**1,761,284**	**1,675,422**

LIABILITIES AND FUND BALANCE

		February 28, 2017	Audited June 30, 2016
	CURRENT LIABILITIES		
(7)	Accounts Payable	21,863	28,519
	Salaries and Related Liabilities	23,447	22,992
	Accrued PTO	22,054	22,984
	Worker's Comp Reserve	2,300	2,300
	Third Party Settlements	13,110	11,314
	Intercompany Payables	53	105
	Malpractice Reserves	1,936	1,936
	Bonds Payable - Current	3,735	3,635
(8)	Bond Interest Payable	1,783	5,459
	Other Liabilities	8,171	10,478
	Total Current Liabilities	**95,560**	**106,830**
	LONG TERM LIABILITIES		
	Post Retirement Benefits	19,339	18,256
	Worker's Comp Reserve	20,958	20,009
	Other L/T Obligation (Asbestos)	3,710	3,637
	Other L/T Liabilities (IT/Medl Leases)	-	-
	Bond Payable	219,502	225,857
	Total Long Term Liabilities	**263,509**	**267,759**
	DEFERRED INFLOW OF RESOURCES	2,892	2,892
	FUND BALANCE/CAPITAL ACCOUNTS		
	Unrestricted	1,071,826	985,583
	Board Designated	327,497	312,358
	Restricted	0	-
(9)	**Total Fund Bal & Capital Accts**	**1,399,323**	**1,297,941**
	TOTAL LIABILITIES AND FUND BALANCE	**1,761,284**	**1,675,422**

El Camino Hospital Comparative Balance Sheet Variances and Footnotes [1]

(1) The increase in cash is due allowing for immediate cash to be available for the recent significant construction projects that have started in MV campus.

(2) The decrease is primarily due to the significant cash payments the Patient Accounts team has brought in during the eight months, two months were in excess of $70M where the projected budgeted was approximately $63M per month.

(3) The decrease is just a timing issue of intercompany payments from one quarter to another. Normally at a fiscal year end, they are higher due to the books being held open for a longer period of time in preparation for audit.

(4) The increase is principally due to two quarterly pension contributions of $2.6M each since July 1, 2016.

(5) A new item, the District allocated its FY 2014 and FY 2015 Capital Appropriation Funds in support of future renovations to the Women's Hospital when the IMOB is completed and those floors become for patient care.

(6) The decrease is due to additional withdraws from the 2015A Project Fund for the renovations at the Los Gatos campus.

(7) The decrease is due significant General Contractor payments being accrued at year end, that were subsequently relieved during the first quarter of fiscal year 2017.

(8) The decrease is due a semi-annual 2015A bond interest payment made in January, 2017.

(9) The increase is due to this fiscal year's P&L affect ($67M from Operations and $30M for Non-Operations – primarily due to unrealized investment gain), and the transfer from the District in support of the future Women's Hospital renovations.

[1] Hospital entity only, excludes controlled affiliates

APPENDIX

El Camino Hospital – Mountain View ($000s)

8 months ending 2/28/2017

PERIOD 8 FY 2016	PERIOD 8 FY 2017	PERIOD 8 Budget 2017	Variance Fav (Unfav)	Var%	$000s	YTD FY 2016	YTD FY 2017	YTD Budget 2017	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
187,826	192,985	191,376	1,609	0.8%	**Gross Revenue**	1,475,112	1,606,267	1,565,280	40,987	2.6%
(139,774)	(144,092)	(140,053)	(4,039)	2.9%	**Deductions**	(1,067,728)	(1,164,557)	(1,145,488)	(19,070)	1.7%
48,052	**48,893**	**51,323**	**(2,430)**	**-4.7%**	**Net Patient Revenue**	**407,384**	**441,710**	**419,792**	**21,918**	**5.2%**
1,885	1,612	1,872	(260)	-13.9%	**Other Operating Revenue**	14,461	15,905	14,981	924	6.2%
49,937	**50,504**	**53,194**	**(2,690)**	**-5.1%**	**Total Operating Revenue**	**421,845**	**457,614**	**434,773**	**22,841**	**5.3%**
					OPERATING EXPENSE					
29,867	31,383	30,860	(522)	-1.7%	**Salaries & Wages**	239,630	246,200	253,895	7,695	3.0%
7,431	7,687	7,807	120	1.5%	**Supplies**	61,662	61,107	63,893	2,786	4.4%
6,953	6,017	6,565	548	8.4%	**Fees & Purchased Services**	54,764	51,299	52,613	1,314	2.5%
1,263	655	545	(110)	-20.1%	**Other Operating Expense**	13,732	5,590	5,304	(286)	-5.4%
602	444	448	4	0.9%	**Interest**	3,746	3,423	3,586	163	4.5%
3,717	3,457	3,944	488	12.4%	**Depreciation**	27,657	28,066	30,231	2,165	7.2%
49,834	**49,642**	**50,170**	**528**	**1.1%**	**Total Operating Expense**	**401,191**	**395,685**	**409,521**	**13,837**	**3.4%**
104	**862**	**3,024**	**(2,162)**	**-71.5%**	**Net Operating Income/(Loss)**	**20,654**	**61,929**	**25,252**	**36,678**	**145.2%**
(4,086)	4,675	729	3,946	541.4%	**Non Operating Income**	(37,057)	29,183	5,831	23,352	400.5%
(3,983)	**5,537**	**3,753**	**1,784**	**47.5%**	**Net Income(Loss)**	**(16,403)**	**91,113**	**31,083**	**60,030**	**193.1%**
8.9%	9.4%	13.9%	-4.5%		**EBITDA**	8.9%	20.4%	13.6%	6.8%	
0.2%	1.7%	5.7%	-4.0%		**Operating Margin**	4.9%	13.5%	5.8%	7.7%	
-8.0%	11.0%	7.1%	3.9%		**Net Margin**	-3.9%	19.9%	7.1%	12.8%	

El Camino Hospital – Los Gatos($000s)

8 months ending 2/28/2017

PERIOD 8 FY 2016	PERIOD 8 FY 2017	PERIOD 8 Budget 2017	Variance Fav (Unfav)	Var%	$000s	YTD FY 2016	YTD FY 2017	YTD Budget 2017	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
39,093	45,253	42,893	2,360	5.5%	**Gross Revenue**	330,814	351,183	356,119	(4,936)	-1.4%
(29,344)	(30,480)	(31,048)	568	-1.8%	**Deductions**	(238,592)	(256,366)	(257,778)	1,412	-0.5%
9,748	**14,773**	**11,845**	**2,928**	**24.7%**	**Net Patient Revenue**	**92,222**	**94,817**	**98,341**	**(3,524)**	**-3.6%**
188	183	214	(31)	-14.4%	**Other Operating Revenue**	1,611	1,326	1,717	(391)	-22.8%
9,936	**14,956**	**12,059**	**2,897**	**24.0%**	**Total Operating Revenue**	**93,834**	**96,143**	**100,059**	**(3,916)**	**-3.9%**
					OPERATING EXPENSE					
5,866	6,545	6,176	(369)	-6.0%	**Salaries & Wages**	48,192	49,901	51,108	1,207	2.4%
1,632	2,090	1,749	(341)	-19.5%	**Supplies**	14,093	14,026	14,180	154	1.1%
1,273	1,468	1,195	(274)	-22.9%	**Fees & Purchased Services**	10,651	10,845	9,948	(897)	-9.0%
1,542	1,424	1,547	123	7.9%	**Other Operating Expense**	12,661	12,907	12,861	(46)	-0.4%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
522	487	678	191	28.2%	**Depreciation**	4,004	4,165	4,487	323	7.2%
10,834	**12,015**	**11,345**	**(670)**	**-5.9%**	**Total Operating Expense**	**89,600**	**91,844**	**92,584**	**740**	**0.8%**
(898)	**2,941**	**714**	**2,227**	**311.9%**	**Net Operating Income/(Loss)**	**4,233**	**4,299**	**7,474**	**(3,175)**	**-42.5%**
0	0	0	0	0.0%	**Non Operating Income**	(26)	(10)	0	(10)	0.0%
(898)	**2,941**	**714**	**2,227**	**311.9%**	**Net Income(Loss)**	**4,207**	**4,289**	**7,474**	**(3,186)**	**-42.6%**
8.78%	22.9%	11.5%	-2.1%		EBITDA	8.8%	8.8%	12.0%	-3.2%	
-9.0%	19.7%	5.9%	13.7%		Operating Margin	4.5%	4.5%	7.5%	-3.0%	
-9.0%	19.7%	5.9%	13.7%		Net Margin	4.5%	4.5%	7.5%	-3.0%	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital

THE HOSPITAL OF SILICON VALLEY

Emergency Preparedness Overview

Ken King, CASO

Board of Directors

April 12, 2017

What defines an Emergency?

Mass Casualty Event

CODE TRIAGE EXTERNAL

A large influx in patients due to an external disaster:

- Plane Crash
- Explosion
- Terrorist Attack
- Other Mass Casualties

Internal Disaster

- Fire
- Flood
- Utility Disruption
- Weapon/Hostage Situation
- Hazardous Material Spill
- Other major failures

Mass Casualty & Internal Disaster

- Earthquake
- Other events that include a large influx of patients and disruption to internal systems or environment.

The Joint Commission & CMS- Emergency Management Standards

EM.01.01.01 - The hospital engages in planning activities prior to developing its written Emergency Operations Plan.

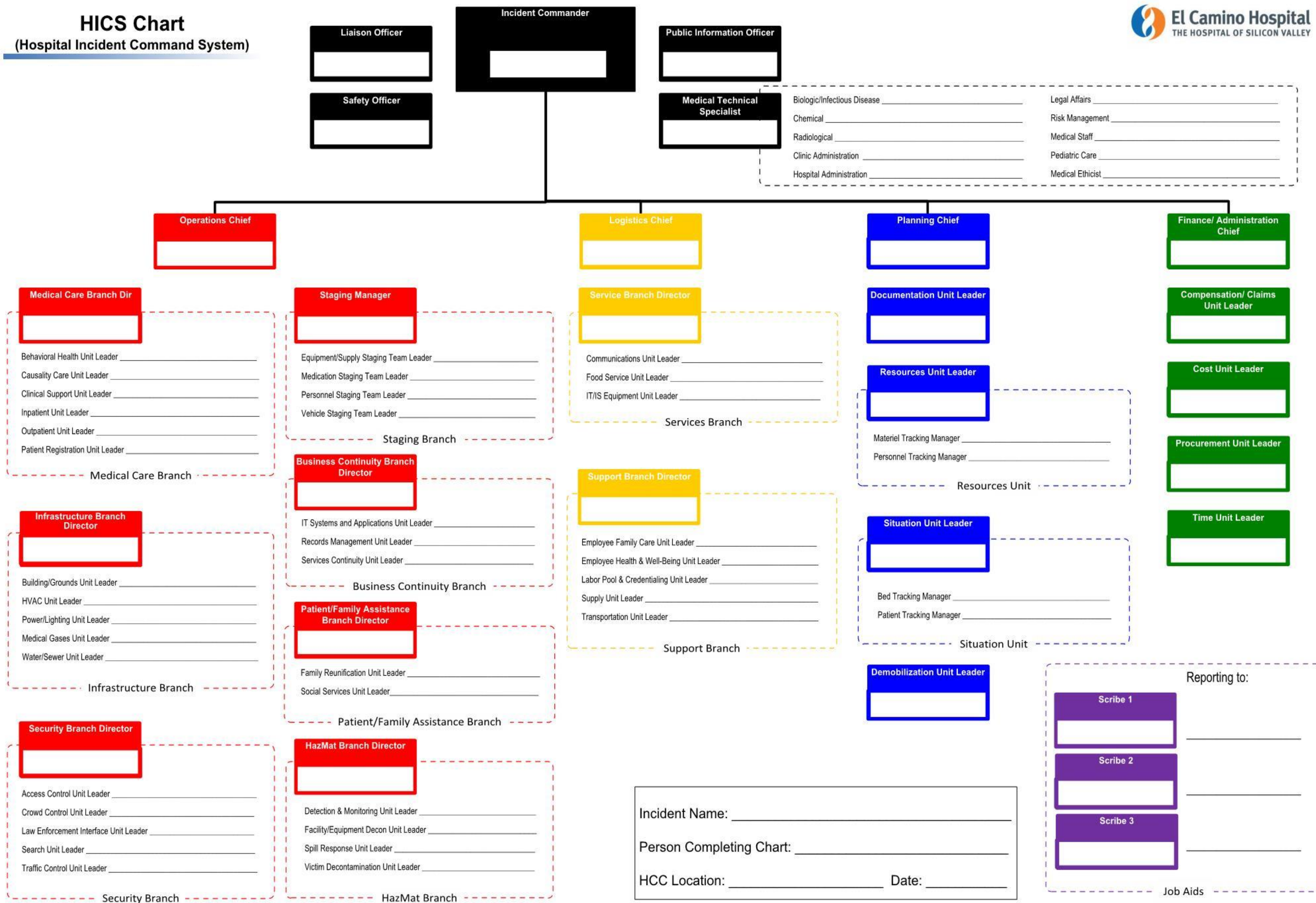
An emergency is an unexpected or sudden event that significantly disrupts the organization’s ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization's services.

EM.02.01.01 – The hospital has an Emergency Operations Plan.

Emergency Operations Plan – Key Elements

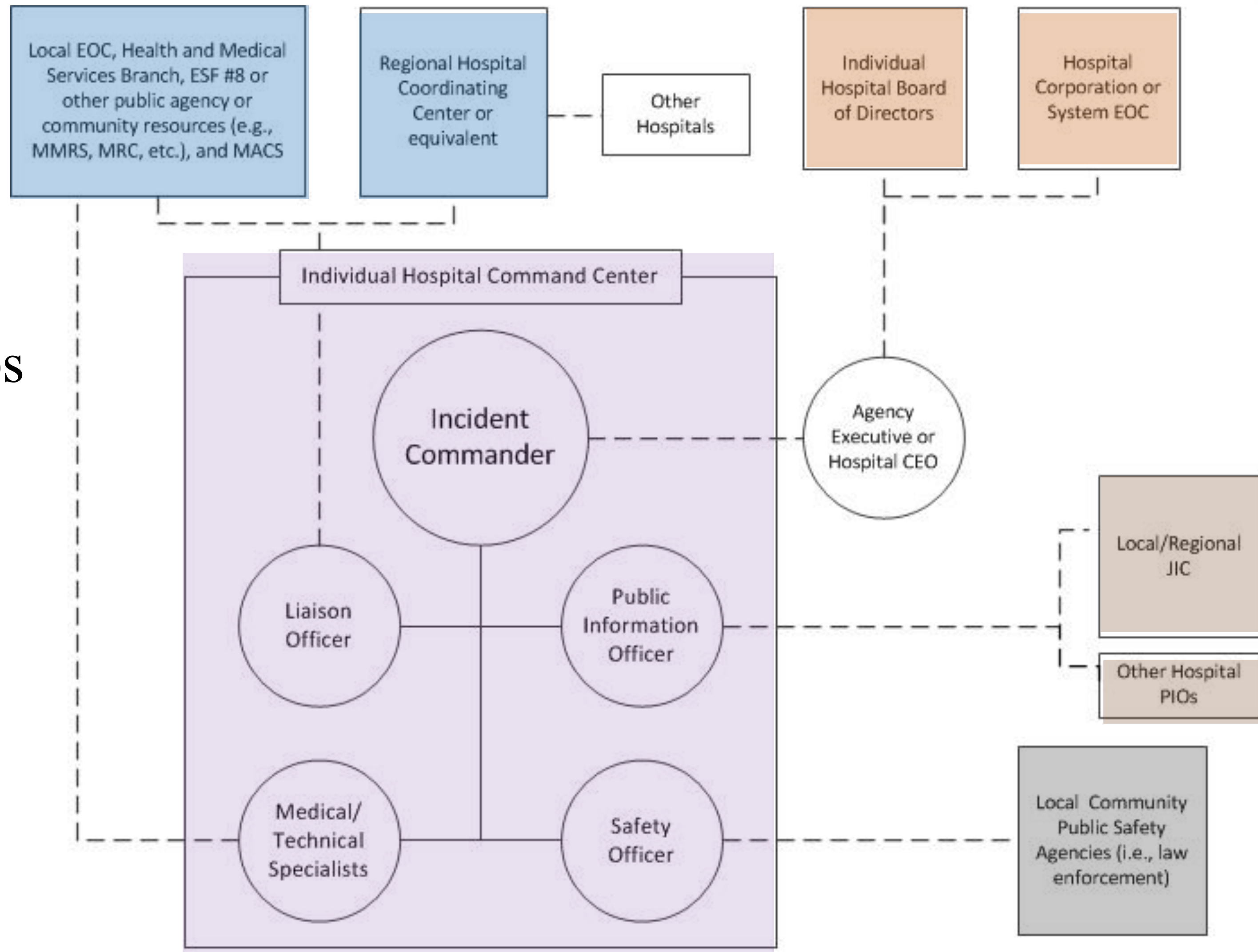
- Communications during emergencies.
- Management of resources and assets during emergencies.
- Management of security and safety during emergencies.
- Management of staff during emergencies.
- Management of utilities during an emergency.
- Management of patients during emergencies.
- Two annual emergency response exercises. (Disaster Drills)
- Annual evaluation of Emergency Operations Plan.

Emergency Operations Management Structure



HICS Chart
(Hospital Incident Command System)
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY
Incident Commander
Liaison Officer
Safety Officer
Public Information Officer
Medical Technical Specialist
Biologic/Infectious Disease
Chemical
Radiological
Clinic Administration
Hospital Administration
Legal Affairs
Risk Management
Medical Staff
Pediatric Care
Medical Ethicist
Operations Chief
Logistics Chief
Planning Chief
Finance/ Administration Chief
Medical Care Branch Dir
Behavioral Health Unit Leader
Causality Care Unit Leader
Clinical Support Unit Leader
Inpatient Unit Leader
Outpatient Unit Leader
Patient Registration Unit Leader
Medical Care Branch
Staging Manager
Equipment/Supply Staging Team Leader
Medication Staging Team Leader
Personnel Staging Team Leader
Vehicle Staging Team Leader
Staging Branch
Service Branch Director
Communications Unit Leader
Food Service Unit Leader
IT/IS Equipment Unit Leader
Services Branch
Documentation Unit Leader
Compensation/ Claims Unit Leader
Resources Unit Leader
Materiel Tracking Manager
Personnel Tracking Manager
Resources Unit
Cost Unit Leader
Procurement Unit Leader
Infrastructure Branch Director
Building/Grounds Unit Leader
HVAC Unit Leader
Power/Lighting Unit Leader
Medical Gases Unit Leader
Water/Sewer Unit Leader
Infrastructure Branch
Business Continuity Branch Director
IT Systems and Applications Unit Leader
Records Management Unit Leader
Services Continuity Unit Leader
Business Continuity Branch
Support Branch Director
Employee Family Care Unit Leader
Employee Health & Well-Being Unit Leader
Labor Pool & Credentialing Unit Leader
Supply Unit Leader
Transportation Unit Leader
Support Branch
Situation Unit Leader
Bed Tracking Manager
Patient Tracking Manager
Situation Unit
Time Unit Leader
Patient/Family Assistance Branch Director
Family Reunification Unit Leader
Social Services Unit Leader
Patient/Family Assistance Branch
Demobilization Unit Leader
Reporting to:
Scribe 1
Scribe 2
Scribe 3
Job Aids
Security Branch Director
Access Control Unit Leader
Crowd Control Unit Leader
Law Enforcement Interface Unit Leader
Search Unit Leader
Traffic Control Unit Leader
Security Branch
HazMat Branch Director
Detection & Monitoring Unit Leader
Facility/Equipment Decon Unit Leader
Spill Response Unit Leader
Victim Decontamination Unit Leader
HazMat Branch
Incident Name:
Person Completing Chart:
HCC Location:
Date:

HICS External Relationships



Emergency Code Announcements!

Code Red

Code Blue

Code White

Code Grey

Code Pink

Code Purple

Code Yellow

Code Silver

Code Triage External

Code Triage Internal

Code Orange

Code Green

Emergency Code Definitions

- **Code Red** = Fire, Flames, Visible Smoke
- **Code Blue** = CPR – Adult
- Code White = CPR – Neonatal/Pediatric
- **Code Grey** = Angry/Violent Person
- **Code Silver** = Weapon or hostage situation
- **Code Pink** = Infant Abduction
- **Code Purple** = Child Abduction (xx – age)
- **Code Orange** = Hazardous Material Spill/Leak
- **Code Yellow** = Bomb Threat
- **Code Green** = Elopement/Missing Patient
- Code Triage – External = External Disaster
- Code Triage – Internal = Internal Disaster

Annual
Hazard Vulnerability Assessment

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Electrical Power Failure	(2) Epidemic/Pandemic
(3) Active Shooter	(3) Active Shooter
(4) Bomb Threat	(4) Mass Casualty Incident – Medical/Infectious
(5) Chemical Exposure, External	(5) Terrorism, Chemical

Annually, separate assessments are completed for the Los Gatos and Mountain View campuses to account for physical differences in the locations and facilities.

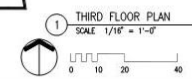
How is ECH Prepared for ….

- **FIRE**
  - ✓ Buildings are constructed with fire resistant materials
  - ✓ Each floor is separated by "Smoke Compartments"
  - ✓ Exit pathways are designed as fire rated corridors
  - ✓ Fire sprinklers protect every square foot (Except Old Main Hospital)
  - ✓ Smoke & Heat detectors protect every building

- **Fire Situations – Paged Overhead**
  - Situation "A" – Evacuate immediate area
  - Situation "B" – Evacuate to adjacent Smoke Compartment
  - Situation "C" – Evacuate Building

Example

3rd Floor – New Main Hospital
6 – Smoke Compartments



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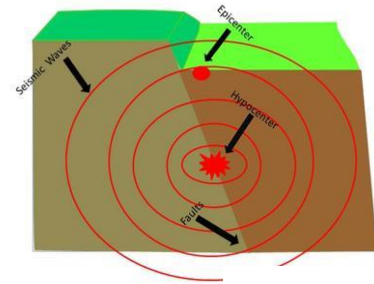
How is ECH Prepared for …



- **Earthquakes**
  - ✓ Seismically compliant structures
  - ✓ 6 Megawatts of Emergency Power Generators (Our peak demand is approximately 5.2 Megawatts)
  - ✓ Redundant Pathways for power, communications & data
  - ✓ Automatic Load Shedding of Electrical and Chilled Water Systems
  - ✓ Ham Radio Systems and Support Process
  - ✓ Emergency Radio's
  - ✓ Supplier agreements for medical supplies, food and diesel deliveries during a disaster
  - ✓ 72 – 96 Hours of the following items stored on site:
    - ✓ Emergency Diesel Fuel
    - ✓ Fresh Water (With additional Onsite Well)
    - ✓ Food (Includes MRE's)
  - ✓ Multiple buildings that can be converted into emergency use areas

Active Shooter Response - Basics

- **Instructions for coping with an active shooter situation**
- Be aware of your environment and any possible dangers
- Take note of the two nearest exits in any facility you visit
- If you are in an office, stay there and secure the door
- If you are in a hallway, get into a room and secure the door
- As a last resort, attempt to take the active shooter down. When the shooter is at close range and you cannot flee, your chance of survival is much greater if you try to incapacitate him/her.

Active Shooter Response Plan Overview

- Seek cover and dial 55 to report Code Silver
- Call Center will call 911 and Police will take control upon arrival
- Code Silver location will be broadcast on Emergency PA System
- Staff outside the area where suspect(s) are reported are to avoid the area. **Do not go into a reported area.**
- Close all doors and get everyone in rooms behind closed doors.
- Await the announcement of "Code Silver, All Clear"

Disaster & Other Drills

Practice
Practice
Practice

- Two annual documented disaster drills, one of which must include outside agencies
- Monthly Fire Drills, each shift quarterly (112 Drills Annually)
- Infant & Child Abduction Drills
- Hazardous Materials Spill Drills

- Prior to the Super Bowl in 2016, 26 ECH Staff were trained at FEMA's Center for Domestic Preparedness (CDP) in Anniston, Alabama. The course was entitled Healthcare Leadership for Mass Casualty Events.

Questions?

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Governance Committee Report a. Approval of Proposed Revised Board Officer Nomination and Selection Election Procedures b. Proposals to Revise El Camino Hospital Board Director Compensation and Reimbursement Policy and Procedure El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	Peter C. Fung, MD, Governance Committee Chair
	Action requested:	Possible Motion(s)

Background:

At its April 4, 2017 meeting, the Governance Committee reviewed the annual Board Advisory Committee Goal Setting Process and did not recommend any changes to it. The Committee also discussed the possibility of chartering a Strategic Planning Oversight Committee. We directed staff to pace the topic for further discussions after the Board considers adopting a new strategic plan (currently scheduled for June 28, 2017) when it can be better determined (1) what the purpose of such a committee would be, (2) whether it might be a standing committee or a temporary committee created from time to time to address specific issues, and (3) what expertise would be needed to populate the membership of the committee.

In addition, the Committee considered and voted to make recommendations regarding the following:

a. **Board Officer Nomination and Selection Procedure:** In May 2013 and 2015, the Board Officer election was conducted using the attached procedures and Board Chair competencies that were approved by the Board following the recommendation of the Governance Committee. The next Board Officer election is scheduled for May 10, 2017. The Committee was asked to consider the following staff recommendations for revisions:
   1. Revised dates for submission of declarations of interest and position statements to the Board Liaison.
   2. A revised process for voting, that provides for an initial round of preliminary balloting by roll call vote, and a motion to select each Board Officer. This method of voting will require that Officers are elected as required by law.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

b. **El Camino Hospital Board Director Compensation and Reimbursement Policy and Procedure:** In June 2015, the Board approved the following revisions to the policy:

- Compensation for attendance at up to 7 events per month.
- $200 stipend per Board meeting.
- $100 stipend per other approved event (Standing Committees, CBAC, Foundation Board, Ad Hoc Committees and PAMF/ECH JOC).
- To receive compensation attendance must be in person, except once per month.
- No additional stipend for Board Chair or other Officers.

At its April 4th meeting, the Committee discussed (1) an annual Board Chair Stipend, (2) a $100 stipend for Committee Chairs' participation in agenda preparation calls/meetings, (3) revising the once per month limitation on payment of the stipend when calling in to meetings, and (4) increasing the stipend for attendance at Board meetings. On the issue of the Board Chair stipend, the Committee considered national survey data showing that 11% of responding hospitals provide a Board Chair stipend, though for a majority it is less than $10,000 annually. The Committee also considered the Board Chair's projected minimum activities (based on the current Chair's activity), which include Regular Board meetings, the annual Board Retreat, agenda preparation calls, biweekly meetings with the CEO, numerous conference calls, occasional dinner meetings, etc. The Committee also reviewed data showing that, under the current policy, ECH Board members on average received $4,200 compensation in calendar year 2016. The Board Chair received less than any other Board member.

Following discussion, the Committee voted to recommend that the Committee Chairs be paid a $100 stipend for participating in each agenda preparation call/meeting and that the Board Chair be paid an annual stipend of $12,000, payable quarterly. The Committee did not discuss an effective date for these proposed revisions. If the Board approves these recommendations, the Board may direct staff to prepare a revised Board Director Compensation and Reimbursement Policy and Procedure for the Board's approval at its May meeting.

Board Advisory Committees that reviewed the issue and recommendation, if any:

a. The Governance Committee voted to recommend that the Board approve the Draft Revised Board Officer Nomination and Selection Procedure and Board Chair Competencies.

b. The Governance Committee voted to recommend that the Board approve an annual Board Chair stipend in the amount of $12,000, payable quarterly, and a Committee Chair stipend in the amount of $100 for participation in each agenda preparation call/meeting.

Summary and session objectives :

To update the Board on the work of the Committee and to obtain the Board's approval of the recommendations noted above.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Suggested discussion questions: 1. If the Board approves the recommendations regarding the Board Chair and Committee Chair stipends, should these provisions be effective immediately (Q4 FY17) or not until Q1 FY18?
	Proposed Board motion(s), if any: a. To approve the Draft Revised Hospital Board Officers Nomination and Selection Procedures and Board Chair Competencies. b. To direct staff to draft a revised Board Director Compensation and Reimbursement Policy and Procedure that provides for an annual Board Chair stipend in the amount of $12,000, payable quarterly, and a Committee stipend in the amount of $100 for participation in each agenda preparation call/meeting effective ___________________ (date) for the Board's consideration at its May 10, 2017 meeting.
	LIST OF ATTACHMENTS: 1. Draft Revised Hospital Board Officers Nomination and Selection Procedures (CLEAN) 2. Draft Revised Hospital Board Officers Nomination and Selection Procedures (REDLINES) 3. Board Chair Competencies 4. El Camino Hospital Board Director Compensation and Reimbursement Policy and Procedure

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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HOSPITAL BOARD OFFICERS

NOMINATION AND SELECTION PROCEDURES

FOR FY18

Draft Revised for Hospital Board Review April 12, 2017

Revised/Approved 4/8/15 by ECH Board of Directors

Any current director of the El Camino Hospital Board is eligible to serve as a Hospital Board Officer. The new Hospital Board Officer terms begin July 1, 2017. El Camino Hospital Board Officer elections shall be held in May of odd numbered years. Following the election, it shall be the role of the Board Chair-Elect to work with the Hospital CEO in May and June to develop a slate of Board Advisory Committee Chairs and members for the following fiscal year and to present the slate to the Board for approval in June.

Hospital Board Chair:

1. Interested Directors will declare their interest to the Board Liaison (Cindy Murphy) by close of business April 24, 2017. The Board Liaison will notify the Board of all declarations of interest by close of business April 25, 2017. Any other interested Directors will then declare their interest to the Board Liaison by close of business on April 26, 2017. The Board Liaison will notify the Board of any additional declarations of interest by close of business April 27, 2017. Interested Directors will prepare a one-page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the attached Hospital Board Chair competencies, no later than close of business May 1, 2017.

2. Position Statements will be distributed to Board members along with other routine Hospital Board materials one week in advance of the May 10, 2017 meeting.

3. Position Statements will be made available to the public and posted on the El Camino Hospital web-site when the Hospital Board materials are issued to the Board.

4. Standard questions for Hospital Board Chair:

   a. What do you see as the ECH strategic priorities over the coming two years?

   b. Name three defining roles of an effective Board Chair.

   c. How would you judge the success of your leadership and the Board at the end of your term?

5. At the May 10, 2017 meeting, Interested Directors will present the information below, in public session, in the sequence outlined. Approximately 25 minutes will be allocated to each

DRAFT

Interested Director: five (5) minutes for the Position Statement, ten (10) minutes for responses to standard questions, and (10) ten minutes to respond to general questions from the board and public:

a. Each interested director will read his or her Position Statement
b. Each interested director will provide responses to the standard questions. (Directors will present one question at a time in random order.)
c. The Public will be invited to ask Interested Directors any questions related to the candidate's interest in the position, and relevant experience as it relates to the Hospital Board Chair competencies
d. The Board will be invited to ask Interested Directors any additional questions related to an Interested Director's candidacy.

6. Upon review and discussion of the candidates, the Board will vote in public session. The CEO will recuse himself or herself from voting. The current Chair will facilitate the discussion and voting process.

7. The Hospital Board Chair will be elected by the Board in accordance with the following procedure at a meeting where a quorum is present.

   a. Preliminary Balloting
      i. Each Board member shall vote for a candidate via roll call.
      ii. In the event a majority is not achieved, the vote will be announced for each candidate and the candidate receiving the lowest number of votes will be dropped from the next ballot.
      iii. This procedure will continue until one candidate receives a majority of the votes cast.
      iv. In the event a tie vote occurs (e.g., 3-3 or 4-2-2), Interested Directors may be asked additional questions by Hospital Board members and the balloting procedure will continue until a majority is achieved by one candidate.
   b. Selection of a Board Chair
      i. Following the preliminary balloting, the Board shall consider a motion to elect the candidate who has received the majority of the votes in his/her favor.
      ii. If a motion pursuant to Section 7(b)(i) is not adopted by a majority of the Board members present at the meeting when a quorum is present, the Board shall continue to consider motions until a Board Chair is elected.

Hospital Vice-Chair:

1. At the May 10, 2017 Hospital Board meeting, Interested Directors will announce their candidacy following the successful election of the Hospital Board Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

Hospital Secretary/Treasurer:

1. At the May 10, 2017 Hospital Board meeting, Interested Directors will announce their candidacy following the successful election of the Hospital Board Chair and the Hospital Vice-Chair.
2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

HOSPITAL BOARD OFFICERS

NOMINATION AND SELECTION PROCEDURES

FOR FY20186

Draft Revised for Governance CommitteeHospital Board Review April 124, 2017

Revised/Approved 4/8/15 by ECH Board of Directors

Any current director of the El Camino Hospital Board is eligible to serve as a Hospital Board Officer. The new Hospital Board Officer terms are begineffective July 1, 20175. El Camino Hospital Board Officer elections shall be held in May of odd numbered years. Following the election, iIt shall be the role of the Board Chair-Elect to work with the Hospital CEO in May and June to develop a slate of Board Advisory Committee Chairs and members for the following fiscal year and to present the slate to the Board for approval in June.

Hospital Board Chair:

1. Interested Directors will declare their interest to the Board Liaison (Cindy Murphy) by close of business April 242, 20175. The Board Liaison will notify the Board of all declarations of interest by close of business April 253, 20175. Any other interested Directors will then declare their interest to the Board Liaison by close of business on April 264, 20175. The Board Liaison will notify the Board of any additional declarations of interest by close of bBusiness April 27, 20175. Interested Directors will prepare a one-page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the attached Hospital Board Chair competencies, no later than close of business May 1, 20175.

2. Position Statements will be distributed to Board members along with other routine Hospital Board materials one week in advance of the May 103, 20175 meeting.

3. Position Statements will be made available to the public and posted on the El Camino Hospital web-site when the Hospital Board materials are issued to the Board.

4. Standard questions for Hospital Board Chair:

    a. What do you see as the ECH strategic priorities over the coming two years?

    b. Name three defining roles of an effective Board Chair.

    c. How would you judge the success of your leadership and the Board at the end of your term?

5. At the May 103, 20175 meeting, Interested Directors will present the information below, in public session, in the sequence outlined. Approximately 25 minutes will be allocated to each

v

Interested Director: five (5) minutes for the Position Statement, ten (10) minutes for responses to standard questions, and (10) ten minutes to respond to general questions from the board and public:

a. Each interested director will read his or her Position Statement
b. Each interested director will provide responses to the standard questions. (Directors will present one question at a time in random order.)
c. The Public will be invited to ask Interested Directors any questions related to the candidate's interest in the position, and relevant experience as it relates to the Hospital Board Chair competencies
d. The Board will be invited to ask Interested Directors any additional questions related to an Interested Director's candidacy.

6. Upon review and discussion of the candidates, the Board will vote in public session. The CEO will recuse himself or herself from voting. The current Chair will facilitate the discussion and voting process.

7. The Hospital Board Chair will be elected by ~~a majority vote of~~ the Board in accordance with the following procedure at a meeting where~~n~~ a quorum is present.

a. Preliminary Balloting
   i. Each Board member shall vote for a candidate via roll call.
   ii. In the event a majority is not achieved, the vote will be announced for each candidate and the candidate receiving the lowest number of votes will be dropped from the next ballot.
   iii. This procedure will continue until one candidate receives a majority of the votes cast ~~(abstentions are not considered to be a vote)~~.
   iv. In the event a tie vote occurs (e.g., 3-3 or 4-2-2), Interested Directors may be asked additional questions by Hospital Board members and the balloting ~~voting~~ procedure will continue until a majority is achieved by one candidate. ~~The successful candidate will be announced at the conclusion of the voting process.~~

b. Selection of a Board Chair
   i. Following the preliminary balloting, the Board shall consider a motion to elect the candidate who has received the majority of the votes in his/her favor.
   ~~7.~~ii. If a motion pursuant to Section 7(b)(i) is not adopted by a majority of the Board members present at the meeting when a quorum is present, the Board shall continue to consider motions until a Board Chair is elected.

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Hospital Vice-Chair:

1. At the May 103, 20175 Hospital Board meeting, Interested Directors will announce their candidacy following the successful election of the Hospital Board Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

Hospital Secretary/Treasurer:

1. At the May 103, 20175 Hospital Board meeting, Interested Directors will announce their candidacy following the successful election of the Hospital Board Chair and the Hospital Vice-Chair.
2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

COMPETENCY CRITERIA Approved by the ECH Board April 10, 2013; April 8, 2015

HOSPITAL BOARD CHAIR COMPETENCIES

Authors: Neal Cohen, MD and Mark Sickles (Former Governance Committee member)

April 10, 2013

Leadership Effectiveness

- Communicates a compelling and inspired vision of the future
- Aligns interests and efforts
- Inspires and motivates
- Orchestrates multiple activities to accomplish goals
- Achieves results representing "business as unusual"
- Engages the entire board in discussion, deliberation and decision making
- Creates a healthy and respectful dissatisfaction with the status quo

Innovative and Generative Thinking

- Engenders creative thinking on the part of all board members and facilitates transformation of ideas into effective actions that produce extraordinary results
- Fosters the creative process in others
- Thoughtfully identifies what may be missing from analysis and decision making to generate renewal and breakthrough

Organizational Awareness

- Enhances performance of people working at all levels of the organization
- Manages the organization at the strategic and systems level to reduce variation and dysfunction and increase predictability, harmony, and sustainable success
- Makes things happen through others without direct involvement
- Leverages people's strengths while managing their developmental needs

Collaborative Spirit

- Ensures that the organization sets goals and objectives that are developed collaboratively and are supported by the entire organization
- Ensures the nature and degree of teamwork matches the task at hand
- Creates common ground to foster cooperation
- Transforms conflict into breakthrough
- Seeks information from a variety of sources before making decisions

Professionalism

- Maintains the highest level of integrity in all interactions with staff, leadership and the community at large
- Cool under pressure
- Fosters organizational integrity
- Holds things together during tough times
- Engages in fact-based conversations and root cause problem-solving
- Utilizes resources effectively and efficiently to get things done
- Inspires respect and trust throughout the organization that causes loyalty, dedication, and optimal performance

Strategy

- Ability to guide the board and leadership in identifying creative approaches to addressing current and anticipated challenges within the organization and, from these, determine the appropriate initiatives to pursue to gain competitive advantage and optimize the likelihood of long term success

Fiduciary Responsibilities

Ability to ensure:

- Maintains a commitment to ensuring positive net present value where operating income exceeds the annual cost of capital to the extent possible
- All work is dedicated to meeting or exceeding the expectations of all stakeholders
- Integrity and accuracy of financial statements and reporting systems

Risk & Risk Management

Ability to ensure the systematic approach to risk assessment and to defining risk management strategies related to the following:

- Investment
- Organizational Structure and Function
- Asset Management
- Strategy
- Operations/Finances
- Size/Diversity
- Compliance
- Reputation

Quality and Compliance

Ability to ensure:

- Internal standards far exceed external compliance standards of governmental and regulatory agencies
- Active identification and elimination of non-value-added work
- Pursuit of six sigma: zero defects, zero variability, and zero lead-times
- A customer-centric culture based on safety, efficacy and affordability

Governance

Ability to ensure:

- Alignment of interests and efforts of all stakeholders
- Shared understanding and pursuit of vision, mission, and strategy
- An approach to governance that causes effective leadership and management throughout the organization

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Board- El Camino Hospital Board Director Compensation and Reimbursement
CATEGORY:	Administration
LAST APPROVAL:	June 10, 2015

TYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT ☑ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	**Board**
OFFICE OF ORIGIN:	**Administration**
ORIGINAL DATE:	February 12, 2014 (applicable to events after 1/8/14)

I. **COVERAGE:** All Members of the El Camino Hospital Board of Directors with the exception of the Chief Executive Officer.

II. **PURPOSE:**

A. To define the events for which Board Directors other than the CEO shall receive compensation and reimbursement.
B. To define the amount of compensation Board Directors shall receive.
C. To define the procedures necessary to implement this policy.

III. **POLICY STATEMENT:**

A. El Camino Hospital shall pay members of its Board of Directors, for in person attendance at each of the events listed below, not to exceed seven events per month. However, one of the compensable events per month may be attended by teleconference. Members of the Board of Directors who do not wish to receive such payments may notify the Board Liaison and the CEO by submitting a "Board of Directors' Compensation Op-Out" form. Any member not receiving compensation may request to receive such compensation for attendance at future events by notifying the Board Liaison and the CEO.

B. Events which are subject to compensation include:
   1. Board members shall be paid $200 for attendance at Regular, Special and Emergency Meetings of the El Camino Hospital Board of Directors.
   2. Board members shall be paid $100 for attendance at meetings of the Standing Board Advisory Committees of which the Director is a member or an alternate.
   3. In addition to the foregoing meetings, the Board, by adoption of this policy, declares that the following events constitute performance of official duties by a member of the Board of Directors for which Board members shall be paid $100 for attending:

a. Meetings of the Board's Ad Hoc Committee established by the Board of which the Director is a member.
b. Meetings of the El Camino Hospital Foundation, when the Director is then serving as an ex-officio member of the Foundation Board.
c. Meetings of the Community Benefit Advisory Council ("CBAC") if the Director has been appointed to the CBAC by the El Camino Hospital Board of Directors.
d. Meetings of the PAMF/ECH Joint Operating Council if the Director has been appointed as the Board's liaison to the Council.

C. El Camino Hospital shall also pay to members of its Board of Directors (who request such payment reimbursement and submit the required form) an amount equal to his or her actual necessary travel and incidental expenses, including but not limited to travel, lodging and meals incurred (1) as a result of attending events specified in Section B above and (2) as a result of attending educational events funded by El Camino Hospital.

D. Board members who reside within the El Camino Healthcare District shall not be eligible for reimbursement for mileage to events at El Camino Hospital.

E. Board members are expected to use prudent judgment in selecting their travel accommodations and otherwise incurring expenses which will be reimbursed by the Hospital.

F. This policy shall be implemented in accordance with the procedures described in Section VI below.

IV. DEFINITIONS (if applicable):

N/A

V. REFERENCES:

N/A

VI. PROCEDURE:

A. Stipends

1. Hospital staff will track Board members' attendance at meetings and, on a monthly basis, provide Board members who have not opted out of the

policy with a "Meeting Attendance Report Confirmation" Form for signature.

2. Upon receipt of the signed Meeting Attendance Report Confirmation and following approval of the Board Chair, (or the Vice Chair, in the case of the Chair's compensation) Hospital staff will forward the document to accounting.
3. Stipends paid to Directors are IRS Form 1099 – Miscellaneous reportable. Directors who have not opted out of participation (See, Section III A) and are accepting stipend payments must submit IRS FORM W-9 to ECH Accounting before receiving payment. Annually, ECH will provide IRS Form 1099-Miscelaneous to Directors receiving stipend compensation in excess of $600.00 in a calendar year.

B. Use of Personal Vehicle for attendance at meetings or educational events.

1. The Hospital will pay the current IRS mileage rate for miles actually traveled, but not more than, from the Board member's home or usual place of business within California to events as defined in Section III B and to educational events funded by the Hospital. Board members who reside within the El Camino Healthcare District shall not be eligible for reimbursement for mileage traveled to events at El Camino Hospital.
2. To be reimbursed, the Board member must complete the Mileage Reimbursement form provided by the Board Liaison. The form must be signed by the Board Chair (or the Vice Chair in the case of the Chair's reimbursement) and sent to accounting (OAK200) for processing.

C. Educational seminars, conferences, events etc. attended for the benefit of the Hospital and in accordance with the Board and Committee Education Policy.

1. **Seminar/conference fees** will be reimbursed in full or at a pro-rated amount in accordance with the Board and Committee Education Policy.
2. **Air travel** will be reimbursed at "coach" airfare rates. No reimbursement should be claimed for personal convenience fees such as those associated with priority boarding or seating upgrades.
3. **Ground travel** to a seminar or a meeting using the Board member's personal vehicle will be reimbursed as noted in item D.1., at the current IRS mileage rate per mile. Board members should consider use of a rental car in cases where the expenses are expected to be less than the reimbursement for a personal vehicle.

4. **Taxi, bus, rail, limo or rental car service**, if required at the destination, may be reimbursed by the Hospital if necessary for business purposes, as follows:
    a. Reimbursement for car rental expenses incurred by the Board member will be limited to the amount charged for a standard “intermediate” car unless there is a business need for a larger vehicle (multiple travelers with luggage, for example). If the requester requests a larger automobile than is necessary to meet the business need, he/she is to have the rental agency document what the price would have been for a standard “intermediate” vehicle and seek reimbursement for only the lower amount. If a larger vehicle is required to meet a business need, this need must be documented on the "Business-Education-Travel Reimbursement Authorization" form.
    b. Limousine service is permitted if it is no more expensive than available alternatives.
    c. Board members should choose the least expensive available alternative suitable for the purpose and situation.
5. **Lodging** will be reimbursed at the standard private room rate at the selected motel/hotel.
6. **Meals** will be reimbursed at actual cost plus tip (normally 15%). The maximum reimbursement per day is $95.00. It is the responsibility of the Board member to decide how he/she spends the per day maximum allowable amount for meals. Detailed receipts indicating the items purchased must be submitted.

    [Note: Other than contracted medical directors, this policy shall not apply to reimbursement for meals involving physicians, regardless of whether submitted by a physician or a non-physician employee. Refer to Policy 37.00 for expenses involving physicians.]

7. **Alcohol** will not be reimbursed unless approved by the CEO, CFO or Board Chair. Because approval will only be granted in unusual circumstances, it is recommended that Board members request approval in advance of the expenditure. The maximum reimbursement of $95.00 per day includes any approved expenses for alcohol.

8. **Telephone calls and Internet Service**, during travel, required for necessary Hospital business will be reimbursed at cost. These expenses should be itemized on the statement. The Hospital will also reimburse expenses for a personal telephone call home each day while on Hospital business. The conversation should be kept to a reasonable length and will be reimbursed at cost.

D. The Hospital will not advance or reimburse for the following:
   1. Any expenses of a spouse or other individual who accompanies the Board member on travel.
   2. Any additional expenses for travel by business or first class, or any charges for special boarding privileges or seats.
   3. Lodging amenities such as subscription television, valet service, cleaning/pressing of clothes (if the function is greater than one week, this service is allowed), concierge, etc. In-room meal service is subject to the normal meal reimbursement rates detailed in D.2.f above.
   4. If an offsite event is within a reasonable radius of the Board member's home or usual place of business and the function is starting after 7:30 a.m. and/or will be ending before 11:30 p.m., the Hospital will not pay for overnight accommodations, as it is expected that the Board member will commute that distance to and from the function within that business day.
   5. Car rental fees on an individual basis where there is the opportunity to share a rental car for a group of participants.
   6. Additional per mileage charge or gasoline expense by a car rental agency for personal pleasure driving.
   7. Any entertainment such as theater, tours, nightclubs, etc.
   8. Discretionary expenses for another Board member or Hospital staff, such as a birthday, holiday (e.g. Christmas), weddings, child birth, special days (i.e. Administrative Day, or some life event.
   9. Professional memberships are generally not reimbursable.

E. Travel Reservations: When booking accommodations and/or air travel, the following points should be noted:
   1. If a deposit is required to be made by the Hospital, prior approval of the travel request must be received in sufficient time for Accounting to process

the request and ensure that the payment reaches its destination by the required date.

2. When booking air travel utilizing a travel agency, the Hospital's current travel agency must be used. Board members may book airfares over the Internet using the employee's personal credit card. The Board member must then seek reimbursement from the Hospital.
3. In most cases, air travel should be booked as a non-refundable fare. The much-lower cost of these non-refundable fares is normally so great that the extra cost, should a trip be re-scheduled, is still much less than paying a full-price fare.

F. Expense Account Reporting

1. Expense account reporting must be in conformity with minimum IRS standards and all expenses of $25.00 or greater must be supported by detailed receipts. Expense reports must indicate as a minimum all of the following:
    a. Business purpose
    b. Date and location
    c. Name and position
2. Noncompliance with the above requirements could cause the reimbursement to be considered as additional compensation to the Board member and thus would become taxable (via a W-2 or Form 1099). To avoid this potential problem, the employee must complete the "Business-Education-Travel Reimbursement Authorization" form and attach all supporting documentation.

G. Procedure for Completing Form

1. All Board members must complete the "Business-Education-Travel Reimbursement Authorization" form (Form 2085). Local business mileage reimbursement may be requested via the use of the Mileage Reimbursement form (form #54.00a).
2. Form #2085 is self-explanatory, but listed below are key points to remember.
    a. <u>All</u> supporting documents must be attached to the request form. Examples of supporting documents include
        i. Copy of registration form
        ii. Lodging receipts

iii. *Detailed* meal receipts
iv. Car rental receipts
v. Parking fee receipts

b. In circumstances where a receipt is not obtainable (or lost), the Board member must attach a statement detailing the expense as to date, place, reason for expense, and amount. All reports with missing receipts require approval by the CFO or CEO.

c. Where receipts are given that include non-reimbursable expenses, these expenses must be marked in some fashion and deducted from the total so that only eligible expenses are reimbursed.

3. When travel advances are provided, the recipient must submit a final accounting of his/her expenses on the Business, Education, and Travel Expense form and return any excess advance, no later than 120 days from the date of the event. If this is not done, disciplinary action may be taken. In addition, any undocumented advance will be considered additional income to the recipient and reported as a W-2 or Form 1099 transaction.
4. Signature Authority (approval) for the completed form, as well as travel agency invoices, is as follows:
   a. Department Manager/Director - up to $5,000.00 per activity.
   b. Department Line Vice President - up to $50,000.00 per activity.
   c. CEO - amounts greater than $50,000.00 per activity.
5. A Board Member cannot approve her/his own reimbursement of funds.

H. Exceptions: Because it is impossible to foresee every possible situation, it is recognized that exceptions may sometimes be appropriate. As a result, expenses which are not generally reimbursed under this policy may be reimbursed by the Hospital upon determination of the appropriateness and reasonableness of the expenses by the CEO or CFO. Any such exception, including the justification for the exception, shall be attached to the request for reimbursement.

VII. APPROVAL:

Approving Committees and Authorizing Body	Approval Dates
Originating Committee or UPC Committee	N/A
(name of) Medical Committee (if applicable):	N/A
ePolicy Committee:	N/A
Pharmacy and Therapeutics (if applicable):	N/A

Medical Executive Committee:	N/A
Board of Directors:	6/10/15
Historical Approvals:	*2/12/14 (applicable to covered events occurring after 1/8/14)*

VIII. <u>ATTACHMENTS (if applicable):</u>

N/A

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Investment Committee Report El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	Iftikhar Hussain, CFO
	Action requested:	For Information

Background:

The Investment Committee meets 4 times per year. The Committee last met on March 6, 2017 and meets next on May 8, 2017.

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 FY17 goals.
2. **Other Key Accomplishments:**
   - Reviewed investment performance, fees and liquidity.
   - Discussed FY18 goals including:
     a. Review of actively managed vs. passive investment strategy in Q3.
     b. Annual meeting with Finance Committee to align investment strategy with capital and cash flow needs
3. **Important Future Activities**:
   - Approve FY18 Committee goals
   - Review 403(b) employee investment options. The Investment Committee charter includes the following duties related to the 403(b) plan:
     a. Monitor the investment performance of the specific investment vehicles made available to employees through their 403(b) Retirement Plan.
     b. Review recommendations from the Retirement Plan Administrative Committee (RPAC) regarding the selection of an independent investment advisor for the employees' 403(b) Retirement Plan and make recommendations to the Board. The Board will appoint the investment advisor, and the RPAC will monitor, select, and replace the Core investment choices.

Suggested discussion questions: None. This is an informational item.

Proposed Board motion, if any: None.

LIST OF ATTACHMENTS: None.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Corporate Compliance/Privacy and Internal Audit Committee Report El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	John Zoglin, Compliance Committee Chair
	Action requested:	For Information

Background:

Date of last Committee Meeting: March 16, 2017
Date of next Committee Meeting: May 18, 2017

1. **Progress Against Goals:**
   The Committee is on track to complete its FY17 goals.
2. **Other Key Accomplishments:**
   - Lica Hartman joined the Committee in January 2017. She has a background in internal audit and enterprise risk management with experience in banking and capital markets.
   - The Committee approved a policy that provides guidelines for when documents would require approval by the Hospital Board. The new guidelines will significantly reduce but not completely eliminate policy oversight by the Board.
   - The Committee reviewed the external Financial Auditors' audit plan and areas of emphasis. The Committee requested additional audit items for consideration to be placed on a rotational basis.
3. **Important Future Activities:**
   - Joint session in June with the Board and Committee to review the Enterprise Risk Management performance and future development of the program.

Other Board Advisory Committees that reviewed the issue and recommendation, if any:

None.

Summary and session objectives:

To update the Board on the work of the Compliance Committee

Suggested discussion questions: None.

Proposed Board motion, if any: None. This is an informational item.

LIST OF ATTACHMENTS: None.

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Special Meeting to Conduct a Study Session
Friday, March 3, 2017
2500 Grant Road, Mountain View, CA 94040
Conference Rooms E,F,&G (ground floor)

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

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the El Camino Hospital Board of Directors (the "Board") was called to order at 1:35 pm by Secretary Fung. A verbal roll call was taken. Directors Cohen and Chiu were absent. Director Chen arrived during the closed session at 1:45 pm. All other Board members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Secretary Fung asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were noted. Secretary Fung welcomed those present and requested that Board members staff, physicians, and consultants from Manatt introduce themselves.	
3. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 1:40 pm pursuant to *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets: Strategic Priorities. **Movant:** Reeder **Second:** Davis **Ayes:** Davis, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Chen, Chiu, Cohen **Recused:** None	***Adjourned to closed session at 1:40 pm.***
4. AGENDA ITEM 7: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 5:35 pm. There were no actions taken during the closed session.	
5. AGENDA ITEM 8: ADJOURNMENT	**Motion**: To adjourn at 5:35 pm. **Movant:** Zoglin **Second:** Miller **Ayes:** Chen, Davis, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Chiu, Cohen **Recused:** None	***Meeting adjourned at 5:35pm.***

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

DRAFT

Minutes of the Open Session of the El Camino Hospital Board of Directors
Special Meeting to Conduct a Study Session
Saturday, March 4, 2017
2500 Grant Road, Mountain View, CA 94040
Conference Rooms E,F,&G (ground floor) | Medical Staff and CEO Conference Rooms (admin)

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

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the El Camino Hospital Board of Directors (the "Board") was called to order at 8:32 am by Secretary Fung. A verbal roll call was taken. Directors Cohen and Chiu were absent. All other Board members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Secretary Fung asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 8:34 am pursuant to *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets: Strategic Priorities. **Movant:** Miller **Second:** Chen **Ayes:** Chen, Davis, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Cohen, Chiu **Recused:** None	***Adjourned to closed session at 8:34 am.***
4. AGENDA ITEM 7: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 2:00 pm. There were no actions taken during the closed session.	
5. AGENDA ITEM 8: ADJOURNMENT	**Motion**: To adjourn at 2:00 pm. **Movant:** Reeder **Second:** Chen **Ayes:** Chen, Davis, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Cohen, Chiu **Recused:** None	***Meeting adjourned at 2:00pm.***

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

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, March 8, 2017
2500 Grant Road, Mountain View, CA 94040
Conference Rooms E, F & G (ground floor)

Board Members Present	**Board Members Absent**	**Members Excused**
Lanhee Chen **Dennis Chiu**, Vice Chair **Neal Cohen, MD**, Chair **Peter Fung, MD** **Julia Miller** **David Reeder** **John Zoglin**	**Jeffrey Davis, MD**	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 5:45 pm by Chair Cohen. A silent roll call was taken. Director Davis was absent. Director Chen arrived at 6:10pm during Agenda Item 6: Resolution 2017-03. All other Board members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Director Cohen asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. BOARD RECOGNITION	**Motion:** To approve *Resolution 2017-02*. **Movant:** Fung **Second:** Chiu **Ayes:** Chiu, Cohen, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Chen, Davis **Recused:** None Donald Sibery, Interim CEO, acknowledged the 50th Anniversary Service Awards Recognition Celebration Committee for their skill, expertise, and talent to create the 2017 Service Awards. He noted that this was the best employee service awards ceremony that he has ever seen in his 45 years of experience.	***Resolution 2017-02 approved***
4. QUALITY COMMITTEE REPORT	Director Reeder, Chair of the Quality Committee, reported that the Committee received a presentation on the Interventional Pulmonology program from Ganesh Krishna, MD. Director Reeder provided an overview of the metrics on the quality dashboard, noting a slight uptick in patient falls, which includes assisted falls. He explained that ECH is on track for its organizational goals, including length of stay, readmission rates, and pain reassessment. The Committee is considering its goals for FY18, including goals related to culture of safety and Quality Review Reports (QRRs). Director Reeder noted that the Committee and Catherine Carson, Sr. Director, Quality Improvement & Patient Safety, are also considering adding a sepsis metric to the dashboard for next year. Director Reeder reported that the Committee requested the Board's input and	

	direction as to whether or not Patient and Family-Centered Care should be the Committee's "big dot" goal. The Board discussed how this request should be reviewed in conjunction with the Hospital's strategic planning process. In response to Director Zoglin's question, the Board discussed ECH's 4-star CMS rating, the challenges of CMS ratings, and the importance of choosing metrics that align with patient needs. In response to Director Miller's question, Cheryl Reinking, CNO, explained that readmission rates for Medicare patients are captured in iCare reports and reviewed in daily huddles and staff meetings (if a patient is discharged and returns within 30 days, staff validate if the return is planned or unplanned). She explained the readmission group is discussing expanding the scope and tracking readmission data for non-Medicare patients as well.	
5. FY17 PERIOD 7 FINANCIALS	Iftikhar Hussain, CFO, outlined the highlights of the FY17 Period 7 Financials, which have not been reviewed by the Finance Committee yet, including: - Inpatient volume has increased, largely due to the late flu season; overall outpatient volume YTD is below budget, but higher than the prior year. - For payor mix, there is a large variance between budget and actual due to the drop in commercial business in the mix and large share of Medicare business. - Total cash on hand in January was at an all-time high of 408 days, which is good position as the large construction projects progress. He explained that these financials include a $3 million understatement in net revenues for Los Gatos and will be corrected in the February financials. Mr. Hussain also provided an overview of some monthly trends: adjusted discharges, operating incoming (ahead of plan all year), days in AR (slight increase in January because of processing slowdowns during holidays at insurance companies), net revenues (consistently ahead of budget) and expenses (consistently below budget).	
6. RESOLUTION 2017-03	Mr. Hussain introduced Chad Kenan from Citigroup who provided an overview of the 2017 Plan of Finance. Mr. Kenan reported that the goal of the transaction is to raise funds to support $290 million of tax-exempt projects. He explained that the interest rate environment is still favorable, but volatile. He reported that the Finance and Investment Committees at their Joint Meeting in January encouraged staff to move as quickly as possible with the transaction to avoid the impact of further volatility in the market. He noted that next steps include mailing a preliminary official statement on March 8, 2017, pending Board approval, and going to market the following week. He outlined the history of El Camino Hospital financing in the past decade and the projects to be financed in the upcoming series of Revenue Bonds, including: Behavioral Health Building, North Parking Garage Expansion, Integrated Medical Office Building, and Women's Hospital updates (the last project remains flexible and can be deferred until a later date). Mr. Kenan reported that both rating agencies have confirmed ECH's ratings, support the strategy and projects to be funded, reaffirmed A+ rating from	

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	Standard &Poor's, A1 rating from Moody's, both with stable outlooks. The Revenue Bonds will be priced on March 14th and the transactions for both the Revenue Bonds for the Hospital and General Obligation Bonds for the District are scheduled to close on March 22nd. **Motion:** To approve Resolution 2017-03 approving transactions for the funding of new projects at the Mountain View campus and paying costs of issuance plus a capitalized interest amount not to exceed $325,000,000. **Movant:** Chiu **Second:** Fung **Ayes:** Chen, Chiu, Cohen, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	
7. COMMUNITY BENEFIT MID-YEAR REPORT (METRICS, GOALS, AUDIT)	Barbara Avery, Director of Community Benefit, introduced Melanie Espino from Actionable Insights. Ms. Espino provided an overview of the audit performed for the three largest grantees receiving Hospital funding: a school nurse program, preventive health screening & education program, and school-based counseling program. In response to Director Zoglin's question, Ms. Espino explained that the audit cost approximately $10,000. In response to Director Miller's question, Ms. Espino outlined the metrics reported by the school nurse program, including: number of children who fail hearing, vision, or dental screenings, corresponding nurse follow up, and scheduled appointments; applications for and enrollment in Medi-Cal due to nurse outreach; and staff CPR training. Ms. Avery presented the FY17 Midterm data. She highlighted that: - In FY17 the number of grants increased by 25%, including 7 new programs. - 93% of the metrics were met or exceeded targets. 83% of grantees achieved at least 90% of their metrics. For the grantees who did not meet metrics, they provide reports as to why metrics were not met, and the Community Benefit Department monitors those grantees, helping where possible. - 12% of metrics were new this year. 88% were trending (i.e. the same metrics from prior years). Ms. Avery also described the staff's efforts to review and select a new, more robust online grants management platform. She explained that it will help automate processes, especially useful for a portfolio of this size. She explained that new metrics are used when staff wants to be responsive to changing needs in the grantees' organizations. She provided an example with a new universal metric now used across the board for all school-based counseling programs. Lessons learned from midyear reports included: - Political climate (anxiety about program enrollment, ACA uncertainty and concerns about access and coverage) - Housing, cost-of-living, and commutes (staff hiring and retention contributing to delays) - Language barriers (more time-intensive services) - Resourceful solutions to meet goals	

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	Ms. Avery also shared a letter from a teacher at a school in Campbell that has received Hospital grants thanking the Board for its support of these programs. In response to Director Zoglin's question, Ms. Avery explained that the historical and YTD data for the grantees will be brought to the Board to inform FY18 funding.	
8. GOVERNANCE COMMITTEE REPORT	Director Fung, Governance Committee Chair, reported on recent activity of the Committee including: - The Committee began discussions about forming a Strategic Planning Oversight Committee, to be discussed further at its next meeting on April 4, 2017. - Gary Kalbach is currently serving as an advisor to the El Camino Hospital Board Member Appointment District Ad Hoc Committee. Upcoming items for review include: 1) FY17 Board Self-Assessment; 2) Further discussions about the utility, charter, and composition of a possible Strategic Planning Oversight Committee; 3) Current Board Officer Election Procedure; and 4) Current Board Director Compensation Policy.	
9. PUBLIC COMMUNICATION	None.	
10. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:39 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (February 8, 2017); Minutes of the Closed Session of the Special Meeting to Conduct a Study Session of the Hospital Board (February 15, 2017); Minutes of the Closed Session of the Executive Compensation Committee Meeting (November 16, 2016); pursuant to *Gov't Code Section 54957* and *54957.6* for report and discussion on personnel matters for approval of the Revised FY17 Incentive Goals: VP, Corporate & Community Health Services; President, CONCERN:EAP and approval of the FY17 Incentive Goals: Chief Medical Officer; pursuant to *Health and Safety Code* 32155 for deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report; pursuant to *Health and Safety Code* 32155 for deliberations concerning reports on Medical Staff quality assurance matters: Organizational Clinical Risks; pursuant to *Gov't Code Section 54956(d)(2)* – conference with legal counsel – pending or threatened litigation: Physician Transaction Compliance Education; pursuant to *Gov't Code Section 54957* and *54957.6* for report and discussion on personnel matters and *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets: Informational Items; pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters and *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets: CEO Search Committee Report; pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters: Executive Session. **Movant:** Chen **Second:** Chiu **Ayes:** Chen, Chiu, Cohen, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	***Adjourned to closed session at 6:39 pm.***

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11. AGENDA ITEM 20: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 8:27pm. Agenda items 11-19 were addressed in closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (February 8, 2017), Minutes of the Closed Session of the Special Meeting to Conduct a Study Session of the Hospital Board (February 15, 2017), Minutes of the Closed Session of the Executive Compensation Committee Meeting (November 16, 2016), the Revised FY17 Incentive Goals: VP, Corporate & Community Health Services; President, CONCERN:EAP, and the Medical Staff Report by a unanimous vote in favor of all members present (Directors Chen, Chiu, Cohen, Fung, Miller, Reeder, and Zoglin). Director Davis was absent. The FY17 Incentive Goals: Chief Medical Officer, were approved as amended (Directors Chen, Chiu, Cohen, Fung, Miller, Reeder, in favor; Director Zoglin opposed and Director Davis absent)	
12. AGENDA ITEM 21: CONSENT CALENDAR	Director Cohen asked if any member of the Board or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting (February 8, 2017); Minutes of the Open Session of the Special Meeting to Conduct a Study Session of the Hospital Board (February 15, 2017); Minutes of the Open Session of the Executive Compensation Committee Meeting (November 16, 2016); Appointment of Executive Compensation Committee Member; and the Medical Staff Report. **Movant:** Chiu **Second:** Fung **Ayes:** Chen, Chiu, Cohen, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	***Consent calendar approved***
13. AGENDA ITEM 22: INFO ITEMS	There were no questions or additional comments on the CEO Report. Director Reeder asked that the organizational goals be reconciled between what is reviewed with Dr. Faber at the Quality Committee and what is presented to the Board.	
14. AGENDA ITEM 23: BOARD COMMENTS	There were no additional Board comments.	
15. AGENDA ITEM 24: ADJOURNMENT	**Motion**: To adjourn at 8:29 pm. **Movant:** Chiu **Second:** Fung **Ayes:** Chen, Chiu, Cohen, Fung, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	***Meeting adjourned at 8:29 pm.***

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
Sarah Rosenberg, Board Services Coordinator

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Minutes of the Open Session of the
Executive Compensation Committee
Thursday, February 16, 2017
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040
Conference Rooms A (ground floor)

Members Present
Lanhee Chen, Chair
Teri Eyre
Bob Miller, Vice Chair
Julia Miller

Members Absent

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Executive Compensation Committee of El Camino Hospital (the "Committee") was called to order at 3:03pm by Chair Chen. All Committee members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Chen asked if any Committee members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. PUBLIC COMMUNICATION	None.	
4. CONSENT CALENDAR	Chair Chen asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Executive Compensation Committee Meeting (November 16, 2016). **Movant:** J. Miller **Second:** Eyre **Ayes:** Chen, Eyre, B. Miller, J. Miller **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Consent calendar approved***
5. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 3:03pm. **Movant:** J. Miller **Second:** B. Miller **Ayes:** Chen, Eyre, B. Miller, J. Miller **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 3:03pm.***
6. AGENDA ITEM 11: RECONVENE OPEN SESSION/ REPORT OUT	Agenda items 6-10 were addressed in closed session. Open session was reconvened at 4:52 pm. During the closed session, the Committee approved the Minutes of the Closed Session of the Executive Compensation Committee Meeting of November 16, 2016 and recommended for approval the Revised FY17 VP of Corporate & Community Health & President, CONCERN:EAP Goals, and the FY17 Chief Medical Officer Goals as amended, by a unanimous vote in favor of all members present (Chen, Eyre, B. Miller, J. Miller).	

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7. AGENDA ITEM 12: COMMITTEE RECRUITMENT	**Motion:** To recommend that the Board appoint Mr. Jaison Layney to the Executive Compensation Committee for a term of service expiring June 30, 2017, renewable annually. **Movant:** B. Miller **Second:** T. Eyre **Ayes:** Chen, Eyre, B. Miller, J. Miller **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Mr. Layney recommended for appointment***
8. AGENDA ITEM 13: FY17 PACING PLAN	Ms. Eyre left the meeting at 4:52. Mr. Miller provided written comments and notes to staff for minor changes on the pacing plan. The next Executive Compensation Committee meeting will be on March 23, 2017.	
9. AGENDA ITEM 14: CLOSING COMMENTS	There were no additional comments.	
10. AGENDA ITEM 15: ADJOURNMENT	**Motion**: To adjourn at 4:53 pm. **Movant:** B. Miller **Second:** Chen **Ayes:** Chen, B. Miller, J. Miller **Noes:** None **Abstentions:** None **Absent:** Eyre **Recused:** None	***Meeting adjourned at 4:53 pm.***

Attest as to the approval of the foregoing minutes by the Executive Compensation Committee and the Board of Directors of El Camino Hospital.

Lanhee Chen
Chair, Executive Compensation Committee

Peter C. Fung, MD
Secretary, ECH Board of Directors

Prepared by: Sarah Rosenberg, Board Services Coordinator

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Executive Compensation Committee Member Appointment El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	Possible Motion
	Background: At its November 16, 2016 meeting, the Executive Compensation Committee requested staff to begin recruitment of a new member in accordance with the Board's Advisory Committee Member Nomination and Selection Policy.* To that end, Cindy Murphy, Board Liaison, Julie Johnston, Director, Total Rewards, Kathryn Fisk, CHRO, and Committee Chair Lanhee Chen developed the attached Position Specification. The Specification was circulated to the Board, Committee Members, and Senior Leadership Team and we advertised in local print media. In addition, at the suggestion of a Committee member, we also worked with the staff at Boardlist to identify potential candidates. We screened a number of candidates and those who expressed interest spoke with Director Chen who recommended that three individuals be invited to interview with the Committee. The Committee interviewed two of those individuals on February 16th and the Board appointed Jaison Layney on March 8, 2017. The Committee interviewed a third candidate, Patricia Wadors, on March 23rd.	
	Advisory Committees that reviewed the issue and recommendation, if any: The Executive Compensation Committee voted to recommend that the Board appoint Patricia Wadors to the Executive Compensation Committee.	
	Summary and session objectives : To obtain Board approval.	
	Suggested discussion questions: None. This is a consent item.	
	Proposed Board motion, if any: To appoint Patricia Wadors to the Executive Compensation Committee for a term of service expiring June 30, 2017, renewable annually.	
	LIST OF ATTACHMENTS: 1. Position Specification 2. Candidate Profile – Patricia Wadors	

Executive Compensation Committee Position Specification – December 2016

Executive Compensation Committee Charter (Attached)

Executive Compensation Committee Membership Requirements

The El Camino Hospital Executive Compensation Committee of the Board presently meets four times per year (beginning at 4:00 pm) and jointly with the Board of Directors for educational sessions 2-3 times per year (beginning at 5:30 pm). This Committee position is non-compensated (i.e. volunteer)

Professional Experience and Competencies

- Candidates will have demonstrated strategic effectiveness in the areas of executive compensation, performance goal setting and evaluation, and executive development and succession planning.
- Candidates with a strong foundation in executive and/or employee benefits, and all elements of a "total remuneration" analysis, are highly desirable.
- An understanding of the healthcare sector would be a plus but is not required.
- Board experience would also be a plus, but is not required.
- Residency with the Silicon Valley would be a strong plus.
- Candidates are likely to have current or recent roles as Chief Human Resources Officers (CHRO), Senior Executive Compensation Officers or General Managers with a strong foundation in executive compensation matters.

Education/Credentials

- Candidates with an advanced degree will be preferred but not required.

Work Style and Personal Traits

- High Integrity
- Collaborative Nature
- Clear Communicator
- Energy and a sense of urgency
- Creative and imaginative
- An innovator
- A sense of humor
- Mission driven
- Comfortable with change

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Patricia Wadors

968 Manor Way, Los Altos, CA 94024
Cell 408 203-2351

Summary:

Results-oriented, business focused leader with over 26 years of progressive experience in Human Resources Management, Executive Coaching, organization effectiveness, program management, change management, and strategic communications. Possess an excellent combination of strategic vision, leadership, and operational execution, with the ability to communicate and influence effectively from line staff to executive management. Have held several leadership roles both in HR as well as line operational functions in major corporations. Seen as a key business leader, talent visionary and a trusted partner.

LinkedIn, Mountain View, California (now MSFT 12/8/16) **2/13 - Present**
Senior Vice President of Global Talent Organization (CHRO)

- Report to the CEO / Employee base is ~ 10,000 globally with a multinational footprint.
- Work closely with the Comp Committee, BOD and Executive team driving to business results.
- Created and launched a new Employee Value Proposition in 2013 that informed our 3 year HR strategy roadmap.
- LinkedIn recognized as the Employee Choice for 2016 as voted in Glassdoor by our employees.
- Engagement score is in the top 5 percentile of the world based on Sirota benchmarking for the last two years.
- Increased female leadership > 10pts in the last two years; increased overall diversity footprint YOY with key initiatives around Belonging, Breaking Bias and community outreach.
- Recognized as CHRO of the Year 2016; Top 50 Women in Tech 2015, 2016 as recognized by the National Diversity Council as well as Top Women in Tech Northern CA 2016.
- Proud to have published on LinkedIn, Huffington Post, HBR and Forbes. Excited to explore new ideas and solve talent challenges.

PLANTRONICS, Santa Cruz, California **4/10 – 2/2013**
Senior Vice President of Human Resources and Facilities

- Reported to the CEO and responsible for people and places.
- Employee base ~ 3,500 globally with a multinational footprint.
- Worked closely with the Comp Committee and Executive team driving to business results.
- Re-designed the workplace and our work philosophy to align with our vision of "Simply Smarter Working"; focusing on leveraging social networking/ systems and technologies to enable employees to do their job anywhere and at anytime.

TWITTER, San Francisco, California **8/11 – Present**
Executive Advisor to CEO and VP HR

- Support the Board, CEO and Head of HR to achieve their business goals – creating a scalable high performing organization that can execute the business strategy with quality.
- Focus – organizational design, talent strategies and corporate culture transformation.

YAHOO! INC., Sunnyvale, California **11/05 – 4/10**
Senior Vice President of Human Resources

- Reported to the Chief People Officer of Yahoo!
- Was responsible for leading the HR Business Partner function for the entire global business line. This equated to over 14,500 employees in over 17 locations. Promoted two times since joining Yahoo!
- Was responsible for Compensation, Benefits, HR Programs/ Operations, and lead the HR efforts for the Microsoft Integration for our Search Business.

- Key responsibilities/ accomplishments:
  - Coached and on-boarded our new CTO; partnered with the President and sat on her staff.
  - Led the change management function for Yahoo! during significant organizational transformations (2 CEO changes and our most recent company-wide organizational redesign.)
  - Manage a cross functional HR global team of approximately 135 HR professionals.
  - Interface with the Comp Committee, CEO staff on a regular basis.
  - Key partner in strategic acquisitions.
  - Led three global reductions in force in the last 18 months

- Worked across the CEO organization on executive on-boarding, org design and change management efforts.
- Re-designed the line HR function establishing a centralized services/ PMO team to focus on efficiencies and quality

ALIGN TECHNOLOGY, INC., Santa Clara, California **12/03 – 11/05**
Vice President of Global Human Resources

- Led the Global Human Resource function a high growth company with over 1100 employees worldwide.
- Reported directly to the CEO / President with a strong working relationship to the Board of Directors and the Compensation Committee.
- Implemented a new Health Benefits Program and a new 401K plan
- Designed and implemented new compensation and incentive plans – Sales, Executives, General
- Equity Compensation management – Plan redesign as a result of FASB101.
- Designed and implemented a global workforce strategy and organizational capability cycle/ development model.

APPLIED MATERIALS, INC., San Jose, CA **96 –1/04**
TCG/ PDC Product Groups, Hayward, CA **9/01 – 12/03**
Senior Director of Human Resources

- Led a global Human Resource organization with over 1,600 employees worldwide
- Partnered and coached Group Presidents to define culture, organizational goals and communication strategies.
- Led workforce planning strategies – right people, in the right role, at the right time
- Managed over 8 reductions in force over the last two and a half years. No legal issues resulting from reductions

Dielectric Systems and Modules Product Division **9/00 – 9/01**
Senior Director Operations - Head of Business Process and eBusiness Strategies

- Led development and execution of e-Business roadmap for $1.8B global business unit including design collaboration, supply chain management, employee collaboration, customer relationship management
- Re-engineered the engineering design business processes – product commercialization process (concept, advanced development, new product ramp, and production/operations)
- Matrix managed three engineering teams to evaluate new engineering design process and implement key technologies to better deliver value to customers
- Served as Program Manager for pilot implementation (to over 100 engineers) of AutoDesk CAD system and new intellectual property management system;
- Partnered with GM, VP of Operations and other senior management to co-lead order-to-cash business process reengineering resulting in on-time delivery increased to 95% from 35%; revenue increased 37% to $51m
- Led creation and implementation of first cross-business unit collaboration community
- Coached key management on people, organization and business strategy for optimal performance

Senior Director Change Management **12/96-9/00**
Product Manager of HR Systems and
Director of Human Resources

- Developed succession plans, mapping of talent to needs and coaching on employee relation issues
- Led team that developed and institutionalized program and change management business process methodology and tools for global IT/eBusiness and business initiatives
- Led the Oracle Change Management Program Office, which was the company's first global Change Management/ Business Readiness model to be successfully implemented
- Consulted with individual project teams to incorporate change management solutions to meet targets
- Led the design, maintained and implemented the Human Resource IT systems around the globe. This included People Soft as well as several web-based tools to administer global compensation programs, manage performance and the tracking of labor
- Led the Software Training organization

Chemical Vapor Dielectric Product Group
Senior Human Resources Manager

- Performed generalist HR functions for a 500+ employee population located in both SCLA and Texas
- Integrated change management methodologies into HR management programs
- Conducted organizational effectiveness evaluations and created programs to improve results

ADVANCE MICRO DEVICES, INC., Sunnyvale, CA **1/96 – 12/96**
Employee Relations Representative

- General employee relations

- Policy and Procedure creation and training
- Created and launched key employee programs to foster employee engagement
- Won the Presidents Award for excellence

MERCK PHARMACEUTICAL/ MEDCO, New Jersey **3/92 – 12/95**
Senior Account Coordinator/ Sales support
- Senior Account Coordinator –one year of experience in the sales force to model the right language for the sales force to improve their overall effectiveness in selling to HR professionals
- Learned product line, how to manage the selling, and implementation of mail order pharmaceutical benefit plans
- Worked on site with customer to roll out new benefit plans to employees – coordinated communications with employee base
- Worked with sales force to position key benefits to hiring HR professional

Manager of Employee Relations/ Recruiting (Medco which was acquired by Merck)
- Manager of Employee Relations & Recruiting – Corporate
- Had a lead integration role with the acquisition team led by Merck
- Led the design of the first automated compensation tool kit for the company

VIACOM INTERNATIONAL, New York, NY **4/89 – 3/92**
Senior Compensation Analyst and 401K Administrator
- Developed compensation programs for the company
- Co-led the implementation of restricted stock and phantom stock to retain key employees
- Managed the compensation focal for the company – Viacom, Nickelodeon, MTV, VH-1 and the broadcasting groups

CALVIN KLEIN COSMETICS, New Jersey **88 – 89**
Manager of Human Resources
- Managed the Human Resources function for a site of 350 employees

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BS, Business Administration 1987
Ramapo College, Mahwah, NJ
Transferred from Louisiana State University
Major Human Resources Management and Minor in Psychology

Formal Training
Systems Thinking
Human Performance Design
Presentation Skills
Large Scale Intervention
Project Management Training
Change Management Methodology

Member of SHRM, WITI, and NASPP

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Silicon Valley Primary Medical Group, P.C. (SVPMG) - Medical Oncologist El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	William Faber, MD, Chief Medical Officer; Mick Zdeblick, COO
	Action requested:	For Approval
	Background: (See attached 10-Step)	
	Board Advisory Committees that reviewed the issue and recommendation, if any: Finance Committee on March 27, 2017; recommended Board approval.	
	Summary and session objectives: To approve delegating to the CEO the authority to execute the agreement described in the attached 10-Step.	
	Suggested discussion questions: None, this is a consent calendar item.	
	Proposed Board motion, if any: To delegate to the CEO the authority to enter into an agreement with Silicon Valley Primary Medical Group, P.C. (SVPMG) for the professional services of a Medical Oncologist to work at the hospital based Cancer Center with Target Total Cash Compensation (TCC) not to exceed $531,000.	
	LIST OF ATTACHMENTS: 1. 10-Step	

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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

April 12, 2017

To: El Camino Hospital Board of Directors

From: Mick Zdeblick, Chief Operating Officer
William Faber, CMO and President of SVPMG

Subject: **Expansion of Oncology Services**

1. **Recommendation:** At its March 27, 2017 meeting, the Finance Committee voted to recommend that the Board of Directors approve delegating to the CEO the authority to enter into an agreement with Silicon Valley Primary Medical Group, P.C. (SVPMG) for the professional services of a Medical Oncologist to work at the hospital based Cancer Center with Target Total Cash Compensation (TCC) not to exceed $531,000. We are now requesting Board approval.

2. **Problem/Opportunity Definition:** In December 2016, Valley Medical Oncology (VMOC) was acquired by University Healthcare Alliance (UHA), a Stanford affiliated medical group. This affects ECH's Oncology Service Line because our two oncologists are now part of UHA/Stanford. Although few changes were made to the Professional Services Agreement with UHA at the time of acquisition, the PSA is expiring May 31, 2017 and UHA has indicated its intent to renegotiate the PSA. ECH must safeguard the care of our oncology patients by maintaining service continuity and engaging a medical oncologist through SVPMG, an ECH affiliated medical group.

   We communicated to our independent primary care physicians who refer patients to the Cancer Center that the VMOC/UHA transition would be seamless to them. There were several who voiced dissatisfaction of sending their patients to a UHA physician, fearing their patients would not come back to them. Personal visits to such physicians' offices were made by our oncology leadership to dispel those fears.

   More importantly, the Cancer Center volume continues to grow demonstrating an increased community need for medical oncology services. In order to schedule new patients within our guaranteed 48 hour window (all lab testing, scans, etc. being done), our physicians are seeing a record number of daily patients. It is not unusual to have 60 patients per day in the clinic. It becomes an overwhelming burden for our physicians to carry such a heavy caseload. Fiscal YTD, month ending December, we were 7.3% ahead of budget which equates to 5,466 clinic outpatient cases. We anticipate this growth to continue. In order to provide access to excellent care for oncology patients in the ECH community, we must contract with another oncologist. This is in keeping with the oncology strategic plan.

3. **Authority:** According to Administrative Policies and Procedures 51.00, Finance Committee and Board approval is required prior to CEO signature for physician services agreements that exceed the Policy's annual compensation threshold of $250,000.

4. **Process Description:** Approval is requested for the execution of an agreement for the professional services of a new full-time Medical Oncologist to be employed by SVPMG to provide hematology and oncology services to the growing number of oncology patients at El Camino Hospital.

5. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** ECH will be unable to execute on strategy to expand oncology services.

6. **Concurrence for Recommendation:** The proposed agreement is supported by the Chief Medical Officer, Chief Financial Officer, and the Medical Director, Oncology Services.

7. **Outcome Measures and Deadlines:** The Medical Oncologist will be held to the same high standards as present UHA medical oncologists and will be expected to participate in accreditation standards set by the Commission on Cancer and the standards set by ECH.

8. **Legal Review:** Legal counsel will review and approve the proposed Agreement and compensation prior to execution.

9. **Compliance Review:** Compliance will review and approve the proposed Agreements and compensation prior to execution.

10. **Financial Review:** Upon approval we will finalize negotiations with the physician. Target Total Cash Compensation under the Professional Services Agreement with SVPMG will not exceed the 75th percentile of $531,000 for FMV based on Sullivan Cotter market data for Hematology and Oncology specialty physicians.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	General Surgery On-Call Panel (MV) - Renewal El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	William Faber, MD, Chief Medical Officer
	Action requested:	For Approval

Background:

The Hospital has for many years maintained a panel of general surgeons at the Mountain View campus that responds when needed for emergency evaluations and surgical interventions for patients in the Emergency Department and inpatient services. On June 10, 2015, the ECH Board of Directors approved an increase to the General Surgery call panel rate from $1,100/day to $1,500/day, and 2-year renewal contracts were entered into with the increased rate. The majority of the General Surgery call panel agreements expire 6/30/17.

*Note: This is slightly below the 90th percentile according to the 2016 Bay Area MD Ranger report (75th is $1,300/day; 90th is $1,550/day). When looking at hospitals with an average daily census over 150 on the 2016 MD Ranger national report, $1,500/day falls between the 75th percentile and 90th percentile (75th is $1,420/day; 90th is $1,850/day).

Board Advisory Committees that reviewed the issue and recommendation, if any:

Finance Committee on March 27, 2017; recommended Board approval.

Summary and session objectives:

To approve delegating to the CEO the authority to execute renewals of the General Surgery on-call panel agreements for the Mountain View campus at the same per diem rate.

Suggested discussion questions:

None, this is a consent calendar item.

Proposed Board motion, if any:

To approve delegating to the CEO the authority to execute two-year renewals of the General Surgery on-call panel agreements for the Mountain View campus at the current rate of $1,500.00 per day.

LIST OF ATTACHMENTS:

1. 10-Step

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

April 12, 2017

To: El Camino Hospital Board of Directors

From: William Faber, MD, Chief Medical Officer

Subject: **General Surgery On-Call Panel for Mountain View Campus - Renewal**

1. **Recommendation:** We request that the Board of Directors approve delegating to the CEO the authority to execute renewals of the General Surgery On-Call Panel agreements for the Mountain View Campus.

2. **Problem/Opportunity Definition:** The Hospital has for many years maintained a panel of general surgeons at the Mountain View Campus that respond when needed for emergency evaluations and surgical interventions for patients in the emergency department and inpatient services. On June 10, 2015, the ECH Board of Directors approved an increase to the General Surgery Call Panel rate from $1100/day to $1500/day, and 2-year renewal contracts were entered into with the increased rate. The majority of the General Surgery Call Panel Agreements expire 6/30/17.

3. **Authority:** According to Administrative Policies and Procedures 51.00, Board approval is required prior to CEO signature for all physician agreements with compensation that exceeds the 75th percentile.

4. **Process Description:** Upon Board approval, amendments to renew the General Surgery Call Panel Agreements for the Mountain View campus will be entered into for an additional two years effective July 1, 2017 at the current rate of $1500/day.

5. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** An alternative solution is not being considered at this time.

6. **Concurrence for Recommendation:** Approval of this recommendation is supported by the Finance Committee and Chief Operating Officer.

7. **Outcome Measures and Deadlines:** Physicians will participate in the peer review process for consultations and subsequent surgeries related to General Surgery call.

8. **Legal Review:** Legal counsel will review the final Agreement prior to execution.

9. **Compliance Review:** Compliance will review and approve the proposed Agreement and compensation prior to execution.

10. **Financial Review:** Compensation will be continued at the current rate of $1500.00 per day, which is slightly below the 90th percentile according to the 2016 Bay Area MD Ranger report (75th is $1300/day; 90th is $1550/day). When looking at hospitals with an average daily census over 150 on the 2016 MD Ranger national report, $1500/day falls between the 75th percentile and 90th percentile (75th is $1420/day; 90th is $1850/day). A renewal term of two years is proposed.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Medical Director, Quality & Physician Services - Renewal El Camino Hospital Board of Directors April 12, 2017
	Responsible party:	William Faber, MD, Chief Medical Officer
	Action requested:	Board Approval

Background:

The Medical Director for Quality and Physician Services has been serving since July 2015, with a term extending through June 30, 2017. The agreement is due for renewal on July 1, 2017. The physician has made significant contributions to quality and physician services efforts. He currently works up to approximately a 0.8 FTE time of 130 hours each month for the following activities: quality assurance matters, transitions in care, clinical documentation, medical informatics, utilization management, communications with medical staff, antibiotic stewardship program, clinical quality improvements, and chief medical information officer activities.

ECH has obtained a FMV opinion from a third party consultant confirming that $312,000.00 maximum compensation is fair market value and commercially reasonable.

Board Advisory Committees that reviewed the issue and recommendation, if any:

Finance Committee on March 27, 2017; recommended Board approval.

Summary and session objectives:

To approve delegating to the CEO the authority to execute the renewal of the Medical Director, Quality & Physician Services agreement at the same compensation.

Suggested discussion questions:

None, this is a consent calendar item.

Proposed Board motion, if any:

To approve delegating to the CEO the authority to execute the two-year renewal of the Medical Director, Quality & Physician Services agreement at a not-to-exceed annual cost of $312,000.00 for 0.8 FTE.

LIST OF ATTACHMENTS:

1. 10-Step

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April 12, 2017

To: El Camino Hospital Board of Directors

From: William Faber, MD, Chief Medical Officer

Subject: **Medical Director, Quality & Physician Services – Renewal**

1. **Recommendation:** We request that the Board of Directors approve delegating to the CEO the authority to execute the renewal of the Medical Director, Quality & Physician Services agreement at the same compensation.

2. **Problem/Opportunity Definition:** The Medical Director for Quality and Physician Services has been serving since July 2015, with a term extending through June 30, 2017. The agreement is due for renewal on July 1, 2017.

   The physician has made significant contributions to quality and physician services efforts. He works up to approximately a 0.8 FTE time of 130 hours each month for the following activities: quality assurance matters, transitions in care, clinical documentation, medical informatics, utilization management, communications with medical staff, antibiotic stewardship program, clinical quality improvements, and chief medical information officer activities.

3. **Authority:** According to Administrative Policies and Procedures 51.00, Board approval is required prior to CEO signature for all physician agreements with an annual compensation that exceeds $250,000.

4. **Process Description:** Upon Board approval, an amendment to renew the Medical Director, Quality & Physician Services agreement an additional two years at the same compensation will be entered into effective July 1, 2017.

5. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** An alternative solution is not being considered at this time.

6. **Concurrence for Recommendation:** Approval of this renewal is supported by the Finance Committee and Sr. Director, Quality and Risk Management.

7. **Outcome Measures and Deadlines:** Quality goals will be included in the renewal agreement.

8. **Legal Review:** Legal counsel will review the final Agreement prior to execution.

9. **Compliance Review:** Compliance will review and approve the proposed Agreement and compensation prior to execution.

10. **Financial Review:** A renewal term of two years is proposed at a not to exceed annual cost of $312,000.00 for a 0.8 FTE. ECH has obtained a FMV opinion from a third party consultant confirming that $312,000.00 maximum compensation is fair market value and commercially reasonable.

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April 12, 2017

To: El Camino Hospital Board of Directors

From: Ken King, CASO

Subject: **Mountain View Campus Master Plan, Women's Hospital Expansion Incremental Funding Request**

1. **Recommendation:** The Board Finance Committee recommends Board approval for the following capital funding request for the Mountain View Campus Master Plan Projects.

   Women's Hospital Expansion (Project Development) - $5,000,000 (Incremental Request)

2. **Authority:** As required by policy, capital projects exceeding $500,000 require approval by the Board of Directors.

3. **Problem / Opportunity Definition:** The Board of Directors has authorized the development of the Mountain View Campus Master Plan Projects listed below:

   North Parking Garage Expansion – Funds Approved

   Behavioral Health Services (BHS) Building – Funds Approved

   Integrated Medical Office Building (IMOB) – Funds Approved

   Central Plant Upgrades (CUP) – Funds Approved

   Women's Hospital Expansion – Current Request

   Old Main Hospital Demolition & Related Site Work – Future Request

   Now that we have begun construction on the initial Campus Master Plan Projects, we are focusing on the planning, design and plan approval of the Women's Hospital Expansion Project. Our goal is to be ready to start construction in the Women's Hospital as soon as we relocate the physicians from the 2nd and 3rd Floors to the new IMOB in late 2018.

4. **Process Description:** To date, we have engaged the design team, the construction manager/general contractor and various consultants to evaluate and document the existing building components and prepare schematic plans. This incremental funding of $5 million along with the initial funding of $1 million will allow the team to proceed through design development and initial OSHPD plan review. Included in this scope of the project are preconstruction services and coordination between design consultants and contractors to effectively plan for construction in an occupied facility with sensitive environmental conditions.

5. **Alternative Solutions:** The only alternatives that are contemplated are the extent of modifications and improvements to be made. This next phase of development will provide various options for consideration.

6. **Concurrence for Recommendation:** This request is supported by the Finance Committee and the Executive Leadership Team and the Women's Hospital medical staff departments of OB and NICU.

7. **Outcome Measures / Deadlines:** The target timeline is to develop this project through design development by the August 2017 and plan final plan submission to OSHPD in early 2018.

8. **Legal Review:** Legal counsel from Cox, Castle, and Nicholson has been engaged to support the development of the major design and construction.

9. **Compliance Review:** NA

10. **Financial Review:** This preliminary project estimate for this expansion of the Women's Hospital is $91 million and once the design effort is substantially complete we will have a detailed cost estimate with various options to consider. The FY 2017 capital budget includes $10 million for the further development of the project and we have concluded that the incremental amount of $5 million is sufficient to effectively evaluate, plan and effectively develop the project plan.

    This project is included in the 2017 Bond Financing Plan and also has the benefit of funding from the El Camino Healthcare District's Designated Capital Outlay Funds in the amount of $9,297,651 from fiscal years 2014 and 2015.

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April 12, 2017

To: El Camino Hospital Board of Directors

From: Ken King, Chief Administrative Services Officer

Subject: **ECH Los Gatos Facility Improvement Project Funding Request**

1. **Recommendation:** The Board Finance Committee recommends Board approval of funding for additional improvements for the Los Gatos Facility at a cost not to exceed $2 million.
2. **Authority:** As required by policy capital projects exceeding $500,000 require approval by the Board of Directors.
3. **Problem / Opportunity Definition:** We began making improvements to the finishes, furniture, fixtures and mechanical systems at ECH Los Gatos in March 2013. We have completed improvements in the Conference & Administrative Areas, the Emergency Department, the Women's Hospital Departments, the Medical/Surgical Unit and the Operating Room Mechanical Systems. We have upgraded electrical systems, boilers and chillers and we are in the process of completing the Lobby, Cafeteria and Main Corridor improvements. The additional improvements requested include ADA Upgrades to staff and public toilets and the installation of a point to point Pneumatic Tube System between the Lab and Emergency Department along with additional improvements to mechanical systems serving both the OR and the sterile processing areas.
4. **Process Description:** As we have executed on the improvement work in multiple small phases we have discovered opportunities to make additional improvements that improve access and productivity and that correct poor functioning systems. The FY 17 capital facilities project budget anticipated $2.3 million in planning and infrastructure improvements in the Los Gatos facility and it is most efficient to extend the existing contracts to the contractor performing the initial upgrades work.
5. **Alternative Solutions:** These projects are necessary to continue providing patient care services, in an acceptable environment, no alternatives have been considered.
6. **Concurrence for Recommendation:** The Finance Committee and the Executive Team supports the recommendation to make these needed improvements.
7. **Outcome Measures / Deadlines:** While the work will be completed in small phases the target completion date for all the additional project work is November 2017.
8. **Legal Review:** All contracts for services and construction will follow organization policies, procedures and protocols. No legal review is required.
9. **Compliance Review:** Not Applicable

10. **Financial Review:** The cost of the entire improvements project breakdown as follows:

ECH Los Gatos Facility Improvement Project	Phase I Approved April 2013	Phase II Approved June 2014	Phase III Approved April 2016	Current Request	Total
Construction & Building Equipment	5,100,000	4,750,000	3,400,000	1,600,000	14,850,000
Moveable & Fixed, FF&E	750,000	250,000	-	200,000	1,200,000
Soft Costs	650,000	1,000,000	900,000	200,000	2,750,000
Contingency	500,000	-	-	-	500,000
Total	7,000,000	6,000,000	4,300,000	**2,000,000**	19,300,000

Note that the Funding Requested for the additional upgrades is less than the $2.3 million forecasted in the FY17 Capital Budget. Also note that the funding for this project is included in the Series 2015 Bond Financing.

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Summary of Financial Operations

Fiscal Year 2017 – Period 7
7/1/2016 to 1/31/2017

Dashboard - ECH combined as of January 31, 2017[2]

	Annual					Month			YTD		
	2014	2015	2016	2017 Proj.	2017 Bud/Target	PY	CY	Bud/Target	PY	CY	Bud/Target
Volume											
Licenced Beds	443	443	443	443	443	443	443	443	443	443	443
ADC	238	246	242	237	245	253	257	260	237	235	241
Adjusted Discharges	22,206	22,342	22,499	23,008	22,992	1,886	2,208	1,932	13,038	13,421	13,523
Total Discharges	19,427	19,637	19,367	19,527	19,781	1,652	1,806	1,678	11,265	11,391	11,612
Outpatient											
ED	46,056	49,130	49,927	47,813	51,258	4,195	4,319	4,346	28,235	27,891	30,075
Procedural Cases											
OP Surg	6,444	6,479	6,053	6,552	6,427	489	542	545	3,651	3,822	3,771
Endo	2,492	2,520	2,322	2,139	2,479	156	180	210	1,369	1,248	1,455
Interventional	1,706	1,878	1,970	1,975	2,323	179	150	197	1,213	1,152	1,363
All Other	69,458	68,052	79,656	85,596	84,566	6,744	7,204	7,170	46,146	49,931	49,618
Financial Performance ($000s)											
Net Revenues	721,123	746,645	772,020	810,619	789,585	61,534	68,826	66,217	441,806	472,861	454,966
Operating Expenses	669,680	689,631	743,044	730,066	764,828	62,492	60,181	63,932	430,123	425,872	440,591
Operating Income $	70,305	78,120	52,613	107,015	49,817	1,116	9,347	4,339	25,682	62,425	28,988
Operating Margin	*9.5%*	*10.2%*	*6.6%*	*12.8%*	*6.1%*	*1.8%*	*13.4%*	*6.4%*	*5.6%*	*12.8%*	*6.2%*
EBITDA $	125,254	128,002	108,554	160,612	109,890	5,756	13,776	9,489	56,248	93,690	62,220
EBITDA %	*16.9%*	*16.7%*	*13.6%*	*19.2%*	*13.5%*	*9.0%*	*19.8%*	*13.9%*	*12.3%*	*19.2%*	*13.3%*
IP Margin [1]	*-3.2%*	*-3.9%*	*-8.7%*	*-6.9%*	*-6.1%*	*-15.9%*	*-15.4%*	*-6.1%*	*-11.6%*	*-6.9%*	*-6.1%*
OP Margin [1]	*25.2%*	*26.7%*	*26.7%*	*32.8%*	*26.4%*	*17.7%*	*29.0%*	*26.4%*	*25.0%*	*32.8%*	*26.4%*
Payor Mix											
Medicare	44.6%	46.2%	46.6%	47.4%	46.4%	49.2%	51.2%	46.4%	45.4%	47.4%	46.4%
Medi-Cal	6.0%	6.6%	7.4%	7.2%	6.5%	7.2%	7.5%	6.5%	7.7%	7.2%	6.5%
Commercial IP	25.4%	24.2%	23.2%	22.7%	24.0%	22.2%	20.6%	24.0%	24.1%	22.7%	24.0%
Commercial OP	18.6%	18.7%	18.7%	20.2%	19.0%	19.1%	18.2%	19.0%	19.9%	20.2%	19.1%
Total Commercial	44.0%	42.9%	41.9%	42.9%	43.0%	41.3%	38.8%	43.0%	44.0%	42.9%	43.1%
Other	5.4%	4.3%	4.1%	2.5%	4.1%	2.3%	2.5%	4.1%	2.9%	2.5%	4.1%
Cost											
Employees	2,435.6	2,452.4	2,542.8	2,479.8	2,547.7	2,587.5	2,527.1	2,578.3	2,616.5	2,479.8	2,547.7
Hrs/APD	29.31	30.45	30.35	30.37	31.03	31.01	29.45	29.46	32.48	30.37	31.03
Balance Sheet											
Net Days in AR	50.9	43.6	53.7	49.0	48.0	53.7	49.0	48.0	53.7	49.0	48.0
Days Cash	382	401	361	408	266	361	408	266	361	408	266
Debt to Capitalization	12.6%	13.6%	13.8%	12.8%	17.3%	13.8%	12.8%	17.3%	13.8%	12.8%	17.3%
MADS	9.5	8.9	6.1	15.5	9.3	6.1	15.5	9.3	6.1	15.5	9.3
Affiliates - Net Income ($000s)											
Hosp	118,906	94,787	43,043	149,016	67,032	(14,838)	21,384	5,068	(8,147)	86,926	52,836
Concern	1,862	1,202	1,823	1,249	2,604	258	255	219	1,372	728	1,440
ECSC	**(5)**	**(41)**	**(282)**	(92)	0	2	(1)	0	17	(54)	0
Foundation	3,264	710	982	2,871	(450)	(268)	147	(122)	(334)	1,675	(267)
SVMD	32	106	156	326	0	(2)	200	(1)	(12)	190	198

(1) Due to timing of month end costing, In Patient and Out Patient Operating Margin % for FYTD 2017 are one month in arrears

(2) Green - Equal to or better than budget

Yellow - Unfav vs budget by up to 5%

Red - Greater than 5% unfav variance from budget

***Inpatient Volume*:**
- January inpatient discharges exceed budget and PY same period; YTD discharge budget gap is narrowed to 1.4%.
- The late flu season is the main reason for jump in General Medicine discharges
- Other services show a modest increase in case volume including Orthopedics and Urology cases.

Outpatient Volume:
- Overall YTD outpatient volume is 2.6% below budget but higher than PY.

***Operating Income*:**
- Operating Income was ahead of budget by $5.0M for the month and $33.4M YTD . The main contributing factors to a strong financial in January include:
  - $3.8M lower operating expense due to better productivity helped by high volume
  - better mix of surgical and outpatient cases
- LG posted a net loss of $1.1M for January due to higher Medicare mix in both IP and OP and lower in PPO cases.
- January's revenue include, a $2.2M loss for BPSI program. This loss covers 3 years.
- This partially offset by the $814K Medi-Cal managed care supplemental payment.
- Net AR increase in January due to slowdown in cash payments during the holidays.
- Total cash on hand is at all time high of 408 days in Jan.

The FY2017 budget presented excludes 2016 bonds cost of issuance and interest expense since the issuance was delayed.

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Budget Variances

$ in Thousands		Month to Date (MTD) Detail	Month to Date (MTD) Net Income Impact	Month to Date (MTD) % Net Revenue	Year to Date (YTD) Detail	Year to Date (YTD) Net Income Impact	Year to Date (YTD) % Net Revenue
	Net Revenue (FY2017 Budget/FY2017 Actual)	68,271	69,528		469,578	488,297	
Budgeted Hospital Operations FY2017			**4,339**	**6.4%**		**28,988**	**6.2%**
Net Revenue			1,257	1.8%		18,719	3.8%
*	Rev cycle improvements	2,610			9,714		
*	Medi-Cal Supplemental	814			1,127		
*	Inter Govt Transfer (IGT)	0			6,535		
*	Prime Medi-Cal	0			3,510		
*	BPCI Settlement	(2,167)			(2,167)		
Labor and Benefit Expense Change			3,801	5.5%		9,793	2.0%
*	Improve Productivity & flexing down staffing during holidays	3,784			15,216		
*	Pay-for-Performance Bonus Accrual	(403)			(2,850)		
*	Repricing of PTO Bank	0			404		
*	Old employee WC settlement	0			(432)		
*	Ratification Bonus to PRN	0			(2,600)		
*	Severance Pay	0			(365)		
*	One time UH expense reduction	420			420		
Professional Fees & Purchased Services			(145)	-0.2%		142	0.0%
*	Physician Fees	180			857		
*	Consulting Fee including LG Surgery Intrim Director, LG Rehab purchase sercice expense.	(307)			(1,415)		
*	Purchased Services mainly due to backfill for vacant IT positions	(347)			(2,195)		
*	Repairs and Maintenance Fees	329			2,894		
Supplies			(171)	-0.2%		3,161	0.6%
*	Drug Exp (due to higher Infusion Center volume; but offset by higher gross revenue)	(336)			(1,466)		
*	Medical Supplies	152			3,144		
*	Misc Net Supplies (Food/Volumes)	13			1,483		
Other Expenses			(456)	-0.7%		(345)	-0.1%
*	Leases & Rental Fees (Rental Lease Costs)	(232)			(307)		
*	Utilities & Telephone (continue on routine PG&E accrual but no payment yet)	5			315		
*	Other G&A	(228)			(244)		
*	MD Income Guarantee forgiveness	0			(109)		
Depreciation & Interest			721	1.0%		1,968	0.4%
*	Depreciation (Ongoing depreciation on the Old 2nd & 3rd Fl & GL improvement projects)	717			1,809		
*	Interest Expense	4			159		
Actual Hospital Operations FY2017			**9,347**	**13.4%**		**62,425**	**12.8%**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital ($000s)

7 month ending 1/31/2017

PERIOD 7 FY 2016	PERIOD 7 FY 2017	PERIOD 7 Budget 2017	Variance Fav (Unfav)	Var%	$000s	YTD FY 2016	YTD FY 2017	YTD Budget 2017	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
227,307	268,834	245,584	23,249	9.5%	**Gross Revenue**	1,579,008	1,719,213	1,687,131	32,082	1.9%
(165,773)	(200,008)	(179,367)	(20,641)	1.0%	**Deductions**	(1,137,202)	(1,246,351)	(1,232,164)	(14,187)	1.2%
61,534	**68,826**	**66,217**	**2,609**	**3.9%**	**Net Patient Revenue**	**441,806**	**472,861**	**454,966**	**17,895**	**3.9%**
2,073	702	2,054	(1,352)	-65.8%	**Other Operating Revenue**	14,000	15,436	14,612	824	5.6%
63,607	**69,528**	**68,271**	**1,257**	**1.8%**	**Total Operating Revenue**	**455,805**	**488,297**	**469,578**	**18,719**	**4.0%**
					OPERATING EXPENSE					
38,775	35,920	39,721	3,801	9.6%	**Salaries & Wages**	252,089	258,173	267,967	9,793	3.7%
8,335	9,650	9,479	(171)	-1.8%	**Supplies**	66,691	65,356	68,517	3,161	4.6%
8,514	7,763	7,618	(145)	-1.9%	**Fees & Purchased Services**	57,190	54,659	54,801	142	0.3%
2,242	2,420	1,964	(456)	-23.2%	**Other Operating Expense**	23,588	16,418	16,073	(345)	-2.1%
449	444	448	4	0.9%	**Interest**	3,143	2,979	3,137	159	5.1%
4,192	3,984	4,702	717	15.3%	**Depreciation**	27,422	28,286	30,095	1,809	6.0%
62,507	**60,181**	**63,932**	**3,751**	**5.9%**	**Total Operating Expense**	**430,123**	**425,872**	**440,591**	**14,719**	**3.3%**
1,100	**9,347**	**4,339**	**5,007**	**115.4%**	**Net Operating Income/(Loss)**	**25,682**	**62,425**	**28,988**	**33,438**	**115.4%**
(15,835)	12,046	729	11,317	1552.6%	**Non Operating Income**	(32,997)	24,497	5,102	19,395	380.1%
(14,735)	**21,393**	**5,068**	**16,325**	**322.1%**	**Net Income(Loss)**	**(7,315)**	**86,923**	**34,090**	**52,833**	**155.0%**
9.0%	19.8%	13.9%	5.9%		**EBITDA**	12.3%	19.2%	13.3%	5.9%	
1.7%	13.4%	6.4%	7.1%		**Operating Margin**	5.6%	12.8%	6.2%	6.6%	
-23.2%	30.8%	7.4%	23.3%		**Net Margin**	-1.6%	17.8%	7.3%	10.5%	

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Non Operating Items and Net Income by Affiliate

$ in thousands

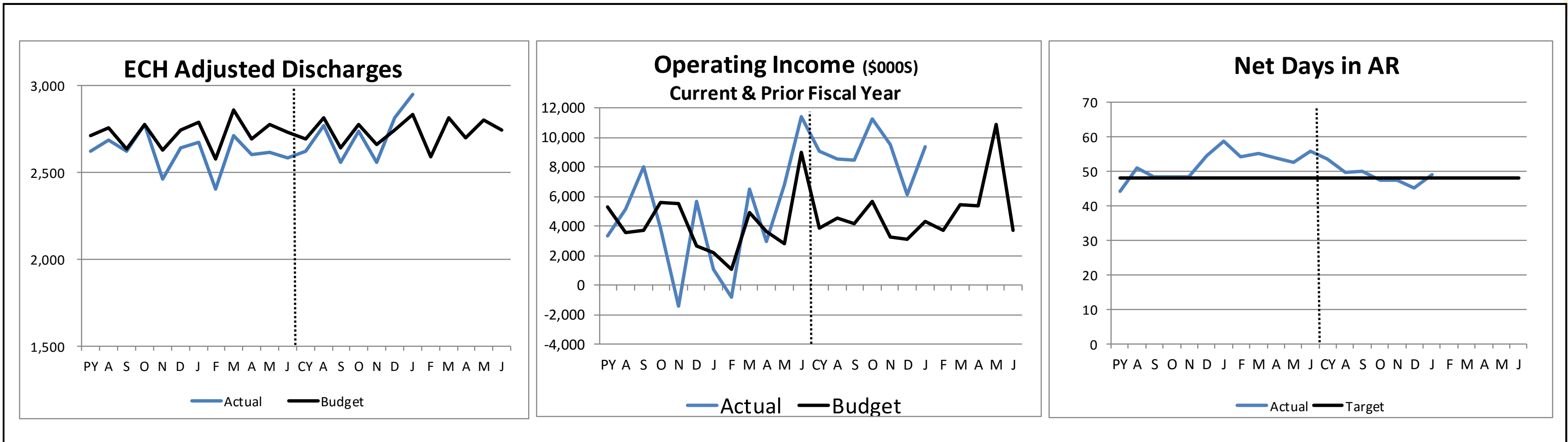
	Period 7 - Month			Period 7 - FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Income (Loss) from Operations						
Mountain View	10,429	3,584	6,845	61,067	22,227	38,840
Los Gatos	(1,082)	755	(1,837)	1,358	6,760	(5,402)
Sub Total - El Camino Hospital, excl. Affilates	**9,347**	**4,339**	**5,007**	**62,425**	**28,988**	**33,438**
Operating Margin %	**13.4%**	**6.4%**		**12.8%**	**6.2%**	
El Camino Hospital Non Operating Income						
Investments	12,747	1,512	11,235	26,158	10,582	15,576
Swap Adjustments	(35)	0	(35)	3,399	0	3,399
Community Benefit	(62)	(283)	221	(2,116)	(1,983)	(133)
Other	(604)	(499)	(105)	(2,944)	(3,496)	552
Sub Total - Non Operating Income	**12,046**	**729**	**11,317**	**24,497**	**5,102**	**19,395**
El Camino Hospital Net Income (Loss)	**21,393**	**5,068**	**16,325**	**86,923**	**34,090**	**52,833**
ECH Net Margin %	**30.8%**	**7.4%**		**17.8%**	**7.3%**	
Concern	255	219	37	728	1,440	(711)
ECSC	(1)	0	(1)	(54)	0	(54)
Foundation	147	(122)	269	1,675	(267)	1,941
Silicon Valley Medical Development	200	(1)	201	190	(7)	198
Net Income Hospital Affiliates	**601**	**95**	**506**	**2,540**	**1,166**	**1,374**
Total Net Income Hospital & Affiliates	**21,993**	**5,163**	**16,830**	**89,462**	**35,256**	**54,207**

Swap gain due to rise in interest rates
Favorable variance in Other due to lower losses at SVMD

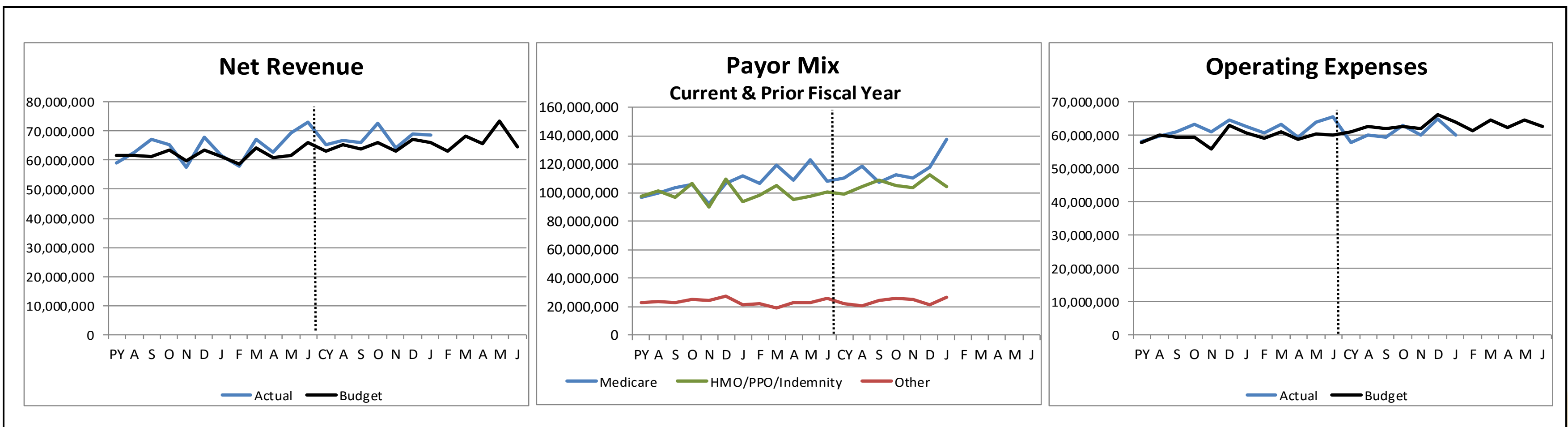
Higher Foundation income due to high unrestricted donations and investment income

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

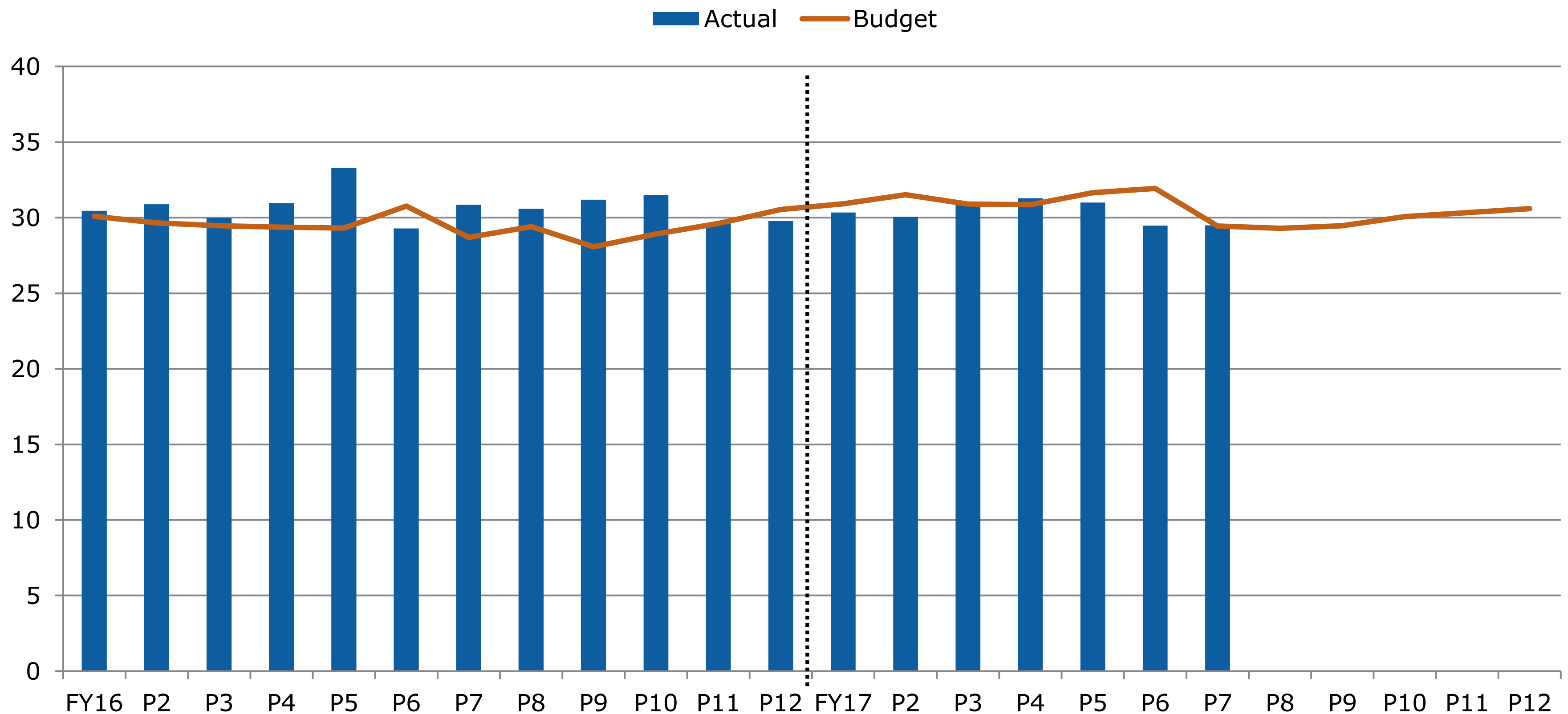
Monthly Financial Trends



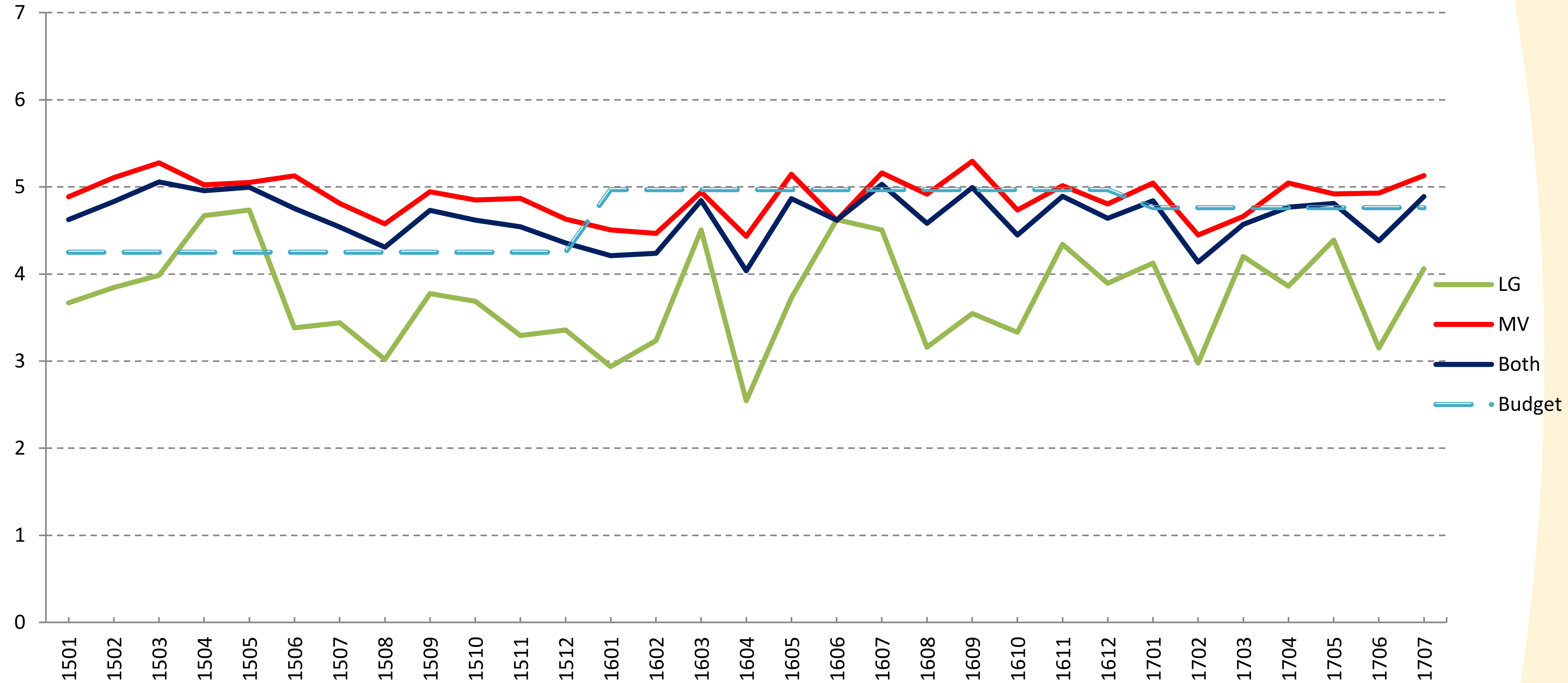
January volume is strong due to flu season.
Operating expenses lower than budgeted in January



Worked Hours per Adjusted Patient Day

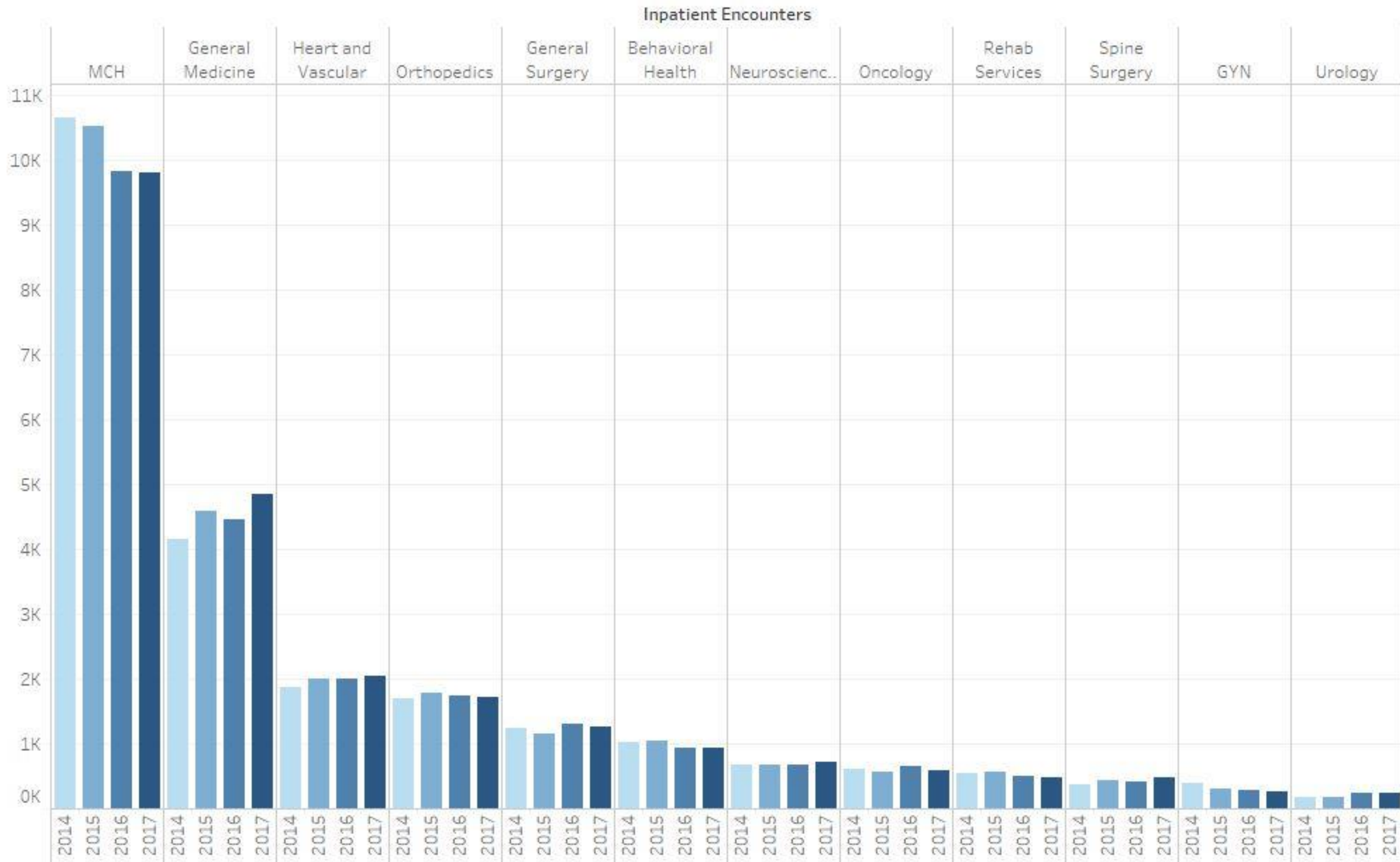


Productivity has improved after EPIC go-live and is favorable compared to budget.



- ALOS increased slightly in January due to outlier cases.

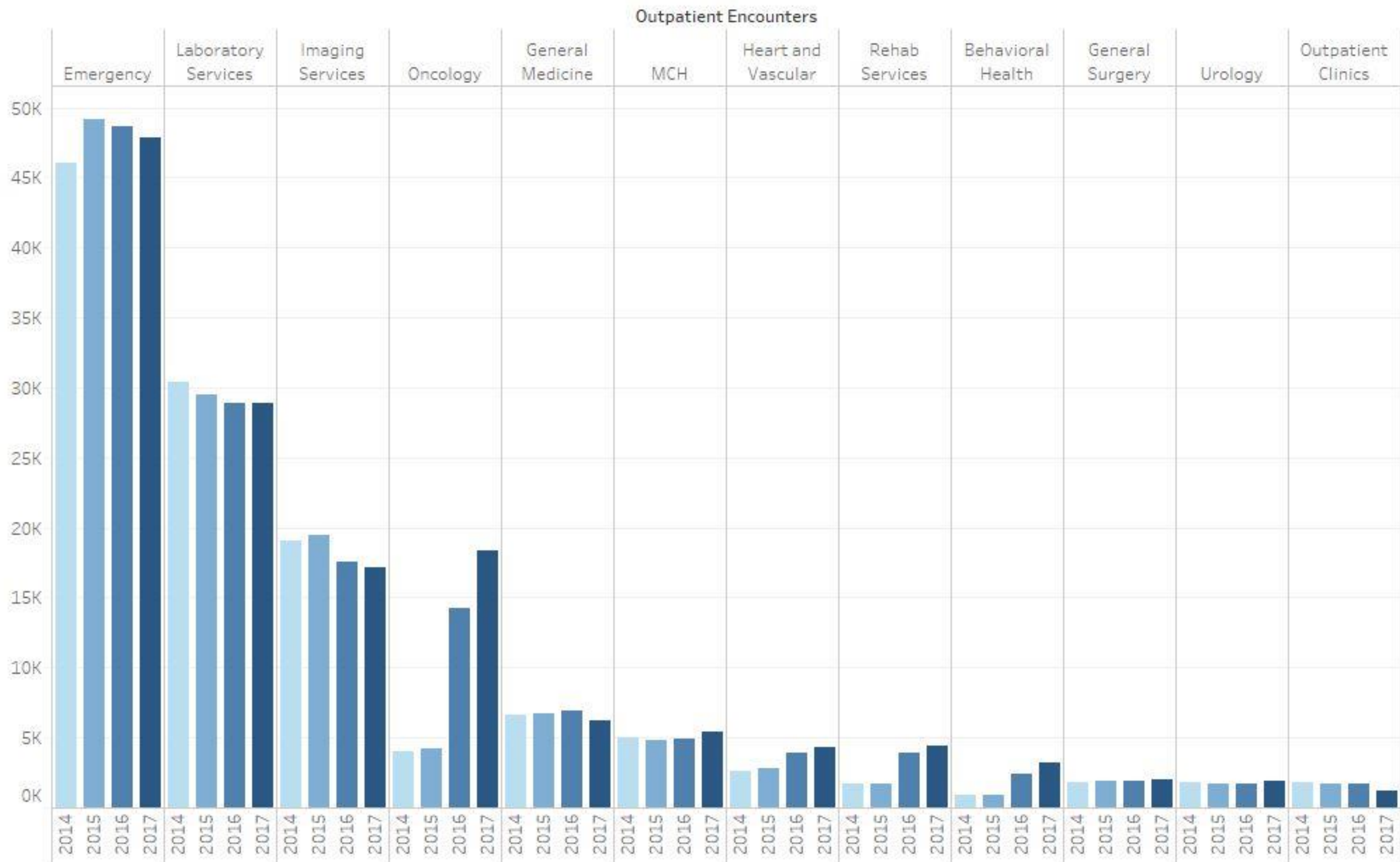
El Camino Hospital Volume Annual Trends – Inpatient
FY 2017 is annualized



- General Medicine experienced significant volume increases in January
- MCH volume recovered slightly from December with increases in vaginal deliveries and decreases in C-sections

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital Volume Annual Trends – Outpatient
FY 2017 is annualized

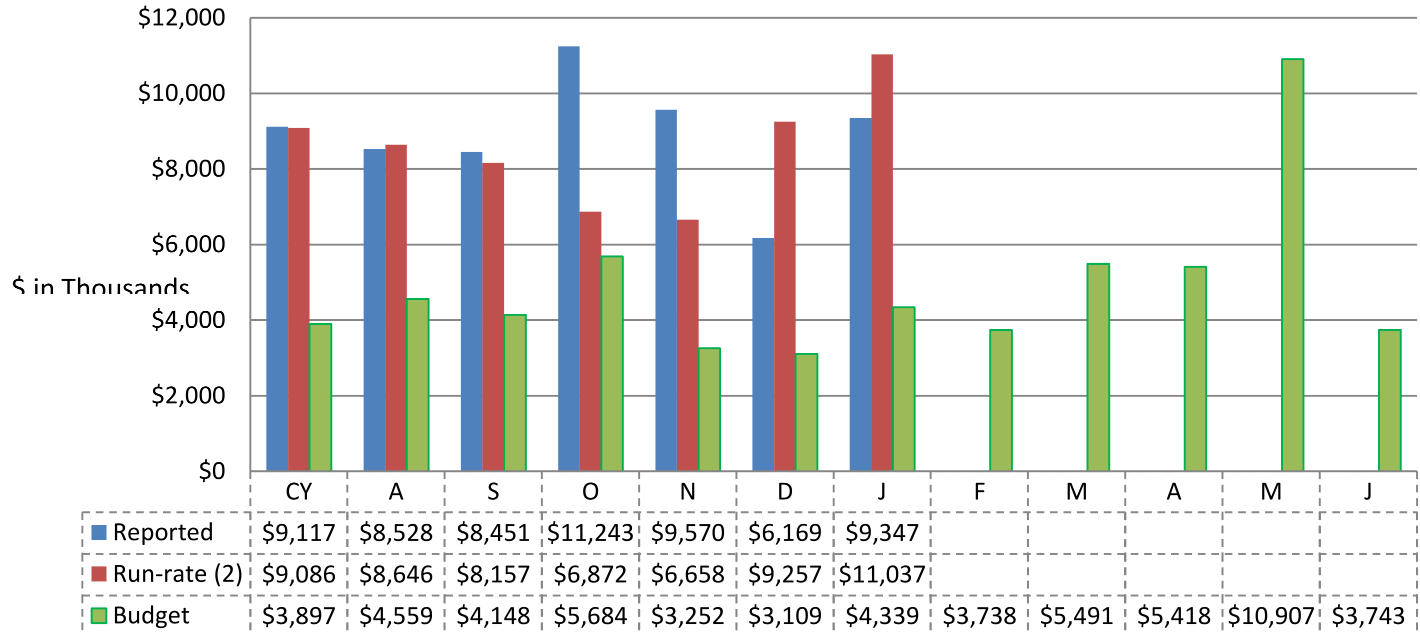


- Emergency room encounters increased 5% from the previous month.
- Infusion Center continues to report strong volume growth.

Medicare data excludes Medicare HMOs

ECH Operating Margin

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



FY 2017 Actual Run Rate Adjustments (in thousands)

		J	A	S	O	N	D	J	F	M	A	M	J
Revenue Adjustments	RAC Release	$76	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Insurance Overpayment Release Spine	$0	$0	-$61	-$145	$0	$0	$0	$0	$0	$0	$0	$0
	Mcare Settlmt/Appeal/Tent Settlmt/PIP	-$100	$158	-$71	-$67	$0	$0	-$2,101	$0	$0	$0	$0	$0
	LPCH Adjstmt	-$8	-$41	-$19	-$25	$0	$0	$0	$0	$0	$0	$0	$0
	Medi-Cal Supplemental	$0	$0	$0	$0	$0	-$312	$814	$0	$0	$0	$0	$0
	Tricare	$0	$0	-$144	$0	$0	$0	$0	$0	$0	$0	$0	$0
	SVPMG Quarterly Payment	$0	$0	$0	$0	$0	-$199	$0	$0	$0	$0	$0	$0
	IGT Supplemental	$0	$0	$0	-$6,535	-$3,510	$0	$0	$0	$0	$0	$0	$0
	Total	**-$31**	**$118**	**-$295**	**-$6,771**	**-$3,510**	**-$512**	**-$1,287**	**$0**	**$0**	**$0**	**$0**	**$0**
Expense Adjustments	Pay-For-Performance Bonus	$0	$0	$0	$0	$0	$2,400	$403	$0	$0	$0	$0	$0
	Ratification Bonus	$0	$0	$0	$2,400	$0	$0	$0	$0	$0	$0	$0	$0
	Inst & Minor Med Equipment	$0	$0	$0	$0	$598	$0	$0	$0	$0	$0	$0	$0
	Worker's Comp Settlement	$0	$0	$0	$0	$0	$700	$0	$0	$0	$0	$0	$0
	Other Purchased Services	$0	$0	$0	$0	$0	$500	$0	$0	$0	$0	$0	$0
	Total	**$0**	**$0**	**$0**	**$2,400**	**$598**	**$3,600**	**$403**	**$0**	**$0**	**$0**	**$0**	**$0**

Medicare data excludes Medicare HOs

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital Investment Committee Scorecard

December 31, 2016

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY17 Year-end Budget	Expectation Per Asset Allocation
Investment Performance		4Q 2016		Fiscal Year-to-date		4y 2m Since Inception (annualized)			May 2016
Surplus cash balance & op. cash (millions)		$801.9	–	–	–	–	–	$657.2	–
Surplus cash return		0.0%	0.3%	2.9%	3.1%	4.6%	4.6%	4.0%	5.2%
Cash balance plan balance (millions)		$227.9	–	–	–	–	–	$220.6	–
Cash balance plan return		-0.2%	0.6%	3.4%	3.8%	7.0%	6.6%	6.0%	5.8%
403(b) plan balance (millions)		$362.4	–	–	–	–	–	–	–
Risk vs. Return		3-year				4y 2m Since Inception (annualized)			May 2016
Surplus cash Sharpe ratio		0.67	0.76	–	–	1.06	1.05	–	0.55
Net of fee return		3.1%	3.6%	–	–	4.6%	4.6%	–	5.2%
Standard deviation		4.5%	4.6%	–	–	4.3%	4.3%	–	8.6%
Cash balance Sharpe ratio		0.65	0.69	–	–	1.18	1.15	–	0.49
Net of fee return		3.8%	4.0%	–	–	7.0%	6.6%	–	5.8%
Standard deviation		6.0%	5.8%	–	–	5.8%	5.6%	–	10.7%
Asset Allocation		4Q 2016							
Surplus cash absolute variances to target		7.5%	< 10%	–	–	–	–	–	–
Cash balance absolute variances to target		5.7%	< 10%	–	–	–	–	–	–
Manager Compliance		4Q 2016							
Surplus cash manager flags		18	< 19 Green < 23 Yellow	–	–	–	–	–	–
Cash balance plan manager flags		21	< 20 Green < 25 Yellow	–	–	–	–	–	–

El Camino Hospital

Capital Spending (in millions)

	Category	Detail	Approved	Total Estimated Cost of Project	Total Authorized Active	Spent from Inception	FY 17 Proj Spend	FY 17 YTD Spent
CIP	EPIC Upgrade				6.1	2.0	6.1	2.0
IT Hardware, Software, Equipment*					5.4	0.3	5.4	0.3
Medical & Non Medical Equipment FY 16**					4.3	0.0	4.3	0.0
Medical & Non Medical Equipment FY 17					10.3	1.1	10.3	1.1
Facility Projects								
	1307	LG Upgrades	FY13	17.3	17.3	12.0	3.3	2.0
	1219	LG Spine OR	FY13	4.1	4.1	2.6	2.7	1.3
	1414	Integrated MOB	FY15	275.0	247.0	30.0	58.2	16.2
	1413	North Drive Parking Expansion	FY15	24.5	24.5	6.9	19.7	5.3
	1245	Behavioral Health Bldg	FY16	91.5	72.5	10.8	17.9	3.5
	1248	LG Imaging Phase II (CT & Gen Rad)	FY16	8.8	8.8	2.8	8.1	3.1
	1313/1224	LG Rehab HVAC System & Structural	FY16	3.7	3.7	3.0	1.6	1.2
	1502	Cabling & Wireless Upgrades	FY16	2.8	2.8	2.4	1.0	0.3
	1425	IMOB Preparation Project - Old Main	FY16	3.0	3.0	2.5	2.5	1.8
	1430	Women's Hospital Expansion	FY16	91.0	0.0	0.0	0.8	0.0
	1422	CUP Upgrade	FY16	9.0	7.5	1.5	4.0	0.5
	1503	Willow Pavilion Tomosynthesis	FY16	1.3	1.3	0.2	1.2	0.1
	1519/1314	LG Electrical Systems Upgrade	FY16	1.2	0.0	0.0	0.0	0.0
	1347	LG Central Sterile Upgrades	FY15	3.7	0.2	0.3	0.4	0.0
	1508	LG NICU 4 Bed Expansion	FY16	7.0	0.5	0.2	0.2	0.2
	1520	Facilities Planning Allowance	FY16	0.6	0.0	0.0	0.0	0.0
New to FP 3	1525	New Main Lab Upgrades		1.6	0.4	0.3	2.6	0.3
New to FP 3	1515	ED Remodel Triage/Psych Observation	FY16	1.6	0.0	0.0	0.6	0.0
New to FP 3		Site Signage and Other Improvements		1.0	0.0	0.0	0.1	0.0
New to FP 3		IR Room #6 Development		2.6	0.0	0.0	0.2	0.0
New to FP 3	1602	JW House (Patient Family Residence)		2.5	0.0	0.0	0.0	0.0
New to FP 3	1507	LG IR Upgrades		1.1	0.0	0.0	0.0	0.0
New to FP 3		LG Building Infrastructure Upgrades		1.5	0.0	0.0	0.0	0.0
New to FP 3	1421	LG MOB Improvements (17)		5.0	0.9	0.7	1.7	0.1
		All Other Projects under $1M		8.6	6.7	4.6	4.1	1.7
				569.9	401.2	80.7	131.0	37.7
GRAND TOTAL					**427.3**		**157.0**	**41.1**

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital

Capital Spending – Facility Projects (in millions)

	($ in ,000)	Approved	A - FY17 Budgeted (Board packet)	D - FY17 Projected Spent	Variance from Budget
	Mountain View Campus Master Plan Projects				
1245	BHS Replacement	FY16	30,000	17,890	12,110
1413	North Dr Parking Structure Expansion	FY15	20,500	19,651	849
1414	Integrated Medical Office Building	FY15	101,500	58,230	43,270
1422	CUP Upgrades	FY16	5,000	4,025	975
1430	Womens Hosp Expansion	FY16	5,500	800	4,700
	Sub-Total		**162,500**	**100,596**	**61,904**
					0
	Other Capital Facilities Projects (Active/Budgeted)				0
1501	Womens Hosp NPC Closeout [1]	FY16	327	595	(268)
1425	IMOB Preparation Project - Old Main		1,000	2,466	(1,466)
1502	Cabling and Wireless upgrades [1]	FY16	400	1,010	(610)
1525	New Main Lab Upgrades		1,200	2,575	(1,375)
1515	ED Remodel Triage / Psych Observation		1,400	600	800
1415	Signage & Wayfinding		300	425	(125)
1416	Digital Directories [1]	FY15	-	108	(108)
1503	Breast Imaging Tomography (Excludes $1M Equip) [1]	FY16	300	1,228	(928)
1316	Willow Pavilion FA Sys and Equip Upgrades		800	100	700
1423	MV MOB TI Allowance [1]	FY16	-	419	(419)
1520	Facilities Planning Allowance		300	-	300
1523	MV Melchor Suite 309 TI's [1]	FY16	-	76	(76)
	Furniture Systems Inventory		250	250	0
	Site Signage & Other Improvements		200	100	100
	MV Equipment & Infrastructure Upgrades (17)		300	-	300
	IR Room #6 Development		500	200	300
1602	JW House (Patient Family Residence)		500	-	500
	MV Capital Projects Sub-Total		**7,777**	**10,153**	**(2,376)**
					0
1219	LG Spine Room Expansion - OR 4	FY13	3,100	2,717	383
1313	LG Rehab HVAC Upgrades (CIP# 1313 / 1224)	FY15	400	1,643	(1,243)
1248	LG Imaging & Sterile Processing		7,250	8,100	(850)
1307	LG Upgrades - Major	FY13	7,300	3,266	4,034
1327	LG Rehab Building Upgrades		500	100	400
1346	LG Surgical Lights OR's 5,6 & 7 [1]	FY15	-	154	(154)
1347	LG Central Sterile Upgrades		-	40	(40)
1421	LG MOB Improvements		150	219	(69)
1507	LG IR Upgrades		800	-	800
1508	LG NICU 4 Bed Expansion		5,000	247	4,753
1600	LG 825 Pollard - Aspire Phase 2 [1]	FY16	-	500	(500)
1519	LG Electrical Systems Upgrade	FY16			
	LG Building Infrastructure Improvements		1,200	-	1,200
	LG Facilities Planning		500	-	500
	LG MOB Improvements (17)		4,000	1,500	2,500
	LG Capital Projects Sub-Total		**30,200**	**18,487**	**11,713**
					0
	Primary Care Clinic (TI's Only)		1,600	1,400	200
	Urgent Care Clinics (TI's Only)		2,400	-	2,400
	Other Strategic Capital Project Sub-Total		**4,000**	**1,400**	**2,600**
					0
	Grand Total Facilities Projects		**204,477**	**130,636**	**73,841**

[1] **Approved Spending prior to FY17**

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Balance Sheet (in thousands)

ASSETS

	CURRENT ASSETS	January 31, 2017	Audited June 30, 2016
(1)	Cash	88,983	59,169
	Short Term Investments	118,444	105,284
(2)	Patient Accounts Receivable, net	104,815	120,960
	Other Accounts and Notes Receivable	2,493	4,369
(3)	Intercompany Receivables	1,310	2,200
(4)	Inventories and Prepaids	45,667	39,678
	Total Current Assets	**361,713**	**331,660**
	BOARD DESIGNATED ASSETS		
	Plant & Equipment Fund	121,973	119,650
(5)	Women's Hospital Expansion	9,298	-
	Operational Reserve Fund	100,196	100,196
	Community Benefit Fund	12,854	13,037
	Workers Compensation Reserve Fund	23,118	22,309
	Postretirement Health/Life Reserve Fund	19,203	18,256
	PTO Liability Fund	21,874	22,984
	Malpractice Reserve Fund	1,800	1,800
	Catastrophic Reserves Fund	15,756	14,125
	Total Board Designated Assets	**326,071**	**312,358**
(6)	**FUNDS HELD BY TRUSTEE**	**25,410**	**30,841**
	LONG TERM INVESTMENTS	**221,582**	**207,597**
	INVESTMENTS IN AFFILIATES	**32,129**	**31,627**
	PROPERTY AND EQUIPMENT		
	Fixed Assets at Cost	1,181,729	1,171,372
	Less: Accumulated Depreciation	(512,495)	(485,856)
	Construction in Progress	77,442	46,009
	Property, Plant & Equipment - Net	**746,675**	**731,525**
	DEFERRED OUTFLOWS	29,464	29,814
	RESTRICTED ASSETS - CASH	0	-
	TOTAL ASSETS	**1,743,045**	**1,675,422**

LIABILITIES AND FUND BALANCE

	CURRENT LIABILITIES	January 31, 2017	Audited June 30, 2016
(7)	Accounts Payable	20,822	28,519
(8)	Salaries and Related Liabilities	16,431	22,992
	Accrued PTO	21,874	22,984
	Worker's Comp Reserve	2,300	2,300
	Third Party Settlements	13,242	11,314
	Intercompany Payables	32	105
	Malpractice Reserves	1,969	1,936
	Bonds Payable - Current	3,735	3,635
(9)	Bond Interest Payable	1,340	5,459
	Other Liabilities	8,076	10,478
	Total Current Liabilities	**86,930**	**106,830**
	LONG TERM LIABILITIES		
	Post Retirement Benefits	19,203	18,256
	Worker's Comp Reserve	20,818	20,009
	Other L/T Obligation (Asbestos)	3,701	3,637
	Other L/T Liabilities (IT/Medl Leases)	-	-
	Bond Payable	219,445	225,857
	Total Long Term Liabilities	**263,167**	**267,759**
	DEFERRED INFLOW OF RESOURCES	2,892	2,892
	FUND BALANCE/CAPITAL ACCOUNTS		
	Unrestricted	1,063,985	985,583
	Board Designated	326,071	312,358
	Restricted	0	-
(10)	**Total Fund Bal & Capital Accts**	**1,390,056**	**1,297,941**
	TOTAL LIABILITIES AND FUND BALANCE	**1,743,045**	**1,675,422**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital Comparative Balance Sheet Variances and Footnotes [1]

(1) The increase in cash is due allowing for immediate cash to be available for the recent significant construction projects that have started in MV campus.

(2) The decrease is primarily due to the significant cash payments the Patient Accounts team has brought in during the four months, two months were in excess of $70M where the projected budgeted was approximately $63M per month.

(3) The decrease is just a timing issue of intercompany payments from one quarter to another. Normally at a fiscal year end, they are higher due to the books being held open for a longer period of time in preparation for audit.

(4) The increase is principally due to two quarterly pension contributions of $2.6M each since July 1, 2016.

(5) A new item, the District allocated its FY 2014 and FY 2015 Capital Appropriation Funds in support of future renovations to the Women's Hospital when the IMOB is completed and those floors become for patient care.

(6) The decrease is due to additional withdraws from the 2015A Project Fund for the renovations at the Los Gatos campus.

(7) The decrease is due significant General Contractor payments being accrued at year end, that were subsequently relieved during the first quarter of fiscal year 2017.

(8) The decrease is due to timing of the release of the bi-weekly payroll liabilities, at June 30 there were 12/14's accrual on the books, at January 31 it was down to 3/14's.

(9) The decrease is due a semi-annual 2015A bond interest payment made in January, 2017.

(10) The increase is due to this fiscal year's P&L affect ($64M from Operations and $24M for Non-Operations – primarily due to unrealized investment gain), and the transfer from the District in support of the future Women's Hospital renovations.

[1] Hospital entity only, excludes controlled affiliates

APPENDIX

El Camino Hospital – Mountain View ($000s)

7 months ending 1/31/2017

PERIOD 7 FY 2016	PERIOD 7 FY 2017	PERIOD 7 Budget 2017	Variance Fav (Unfav)	Var%	$000s	YTD FY 2016	YTD FY 2017	YTD Budget 2017	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
187,196	220,743	200,942	19,800	9.9%	**Gross Revenue**	1,287,286	1,413,282	1,373,904	39,378	2.9%
(130,246)	(162,494)	(147,053)	(15,441)	10.5%	**Deductions**	(927,954)	(1,020,465)	(1,005,435)	(15,031)	1.5%
56,950	**58,248**	**53,889**	**4,359**	**8.1%**	**Net Patient Revenue**	**359,332**	**392,817**	**368,470**	**24,348**	**6.6%**
1,894	664	1,839	(1,175)	-63.9%	**Other Operating Revenue**	12,576	14,293	13,109	1,184	9.0%
58,844	**58,913**	**55,728**	**3,184**	**5.7%**	**Total Operating Revenue**	**371,908**	**407,110**	**381,579**	**25,531**	**6.7%**
					OPERATING EXPENSE					
32,149	29,836	33,119	3,282	9.9%	**Salaries & Wages**	209,763	214,818	223,035	8,217	3.7%
6,401	7,521	7,772	251	3.2%	**Supplies**	54,230	53,420	56,086	2,666	4.8%
7,178	6,378	6,395	17	0.3%	**Fees & Purchased Services**	47,812	45,282	46,048	765	1.7%
715	822	404	(418)	-103.3%	**Other Operating Expense**	12,469	4,935	4,759	(176)	-3.7%
449	444	448	4	0.9%	**Interest**	3,143	2,979	3,137	159	5.1%
3,694	3,482	4,006	524	13.1%	**Depreciation**	23,941	24,609	26,287	1,677	6.4%
50,586	**48,483**	**52,144**	**3,660**	**7.0%**	**Total Operating Expense**	**351,357**	**346,043**	**359,351**	**13,308**	**3.7%**
8,258	**10,429**	**3,584**	**6,845**	**191.0%**	**Net Operating Income/(Loss)**	**20,551**	**61,067**	**22,227**	**38,840**	**174.7%**
(15,809)	12,046	729	11,317	1552.6%	**Non Operating Income**	(32,971)	24,508	5,102	19,405	380.3%
(7,551)	**22,475**	**4,313**	**18,162**	**421.1%**	**Net Income(Loss)**	**(12,421)**	**85,575**	**27,330**	**58,245**	**213.1%**
19.0%	22.2%	12.2%	10.1%		**EBITDA**	10.5%	19.6%	11.2%	8.4%	
14.0%	17.7%	6.4%	11.3%		**Operating Margin**	5.5%	15.0%	5.8%	9.2%	
-12.8%	38.1%	7.7%	30.4%		**Net Margin**	-3.3%	21.0%	7.2%	13.9%	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital – Los Gatos($000s)

7 months ending 1/31/2017

PERIOD 7 FY 2016	PERIOD 7 FY 2017	PERIOD 7 Budget 2017	Variance Fav (Unfav)	Var%	$000s	YTD FY 2016	YTD FY 2017	YTD Budget 2017	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
40,111	48,091	44,642	3,449	7.7%	**Gross Revenue**	291,722	305,930	313,226	(7,296)	-2.3%
(35,526)	(37,514)	(32,314)	(5,199)	16.1%	**Deductions**	(209,248)	(225,886)	(226,730)	844	-0.4%
4,584	**10,577**	**12,328**	**(1,750)**	**-14.2%**	**Net Patient Revenue**	**82,474**	**80,044**	**86,497**	**(6,452)**	**-7.5%**
179	38	215	(177)	-82.4%	**Other Operating Revenue**	1,424	1,143	1,503	(360)	-24.0%
4,763	**10,615**	**12,543**	**(1,928)**	**-15.4%**	**Total Operating Revenue**	**83,898**	**81,187**	**88,000**	**(6,813)**	**-7.7%**
					OPERATING EXPENSE					
6,626	6,083	6,602	519	7.9%	**Salaries & Wages**	42,327	43,356	44,932	1,576	3.5%
1,934	2,129	1,708	(422)	-24.7%	**Supplies**	12,461	11,936	12,431	495	4.0%
1,336	1,385	1,223	(162)	-13.2%	**Fees & Purchased Services**	9,378	9,376	8,753	(623)	-7.1%
1,527	1,598	1,560	(38)	-2.4%	**Other Operating Expense**	11,119	11,483	11,314	(169)	-1.5%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
497	503	696	193	27.7%	**Depreciation**	3,481	3,677	3,809	132	3.5%
11,921	**11,698**	**11,788**	**90**	**0.8%**	**Total Operating Expense**	**78,766**	**79,829**	**81,239**	**1,410**	**1.7%**
(7,157)	**(1,082)**	**755**	**(1,837)**	**-243.3%**	**Net Operating Income/(Loss)**	**5,132**	**1,358**	**6,760**	**(5,402)**	**-79.9%**
(26)	0	0	0	0.0%	**Non Operating Income**	(26)	(10)	0	(10)	0.0%
(7,184)	**(1,082)**	**755**	**(1,837)**	**-243.3%**	**Net Income(Loss)**	**5,106**	**1,347**	**6,760**	**(5,413)**	**-80.1%**
-113.6%	6.3%	21.5%	-15.2%		**EBITDA**	20.7%	17.0%	22.0%	-5.0%	
-150.3%	-10.2%	6.0%	-16.2%		**Operating Margin**	6.1%	1.7%	7.7%	-6.0%	
-150.8%	-10.2%	6.0%	-16.2%		**Net Margin**	6.1%	1.7%	7.7%	-6.0%	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Board of Directors Open Session – April 12th, 2017

To: El Camino Hospital Board of Directors

From: Rebecca Fazilat, MD, Chief of Staff MV
J. Augusto Bastidas, MD, Chief of Staff LG

Date: March 28th, 2017

RE: REPORT FROM THE MEDICAL STAFF EXECUTIVE COMMITTEE

This report is based upon the Medical Staff Executive Committee meeting of **March 23rd, 2017**.

Request Approval of the Following:
Patient Care Policies & Procedures – Policy Summaries (pp. 2-3)

- **New Policies (attached)**
  - Infection Control Plan (pp. 4-34)
  - Musculoskeletal Injury Prevention Plan (pp.35-41)

- **Policies with Minor Revisions/No Revisions (see summary pp. 2-3)**
  - Procedure: NICU Car Seat Trial
  - Guidelines: NICU Transition Care Guidelines for the Newborn
  - Procedure: NICU Transport of the Neonate for Off Unit Procedures
  - Protocol: Same Day Discharge Radial Percutaneous Coronary Intervention

Medical Staff

- Revised-Peer Review Policy / Form (pp.42-51)
- Revised-Medical Staff Bylaws (pp.52-153)
- Direct Patient Care Contracts (pp.154-177)

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES/PROCEDURES			
Document Name	**Department**	**Date**	**Summary of Policy Changes**
Infection Control Plan	Infection Control	3/17	Plan that is updated yearly - needs to go to Board
Musculoskeletal Injury Prevention Plan	Education	3/17	
POLICIES WITH MINOR REVISIONS			
Document Name	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
Procedure: NICU Car Seat Trial	NICU	1/2017	Clarification of correct positioning in car seat
Guidelines: NICU Transition Care Guidelines for the Newborn Requiring	NICU	1/2017	Changed term newborn to neonate
Procedure: NICU Transport of the Neonate for Off Unit Procedures	NICU	1/2017	Clarification of current procedure
Protocol: Same Day Discharge Radial Percutaneous Coronary Intervention	HVI	3/17	Clarification of exclusion criteria: use of glycoprotein llb/llla inhibitor only if it is a full infusion dose or an extended IV infusion after the procedure2.Addition of an algorithm for visual aid summarizing the protocol
POLICIES WITH NO REVISIONS			
Document Name	**Department**	**Review or Revised Date**	
Guidelines: Guidelilnes for Attendance of Neonatologists at High Risk Deliveries	NICU	1/17	
Protocol: NICU Breastmilk and Breastmilk Products, Management of Inpatient Use	NICU	1/17	
Procedure: NICU - Neonatal Alert (MV)	NICU	1/17	
Procedure: NICU - Central Line Sterile Tubing Change	NICU	1/17	

Protocol: NICU - Hypoglycemia, Management of the Neonate at Risk Form	NICU	1/17	
Procedure: NICU-Infant Driven Feeding MV	NICU	1/17	
Procedure: NICU - Transfer to Higher Level of Care	NICU	1/17	
Protocol: NICU Electroencephalography Neurological Monitoring Protocol (MV)	NICU	1/17	
Scope of Service NICU	NICU	1/17	
Procedure: Blood Culture in the Neonate	NICU	1/17	

POLICY/PROCEDURE TITLE: **Infection Control Plan**
CATEGORY:
LAST APPROVAL DATE:

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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.
Goals to reduce the possibility of transmitting infections will be set based upon the identified risks. The plan includes risk reduction strategies supported by evidence based guidelines and ~~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 completed~~done~~. This evaluation will include a review of the prioritized risks, the

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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.

- **DEFINITIONS ~~*(as applicable)*~~:**

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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 evaluates the risk of communicable disease~~s~~ 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.~~

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 and the most populated in the Bay Area. 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

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northwestern part of the county, adjacent to the waters of San Francisco Bay. Nearly 92% of the population lives in cities.
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.

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.
Los Gatos Demographics: need to add as above

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(Source: US Census Bureau. State and County Quick Facts. January 2014)
The resident population of Los Gatos is approximately 30,705. The median age resident is 45.4 years young. The largest racial/ethinc groups are White (73.8%) followed by Asian (14.5%) and Hispanic (6.3%)

Santa Clara County Community Health Status Assessment:
(Data: 20142 Santa Clara County Community Assessment Project Survey)

Comment [CC1]: Need to obtain more recent assessment – 2012 is too old. Here is the link to the 2014 assessment: https://publichealth.sccgov.org/sites/g/files/exjcpb916/files/SCC_Community_Health_Assessment-2014.pdf

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 3325% of adolescents in the county are overweight or obese
HIV/ AIDS	Over 33424,500 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: *(retrieved from Santa Clara County TB Control Report; based on CY 2015)*

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California Overview

- CA reported 2,137 new TB cases in 2015 compared to 2,134 cases in 2014.
- California's annual TB incidence remained at 5.5 cases per 100,000 persons.
- An estimated $72 million was spent on medical management of TB cases in CA during 2015.
- TB cases were reported in 42 of California's 61 local health jurisdictions
- Of 24 jurisdictions that reported at least 10 cases in 2015, 11 (46%) experienced an increased from 2014
- Among California's TB cases, and estimated 7% were imported from outside of the United States, 13% resulted from recent transmission and 80% were due to reactivation of latent tuberculosis infection (LTBI)
- The percentage of CA TB cases occurring in foreign-born persons increased from 78% in 2014 to 80% in 2015.

COMMUNITY TB PROFILE

- Santa Clara County (SCC) has the third highest number of cases among all jurisdictions in CaliforniaA, after Los Angeles and San Diego counties
- Santa Clara County (SCC) had 198 cases of active tuberculosis in 2015
- 22% increase compared with 162 cases in 2014
- Case rate of 10.5 per 10,000 residents which is 1.9 times as high as the overall CA rate
- CaliforniaA rate 5.5/100,000 persons

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.

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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.

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Comment [CC2]: A risk assessment needs to be included base on the information above. I will forward an example Catherine.

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PROCEDURE:

1. **Purpose**

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- 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 Neonatal Intensive Care Unit (NICU) CLABSI rate below SIR < 1.0 with a goal of "0" CLABSI's

c. Achieve 95% bundle compliance rate with Central Line Insertion Practice (CLIP) organization-wide.

d. Maintain Enterprise hospital onset *Clostridium difficile* infection rate to ≤ 5.0 /10,000 patient days.

e. Maintain Enterprise hospital onset Methicillin Resistant *Staphylococcus aureus* (MRSA) infection rate to ≤ 0.9 /10,000 patient days.

f. Maintain Enterprise MRSA screening compliance rate to 90% or more.

g. Maintain Enterprise hospital onset Multi- Drug Resistant Gram Negative Rods (MDRGNR) infection rate to ≤ 0.5 / 10,000 patient days.

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h. Maintain Coronary Artery Bypass Graft (CABG) SSI rate at or below NHSN Rates/Risk of SIR <1.00 (MV campus).

i. Maintain Total Knee Surgical Site Infection rate at or below NHSN Rates/Risk of SIR <1.00. (MV and LG campus).

j. Maintain Total Hip Surgical Site Infection rate to at or below NHSN Rates/Risk of SIR <1.0. (MV and LG campus).

k. Maintain laminectomy surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).

l. Maintain spinal fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR < 1.00. (MV and LG campus).

m. Maintain spinal re-fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).

n. Maintain hand hygiene compliance at ≥ 95%.

o. Maintain Personal Protective Equipment (PPE) compliance at ≥ 95%.

p. Maintain Enterprise Catheter Associated Urinary Tract Infection (CAUTI) rate at ≤ 0.23 1000 Foley catheter days.

Comment [CC3]: What about a goal regarding flu vaccination rates – isn't this required to report to NHSN.

~~p.~~q. Flu Vaccination rate: LG: 96%/MV: 90%~~??~~

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3. **Goals**

a. Recommend methods for early identification of infections using epidemiological and scientific methodologies.

b. Analyze practices that have the potential to affect hospital onset infection rates and recommend changes.

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c. Provide advice and consultation as appropriate to other departments including but not limited to: Nursing, Employee Wellness and Health Services, Clinical Laboratory, Environmental Services, Sterile Processing Department and Safety/Emergency Management.

d. Monitor compliance with hospital regulatory reporting requirements to various public health agencies, National Healthcare Safety Network (NHSN), California Department of Public Health (CDPH), Santa Clara County Public Health Department (SCCPHD), Santa Clara County TB Control, Centers for Medicare and Medicaid Services (CMS) Hospital In-patient Quality (IQR).

e. Coordinate monitoring and surveillance activities for targeted infections and microorganisms selected by Infection Control Committee based on annual Risk Assessment.

Comment [CC4]: Where is this?

f. Monitor infection control practices of healthcare workers. Provide feedback and education with recommendations for improvement.

g. Provide guidelines on infection prevention and control and how to reduce the spread of infections at the general hospital orientation in for all employees.

h. Review and revise infection control policies every three years, or as needed.

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,

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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.

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j. Provide liaison activities with community health care providers that impact our ability to control communicable diseases. Continue to expand infection control role over the continuum of care with the assistance of Public Health Department.

k. Provide input and education on infection control issues related to construction and renovation within the hospital. Perform infection control risk assessment prior to start of construction projects and monitor construction sites for compliance with infection control practices.

4. Infection Prevention and Control Program and the Infection Control Committee (ICC)

~~a.~~(1) The responsibility for monitoring the Infection Prevention and Control Program is invested in the Infection Control Committee (ICC). The Infection Control (IC) Medical Director has the authority to institute any appropriate control measures or studies when ~~athe situationa~~ a situation is reasonably ~~felt~~ felt to be a danger to any patient, Healthcare Worker (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.

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~~b.~~(2) The ICC shall be a multi-disciplinary committee consisting of representatives from at least the Clinical Laboratory, Quality Department administration, Sterile Processing Department, Perioperative services, Nutrition Services, Environmental Services, Employee Wellness and Health and the Infection Prevention Nurses. The Chairman is the Infection Control Medical Director, a physician with knowledge of and special

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interest in infectious disease. Representatives from key hospital departments such as but not limited to Facilities Services, Pharmacy, and shall be available on a consultative basis when necessary.

c. The Infection Prevention and Control Department will collaborate with the ICC in developing a hospital-wide program and maintain surveillance over the program.

d. The Infection Prevention and Control Department in collaboration with the ICC 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 Prevention and Control Department in collaboration with the ICC 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 Prevention and Control Department 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.

g. The Infection Prevention and Control Department will collaborate with the ICC to identify new indicators and thresholds of diseases, recommend and assess corrective measures based upon the analysis of relevant data, and

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communicate its findings and interventions to the appropriate departments.

h. 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.

i. The committee minutes shall be reviewed by the Medical Executive Committee., and the Board of Directors.

5. Infection Prevention Department

a. The Manager of Infection Prevention is responsible for the
b. development, implementation, and evaluation of the infection prevention performance improvement activities, ensuring that they are based upon accurate data collection, analysis, and interpretation.

c.
~~d. Qualifications for Infection Prevention Nurse are:~~
~~e.~~
~~f. Baccalaureate degree from an accredited college or university. A current California license as a registered nurse.~~
~~g. 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.~~
~~h.~~d. ~~In the absence of certification by CBIC, three to five years' general clinical nursing experience. Knowledge of current infection prevention and 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~~

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Comment [CC5]: Can you demonstrate that ICC minutes are reviewed by MEC and the Board? I don't think they ever make it to the Board.

Comment [CC6]: I don't think this should be included . These are hospital operations information. Instead "b" could read "Infection Prevention Nurses are staff in the Infection Prevention Department.

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duties listed aboProvides input and assistance in the revision, updating and formulation of policies and procedures related to infection prevention and control.

i.e. Identifies possible trends and risks of disease transmission through ongoing surveillance process.

j.f. Participates with members of Infection Control Committee to provide solutions to potential infection control problems.

k.g. Communicates potential infection control risks to appropriate departments either verbally or through written report.

l.h. 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.

m.i. Provides education for all staff, patients and families regarding infection prevention and control principles that reduce the spread of disease.

n.j. Acts as consultant in the management of patient's infection problem while in the hospital or upon discharge.

6. Scope of Services

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.

b. Hospital Onset Infection Surveillance and Prevention

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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) 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.

7. **General Surveillance Activities**

8. 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.

~~a.~~

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a. 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,

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facilitation of data collection for selected quality indicators and the collection of required information for reporting to the Public Health Department.

b. 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.

c. The amount of time spent on infection surveillance, control and prevention activities is based upon the following:

- Acute Care Hospital Services:
  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:
    275 General Acute Care
    - 44 Perinatal Services
    - 24 Intensive Care
    - 20 Intensive Care Newborn Nursery
    - 7 Pediatric Services
    - 180 Unspecified General Acute Care
    - 25 Acute Psychiatric

    El Camino Hospital Los Gatos:
    143 General Acute Care
    - 30 Rehabilitation Center
    - 14 Perinatal Services
    - 8 Coronary Care
    - 7 Intensive Care

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2 Intensive Care Newborn Nursery
82 Unspecified General Acute Care

- ~~Department Resources: FTE staff~~
  a. ~~1.0 FTE as Manager of Infection Prevention~~
  b. ~~2.0 FTE RNs as Infection Prevention Nurses~~
  c. ~~0.5 FTE for administrative support~~

Comment [CC7]: The Department is described above, no need for this here and it is limiting.

- Patient Population:
  a. Various ages, ethnic, socio-economic backgrounds
- Risk factors of the population:
  Infectious agents related to construction
  a. Tuberculosis
  b. MRSA
  c. Carbapenem-resistant enterobacteriaceae (CRE)
  d. Extended spectrum beta-lactamase (ESBL)
  e. Multi-Drug Resistant Gram Negative Rods (MDRGNRs)
  f. *Clostridium difficile*
  g. *Vancomycin Resistant Enterococcus (VRE)*
- Complexity of the services provided:
  a. Basic Emergency Medical Services
  b. Behavioral Health
  c. Cardiac Catheterization Lab
  d. Cardiovascular Surgery
  e. Critical Care- adult and NICU
  f. Dialysis-inpatient
  g. General Surgery (including Bariatrics)
  h. Infusion Center (outpatient)

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i. Medical / Surgical
j. Oncology – inpatient and outpatient
k. Nuclear medicine, radiology, diagnostic imaging
l. Radiation oncology (outpatient)
m. Rehabilitation Services
n. Senior Health Center

o. 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.

a. Surgical Site Infection Surveillance

b. 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.

c. Targeted "high-risk" surgical procedures are monitored for surgical site infections and results are reported quarterly to the Infection Control Committee. Surveillance activities include: daily census review of admission diagnosis, daily review of

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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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a. Monitor targeted hospital and community onset infections and specific organisms as determined by the annual R risk Aassessment.

b. Surveillance for FY 2017**:**

1. Surgical site infections of high-risk procedures: Total knee, total hip, laminectomy, fusion, refusion and CABG procedures.
2. Marker organisms: MRSA, *C. difficile* and MDR GNRs
3. BSI related to central lines hospital-wide
4. Foley catheter related UTIs hospital-wide

c. Active disease surveillance at both campuses

1. Daily surveillance of MRSA, C difficile, Multi-Drug Resistant Organisms (MDRO), Tuberculosis, & other communicable diseases
2. Active surveillance of Surgical Site Infections (SSI), Central Line-Associated Blood Stream Infection (CLA-BSI), Catheter-Associated UTI (CA-UTI)
3. Carbapenem Resistant Enterobacteriacae (CRE) surveillance (patients hospitalized outside the U.S. within 6 months)
4. Tracking: mold-related organisms in construction areas
5. Evaluation/segregation of persons at risk
6. Specialized response to exposure & outbreaks

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9. **C. Diff Prevention Strategy**

9. Plan: Use Clostridium rates as quality indicators to evaluate the effectiveness of compliance with transmission-based precautions and cleaning and decontamination protocols. Goal is to reduce hospital onset infections of *C. difficile.*

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a. Do: (1) Determine number of new *C. difficile* cases per 10,000 patient days. (2) Track daily Cdiff patients by room location.

b. Study: Review and analyze data on a quarterly basis to identify trends and potential high-risk areas.

c. Act: (Clostridium difficile) – Staff to 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

10. Data Collection Methods

a. 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.

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b. Surveillance shall be a blend of routine physical presence in all area of the facility and use of clinical and laboratory computer information systems.

11. **Investigation of Disease Clusters (Outbreak Control)**

a. The Infection Control Infection Control Medical Director in coordination with the Manager of Infection Control 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 Outbreak Investigation).

12. **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 Communicable Diseases).

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 Pre-hospital Communicable Disease Exposure).

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

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- Hospital Onset and community onset CRE-Klebsiella BSI's
- All Hospital cases of *Clostridium difficile* infections
- Hospital wide CLABSI's
- 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.

13. 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.

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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.).

14. ECH Infection Prevention and Management Infection Control Committee Involvement– FY 2017

a. The Infection Prevention Nurses are active members of the following committees:
1) CA-UTI Reduction Task Force
2) CLABSI Reduction Taskforce
3) SSI Reduction Task Force: Los Gatos Campus
4) Critical Care Committee
5) Antibiotic Stewardship
6) Emergency Management
7) Sepsis Committee
8) Value Analysis

15. Research

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a) Research and investigate unusual cases, infections, or issues pertaining to Infection Control through ongoing literature review and web-based search activities.
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.

16. 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 Infection Control Programs at other hospitals and long-term care facilities.

17. Policy Formation

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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.
d) Infection control departmental policies are found on the toolbox.

18. 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.

19. Environmental Conditions

a. To ensure a safe environment during times of construction and or remodeling, protective measures shall be approved by the Infection Control 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.

b. Routine microbiological surveillance of the inanimate hospital environment or of personnel, with the exception of

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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 quality indicators according to current best practice guidelines and manufacturer's instructions for use.

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/Ml).

20. 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.

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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 Pre-hospital Communicable Disease Exposure.)

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

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POLICY/PROCEDURE TITLE: **Infection**

APPROVAL	APPROVAL DATES
Infection Control Committee	1/2017
Medical Committee (if applicable):	n/a
ePolicy Committee:	11/2015
MEC:	12/2015
Board of Directors:	01/2016

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, 11/15, 1/17

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, 12/2015

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, 1/2016

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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.

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POLICY/PROCEDURE TITLE: Infection

Infection Control Risk Assessment

Enterprise Risk Factor/Event *Measurement* *FY16 Rate*	**FY16 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.*	**FY17 Goal / Benchmark**	**Comments:**
Acute HO Foley Cath Urinary Tract Infection **MV:# 7/LG:# 1** *New Infections/1000 Cath Days* *rate: 0.32*	Rate: 0.23 SIR < 1.0	3	2	2	2	9	0.23 or SIR ≤1	**Rate increase FY15: 0.23 vs FY16: 0.32** *Enterprise: FY15 (6) vs FY16 (8)* CAUTI Task Force in place. Daily tracking of Foley Catheters. New NPSG for CAUTI Prevention. Provide education to patients. Provide education to physicians. Provide education to nurses. Partner with nursing to evaluate patient hygiene management policy
Total Knee Surgical Site Infection **MV:#0/LG# 2** *New Infections/100 Procedures* *0.34/LG-SIR 1.73*	SIR ≤1.0	2	3	2	2	9	SIR < 1.0	**Enterprise rate increase from FY15: 0.17 vs. FY16: 0.34** *MV: FY15/FY16 (0)* *LG: FY15 (1) vs FY16 (2)* NHSN -LG had (1) more Knee infection than expected, increase SIR rate >1.0. Strategies: Start SSI Reduction Task Force at LG to include Peri-op, Medical Director of Quality, Risk Management to work on best practice guidelines to reduce SSI.

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Total Hip Surgical Site Infection **MV:#3/LG:#1** *New* *Infections/100 Procedures rate: 0.68/-SIR ≤1.0*	SIR ≤1.0	2	3	2	1	8	SIR < 1.0	**Enterprise rate increase from FY15: 0.67 vs FY16: 0.68** *MV: FY15 (3) HIP SSI's vs. FY16 (3)* LG: FY15 (0) SSI vs. FY16 (1) Continue to investigate SSI to determine best practice guidelines to decrease SSI. Med. Dir. to follow-up with surgeons
Spinal Fusion Surgical Site Infection **MV:#1/LG# 2** *New* *Infections/100 Procedures 0.56/ ≤1*	SIR ≤1.0	2	3	2	1	8	SIR < 1.0	**Enterprise rate increase FY15: 0.56 vs. FY16: 0.39** MV: FY16: 1 case vs FY15: 1 cases LG: increase FY16: 2 case vs FY15: 1 case
Laminectomy Surgical Site Infection **MV:#0/LG:1** *-New* *Infections/100 Procedures 0.23/SIR ≤1*	SIR < 1.0	2	3	2	1	8	SIR < 1.0	**Enterprise rate decrease FY15: 0.43 vs.FY16: 0.23** *MV: FY16 (0) vs. FY15 (2)* *LG: FY16 (1) vs. FY15 (0)* MV: met goal, post discharge surveillance monitoring for identifying SSI in place. Implemented SSI reduction taskforce with neurosurgeons, ID and peri-op director, established strategies to decrease spine SSI. Accomplished goal of providing CHG Scrubs, in pre-op to spine patients.
CLABSI (ICU/non-CCU depts.) **MV:#1/LG:#0** *Infections/1000 Central Line Days 0.08*	SIR ≤1.0	2	3	1	1	7	SIR < 1.0	***Decrease from FY15: rate 0.71 vs FY16: rate 0.48*** *MV: FY15 (6) CLABSI vs FY16 (1)* *LG:FY15/FY16: (0)* Improved outcome was the result of the CLABSI Reduction Task Force. Multiple measures were implemented to re-educate the nursing staff on best practice guidelines for: CVL, line care, dressing changes, blood draws

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MDRGNR: Hospital OnsetInfections **MV:#1/LG:#0**Infections/*10 ,000 Patient Days**Rate:0.11*	1.40	1	2	1	1	5	0.50	Met goal. Continue to work to sustain improvement with current measures. **Enterprise rate decrease FY2015: 0.23 vs FY2016: 0.11** MV: decrease FY15 (2) cases vs FY16 (1) case Note: Increase risk of CRE in local SNF. Strategy to screen patients on admission from high risk facilities
MRSA: Hospital Onset Infections **MV:#5/LG:#0** *Infections/10,000 Patient Days* *Rate: 0.56*	1.40	1	2	1	1	5	0.90	Met goal. Continue to work to sustain improvement with current measures. **Enterprise rate FY2015: 0.69 vs FY2016: 0.56**
***Clostridium difficile*: Hospital Onset** **MV:#16/LG:#1** *Infections/10,000 Patient Days* *1.96*	≤7.0	2	1	1	1	5	≤5.0	**Decreased HO rate FY15 rate: 5.61 vs FY16 rate: 1.96.** *Enterprise: FY15 (49) vs. FY16 (17)* **S**ustain 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.
Operating Room/ IUSS	IUSS <5.0%	1	2	1	1	5	IUSS <5%	Sustained improvement with current measures. Daily huddle with SPD staff and OR Staff
Personal Protective Equip *% Observed Compliance* *100%*	95%	1	2	1	1	5	1.00	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.

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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.
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.
MRSA Screening *% "At Risk" with Screen Ordered* *91%*	90%	1	1	1	1	4	90%	Met goal. Continue daily census audit for high-risk patients. Documentation of MRSA education by IC Nurses/staff nurses.

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POLICY/PROCEDURE TITLE: Musculoskeletal Injury Prevention Plan (MIPP); Policy and Procedure

CATEGORY: Human Resources

LAST APPROVAL DATE: NEW

SUB-CATEGORY: **Patient Care Services**

ORIGINAL DATE: **2015**

COVERAGE:

All El Camino Hospital staff, physicians and contracted staff who have contact with patient handling

PURPOSE:
To describe El Camino Hospital's policy and procedure to comply with the intent of Cal/OSHA's Safe Patient Handling Regulation for "patient protection and health care worker back and musculoskeletal injury prevention plan (MIPP) as required by Title 8, California Code of Regulations, Section 5120" (Cal/OSHA, 2014).

STATEMENT:
El Camino Hospital will comply with the intent of California Law to protect the health care worker with the replacement of manual lifting of patients with appropriate safety policies/procedures, equipment, professional judgment and clinical assessment of the registered nurse. According to this law, the RN is the coordinator of care in relation to mobility assessment and mobility tasks.

DEFINITIONS *(as applicable)*:
Awareness Training: Training for employees, other than those who regularly participate in patient handling (i.e. nurses, CNAs, rehabilitation therapists) whose job assignment includes being present on patient care units

POLICY:

1. Plan implementation methods and coordination of MIPP
   a. MIPP implementation will ultimately be the responsibility of the Chief Human Resource Officer.
   b. Responsibility for oversight, operationalization and evaluation of the MIPP will be the Central Safety Committee. Evaluation shall occur at the department level. Additionally, Safe Patient Handling Committee will

include direct care staff and will report activities to the Central Safety Committee. The MIPP will include:

i. Plan for employers whose employees have work assignments that include being present on patient care units (e.g. Registry and Traveler agencies):
   1. Plan for awareness training: designed by Education Department.
   2. Procedure for reporting, investigation and recording of injuries: commensurate with Central Safety and Employee Wellness and HealthServices Policies.
   3. Training plan: designed by the Education Department.

ii. Plan to ensure El Camino Hospital employees (supervisor and non-supervisor) comply with the MIPP, specified procedures, and recommended equipment: designed and updated as necessary by the Education Department/Human Resources

2. Correction of hazards relating to patient handling:
   a. All staff, physicians and contracted staff are encouraged to bring any recognized hazard to the attention of their supervisor, manager or hospital supervisor as soon as feasible after discovery without fear of reprisal.
   b. No patient handling will occur without sufficient number of staff and sufficient equipment to safely handle patient and comply with this policy and procedure.

PROCEDURE:

1. Identification and Evaluation of Patient Handling Hazards
   a. Patient Handling Equipment
      i. The Safe Patient Handling Committee will be responsible for determining types, quantities and locations of patient handling equipment and where the equipment is located by unit/department (see Appendix A).
      ii. Safe Patient Handling Committee will use methods such as demonstrations, vendor fairs, interviews and/or online surveys to solicit input into evaluation of equipment.
      iii. Evaluation of Patient Handling Equipment will be managed by the Safe Patient Handling Committee annually and as needed for new equipment or if an unrecognized hazard is discovered.
      iv. Procurement of equipment will be commensurate with hospital procedures for minor and capital equipment requests.

POLICY/PROCEDURE TITLE: Musculoskeletal Injury Prevention Plan (MIPP); Policy and Procedure

CATEGORY: Human Resources

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v. Regular use and care of equipment is at the unit level and the ultimate responsibility of the manager. All unit staff is expected to use and care for equipment as per manufacturer guidelines.

vi. Maintenance/Repair of equipment will be commensurate with Clinical Engineering and Facilities procedures.

b. Registered Nurse (RN) assessment of Mobility Needs

i. El Camino Hospital RNs will use the “Patient Mobility Assessment Tool” (PMAT) to assess patient mobility and determine appropriate interventions (see Appendix B)

ii. CNAs and Ancillary Healthcare Workers (e.g. Physical Therapy) shall verbally communicate to the patient’s primary RN input regarding mobility

2. Investigation of musculoskeletal injuries related to patient handling
   a. Injury investigation is the responsibility of the manager of the employee and Employee Wellness and Health Services in accordance with 1.11 Accident, Incident, and Exposure Investigation.
   b. Guidelines for investigation of patient handling injuries will include:
      i. Patient specific risk factors,
      ii. RN safe patient handling instructions,
      iii. Review if MIPP was effectively implemented (i.e. correct equipment used),
      iv. Feedback from injured person and others involved in the incident regarding any measure on how the injury could have been prevented.
   c. Injury data and trends will be used to evaluate the MIPP on an annual basis. Adjustments to the MIPP will be made as needed annually or more often should a trend dictate.
3. Correcting patient handling hazards:
   a. Whenever possible, patient’s primary RN will complete PMAT prior to first mobility attempt during acute care hospitalization, and whenever major change in condition has occurred. If unable to do PMAT before first mobility attempt, RN to do PMAT as soon as possible. For the outpatient setting, RN will observe mobility ability at initial intake into service, and then prnRN will communicate results of PMAT, and thereby directions for mobility, via the EMR, signage and/or patient communication board (inpatient only). Signage and/or patient communication board information will also serve to communicate mobility assessment findings to patient’s family/significant others. Any

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changes in the plan shall be updated in the EMR, signage and communication board.

b. Special circumstances:
   i. Emergency Situations: primary nurse or physician will evaluate benefits/risks of patient handling and current emergency to best protect both the patient and the staff. For example, evacuation due to fire or earthquake may supersede use of equipment uses that would happen under normal circumstances.
   ii. No RN present: Other healthcare workers are expected to follow the contents of this policy/procedure.
   iii. Patient not cooperative with handling instructions: Utilize extra staff or alter plan for handling.
   iv. Unique situations that are not currently covered by the plan: Consult with patient's RN and/or other resource such as Rehabilitation Services or Employee Wellness and Health Services.

4. Employee Communication
   a. Any employee may communicate concerns regarding patient handling via direct communication with supervisor, manager, hospital supervisor or via incident reporting. Concerns may be filed anonymously.
      i. Follow up on reports will be commensurate with the QRR Policy.
5. Training
   a. The Education Department will be responsible for design and execution of all training related to safe patient handling. Design of materials will take into account literacy, educational level and vocabulary of the employees.
   b. All employees, with regard to safe patient handling, will receive training:
      i. Initially upon hire or transfer, which will include:
         1. Type of injury/area of body most at risk most likely from patient handling with: vertical movement, lateral movement, bariatric patients, repositioning and ambulation
            a. How patient risk factors affect the above,
         2. Importance of early recognition and management of an injury,
         3. Communicating with patient and family/significant other regarding safe patient handling practices,

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4. Appropriate use and procedures for using various patient handling equipment,
5. Importance of reporting any concern related to patient handling/patient handling equipment,
6. The MIPP Policy and Procedure is available on the Toolbox,
7. Right of refusal of any employee to lift, reposition, mobilize or transfer a patient if concerned about patient or staff safety or lack of training, and how to communicate reasons for refusal to supervisor,
8. Role of the RN in safe patient handling,
9. Additional training is available by calling the Education Department,
10. Opportunity for practice and inter-active questions/answers and regarding safe patient handling.

ii. Refresher training coordinated by the Education Department and conducted every 12 months shall include:
1. Use of powered and non-powered equipment to handle patients safely,
2. Procedures of safe patient handling,
3. Review of items in initial training,
4. Opportunity for inter-active questions/answers regarding safe patient handling equipment and procedures.

iii. Whenever new equipment or procedures dictate.

iv. Awareness training will be provided for any other staff member present on patient care units and not part of aforementioned training. This shall include: recognition of safe patient handling situation, how to get assistance if needed, and emergency procedures related to safe patient handling.

c. RN Training:
   i. In addition to above, RNs will be specifically trained on the Mobility Assessment and the role of the RN in safe patient handling.

d. Supervisor/Management Training shall include:
   i. Staff may not be disciplined for refusal to lift, reposition, or transfer a patient due to concerns about patient/staff safety or lack of training or lack of equipment.

6. Record-keeping

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a. Records of inspections including hazard identification and evaluation will be maintained by Employee Wellness and Health Services.and reviewed by the Central Safety Committee .
b. Training records will be maintained by the Education Department and reported to the Central Safety Committee.
c. Injury investigations will be maintained by Employee Wellness and Health Services and reported in aggregate/trend format to the Central Safety and Safe Patient Handling Committees.

CROSS REFERENCE:
1.11 Accident, Incident, and Exposure Investigation Guidelines
14.00 Quality Review Report- QRR Unusual Occurrence Policy

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POLICY/PROCEDURE TITLE: **(**Inserted PolicyTech field)

APPROVAL	APPROVAL DATES
Safe Patient Handling Committee: 2/2016	
Director Leadership	3/16
______Medical Committee (if applicable):	
ePolicy Committee:	3/17
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: n/a

REFERENCES: (*as applicable*)

Cal/OSHA, (2014). The Cal/OSHA safe patient handling regulation. California Hospital Association, 1st ed. Retrieved from: www.calhospital.org/publications.

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

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TITLE:	Medical Staff- Medical Staff Peer Review
CATEGORY:	Administration
LAST APPROVAL:	10/2015

Ned abEl caminoTYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT ☑ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Medical Staff***
OFFICE OF ORIGIN:	***Medical Staff Services***
ORIGINAL DATE:	February 2013

I. COVERAGE:
All members of the medical staff

II. PURPOSE:
To assure standards of care are maintained at El Camino Hospital and to provide a process for peer review of the medical staff.

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

IV. DEFINITIONS

1. **Practitioner-** The word Practitioner used throughout this policy means both licensed independent practitioner and allied health practitioner.
2. **Care Appropriate:** The Practitioner care provided was consistent or compliant with either:
   - best clinical practices (including evidenced based medicine when available),
   - common practices for the vast majority of Practitioner in those circumstances,
     - defined medical staff expectations for all general competencies (e.g. medical staff bylaws, rules, regulations or medical staff of hospitals policies), or
     - generally accepted medical ethics
3. **Care Inappropriate**: The Practitioner's care varied from the appropriate rating either because the vast majority of Practitioners on the committee would not have

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provided care in that manner under those circumstances and the level of significance of issue was relatively high.

3.4. **Care Controversial Further Care Review Required**: The Practitioner care varied from the appropriate rating either because:

- a majority of Practitioner on the committee (but not all) would not have provided care in that manner under those circumstances or
- the care was not clearly inappropriate but an alternative approach was viewed as consistently better practice.
- while the care was not appropriate, the level of significance of issue was relatively low as part of the overall care provided in that case.

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

~~5.1. **Care Inappropriate**: The Practitioner's care varied from the appropriate rating either because the vast majority of Practitioners on the committee would not have provided care in that manner under those circumstances and the level of significance of issue was relatively high.~~

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

V. PROCEDURE:

A. Case Selection and Referral for Peer Review

1. The peer review process will evaluate any occurrence or practice pattern that may contribute to an adverse patient outcome. The process shall be applied in an objective, uniform and consistent fashion to the entire Medical Staff.

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2. Case selection for peer review may be initiated by the Clinical Effectiveness Department, Chief of Staff, Chief Medical Officer, Medical Staff Department Chairs, medical staff members, or other clinical staff members. Sources for identifying cases for review include but are not limited to direct referrals, chart reviews, quality indicators, data from hospital data collection systems, referrals from medical staff committees, patient or family complaints and incident reports (QRRs). These screens are applied objectively and uniformly to the entire Medical Staff.

3. Case referrals are reviewed by clinical staff in Clinical Effectiveness and the Medical Directors for Quality and Safety for suitability for peer review. Cases may be closed, trended for practitioner performance, referred to Department peer review committees, or referred to Leadership Council for complex issues as defined above. Decisions shall be documented in the appropriate database used by Clinical Effectiveness for quality monitoring.

4. Clinical Effectiveness staff shall enter referrals for peer review and complete required documentation on the Peer Review Assessment form.

B. Peer Review Procedure

1. The Executive Committee of the Department of the Practitioner or the designated peer review committee will conduct the peer review in accordance with the Medical Staff Bylaws.

   a. The Department Executive Committee may, from time to time, appoint an ad hoc subcommittee to deliberate a specific peer review issue if other expertise is necessary to adequately assess a peer.

   b. Cases referred to the Leadership Council shall be reviewed by members to identify appropriate venue for review of case. Appropriate venues include departmental peer review, review by Care Review Committee or need for external review. Cases shall be referred as requested by the Leadership Council.

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c. In instances where the Department Executive Committee or the practitioner is concerned that an unbiased review cannot be satisfied, the Care Review Committee may review or an external review may be requested by either party.

d. External Reviews may be initiated by either the Care Review Committee or the MEC. External Peer Review is an impartial evaluation of a practitioner's clinical performance or professional conduct which, for whatever reason, cannot be resolved internally. Situations which may require external peer review include:

i) Conflicting conclusions by peer review bodies that affect a practitioner's membership or privileges (when internal reviewers submit conflicting or vague recommendations or fail to agree).
ii) Lack of internal expertise – when the only practitioners on the medical staff with expertise to review the specialty are associates, partners, or direct competitors of the practitioner under review.
iii) Conflict of interest – i.e. one practitioner reviewing a partner's performance would trigger a conflict of interest.
iv) New technology – When the medical staff does not have the necessary tools to assess whether a practitioner requesting privileges possesses the required skills and competence.
v) Miscellaneous issues – The MEC may use external peer reviewers whenever it is deemed appropriate.

2. Customarily, a Department Executive Committee will complete the peer review process within 90 days of receipt of a case.

3. The Peer Review Assessment form shall be forwarded to the Peer Review Practitioner assigned to review the case.

4. The involved practitioner shall be notified that the case will be reviewed and the involved practitioner shall be given an opportunity to respond to the inquiry or specific questions by presence at the committee (virtually or in person), or in writing (email communication or written response letter). If the practitioner does not

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respond to inquiry of committee within reasonable time frame, the case shall be reviewed without the practitioner's input.

5. The Department Peer Review Committee or designated peer review committee shall review the case and complete the Peer Review Assessment form in its entirety, including final case evaluation using definitions above to rate care. Decisions of the Department Peer Review Committee will be determined by majority vote.

6. The Practitioner shall be notified of the conclusions of the committee and expected actions if necessary. Information shall also be documented in the practitioner's credentials file as appropriate. Available action items include but are not limited to: no action warranted, educational opportunity identified and letter sent to practitioner, trend-monitor practice over time, discussion with Department chairman, referral to physician well-being committee, formal letter in practitioner's credentials file, formal counseling by Department Chair with formal improvement plan or proctoring, recommendation of FPPE.

7. Documentation of the peer review shall be maintained in the appropriate databases and available for use for ongoing monitoring of medical staff.

8. Peer review is considered confidential and privileged information. Discussions of peer review are confined to meetings and committees designated to complete this function. Discussion may include fact-finding and phone calls between officers, the practitioner and other peer review bodies. Confidentiality of the process includes protecting the identity of individuals making complaints to the department executive committee and reviewers.

a. Those individuals and entities legally permitted access to peer review include the following but are not limited to:

1) Practitioner whose credential's file is being requested.
2) Officers of the practitioners department.
3) Medical Staff Officers, Quality Assessment Medical Director, Medical Director of Service, Administration: CEO or designee.
4) Regulatory Agencies, Joint Commission, Federal and State agencies.
5) Legal Counsel for the Medical Staff.
6) Medical Staff Services personnel.
7) Clinical Effectiveness staff
8) Board of Directors during appointment and reappointment period.

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9) Other Department Executive Committees only if germane to privileging process.

b. Practitioner's access to peer review records must take place in the Medical Staff Office. Access for other individuals or entities listed above must have prior approval by the Chief of Staff or Quality Assessment Medical Director. Under no circumstances should issues be discussed with non-involved individuals and at no time may copies of minutes or peer

1. review records be given to practitioners unless there is a judicial review hearing.

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2. 9. Cases ratesd as controversial and inappropriate or further review required will automatically be forwarded to the Care Review Committee for review of findings and action plan. Summaries of all cases determined to be appropriate shall also be periodically reviewed by designated members of the Care Review Committee to ensure that reviews are being conducted fairly and consistently.

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VI. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Planning:	August 18, 2015, January 2017
ePolicy Committee:	January 2017
Medical Executive Committee:	September 24, 2015, March 2017
Board of Directors:	October 14, 2015
Historical Approvals:	*February 2013, October 2014*

Peer Review Case Rating Form

Referred to XXXX Committee

From Quality/MCCM Feed

MR#:	Admit Date:	Occurrence Date:	Discharge Date	Physician ID#:	Referral Date:

Referral Source: Check the corresponding box

	Incident Report/QRR		AHRQ PSI 90 (need to list them all)		Medical Director Referral		Other
	Dept. Quality Indicator (need to list them all)		Guest Services		Core Measure Fallout (list them all)		

Clinical Case Summary:

Key Issues for Practitioner reviewer

To be completed by Practitioner Review-Answer required for all fields. If item circled, please describe issue.

Practitioner Reviewer: ______________________________ Review Date: ____________________

Outcome: Please check ***(one)***			**Documentation:** Check ***(all)*** that apply (** Flow to OPPE)		
1.		No Adverse Outcome	1.		No issue with documentation
2.		Temporary Adverse Outcome (complete recovery expected)	2.		Documentation exemplary
3.		Permanent Adverse Outcome (complete recovery NOT expected)	3.		Documentation does not substantiate clinical course and treatment (eg missing/incomplete/inadequate)
4.		Death	4.		Documentation not timely to communicate with other caregivers
PLEASE DESCRIBE ITEM CIRCLED ABOVE:			6.		Failure to use EHR as required
			7.		System Documentation Issue

Peer Review Case Rating Form

Referred to XXXX Committee

Issue Identification: Check all that apply			Overall Practitioner Care: Check one See definitions in Peer Review policy for guidance (** Items marked as inappropriate and further review required are automatically referred to Care Review Committee)		
1.		Issue with Practitioner diagnosis	1.		Practitioner care appropriate Does case need further review? No Yes: Identify question to be reviewed: ________________
2.		Issue with Practitioner judgment	2.		Practitioner care inappropriate Does case need further review? No Yes: Identify question to be reviewed: ________________
3.		Issue with Practitioner technique/skills	3.		Further Review Required Does case need further review? No Yes: Identify question to be reviewed: ________________
4.		Issue with Practitioner communication (delay in response/call back/on call availability)	4.		Practitioner care exemplary
5.		Issue with plan of care/discharge planning	Overall Practitioner Vote Tally: # Agree # Dissent		
6.		Issue with Practitioner policy compliance			
7.		Issue with Practitioner supervision of AHP or house staff			
8.		Issue with Practitioner Behavior			
9.		Issue with Impaired Physician			
10.		Issue with Utilization Management			
11.		**PLEASE DESCRIBE ITEM CIRCLED ABOVE**:			

Peer Review Case Rating Form

Referred to XXXX Committee

Brief description of the basis for reviewer findings of overall practitioner's care:

____

____

____

____

What questions are to be addressed by the Practitioner?

____

____

Committee Review

Is physician response needed? ________ Yes ________ No Date Practitioner Notified of Results: _________

Date of Appearance at Committee ____________ Date Written Response Received: _________________

Committee Action (check one)		Date Completed
	No action warranted	
	Educational opportunity identified for all practitioners-refer to CME Director	
	Trend, Monitor practice over time	
	Physician self-acknowledged action plan sufficient	
	Educational letter to Practitioner sufficient	
	Department Chairman discussion of informal improvement plan with Practitioner	
	Referral to Physician Well Being Committee	
	Formal letter in practitioner in file (eg strike under Disruptive Behavior policy)	
	Formal counseling by Department Chair formal improvement plan (eg proctoring)	
	Recommendation of FPPE (** Referral to CRC)	

How was Practitioner Notified of Findings

☐ Discussed with Department Chairman Date: _______

☐ Written communication Date: _______

☐ Committee Appearance Date: _______

☐ No Notification Necessary

Systems Concerns:

☐ Referral to Other Department_________________________

☐ System Problem Identified: Date Sent to Clinical Effectiveness ____

Describe system issue: ____

☐ Referral to Nursing Administration   Date sent to CNO: ____

Describe nursing concern: ____

☐ Referral for General CME / Dept. M&M Date sent: ____

Department Chairman Signature: ____________________________   Date: _____________________

MEDICAL STAFF BYLAWS

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DEFINITIONS

1. AUTHORIZED REPRESENTATIVE means the individual designated by the Chief of Staff and approved by the Medical Staff Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

2. CHIEF OF STAFF means the chief officer of the Medical Staff elected by members of the Medical Staff.

3. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.

4. CONTRACTED PRACTITIONER means a Medical Staff member who is engaged as an independent contractor to perform certain administrative functions (e.g. as a medical director) beyond the professional services otherwise provided by the member.

5. BOARD OF DIRECTORS means the Board of Directors responsible for El Camino Hospital.

6. HOSPITAL means El Camino Hospital and includes the Mountain View and Los Gatos campuses. The term “Enterprise” refers to both campuses.

7. MEDICAL STAFF or ORGANIZED MEDICAL STAFF (OMS) means the formal organization of all licensed physicians, dentists, and podiatrists who are privileged to attend patients in the Hospital.

8. MEDICAL STAFF YEAR means the period from July l to June 30.

9. EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

10. PHYSICIAN means an individual with a M.D. or D.O. degree who is licensed to practice medicine.

11. PRACTITIONER means, unless otherwise expressly limited, any physician, dentist, or podiatrist who is applying for Medical Staff membership and/or clinical privileges, or who is a Medical Staff member and/or who exercises clinical privileges in this Hospital.

12. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a Medical Staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these Bylaws and by other Hospital and Medical Staff rules and regulations.

13. ADMINISTRATOR/CHIEF EXECUTIVE OFFICER (CEO) means the person appointed by the Board of Directors to act on its behalf in the overall management of the Hospital, or his/her designee.

14. INVESTIGATION means a process specifically instigated by the Medical Staff Executive Committee to determine the validity, if any, of a concern or complaint regarding a Medical Staff member. It does not include any activity of the Physician Health & Well-Being Committee or of any other Medical Staff committee unless such other committee is directed to conduct the investigation by the Medical Staff Executive Committee.

15. IN GOOD STANDING means a member is currently not under suspension or serving with any limitation of voting or other privileges or prerogatives imposed by operation of the bylaws, rules and

regulations or policy of the Medical Staff.

ARTICLE 1
NAME

The name of this organization is the Medical Staff of El Camino Hospital.

ARTICLE 2
PURPOSES

2.1 ORGANIZATION

The Medical Staff organization is composed of doctors of medicine and osteopathy. The Medical Staff organization also includes dentists and podiatrists and non-physician practitioners who are determined to be eligible for appointment set forth in these Bylaws.

The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff category depending upon nature and tenure of practice at the hospital. All new members are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the Staff categories described in Bylaws, Article 4, Categories of the Medical Staff.

Members are also assigned to departments, depending upon their specialties, as noted in Article 9. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review.

There are medical staff committees which perform staff-wide responsibilities and which oversee related activities being performed by the departments.

Overseeing all of this is the Medical Executive Committee, comprised of the elected officials of the Medical Staff, Hospital-based Division Chiefs, and others as noted in the Medical Staff Executive Committee composition, Article 11.14.

2.2 PURPOSES OF THIS ORGANIZATION

To assure excellence in the quality of care delivered to patients at El Camino Hospital, to be an advocate for patients' health care needs and their rights, and to govern the activities of the Medical Staff.

Through its governance structure, the Medical Staff Organization will:

(a) Assure that physician clinical activities strive for high professional standards, are efficient, effective and ethical.

(b) Assure that practitioners have and maintain competencies for their clinical activities.

(c) Assure that opportunities for providing care are fair and accessible to all qualified members.

(d) Promote clinical quality improvement and the environment of a learning organization through Continuing Medical Education and communication.

(e) Emphasize caring and compassion towards patients.

2.3 PURPOSES OF THESE BYLAWS

These Bylaws are adopted in order to provide for the organization of the Medical Staff of El Camino Hospital and to provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for Medical Staff operations, Organized Medical Staff

relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

Subject to the authority and approval of the Board of Directors, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated Rules and Regulations, Policies/Procedures, and under the corporate Bylaws of El Camino Hospital in compliance with law and regulation.

Providing quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and El Camino Hospital for the proper performance of their respective obligations. The Medical Staff's right of self-governance shall include, but not be limited to, establishment of these bylaws. The El Camino Hospital Board has a duty to act on behalf of the Medical Staff to protect patients in the event the Medical Staff fails in any of its important duties or responsibilities. El Camino Hospital shall not act in the stead of the Medical Staff precipitously, unreasonably or in bad faith.

ARTICLE 3
MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

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

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

A pre-application questionnaire will be sent to the practitioner requesting membership. An application for membership will be sent if the following qualifications are met:

(a) Practitioner has actively practiced clinical medicine within the past 24 months;

(b) Practitioner is board certified in his/her primary specialty (or if recently completed residency/fellowship, will become board certified within five (5) years of completion of residency/fellowship). Boards accepted:

- American Board of Medical Specialties for MDs
- American Board of Foot and Ankle Surgery for DPMs
- American Board of Oral & Maxillofacial Surgery for O/M Surgeons
- American Board of General Dentistry or American Board of Pediatric Dentistry – Hospital Dentistry

(c) During the past 7 years, practitioner <u>may not</u>

1. Have had medical staff membership or any clinical privileges denied or terminated by the medical staff of another hospital, ASC, or healthcare facility;
2. Have had adverse action taken by any state licensing board (for example the Medical Board of California) to include letters of reprimand, probation or any more significant adverse action;
3. Been convicted of a felony or misdemeanor (other than a minor traffic violation);

(d) Are currently <u>not the subject of an investigation by any state licensing board.</u>

Once the applicant qualifies as noted above and an application has been received, minimum qualifications include:

(a) Documentation of: (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care

(b) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff; and

(c) maintain in force professional liability insurance covering the exercise of all requested privileges, in not less than one million per occurrence and three million annual aggregate or such other amount as may be determined and approved by the Board of Directors and Medical Staff Executive Committee from time to time.

3.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership in the Medical Staff must hold a M.D. or D.O. degree issued by a medical or osteopathic school and a valid, unrevoked, and unsuspended certificate to practice medicine issued to him/her by the Medical Board of California or the California Board of Osteopathic Examiners. An applicant for physician membership must be board certified in his/her primary specialty within five (5) years of completion of residency/fellowship. Board certification must be maintained in the physician's primary specialty in order for the physician to be qualified for continued medical staff membership (a two year grace period will be granted if needed, for practitioners to obtain recertification). Physicians who are on staff prior to July 14, 2010 (BOD approval date) are exempt but are encouraged to obtain and maintain board certification.

(b) Dentists. An applicant for dental membership in the Medical Staff must hold a D.D.S. or equivalent degree issued by a dental school and a valid, unrevoked, and unsuspended certificate to practice dentistry issued to him/her by the California Board of Dental Examiners.

(c) Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree and a valid, unrevoked, and unsuspended certificate to practice podiatry issued to him/her by the Medical Board of California. An applicant for podiatry membership must be board certified in podiatry within five (5) years of completion of residency/fellowship. Board certification must be maintained in order for the podiatrist to be qualified for continued medical staff membership (a two year grace period will be granted if needed, for practitioners to obtain recertification). Podiatrists who are on staff prior to July 14, 2010 (BOD approval date) are exempt but are encouraged to obtain and maintain board certification.

3.3 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be automatically entitled to Medical Staff membership, or to exercise any particular clinical privileges, merely because he/she holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board, or had, or presently has, Staff membership or privileges at this Hospital or at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

3.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, or national origin, or whether the physician and surgeon or podiatrist holds an MD, DO, or DPM degree, or on the basis of any other criterion, unrelated to the delivery of quality patient care in the Hospital setting, to the professional qualifications, the Hospital's purposes, needs and capabilities, or community needs.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the emeritus staff, the ongoing responsibilities of each member of the Medical Staff include:

(a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this hospital;

(b) complying with the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Policies, and engaging in performance improvement activities.

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

(d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;

(e) abiding by the lawful ethical principles of the California Medical Association and the member's specialty board, if any;

aiding in any Medical Staff, department, or division approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;

(f) working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;

(g) making appropriate arrangements for coverage of that member's patients as determined by the Medical Staff;

(h) refusing to engage in improper inducements for patient referral;

(i) participating in continuing education programs as determined by the Medical Staff;

(j) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;

(k) discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Staff Executive Committee; and

(l) providing information to the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 7.1-3, and

(m) those which are the subject of a hearing pursuant to Article 8.

3.6 DURATION OF APPOINTMENT

Except as otherwise provided in these bylaws, initial appointments and reappointments to the Medical Staff shall be for a period up to2-years..

3.7. HARASSMENT/DISRUPTIVE/INTIMIDATING BEHAVIOR PROHIBITED

Harassment by a Medical Staff member against any individual (e.g., against another Medical Staff member, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated. Refer to Medical Staff Policy 7.1-4 for details.

ARTICLE 4
CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Provisional, Courtesy, Active Community, Affiliate, Emeritus and Dialysis Affiliate.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

The Active Staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

It is recognized that even though physicians may not admit patients to the hospital, they may wish to remain involved in the hospital and medical staff's functions.

There are 2 ways to satisfy the activity requirements for Active Staff membership:

1. 11+ patient contacts per year (defined below *)
2. A practitioner who wishes to serve on the ER call panel, or otherwise participate in medical staff functions, may request that the Medical Staff Executive Committee (Medical Staff Executive Committee) appoint him/her to the Active Staff for this purpose. Active Staff membership may be granted by the Medical Staff Executive Committee for as long as the practitioner is involved in medical staff functions.

(b) *Patient contact defined as an admission, discharge, surgical assist, ED short stay, ED discharge, consultation, or procedure.

4.2-2 PREROGATIVES

The prerogatives of an Active Medical Staff member shall be to:

(a) Provide patient care consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.

(b) Exercise such clinical privileges as are granted to him/her pursuant to Article 6.

(c) Hold office in the Medical Staff and in the department and committees of which he/she is a member, and serve on committees, unless otherwise provided in the Medical Staff Bylaws.

(d) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.2-3 RESPONSIBILITIES

Each Active Medical Staff member shall:

(a) Meet the basic responsibilities set forth in Section 3.5.

(b) Actively participate in and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of his/her professional competence, including, but not limited to, emergency service and back up function **, peer review, utilization management, case management, quality evaluation and related monitoring activities required of the Medical Staff in supervising and proctoring initial appointees and allied health practitioners, and in discharging such other functions as may be required by the Medical Staff Executive Committee from time to time.

(c) Participate in such emergency service coverage or consultation panels as

may be determined by the Medical Staff.

** Emergency Service and backup function – practitioners will be responsible for providing continuous care for his/her patients at the campus they have designated as their "primary" campus (either MV or LG). If the practitioner wishes to provide emergency coverage at the campus where he/she is not designated as "primary", he/she may contact the emergency room and indicate that he/she is available for such call.

4.3 PROVISIONAL STAFF

4.3-1 QUALIFICATIONS

The Provisional Staff shall consist of practitioners who:

(a) Meet the qualifications specified for members of the Medical Staff, except that they have not yet satisfactorily completed the focused professional practice evaluation (FPPE) requirements specified in Section 6.3; have been Medical Staff members for less than six (6) months; and/or have not fulfilled such other requirements as may be set forth in these Bylaws, the Medical Staff and department guidelines, or Hospital policies.

A practitioner may remain a Provisional Staff member for a maximum period of twelve (12) months. At the conclusion of 12 months, an activity profile will be generated and the practitioner will be advanced to the appropriate staff category based on the level of patient contacts (see definition under section 4.2-1). If Focused Professional Practice Evaluation (FPPE) requirements have not yet been satisfied at the end of 12 month period, the privileges that still require proctoring will be relinquished.

4.3-2 PREROGATIVES

The prerogatives of a Provisional Staff member shall be to:

(a) Provide patient care consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.

(b) Exercise such clinical privileges as are granted to him/her pursuant to Article 6.

(c) Serve on committees as a voting member, unless provided otherwise in these Bylaws. A Provisional member may not hold office in the Medical Staff or in the Department of which he/she is a member.

4.3-3 RESPONSIBILITIES

Each Provisional Staff member shall be required to discharge the applicable responsibilities which are specified in Section 4.2-3 for Active Staff members. Failure to fulfill those responsibilities shall be grounds for denial of advancement and termination of Provisional Staff status.

4.4 COURTESY STAFF

4.4-1 QUALIFICATIONS

The Courtesy Staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2

(b) 1-10 patient contacts per year (as defined in Section 4.2-1). If this number is exceeded for two consecutive 12 month periods, practitioner will be transferred to the Active Staff.

4.4-2 PREROGATIVES

The prerogatives of a Courtesy Staff member shall be to:

(a) Exercise such clinical privileges as are granted to him/her pursuant to Article 6.
(b) Attend meetings of the Medical Staff and the Department of which he/she is a member with vote. A Courtesy Staff member may not hold office in the Medical Staff or in the department of which he/she is a member.
(c) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.4-3 RESPONSIBILITIES
Each Courtesy Staff member shall meet the basic responsibilities set forth in Section 3.5.

4.5 ACTIVE COMMUNITY STAFF
4.5-1 QUALIFICATIONS
The Active Community Staff shall consist of members who:
(a) Meet qualifications set forth in Section 3.2
(b) Is active in the medical community and refers patients to El Camino Hospital.

4.5-2 PREROGATIVES
Active Community Staff members hold no clinical privileges. The prerogatives of an Active Community Staff member shall be to:
(a) Attend meetings of the Medical Staff and the Department of which he/she is a member.
(b) Hold office in the Medical Staff and in the department and committees of which he/she is a member, and serve on committees, unless otherwise provided in the Medical Staff Bylaws.
(c) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.6 AFFILIATE STAFF
4.6-1 QUALIFICATIONS
The Affiliate Staff shall consist of practitioners who do not have a hospital practice but regularly provide professional services for patients in the community served by El Camino Hospital.

4.6-2 PREROGATIVES
Affiliate Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. The prerogatives of an Affiliate Staff member shall be to:
(a) Attend meetings of the Medical Staff and the Department of which he/she is a member in a non-voting capacity, except within committees when the right to vote is specified at the time of appointment. An Affiliate Staff member may not hold office in the Medical Staff or in the department and committees of which he/she is a member.
(b) An Affiliate Staff member may not vote on any Medical Staff matter, except as specified in 4.6-2(a).

4.6-3 RESPONSIBILITIES

Each Affiliate Staff member shall meet the basic responsibilities specified in Section 3.5, Paragraphs (b), (c), (e), (f), (i), (j), (l), and (m).

4.7 HONORARY AND EMERITUS STAFF

4.7-1 QUALIFICATIONS

The Honorary Staff shall consist of physicians, dentists, and podiatrists who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing and exemplary service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

The Emeritus Staff shall consist of practitioners, each of whom:

(a) Wishes to take a less active role on the Medical Staff and refrain from the active care of patients at the Hospital.

(b) Has passed the age of sixty (60) years

(c) Has served more than ten (10) years on the Active Staff

4.7-2 PREROGATIVES

The prerogatives of an Honorary or Emeritus Staff member shall be to:

(a) Serve on Medical Staff committees and vote on such committees

(b) Attend meetings of the Medical Staff and his/her department/division

4.7-3 RESPONSIBILITIES

Members shall have no specific responsibilities and shall not be required to pay dues. They shall be required to abide by these Bylaws, the Rules and Regulations of the Medical Staff and policies of the Medical Staff Executive Committee as they may apply.

Honorary and Emeritus Staff members shall not be eligible to admit or otherwise care for patients, hold office in the Medical Staff or department/divisions, nor shall they be eligible to vote on matters presented at general or special meetings of the Medical Staff.

4.8 CONTRACTED PRACTITIONERS – QA/UR MEDICAL DIRECTOR STATUS AND RECOMMENDATIONS

4.8-1 CONTRACTED PHYSICIANS.

A practitioner who is engaged as an independent contractor to perform certain administrative functions (e.g. medical directors, QA/UR Medical Director) must be a Medical Staff member and obtain any necessary clinical privileges through the procedures provided for in Articles 5 and 6. The clinical practice of such practitioners will be subject to the same quality assurance and peer review processes as applies to all Medical Staff members.

4.8-2 MEDICAL DIRECTOR REVIEW/RECOMMENDATIONS.

Periodically, and no less than every two years, the Medical Staff Executive Committee shall review the quality of care and clinical efficiency of services directed by medical directors. The Medical Staff Executive Committee shall also review the quality of care issues at the time of initial appointment of a medical director. Such reviews shall be based on objective criteria. The Medical Staff Executive Committee shall make recommendations to the Board of Directors regarding retention/appointment of medical directors based on its quality reviews. Such recommendations shall be carefully considered by the Board of Directors. The Board of Directors will not act arbitrarily, and any decision regarding retention/appointment which is contrary to the Medical Staff Executive Committee's recommendation shall be justified in writing. This section shall in no way affect the ongoing

quality assurance/peer review process applicable to such physicians in the normal course of their clinical practice.

4.9 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other Sections of these Bylaws, or by the Medical Staff Rules and Regulations. The staff shall be limited to those for which they can demonstrate the possession of the requisite licensure, education, training, experience, and current competence.

4.10 EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited licensed members:

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the Medical Staff Executive Committee; and

(b) shall exercise clinical privileges within the scope of their licensure.

4.11 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Department Chair, or pursuant to a request by a member or upon request by the Board of Directors, the Medical Staff Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the bylaws.

ARTICLE 5
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

The Medical Staff through its designated departments, committees, and officers shall consider each application for appointment or reappointment to the Medical Staff, and for clinical privileges, and each request for modification of staff membership status or clinical privileges, before adopting and transmitting its recommendations to the Board of Directors. Appointments, denials, and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff Executive Committee or as set forth in Section 5.3-8(b).

5.2 APPLICATION FOR APPOINTMENT

5.2-1 CONTENT

All applications for appointment to the Medical Staff shall be in writing, signed by the applicant and submitted on a form prescribed by the Medical Staff Executive Committee. The application shall require the applicant to provide:

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

(b) The names of at least three (3) persons who hold the same professional license as does the applicant, including, whenever possible Active Staff members who can provide adequate references based on their current knowledge of the applicant's qualifications, professional competency, and ethical character.

(c) Experience, ability, and current competence in performing the requested privilege(s) is verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment for proficiency in the following six areas of "General Competencies" adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

1. Patient Care
   Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
2. Medical/Clinical Knowledge
   Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
3. Practice-based Learning and Improvement
   Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
4. Interpersonal and Communication Skills
   Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
5. Professionalism
   Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity* and a

responsible attitude toward their patients, their profession, and society.

6. Systems-based Practice
Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

(d) Information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, or voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or prerogatives, or clinical or admitting privileges at any other Hospital or Institution; membership or fellowship in any local, state regional, national or international professional organization for cause; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

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

(f) Information as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations), or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent, or willful omission in rendering services.

(g) Information as to details of any prior or pending government agency or third party payor proceeding, or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medi-Cal fraud and abuse proceedings and convictions, not to include usual and customary withhold denials from insurance payors.

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

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

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

The applicant shall also identify the clinical Department, and clinical privileges for which the applicant wishes to be considered. Each applicant for membership shall pay a non-refundable application fee in the amount established by the Medical Staff Executive Committee pursuant to Section l4.3

5.2-2 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff each applicant:

(a) signifies willingness to appear for interviews in regard to the application;

(b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection and copying of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

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

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

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

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

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

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

(k) agrees that so long as he/she is an applicant/member, he/she shall promptly advise the Medical Staff Services Office of changes in the information identified in Section 5.2-1.

5.3 PROCESSING THE APPLICATION

5.3-1 APPLICANT'S BURDEN

The applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, physical and mental health status, and all other qualifications specified in the Medical Staff Bylaws and Rules and Regulations, and of his/her compliance with standards and criteria set forth in the Medical Staff Bylaws and Rules and Regulations, and for resolving any doubts about these matters. The application will not be considered complete until all information requested of the applicant or other sources has been received and the verifications under Section 5.3-2 have been completed. The provision of information containing misrepresentations or omissions, and/or a failure to sustain the burden of producing adequate information, shall be grounds for ineligibility for Medical Staff membership and denial of his/her application.

5.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Medical Staff Services Office, which shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Services Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. The Hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant (or member). The resulting report shall be placed in the applicant's/member's credential file. An applicant whose application is not completed within six (6) months after it was received by the Medical Staff Services Office shall be automatically removed from consideration for staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, has been resubmitted.

When collection and verification is accomplished, the Medical Staff Services Office shall transmit the application and all supporting materials to the chief of each department in which the applicant seeks membership and privileges.

5.3-3 DEPARTMENT ACTION

Upon receipt, the chief of each such department shall review the application, and supporting documentation, and transmit to the Medical Staff Executive Committee his/her written report and recommendations prepared in accordance with Section 5.3-5. A department chief and/or any other appropriate staff committee may ask the applicant to appear for an interview or request further documentation.

Applicants requesting privileges for surgical or other invasive procedures will receive recommendations from the appropriate department/committee monitoring the privileges being requested.

5.3-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

The Medical Staff Executive Committee shall consider the department chief's recommendation, and such other relevant information as may be available. The committee shall then forward to the Administrator/ Chief Executive Officer, for transmittal to the Board of Directors, its written report and recommendations, prepared in accordance with Section 5.3-5. The Committee may also defer action on the application pursuant to Section 5.3-7(a).

5.3-5 APPOINTMENT REPORTS

The department chief and Medical Staff Executive Committee reports and recommendations shall be submitted in the form prescribed by the Medical Staff Executive Committee. Each report and recommendation shall specify whether Medical Staff appointment and privileges are recommended, and, if so, the membership category, department affiliation, and clinical privileges to be granted and any special conditions to be attached to the appointment. The reasons for each recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

5.3-6 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant for Medical Staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.2, can carry out the responsibilities specified in Section 3.5, and meets all the standard and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the

practitioner's compliance with legal requirements applicable to the practice of his/her profession and other Hospitals' Medical Staff Bylaws, Rules and Regulations, and policies, rendition of services to his/her patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, and his/her provision of accurate and adequate information to allow the Medical Staff to evaluate his/her competency and qualifications.

5.3-7 EFFECT OF EXECUTIVE ACTION

(a) Interview, Further Documentation, Deferral. After all outstanding documentation has been received, action by the Medical Staff Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within seventy (70) days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for Medical Staff membership/privileges.

(b) Favorable Recommendation. When the Medical Staff Executive Committee's recommendation is favorable to the applicant, the Administrator shall promptly forward it, together with all supporting documentation, to the Board of Directors. For the purposes of this Section 5.3-7(b), "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the department chiefs and the Medical Staff Executive Committee.

(c) Adverse Recommendation. When the Medical Staff Executive Committee's recommendation is adverse to the applicant regarding membership or privileges, the Chief of Staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2, and the applicant shall be entitled to the procedural rights as provided in Article 8. For the purpose of this Section 5.3-7(c), and "adverse recommendation" by the Medical Staff Executive Committee is as defined in Section 8.2. The Board of Directors shall be informed of, but not take action on, the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

5.3-8 ACTION BY THE BOARD OF DIRECTORS

(a) On Favorable Medical Staff Executive Committee Recommendation: The Board of Directors shall, in whole or in part, adopt or reject a Medical Staff Executive Committee recommendation which is favorable to the applicant, or refer the recommendation back to the Medical Staff Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the Board of Directors is one of those set forth in Section 8.2, the Administrator/ Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2; and the applicant shall be entitled to the procedural rights as provided in Article 8 before any final adverse action is taken.

(b) Without Benefit of Medical Staff Executive Committee Recommendation: If the Board of Directors does not receive a Medical Staff Executive Committee recommendation within the time period specified in Section 5.3-11, it may, after notifying the Medical Staff Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Board of Directors. If the recommendation is one of those set forth in Section

8.2, the Administrator/ Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2; and the applicant shall be entitled to the procedural rights as provided in Article 8 before any final adverse action is taken.

(c) After Procedural Rights: In the case of an adverse Medical Staff Executive Committee recommendation pursuant to Section 5.3-7(c) or an adverse Board of Directors recommendation pursuant to Section 5.3-8(a) or (b), the Board of Directors shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article 8. Action thus taken shall be the conclusive decision of the Board of Directors, except that the Board of Directors may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board of Directors shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and new evidence in the matter, if any, the Board of Directors shall make a final decision.

5.3-9 NOTICE OF FINAL DECISION

(a) Notice of the Board of Directors' final decision shall be given to the Medical Staff Executive Committee, the chief of each department concerned, and the applicant.

(b) A decision and notice to appoint shall include: (l) the Staff category to which the applicant is appointed; (2) the department to which he/she is assigned; (3) the clinical privileges he/she may exercise; (4) a description of focused professional practitioner evaluation (FPPE) requirements; and (5) any special conditions attached to the appointment.

(c) In the case of adverse decision regarding appointment to the Medical Staff and after exhaustion or waiver of the applicant's procedural rights, a report shall be made to the Medical Board of California and to the National Practitioner Data Bank.

5.3-10 REAPPLICATION AFTER WITHDRAWAL/ADVERSE DECISION/OMISSION BY APPLICANT

An applicant who has received a final adverse decision regarding appointment, reappointment or clinical privileges; has withdrawn any application after questions regarding qualifications or competence have been raised; or whose application has been removed from consideration due to omissions/misstatements shall not be eligible to reapply for a period of two (2) years from the date the adverse decision became final or the application was withdrawn.

5.3-11 TIME PERIODS FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this Section 5.3-12. The Medical Staff Services Office shall transmit an application to the Department Chief within thirty (30) days after all information collected and verification tasks are completed and all relevant materials have been received. In the event the relevant materials are not received within ninety (90) days after the application is received, the applicant shall be notified and the application shall remain pending until either the materials are received by the Medical Staff Services Office or the expiration of six (6) months after receipt shall automatically be removed from

consideration as specified in Section 5.3-2. The applicable department chiefs shall act on an application within thirty (30) days after receiving it from the Medical Staff Office. The Medical Staff Executive Committee shall review the application and make its recommendation to the Board of Directors within forty-five (45) days after receiving the department report. The Board of Directors shall then take final action on the application within forty-five (45) days. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his/her application process within those periods.

5.4 REAPPOINTMENTS

5.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

At least one hundred eighty (180) days prior to the expiration of each member's current staff appointment, the Medical Staff Services Office shall mail a reappointment application to the staff member.

At least one hundred twenty (120) days prior to the expiration date of his/her Staff appointment, each Medical Staff member shall submit to the Medical Staff Services Office a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the Medical Staff, and it shall require detailed information concerning the changes in the applicant's qualifications since his/her last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the appointment application form, as described in Section 5.2, except for that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to continuing education activities during the past two (2) years and whether the applicant requests any change in his/her staff status and/or in his/her clinical privileges, including any reduction, deletion, or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same. The results of peer review at this Hospital and others will be considered as a part of the reappointment review. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital must also be reported at this time in addition to information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, or voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or prerogatives, or clinical or admitting privileges at any other Hospital or Institution; membership or fellowship in any local, state regional, national or international professional organization for cause; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

5.4-2 VERIFICATION OF INFORMATION

The Medical Staff Services Office shall, in timely fashion, seek to collect and to verify the additional information made available on each reappointment application form including information regarding the practitioner’s experience, ability, and current competence with regard to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice (see 5.2 (c) for details regarding these competencies). The Medical Staff Services Office shall transmit the completed reappointment application form and supporting materials to the chief of each department in which the staff member has or requests privileges.

5.4-3 DEPARTMENT ACTION

(a) The department chief shall review the application and the staff member's file and shall transmit to the Medical Staff Executive Committee his/her written report and recommendations, which are prepared in accordance with Section 5.4-5. This may include a recommendation for change in staff category, change or no change in clinical privileges, or reappointment for one year, based on departmental guidelines.

(b) The following applies to the review of information in the Medical Staff member's credentials file at the time of reappraisal or reappointment.

1 Prior to recommendation on reappointment the Department Chief, as part of the reappraisal function, shall review information in the credentials file pertaining to a member.

2. Following this review, the Department Chief, after consultation with the Department Executive Committee, shall determine whether documentation in the file warrants further action.

3. With respect to adverse information, if it does not appear that an investigation and/or adverse recommendation on reappointment is warranted, the Department Chief shall so inform the Medical Staff Executive Committee.

4. However, if an investigation and/or adverse recommendation on reappointment is warranted, the Department Executive Committee shall so inform the Medical Staff Executive Committee and shall proceed appropriately with such investigation as part of the reappointment process.

5.4-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

The Medical Staff Executive Committee shall review the department chief's report, all other relevant information available to it, and shall forward to the Board of Directors, through the Administrator/ Chief Executive Officer, its favorable reports and recommendations, prepared in accordance with Section 5.4-5.

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

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

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

5.4-5 REAPPOINTMENT REPORTS

The department chiefs and Medical Staff Executive Committee reports and recommendations shall be written and shall be submitted in the form prescribed by the

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

5.4-6 BASIS FOR REAPPOINTMENT
Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.5, and met all of the standards and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession, with the Medical Staff Bylaws and Rules and Regulations and Hospital policies, rendition of services to his/her patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, and his/her competency and qualifications.

5.4-7 FAILURE TO FILE REAPPOINTMENT APPLICATION
If the member fails to submit an application for reappointment completed as required, he/she shall be deemed to have resigned his/her membership and privileges in the Medical Staff, effective on the expiration date of his/her appointment.

5.5 LEAVE OF ABSENCE

5.5-1 LEAVE STATUS
A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Medical Staff Executive Committee and the Administrator/Chief Executive Officer stating the approximate period of time of the leave, which may not exceed one (1) year at a time, renewable up to a total of two (2) years. During the period of the leave, the membershall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be suspended, except that the member shall still have the responsibility of submitting a reappointment application and dues, if required during the period of requested leave. Alternatively, the Chief of Staff, subject to approval by the Medical Staff Executive Committee, may place a member on a leave of absence if the circumstances warrant such an action.

5.5-2 MEDICAL LEAVE OF ABSENCE
The Medical Staff Executive Committee may also grant a leave of absence specifically for the purpose of obtaining treatment for a medical condition or disability. The Committee shall determine the circumstances under which such a leave is appropriate. Unless accompanied by a specific restriction of privileges, beyond the normal suspension of privileges as described in Section 5.5-1, the leave shall be deemed a “medical leave” which is not related to a medical disciplinary cause or reason.”

5.5-3 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Staff Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 5.5-2 and 5.5-3, but may be granted subject to focused professional practitioner evaluation (FPPE) as determined by the Medical Staff Executive Committee.

5.5-4 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave (which may be waived by the Medical Staff Executive Committee), or at any earlier time, the Medical Staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to that effect to the Administrator and to the Medical Staff Executive Committee. If so requested by the Medical Staff Executive Committee or the Administrator/ Chief Executive Officer, the staff member shall submit a written summary of his/her relevant activities during the leave. The Medical Staff Executive Committee shall recommend whether to approve the member's request for reinstatement of his/her privileges and prerogatives. Thereafter, the procedure set forth in Sections 5.3-7 through 5.3-11 shall be followed.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article 8, for the sole purpose of determining whether the failure was with or without good cause. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE 6
CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

A member providing direct clinical services at this Hospital, in connection with such practice and except as otherwise provided in Section 6.6, shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Directors. Said privileges must be within the scope of any license, certificate, or other legal credential authorizing him/her to practice in this State and consistent with any restrictions thereon. Medical staff privileges may be granted, continued, modified or terminated by the Board of Directors of this hospital only upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care, other provisions of the Medical Staff bylaws, and only following the procedures outlined in these bylaws.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Requests from an applicant for privileges, or from members for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges and continuing medical education. Requests for alteration in privileges may be made at any time and shall not be restricted to the time of renewal.

6.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of professional criteria to include the member's education, training, experience, current competence, and demonstrated ability to perform the privileges requested. All privileges requested will be hospital specific. The elements to be considered in determining current clinical competency regarding privileges, whether in connection with periodic reappointment or otherwise, shall include experience, ability, and current competence with regard to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice (see 5.2 (c)) for details regarding these competencies); professional liability claims history, results of queries with the Medical Board of California, National Practitioner Data Bank, and the OIG website; board certification and the documented results of patient care audit and other quality review, evaluation, and monitoring activities required. Privilege determinations shall also take into account pertinent information concerning professional performance obtained from other sources, especially peer recommendations and other institutions and health care settings where a member exercises clinical privileges.

6.2-3 PROCEDURE

All requests for clinical privileges from dentists and podiatrists shall be processed pursuant to the procedures outlined in Article 6.

6.2-4 GENERAL CONDITIONS

Except as otherwise recommended by the Medical Staff Executive Committee and approved by the Board of Directors, all initially granted clinical privileges shall be subject to the focused professional practice evaluation requirements identified in Section 6.3.

6.3 PROFESSIONAL PRACTICE EVALUATION

6.3-1 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE), for additional

information regarding FPPE process, see Medical Staff Policy 13.5.1

(a) FOR INITIAL APPOINTMENTS

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

His/her exercise of clinical privileges in any other department shall also be subject to proctoring by that department's chief, or his/her designee, for the term of proctoring required by that department.

(b) MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

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

(c) TERM OF PROCTORING PERIOD

Each department will establish terms for proctoring with a minimum number of cases, and/or a specific number of cases applicable to particular clinical privileges, whenever such requirements are appropriate in view of the clinical privileges which are involved. The period of proctoring may be extended in increments of not more than six (6) months each, for a total proctoring period of not more than (12) twelve months. If an initial appointee fails within that period to complete the applicable minimum number of cases and/or to furnish the certifications required in Section 6.3-1, his/her Medical Staff particular clinical privileges, as applicable, shall be relinquished. If a Medical Staff member requesting modification fails within that period to complete the minimum number of cases and/or furnish the certifications required in Section6.3-1, the change in Medical Staff category or Department assignment or the additional privileges, as applicable, shall be relinquished. The practitioner will be given written notice at least 30 days in advance that his/her Medical Staff clinical privileges will be relinquished because he/she failed to satisfactorily complete the proctoring requirements. In such circumstances, the affected practitioner has no right to a hearing pursuant to Section 8.3-2.

(d) FOR PHYSICIAN PERFORMANCE ISSUES

FPPE shall be conducted when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care that have been identified through the peer review process, ongoing feedback reports, or pursuant to the corrective action plan.

6.3-2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE), for additional information regarding OPPE process see Medical Staff Policy 13.5.2

(a) PURPOSE

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

(b) POLICY

OPPE is conducted on an ongoing basis and will include review of performance data for all practitioners with clinical privileges at ECH.

6.4 SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES AS DIRECTED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE

(a) Requests for clinical privileges from dentists and podiatrists shall be processed in the same manner as specified in Section 6.2. Surgical procedures performed by dentists and podiatrists shall be under the supervision of the chief of their respective departments. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services.

(b) Admission history and physical examination on dental and podiatric patients must be performed and recorded in the hospital record in accordance with Rules and Regulations B – History & Physicals (included at the end of these Bylaws).

(c) The treating dentist or podiatrist must, when indicated, request consultation and medical management from the admitting staff physician or any physician staff member.

6.5 TEMPORARY PRIVILEGES

6.5-1 CIRCUMSTANCES

The Chief Executive Officer, or his/her designee, upon the recommendation of the Department Chief, when available, or the Chief of Staff in all other circumstances, may grant temporary privileges to a practitioner, subject to the conditions set forth in Section 6.5-2 below, in the following circumstances:

(a) Pendency of Application: Temporary privileges may be granted upon the recommendation of the department chief for a period not to exceed 120 days when a new applicant with a complete application that raises no significant concerns is awaiting review and approval of the Medical Staff Executive Committee and Board of Directors. The following items must be verified:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- NPDB report
- Complete application
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

(b) Temporary Privileges to Meet an Important Patient Care Need (Care of Specific Patient in physician database): Upon receipt of an application for specific temporary privileges, a practitioner may be granted temporary privileges for the care

of up to six (6) specific patients in any one calendar year, for the term of their hospitalization. Practitioners requesting temporary privileges for more than six (6) times in any one (1) year shall be required to apply for membership in the Medical Staff before being granted the requested privileges. The medical staff verifies, at a minimum, current licensure, current competence, and current malpractice insurance. An AMA and NPDB report will be obtained prior to granting privileges.

6.5-2 CONDITIONS

Temporary privileges may be granted only when the practitioner has submitted a written application for appointment for temporary privileges and the information reasonably supports a favorable determination regarding the requesting practitioner's current licensure, qualifications, ability and judgment to exercise the privileges requested, and only after these items are verified and the practitioner has satisfied the requirement of Section 3.2 (c) regarding professional liability insurance. The chief of the department to which the practitioner is assigned shall be responsible for supervising the performance of the practitioner granted temporary privileges, or for designating a department member who shall assume this responsibility. Special requirements of consultation and reporting may be imposed by that chief.

6.5-3 TERMINATION

(a) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles 6 and/or 7 of these Bylaws. As necessary, the appropriate department chair or, in the chair’s absence, the Chief of Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such member’s patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.

(b) On the discovery of any information, or the occurrence of any event, of a nature which raises a question about a practitioner's professional qualifications, ability to exercise any or all of the temporary privileges granted, or compliance with any Bylaws, rules, regulations, or special requirements, the Chief of Staff or his/her respective designee, may, after consultation with the department chief responsible for supervision, or his/her designee, terminate any or all of such practitioner's temporary privileges, provided that where a patient's life or well-being is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article 7. In the event of any such termination, the practitioner’s patients then in the Hospital shall be assigned to another practitioner by the department chief responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

6.5-4 RIGHTS OF THE PRACTITIONER

A practitioner shall be entitled to the procedural rights afforded by Article 8 because his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated or suspended.

6.6 EMERGENCY PRIVILEGES

For the purposes of this Section, an “emergency” is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of department, Medical Staff status, or clinical privileges, shall be permitted to do, and shall be assisted by Hospital personnel in

doing, everything possible to save a patient from such danger. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are either not requested or denied, the patient shall be assigned to an appropriate member of the staff by the chief of staff or his/her designee.

6.7 PRIVILEGING LICENSED INDEPENDENT PRACTITIONERS DURING DISASTER EVENTS

(a) 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:

1. The Emergency Management Plan (Code Triage) has been activated
2. El Camino Hospital is unable to meet immediate patient needs

(b) Procedure:

1. 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.
2. All staff will be alerted to direct the practitioner to the hospital triage officer or the medical staff office to process disaster privileges.
3. 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.
4. 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.
5. The Chief of Staff (or designee) may grant these disaster privileges. If the Chief of Staff (or designee) is not available, the Administrator/ Chief Executive Officer (or designee) may grant disaster privileges.
6. 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 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. The practitioner will wear a temporary El Camino Hospital nametag issued by Security, while working in the facility.
7. A practitioner's privileges, granted under this situation, may be terminated at any time without reason or cause.
8. Termination of these privileges will not give rise to a hearing or review.

6.8 POST-DOCTORAL PRACTITIONER LIMITED PROCEDURAL TRAINING

Privileges may be granted to practitioners to pursue a limited period of clinical training and education in a particular area of their specialty. Upon submission of a written application, completely verified, and with established documentation of licensure of good standing and

adequate malpractice coverage, a practitioner of documented current competence in their specialty field of practice may be granted time-limited privileges for a period not to exceed 1 year, without applying for active Medical Staff appointment or privileges. The burden will rest on the applicant to ensure that all pre-requisite information is accurate and received by the Medical Staff Office in a timely manner to permit processing of this application before the initial date of his/her scheduled procedural training tenure at El Camino Hospital.

Clinical care provided by the applicant practitioner shall always be under the direct supervision of a designated member of the Active Medical Staff of the Hospital, qualified by training, experience and privileging to mentor such care and procedural training. Privileges shall be limited to treatment of his/her patients admitted to El Camino Hospital and/or to the treatment of patients of his/her supervising practitioner as appropriate. He/she shall not be entitled to admit his/her own patients to the Hospital. Applicant practitioners seeking post-doctoral privileges must provide evidence of licensure, malpractice insurance with written verification from his/her malpractice carrier which summarizes information regarding pending or closed malpractice activity, and written verification of good standing at another hospital where he/she maintains Active Staff privileges. The Hospital's authorized representative shall query the National Practitioner Data Bank. The burden rests on the applicant to ensure that pertinent information is received by the Medical Staff Office in a timely manner.

Practitioners engaged in post-doctoral procedural training at El Camino Hospital must be licensed by the Medical Board of California and will be authorized to perform certain pre-approved procedures.

6.9 LOCUM TENENS PRIVILEGES

Locum Tenens privileges may be granted physicians serving locum tenens when an application has been submitted and completely verified in writing.

Upon receipt of a written application, a practitioner of documented current competence who is serving or will serve as a locum tenens for an Active Staff Member of the Hospital may be granted locum tenens privileges for an initial period of sixty (60) days. Such privileges may be renewed for two (2) successive periods of sixty (60) days but not to exceed his/her services as locum tenens, and shall be limited to treatment of the patients of the practitioner for whom he/she is serving as locum tenens. He/she shall not be entitled to admit his/her own patients to the Hospital as a locum tenens.

Physicians seeking locum tenens privileges must provide evidence of licensure, malpractice insurance with written verification from his/her malpractice carrier which summarizes information regarding pending or closed malpractice activity, and written verification of good standing at another hospital where he/she holds Active Staff privileges. If the physician is not on staff at another hospital, evidence of satisfactory completion of a training program within the prior six months must be submitted. The burden rests on the applicant to ensure that pertinent information is received by the Medical Staff Services Office in a timely manner.

6.10 HISTORY & PHYSICAL – PRIVILEGES AND TIMEFRAMES

(a) H&P must be completed by a practitioner privileged to perform H&Ps – these are defined as:

1. MD/DO
2. DDS/DMD

3. DPM
4. Nurse Practitioner – must be countersigned by supervising practitioner with 14 days of the patient's discharge.
5. Certified Nurse Midwife
6. Physician Assistant – must be countersigned by supervising practitioner with 14 days of the patient's discharge.

(b) H&P must be completed and documented for each patient no more than 30 days before or 24 hours after admission, but prior to surgery or procedure requiring anesthesia services.

(c) **H&P Updates**: When the H&P is conducted within 30 days of admission (inpatient or outpatient), an updated examination, including any changes in the patient's condition, must be completed and documented by a qualified practitioner (see (a) in this section) within 24 hours of admission (inpatient or outpatient), but prior to surgery or a procedure requiring anesthesia services when the H&P was completed within the previous 30 days.

(d) The content of complete and focused history and physical examination is delineated in the Rules and Regulations appended to these Bylaws (R&R #B.1).

6.11 TELEMEDICINE PRIVILEGES

(a) Coverage: Licensed Independent Practitioners (LIPs) who have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine link. Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provided and for the purpose of improving patient care, treatment, and services.

(b) Scope:

1. The Medical Staff Executive Committee recommends to the Board of Directors which clinical services are appropriately delivered by LIPs through telemedicine. The clinical services offered are consistent with commonly accepted quality standards.
2. For contracted services, the contracting entity will ensure that all services provided by contracted individuals who are LIPs will be within the scope of his or her privileges and obtained through a Joint Commission accredited entity. All such LIPs will also be licensed in the State of California, carry professional liability insurance and meet any other qualification standards required by the Medical Staff Bylaws.

(c) Definitions:

1. Originating Site (El Camino Hospital) – the site where the patient is located at the time the service is provided.
2. Distant Site – the site where the practitioner providing the professional service is located.

(d) Procedure: All LIPs who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:

1. El Camino Hospital may fully privilege and credential the practitioner according to Joint Commission standards and its medical staff processes and requirements.
2. The practitioner may be privileged at El Camino Hospital using credentialing information from the distant site if the distant site is a Joint Commission accredited organization. The Board of Directors of grants privileges based on ECH medical staff recommendations.
3. Regardless of the privileging procedure utilized (d 1-2 above), each LIP

must possess those qualifications for LIP utilization of privileges at El Camino Hospital (e.g. California licensure, professional liability insurance, education, training, etc).

ARTICLE 7
CORRECTIVE ACTION

7.1 ROUTINE CORRECTIVE ACTION

7.1-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the Medical Staff bylaws and rules or regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chair, or the Medical Staff Executive Committee.

7.1-2 INITIATION

An investigation may be initiated by the Medical Staff Executive Committee on its own initiative or by a written request which is submitted to the Medical Staff Executive Committee and identifies the specific activities or conduct which are alleged to constitute the grounds for proposing an investigation or specific corrective action. The Chief of Staff shall promptly notify the practitioner of the formulation of an investigative body. The Chief of Staff shall promptly notify the Administrator/ Chief Executive Officer and Board of Directors of all corrective action investigations and shall continue to keep them fully informed of all action taken in conjunction therewith.

7.1-3 INVESTIGATION

Upon receipt, the Medical Staff Executive Committee may act on the proposal or request or direct that an investigation be undertaken. The Medical Staff Executive Committee may conduct that investigation itself or may assign this task to an appropriately charged officer, or standing or Medical Staff ad hoc committee. If the proposed corrective action could result in an action which is grounds for a hearing under Section 8.2, the Chief of Staff shall promptly notify the practitioner and the practitioner shall be given an opportunity for an interview(s) with the investigating committee or officer and the Medical Staff Executive Committee, as applicable. Any such interview(s) shall be conducted in accordance with Section 7.4. No such investigative process shall be deemed to be a "hearing" as described in Article 8.

If the investigation is delegated to an officer or committee other than the Medical Staff Executive Committee, such officer or committee shall forward a written report of the investigation to the Medical Staff Executive Committee as soon as is practicable after the assignment to investigate has been made. The Medical Staff Executive Committee may, at any time within its discretion, terminate the investigative process and proceed with action as provided in Section 7.1-4 below.

7.1-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, the Medical Staff Executive Committee shall act thereon. Such action may include, without limitation, recommending:

(a) No corrective action.
(b) Rejection or modification of the proposed corrective action.
(c) Letter of admonition, letter of reprimand, or warning.
(d) Terms of probation or individual requirements of consultation.
(e) Reduction or revocation of clinical privileges.

(f) Suspension of clinical privileges until completion of specific conditions or requirements.
(g) Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.
(h) Suspension of Medical Staff membership until completion of specific conditions or requirements.
(i) Revocation of Medical Staff membership.
(j) Other actions appropriate to the facts which prompted the investigation.

Nothing set forth herein shall inhibit the Medical Staff Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 7.2.

7.1-5 PROCEDURAL RIGHTS
Any recommendation by the Medical Staff Executive Committee, pursuant to Section 7.1-4 which constitutes grounds for a hearing as set forth in Section 8.2, shall entitle the practitioner to the procedural rights as provided in Article 8. In such cases, the Chief of Staff shall give the practitioner written notice of the adverse recommendation and of his/her right to request a hearing in the manner specified in Section 8.3-2.

7.1-6 INITIATION BY BOARD OF DIRECTORS
If the Medical Staff Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Directors may direct the Medical Staff Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Staff Executive Committee. The board's request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the Medical Staff Executive Committee fails to take action in response to that Board of Directors direction, the Board of Directors may initiate corrective action after written notice to the Medical Staff Executive Committee, but this corrective action must comply with Articles 7 and 8 of these Medical Staff bylaws.

7.2 SUMMARY SUSPENSION

7.2-1 CRITERIA FOR INITIATION
Whenever a practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient or other person, the Chief of Staff, the Medical Staff Executive Committee, or the head of the department or designee in which the member holds privileges may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Board of Directors, the Medical Staff Executive Committee and the Administrator/ Chief Executive Officer and pertinent hospital staff/departments. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chairman or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

7.2-2 INITIATION BY BOARD OF DIRECTORS

If the Chief of Staff, members of the Medical Staff Executive Committee and the chief of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Directors or its designee may immediately suspend a member's privileges if a failure to summarily suspend those privileges is likely to result in imminent danger to the health of any patient, prospective patient, or other person, provided that the Board of Directors or its designee made reasonable attempts to contact the Chief of Staff, members of the Medical Staff Executive Committee and the head of the applicable department (or its designee) before the suspension. Such a suspension is subject to ratification by the Medical Staff Executive Committee. If the Medical Staff Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically.

7.2-3 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

As soon as practicable after such a summary restriction or suspension has been imposed and in any event within ten (10) days, a meeting of the Medical Staff Executive Committee shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Staff Executive Committee may impose, although in no event shall any meeting of the Medical Staff Executive Committee, with or without the member, constitute a hearing within the meaning of Article 8, nor shall any of the procedural rules in Section 8.4 apply. The Medical Staff Executive Committee may modify, ratify, or terminate the summary restriction or suspension, but, in any event it shall notify the member, the Board of Directors, and the Administration of its decision.

7.2-4 PROCEDURAL RIGHTS

Unless the Medical Staff Executive Committee promptly terminates a summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article 8.

7.3 AUTOMATIC SUSPENSION

7.3-1 LICENSE

(a) Revocation: Whenever a practitioner's license authorizing him/her to practice in this State is revoked, his/her Medical Staff membership, prerogatives, and clinical privileges shall be immediately and automatically terminated. Such practitioners shall not be entitled to the procedural rights afforded by Article 8.

(b) Expiration: If a practitioner’s license expires, then his/her clinical privileges shall be suspended for up to 60 days, pending notification of reinstated license. If reinstatement is not received in 60 days, practitioner’s membership, prerogatives, and clinical privileges shall be terminated. Such practitioners shall not be entitled to the procedural rights afforded by Article 8.

(c) Restriction: Whenever a practitioner's license authorizing him/her to practice in this state is limited or restricted by the applicable licensing authority, those clinical privileges which he/she has been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.

(d) Suspension: Whenever a practitioner's license authorizing him/her to practice in this state is suspended, his/her staff membership and clinical privileges shall be automatically suspended effective upon, and for at least the term of, the suspension.

(e) Probation: Whenever a practitioner is placed on probation by the applicable licensing authority, his/her application membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

7.3-2 DRUG ENFORCEMENT ADMINISTRATION

(a) Revocation or Expiration: Whenever a practitioner's DEA certificate is revoked or has expired, he/she shall immediately and automatically be divested of his/her right to prescribe medications covered by the certificate. See Rules & Regs "O" for information regarding a DEA Certification Waiver.

(b) Suspension: Whenever a practitioner's DEA certificate is suspended, he/she shall be divested, at a minimum, of his/her right to prescribe medications covered by the certificate effective upon, and for at least the term of, the suspension.

(c) Probation: Whenever a practitioner's DEA certificate is subject to an order of probation, his/her right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

7.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails, without good cause, to appear and satisfy the requirements of Section 12.7-1, shall automatically be suspended from exercising all, or such portion of his/her clinical privileges as may be suspended, in accordance with the provisions of said Section 12.7-1.

7.3-4 EXECUTIVE COMMITTEE DELIBERATIONS ON MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION, FAILURE TO SATISFY SPECIAL APPEARANCE, AND RELEASE OF CONFIDENTIAL INFORMATION

As soon as practicable after action is taken as described in Section 7.3-2, Paragraphs (b) or (c), or in Sections 7.3-3, 7.3-4, the Medical Staff Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Medical Staff Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it, and/or it may direct that an investigation be undertaken pursuant to Section 7.1-3. The procedure to be followed shall be as provided in Sections 7.1-4 through 7.1-7, as applicable, if the Medical Staff Executive Committee directs a further investigation.

7.3-5 PROCEDURAL RIGHTS – MEDICAL RECORDS

Whenever the Medical Staff Executive Committee has determined that suspensions or deemed resignations for failure to complete medical records were in circumstances where such failure affected or could reasonably affect patient care, a report shall be filed with the Medical Board of California as required under California Business and Professions Code Section 805 and the affected practitioner shall be entitled to the procedural rights set forth in Article 8. In the absence of such a report, a practitioner is not entitled to the procedure rights of Article 8.

7.3-6 MALPRACTICE INSURANCE

For failure to maintain the amount of professional liability insurance, a practitioner's membership and clinical privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Medical Staff Executive Committee that he/she has secured professional liability coverage. A failure to provide such evidence within sixty (60) days after the date

the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

7.3-7 MEDICARE/MEDICAID EXCLUSION
A practitioner who is the subject of a final administrative decision excluding his/her participation in Medicare, Medicaid, or any similar governmental program is deemed to have resigned from the Medical Staff and is not eligible to apply/reapply until all such sanctions have been lifted.

7.3-8 FAILURE TO PAY DUES
For failure to pay dues, if any, as required under Section 14.3, a practitioner's Medical Staff membership and clinical privileges shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues. A failure to pay such dues within sixty (60) days after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

7.3-9 PROCEDURAL RIGHTS – MEDICAL RECORDS, MALPRACTICE INSURANCE, AND FAILURE TO PAY DUES
Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of 7.3-5 (failure to complete medical records), 7.3-7 (failure to maintain malpractice insurance), or 7.3-7 (failure to pay dues) shall not be entitled to the procedural rights set forth in Article 8.

7.3-10 FAILURE TO COMPLY WITH THE REQUIREMENTS OF A MEDICAL SATFF POLICY
Whenever a practitioner fails to comply with the requirements of a Medical Staff policy (e.g., medical record/HIPPA training, vaccination or required testing/screening, etc.) that practitioner’s privileges may be suspended by action of the Medical Staff Executive Committee or its designee. The practitioner shall be given notice of the failure to comply with the applicable policy and be given a period of thirty (30) days to achieve compliance. Absent compliance, the practitioner’s privileges will be suspended after the thirty (30) day notice period has run. Compliance must be completed within ninety (90) days of suspension initiation or the practitioner is deemed to have resigned from the Medical Staff.

7.3-11 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS
Whenever a practitioner’s privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner, the Medical Staff Executive Committee, the Administrator/ Chief Executive Officer, pertinent hospital staff/departments, and the Board of Directors. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner is terminated by the automatic suspension, his/her patient(s) shall be assigned to another practitioner by the department chief or Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

7.4 INTERVIEWS

Interviews shall neither constitute, nor be deemed, a “hearing,” as described in Article 8, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Staff Executive Committee shall be required, at the practitioner's request, to grant him/her an interview. In the event an interview is granted, the practitioner shall be informed of the general nature of the

circumstance leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

ARTICLE 8
HEARINGS AND APPELLATE REVIEWS

8.1 PREAMBLE AND DEFINITIONS

8.1-1 INTRAORGANIZATIONAL REMEDIES

The remedies, hearing and appellate review procedures provided for in this Article are strictly quasi-judicial in structure and function. Accordingly, the Article 8 Judicial Review Committee process shall have no power or authority to make determinations as to the substantive validity of bylaws, rules or regulations.

Notwithstanding the foregoing, the Board of Directors may entertain challenges to the substantive validity of bylaws, rules or regulations and in all proper cases shall hear and decide such challenges. Where the substantive validity question is the sole issue, the petitioner shall be permitted a direct appeal in the first instance, before the Medical Staff Executive Committee, under procedures which it shall determine. The Medical Staff Executive Committee shall make a decision regarding the issue and transmit its decision, together with any record it has compiled to the Board of Directors for final decision. Utilization of this process shall be a condition precedent to the petitioner's right to seek judicial review in a court of law.

8.1-2 EXHAUSTION OF REMEDIES

If an adverse ruling is made concerning a practitioner, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust any remedies provided by these Bylaws before resorting to legal action. The exclusive procedure for obtaining judicial review shall be by Petition of Writ of Mandate pursuant to Part 3, Title 1, Chapter 2 of the California Code of Civil Procedure.

8.1-3 DEFINITIONS

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

(a) “Body” whose decision prompted the hearing" refers to the Medical Staff Executive Committee in all cases where the Medical Staff Executive Committee or authorized officers, members or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing being requested.

(b) “Notice” refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his/her or its address as it appears in the records of the Hospital and pursuant to Section 8.3-4.

(c) “Petitioner” refers to the practitioner who has requested a hearing pursuant to Section 8.3 of these Bylaws.

(d) “Date of Receipt” of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 8.1-3.

8.2 GROUNDS FOR HEARING

8.2-1 GROUNDS

Any one or more of the following actions or recommended actions shall constitute grounds for a hearing if such action requires a report under California Business & Professions Code

Section 805:

(a) Denial of Medical Staff membership;

(b) Denial of requested advancement in staff membership status (except that a refusal to advance a Provisional Staff member before the conclusion of the permissive twelve (12) month proctoring period shall not constitute grounds for a hearing);

(c) Denial of staff reappointment;

(d) Demotion to lower staff category or membership status;

(e) Suspension of staff membership for a certain time period or until completion of specific conditions or requirements;

(f) Summary suspension of staff membership during the pendency of corrective action hearing and appeals procedures;

(g) Expulsion from staff membership;

(h) Denial of requested privileges (not including temporary privileges);

(i) Reduction in privileges;

(j) Suspension of privileges until completion of specific conditions or requirements;

(k) Summary suspension of privileges (including temporary privileges);

(l) Termination of privileges;

(m) Requirement of consultation;

(n) Monitoring requirements for other than investigational purposes (excluding monitoring incidental to Provisional Staff status);

(o) Any other actions which requires a report be made to the Medical Board of California under the provisions of Section 805 of the California Business and Professions Code and the National Practitioner Data Bank.

Recommendation of any one of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws.

8.2-2 FINAL ACTION

Adverse recommendations shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Hospital Board of Directors.

8.3 REQUEST FOR A HEARING

8.3-1 NOTICE OF ACTION

In all cases in which actions have been taken or recommendation made which give rise to rights of appeal under Section 8.2 of the Bylaws, the person or body responsible for such action or recommendation shall give the affected practitioner: (i) written notice of the recommendation or final proposed action, (ii) notice that the action, if adopted, shall be taken and reported pursuant to California Business and Professions Code Section 805 and the National Practitioner Data Bank, (iii) notice of his or her right to request a hearing pursuant to section 8.3-2 (iv) notice that such hearing must be requested within thirty (30) days, and (v) a summary of the hearing and appeal rights under these Bylaws.

8.3-2 REQUEST FOR HEARING

The affected practitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing. Said request shall be effected by notice to the Chief of Staff with a copy to the Administrator/ Chief Executive Officer. In the event the affected practitioner does not request a hearing within the time and in the manner herein above set forth, he or she shall be deemed to have accepted the recommendation, decision, or action

involved and it shall there upon become the final recommendation of the Medical Staff. Such final recommendation shall be considered by the Board of Directors within forty-five (45) days.

8.3-3 TIME AND PLACE OF HEARING

Upon receiving a request for a hearing, the Chief of Staff shall schedule and arrange for a hearing which will commence within sixty (60) days after receipt of the request for the hearing unless such time period is otherwise extended as permitted under these Bylaws.

The Chief of Staff shall give notice to the affected practitioner of the time, place and date of the hearing not less than thirty (30) days before the commencement of the hearing.

8.3-4 NOTICE OF CHARGES

Together with the notice stating the place, time and date of the hearing, the chief of staff, on behalf of the Medical Staff Executive Committee, shall state the reasons for the final proposed action, including the acts or omissions with which the affected practitioner is charged and a list of the charts in question, where applicable.

8.3-5 JUDICIAL HEARING BODY

When a hearing is requested, it shall be held before a Judicial Hearing Committee appointed by the Medical Staff Executive Committee, consisting of at least three (3) individuals, and alternates as appropriate.

The Judicial Hearing Committee shall be composed of individuals who gain no direct financial benefit from the outcome of the hearing, who have not acted as accusers, investigators, fact finders or initial decision makers in the matter at any previous level and shall include, where feasible, and an individual practicing in the same specialty as the affected practitioner. Preferably, the members of the Judicial Hearing Committee shall be members of the Medical Staff.

When a Judicial Hearing Committee is appointed, the Chief of Staff shall designate a chair who shall preside in the manner described in section 8.4-3 and who shall handle all pre-hearing matters and preside until a Hearing Officer, as described in Section 8.4-4 below is appointed.

8.3-6 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the affected practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved. Such final recommendations shall be considered by the Board of Directors within forty-five (45) days.

8.3-7 CONTINUANCES

Continuances shall be granted upon agreement of the parties or by the hearing officer on a showing of good cause.

8.3-8 DISCOVERY

(a) The affected practitioner shall have the right to inspect and copy at his or her expense any documentary information relevant to the charges which the Medical Staff has in its possession or under its control as soon as practicable after receipt of the request for a hearing. The Medical Staff Executive Committee shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the affected practitioner has in his or her possession or control as

soon as practicable after receipt of the request for a hearing. Any request for inspection of documentary information relevant to the charges must be submitted in writing. The failure by either party to provide access to such information at least thirty (30) days before the hearing shall constitute good cause for continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the affected practitioner under review. The hearing officer appointed pursuant to Section 8.4-4 shall consider and rule upon any request for access to information and may impose any safeguard as the protection of the peer review process and justice requires. When ruling upon requests for access to information and determining the relevance thereof, the Hearing Officer shall, among other factors, consider the following: (i) whether the information sought may be introduced to support or defend the charges; (ii) the exculpatory or inculpatory nature of the information sought, if any; (iii) the burden imposed on the party in the possession of the information sought, if access is granted, and (iv) any previous requests for access to any information submitted or resisted by the parties to this same proceeding.

(b) If either side to the hearing requests in writing a list of witnesses, each party shall furnish to the other within fifteen (15) days of such request a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Failure to disclose the identity of a witness at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance. Requests for a list of witnesses shall be submitted in writing to the other party.

(c) At the request of either side, the parties shall exchange copies of all documents expected to be introduced at the hearing. Failure to produce copies of all such documents at least ten (10) days before commencement of the hearing shall constitute good cause of continuance. A request for all documents expected to be introduced at the hearing shall be submitted in writing to the other party.

8.4 HEARING PROCEDURE

8.4-1 PREHEARING PROCEDURE

It shall be the duty of the petitioner and the body whose decision prompted the hearing to raise objections regarding procedural issues and the composition of the hearing committee as soon as such objections are or should have been known. For these purposes, all such objections should be submitted in writing to the presiding officer identified in Section 8.4-3 at least seven (7) days before the scheduled hearing. Objections to any prehearing decisions concerning procedural issues and committee composition shall be raised at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing which, thereafter, might be requested.

8.4-2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. The member shall be entitled to representation by legal counsel at his or her expense in any phase of the hearing, should he/she so choose. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney-at-law, and the Medical Staff Executive Committee shall not be represented by an attorney-at-law if the affected practitioner elects not to be so represented.

8.4-3 THE PRESIDING OFFICER

The presiding officer at the hearing shall be a hearing officer as described in Section 8.4-4, or if no such hearing officer has been appointed, the chair of the Judicial Hearing Committee shall preside over the hearing. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He/she shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He/she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence. He/she shall also have discretion to make all rulings necessary to assure a timely, efficient and orderly hearing process.

8.4-4 HEARING OFFICER

The Medical Staff Executive Committee shall appoint a hearing officer to preside with respect to pre-hearing issues and at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, however, an attorney regularly utilized by the hospital, the Medical Staff or the individual Medical Staff member or applicant for membership, for legal advice regarding its affairs and activities shall not be eligible to serve as a hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have an reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and arguments during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence including those which arise prior to the hearing. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Hearing Committee, the hearing officer may participate in the deliberations of such a committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

8.4-5 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by such person lawfully authorized to administer such oath.

8.4-6 RIGHTS OF THE PARTIES

At a hearing both sides shall have the following rights to ask Judicial Hearing Committee members and the hearing officer questions which are directly related to determine whether they are impermissibly biased and challenge the impartiality of any member or hearing officer, to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issued, and otherwise to rebut evidence, and to be provided with all information made available to the Judicial Hearing Committee. The affected practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. Any challenge directed at one or more members of the committee or hearing officer shall be ruled on by the hearing officer.

8.4-7 BURDENS OF PRESENTING EVIDENCE AND PERSUASION

(a) The Medical Staff Executive Committee shall have the initial duty to present evidence which supports the charge(s) or recommended action.

(b) When the hearing involves an applicant, and his or her Medical Staff membership, the applicant shall bear the burden of persuading by a preponderance of the evidence of his or her qualifications by producing information which allows for adequate information and resolution of reasonable doubts concerning his or her current qualifications for staff privileges, membership or employment. Initial applicants shall not be permitted to introduce information not produced upon request of the Medical Staff Executive Committee during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided for initial applicants in paragraph (b) above, the Medical Staff Executive Committee shall bear the burden of persuading by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

8.4-8 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement to be filed following the conclusion of the presentation of oral testimony. The Judicial Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

8.4-9 BASIS OF DECISION

If the Judicial Hearing Committee should find the charge(s) or any of them to be true, it shall impose such form of discipline as it shall find warranted, provided, however, that such form of discipline shall not be more stringent than that recommended by the body whose decision prompted the hearing. The decision of the Judicial Hearing Committee shall be based on the evidence produced at the hearing. Such evidence may consist of the following:

(a) Oral testimony of witnesses.

(b) Briefs or written statements presented in connection with the hearing.

(c) Any material contained in the Hospital or Medical Staff personnel files regarding the petitioner, which shall have been made a part of the hearing record.

(d) Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.

(e) Any other evidence admissible hereunder.

8.4-10 ADJOURNMENT AND CONCLUSION

The hearing officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Both parties shall have the right to submit written statements at the close of the hearing. Upon conclusion of the presentation of oral and written evidence and argument and written statements, if any, the hearing shall be closed. The Judicial Hearing Committee shall there upon, outside the presence of any persons, except the hearing officer, conduct its deliberations, and render a decision and accompanying report.

8.4-11 DECISION OF THE JUDICIAL HEARING COMMITTEE
Within thirty (30) days after final adjournment of the hearing, the Judicial Hearing Committee shall render a decision which shall be accompanied by a report in writing and which shall be delivered to the Medical Staff Executive Committee. If the affected practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the affected practitioner, the Administrator/ Chief Executive Officer, and the Board of Directors. The report shall contain a precise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached.

Both the affected practitioner and the Medical Staff Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Hearing Committee shall be subject to the right of appeal to the Board of Directors as provided in 8.5-4.

8.5 APPEALS TO THE BOARD OF DIRECTORS

8.5-1 TIME FOR APPEAL
Within thirty (30) days after the date of receipt of the Judicial Hearing Committee decision, either the petitioner, or the body whose decision prompted the hearing may request an appellate review by the Board of Directors. Said request shall be delivered to the Administrator/ Chief Executive Officer in writing either in person, or by certified or registered mail, return receipt requested, and it shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Directors within forty-five (45) days, but shall not be binding on the Board of Directors.

8.5-2 REASONS FOR APPEAL
The reasons for appeal from the hearing shall be: (a) substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny petitioner of fair hearing; (b) the lack of substantive rationality of a Medical Staff bylaw, rule or regulation relied upon by the Judicial Hearing Committee in reaching its decision; and/or (c) action taken arbitrarily, unreasonably or capriciously.

8.5-3 TIME, PLACE AND NOTICE
When appellate review is requested pursuant to the preceding subsection, the Board of Directors shall, within thirty-five (35) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Board of Directors shall give the petitioner notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Board of Directors, or appeal board (if any).

8.5-4 APPEAL BOARD

When an appellate review is requested, the Board of Directors may sit as the appeal board or in its sole discretion it may appoint a hearing officer who shall conduct the appellate hearing and make recommended findings, conclusions and a decision which may be adopted, modified or rejected by the Board of Directors. If a hearing officer is appointed, he/she shall be an attorney at law, admitted to practice in California for at least ten (10) years, shall not be legal counsel to the Hospital and shall not act as a prosecuting officer, an advocate for the Hospital, the practitioner, the Board of Directors or any other body whose action prompted the proceeding. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board or hearing officer, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this Section, participating in an initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter.

8.5-5 BOARD OF DIRECTORS APPEALS PROCEDURE

The proceedings by the Board of Directors shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Hearing Committee, provided that the Board of Directors may accept additional oral or written evidence, subject to the foundational showing that such additional evidence could not have been made available to the Judicial Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Hearing Committee hearing; or may remand the matter to the Judicial Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his or her position on appeal, the right to present a written statement in support of his or her position on appeal, the right to appear and respond, and the right to be represented by an attorney or any other representative designated by the party. At the conclusion of oral argument, the Board of Directors may there upon conduct, at the time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Board of Directors shall have the option of having legal counsel present during the appeal and their deliberations to advise them in questions relating to the conduct of the appellate review. The legal counsel's role shall be limited to that of an advisor.

8.5-6 ACTION BY A HEARING OFFICER

If the Board of Directors has appointed a hearing officer, he/she shall prepare findings of fact and a proposed decision in such form that it may be adopted as the decision of the Board of Directors. The findings of fact and proposed decision shall be filed by the hearing officer with the Board of Directors within fifteen (15) days after conclusion of the hearing, and a copy thereof shall be served at the same time on all parties to the action. Within ten (10) days after the filing of such findings and proposed decision with the Board of Directors by the hearing officer, the practitioner or the chairman of the committee whose decision prompted the hearing may file a request to present oral or written argument directly to the Board of Directors. No later than the next regular meeting of Board of Directors, a time shall be fixed for hearing of such arguments by the Board of Directors, which shall not be more than thirty (30) days after the filing of the hearing officer's findings and proposed decision. At the time so fixed, such arguments shall be presented and heard by the Board of Directors. In such event, no member of the Board of Directors shall vote on the final decision who is not present at oral argument, or who did not read written argument.

8.5-7 FURTHER REVIEW OF FINDINGS AND RECOMMENDED DECISION

After the hearing officer's findings and recommended decision have been filed with the Board of Directors, if the findings and recommended decision are at material variance with

the recommendations of the Medical Staff, or if Board of Directors deems that there are matters raised by the hearing officer's findings and recommended decision which the Board of Directors believes were not considered in the Medical Staff proceedings, or if Board of Directors proposes to render a decision at variance with the recommendations of the Medical Staff or the hearing officer, Board of Directors may refer the findings and proposed decision to the Judicial Hearing Committee or any other body or person for further review and recommendation. If the matter is so referred for further review and recommendation, that committee or person shall, within thirty (30) days after such referral, conduct its review and make its further recommendations to the Board of Directors in accordance with the instructions given by the Board of Directors.

8.5-8 DECISION

Within ten (10) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision in writing. The Board of Directors may affirm, modify or reverse the Judicial Hearing Committee decision or, at its discretion, remand the matter for further review and recommendation by the Judicial Hearing Committee or any other body or person. The decision shall be in writing and shall specify the reasons for the action taken, and shall be forwarded to the affected practitioner, the Medical Staff Executive Committee, and the Administrator/ Chief Executive Officer.

8.5-9 RIGHT TO ONE HEARING

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one judicial, evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Medical Staff Executive Committee or the Board of Directors (whether or not in conjunction with a hearing officer) or by both.

8.6 EXCEPTIONS TO HEARING RIGHTS

(a) The Medical Staff Executive Committee shall review and make written recommendations to the Board of Directors regarding quality of care issues related to exclusive arrangements for physician services, prior to any final Board decision being made to execute an exclusive

contract in a previously open department or service. In such cases, the Medical Staff Executive Committee's recommendation shall be made within a reasonable time in light of the Hospital's need to execute such an exclusive contract, as determined by the Board of Directors in its sole discretion. Regarding Board decisions (i) to renew or modify an exclusive contract in a particular department or service, or (ii) to terminate an exclusive contract in a particular department or service, the Board shall consult with the Medical Staff Executive Committee regarding quality of care issues related to such decisions prior to taking final action on the contracts, unless the Board decides, in its sole discretion, that such prior consultation would subject the Hospital's business interests or its patients to a risk of imminent harm. In cases in which the Board decides it must proceed without such prior consultation, the Board shall, within thirty (30) days of taking action, inform the Medical Staff Executive Committee of the reasons for its decision, excluding confidential financial information.

(b) The hearing and appellate review rights of any physician whose Medical Staff membership or privileges are adversely affected by decision by the Board of Directors falling within the provisions of 7.6-1 shall be governed by Article 7 of these Bylaws. The hearing rights of Article 7, however, shall apply only to the extent that an action is taken or a recommendation is made which, when final, must be reported to the Medical Board of California under Business and Professions Code section 805 and to the extent that Medical Staff membership status or clinical privileges which are independent of the practitioner's

contract are also removed or suspended.

8.7 REPORTS

The Chief of Staff or Authorized Representative shall provide the affected Practitioner with a copy of any Section 805 and/or National Practitioner Data Bank report filed with respect to him/her.

ARTICLE 9
CLINICAL DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

The unified El Camino Medical Staff will be comprised of a combination of campus-specific departments and enterprise departments. Enterprise departments are those departments that serve constituency at all campuses (including MV & LG). All departments ultimately report to a unified Medical Staff Executive Committee. Each Department shall be organized as a separate part of the Medical Staff and shall have a Chief and a Vice-Chief who are elected and have the authority, duties, and responsibilities specified in Article 10. Each Division of a Department shall be organized as a specialty subdivision within a Department, shall be directly responsible to the Department within which it functions, and shall have a Division Chairman who has the authority, duties, and responsibilities specified in Article 10.

9.2 DESIGNATION

The current departments and divisions are:
<u>Campus Departments:</u>

MV Medicine, Obstetrics/Gynecology, Orthopedics, , Surgery

LG Medicine, Surgery, Orthopedics, Ob/Gyn
<u>Enterprise Departments</u>

Family Practice, Pediatrics, Perinatal, , Psychiatry

<u>Divisions:</u> Divisions reporting to Medical Department – Emergency Medicine, Radiology, Hospitalists
Divisions reporting to Surgical Department – Pathology, Anesthesia

9.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each practitioner will declare his/her primary campus and shall be assigned membership in one Department and/or Division within such Department within that campus. The exercise of privileges within each Department and Division shall be subject to the Rules and Regulations thereof and to the authority of the Department Chief and Division Chairman.

9.4 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each Department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by the members of the Department.

To carry out this responsibility, each Department shall:

(a) Conduct patient care reviews for the purpose of analyzing and evaluating the quality of care and appropriateness of treatment provided to patients by the members of the Department. Such reviews shall be conducted in accordance with such procedures as may be adopted by Medical Staff Executive Committee in consultation with other appropriate committees. Each Department shall review all clinical work performed under its jurisdiction, whether or not the particular person whose work is subject to such review is a member of that Department. The criteria to be used in such review shall be objective and reflect current knowledge and clinical experience. Each Department shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the

effectiveness of actions which have been taken in resolving such problems.

(b) Prepare written reports for submission to the Medical Staff Executive Committee concerning:

1. findings of the Department's review, evaluation, and monitoring activities, conclusions, actions taken thereon, and the results of such action; and
2. recommendations and actions taken for maintaining and improving the quality of care provided in the Department and the Hospital.

(c) Meet as necessary for the purpose of receiving, reviewing, and considering patient care review findings and for the performance or reception of reports on other Department and Staff functions.

(d) Establish criteria for the granting of clinical privileges within the Department for approval by the Medical Staff Executive Committee.

(e) Submit to the Medical Staff Executive Committee the recommendations required under Articles 5 and 6 regarding the clinical privileges each member or applicant should be authorized to exercise.

(f) Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and regarding findings of review, evaluation, and monitoring activities.

(g) Take appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

(h) Coordinate the patient care provided by the Department's members with nursing and ancillary patient care services and with administrative support services.

(i) Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

9.5 FUNCTIONS OF DIVISIONS

Each Division, upon the approval of the Medical Staff Executive Committee, shall perform the functions assigned to it by the Department Chief. Such functions may include, without limitation, the continuous monitoring of patient care practices, credentials review and privileges delineation, and continuing education programs. The Division shall transmit regular reports to the Department Chief on the conduct of its assigned functions.

9.6 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Medical Staff Executive Committee and the Board of Directors, by their joint action, may create, eliminate, subdivide, further subdivide, or combine departments, divisions, and/or clinical services.

(a) Creation of Subdivision: If (i) a sufficient number of practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and relevant Rules and Regulations adopted pursuant hereto; and, (ii) the patient or service activity to be associated with the new component is substantial enough to warrant imposition on the members thereof the responsibility to accomplish such functions, a subdivision may be created.

(b) Eliminations: If the number of members available is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions on the members of such subdivision, a subdivision may be eliminated.

(c) Combination: If the union of the two or more organizational components will result

in more effective and efficient accomplishment of assigned functions, and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions on the members of such combined components, subdivisions may be combined. In all instances of modification, the Hospital's written plan of development, as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall also be considered.

9.7 FUNCTIONS OF HOSPITAL BASED DIVISIONS

Each Hospital Based Division shall be organized as part of the Medical Staff and have a Medical Director who is appointed by Hospital Administration. Members of the individual Hospital Based Divisions (Emergency Services, Radiology, Pathology, Anesthesia, and Hospitalists), shall have the following authority and duties: They shall meet independently as necessary; review on-going care of patients; review morbidity and mortality of these patients; attend the Medical Staff Executive Committee and Quality Council; and report on their activity to Medical Staff Executive Committee. Radiation Therapy physicians shall act as a subdivision of Radiology. One representative from Radiology, Emergency Medicine, and Hospitalists shall be a member of the Medicine Department Executive Committee. One representative from Anesthesia and one representative from Pathology shall be a member of the Surgery Department Executive Committee.

ARTICLE 10
OFFICERS

10.1 GENERAL OFFICERS OF THE MEDICAL STAFF

10.1-1 IDENTIFICATION

The general officers of the Medical Staff shall be the MV Chief of Staff, the Vice-Chief of Staff, Immediate Past Chief of Staff, and the LG Chief of Staff, Vice-Chief of Staff, and Immediate Past Chief of Staff. The MV Chief of Staff will serve as Chair of the Medical Executive Committee and will act as Enterprise Chief of Staff.

10.1-2 QUALIFICATIONS

General officers must be members of the Active or Active Community Staff and must be board certified or qualified in his/her primary specialty at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 NOMINATIONS

The Medical Staff election shall be held bi-annually. The Nominating Committee shall consist of the past Chiefs of each Department. The Immediate Past Chief of Staff shall Chair the Committee. The Nominating Committee shall nominate one or more nominees for Chief and Vice-Chiefs for each campus. The Nominating Committee's nominees shall be presented to the Medical Staff.

Further nominations may be made for any Medical Staff or Department office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least 10% of the Medical Staff/Department members who are eligible to vote, and bears the candidate’s written consent. These nominations shall be delivered to the chair of the nominating committee as soon as reasonably practicable, but at least five (5) days prior to mailing of the written ballots under Section 10.1-4. Candidates nominated by this procedure shall have their names included on the written ballot mailed to eligible voting members of the Medical Staff/Department.

10.1-4 ELECTION

Voting shall be by: (1) Secret written mail ballot, as defined in Article 14, Section 14.9, which shall be mailed to eligible voting members of the Medical Staff during the first week of March of an election year and must be returned to the Medical Staff Office within two weeks of receipt of the ballot or (2) Electronic vote, with the voting method to be determined by the Medical Staff Executive Committee. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote, a runoff election shall be arranged promptly between the two candidates receiving the highest number of votes. Elected officers shall be announced to the entire Medical Staff, method of communication to be determined by the Medical Executive Committee.

10.1-5 IMMEDIATE PAST CHIEF OF STAFF PROVISIONS

Sections 10.1-4 and 10.1-5 shall not apply to the office of Immediate Past Chief of Staff. The Chief of Staff shall, upon completion of his/her term of office in that position, immediately succeed to the office of Immediate Past Chief of Staff.

10.1-6 TERM OF ELECTED OFFICERS
Each officer shall serve a two year term, commencing on the first day of the Medical Staff year following election. Each officer shall serve until the end of this term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1-7 REMOVAL OF ELECTED OFFICERS
Except as otherwise provided in these Bylaws, grounds for dismissal of an elected officer may be initiated by the Medical Staff Executive Committee or upon the written request of twenty percent (20%) of the members eligible to vote for officers. Such removal may be effected by a two-thirds (2/3) vote of the members eligible to vote for officers. Voting on removal of an elected officer shall be by secret written mail ballot, as defined in Article 14, Section 14.9.

The written mail ballots shall be sent to each voting member at least two weeks before the voting date and the ballots shall be counted by the Immediate Past Chief of the Medical Staff (except when he/she is the subject of the balloting, in which case the Chief of Staff shall count the ballots) and the Vice Chief of Staff and, in the case of a petition by members, a representative of the petitioners and the officer subject to recall or his/her designee.

Grounds for removal of an officer are as follows:

(a) Failure to remain a member in good standing of the Active or Active Community Staff.
(b) Failure to perform his/her duties in a timely or appropriate manner.
(c) Subjection to corrective action (as defined in Article 7).
(d) Subjection to a summary suspension, imposed pursuant to Article 7, which remains in effect for fourteen days (14) or longer.
(e) Declaration that the officer is of unsound mind by order of court or convicted of a felony.
(f) Evidence that the officer has acted in a fraudulent or dishonest way or has grossly abused authority or discretion with reference to the Medical Staff or Hospital.

10.1-8 VACANCIES IN ELECTED OFFICES
Vacancies in office, other than that of Chief of Staff, shall be filled by the Medical Staff Executive Committee. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term and shall then serve as Chief of Staff for the following term. A vacancy in the office of Immediate Past Chief of Staff need not be filled, except that the Medical Staff Executive Committee may appoint qualified successors to serve as the Chief of, or as a member of, any committee that the Immediate Past Chief of Staff is automatically appointed to pursuant to these Bylaws.

10.1-9 COMPENSATION
The amount and source of compensation of Medical Staff Officers shall be determined annually by the Medical Staff Executive Committee in consultation with the Board of Directors.

10.2 DUTIES OF GENERAL OFFICERS

10.2-1 CHIEF OF STAFF
The MV and LG Chiefs of Staff shall serve as the Chief Executive Officer of the Medical Staff members of his/her primary campus. He/she shall:

(a) Act in coordination and cooperation with the Administrator in all matters of mutual concern within the Hospital where consistent with these Bylaws.
(b) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
(c) The MV Chief of Staff will serve as Chairman of the Enterprise Medical Staff Executive Committee.
(d) Serve as an ex officio member of all other Staff committees without vote, unless his/her membership in a particular committee is required by these Bylaws.
(e) Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations, for the implementation of sanctions where indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
(f) Appoint, with Medical Staff Executive Committee approval, committee members to all standing and special Medical Staff committees, except where otherwise provided by these Bylaws or by Medical Staff Rules and Regulations.
(g) Serve as a member of the Board of Directors in such capacity as may be permitted or required by the Hospital's corporate Bylaws.
(h) Represent the views, policies, needs, and grievances of the Medical Staff to the Board of Directors and to the Administrator/Chief Executive Officer.
(i) Interpret the policies of the Board of Directors to the Medical Staff.
(j) Serve as a spokesperson for the Medical Staff in external professional and public relations.
(k) Perform such other functions as may be assigned to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee or by the Board of Directors and where consistent with these Bylaws.

10.2-2 VICE CHIEF OF STAFF
The MV and LG Vice-Chief*s* of Staff, in the absence of the Chief of Staff shall assume all duties and authority of the Chief of Staff; shall be a member of the Medical Staff Executive Committee; perform such other supervisory duties as the Chief of Staff may assign to him/her; safeguard and be accountable for all funds of the Medical Staff and carry out such other functions as may be delegated to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee, or by the Board of Directors. He/she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.

10.2-3 IMMEDIATE PAST CHIEF OF STAFF
The Immediate Past Chief of Staff shall be the Chairman of the Nominating, Bylaws and Capital Expenditure Committees; perform such other supervisory duties as the Chief of Staff may assign him/her, and carry out such other functions as may be delegated to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee or by the Board of Directors.

10.3 DEPARTMENT OFFICERS

10.3-1 QUALIFICATIONS
Each Department Chief and Vice-Chief shall be a member of the Active or Active Community Staff, shall be certified by the appropriate specialty board or have affirmatively demonstrated comparable ability, through the credentialing process, in at least one of the clinical areas covered by the Department, and be willing and able to faithfully discharge the functions of the office.

10.3-2 SELECTION
The Department Chief and Vice-Chief shall be elected by the eligible voting staff members of the Department. Each Department shall appoint a Department Nominating Committee consisting of three (3) Active or Active Community Staff members who are members of the Department. The Committee shall be appointed not later than January of each election year. The Nominating Committee recommendations for one or more nominees for Department Chief and Vice-Chief shall be reported to the members of each Department prior to the election. Nominations will be accepted from the floor in the manner described in 10.1-3. The Department officers may be elected at the Department meeting. Eligible voting members of the Department may vote. If more than one candidate is proposed, voting shall be conducted by written ballot or by electronic methods, as determined by the current Department Chair.

10.3-3 TERM OF OFFICE
Each Department Chief and Vice-Chief shall serve a two year term commencing on their appointment. They shall serve until the end of the Medical Staff year and until their successors are chosen, unless either shall sooner resign or be removed from office.

10.3-4 REMOVAL
Removal of a Department Chief and Vice-Chief from office may be initiated by the Medical Staff Executive Committee or by written request from twenty percent (20%) of the members of the Chief's or Vice-Chief's Department who are eligible to vote. Grounds for removal shall be consistent with those listed in 10.1-7 in this section. Such removal may be effected by a majority vote of the Medical Staff Executive Committee members or by a majority vote of the Department members eligible to vote on departmental matters. All voting shall be conducted by written secret mail ballot, as defined in Article 14, Section 14.9, which shall be sent to those eligible to vote within forty-five (45) days after the initiation of removal, pursuant to this Section. The ballots must be received no later than two weeks days after they are mailed and shall be counted by the Chief of Staff, Vice Chief of Staff, and Medical Staff Coordinator and the officer subject to recall or his/her designee. No removal shall be effective unless and until it is ratified by the Medical Staff Executive Committee.

10.3-5 DUTIES
Each Department Chief shall have the following authority, duties, and responsibilities, and the Vice-Chief, in the absence of the Chief, shall assume all of them and shall otherwise perform such duties as may be assigned to him/her:

(a) Be accountable to the Medical Staff Executive Committee and to the Chief of Staff for all clinical and administrative activities within his/her department, and particularly for the quality of patient care rendered by members of his/her department and for the continuous assessment and improvement of the quality of care, treatment, and services provided by his/her department and the maintenance of quality control programs as appropriate.

(b) Develop, implement and evaluate departmental programs in cooperation with the Chief of Staff, and/or Quality Assessment/Utilization Management Director for monitoring and evaluation of patient care, credentials review, privileges delineation, medical education and utilization management.

(c) Be a member of the Medical Staff Executive Committee, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions to the Medical Staff Executive

Committee and the Medical Staff, as appropriate regarding his/her own Department including, but not limited to, criteria for clinical privileges in the department.

(d) Maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report thereon to the Medical Staff Executive Committee.

(e) Provide to the Medical Staff Executive Committee his or her recommendations concerning appointment and classification, completion of FPPE requirements, reappointment, delineation of clinical privileges, and corrective action with respect to practitioners in his/her department. Provide input to the Hospital and/or the Interdisciplinary Practice Committee, as appropriate, regarding the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

(f) Enforce the Hospital and Medical Staff Bylaws, rules, regulations, and policies within his/her department, including initiation of corrective action and investigation of clinical performance and ordering of consultations to be provided or sought when necessary.

(g) Participate in the integration of the department into the primary functions of the hospital in cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, space and other resources, supplies, special regulations, standing orders and techniques, and assessing and recommending sources for needed patient care services not provided by the department or organization.

(h) Be involved in orientation and continuing education of all persons in the department.

(i) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her Department as may be required by the Medical Staff Executive Committee or the Board of Directors.

(j) Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Chief of Staff, the Medical Staff Executive Committee, or the Board of Directors and where consistent with these Bylaws.

(k) Vice Chief shall be a member of the Quality Council; and
perform other duties as ordinarily pertain to that office or as may be assigned from time to time by the Department Chief.

(l) The Immediate Past Chief shall be a member of the Capital Expenditure Committee.

10.4 DIVISION CHIEFS

10.4-1 QUALIFICATIONS

Each Division Chief shall be a member of the Active or Active Community Medical Staff and a member of the Division which he/she is to head, shall be qualified by training, experience, interest, and demonstrated current ability in the clinical area covered by the Division, and shall be willing and able to discharge the administrative responsibilities of his/her office.

10.4-2 SELECTION

Each Division Chief shall be elected by the Division.

10.4-3 TERM OF OFFICE
Each Division Chief shall serve a one-year term, commencing on his/her appointment. He/she shall serve until the end of the succeeding Medical Staff year and until his/her successor is chosen, unless he/she shall sooner resign or be removed from office. A Division Chief may be removed by majority of the Board of Directors, the Medical Staff Executive Committee, the Department Executive Committee or the members of the Division. Grounds for removal shall be consistent with those listed in 10.1-7.

10.4-4 DUTIES
Each Division Chief shall:

(a) Account to his/her Department Chief and to the Medical Staff Executive Committee for the effective operation of his/her Division.

(b) Develop and implement, in cooperation with his/her Department Chief, and/or the Quality Assessment/Utilization Management Director, programs to carry out the quality review, evaluation, and monitoring functions assigned to his/her Division.

(c) Exercise general supervision over all clinical work performed within his/her Division.

(d) Conduct investigations and submit reports and recommendations to his/her Department Chief regarding the clinical privileges to be exercised within his/her division by members of, or applicants to, the Medical Staff.

(e) Act as presiding officer at all Division meetings.

(f) Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by his/her Department Chief, the Chief of Staff, the Medical Staff Executive Committee or the Board of Directors.

No person shall occupy two of the following offices, General Officer, Department Officer, or elected Division Chief at the same time. He/she shall resign one or the other position.

ARTICLE 11

COMMITTEES

11.1 GENERAL

There will be enterprise committees (those serving all campuses, including MV and LG campuses) and campus-specific committees. The enterprise committees are designated as such – all others are campus-specific. Enterprise committees will have appropriate representation from members of both campuses.

11.1-1 DESIGNATION AND SUBSTITUTION

The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the members of such committees and the chairman of such committees shall be appointed by the MV or LG Chief of Staff if the committee is a campus-specific committee; by the Enterprise Chief of Staff if an enterprise committee and is subject to Medical Staff Executive Committee approval. Unless specified, non-Medical Staff committee members shall be appointed by the Chief Executive Officer or his/her designee, subject to approval by the Medical Staff Executive Committee. Medical staff committees shall be responsible to the Medical Staff Executive Committee.

In addition, special committees may be created by the Medical Staff Executive Committee on an ad hoc basis to perform specified tasks. The members of special committees shall also be appointed by the Enterprise, MV, or LG Chief of Staff as appropriate, and is subject to the Medical Staff Executive Committee's approval.

11.1-2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a committee member shall be appointed for a term of one (1) year and shall serve until the end of this period and until his/her successor is appointed, unless he/she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Enterprise, MV, or LG Chief of Staff as appropriate may be removed by a majority vote of the Medical Staff Executive Committee. Any committee member who is appointed by the Department Chief may be removed by a majority vote of the Department Executive Committee or the Medical Staff Executive Committee. The removal of any committee member who is automatically assigned to a committee because he/she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official pursuant to Article 10, Section 10.1-7.

11.1-3 VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

11.1-4 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article 12.

11.1-5 VOTING

Practitioners in all categories may vote on committees to which they have been appointed.

11.2 BYLAWS COMMITTEE – *Enterprise Committee*

11.2-1 COMPOSITION

The Bylaws Committee shall be a subcommittee of the Medical Staff Executive Committee and shall be filled by the immediate past chiefs of the Medical Staff departments. The

Chairman of the Bylaws Committee shall be the Immediate Past Enterprise Chief of Staff. The MV and LG Immediate Past Chief of Staff will also serve as a member.

11.2-2 DUTIES

The duties of the Bylaws Committee shall be to:

(a) Review the Bylaws and the rules, regulations, procedures, and forms promulgated in connection therewith as necessary.

(b) Submit recommendations to the Medical Staff Executive Committee and to the Board of Directors for changes in these documents as necessary to reflect current Medical Staff practices.

(c) Receive and consider all matters specified in subparagraph (a) as may be referred by the Board of Directors, the Medical Staff Executive Committee, the Departments, the Chiefs of Staff and the Administrator/ Chief Executive Officer.

11.2-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Staff Executive Committee.

11.3 CANCER CARE COMMITTEE – ***Enterprise Committee***

11.3-1 COMPOSITION

The Committee shall consist of at least one Board certified physician representative, from Surgery, Gyn Oncology, Medical Oncology, Radiation Oncology, Radiology and Pathology, and all other representatives as required by the current American College of Surgeons/Commission on Cancer Standards.

11.3-2 DUTIES

The Committee shall:

(a) develop and evaluate annual goals and objectives for clinical, educational and programmatic activities related to cancer;

(b) promote a coordinated, multi-disciplinary approach to patient management;

(c) coordinate educational and consultative cancer conferences to cover all major sites and related issues;

(d) monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes;

(e) promote clinical research;

(f) supervise the Cancer Registry and ensure accurate and timely abstracting, staging and follow-up reporting;

(g) perform quality control of registry data;

(h) encourage data usage and regular reporting;

(i) uphold medical ethical standards; and

(j) annually provide a summary quality management report to the Medical Staff Executive Committee.

11.3-3 MEETINGS

The committee shall meet at least quarterly and will submit an annual report to the Medical Staff Executive Committee.

11.4 CAPITAL EXPENDITURE COMMITTEE – *Enterprise Committee*

11.4-1 COMPOSITION

The committee will be interdisciplinary and at least composed of physicians from Surgery, Medicine, Radiology, Pathology, Obstetrics/Gynecology, Family Practice and Orthopedics. Additionally, there will be a representative from Finance, OR, Nursing Administration, Ancillary Services and Administration. The committee will be co-chaired by the MV and LG Vice Chiefs of Staff.

11.4-2 DUTIES

(a) Participate in the selection of patient care equipment/instrumentation.
(b) Review and approve recommendations from clinical departments or divisions.
(c) Participate in the review of equipment evaluation.
(d) Submit recommendations to the Medical Staff Executive Committee.

11.4-3 MEETINGS

As necessary.

11.5 CARDIOVASCULAR/PERIPHERAL VASCULAR SERVICES (CPVS) COMMITTEE – *MV Campus*

11.5-1 COMPOSITION

Committee members may include healthcare professionals involved in the diagnosis and treatment of cardiovascular and peripheral vascular disease including interventional cardiologists, vascular surgeons, vascular medicine surgeons, interventional radiologists, interventional neuroradiologists, interventional nephrologists. Nonvoting members may include support staff from the Cardiac Catheterization Laboratory, Angiography and Interventional Radiology Services, Non-invasive Imaging and Surgery. The peer review portion of the Cardiovascular/Peripheral Vascular Services Committee will be attended by physicians of the committee.

11.5-2 DUTIES

(a) Conduct multidisciplinary review of coronary and peripheral vascular intervention procedures performed at El Camino Hospital.
(b) Develop recommendations and/or criteria for clinical privileges for percutaneous endovascular procedures.
(c) Develop protocols for a registry of cases performed at El Camino to include indications and outcomes statistics to ensure consistent quality of care
(d) Promote teaching and education amongst the healthcare professionals involved in the evaluation, combined percutaneous-surgical diagnostic and therapeutic endovascular procedures.
(e) Review selected cases identified via medical staff approved criteria and refer cases for secondary peer review to the appropriate department executive committee.

11.5-3 MEETINGS

As often as necessary, but at least quarterly.

11.6 CARE REVIEW COMMITTEE – *Enterprise Committee*

11.6-1 COMPOSITION OF COMMITTEE

The committee shall be multidisciplinary and shall include:

Voting Members

(a) Chair will be a past chief of staff and will be appointed by the current Enterprise Chief of Staff and is subject to Medical Staff Executive Committee approval. The chair may serve up to two consecutive terms.

(b) The Immediate Past Chiefs of all Medical Staff Department and Divisions or a physician from the department or division selected by majority vote of the Department/Division chair, Chief of Staff and Chair of the Care Review Committee if such alternate selection is deemed appropriate by a majority of those three physicians.

At-large members will be rotating to provide consistency, with representation from MV and LG campuses.

The At-large members shall be appointed by the CRC chair, with Enterprise Chief of Staff approval, to a 3-year term. The At-large member may serve subsequent 3-year terms with approval of the CRC chair and Enterprise Chief of Staff.

Non-voting Members

(d) Medical Director of Quality and Patient Safety
(e) Immediate Past Chief of Staff from LG and MV campuses
(f) Medical Director of continuing medical education
(g) Director Risk Management
(h) Sr. Quality Director/Chief Quality Officer
(i) Chief Medical Officer
(j) Chief Nursing Officer
(k) Associate Chief Medical Officer

11.6-2 MEETINGS

(a) Committee shall meet monthly, or at the discretion of the chair.
(b) The chair shall report to the Medical Staff Executive Committee monthly, as a standing report.

11.6-3 DUTIES

The Care Review Committee shall perform the following duties:

(a) Perform peer review. Cases will be referred to the committee from:
1. Department Chiefs
2. QA/UR Medical Directors
3. Leadership Council

(b) Review Medical Staff departmental peer review
(c) Identify hospital systems problems.
(d) Identify cases with educational value, in liaison with the Medical Director of continuing education, for presentation to continuing medical education program.
(e) Review selected new procedures and technology that have been screened and referred by the Leadership Council.
(f) Act as ad hoc committee in the event that indications for surgical or other invasive procedures are questioned and intervention needs to be considered. The Medical Staff Planning Committee will act as the body to which an appeal may be presented.
(g) Approves Ongoing Professional Practice Evaluation (OPPE) data elements and Focused Professional Practice Evaluation (FPPE)

indicators developed by departments

(h) Decides which data elements/indicators do not require physician review (informational letter only)

(i) Reviews determinations from prior levels of review

- Quality Department
- Leadership Council
- Department Chiefs

If the Care Review Committee disagrees with the prior level of review:

- Send the matter back to Leadership Council or Department Chief with questions or concerns/ask that matter be reconsidered
- Refer the matter to an individual Medical Staff member, another Medical Staff Committee or hospital department for review
- Review the matter itself.

(j) Cases before the Care Review Committee

- Presenter of the case
  - Department Chief
  - Assigned Reviewer
  - Appropriate Care Review Committee member
- Obtain additional clinical expertise if necessary
  - Internal
  - External

(k) Develop Performance Improvement Plans (PIP) when warranted. A PIP may consist of (but is not limited to):

- Additional education/CME
- Prospective monitoring/review of a specific number of cases
- Second opinions/consults
- Concurrent proctoring
- Participation in formal evaluation/assessment program
- Additional training
- Educational LOA
- Other

11.7 CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE – *Enterprise Committee*

11.7-1 COMPOSITION

The continuing medical education/library committee shall be composed of physician members and other health professionals of the Medical Staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The chairperson shall be the MV Director of Medical Education, who shall serve for at least two years, the Medical Librarian, and committee members selected by the MV Director of Medical Education who shall serve staggered terms in order to assure continuity. The LG Director of Medical Education will serve as assistant chair.

11.7-2 DUTIES

The continuing medical education/library committee shall perform the following duties:

(a) plan, implement, coordinate and promote educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital for the Medical Staff. This includes:

1. identifying the educational needs of the Medical Staff;
2. formulating clear statements of objectives for each program;
3. assessing the effectiveness of each program;
4. choosing appropriate teaching methods and knowledgeable faculty for each program; and
5. documenting staff attendance at each program.

(b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.

(c) establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.

(d) maintain close liaison with other hospital Medical Staff and department committees concerned with patient care.

(e) make recommendations to the Medical Staff Executive committee regarding library needs of the Medical Staff.

(f) advise administration of the financial needs of the continuing medical education program.

11.7-3 MEETINGS

At least quarterly. It shall maintain minutes of the program planning discussions and report to the Medical Staff Executive committee.

11.8 DEPARTMENT EXECUTIVE COMMITTEES – *Campus-Specific*

11.8-1 COMPOSITION

Each department designated in Article 9 shall have a Department Executive Committee including but not limited to the Department's Chief and Vice-Chief. The Department Chief will select members that are representative of the specialties and sub-specialties within the department whenever possible. The Department Chief may designate the department as a whole to act as the Department Executive Committee. The Department Chief shall act as Chairman of the Department Executive Committee. The peer review portion of the Department Executive Committees will be attended by physicians, dentists, and/or podiatrists of the committee.

11.8-2 DUTIES

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

11.8-3 MEETINGS

As often as necessary but at least quarterly.

11.9 INFECTION CONTROL COMMITTEE – *Campus-Specific*

11.9-1 COMPOSITION

The Infection Control Committee shall be a multi-disciplinary committee consisting of the Infection Control Officer and representatives from the Medical Staff departments as needed: the departments of medicine, surgery, obstetrics/gynecology, pediatrics, pathology, nursing, Administration, and the Nurse Epidemiologist, nursing, Administration and the Nurse Epidemiologist. The Chairman shall be a physician with knowledge of and special interest in Infection Control. Representatives from key hospital departments such as but not limited to Facilities Services, Environmental Services, Pharmacy, Central Services, Operating Room and Employee Health.

11.9-2 DUTIES
The Infection Control Committee shall:

(a) Develop a hospital-wide infection program and maintain surveillance over the program.

(b) Develop a system for reporting, identifying and analyzing the incidence and cause of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.

(c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques. Such techniques shall be defined in written policies and procedures.

(d) 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.

(e) Act upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, the departments, and other Medical Staff and Hospital committees.

11.9-3 MEETINGS
The Committee and subcommittees (if any) shall meet at least quarterly. It shall maintain a record of its proceedings and shall submit quarterly reports to the Medical Staff Executive Committee.

11.10 INTERDISCIPLINARY PRACTICE COMMITTEE – ***Enterprise Committee***

11.10-1 COMPOSITION
The Committee shall be a multi-disciplinary committee consisting of at least eight (8) members, including, as the minimum, the Chief Nursing Officer, the Administrator/ Chief Executive Officer or his/her designee, and an equal number of physicians appointed by the Medical Staff Executive Committee and of registered nurses appointed by the Chief Nursing Officer.

(a) The committee shall be responsible for appointment and reappointment of all allied health practitioners in approved categories.

(b) The committee shall review quality assessment issues pertaining to allied health practitioners at the time of reappointment as needed.

11.10-2 DUTIES

(a) The Committee shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:

1. Provision for securing recommendations from Medical Staff members in the medical specialty or clinical field of practice under review, and from persons in the appropriate non-medical category who practice in the clinical field or specialty under review.

2. Methodology for the approval of standardized procedures in accordance with Section 2725 of the Business and Professions Code, which requires affirmative approval of the procedures by the Administrator/ Chief Executive Officer or his/her designee, a majority of the physician members, and a majority of the registered nurse members after consultation has been obtained from medical and nursing staff members practicing in the medical and nursing specialties under review.

3. Provision for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the Medical Staff for medical services in the Hospital.

4. Provision for securing approval for each recommendation of the Committee from the Medical Staff Executive Committee and, if so approved, the Board of Directors.

(b) Registered Nurses: The Committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in the Hospital. These policies and procedures will be administered by the Committee, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.

(c) Standardized Procedures for Registered Nurses: The Committee shall be responsible for:

1. Identifying the functions and/or procedures which required the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the Hospital, and initiating the preparations of such standardized procedures in accordance with this Section.

2. The review and approval of such standardized procedures covering practice by registered nurses in the Hospital.

3. Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee or by delegation to the Director of Patient Care Services.

(d) Each standardized procedure approved by the Committee shall:

1. Be in writing and set forth the date it was approved by the Committee.

2. Specify the standardized procedures which registered nurses are authorized to perform and under what circumstances.

3. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.

4. Specify any experience, training or special education requirements for performance of the standardized procedures.

5. Establish a method of initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedures.

6. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedures.

7. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedures; for example, if the standardized procedure is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.

8. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.

9. State any limitation on settings or departments within the Hospital where the standardized procedure may be performed.

10. Specify any special requirements for procedures relating to patient record keeping.
11. Provide for periodic review of the standardized procedure.

11.10-3 MEETINGS
As necessary.

11.11 INSTITUTIONAL REVIEW BOARD – *Enterprise Committee*

11.11-1 COMPOSITION

The Institutional Review Board ("IRB") shall be composed in a manner which meets the requirement of the federal Health and Human Services ("HHS") and Food and Drug Administration ("FDA") regulations for the protection of human subjects. The IRB shall have at least five (5) members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted in the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members' backgrounds, including consideration of the racial and cultural backgrounds of members and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to possessing the professional competence necessary to review specific research activities, the IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB shall, therefore, include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a vulnerable category of subjects, including but not limited to subjects covered by specific regulations, the IRB shall include one or more individuals who are primarily concerned with the welfare of these subjects.

The IRB may not consist entirely of men or entirely of women, or entirely of members of one profession. It shall include at least one (1) member whose primary concerns are in nonscientific areas (for example: lawyers, ethicists, members of the clergy), and at least one (1) member who is not otherwise affiliated with the institution or part of the immediate family of a person who is affiliated with the institution. No member may participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

11.11-2 DUTIES

(a) The IRB must adopt and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, including procedures for:

1. Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and to the institution.
2. Determining which projects require review more often than annually, which projects need verification from sources other than the investigators, and that no material changes have occurred since previous IRB review.
3. Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject.
4. Assuring prompt reporting to the IRB of unanticipated problems involving risks to subject or others.
5. For research subject to HHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.

6. Assuring timely reporting to the appropriate institutional officials of any serious or continuing noncompliance by investigators with the requirements and determinations of the IRB. For research subject to the HHS and FDA regulations, these reports must also be made to HHS, or to the FDA, as appropriate.

(b) Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one (1) member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth in Paragraph (c) below. In order for the research to be approved it must meet the criteria set forth in California law and federal regulations and it must receive the approval of a majority of those members present at the meeting. Research which is approved by the IRB may be subject to further appropriate review and approval or disapproval by officials of the institution, but such review is not required. However, those officials may not approve any research subject to the California law and/or federal regulations referenced herein if it has not been approved by an IRB.

(c) The Institutional Review Board shall:

1. Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by HHS, FDA, or California law and regulations.
2. Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The IRB may require that information, in addition to that specifically mentioned in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.
3. Require documentation of informed consent or waive documentation in accordance with the provisions of applicable law or regulations.
4. Notify the investigator in writing of its decision to approve or disapprove a proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.
5. Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research.
6. Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and appropriate regulatory authorities.

11.11-3 MEETINGS
At least quarterly.

11.12 JOINT CONFERENCE COMMITTEE – *Enterprise Committee*
11.12-1 COMPOSITION:
Chief Executive Officer or designee, Chiefs of Staff, Vice Chiefs of Staff, Immediate Past Chiefs of Staff, Board of Directors' representative, Medical Director of Quality Assessment/Utilization Management, Chief Nursing Officer, Senior Director of Quality and Patient Safety.

11.12-2 DUTIES:
The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and Medical Staff policy, practice and planning, conflict resolution, and a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Staff Executive Committee or the Board of Directors. The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

11.12-3 MEETINGS:
As needed.

11.13 MEDICAL ETHICS COMMITTEE – *Enterprise Committee*
11.13-1 COMPOSITION
The committee will be multi-disciplinary with at least representatives from Medical Staff and Patient Care Services. It may also include members of other professions or the public.

11.13-2 DUTIES
(a) Provide counsel to physicians, hospital staff, administration in the understanding, delineations and clarification of medical ethical dilemmas.
(b) Provide regular educational activities on medical ethical dilemmas to the institution.
(c) Assist in the development of ethical guidelines where appropriate.
(d) Submit recommendations to the department executive committee or Medical Staff Executive Committee as appropriate.

11.13-3 MEETINGS
As needed and no less than annually.

11.14 MEDICAL STAFF EXECUTIVE COMMITTEE (MEC) – *Enterprise Committee*
11.14-1 COMPOSITION
The Medical Staff Executive Committee members shall consist of:
(a) The general officers of the Medical Staff as listed in Section l0.l-1; The Chair of Medical Staff Executive Committee will be the MV Chief of Staff. The Chair of Medical Staff Executive Committee will act as the Enterprise Chief of Staff.
(b) The department chief(s) and vice chief(s) of all Medical Staff Departments. If either the department chief or vice chief is unable to attend a Medical Staff Executive Committee meeting, the immediate past chief may attend and vote in both General and Executive Sessions.
(c) The Chief of each Hospital Division (Emergency, Radiology, Pathology, Hospitalist, and Anesthesia) or designee approved by the Enterprise Chief of Staff.

In addition, the following may attend General and Executive Sessions without vote:

(a) The Chief Executive Officer;
(b) The Chief Medical Officer;
(c) Associate Chief Medical Officer;
(d) The Medical Director of Psychiatric Services;
(e) Medical Director of Quality and Patient Safety;.
(f) The Chair of the Care Review Committee;
(g) The Medical Director of Neonatology Intensive Care Unit;
(h) The Chief Nursing Officer;
(i) Sr. Quality Director/Chief Quality Officer

The following may attend the General Session (without vote). Executive Session attendance will be by invitation in order to discuss specific pertinent issues:

(a) The Hospital Administrator of El Camino Hospital Los Gatos Campus;
(b) The Santa Clara County Medical Association Councilor.

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

11.14-2 DUTIES

The duties of the Medical Staff Executive Committee (MEC) shall be to:

(a) Represent and to act on behalf of the organized medical staff in the absence of a general staff meeting, subject to such limitations as may be imposed by these Bylaws.
(b) The Medical Staff Executive Committee shall recommend Bylaws amendments to the organized medical staff for approval in accordance with Article 15 of these Bylaws.
(c) The Medical Staff Executive Committee shall formulate, review, and propose to the Board of Directors any medical staff rule, regulations, policies/procedures, and amendments as needed and in accordance with Article 15 of these Bylaws.
(d) Coordinate the activities and general policies of the Medical Staff not otherwise established as the responsibility of the Departments.
(e) Receive and act upon Department, Division, and committee reports and requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.
(f) Implement policies of the Medical Staff not otherwise the responsibility of the Departments.
(g) Provide liaison between the Medical Staff and the Administrator/ Chief Executive Officer and the Board of Directors.
(h) Recommend action to the Administrator/ Chief Executive Officer/ Board of Directors on matters of a medico-administrative nature.
(i) Make recommendations on Hospital management matters, such as long-range planning, to the Board of Directors through the Administrator/ Chief Executive Officer.
(j) Fulfill the Medical Staff's responsibility of accountability to the Board of Directors for the medical care rendered to patients in the Hospital.

(k) Assure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.

(l) Review the credentials of applicants through Department Chief reports and make recommendations to the Board of Directors for staff membership, assignments to departments, delineation of clinical privileges, disciplinary actions, terminations.

(m) Review periodically all information available regarding the performance and clinical competence of staff members, other practitioners, and allied health practitioners with practice privileges, and as a result of such review, make recommendations for reappointments and renewals or changes in clinical or practice privileges.

(n) Take all reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and allied health practitioners including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

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

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

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

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

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

(t) Monitors the quality of medical histories and physical examinations.

11.14-3 MEETINGS
Monthly or at the discretion of the chair.

11.15 MEDICAL STANDARDS FOR INFORMATION TECHNOLOGY (MSIT) COMMITTEE – *Enterprise Committee*

11.15-1 COMPOSITION
The MSIT Committee shall be chaired by the. Members will consist of physicians selected by the Chief of Staff and one representative each from nursing, the Health Information Management Department, Administration, and Information Systems.

11.15-2 DUTIES
The duties of the MSIT shall include:

(a) Review and evaluation of the electronic medical record, or a representative sample, to determine whether they: 1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and 2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital;

(b) Review and make recommendations for Medical Staff and hospital policies, rules and regulations relating to the electronic medical record, including

completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement;

(c) Provide liaison with hospital administration and Health Information personnel in the employ of the hospital on matters relating to practices involving the electronic medical record;

(d) Incorporate Medical Staff input into information systems planning and decisions, such as internet, intranet, e-mail, software applications, and Medical Information Systems (MIS) development, maintenance and upgrade, and other clinical data systems;

(e) Review the hospital-wide Information Management Plan on an annual basis and recommend additions or revisions as may be warranted based upon clinical needs assessment;

(f) Review the Medical Staff clinical data collections applications and recommend changes or upgrades as may be warranted.

11.15-3 MEETINGS

Will meet at the discretion of the chair and report annually to the Medical Staff Executive Committee.

11.16 MEDICAL STAFF PLANNING COMMITTEE – *Enterprise Committee*

11.16-1 COMPOSITION

The committee shall consist of the Medical Staff Officers, Service Leaders, Chief Nursing Officer, the Hospital Administrator of El Camino Hospital Los Gatos, Medical Director of Quality and Patient Safety, Chief Medical Officer, Associate Chief Medical Officer, and the Administrator/ Chief Executive Officer of El Camino Hospital.

11.16-2 DUTIES

(a) Integrate Medical Staff working issues with Administration and Hospital Departments;

(b) Assist Medical Staff departments with their functions;

(c) Provide planning for the Medical Staff Executive Committee;

(d) Serve as a forum for preliminary discussions of Medical Staff interdepartmental or multi-department issues;

(e) Receive and review reports from the Quality Council Committee;

(f) Will not serve as a decision making body and votes will not be taken.

(g) May spend or contract to spend up to $5,000 for any single item not previously budgeted and/or approved by the Medical Staff Executive Committee. Funds so expended shall be reported to the next meeting of that group.

11.16-3 MEETINGS

Meets at least monthly or at the discretion of the chair.

11.17 NOMINATING COMMITTEE – *Enterprise Committee*

11.17-1 COMPOSITION

Nominating Committee will consist of the immediate past chief of each Medical Staff Department. The chair of this committee shall be the Immediate Past Enterprise Chief of Staff.

11.17-2 DUTIES

Submit nominations for MV and LG Chiefs of Staff and MV and LG Vice Chiefs of Staff as

required by these Bylaws.

11.17-3 MEETINGS
Bi-annually.

11.18 PERINATAL COMMITTEE – *Enterprise Committee*

11.18-1 COMPOSITION
This committee will be multi-disciplinary and at least composed of representatives from Pediatrics, OB/GYN, Neonatology, Anesthesia, Care Coordinator and Chief Nursing Officer.

11.18-2 DUTIES

(a) Review the ongoing care of patients in Labor and Delivery, NICU, Maternity, and the Nursery.

(b) Establish guidelines for the care of patients in Labor and Delivery, NICU, Maternity, and Nursery.

(c) Submit recommendations/concerns to Pediatric Department Executive Committee, OB/GYN Department Executive Committee, or Maternal-Child Health Department Executive Committee as appropriate.

11.18-3 MEETINGS
Monthly, or at the discretion of the chair.

11.20 PHARMACY AND THERAPEUTICS COMMITTEE – *Enterprise Committee*

11.20-1 COMPOSITION
The Pharmacy and Therapeutics Committee shall consist of at least five (5) representatives from the Medical Staff. Additional voting members shall include one (1) pharmacist, the Chief Nursing Officer or his/her representative, and Administrator or his/her representative.

11.20-2 DUTIES
The Pharmacy and Therapeutics Committee shall:

(a) Assist in the formulation of broad professional policies regarding the procurement, evaluation, selection, storage, distribution, dispensing, use, safety procedures, administration and all other matters relating to drugs and diagnostic testing materials in the Hospital.

(b) Advise the Medical Staff and the Hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs and review all significant untoward drug reactions.

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(d) Develop and review periodically a formulary or drug list for use in the Hospital.

(e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(f) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(g) Perform an annual review of all Standing Orders.

(h) Perform such other duties as assigned by the Chief of Staff or the Medical Staff Executive Committee.

11.20-3 MEETINGS

At least quarterly.

11.21 PHYSICIAN HEALTH & WELL-BEING COMMITTEE – *Enterprise Committee*

11.21-1 COMPOSITION

The committee will at least be composed of licensed independent practitioners (LIPs) from the clinical specialties of Anesthesia, Surgery, Addiction Medicine and Emergency Medicine and representatives from Behavioral Health. Except for initial appointments, each member shall serve a term of at least three years and the term shall be staggered as deemed appropriate by the Medical Staff Executive Committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment committees while serving on the committee.

11.21-2 DUTIES

(a) Receipt of Reports, Evaluation and Referrals: Receive reports related to the physical or mental health, well-being or impairment of LIPs, including reports of self-referrals or referrals by other organizational staff, and as it deems appropriate, evaluate such reports. For matters involving individual LIPs, the committee shall evaluate the credibility of a complaint, allegation, or concern and provide such advice, counseling, or referral to an appropriate internal or external professional resource for evaluation, diagnosis, and treatment of the condition or concern.

(b) Confidentiality: The activities of this committee shall be confidential except as limited by law, ethical obligation, or when the health and safety of a patient is threatened. The Committee shall have no investigatory or disciplinary responsibility or any role in the corrective action process under these Bylaws.

(c) Reporting: If information received by the Committee demonstrates that the LIP is providing unsafe treatment, that information shall be referred to the organized medical staff leadership for consideration of initiating an investigation under Section 8.1-2 of these Bylaws.

(d) Monitoring: Review and monitor a LIP's progress in and adherence to any treatment program and the safety of patients until rehabilitation is complete and periodically thereafter, if required. Provide recommendations to other appropriate committees or officers regarding reasonable safeguards concerning a LIP's continued practice in the Hospital while undergoing treatment, rehabilitation or during any disciplinary process. Appropriate actions will be initiated if a LIP fails to complete the required rehabilitation program.

(e) Education: Consider general matters related to the health and well-being of the LIP, including educational programs about illness- and impairment-recognition issues specific to —LIPs or related patient safety in coordination with other appropriate committees.

(f) Policy Setting: Establish guidelines for the management of licensed individual practitioners thought to be acting under the influence of chemical agents (reference Medical Staff Policy 7.1-2, Impaired Physicians, and Physician Health & Well-Being Committee Guidelines).

11.21-3 RECORDS/REPORTING

The committee shall maintain such records of its proceedings as it deems advisable, and shall report on its activities on a quarterly basis to the Medical Staff Executive Committee and the Board of Directors. Any records regarding individual licensed individual practitioners shall be kept strictly confidential and maintained independently from the general records of the committee and the affected licensed individual practitioner's credentials file, subject to any need for disclosure to protect patients.

11.21-4 MEETINGS
At least quarterly, or more often if necessary.

11.22 QUALITY COUNCIL – *Enterprise Committee*

11.22-1 COMPOSITION
The committee shall be composed of vice chiefs of Medical Staff Departments, Medical Director of Quality and Patient Safety, Senior Director of Quality and Patient Safety, , and other members as appointed by the Chief of Staff.

11.22-2 DUTIES

(a) Review information on clinical path variances.

(b) Assure uniform standards of care and heightened awareness of resource allocation in all Medical Staff and hospital departments. Optimal outcomes management will be emphasized.

(c) Identify certain projects that require multidisciplinary action, hear results and follow-up on these actions.

11.22-3 MEETINGS
At least quarterly.

11.23 RADIATION SAFETY COMMITTEE - *Enterprise Committee*

11.23-1 COMPOSITION
The Committee shall consist of members from the departments of Medicine and Surgery, Radiology, a physician experienced in the safe handling of radioisotopes and in determining radioisotope dosage for various patients, studies or treatments. Other members should include a Radiation Safety Officer, Nuclear Medicine Supervisor and Administration.

11.23-2 DUTIES

(a) Establish radiation safety guidelines for staff and patients at El Camino Hospital.

(b) Review ongoing activities relative to radiation safety.

(c) Review proposals for diagnostic and therapeutic uses of unsealed radio nuclides.

(d) Review regulations for the use, transport, storage and disposal of radioactive materials used in Nuclear medicine

(e) Recommend remedial action when there is a failure to observe protection recommendations, rules and regulations.

11.23-3 MEETINGS
Meet every six months.

11.24 SPECIAL SERVICES COMMITTEE – *MV Campus*

11.24-1 COMPOSITION
The committee shall be multi-disciplinary and shall be composed of at least the physician representatives from Medical Staff, Care Coordinator and Chief Nursing Officer.

11.24-2 DUTIES

(a) Establish guidelines for care of patients on the critical care units

(b) Perform ongoing review of patient care on the critical care units

(c) Review of cases as brought to the Committee by the Medical Director or any member. Refer as appropriate to the Care Review Committee or the Department Executive Committee.
(d) Participate in evaluation and selection of equipment purchases.
(e) Review cases referred from other medical/staff committees as requested.

11.24-3 MEETINGS
As least quarterly.

11.25 TISSUE REVIEW FUNCTION – ***Enterprise Committee***

The tissue review function shall include review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed. In the latter case, however, a screening mechanism based upon pre-established criteria may be established. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis. The Medical Staff Executive committee may describe a system by which the tissue review function shall be coordinated with departmental surgical case review.
A report will be made to the Medical Staff Executive Committee as needed, but at least annually.

11.26 UTILIZATION REVIEW COMMITTEE – ***Enterprise Committee***

11.26-1 COMPOSITION
The utilization review committee shall consist of a sufficient number of members to afford fair representation. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate.

11.26-2 DUTIES
The duties of the utilization review committee shall include:
(a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Staff Executive committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;
(b) establishing a utilization review plan which shall be approved by the Medical Staff Executive committee; and
(c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

11.26-3 MEETINGS
The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a quarterly report of its activities and recommendations to the Medical Executive Committee.

11.27 PERFORMANCE IMPROVEMENT (PI)/SAFETY COMMITTEE – ***Enterprise Committee***

11.27-1 COMPOSITION
The Performance Improvement/Safety Committee shall be composed of the Chief Nursing Officer, Chief Medical Officer, Senior Director of Quality and Patient Safety, Physician

members of the Medical Staff, Nurse Managers, Infection Control Practitioner, Manager of QI/PI, Safety Management Specialist, and the Risk Manager.

11.27-2 CHAIRS
The committee will be co-chaired by the Chief Nursing Officer and one of the physician members (to be determined by the Chief of Staff).

11.27-3 DUTIES
(a) Oversee PI/Safety Teams
(b) Assess goals and monitor performance of the PI/Safety Teams
(c) Ensure PI/Safety Teams have adequate resources
(d) Identify gaps in hospital safety and performance – set targets for improvement

11.27-4 MEETINGS
The committee shall meet quarterly, or at the discretion of the chairs.

11.28 QUALITY STEERING COMMITTEE – *Enterprise Committee*
11.28-1 COMPOSITION
The Quality Steering Committee shall be composed of the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, two members of the Board of Directors (including the Chairman of the Board), Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Associate Chief Medical Officer, Medical Director of Quality and Patient Safety, Senior Director Clinical Quality and Patent Safety, Manager QA/PI, Director Medical Staff Services

11.28-2 CHAIRS
The committee will be co-chaired by the Chief of Staff and the Chairman of the Board.

11.28-3 DUTIES
(a) Set overall direction for QI activities at El Camino Hospital
(b) Align medical staff and hospital QI activities
(c) Align service line development and hospital growth initiatives with medical staff and hospital QI activities
(d) Continually review committees and reporting structures to ensure collaboration and teamwork with regard to QI activities.

11.28-4 MEETINGS
The committee shall meet quarterly, or at the discretion of the chairs.

11.29 **LEADERSHIP COUNCIL – Enterprise Committee**
11.29-1 COMPOSITION
The Leadership Council shall be comprised of the Chiefs of Staff from MV and LG campuses, Care Review Committee Chair, Chief Medical Officer, Associate Chief Medical Officer, Medical Director of Quality and Patient Safety, Service Leaders, and clinical expertise as needed (ex-officio, no vote). Support personnel will include the Senior Director of Quality and Patient Safety, and Director Risk Management (ex-officio, no vote), Director, Medical Staff Services MV (ex-officio, no vote), and the Manager, Medical Staff Services LG (ex-officio, no vote).

11.29-2 CHAIR

The committee will be chaired by the Enterprise Chief of Staff (Chief of Staff MV)

11.29-3 DUTIES

(a) Performs prompt, initial review of complex* cases and handles matter if possible. Cases will be brought to the Leadership Council through the QRR process, or individuals with concerns may refer cases to the Leadership Council for review and disposition.

- No further review or action
- Address through alternate policy
- Educational letter
- Collegial intervention

The above will be reported to CRC

(b) Determines appropriate avenue for full review if needed

- Further review is required, refer as appropriate, to:
    - Department Executive Committee
    - Expert reviewer of case, expert chosen in consultation with department chief
    - Care Review Committee – refer cases that are defined as complex
    - Medical Executive Committee – requires immediate disciplinary action

Leadership Council will provide oversight of the cases that are referred until they are concluded.

(c) Review new technology/procedures – refer to Care Review Committee if additional expertise is necessary.

***Definition of a complex issue:**

- Requires immediate or expedited review
- Involves practitioners from two or more departments or specialties
- Involves department chief
- Involves possible conflicts of interest
- Involves professional conduct, disruptive practitioner behavior
- Involves possible health issue
- Pattern has developed despite prior interventions
- Prior PIP; recurrence of issues
- EMTALA violations
- Serious Safety Event – if referred to Leadership Council due to need for peer review or medical staff input.

11.29-4 MEETINGS

The council will meet monthly or as needed (determined by the chair)

11.29-5 REPORTING REQUIREMENTS

Council reports directly to the Medical Staff Executive Committee with regard to activity/reviews performed, recommendations made, actions taken.

ARTICLE 12
MEETINGS

12.1 MEETINGS

12.1-1 GENERAL MEDICAL STAFF ANNUAL MEETING

There shall be an annual meeting of the Medical Staff members in June. The meeting shall be chaired by the Enterprise Chief of Staff – see Article 10, Officers of the Medical Staff. The Enterprise Chief of Staff, or such other officers as the Enterprise Chief of Staff or Medical Staff Executive Committee may designate, shall present a summary report on events of the preceding year and matters believed to be of interest and value to the membership. Notice of this meeting shall be given to the membership at least thirty (30) days prior to the meeting.

12.1-2 REGULAR MEETINGS

Regular meetings of the medical staff shall be held as determined by the Medical Staff Executive Committee and will be chaired by the Enterprise Chief of Staff. The date, place and time of the regular meetings shall be determined by the Medical Staff Executive Committee, and adequate notice shall be given to the members. The annual meeting shall count as a regular meeting of the Medical Staff.

12.1-3 AGENDA

The order of business at a regular meeting shall be determined by the Enterprise Chief of Staff. The agenda may include:

(a) Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.

(b) Administrative reports from the Administrator/ Chief Executive Officer, the Chief of Staff, the departments and committees.

(c) Reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of the other required staff functions.

(d) Recommendations for improving patient care within the Hospital.

(e) Old business.

(f) New business.

12.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Enterprise Chief of Staff and shall be called at the request of the Board of Directors, the Medical Staff Executive Committee, or ten percent (10%) of the eligible voting members. The meeting must be called within thirty (30) days after receipt of such request and notice must be given at least ten (10) days prior to the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Committees and departments, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. The Chairs shall make every effort to ensure that the meeting dates are disseminated to the members.

12.2-2 SPECIAL MEETINGS

A special meeting of any committee or department may be called by, or at the request of, the Chairman thereof, the Medical Staff Executive Committee, the Chief of Staff or by one-third of the group's current members eligible to vote, but not less than three (3) members.

12.3 NOTICE OF MEETINGS

Written notice stating the place, day, and hour of any regular or special committee or Department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than seven (7) days before the date of such meeting, in the manner specified in Section 14.8, hereof. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

12.4-1 STAFF/COMMITTEE MEETINGS

A quorum for any regular or special meeting of the general medical staff shall consist of the presence of ten (10) percent of those eligible to vote. A quorum of fifty (50) percent of the voting members shall be required for Medical Staff Executive Committee meetings. For other Committees, a quorum shall consist of the majority of those present and voting.

12.4-2 IRB MEETINGS

At IRB meetings, a majority of the total membership must be present to transact business, one member to be a lay person.

12.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone/electronic conference which shall be deemed to constitute a meeting for the matters discussed in that conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

12.6 MINUTES

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the resultant conclusions, recommendations and actions taken on each matter. The minutes shall be signed by the presiding officer. Each Committee and Department shall maintain a permanent file of the minutes of each meeting in the Medical Staff Office.

12.7 ATTENDANCE REQUIREMENTS

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance may be used by the Executive Committee in evaluating Medical Staff members at the time of reappointment.

12.8 SPECIAL APPEARANCE

Whenever an apparent or suspected deviation from standard clinical practice is involved, notice shall be given at least fourteen days (14) days prior to the meeting and shall include the time and place of the meeting, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to

which he/she was given such notice, unless excused by the Medical Staff Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Staff Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Staff Executive Committee, as provided in Section 7.3-4.

12.9 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order, however, minor technical failures to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE 13
CONFIDENTIALITY, IMMUNITY, AND RELEASES

13.1 AUTHORIZATIONS AND CONDITIONS

By applying for or exercising clinical or practice privileges within this Hospital, a health practitioner:

(a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing on his/her professional ability and qualifications.

(b) Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such health practitioner to the Hospital and its Medical Staff.

(c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

(d) Acknowledges that the provisions of this Article are express conditions to his/her application for or acceptance of Medical Staff membership and the continuation of such membership, or to his/her exercise of clinical privileges at this Hospital, or to his/her application for or acceptance of approval and exercise of practice privileges at this Hospital.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under Article 14, and meetings of special or ad hoc committees created by the Medical Staff Executive Committee or by departments and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the peer review discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff bylaws, and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Staff Executive Committee may undertake such corrective action as it deems appropriate.

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and hospital shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff, hospital or El Camino Hospital District.

13.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or

other relief by reason of providing information to a representative of the Medical Staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) department, or division, committee, or Medical Staff activities conducted in executive sessions; and

(e) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

13.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities, as long as such activities are subject to a privilege afforded by State or Federal law. These activities include, but are not limited to, (1) as a member of or witness for a Medical Staff department, service, committee or hearing panel, (2) as a member of or witness for the hospital board or any hospital task force, group, or committee, and (3) as a person providing information to any Medical Staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant. The Medical Staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff or member sees fit, and concurrently or in such sequence as the Medical Staff or member may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the hospital's indemnification obligations hereunder.

ARTICLE 14
GENERAL PROVISIONS

14.1 RULES AND REGULATIONS

14.1-1 MEDICAL STAFF RULES AND REGULATIONS
The Medical Staff Rules and Regulations may be adopted, amended or repealed by the Medical Staff Executive Committee subject to approval of the Board of Directors, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Rules and Regulations.

14.1-2 DEPARTMENT GUIDELINES
Subject to approval of the Medical Staff Executive Committee, each Department shall formulate and approve its own guidelines, each Clinical Service shall formulate and approve its own protocols, and each committee its own standing orders.

Such guidelines, protocols and standing orders shall not conflict with these Bylaws, the rules and regulations of the Medical Staff, or other policies of the Staff and Hospital. When adopted and approved by the Medical Staff Executive Committee, the guidelines, protocols and standing orders shall have the same force and effect as these Bylaws.

14.2 DUES

Active, Provisional, Courtesy, Active Community, and Affiliate Staff members are required to pay annual dues. A failure to pay such dues shall result in those actions specified in Section 7.3-8. The Medical Staff Executive Committee shall have the authority to set the amount of annual dues, if any, for each category of Medical Staff membership and the amount of the processing fee for initial applications, and to determine the manner of expenditure of funds received.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. 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.

14.4 AUTHORITY TO ACT

Action of the Medical Staff in relation to any person other than the members thereof shall be expressed only through the Chief of Staff or the Medical Staff Executive Committee, or his/her or its designee, and they shall first confer with the Administrator. Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Staff Executive Committee or Board of Directors may deem necessary.

14.5 ACCEPTANCE OF PRINCIPLES

All members of whatever class or category, by application for membership in this Medical Staff, do thereby agree to be bound by the provisions of these Bylaws, a copy of which shall be delivered to each member on his/her initial appointment, and a copy of each amendment thereto, promptly after adoption. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Staff Executive Committee or Board of Directors shall direct.

14.6 DIVISION OF FEES

The practice of the division of professional fees under any guise whatsoever is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

14.7 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested.

In the case of notice to hospital, Board of Directors, Medical Staff or officers or committee thereof, the notice shall be addressed as follows:

El Camino Hospital
2500 Grant Road
Mountain View, CA. 94039-7025

In the case of a notice to a practitioner, Allied Health Practitioner, or other party, the notice shall be addressed to the address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery, and if mailed as provided for above, such notice shall be effective two (2) days after it is placed in the mail. Any party may change its address, as indicated above, by giving written notice of such change to the other party in the manner as above indicated.

14.8 SECRET WRITTEN BALLOT

Whenever these Bylaws require voting by secret, written mail ballot, the mail ballots shall be returned in an unmarked envelope, which shall be placed inside a properly identified return envelope on which the staff member has printed and signed his/her name, and their participation shall be confidential. The staff member's name shall be verified against the Medical Staff records. Whenever electronic voting is utilized, appropriate safeguards for confidentiality shall be implemented as determined by the Medical Staff Executive Committee.

14.9 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairships, or the Medical Staff Executive Committee shall, at least 5 days prior to the date of election or appointment, disclose in writing to the Medical Staff Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Such disclosures shall also be made during physician’s term as they occur.

ARTICLE 15
ADOPTION AND AMENDMENT OF MEDICAL STAFF DOCUMENTS

15.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review, adopt and propose to the Board of Directors the Medical Staff documents and amendments thereto which shall be effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. The medical staff exercises this responsibility regarding Bylaws through direct vote of its medical staff members who are eligible to vote. The medical staff exercises this responsibility regarding Rules and Regulations and Policies/Procedures through its elected and appointed leaders via the Medical Staff Executive Committee. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board of Directors and with the Community.

15.1-1 MEDICAL STAFF DOCUMENTS

Medical Staff documents consist of the following:

(a) Medical Staff Bylaws
(b) Medical Staff Rules & Regulations – attached to these Bylaws
(c) Medical Staff Policies/Procedures – located in Medical Staff Policy Binder
(d) Allied Health Professionals Policy Manual – located in Medical Staff Policy Binder

15.2 PROCEDURE FOR AMENDMENTS/ADOPTION MEDICAL STAFF DOCUMENTS

(a) Medical Staff Bylaws: Amendments to the Bylaws occur through direct vote of the medical staff members. Proposed amendments occur in one of the following ways:

1. Upon the request of (i) the Medical Staff Executive Committee (MEC), (ii) the Chief of Staff or Bylaws Committee after approval by the Medical Staff Executive Committee.
2. The organized medical staff (OMS) has the ability to adopt medical staff bylaws, rules, regulations, and policies, and amendments thereto, and to propose them directly to the Board of Directors. Proposed amendments to the Bylaws or Rules and Regulations may be originated by the Medical Staff Executive Committee or by a petition signed by twenty-five percent (25%) of the voting members of the medical staff. Any amendments proposed by this procedure must be in writing and accompanied by a written description of the reasons for the amendment. Proposals received in this manner will then follow the usual and customary method of voting for an amendment prior to the proposal being forwarded to the Board of Directors for approval.
   - When proposed by the Medical Staff Executive Committee, there will be communication of the proposed amendment to the OMS before a vote is taken by the OMS.
   - When proposed by the OMS, there will be communication of the proposed amendment to the Medical Staff Executive Committee before a vote is taken by the OMS.

(b) Medical Staff Rules and Regulations: The OMS delegates authority for amendments to the Rules and Regulations to the Medical Staff Executive Committee. Proposed amendments to these Rules and Regulations may be originated by the Medical Staff Executive Committee or by a petition signed by twenty-five percent (25%) of the voting members of the OMS.

1. When proposed by the Medical Staff Executive Committee, there will be communication of the proposed amendment to the OMS before a vote is taken by the Medical Staff Executive Committee.
2. When proposed by the OMS, there will be communication of the proposed amendment to the Medical Staff Executive Committee. If the Medical Staff Executive Committee does not pass the proposed amendment to the Rules and Regulations, the OMS can ask for a medical staff vote using the mechanisms noted in the conflict resolution process (Article 15.2-1).

(c) The Medical Staff Executive Committee and Board of Directors may adopt such provisional amendments to these Rules and Regulations that are in the Medical Staff Executive Committee's and Board's judgments necessary for legal or regulatory compliance without first communication to the OMS. After adoption, these provisional amendments to the Rules and Regulations will be communicated to the OMS for their review. If the OMS does not approve of the provisional amendment, this will be resolved using the conflict resolution mechanism noted in Article 15.2-1. If a substitute amendment is then proposed, it will follow the usual approval process.

(d) Medical Staff Policies/Procedures – Allied Health Procedures: The OMS delegates authority for amendments to the Policies/Procedures to the Medical Staff Executive Committee. When the Medical Staff Executive Committee adopts a policy or amendment thereto, there will be communication of the policy or amendment to the OMS.

15.2-1 CONFLICT RESOLUTION (Between OMS and the MEC)

Any conflict between the OMS and the Medical Staff Executive Committee will be resolved using the mechanisms noted below:

(a) Each medical staff member eligible to vote may challenge any rule or policy established by the Medical Staff Executive Committee through the following process:

1. Submission of written notification to the Enterprise Chief of Staff of the challenge and the basis for the challenge, including any recommended changes to the rule or policy.
2. At the meeting of the Medical Staff Executive Committee that follows such notification, the Medical Staff Executive Committee shall discuss the challenge and determine if any changes will be made to the rule or policy.
3. If changes are adopted, they will be communicated to the OMS, at such time each medical staff member eligible to vote may submit written notification of any further challenges(s) to the rule or policy to the Enterprise Chief of Staff.
4. In response to a written challenge to a rule or policy, the Medical Staff Executive Committee may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.
5. If a task force is appointed, following the recommendations of such task force, the Medical Staff Executive Committee will take final action on the rule or policy.
6. Once the Medical Staff Executive Committee has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member may submit a petition signed by twenty-five percent (25%) of the medical staff members eligible to vote requesting review and possible change of a rule, regulation, policy, or procedure. Upon presentation of such a petition, the adoption procedure outlined in Article 15.2 will be followed.

(b) If the OMS votes to recommend directly to the Board an amendment to the Bylaws, Rules and Regulations, or Policy/Procedure that is different from what has been

recommended by the Medical Staff Executive Committee, the following conflict resolution process shall be followed:

1. The Medical Staff Executive Committee shall have the option of appointing a task force to review the differing recommendations of the Medical Staff Executive Committee and the medical staff, and recommend language to the Bylaws, Rules and Regulations or Policy/Procedure that is agreeable to both the OMS and the Medical Staff Executive Committee.
2. Whether or not the Medical Staff Executive Committee adopts modified language, the medical staff shall still have the opportunity to propose directly to the Board of Directors the alternative language. If the Board receives differing proposals for amendments for Bylaws, Rules and Regulations, or a policy from the Medical Staff Executive Committee and the OMS, the Board shall also have the option of appointing a task force of the Board to study the basis of the differing recommendations and to recommend appropriate Board action. Whether or not the Board appoints such a task force, the Board shall have final authority to resolve the difference between the OMS and the Medical Staff Executive Committee.

(c) At any point in the process of addressing a disagreement between the OMS and the Medical Staff Executive Committee regarding the Bylaws, Rules, Regulations, or Policy/Procedures, the OMS, the Medical Staff Executive Committee, or the Board of Directors shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed in so doing, is the responsibility of the Board of Directors.

15.3 METHODOLOGY

Neither the Board of Directors nor the Medical Staff may unilaterally amend the Medical Staff Bylaws. Medical Staff Bylaws may be adopted, amended or repealed by the following combined action:

15.3-1 STAFF MEMBERS

(a) The affirmative vote of a majority of the medical staff members eligible to vote Staff Members voting on this matter by secret written ballot, or

(b) By the affirmative vote of a majority of those eligible staff members voting by electronic voting, method to be determined by the Medical Staff Executive Committee.

The method of voting will be determined by the Medical Staff Executive Committee and at least fourteen (14) days prior written notice, accompanied by the proposed Bylaws and/or amendments, will be provided to Staff Members eligible to vote.

15.3-2 BOARD OF DIRECTORS

Amendments will be approved by the affirmative vote of a majority of the Board of Directors. If approval is withheld, the reason for doing so shall be so specified by the Board of Directors in writing and shall be forwarded to the Medical Staff Executive Committee and Bylaws Committee.

ADOPTED by the Medical Staff	**APPROVED by the Board of Directors**
on: August 2015	**on: August 12, 2015**

EL CAMINO HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

Appendix I

A. ADMISSIONS/DISCHARGES

1. Patients shall be admitted only under the care of a qualified member of the Medical Staff. The attending physician must be available to the admitted patient at all times or must arrange such coverage.

Allied health practitioners may initiate arrangements for admission and complete charts and forms pertinent to the admission and the medical record if privileged to do so within their scope of practice and under the supervision of the attending physician (if applicable).

2. Except in an emergency, patients shall not be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.

3. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary or appropriate to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

4. According to policy of Medical Staff (see Operating Room Committee policy), pre-operative lab work shall be ordered at the discretion of the admitting surgeon. If pre-op lab work is ordered, the attending surgeon will be responsible for either including a copy of the lab work in the chart or in the dictated H&P or the admission note in the progress notes.

5. Potassium levels shall be obtained within 72 hours of surgery for all patients on potassium depleting diuretics.

6. All laboratory procedures, for patients being investigated or treated within the Hospital, shall be done in the Hospital except in those circumstances where the Hospital refers laboratory work outside the Hospital.

7. Decisions concerning the use of reference laboratories for studies not performed in the Hospital shall be delegated to the director of the medical laboratory services.

8. Each patient on admission shall be provided with a wristband unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient and the Hospital admission number.

9. Patients shall not be routinely admitted to a distinct part of the Hospital unless it is appropriate for the level of care required by those patients.

10. Patients with critical burns shall be treated in a Burn Center unless transfer of the patient to the center is contraindicated in the judgment of the attending physician.

11. Any outpatient psychotherapist arranging for inpatient psychiatric care of his/her patient at El Camino Hospital will share with the ECH treatment team all information relevant to the patient's treatment. When the outpatient therapist is not the admitting psychiatrist, a special effort should be made to inform the admitting psychiatrist of all

relevant treatment issues. This communication is for purposes of ensuring optimal short-term patient care. Information must be held in strict confidence within the treatment setting, but the availability of relevant information to the treatment team is essential to provide adequate and appropriate therapy.

12. A mentally competent adult shall not be detained in the Hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where the law permits an unemancipated minor to contract for medical care without the consent of his/her parent or guardian, he/she shall not be detained in the Hospital against his/her will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the Hospital in his own interest nor the detention of a mentally disordered patient for the protection of himself or others under the applicable provisions of the Welfare and Institutions Code, Section 5000, et seq., until transfer to an appropriate facility can be arranged.

13. Patients shall not be transferred or discharged for purposes of effecting a transfer from the Hospital to another health facility unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or after reasonable attempts have been made to notify the responsible person. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.

14. A minor shall be discharged only to the custody of his or her parent or to his legal guardian or custodian, unless such parent or guardian shall otherwise direct. This provision shall not be construed to preclude a minor legally contracting for medical care from assuming responsibility for himself upon discharge.

15. Patients may only be discharged upon the order of a Medical Staff member.

16. In the event that a hospitalized patient refuses treatment by a physician, the affected physician will:

a. Communicate with the patient with regard to what he/she needs (tests, follow-up care, etc).

b. Ask a physician in his/her call group or specialty to take over care of the patient ***or,***

Ask the chief of department or chief of staff for assistance in assigning another physician to care for the patient.

If the affected physician is acting as a consultant, the primary physician will find another consultant, absent an emergency situation. The primary physician is always responsible for the patient's care in the immediate emergency situation absent the patient's direct wishes to not be cared for in the interim.

17a. Prior to initiation of definitive therapy at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, it is strongly recommended that review and report of the findings must be documented by an ECH pathologist.

17b. Prior to initiation of definitive therapy for breast cancer at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, review and report of the findings must be documented by an ECH pathologist.

B. <u>RECORDS</u>

The responsible staff member shall be accountable for the preparation of a complete medical record for each patient. Unless otherwise provided in standing orders, protocols, or guidelines, a record shall include (a) identification data; (b) chief complaint; (c) details of present illness; (d) relevant past, social, and family histories; (e) inventory of body systems; (f) complete physical examination; (g) provisional diagnosis; (h) consultation reports; (i) reports from laboratory, i.e., pathology, radiology, etc.; (j) progress notes detailing medical surgical treatment that reflect any change in condition and results of treatment; (k) reports of procedures (also see below), e.g., nuclear medicine, radiology, anesthesia; (l) principal & secondary diagnosis(es); (m) discharge summary, discharge instructions; (n) follow-up plans; and (o) appropriate consents; and (p) autopsy results, if applicable. All entries shall be dated, timed, and authenticated by the appropriate practitioner. Any entries made for the practitioner (fellow, resident, physician assistant, etc.) must be dated, timed, and counter-signed by the practitioner, except emergency department (ED) reports. ED assessments may be dictated and signed by the responsible nurse practitioner or physician's assistant, and must include the name of the supervising ED physician. The ED physician must document in the ED record that he/she has reviewed the assessment and care provided.

Medical Records may be authenticated by a computer key code, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who has possession of the key code and the only person who will use the key code. 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.

<u>History & Physical (H&P)</u>

1. H&P must be completed by a practitioner privileged to perform H&Ps – these are defined as:
   a. MD/DO
   b. DDS/DMD
   c. DPM
   d. Nurse Practitioner – must be countersigned by supervising practitioner with 14 days of the patient's discharge.
   e. Certified Nurse Midwife
   f. Physician Assistant – must be countersigned by supervising practitioner with 14 days of the patient's discharge.

2. H&P must be completed and documented for each patient no more than 30 days before or ***within*** 24 hours ~~after~~ ***of*** admission ***or registration***, but prior to surgery or procedure requiring anesthesia services.

   At a minimum, the following systems must be included in the H&P:
   a. Heart and lungs
   b. Abdomen
   c. General appearance and orientation
   d. Vital signs (including blood pressure, heart rate, respiratory rate, and temperature – afebrile is acceptable) or reference to vital signs obtained elsewhere in the admission process
   e. Major integumentary
   f. Musculoskeletal or sensory systems when problems such as blindness, deafness, missing limbs, or open sores and wounds exist

g. Rectal/pelvic examinations are recommended when pertinent to the admission diagnosis
h. Salient features of the case
i. Drug tolerances
j. Pertinent positive and negative findings that relate to the reason for admission.

Outpatients receiving local anesthesia or conscious sedation require, as a minimum, a current statement of present illness, a statement of absence of infection or intercurrent disease, a description of cardiorespiratory status, known allergies, current medications, and a preoperative diagnosis.

Obstetrical records should include all pertinent and significant prenatal information. A durable, legible original or reproduction of the office or clinical prenatal record is acceptable. The report of the physical examination shall reflect a comprehensive current physical assessment

ECT Patients - For patients receiving a series of ECT treatments, the history and physical must be within thirty (30) days prior to the initial treatment. For subsequent treatments within the same series, an update to the H&P will be required (the update must include auscultation of the lungs and heart and any significant change in condition or absence of any significant change). This may be documented on the anesthesiologist pre-anesthesia assessment form.

3. **Updates**: When the H&P is conducted within 30 days of admission (inpatient or outpatient), an updated examination, including any changes in the patient's condition, must be completed and documented by a qualified practitioner (see #1 in this section) within 24 hours of admission (inpatient or outpatient) or registration, but prior to surgery or a procedure requiring anesthesia services when the H&P was completed within the previous 30 days.

a. The update must include review of the H&P, updated examination including auscultation of the lungs and heart, and any significant change in condition or absence of any significant change from the previous report. If the patient is an inpatient, the update may be documented in the progress note or on the 'Procedure Notes' form.

4. If the reviewing practitioner finds the H&P incomplete, inaccurate, or otherwise unacceptable, he/she may disregard the H&P and perform a new H&P within 24 hours or prior to surgery/procedure as noted above.

<u>Other Medical Record Documentation:</u>

1. There shall be pre-anesthetic and post-anesthetic notes documented in the medical record which include the anesthesiologist's pre-anesthetic evaluation, the patient's condition upon admission to the Post Anesthesia Care Unit, a description of the post-operative course, a description of any anesthesia complications, and a description of the patient's condition upon discharge from the Post Anesthesia Care Unit.

2. Operative Reports

The immediate post-operative note must be entered in the medical record before the patient is transferred to the next level of care. This documentation includes the name(s) of the primary surgeon and assistants, procedures performed and a description of each procedure

finding, estimated blood loss, specimens removed, and complications, if any; condition at the end of the case, and postoperative diagnosis. This documentation must be documented in the electronic medical record on the 'post procedure note'. Downtime paper forms may be used when the EMR is not functional.

The comprehensive operative report describing techniques, findings, and tissues removed or altered must be written or dictated within 24 hours of surgery and signed by the surgeon**.**

- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

3. Progress notes shall be written/dated/timed/signed on each day of the hospital stay and within 24 hours of discharge by the attending physician, his/her associate, or his/her designated PA or NP with El Camino Hospital privileges.

4. Orders for treatment and tests must be entered into the computer system by the Medical Staff member or authorized person at the direction of the staff member. When ordering diagnostic CT, MRI, PET, or nuclear medicine imaging exams, the practitioner should consider the patient's age and recent imaging exams. Drug and treatment orders must be appropriately signed within forty-eight (48) hours. All other orders must be signed within seventy-two (72) hours or prior to the discharge or transfer of the patient. Telephone orders shall immediately be recorded and then read back to the staff member for confirmation, shall be signed by the person to whom dictated with the name of the Medical Staff member per his own name, and shall be signed by the Medical Staff member within the prescribed time limits.

Persons authorized to accept orders defined: Persons to accept and transcribe orders at the direction of Staff Member shall include the nursing staff, pharmacists, and those persons designated by department guidelines or service protocols in conformity with applicable statutory provisions.

Orders and patient referrals for outpatient services shall be accepted from any member of the El Camino Hospital Medical Staff or Allied Health Professional Staff who holds a current, unrestricted California license and is privileged to do so.

Practitioners (physicians, podiatrists, dentists, and other allied health professionals) who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order outpatient services and refer patients for outpatient services in accordance with the provisions and condition set forth below.

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

patient on discharge, medications, and any specific instructions given to the patient and/or family regarding follow-up care.

For stays less than forty-eight (48) hours, a final progress note may be completed in lieu of a discharge summary unless the patient is transferred or dies. If a discharge summary is not required, the following information must be included in the final progress note: diagnosis, condition of the patient, diet, activity, medications, and follow-up instructions (if not covered with a preprinted form).

8. Discharge instructions are required on all hospital stays, including short-stay and cancelled surgeries. Discharge instructions must include the following elements: 1) Discharge medication reconciliation; 2) discharge diet; 3) follow-up appointments; 4) activity level; 5) signs/symptoms to watch for.

9. In the event of a death, a discharge summary should be added to the record which the physician must authenticate. The final summary should indicate the reason for admission, the findings, course in the hospital including significant conditions (present on admission and comfort care), and immediate cause of death.

10. When a necropsy is performed, the provisional anatomic diagnosis should be recorded on the medical record within seventy-two (72) hours and a final completed report shall become a part of the record.

11. The records of discharged patients will be completed within 14 days following discharge.

12. All forms designed to become a part of the medical record must be approved by the Medical Records Committee and by the Medical Staff Executive Committee.

13. Procedures for making changes or amendments to record entries:

a. Any individual who discovers an error or omission of his or her own shall immediately upon discovery correct it and do so in accordance with the procedures in this section.

b. Simple corrections may be made during the actual writing of a record entry and shall be lined through (not obliterated), initialed and dated/timed.

c. Errors or omissions discovered at a later time shall be corrected by a separate entry to the appropriate portion of the record. The original entry shall be lined out (not obliterated).

14. Physician Review of Medical Records

A physician may request to review a chart only when he/she is actively involved in that patient's care or if reviewing the case for official peer review or quality assessment purposes. Any abuse of this privilege may result in disciplinary action.

15. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Act, as implemented by the HIPAA Privacy Regulation (42 CFR Parts 160 and 164) requires that El Camino Hospital implement policies and procedures to protect the privacy and security of "protected health information" and to afford patients certain rights with regard to their information. "Protected health information" includes any health-related information that identifies or could be used to identify an individual, including patient medical and billing records. HIPAA applies both to the Hospital and to the members of the Medical Staff

a. El Camino Hospital has adopted privacy practices for the use and disclosure of patient information within the Hospital. These privacy practices are summarized in the Hospital's Notice of Privacy Practices, which is furnished to patients and posted at the Hospital's facilities.

b. The Notice of Privacy Practices applies to all patient health information created or received in the course of providing health care or conducting business operations at any hospital operated location. The Notice is given jointly on behalf of the Hospital and the members of the Medical Staff. It does not, however, apply to patient health information at other locations, such as a Medical Staff member's private office.

c. Each member of the Medical Staff shall abide by the terms of the Notice of Privacy Practices and with the Hospital's policies and procedures for health information privacy and security, as amended from time to time. Medical Staff members must adopt their own notice of privacy practices at their private offices as necessary to comply with the Privacy Regulations.

C. <u>REMOVAL OF ORIGINAL RECORDS FROM THE HOSPITAL</u>

Original records may be removed from the Hospital's custody only pursuant to court order, subpoena or statute, with exception of x-rays and other images, tracings, recordings and clinical and anatomical pathological materials which are sought for purposes of continuing care of the patient.

D. <u>AUTOPSIES</u>

Every member of the Medical Staff shall try to secure permission for autopsy when appropriate. No autopsy shall be performed without the written consent of the appropriate party. All autopsies shall be performed by the hospital pathologist(s) or by a physician to whom he may delegate the duty. In all cases where any doubt exists regarding the legal status of death, the coroner shall be notified and request for an autopsy made. (Indications for autopsy are found in the Pathology Department Policy "Autopsies for QA – Indications for Autopsy".)

E. <u>CONSULTATIONS</u>

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

The Consultant shall document the fact that all available, pertinent past medical records were examined.

F. <u>MANDATORY CONSULTATIONS</u>

Mandatory consultation(s); in specific, urgent or critical clinical conditions; may be imposed at the discretion of a Medical Staff officer, department or division chief or their designees with concurrence of a Medical Staff officer. Mandatory consultations may be imposed on any staff member in a specific urgent clinical management problem and/or as an overall continuing requirement in all similar types of clinical management cases.

Mandatory consultations may be imposed by departments or division guidelines for all staff members or classes of members in specific clinical conditions, subject to approval of the Medical Staff Executive Committee.

The consultant in a specific urgent or critical situation may or may not be a staff member, but must be a practitioner with acknowledged expertise. Temporary privileges, if necessary, may be granted at the discretion of an appropriate Department Chief, Chief of Staff, and Hospital Administration and are subject to Sections 6.5-l and 14.2 of the Bylaws.

The imposition of mandatory consultation requirements on a member in a specific, urgent or critical clinical condition, or such imposition on all members or a class of members, does not constitute a reduction in privileges. Mandatory consultation requirements constitute a reduction in privileges of a member when the requirement is imposed on the individual member and as a continuing requirement in all similar cases.

Patients who have attempted suicide prior to or during their hospitalization, or who have suicidal ideation identified following hospitalization, must be evaluated for suicidal risk prior to discharge. Such evaluation is to be done by a psychiatrist or by a member of the Behavioral Health Services staff who must then review the case with a psychiatrist prior to discharge.

If an inpatient is on an involuntary psychiatric hold (i.e. 5150 or 5152), then a psychiatrist must evaluate the patient directly prior to such a hold being released.

G. <u>PATIENT COVERAGE</u>

Each staff member is responsible to respond to an emergency involving a member's patient or have a substitute staff member respond. In case of failure to respond, the Medical Staff officers or department executive officers of the appropriate department or service shall have the authority to request emergency services from any staff member. When a staff member finds a substitute for coverage of his practice that substitute physician must be a member in good standing of the El Camino Hospital Medical Staff with similar scope of privileges and will assume all duties of the primary physician.

H. <u>HOSPITAL SERVICES</u>

Outpatient diagnostic or therapeutic services may be performed only on request of a Medical Staff member with clinical privileges or practitioners who by training, practice, and California licensure would otherwise qualify for Medical Staff membership or if approved by the Medical Staff Executive Committee.

I. <u>PROCEDURE FOR CREATION OF NEW MEDICAL STAFF DEPARTMENTS</u>

Existing services or divisions of the Medical Staff may be considered for provisional department status if:

1. This is mandated by Joint Commission or Hospital Board of Directors, and
2. A majority of the members of the considered service or division approve, and
3. The considered service or division has at least 15 Medical Staff members.

Procedure for obtaining provisional department status:
Following approval by a majority of its members, a written request shall be forwarded to the Medical Staff Executive Committee. If the Medical Staff Executive Committee grants provisional departmental status, it shall be bound to review the performance of this provisional department after one year. At this review, the Executive Committee may grant full department status or mandate an additional six month provisional period. If an additional six month provisional period is mandated, the Medical Staff Executive Committee will again review the performance of this provisional department at the end of this time and will either grant full department status or will return it to its prior division or service level.

Responsibilities of a provisional Medical Staff department shall include:

1. The establishment of regular meetings at the frequency of not less than quarterly, which must be attended by not less than 50% of its members.
2. The maintenance of minutes that reflect concurrent review of appropriateness of care provided by its members consistent with the Quality Assessment program of the Medical Staff.
3. The review and recertification of its members' privileges in accord with established guidelines.
4. The development of departmental guidelines which are to be submitted to the Medical Staff Executive Committee within three months.
5. The development of member privileging criteria which are also to be submitted for approval to the Medical Staff Executive Committee within three months.

The Chief and Vice-Chief may sit on the Medical Staff Executive Committee during the provisional period, but may not vote until the department has been granted full status.

J. FEES

An applicant to the Medical Staff shall be required to pay $300 as a processing fee. In addition, members of the Medical Staff shall be charged $150 at the time of reapplication.

K. RESIDENTS

1. Nature of Affiliation: Residents engaged in patient care at El Camino Hospital must be post-doctoral trainees (residents or fellows) in training programs of approved teaching institutions which have a contract with El Camino Hospital. Residents must be licensed by the Medical Board of California. They may be authorized to perform clinical duties consistent with their training program, and as outlined in the contract between El Camino Hospital and the residency program and the Medical Staff Guidelines for Supervision of Residents (Medical Staff Policy/Procedure, Section 9). The contracting teaching institution must provide professional liability insurance for residents to cover the performance of all clinical duties at El Camino Hospital. The Medical Staff Executive Committee and Board of Directors shall approve the residency contract. Authorization to perform clinical duties will cease at the completion of an individual physician's rotation or under the terms of the contract. Residents are required to comply in all respects with the Medical Staff Bylaws and Rules and Regulations, departmental or service rules and regulations as well as applicable policies and procedures.

Residents do not enjoy the due process rights afforded Medical Staff members. Moreover, the Medical Staff retains the right to require the immediate suspension or withdrawal of any resident if such action is deemed warranted in order to protect patients or other individuals.

2. Supervision: All clinical care provided by residents shall be under the supervision of a member of the Medical Staff. Guidelines for supervision can be found in the ECH Medical Staff Policies and Procedures, Section 9. All policies related to supervision of residents shall be approved by the Medical Staff Executive Committee.

3. Authorized Activities: A resident may make entries in the patient's medical record as delineated in the Medical Staff Guidelines (Medical Staff Policy/Procedure, Section 9). The extent to which the resident may otherwise participate in patient care services and make entries in the medical record shall be determined by the Supervising Physician and Training Program and shall be consistent with the applicable Guidelines.

L. **ALLIED HEALTH PROFESSIONALS**

Allied Health Professionals ("AHPs") are covered in the Medical Staff policy regarding these practitioners.

M. **DEA Certification Waiver**

Exemption may be granted upon written attestation of the physician that the physician will not prescribe controlled substances in the hospital. The Department Chief and Medical Staff Executive Committee need to concur that a DEA is not required based on the physician's attestation.

Direct Care Clinical Contract Evaluation 2016 March 2017 - 13 contract evaluations completed

Department	Vendor Name and Mailing Address	Contact Info	Scope of Service	MediTract #	Authorizing Manager	Med Staff Cmte Oversight	Completed Y/N
Pediatrics MV& LG	Discharge Resource Group 1150 Bascom Ave, Ste 8 San Jose, CA 95128 400 Oyster Point Blvd, #440 S. San Francisco, CA 94080	Carol Block Director, Pediatric Resources Pediatric@drgstaffing.com 408-885-9000	Physical Therapy Services – Pediatric & NICU Specialty medical services in the areas of discharge planning, utilization review and home health nursing	231	Cheryl Reinking, CNO/ Chief Operations Officer **JUDY LEYDIG**	Dept. of Medicine Exec. Committee	Yes, On July 1,2017 Services transferring to LPCH.
Renal Dialysis (Los Gatos)	Fresenius Medical Care -- Bay Area Acutes 2430 Mariner Sq, Loop #8 Alameda, CA 94501	Cheeno Tenoso princevirgil@FMC-NA.com 510-769-6935	Renal Dialysis	1386	Cheryl Reinking, CNO **JINA CANSON**	Dept. of Medicine Exec. Committee	Yes/ Termination Letter sent 12/16/16 eff. Date 3/31/16
Medicine MV&LG	Mitra Rasti Meister, CNIM P.O. Box 1408 Aptos, CA 95001 831-688-2455	Mitra Rasti Meister, CNIM Mitrameister63@yahoo.com MitraRasti@gmail.com	Electroencephalograph	1693	Cheryl Reinking, CNO PATTI SMITH	Dept. of Medicine Exec. Committee	Contract discontinued
Medicine MV&LG	P&A PICC, LLC 2059 Camden Ave #289 San Jose, CA 95124	Gail Heckler Gail@papicc.com	PICC Insertion	1480	Cheryl Reinking, CNO/ Chief Operations Officer **CHRIS TARVER**	Dept. of Medicine Exec. Committee	Yes
Surgery MV	Pacific Life Lines 3481 La Mesa Drive San Carlos, CA 94070	Paul Shuttleworth PO Box 27573 South SF, CA 94127 pllccp@yahoo.com 650-799-8991	Perfusion Services - Cardio	808	Cheryl Reinking, CNO/ Chief Operations Officer SHELLY REYNOLDS	Cardiovascular Surgery	YES
Pediatrics MV & LG	Pediatrix Medical Group 770 The City Drive South, Ste 4000 Orange, CA 92868	Jeryl Barganski 602-256-4628 jeryl_Barganski@pediatrix.com	Infant Hearing Screening	1581	Cheryl Reinking, CNO/ Chief Operations Officer DEBBIE GROTH	Dept. of Pediatric Exec. Committee	YES

Direct Care Clinical Contract Evaluation 2016 March 2017 - 13 contracts evaluations completed

Department	Vendor Name and Mailing Address	Contact Info	Scope of Service	MediTract #	Authorizing Manager	Med Staff Cmte Oversight	Completed Y/N
Surgery MV&LG	Blood Guys 1970 Fairway Oaks Drive Ripon, CA 95366	Anderson Ward, President 209-345-1200 (Direct) andy@bloodguys.com 1-888-841-4206 (General)	Auto transfusion		Cheryl Reinking, CNO/ Chief Operations Officer SHELLY REYNOLDS	Dept. of Surgery and Ortho	YES
Medicine and Surgery MV&LG	Language Line One Lower Ragsdale Dr, Bldg2 Monterey, CA 93940	Michelle Garlow MGarlow@languageline.com	Interpreter Services	1004.163C	Cheryl Reinking, CNO/ Chief Operations Officer RJ SALUS	All Departments	YES
Mother/Baby	Deaf Services of Palo Alto, Inc. PO Box 60651 Palo Alto, CA 94306	Please contact either Debbie Ojala or Jody Charles for contact info	Interpreter Services		Cheryl Reinking, CNO/ Chief Operations Officer **RJ SALUS**	Mother/Baby	No 4/2016, Amend sent to vendor/no response. Contact terminated
Medicine MV & LG	RehabCare Group, Inc. 7733 Forsyth Blvd, Ste 2300 Clayton, MO 63105	Lynnae Brady Lynnae.Brady@elcaminohospital.org	Physical, Occupational, Speech Therapy, Social Services	1004.1734E	Cheryl Reinking, CNO Kris M.	Dept. Medicine MV & LG	YES
Medicine	Apheresis Group 1700 California Street, #350 San Francisco, CA 94109	sheila.smith@FMC-NA.com 415-928-1352	Therapeutic Apheresis		Cheryl Reinking, CNO **JINA CANSON**		Yes
Surgery	SpecialtyCare, Inc. IOM Services, LLC One American Center 3100 West End Avenue, Suite 800 Nashville, TN 37203	Nancy M. Jones, BSN, RN Vice President, Business Dev. West 916-281-9797 Nancy.jones@specialtycare.net	Neuromonitoring		Cheryl Reinking, CNO/ Chief Operations Officer SHELLY REYNOLDS	Dept. of Surgery	YES
Medicine	AKSM/Oncology Management, LLC 100 West Third Avenue, Suite 350 Columbus, OH 43201	Don Jackson National Clinical Director 843-670-5452 djackson@aksm.com	Physicist		Cheryl Reinking/CNO MONICA HITE		YES

Direct Care Clinical Contract Evaluation 2016 March 2017 - 13 contract evaluations completed

Department	Vendor Name and Mailing Address	Contact Info	Scope of Service	MediTract #	Authorizing Manager	Med Staff Cmte Oversight	Completed Y/N
	Blood Centers of the Pacific 270 Masonic Ave San Francisco, CA 94118 ***PLEASE NOTE THIS WILL BE INCLUDED FOR 2015 MAILING	Debbie Spencer Customer Account Manager Blood Centers of the Pacific 2324 Bethards Drive, Santa Rosa, CA 95405 707-548-1989 | efax 707-293-2761 DSpencer@bloodcenters.org	Provision of blood services for MV and LG	1004.2832C	Cheryl Reinking, CNO/ Chief Operations Officer **EDWINA SEQUIERA**	Transfusion Committee	Contract cancelled ends Nov. 2017. Metrics returned for 2016
	Applied Orthotics & Prosthetics, Inc. 2577 Samaritan Drive San Jose, CA 95124	Michael J. Dodd mikedodd@appliedop.com	Orthotics and prosthetics for LG		Cheryl Reinking, CNO **JUDY LEYDIG**		Yes
	Bullseye Translation, LLC	Bullseye Translation, LLC t 925.998.8961 f 650.832.1099 http://www.bullseyetranslation.com/	Translation Services		Cheryl Reinking, CNO/ Chief Operations Officer RJ SALUS		Discontinued

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:____DRG Resourse Group ____________________

Nature of Service:______Physical Therapy Svs for Pediatric and NICU ______________________

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	Yes	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	Yes	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	Yes	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	Yes	Unable to meet requirement of organizations quality improvement program
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to -- as applicable to the scope and nature of the contract service -- improve health outcomes and the prevent and reduce medical errors.	Yes	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
None Submitted				

Comments (Required if contract does not meet expectation in any area.)
Director of DRG stated that she had consulted with Nursing Leadership and explained that she was unable To Determine meaningful performance improvement metrics excusing participation in this requirement.

Conclusion (check one)

☒ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☒ Other: Will be transferring services to LPCH by beginning of new fiscal year

Vendor Contact (Print Name) Carol Block DRG Pediatric Resource Group-Carol Block	Title Director Director of Pediatric Resources
Signature [signature]	Date 3/15/17
Responsible ECH Director Judy Leydig	Title Director of Rehabilitation Services
Signature [signature: Judy Leydig]	Date 3/115/17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: Fresenius Medical Care

Nature of Service: Dialysis Services

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
Staff Credentials	100%	100%	100%	100%
Treatment Record	98.3%	98.6%	100%	100%
Water Quality	100%	100%	100%	100%
Patient Safety measures	100%	100%	100%	100%
Infection Control	100%	100%	100%	100%
Patient Satisfaction Goal >4.0	5	5	5	5

Comments (Required if contract does not meet expectation in any area.)

Conclusion (check one)

✓ Contract service has met expectations for the review period

Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☑ The contractual agreement has been terminated without disruption in the continuity of patient care – 4/2017
- ☐ Other:

Vendor Contact (Print Name) Ken Membreve	Title Director of Operations
Signature K. Membreve RN	Date 3/17/2017
Responsible ECH Director (Print Name) Tina Canson	Title Director Patient Care Resources
Signature JCanson	Date 3-17-17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:_____ P&A PICC, LLC
Nature of Service:____PICC line insertion____

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	X	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	X	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016	Annual
# PICC/Midlines placed – LG/MV	13/71	12/42	7/80	16/62	48/255
# P:IV's were placed – LG/MV	0/0	0/0	0/2	0/4	0/6
# CVC assessments,declots,repositions, dressing chg	1/3	2/2	0/0	0/3	3/8
# pts w/ pain, phlebitis/sweeling, sepsis, malposition	0/0	0	0/0	0/0	0/0
# of physician and patient compliants	0/0	0	0/0	0/0	0/0
Annual Competency completion					100%

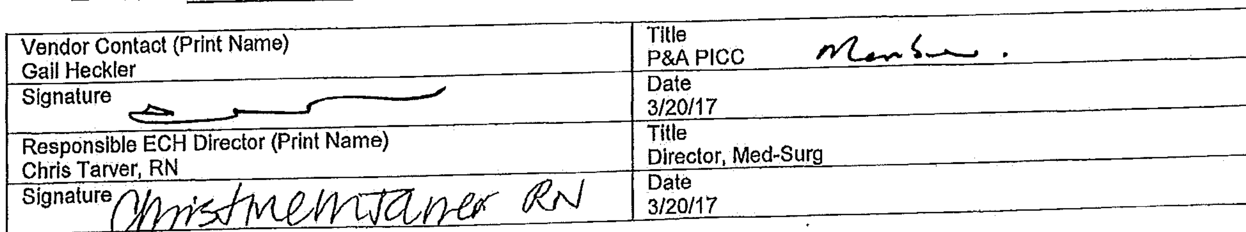
Comments (Required if contract does not meet expectation in any area.)

____

____

Conclusion (check one)

- ☐ Contract service has met expectations for the review period
- ☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
  - ☐ Monitoring and oversight of the contract service has been increased
  - ☐ Training and consultation has been provided to the contract service
  - ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
  - ☐ Penalties or other remedies have been applied to the contract entity
  - ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
  - ☐ Other: ______________________________



Vendor Contact (Print Name) Gail Heckler	Title P&A PICC
Signature	Date 3/20/17
Responsible ECH Director (Print Name) Chris Tarver, RN	Title Director, Med-Surg
Signature	Date 3/20/17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: Pacific Life Lines

Nature of Service: Cardiovascular Perfusion Services

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	Jan-June 2016	July – Dec 2016	Annual
80% of cases will use <1200 cc prime volume	93%	95%	94%
80% of cases will have highest pH values < 7.50	100%	92%	96%
80% of cases will have lowest pH values >7.30	96%	81%	88.7%
80% of cases will have < 12 drop in HCT on initiation of CPB	94%	84%	88.9%
80% of cases will have lowest SV02 > 65%	100%	98%	98.8%
80% of cases will have Last SV02 >65%	100%	100%	100%
Heater – Cooler Cleaning Status	92.31%	100%	
Annual recertification of perfusionists			100%

Comments (Required if contract does not meet expectation in any area.)

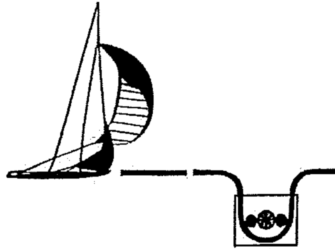
Conclusion (check one)

☑ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ____

Vendor Contact (Print Name) Mary Ann Overton	Title Lead perfusionist
Signature Mary Ann Overton	Date 3/21/17
Responsible ECH Director (Print Name) Shelly Reynolds	Title Director - Peri-Op r FS
Signature Shelly Reynolds	Date 3-21-17

Perfusion Quality Report: 2016



This report presents the results of the indicators selected for 2016 to track the perfusion quality at El Camino

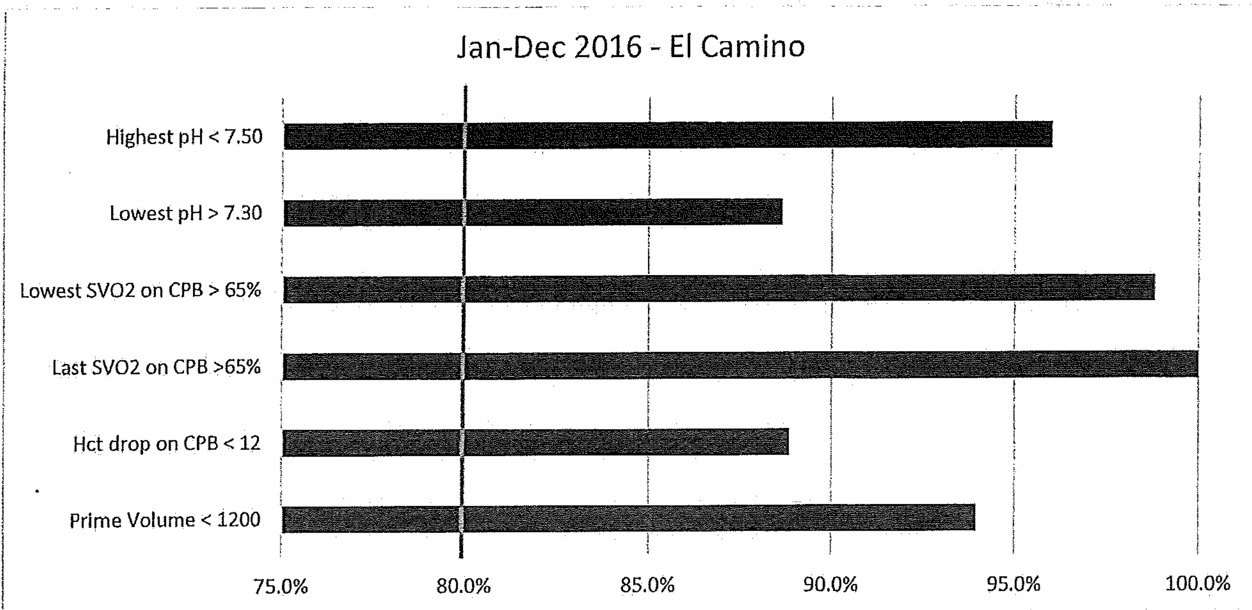
Month		Services Volumes		CPB	Perf STBY	IABP	CathLab Cases	Platelet Phresis	Cardiac Assist
Jan-Dec2016				276	27	5	104	0	4

1. Service provider shall maintain evidence of yearly competencies appropriate for services rendered.

INDICATORS

1 - 80% of cases will use < 1200 cc prime volume:
Selected as one indication in our process to reduce dilution, therefore help reduce blood product usage.
2 - 80% of cases will have highest pH values < 7.50
80% of cases will have lowest pH values > 7.30
pH value is an indication of quality of perfusion while patient is on the heart-lung machine.
3 - 80% of cases will have < 12 drop in HCT on initiation of CPB:
An additional indicator to prevent dilution utilizing techniques such as autologous priming of the heart-lung circuit. If the drop in HCT is small, less dilution occurred.
4 - 80% of case will have the lowest SVO2 > 65%:
Venous Saturation is indication of the quality of perfusion provided by the heart-lung machine while on bypass.
5 - 80% of case will have the Last SVO2 > 65%:

Summary of all indicators show in all areas of performance the 80% goal was achieved.



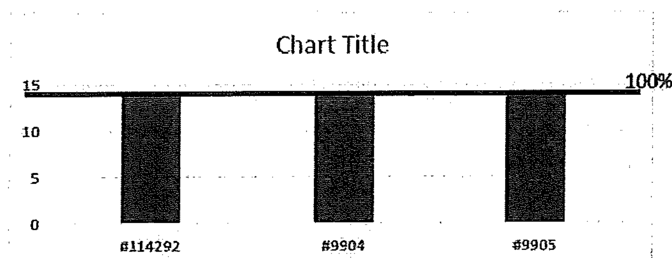
Certifications from the American Board of Cardiovascular Perfusion are sent to the Medical Staff Office each year at the end of December, the certificates should be on file. Certificates are included in this email.

Continuing Education CEU/ContactHr: The American Board of Cardiovascular Perfusion requires each perfusionist to attend 45 hours of continuing education every 3 yrs to maintain certification. If the perfusionist is a Certified Clinical Perfusionist (CCP), as denoted by the attached certificates, they have completed the continuing education requirement of the American Board.

2. Service provider shall maintain equipment to include proper cleaning between procedures and perform regular quality control checks.

Heater.Cooler Cleaning Status:

July-Dec 2016 28 weeks **100.00 %**
Hosp: ELC
Protocol: Water change with Hydrogen Peroxide every other week.



# of Events:	42	"Pass"	42	Pass %	100.00

Machines			
	#114292	14	14 out of 14
	#9904	14	14 out of 14
	#9905	14	14 out of 14

3. Any substantiated patient or staff complaints against Service Provider or its representative(s) shall be grounds for substituting such service Provider representative or termination of the agreement.

Pacific Life Lines received no patient or physician complaints regarding our care at El Camino Hospital in the period Jan-Dec 2016.

Please let me know if you need additional information.

Sincerely,

PShuttleworth

Paul Shuttleworth, BSN, MBA
Chief Perfusionist
Pacific Life Lines, Inc.
650-321-9999

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: Pediatrix Medical Group

Nature of Service: Infant Hearing Screening

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	Jan – Dec 2016
Performance of quality control tests, action plan for failures	N/A no failures test performed monthly
# of infants screened and pass rates	4137 99.52%
Staff training and bi-annual competencies	Staff QA's performed June + Dec, CA HS competencies performed Dec 2016
Minimum of 95% of hearing screening within 48 hrs of baby's life	yes
100% of eligible NICU infants to be screened prior to discharge	yes
Volume of hearing screening	4137

Comments (Required if contract does not meet expectation in any area.)

____

____

Conclusion (check one)

- ☑ Contract service has met expectations for the review period
- ☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
  - ☐ Monitoring and oversight of the contract service has been increased
  - ☐ Training and consultation has been provided to the contract service
  - ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
  - ☐ Penalties or other remedies have been applied to the contract entity
  - ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
  - ☐ Other: ______________________

Vendor Contact (Print Name) Teryl Barganski	Title Regional Hearing Scrn. Manager
Signature [signature]	Date 3/18/17
Responsible ECH Director (Print Name) Debbie Groth	Title Director MCH
Signature [signature]	Date 3/17/17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: Pediatrix Medical Group

Nature of Service: Infant Hearing Screening for LG

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	Jan – Sept 2016	4th Qtr 2016
Performance of quality control tests, action plan for failures	completed monthly no failures	
# of infants screened and pass rates	454 - 99.34%	157 - 99.36%
Staff training and bi-annual competencies	Staff OAS performed June + Dec,	CA HS competencies performed in Dec 2016
95% of hearing screening w/i 48 hrs of baby's life	yes	yes
100% of eligible NICU infants to be screened prior to discharge	yes	yes
Volume of hearing screening	454	157

Comments (Required if contract does not meet expectation in any area.)

Conclusion (check one)

☑ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other:

Vendor Contact (Print Name) Teri Barganski	Title Regional HS Manager
Signature [signature]	Date 3/16/17
Responsible ECH Director (Print Name) Jacqueline	Title CT Manager
Signature [signature]	Date 3/

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:_____ _Blood Guys Operations__________

Nature of Service:____Blood Services____

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	1st Qtr	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016	Annual
Lab testing Hematocrit/Potassium Post Wash	60% / 2%	66% / 1.1 %	44.1% / 0.8 %	60.5 %/ 1.7 %	
Annual Staff Competency					100%
Annual Staff Education (7 modules)					100%

Comments (Required if contract does not meet expectation in any area.)

____

____

Conclusion (check one)

☑ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ____

Vendor Contact (Print Name) KYLE NEEDHAM	Title MANAGER
Signature [signature]	Date 3-15-17
Responsible ECH Director (Print Name) Shelly Reynolds	Title Director - Peri-Op + IS
Signature Shelly Reynolds	Date 3-15-17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: Language Line Solutions
Nature of Service: Interpreter Services

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	X	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	X	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
Please see attached Service Metrics for 2016				

Comments (Required if contract does not meet expectation in any area.)

Conclusion (check one)

X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ______

Vendor Contact Michelle Garlow	Title Premier Account Executive
Signature DocuSigned by: Michael F. Schmidt C4899DFDED494D7...	Date 3/17/2017
Responsible ECH Director (Print Name)	Title
Signature	Date

DocuSign Envelope ID: 5DA16708-BBDD-474D-BE8A-C7543CFAD567

Customer Service Metrics, El Camino Hospital

From 01-01-2016 Through 12-31-2016 Units: US, Canada, JMO, LL London, NIS, Tangerine

	Billable Calls	Lost Calls	Connect Time (seconds)							Hang-Ups			
			Actual	1-10	11-20	21-30	31-45	46-60	60+	0-15 sec	16-60 secs	61+ secs	Total
I. Total All Languages	6,859	5	22.7	3,316	2,196	496	272	105	474	131	30	79	240
II. Emergency 911	6,859	5	22.7	3,316	2,196	496	272	105	474	129	30	79	238
III. Language Group													
SPA	2,766	0	14.4	1,637	789	139	77	35	89	30	6	14	50
%	40.3%	.0%		59.2%	28.5%	5.0%	2.8%	1.3%	3.2%				
NEXT9	3,385	3	27.7	1,441	1,114	307	165	40	318	47	19	63	129
%	49.4%	60.0%		42.6%	32.9%	9.1%	4.9%	1.2%	9.4%				
OTHER	708	2	31.5	238	293	50	30	30	67	54	5	2	61
%	10.3%	40.0%		33.6%	41.4%	7.1%	4.2%	4.2%	9.5%				
Total All Languages	6,859	5	22.7	3,316	2,196	496	272	105	474	131	30	79	240
%				48.3%	32.0%	7.2%	4.0%	1.5%	6.9%				
IV. Language Detail													
SPA													
SPA	2,766	0	14.4	1,637	789	139	77	35	89	30	6	14	50
Subtotal SPA	2,766	0	(15.6)	1,637	789	139	77	35	89	30	6	14	50
NEXT9													
MAN	1,664	2	31.2	687	488	173	110	24	182	21	10	40	71
VIE	310	0	33.0	116	106	36	8	1	43	5	2	8	15
KOR	204	1	28.5	72	77	23	9	4	19	5	2	3	10
RUS	914	0	19.7	454	330	48	19	9	54	10	3	11	24
CAN	205	0	23.7	79	78	22	16	0	10	3	2	0	5
ARA	39	0	35.2	10	17	4	0	1	7	2	0	0	2
POR	28	0	21.3	12	13	1	1	0	1	1	0	1	2
POL	6	0	5.5	6	0	0	0	0	0	0	0	0	0
FRE	15	0	64.9	5	5	0	2	1	2	0	0	0	0
Subtotal	3,385	3	(17.3)	1,441	1,114	307	165	40	318	47	19	63	129
OTHER													
JPN	256	0	35.2	89	83	22	13	19	30	4	3	0	7
FAR	153	0	31.0	49	79	10	3	1	11	0	1	1	2
HIN	47	0	27.9	10	20	4	2	8	3	0	0	1	1

Customer Service Metrics, El Camino Hospital

From 01-01-2016 Through 12-31-2016 Units: US, Canada, JMO, LL London, NIS, Tangerine

Language	Billable Calls	Lost Calls	Connect Time (seconds)							Hang-Ups			
			Actua	1-10	11-20	21-30	31-45	46-60	60+	0-15 sec	16-60 secs	61+ secs	Total
CHIN	1	0	4.0	1	0	0	0	0	0	0	0	0	0
ALB	0	0	0.0	0	0	0	0	0	0	0	0	0	0
UKR	0	0	0.0	0	0	0	0	0	0	1	0	0	1
SLO	0	0	0.0	0	0	0	0	0	0	1	0	0	1
SAM	0	0	0.0	0	0	0	0	0	0	0	0	0	0
LAO	0	0	0.0	0	0	0	0	0	0	0	0	0	0
MAL	0	0	0.0	0	0	0	0	0	0	0	0	0	0
HAI	0	0	0.0	0	0	0	0	0	0	0	0	0	0
ENG	0	0	0.0	0	0	0	0	0	0	37	0	0	37
Subtotal	708	2	(28.5)	238	293	50	30	30	67	54	5	2	61
Total All Languages	6,859	5	22.7	3,316	2,196	496	272	105	474	131	30	79	240

Notes

Billable	Billable refers to "likely billable", where the call's dontbill flag is false, the call has an interpreter, and the billing duration is greater than .1 minutes. This is a measure that is unique to the Service Metrics report and will not match older reports that only look at the call's dontbill flag. Connect Times stats are compiled against billable calls only. Availability, Lost, Longest Call, and Hangups are compiled for all calls.
Billable Calls	Total number of calls less non-billable calls.
Lost Calls	Number of call records with a call exception status code of 'L'. Warning, because lost calls are non-billable, occasionally Availability will be negative.
Connect Time	After customer data has been collected, the time it takes to connect to the appropriate interpreter (same as "search time").
1-10	Number of calls where the connect time was within 1-10 seconds.
11-20	Number of calls where the connect time was within 11-20 seconds.
21-30	Number of calls where the connect time was within 21-30 seconds.
31-45	Number of calls where the connect time was within 31-45 seconds.
45-60	Number of calls where the connect time was within 45-60 seconds.
60+	Number of calls where the connect time was greater than or equal to 60 seconds.
Hangups	
<= 60 secs	Number of hang-ups that occurred less than or equal to "n" seconds into the call.
61+secs	Number of hang-ups that occurred greater than "n" seconds into the call.
Total	Total number of hang-up calls.

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: RehabCare Group Inc.

Nature of Service: Acute Rehabilitation Unit

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
CMI	1.35	1.42	1.36	1.23
Discharge to Community	78%	80%	82%	83%
FIM Gain	27	29	30	26
Average LOS	13.95	13.35	13.11	12.42

Comments (Required if contract does not meet expectation in any area.)

Conclusion (check one)

☒ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other:

Vendor Contact (Print Name) Lynnae Brady	Title Program Director
Signature L Brady	Date 3-17-17
Responsible ECH Director (Print Name) Kris Malmsheimer	Title Director
Signature [signature]	Date 3-17-17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:_____ Apheresis Group
Nature of Service:_____Therapeutic Apheresis ______________________

Review Period: January 1, 2016 – December 31, 2016 (Mt View)

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
Staff Credentials	100%	100%	100%	100%
Treatment Record	N/A	N/A	N/A	100%
Infection Control	N/A	N/A	N/A	N/A
Patient Observation	N/A	N/A	N/A	100%
Patient Satisfaction	N/A	N/A	N/A	100%
Facility Satisfaction	N/A	N/A	N/A	N/A

Comments (Required if contract does not meet expectation in any area.)

N/A =No treatment during those Quarter

Conclusion (check one)

X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ______________________

Vendor Contact (Print Name) Ken Membrew	Title Director of Operations
Signature K. Membrew, RN	Date 3/17/2017
Responsible ECH Director (Print Name) Tina Canson	Title Director Patient Care Resources
Signature TCanson	Date 3-17-17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:_____ Apheresis Group
Nature of Service:_____Therapeutic Apheresis ________________________

Review Period: January 1, 2016 – December 31, 2016 (Los Gatos)

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
Staff Credentials	100%	100%	100%	100%
Treatment Record	N/A	N/A	N/A	N/A
Infection Control	N/A	N/A	N/A	N/A
Patient Observation	N/A	N/A	N/A	N/A
Patient Satisfaction	N/A	N/A	N/A	N/A
Facility Satisfaction	N/A	N/A	N/A	N/A

Comments (Required if contract does not meet expectation in any area.)

N/A =No treatment during those Quarter

Conclusion (check one)

X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ________________________

Vendor Contact (Print Name) Ken Membreno	Title Director of Operations
Signature K. Membreno, RN	Date 3/17/2017
Responsible ECH Director (Print Name) Tina Canson	Title Director Patient Care Resources
Signature JCanson	Date 3-17-17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:_____ _SpecialtyCare Inc, IOM Services_______

Nature of Service:________Intraoperative Neuromoniting____________________

Review Period: **January 1, 2016 – December 31, 2016**

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	✓	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	✓	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	✓	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	✓	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	✓	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016

Comments (Required if contract does not meet expectation in any area.)

____

____

Conclusion (check one)

- ☒ Contract service has met expectations for the review period
- ☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
  - ☐ Monitoring and oversight of the contract service has been increased
  - ☐ Training and consultation has been provided to the contract service
  - ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
  - ☐ Penalties or other remedies have been applied to the contract entity
  - ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
  - ☐ Other: ____________________

Vendor Contact (Print Name)	Title
Signature	Date
Responsible ECH Director (Print Name) SHELLY REYNOLDS	Title Director - Peri-op + IS
Signature	Date 3/20/17

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:_____ ___ASKM Oncology Management
Nature of Servic___________Medical Physics Services________________________________

Review Period: January 1, 2016 – December 31, 2016

Evaluation	**Met Expectation**	**Did Not Meet Expectation**
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.		
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.		
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.		
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.		
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.		

Performance Metrics

Metric	**1st Qtr 2016**	**2nd Qtr 2016**	**3rd Qtr 2016**	**Annual 2016**
Patient or Physician complaints regarding Physics Svs.				None
CyberKnife Calcs				1030
CyberKnife Txs				229
Standard Plans				140
IMRT Plans				88
Basic Dosimetry Calcs				1332
Physics Consultations				1034
HDR Tsc				73
Respiratory Management				46
Annual continuing Education/ Licensse				complete

Conclusion (check one)

☐ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ______________________________

Vendor Contact (Print Name) DON JACKSON. ASKM ONC. Mgt	Title
Signature	Date
Responsible ECH Director (Print Name) MONICA NITTE	Title ~~Director~~ CLINICAL MANAGER
Signature	Date 3/20/2017

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: **Blood Centers of the Pacific**

Nature of Service: **Blood Bank Services**

Review Period: **January 1, 2016 – December 31, 2016**

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	X	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	X	

Performance Metrics

Metric (combined MV & LG locations)	Target	2016 Average
Net distribution – Product Utilization Rate	85%	89.97%
Overall Fill Rate - % Units Shipped	90%	94.57%
O-Neg Fill Rate - % Units Shipped	90%	61.48%

Comments (Required if contract does not meet expectation in any area.)

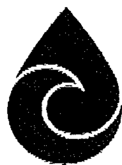
- 2016 Annual Data was provided. Quarterly data will be submitted for 2017.
- Detail data for individual campuses (MV & LG) are attached.
- There has been a shortage of O-negative donor units nationwide. BCP has done their best retreiving units from across the country and calling in donors during severe crisis periods. Fortunately the shortage did not impact any of our patients at ECH – we have only had difficulty filling our par inventory level. We have initiated 2 service meetings with BCP representatives in recent months. BCP is now sending daily inventory fill data to each laboratory and the communication with the new BCP rep has improved.

Conclusion (check one)

X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ______

Vendor Contact (Print Name) Fred McFadden	Title Customer Account Manager, Hospital Services
Signature	Date
Responsible ECH Director (Print Name) Edwina Sequeira	Title Director of Laboratory & Pathology Services
Signature *Edwina Sequeira*	Date March 20, 2017



Blood Centers *of the* Pacific

a member of the Blood Systems Family

Irwin Center
270 Masonic Avenue
San Francisco, CA 94118
PH: 415/567-6400
FAX: 415/921-6184

2016 El Camino Hospital Usage Reports Information

- Net Distribution - by Product Category - by Location

Facility Name	Final Product Group	Metrics	Ship Quantity	Return Quantity	Net Quantity	Utilization Rate
EL CAMINO HOSPITAL	Cryoprecipitate		5	0	5	100.00%
	Pedi Plasma		48	0	48	100.00%
	Platelets		1,812	784	1,028	56.73%
	Pooled Cryo		109	1	108	99.08%
	RBC		5,326	125	5,201	97.65%
	Single Plasma		1,123	0	1,123	100.00%
El Camino Hospital Los Gatos	Platelets		369	302	67	18.16%
	Pooled Cryo		15	0	15	100.00%
	RBC		1,144	495	649	56.73%
	Single Plasma		158	0	158	100.00%

- Net Distribution - by Product Category - Both Locations Combined

Customer Parent	Final Product Group	Metrics	Ship Quantity	Return Quantity	Net Quantity	Utilization Rate
	Cryoprecipitate		5	0	5	100.00%
	Pedi Plasma		48	0	48	100.00%
	Platelets		2,181	1,086	1,095	50.21%
	Pooled Cryo		124	1	123	99.19%
	RBC		6,470	620	5,850	90.42%
	Single Plasma		1,281	0	1,281	100.00%

$\bar{X} = 89.97\%$

- Overall Fill Rate - by Product Category - Both Locations Combined

Account Parent	Product Family Description	Order Qty	Ship Qty	% of Units Shipped
	Plasmas	1,364	1,323	96.99%
	Platelets	2,259	2,155	95.40%
	Red Cells	7,079	6,465	91.33%

$\bar{X} = 94.57\%$

- Overall Fill Rate - by Product Category - by Location

Account Name	Product Family Description	Order Qty	Ship Qty	% of Units Shipped
EL CAMINO HOSPITAL	Plasmas	1,209	1,171	96.86%
EL CAMINO HOSPITAL	Platelets	1,882	1,788	95.01%
EL CAMINO HOSPITAL	Red Cells	5,820	5,319	91.39%
El Camino Hospital Los Gatos	Plasmas	155	152	98.06%
El Camino Hospital Los Gatos	Platelets	377	367	97.35%
El Camino Hospital Los Gatos	Red Cells	1,259	1,146	91.02%

- O-Neg Fill Rate - by Location

Account Name	Account Number	Order Qty	Ship Qty	% of Units Shipped
EL CAMINO HOSPITAL	0000712090	781	474	60.69%
El Camino Hospital Los Gatos	0000710999	221	142	64.25%

- O-Neg Fill Rate - Both Locations Combined

Account Parent	Order Qty	Ship Qty	% of Units Shipped
	1,002	616	61.48%

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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service:_____ Applied Orthotics and Prosthetics, Inc.

Nature of Service:____Orthotics and Prosthetics for Los Gatos_________

Review Period: January 1, 2016 – December 31, 2016

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	Yes	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	Yes	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	Yes	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	Yes	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, equitable, patient centered and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	Yes	

Performance Metrics

Metric	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
Brace Adjustment	Yes	-	-	-
Patient Satisfaction	Yes	Yes	Yes	Yes
Patient Complaints	Yes			

Comments (Required if contract does not meet expectation in any area.)

____

____

Conclusion (check one)

☐ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply:)
- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ______________________________

Vendor Contact (Print Name) Mike Dodd	Title Owner Orthotics and Prosthetics for Los Gatos
Signature	Date
Responsible ECH Director (Print Name) Judy Leydig	Title Director of Rehabilitation Services
Signature Judy A. Leydig	Date 3/10.2017

February 2017 Summary Report Quality Committee

NEW POLICIES			
Policy Name	**Department**	**Date**	**Summary of Policy Changes**
POLICIES WITH MAJOR REVISIONS			
Policy Name	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
POLICIES WITH MINOR REVISIONS			
Policy Name	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
Inspection and Testing	Facilities	1/17	Combined 8 inspection policies into 1
Preventive Maintenance	Facilities	1/17	Combined 9 maintenance policies into 1
POLICIES WITH NO REVISIONS - REVIEWED			
Policy Name	**Department**	**Review or Revised Date**	

El Camino Hospital®

THE HOSPITAL OF SILICON VALLEY

Capital Facilities Project Update > $2.5m

April 12, 2017

Ken King

Chief Administrative Services Officer

Informational Update

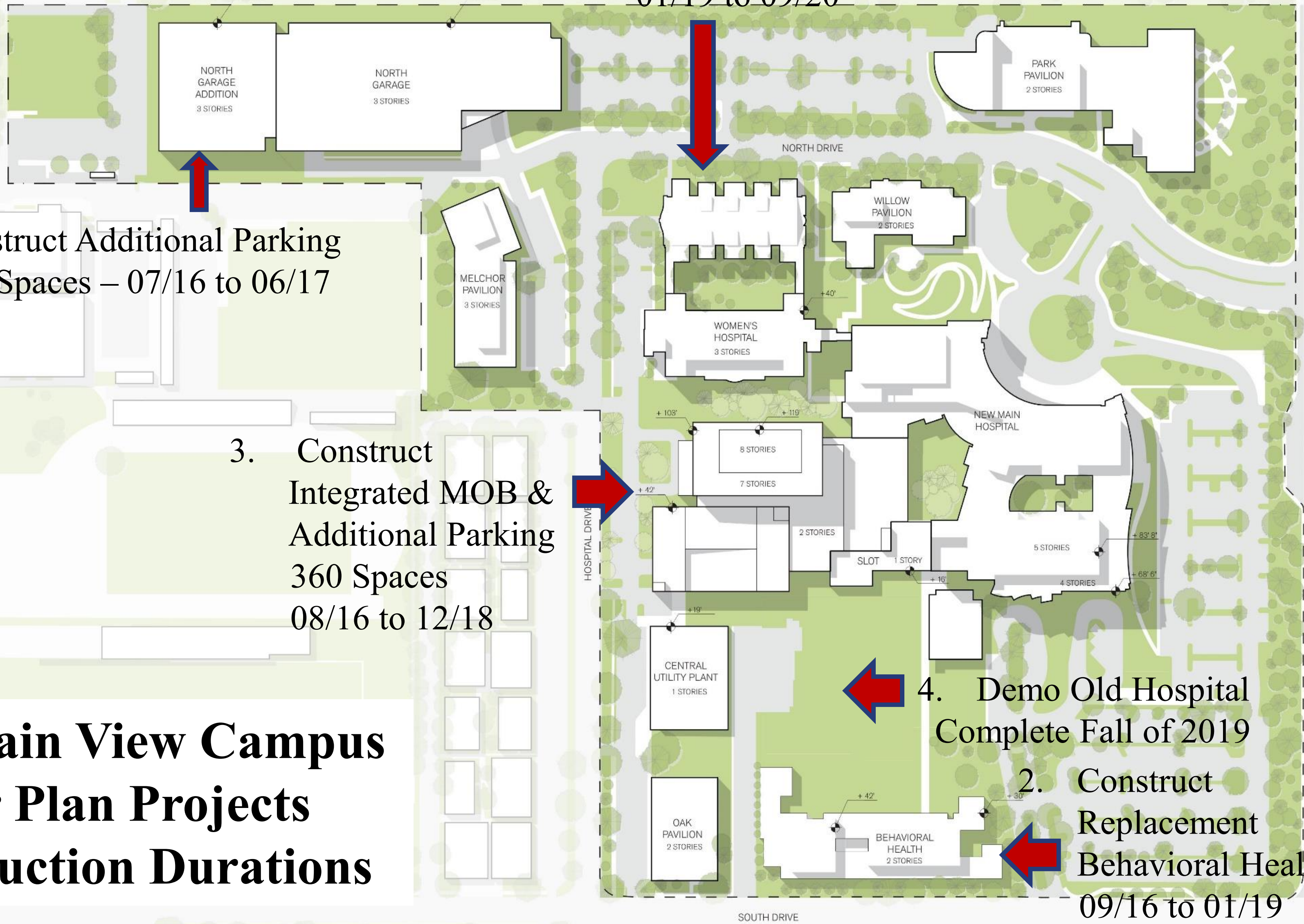
- This Capital Facilities Project Update regarding projects over $2.5 million is provided for information only.
- Update Outline
  - Project List – Projects > $2.5m
  - Project Updates

Project List

Projects > $2.5M

	Project #	Project Name	Total Estimated Cost	Board Approved Funding to Date	Anticipated Future Funding Request	Note
MV Campus Master Plan Projects	1245	BHS Replacement	91,500,000	91,500,000	?	GMP Final Negotiation
	1413	North Dr Parking Structure Expansion	24,500,000	24,500,000	0	Construction
	1414	Integrated Medical Office Building	275,000,000	275,000,000	?	GMP Final Negotiation
	1422	CUP Upgrades	9,000,000	9,000,000	0	Construction
	1430	Womens Hosp Expansion	91,000,000	1,000,000	90,000,000	Design
MV Capital Projects	1425	IMOB Preparation Project - Old Main	2,990,000	2,990,000	0	Substantially Complete
	1502	Cabling and Wireless upgrades	2,800,000	2,800,000	0	Substantially Complete
	1525	New Main Lab Upgrades	3,100,000	3,100,000	0	OSHPD Plan Review
	1602	JW House (Patient Family Residence)	2,500,000	0	2,500,000	Feasibility Assessment
Los Gatos Capital Projects	1219	LG Spine Room Expansion - OR 4	4,100,000	4,100,000	0	Substantially Complete
	1313	LG Rehab HVAC Upgrades	3,700,000	3,700,000	0	Substantially Complete
	1248	LG Imaging Phase II & Sterile Processing	8,750,000	8,750,000	0	Construction
	1307	LG Upgrades - Major	19,500,000	17,300,000	2,200,000	Construction
	1603	LG MOB Improvements (17)	5,000,000	5,000,000	0	City Plan Review
Other	1606	828 Winchester - Primary Care Clinic	3,400,000	0	3,400,000	Schematic Design

Construction Durations



5. Expand to Upper Floors
01/19 to 09/20

1. Construct Additional Parking
400 Spaces – 07/16 to 06/17

3. Construct
Integrated MOB &
Additional Parking
360 Spaces
08/16 to 12/18

4. Demo Old Hospital
Complete Fall of 2019

2. Construct
Replacement
Behavioral Health
09/16 to 01/19

Mountain View Campus
Master Plan Projects
Construction Durations

Behavioral Health Services Building Project Site

North Garage – Top Level View

Integrated Medial Office Building Project Site

Mountain View Campus Development Projects Status Update

- Behavioral Health Services (BHS) Building - $91.5m
  - Increment #1 Demolition and Construction of site elements is nearly complete and OSHPD Plan Approval of Increment #2 (New Building) was finally received in mid-March after 27 months of reviews and back checks. The contractor is finalizing the GMP Proposal and initial indicators point to higher than projected costs for various elements of construction. Schedule critical elements have been released and construction of the new building will begin in the next two weeks. Final negotiations of GMP may require additional project funding.
- North Parking Garage Expansion - $24.5 m
  - The construction of the North Garage Expansion is progressing well with the initial occupancy anticipated in the first week of May 2017. The date for substantial completion of construction including the installation of Solar Panels is early June 2017. This project is projected to be completed within budget.
- Integrated Medical Office (IMOB) Building - $275 m
  - The Demolition and Site Utilities Phases are complete and we are currently awaiting the excavation and foundation permits from the City of Mountain View, which are contingent on the approval from OSHPD of the "Examination Project". The OSPHD Examination Project is the method we were required to follow due to the proximity and impact of the new non-OHSPD structures on the existing OSHPD utility tunnels and New Main Hospital structures. This includes a foundation pile test protocol that both jurisdictions must approve. Permits are expected to be released in the next few weeks. The contractor is finalizing the GMP Proposal and initial indicators point to higher than projected costs for various elements of construction. Schedule critical elements have been released and construction of the new building will begin as soon as permits are received. Final negotiations of GMP may require additional project funding.

Mountain View Campus Development Projects Update - Continued

- Central Utility Plant (CUP) Upgrades - $9 m
  - The OSHPD Permit for this project has been issued and we are in the process of finalizing the GMP with the contractor. It is projected that this project will be within the approved budget. Schedule critical elements have been released and the critical path construction elements are underway. There are currently no problems anticipated for completing the upgrades in time to support the new BHS and IMOB projects.
- Women's Hospital Expansion - $91 m
  - To date we have engaged the design team, the construction manager / general contractor and various consultants to evaluate and document the existing building components and prepare schematic plans. The target timeline is to develop this project through design development by the August 2017 and plan final plan submission to OSHPD in early 2018. A funding request for this work has been submitted. The project is preliminarily estimated to cost $91 million. A detailed cost estimate with various options to consider will be an element of the completed design development phase. This will allow for a more precise projection of costs for the project.

Mountain View Capital Projects Status Update

- IMOB Preparation Project – Old Main Hospital - $2.99 m
  - This project to make necessary improvements to house service and support functions in the old main hospital is substantially complete and in the closeout phase. It will be closed out approximately $33,000 below the approved budget.
- Cabling and Wireless Upgrades - $2.8 m
  - This project to reroute the incoming MPOE and primary cabling infrastructure along with required wireless network upgrades is substantially complete and in the closeout phase. It will be closed out approximately $48,000 below the approved budget.
- New Main Lab Upgrades - $3.1 m
  - This project was approved by the Board in January 2017 and plans are currently in OSPHD Review. Key equipment has been ordered and preparations not requiring a building permit are underway. The project is currently proceeding in accordance with the target schedule and approved budget.
- JW House (Patient Family Residence) - $2.5 m
  - This is an FY 2017 Budgeted project that we are currently completing a feasibility study on. Other than preliminary expenditures, no funding approvals have been requested. The concept is consider the development of a "Ronald McDonald' type facility on the "Higgins" property at the end of South Dr. where a single family residence owed by the El Camino Healthcare District exists. We are exploring the possibilities of developing a facility that could be operated by the "JW House" non profit organization that operates a similar facility near the Santa Clara Kaiser Hospital. This project was identified as an element of our Patient Centered Care initiative and would provide a much needed service to patients families.

Los Gatos Capital Projects Status Update

- LG Spine Room Expansion – OR 4 - $4.1 m
  - This project is substantially complete with only a few schedule scope elements remaining. The expanded Spine Room has been in operation since November 2016 and the project is anticipated to be complete and closed out within the approved budget.
- LG Rehab HVAC Upgrades - $3.7 m
  - This project is complete. The new HVAC system has been in operation since September 2016 and the project is in the process of being closed out $54,000 or 1.4% over budget. This was due to the complexity of working in and around and occupied environment.
- LG Imaging Phase II & Sterile Processing - $8.75 m
  - This project is nearing the completion of construction and major equipment including the CT Scanner, X-ray and Sterilizers are scheduled to be installed during the month of April. The anticipated occupancy of all the upgrades spaces is late May 2017. This project is projected to be completed within the approved budget.
- LG Upgrades – Major - $17.3 m ($2 m additional requested)
  - This project is in the final phase of construction and funding for additional improvements has been requested. We began making improvements to the finishes, furniture, fixtures and mechanical systems at ECH Los Gatos in March 2013. We have completed improvements in the Conference & Administrative Areas, the Emergency Department, the Women's Hospital Departments, the Medical/Surgical Unit and the Operating Room Mechanical Systems. We have upgraded electrical systems, boilers and chillers and we are in the process of completing the Lobby, Cafeteria and Main Corridor improvements. (See submitted funding request for additional information)

Los Gatos Capital Projects Status Update

- LG MOB Improvements (17) - $5 m
  - The primary scope of this project is to reconstruct approximately 14,500 of medical office space in 340 Dardanelli for a new tenant, along with other improvements required on the site and within other LG medical offices. The Lease was fully executed on January 16th and the improvement plans are scheduled to be submitted to the Town of Los Gatos by the end of the month. We have engaged an architect and a contractor and we are currently on schedule for a September 2017 substantial completion date.

Date: April 12, 2017

To: El Camino Hospital Board of Directors

From: Donald Sibery, Interim CEO

Re: CEO Report - Open Session

	Organizational Goals FY17	Benchmark	2016 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY17 through Feb
Threshold Goals									
	Budgeted Operating Margin	90% threshold *[Recommended by Exec Comp Consultant (FY16)]*	105% of Budgeted	90% of Budgeted			Threshold	FY 17	Met
Quality, Patient Safety & iCare									
Quality Pain Management	**Pain Reassessment** (% Pain Reassessment Documented within 60 min on RN Flowsheet)	Internal Improvement	56.3% *Nov 2015 (post iCare go-live) to Apr 2016 [6-month measurement]*	75%	80%	90%	34%	Q4 FY 2017	75%
Quality Pain Management	**Pain Patient Satisfaction** (CMS HCAPHS Pain Management % Scored Top Box- **2 month delay)**	Internal Improvement	72.9% *FY 2016 Q1 - Q3 [9-month measurement]*	73%	74%	76%			75%
LOS & Readmission	Achieve Medicare **Length of Stay** Reduction while Maintaining Current **Readmission Rates** for Same Population **(Readmission - 45 day delay)**	Internal Improvement	FY16 Max Goal 4.86 LOS Readmission Target 12.39%	4.81 .05 Day Reduction from FY16 Max, Readmission at or below FY16 Target	4.76 .10 Day Reduction from FY16 Max, Readmission at or below FY16 Target	4.66 .20 Day Reduction from FY16 Max, Readmission at or below FY16 Target	33%	FY17	LOS: 4.58 Readmission: 11.36% (312/2746)
Smart Growth									
	Achieve budgeted inpatient growth (surgical and procedural cases plus Deliveries and NICU), and budgeted outpatient growth (surgical and procedural cases plus infusion).	Internal Documentation	94.26% of FY17 Budget	95% of Budgeted Volume	100% of budgeted Volume	110% of Budgeted Volume	33%	FY 17	93.9% of Budgeted Volume

El Camino Hospital Auxiliary
Activity Report to the Hospital Board
April 12, 2017

March Highlights:

- The Auxiliary has been heavily engaged with in-service meetings, in compliance with Joint Committee requirements. This involves meetings for each of 39 services across the two campuses. In addition, for the larger services, such as Escort, multiple meetings were held. The purpose of these meetings is to review current practices, implement ideas of how to improve each service, and review changes in hospital policies and procedures.

- The Java Junction staff was asked by Administration to open the coffee cart for two succeeding weekends. With the close of the Bistro, this was helpful to families and staff who needed sustenance in the morning hours, prior to the opening of the cafeteria for its regular luncheon service. These openings were very well received.

- The Scholarship Committee has been meeting with applicants to review their needs and to make decisions about the level of funding which the Auxiliary will provide. We have 12 applicants this year and have $25,000 to award.

- The Auxiliary is in the process of planning for its Annual General Meeting. A location has been secured and a theme chosen. We are working with the Marketing Department in preparation for the mailing of the invitations. This year's event will be held at the Crowne Plaza Cabana Hotel on May 18th.

El Camino Hospital Auxiliary

Membership Report to the Hospital Board
Meeting of April 12, 2017

Combined Data as of February 28, 2017 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	399	+8 relative to previous month
Dues Paid Inactive	89	(Includes Associates & Patrons)
Leave of Absence	13	
Subtotal	**501**	

Resigned in Month	2
Deceased in Month	0

Junior Members

Active Members	248	-1 relative to previous month
Dues Paid Inactive	0	
Leave of Absence	2	
Subtotal	**250**	

Total Active Members	**647**
Total Membership	**751**

Combined Auxiliary Hours from Inception (to February 28, 2017): 5,698,303

Combined Auxiliary Hours for FY2016 (to February, 28, 2017): 63,214

Combined Auxiliary Hours for February 2017: 6,931

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: March 29, 2017

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 2017 – Period 8

ACTION: For Information

El Camino Hospital Foundation advances health care through philanthropy by raising funds that support El Camino Hospital's strategic priorities, foster innovation, and support patient and family-centered care.

During period 8, the Foundation secured $217,342, bringing total FY 2017 revenue to date to $5,954,459, which is 97% of the annual goal.

Santa Clara Sporting Club made its 9th annual donation to the free mammogram program with funds raised through their Goals for a Cure program. This brings their cumulative giving to El Camino Hospital Foundation for that program to $275,237.45.

Upcoming Events

Please mark your calendars and plan to support one or more of the following events:

April 29, 2017 – Sapphire Soirée, celebrating the Cancer Center's 10th anniversary

February 8, 2018 – 6th annual Norma's Literary Luncheon featuring mystery writer Jacqueline Winspear

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
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Memorandum

DATE: March 29, 2017

TO: El Camino Hospital Board of Directors

FROM: Lane Melchor, Chair, El Camino Hospital Foundation Board of Directors
Jodi Barnard, President, El Camino Hospital Foundation

SUBJECT: Report on Foundation Activities FY 2017 – Period 8

ACTION: For Information

During the month of February, the Foundation raised $217,342. This brings total revenue secured through period 8 in fiscal year 2017 to $5,954,459. As of February 28, the Foundation has reached 97% of our fundraising goal.

Major Gifts

In period 8, the Foundation received $50,000 in major gifts, including a $10,000 donation designated for mental health and addiction services, and a $40,000 donation from Santa Clara Sporting Club for El Camino Hospital's free mammogram program. This is the 9th year Santa Clara Sporting Club has donated proceeds from its annual "Goals for a Cure" fundraiser, bringing their cumulative giving to $275,237.45.

Planned Gifts

In February, the Foundation received $4,190 in sponsorships and ticket purchases for the annual Allied Professionals Seminar, which took place on February 16.

Special Events

- ***Sapphire Soirée*** – The Foundation received $46,250, including $25,000 in sponsorships, during the month of February. Online registration is now open and invitations have been mailed. To date, 36 tables have been sold toward a goal of 470-500 attendees. The gala benefit will be held at the Menlo Circus Club in Atherton on Saturday evening April 29 and will celebrate the Cancer Center's 10th anniversary.

- ***Scarlet Masquerade*** – The Foundation received an additional $17,188 in ticket sales and sponsorship payments for the South Asian Heart Center's annual gala. By the end of February, the event had raised $133,105. It took place on March 18, 2017 at The Mountain Winery in Saratoga and 304 people attended. The masquerade ball was sold out and had the highest yield on record for this event, $304,450.

- ***Norma's Literary Luncheon*** – In period 8, the Foundation received $39,085 in table sponsorships and individual ticket sales for the 5th annual Norma's Literary Luncheon, which took place on February 2, 2017 at Sharon Heights Golf & Country Club. A sold-out audience of 300 guests attended. Proceeds will support specialty treatment for women in the new behavioral health building. We are still receiving outright gifts from the event and the March fundraising report will reflect an additional $15,000 in table sponsorship payments. We anticipate the fundraising total will exceed our goal of $145,000. The 6th annual Norma's Literary Luncheon will take place on February 8, 2018. Mystery writer Jacqueline Winspear will be the featured speaker.

Annual Giving

The Foundation raised $17,501 through its annual giving program in February, the result of direct mail, online donations, Hope to Health memberships, and the 2017 Employee Giving Campaign. There will continue to be additional direct mail and online outreach to annual donors before the end of the fiscal year.

El Camino Hospital® Foundation
THE HOSPITAL OF SILICON VALLEY

ECH Foundation Fundraising Report

FY17 Income figures through February 28, 2017 (Period 8)

ACTIVITY		FY17 YTD (7/1/16 - 2/28/17)	FY17 Goals	FY17 % of Goal	Difference Period 7 & 8	FY16 YTD (7/1/15 - 2/29/16)	FY15 YTD (7/1/14 - 2/28/15)
Major Gifts		$520,000	$2,500,000	21%	$50,000	$1,687,737	$3,636,200
Planned Gifts		$3,464,122	$1,000,000	346%	$4,190	$673,116	$1,478,217
Special Events	**Sapphire Soirée**	$46,250	$850,000	5%	$25,000	$102,200	$38,100
	Golf	$273,100	$325,000	84%	-	$326,205	$326,650
	Scarlet Masquerade	$130,583	$300,000	44%	$17,188	$110,141	$73,195
	Norma's Literary Luncheon	$133,105	$145,000	92%	$39,085	$164,694	$117,691
Annual Gifts		$459,584	$550,000	84%	$17,501	$442,839	$489,931
Grants*		-	-	-	-	$52,083	$339,350
Investment Income		$927,714	$500,000	186%	$64,378	$527,326	$542,765
TOTALS		***$5,954,459***	***$6,170,000***	***97%***	***$217,342***	***$4,086,341***	***$7,042,099***

*Beginning in FY17 Grants is no longer an activity line. Any grants received in the future will either be reflected in the Annual Gifts or Major Gifts activity line pending funding level.