PLEASE NOTE: Times stated for matters are estimates only.
Please arrive at least l/2 hour before the time stated if you intend to speak on an issue.
Hospital Open Session will commence at approximately 7:00 p.m.

ELCAMINO HOSPITAL
AMENDED REGULAR MEETING AGENDA
Wednesday, December 12, 2012
7:00 p.m.

El Camino Hospital, Conference Rooms, E, F & G, ground floor
and Medical Staff Conference Room, first floor
2500 Grant Road
Mountain View, California

and via teleconference
The Walk, Jumeirah Beach Residence, Dubai, 000000, U.A.E

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.

		PRESENTED BY		
I.	**CALL TO ORDER/ROLL CALL**	John Zoglin Board Chairman		4:00 p.m.

II. **ADJOURN TO CLOSED SESSION**

1. Conflict of Interest disclosures relating to Items 2-5 on the Closed Session agenda pursuant to the Code provisions listed below.
2. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets --Development of New Services and Programs
3. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets --Development of New Services and Programs
4. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets --Development of New Services and Programs
5. *Health and Safety Code Section 32106(b)* for a report involving health care facility trade secrets --Development of New Services and Programs
6. Adjourn to Open Session

III.	**RECONVENE OPEN SESSION** To report any required disclosure regarding permissible actions taken during Closed Session.	John Zoglin Board Chairman		7:01-7:02 p.m.
IV.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	John Zoglin Board Chairman		7:02-7:03 p.m.
V.	**BOARD RECOGNITION** *Resolution 2012-20* The Board will recognize individual/individuals who enhance the experience of the Hospital's patients and the community. **ATTACHMENT 4**	John Zoglin Board Chairman	*public comment*	**motion required** 7:03-7:08
VI.	**ACTION** A. Consent Calendar All items listed on the Consent Calendar are considered to be routine matters or are		*public comment*	**motion required** 7:08-7:15

considered formal documents covering previous Board instructions. One motion, a second and a vote may enact all of the items listed on the Consent Calendar. There will be no separate discussion of Consent Calendar items unless members of the Hospital Board, Hospital staff or the public request discussion on a specific item at the beginning of the consideration of the Consent Calendar.

Approval:

- Minutes of Regular Board Meeting
  -November 14, 2012
- Minutes of Study Session
  -November 20, 2012
- October Financials
- Measure M – *Resolution 2012-19*

Reviewed by Finance Committee

- Retirement Plan
  --Delegation of Authority: Cash Balance Plan Resolution 2012-16
  --Cash Balance Plan Adjusted Funding Target Percentage – Resolution 2012-17
  --Delegation of Authority: 403 (b) Retirement Plan – Resolution 2012-18
- Facilities Project – Slot/Data Center
- Neurology Call Contract for Los Gatos
- Medical Oncology Clinic
- Electronic Intensive Care Unit
- Cardiothoracic Surgery Medical Director
- Virtual Desktop with Single Sign-Off
- Electronic Data Warehouse
- EMR to EMR Middleware

Review by Governance Committee

--FY 2013 Quality Committee Charter and Goals
--Silicon Valley Medical Development, LLC
Member Management

- Policies
  --Dietary
  --E-Mail
  --Human Resources
  --Internet
  --Administrative

Acceptance:

- Minutes
  --Finance Committee
  October 2, 2012
  -- Quality Committee
  October 15, 2012
  -- Governance Committee
  November 8, 2012
- Auxiliary Report
- Foundation Report

ATTACHMENT 5

	B. Medical Staff Report The Chiefs of Staff will report on Medical Staff membership and activities. **ATTACHMENT 6**	Vivien D'Andrea, MD Chief of Staff, MV Neeraj Kochhar, MD Chief of Staff, LG	*public comment*	**motion required** 7:15-7:25
	C. Appointment of Ad Hoc Committee	John Zoglin Board Chairman	*public comment*	**motion required** 7:25-7:30
VII.	**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	John Zoglin Board Chairman		7:30-7:40
VIII.	**INFORMATIONAL ITEMS AND POSSIBLE MOTION ITEMS** A. CEO Report The Board will receive an informational update on the activities of the organization. **ATTACHMENT 7**	Tomi Ryba President and CEO		7:40-7:45
	B. Quality Committee Update	Patricia Einarson, MD, Chair Quality, Patient Care and Patient Experience Committee	*public comment*	7:45-7:50
	C. Governance Committee • Committee Chairs and Committee Composition • Board Management Compact • Board Retreat • Risk Management and Policy Oversight • Committee Indemnification **ATTACHMENT 8**	John Zoglin, Chair Governance Committee	*public comment*	**possible motion** 7:50-8:10
IX.	**BOARD COMMENTS/OTHER COMMITTEE UPDATES** ***(Gov't Code Section 54954.2 (a))***	John Zoglin Board Chairman		information 8:10-8:25

X. **ADJOURN TO CLOSED SESSION**

1. Conflict of Interest disclosures relating to Items 2-9 on the Closed Session agenda pursuant to the Code provisions listed below.
2. Approval of Minutes of the Closed Session Regular Board Meeting (November 14, 2012); Study Session Minutes (November 20, 2012) ; Safety Report for Managing the Environment of Care; and Acceptance of the Minutes of the Finance Committee (October 2, 2012) and Quality Committee (October 15, 2012) — **motion required**
3. Conference with Legal Conference – pending or threatened litigation *Gov't Code Section 54957.6* (b) and (c)
4. Report of the Medical Staff Quality Assurance Committee, *Health and Safety Code Section 32155* — **motion required**
   --Deliberations concerning reports on Medical Staff quality assurance matters
   --Medical Staff Report
5. *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets,
   --Development of Services and Programs
6. *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets,
   --Development of Services and Programs
7. *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets,
   --Development of Services and Programs
8. *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets,
   --Development of Services and Programs
9. Report involving *Gov't Code Section 54957* for discussion and report on personnel matters — **possible motion**
   -Executive Session
10. Adjourn to Open Session

XI. **RECONVENE OPEN SESSION** — John Zoglin, Board Chairman — 10:01-10:02
To report any required disclosure regarding permissible actions taken during Closed Session.

XII. **ADJOURNMENT** — 10:03 p.m.

2012-20 Board Resolution.doc

Resolution 2012-20

Resolution of the Board of Directors of the El Camino Hospital Regarding Recognition of Service to the Community

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

Whereas, the Board would like to recognize a model of patient care being developed by a multidisciplinary team of caregivers here at El Camino Hospital that, while still evolving, is demonstrating the power that proactive involvement, collaboration and diligent attention to detail have in stabilizing, healing, even saving the lives of our most vulnerable patients. Supported by a grant from the Gordon and Betty Moore Foundation, and guided by a patient/family centered care philosophy, a Transitions Team has been working over the past two years to help ensure that elderly and high risk patients along with their families receive the best possible post-hospitalization care and information when transitioning to skilled nursing facilities or to home.

Whereas, the Board would like to acknowledge the innovative spirit and sustained work of the team over the span of this project that has resulted in tangible improvements for patient care among this often challenging population. From ongoing thorough analyses of why patients are readmitted, to use of an assessment tool to more accurately assign a risk score for each individual patient, to development of detailed discharge checklists for both hospital and skilled nursing staff, to staff members personally ensuring a seamless transition between caregivers and physicians at both locations, the team has consistently examined the process of care and then applied a detail or an added step that has improved the transition from hospital to home or another facility, resulting in better patient outcomes.

Whereas, the Board would also like to commend the work of the team that has resulted in a second grant from the Gordon and Betty Moore Foundation to continue this important work, expand the team and make improvements in the area of medication management.

Now therefore be it resolved that the Board does formally and unanimously pay tribute to:

Transition Team: Cheryl Reinking, RN, Patrick Kearns, MD: leaders; Susan Bukunt, RN, Megan Williams, RN, Carla Paul, Cathy Chavez: steering group; Ruth Zaltsmann, RN, Mae Lavente, RN, Evelyn Taverna, RN, Katie Erwin, RN, Jocelyn Reynoso, Pharm.D., Monique Schwartz, Stacey Burnell, Denise Pandya, team members.

For taking what they are learning individually and as a team to improve the care of vulnerable patients and to improve models of care for the benefit of all patients in the future.

In witness thereof, I have hereunto set my hand this **12th day of December, 2012.**

_____

David Reeder, Secretary/Treasurer
El Camino Hospital Board of Directors

EL CAMINO HOSPITAL
BOARD OF DIRECTORS
Regular Meeting – November 14, 2012

MINUTES

The Regular Meeting of the Board of Directors of El Camino Hospital (the "Hospital") was called to order by John Zoglin, Chairman at 5:30 p.m. on **Wednesday, November 14, 2012** in Conference Rooms E, F, & G, ground floor, El Camino Hospital, 2500 Grant Road, Mountain View, California.

Roll call was taken. The Directors present were John Zoglin; Wesley Alles; Patricia Einarson, MD; David Reeder; Tomi Ryba; and Nandini Tandon. Directors Cohen and Davis were absent. The meeting was videotaped.

BOARD RECOGNITION:
Resolution 2012-14

Action: Upon a motion duly made and seconded, *Resolution 2012-14* was approved by a vote of five Directors in favor; Directors Neal Cohen, MD and Jeffrey Davis were absent; and Director Ryba nonvoting.

The Board wished to recognize the leadership and staff of Oak, Evergreen and Rose Garden Outpatient Dialysis Centers as they recently transitioned from their familiar, combination internal IT and paper-based patent information system to a computerized, highly sophisticated, fully integrated electronic medical record.

The Board also wished to commend the cooperation between Satellite and dialysis centers' staff that enabled Satellite Patient Information Network's first implementation in a hospital environment and that resulted in such a smooth activation.

ADJOURN TO CLOSED SESSION:

Upon motion duly made, seconded, and approved by a vote of five Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting, the Open Session of the meeting was adjourned to Closed Session at 5:35 p.m. pursuant to *Gov't Code Section 54957.2* to approve the Closed Session minutes of the Regular Board Meeting (October 10, 2012); the Corporate Compliance Committee Meeting Minutes (September 18, 2012) and acceptance of the minutes of the Governance Committee Meeting (October 2, 2012, FY 2012 Corporate Compliance Report, FY 2013 Internal Audit Work Plan, and FY 2013 Corporate Compliance Work Plan, and Board Pacing Plan; *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets for the development of new services and programs; Conference with Legal Counsel - pending or threatened litigation Gov't Code Section 54957.6 (b) and (c); Report involving *Govt. Code Sections 54957 and 54957.6* for discussion on personnel matters; FY 2012 Scoring of Individual Performance Goals of CEO, FY 2012 Executive Performance Incentive Payouts, FY 2012 CEO Performance Incentive Payout, FY2013 Organizational Goals and Measurements, and FY 2013 Individual Performance Goals of CEO and Executive Team; and Medical Staff Quality Assurance Committee, *Health and Safety Code Section 32155* for a report and discussion of Medical Staff quality assurance matters.

CLOSED SESSION

The Board completed its business of the Closed Session at 7:15 p.m.

RECONVENE OPEN SESSION

The Board reconvened Open Session at 7:20 p.m.

CLOSED SESSION REPORTS:

Director Zoglin reported on the following actions taken in Closed Section, which are required to be disclosed in Open Session:

Consent Calendar
The Board reviewed and approved the Consent Calendar Closed Session items as follows: Approval of the minutes of the Regular Meeting (October 10, 2012), the Corporate Compliance Committee Meeting Minutes (September 18, 2012) and acceptance of the minutes of the Governance Committee Meeting (October 2, 2012); FY 2012 Corporate Compliance Report; FY 2013 Internal Audit Work Plan; FY 2013 Corporate Compliance Work Plan; and Board Pacing Plan by a vote of five Directors in favor; Director Cohen absent, and Director Ryba nonvoting.

Measure M
The Board reviewed and authorized legal counsel to explore bringing a lawsuit to determine whether Measure M is legal by a vote of six Directors in favor, Director Cohen absent, and Director Ryba nonvoting.

Executive Compensation Committee
The Board reviewed and approved the FY 2012 Scoring of Individual Performance Goals of CEO, as presented, by a vote of six Directors in favor, Directors Cohen and Ryba absent.

The Board reviewed and approved the FY 2013 Organizational Goals and Measurements, as presented, by a vote of five Directors in favor, Director Cohen absent, Director Davis abstained; and Director Ryba nonvoting.

The Board reviewed and approved the FY 2013 Individual Performance Goals of CEO and Executive Team, as presented, by a vote of six Directors in favor, Director Cohen absent, and Director Ryba nonvoting.

Medical Staff Report
The Board reviewed and approved the Medical Staff Executive Committee Reports (general and executive sessions) of October 25, 2012 as presented by Dr. Neeraj Kochhar, Chief of Staff, by a vote of four Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting.

The Credentials and Privileges Report for September was also approved by a vote of four Directors in favor, Directors Cohen and Davis absent; and Director Ryba nonvoting.

OPEN SESSION

CONFLICT OF INTEREST DISCLOSURES:

Director Zoglin asked if there was any Board member or anyone in the audience who believes any Board member may have a conflict of interest on any of the items on the agenda. No conflict was stated.

SPOTLIGHT: MEDICAL ADVANCES AT EL CAMINO HOSPITAL:

Dr. Nicholas Colyvas, President Orthopaetic Management Associates, gave an overview of the orthopedic surgery program.

Dr. Colyvas reported that orthopedic surgery is the branch of surgery concerned with conditions involving the musculoskeletal system. He also stated that the orthopedic surgeons use both surgical and nonsurgical means to treat musculoskeletal trauma, sports injuries, degenerative diseases, infections and congenital disorders.

Dr. Colyvas also reported that there are 37 active orthopedic surgeons providing care at both campuses, the Mountain View campus is a Blue Cross Center of Excellence for hips and knees and have a disease-specific certification for total joint.

Dr. Colyvas also reported that expansion of the Mountain View campus will include an orthopedic spine surgeon in December of 2012.

Dr. Colyvas also briefly discussed the upcoming service plans:

- Total Joint Implant Cost Reduction Committee (January 2012)
- Expansion of the Co-Management concept to the Mountain View Campus (Spring 2012)
- Orthopedic Symposium focusing on the educational needs of the primary care provider (Fall 2013)
- Survey of the Los Gatos Campus by the Joint Commission Disease-Specific Certification process for total joint and spine certifications (Summer 2013)

MEDICAL STAFF REPORT:

Dr. Kochhar presented the Medical Staff report regarding the Medical Staff Executive Committee meeting of October 25, 2012.

Medical Staff Policy/Procedures:
A. Clarification – Proposed Categories and Activity Requirements. Revisions were approved by the Board in July 2012. Clarification is provided for the definition of a patient contact and approval is requested.

B. Medical Staff Rules and Regulations. These revisions clarify that even though the Physician Assistant or Nurse Practitioner may round on the patient, the supervising physician will be readily available should questions or concerns arise.

C. Quality Peer Review Assessment Process Draft. MEC would like to remove the requirement "standard of care met, not met, improvable" and change to "no issues/concerns" or "some issues/concerns"

D. OB-GYN Privilege List. Recommend deletion of the nomenclature course requirement for reappointment.

Patient Care Policy/Procedures:
Policies with minor revisions (see summaries)
Scheduled policy review – no changes
New Policies - None
Policies with major revisions (see summaries)

Director Zoglin asked if there were any questions or comments from the Board or the audience.

Action: Upon motion duly made and seconded, the Medical Staff report as presented by Dr. Kochhar was approved by a vote of five Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting.

CONSENT CALENDAR:

Director Zoglin stated that all items listed on the consent calendar are considered to be routine matters. One motion, a second and a vote may adopt all of the items listed on the Consent Calendar with no discussion unless requested by a Board Member, staff, or a member of the audience. At this time a member of the Board, staff, or the audience may request an item be added to or deleted from the Consent Calendar.

Action: Upon a motion duly made and seconded, the following items on the Consent Calendar were approved or accepted as follows by a vote of five Directors in favor; Directors Cohen and Davis absent and Director Ryba nonvoting: Minutes of the Regular Board Meeting (October 10, 2012); Corporate Compliance Meeting Minutes (September 18, 2012); Foundation Board Appointment (Roger Borovoy); Policies (Emergency Management and Spiritual Care); Resolution 2015 403 (b) Plan Retirement re changes to matching contribution; 403(b) and Cash Balance Plan Audit and acceptance of the Minutes of the Governance Committee (October 2, 2012); FY 2012 Corporate Compliance Report; and the Foundation Report and Auxiliary Reports.

EXECUTIVE COMPENSATION COMMITTEE RECOMMENDATIONS:

Director Zoglin commented that the ballot results for Measure M have not been validated by the Registrar of Voters, and that even though the Board has tremendous respect for the voters they are very disappointed in the outcome. Director Zoglin then stated that the Hospital Board has asked their legal counsel to explore bringing a lawsuit to determine whether this measure is legal.

Director Zoglin then stated that until something, in a different direction, is confirmed in court, El Camino Hospital will continue to pay the executive staff according to their contracts.

Director Zoglin asked if there were any questions or comments from the Board or the audience.

Director Reeder commented that they have been watching the numbers closely and several thousand ballots have not been counted, El Camino Hospital being short by 1.2%, which is unlikely that Measure M will be rejected. Director Reeder then read an excerpt from the Mercury News "This was no grass roots rebellion against lavish pay. It was a negotiating ploy by Hospital unions. They admit they floated the measure as a bargaining chip, and they stopped campaigning when they got their way in a labor contract".

Director Reeder thanked the Committee for the "No on Measure M" Campaign. Director Reeder emphasized that El Camino Hospital did not have hospital employees involved in the campaign. A committee of community members was formed that did the majority of the work. He also stated that the Hospital set a policy that was followed stating that no campaign meetings would be held on District property, no campaign discussions would be held with any employees during business hours, and no Hospital e-mail addresses or phone numbers would be used. Director Reeder thanked Russ Melton, Gary Kalbach, King Lear, and Claudia Coleman for their dedication in this effort. Director Reeder also stated that several auxilians, as private citizens, helped distribute signs etc. Director Reeder also thanked Director Ryba and the executive staff for helping in the evenings and weekends.

Director Zoglin asked if there were any questions or comments from the Board or the audience.

Ms. Stephanie Munoz stated that she feels the District was very appreciative of the efforts of everyone who contributed their time.

Director Alles, Chair, Executive Compensation Committee, stated that before the motion regarding FY 2012 incentive pay, he would provide information about the executive compensation plan. He stated that El Camino Hospital utilizes an independent compensation consulting firm to conduct market analysis and make recommendations to the Board. He stated that the Hospital has a compensation philosophy to provide executives base pay, incentives, and benefits relative to comparable hospitals nationally and that the hospitals will be comparable in size and complexity based upon net operating revenues. El Camino Hospital's competitive position for base salaries is the median plus a cost-of-labor adjustment for Silicon Valley to account for the higher than cost-of-labor and cost-of -living in Silicon Valley.

Director Alles stated that the executive performance incentive plan is part of the executives' total compensation and that such pay is based on their achievement toward pre-defined organizational and individual goals.

Director Zoglin asked if there were any questions or comments from the Board or the audience.

Director Alles then presented for approval the FY 2012 Executive Performance Incentive Payouts and FY 2012 CEO Performance Incentive Payout

Action: Upon motion duly made and seconded by a vote of five Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting, the FY 2012 Executive Performance Incentive Payouts were approved as presented

Action: Upon motion duly made and seconded by a vote of five Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting, the FY 2012 CEO Performance Incentive Payout was approved as presented.

SEPTEMBER FINANCIALS:

Mr. Mike King, Chief Financial Officer, presented for approval the financial results for September. These results included the six entities and two hospital sites (which were included in the materials circulated to the Board and are available at the meeting).

Action: Upon motion duly made and seconded, the September financials were approved, as presented, by a vote of four Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting.

PUBLIC COMMUNICATION:

Mr. Geoffrey Managers spoke of the Mental Health Program.

Ms. Stephanie Munoz raised concerns regarding the perception in Silicon Valley generally that people at the top are being overcompensated and people at the bottom are being undercompensated.

CEO REPORT: Director Ryba highlighted the following:

- The patient-centered medical home that El Camino Hospital created to care for the frail and elderly will have an open house on Friday, November 16, 2:00-6:00 p.m. and the public is invited.
- El Camino Hospital received the prestigious Gold plus Award from the American Heart/American Stroke Association. This is the highest award for quality of care provided to stroke patients in a primary certified stroke center.
- Relative to the strategic plan around efficiency, El Camino Hospital has extended the work around using Lean methodology to transform patient-centered care. Healthcare Performance Partners (HPP), who has experience in the methodology, has been retained.
- With regard to continuum of care, Dr. Pifer and Diana Russell have brought together with work on wellness, community health, avoiding readmissions, and the patient-centered medical home into a clinical program. This would integrate related work in caring for patients beyond the walls of the hospital to be done in a very intentional, coordinated fashion. Final interviews are underway for a wellness and community health leader.
- The Joint Commission is expected to be here between now and March. Mock surveys are underway.
- El Camino Hospital achieved all of the elements for meaningful use which took over a year to accomplish.

- Brenda Taussig has been hired as the government affairs manager, as it was felt important to strengthen El Camino Hospital's government and community relations.
- Director Ryba reported that she had authorized funds requested by the Citizens for Responsible Health Care at El Camino Hospital and, to date, $219,000 in expenditures have been authorized to support the defeat of Measure M.

Director Zoglin asked if there were any questions or comments from the Board or the audience.

FINANCE COMMITTEE:

Director Reeder stated that that in 1998 or 1999 there was a ruling that El Camino Hospital, because of its relationship to the District, was not required to submit the Form 990, a tax return form. Since that time, Form 990 has been prepared but not submitted. The information found on Form 990 is made public every year, and Mr. King, Chief Financial Officer, is requesting discontinuation of this preparation, except the section relation to individual compensation.

Director Zoglin asked if there were any questions or comments from the Board or the audience.

Action: Upon motion duly made and seconded by a vote of four Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting, effective ending FY June 30, 2012, El Camino Hospital will begin preparing only the portions of the Form 990 tax return regarding certain individual's compensation.

INVESTMENT COMMITTEE:

Director Zoglin stated that the Investment Committee is in the process of executing the policy that the Board passed last spring which was based on analysis of various portfolio structures. both for excess cash on hand as well as pensions. Director Zoglin stated that these documents are available upon request. He then stated that Mr. King is leading a team to convert the portfolio to a new set of investments and investment advisors.

Director Zoglin asked if there were any questions or comments from the Board or the audience.

Director Alles stated that five years ago the Board made a decision not to invest in mutual funds where there were tobacco companies and wanted to know if that was still the case. Director Zoglin stated that yes that has been clearly communicated.

KEY ISSUES OF COMMITTEES:

Director Einarson, Chair, Quality, Patient Care and Patient Experience Committee, reported that this committee was recruited to meet quarterly, but the needs and vision that is being developed is enabling the committee to meet more often and commended the committee members and staff for stepping up. Director Einarson then commented that tremendous progress is being made, especially in the areas of vision, governance, goals, and quality infrastructure for the organization. She also stated that they have reviewed the charter and goals for which changes are

being made, incorporating from the *Institute of Medicine* the six dimensions of care which include safe, effective, patient-centered, timely, efficient and equitable care.

Director Einarson then reported that she is not only seeing a great oversight role with the new committee members, but the executives have begun to collaborate and use the expertise available in an advisory capacity which is enhancing the thinking on El Camino Hospital's our governance structure.

Director Einarson stated that at the next meeting the committee will be focusing on the Hospital strategy along with performance improvement and safety.

CORPORATE COMPLAINCE, PRIVACY AND INTERNAL AUDIT COMMITTEE:

Director Alles, Chair, Corporate Compliance Committee, reported on the results of the 403(b) and cash balance plan audit. He stated that the Department of Labor requires that the audit be conducted and filed as part of Form 5500, which is required for Pension Plans. Director Alles also stated that there was nothing of concern found in the audit. The committee is on track with the Committee goals, and will have them completed by the end of the fiscal year**.**

GOVERNANCE COMMITTEE:

Board and Committee Continuing Education Policy
Director Zoglin presented the Board and Committee Continuing Education Policy that had been reviewed by the Governance Committee for recommendation to the Board. Director Zoglin then highlighted the recommendation:

- Budget of about $50,000 per year for an annual training for Board and Committees
- Individual Board members will be allotted up to $2500 at their own discretion for training
- Committee chair will be allotted $2500 per committee

Director Zoglin stated that for all training sessions, a summary will be requested to validate the linkage between training and strategy.

Director Zoglin then stated that the Board and Committees have the opportunity next year to attend an Estes Park event in Half Moon Bay. He also stated that since this will be the first year with all the new committees, an opportunity to provide a deeper background of the healthcare industry is too great to miss and if all the Committee and Board members take advantage of this session, it would cost approximately $90,000. The Governance Committee is, thus, recommending a break in the budget for FY 2013.

Director Zoglin asked if there were comments or questions from the Board or the audience.

Action: Upon motion duly made and seconded, the Board and Committee Continuing Education Policy was approved, as presented, by a vote of five Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting.

Board and Committee Member Requests:
Director Zoglin then noted a process to be followed for all Board and Committee member requests. Director Zoglin stated that he will work with the staff to provide information to the new Board members that has been provided publicly. He then stated that if a request is a committee-related item, the request is to go to the chair of the committee. If the request is a broader Board item, staff can contacted directly. If the request is a legal matter, the requests need go through the Committee chair or Directors Zoglin or Ryba.

Appointment of New Directors
Director Zoglin then stated that the Governance Committee recommends that the Hospital Board make a recommendation to the District Board that, upon completion of the validation of the votes, a District Board meeting be scheduled Monday, December 10 or Tuesday, December 11 to enable the newly elected District Board members to be appointed to the Hospital Board before the regularly scheduled meeting on December 12.

Director Tandon thanked Director Alles for all his generous contributions on the Board and, in particular, for welcoming and taking the time to make the new Board members feel welcome.

Board Committee Chairmanship
Director Zoglin stated that if the current policy is followed, the three current Board members would have to chair two committees. He felt at this time the expertise was not as deep as they would like commensurate with the experience within the Hospital. This was discussed with the Governance Committee and the recommendation was to relax the two-year requirement. This will be addressed by the Governance Committee over the next month to be in a position to appoint new committee chairs and/or members where needed in December.

Director Zoglin asked if there were any questions or comments from the Board or the audience.

Director Reeder stated that relaxing the two-year requirement is reasonable, and stated for a short period of time he would be willing to take on a second committee to provide continuity.

Director Zoglin stated that he and Director Ryba will reach out to the Board members to inquire as to their expressions of interest and will submit recommendation to the Governance Committee.

BOARD COMMENTS:

Director Alles thanked the Board for all of the goodness that exists among the Board members. He stated that this is a thoughtful and compassionate Board, and a Board that wants to do right by the community. Director Alles then thanked Director Ryba and all the executives who have provided excellent leadership to this Hospital. He also thanked Julie Johnston and Diane Wigglesworth for all the work that they did in staffing the committees on which he served.

Director Reeder stated that this Hospital was very different 10 years ago and a lot of progress has been made towards the quality of patient care and putting patients first because of Director Alles, and he stated that he is very proud what he has done to help this Hospital.

Director Einarson stated that Director Alles is a true gentleman and his eloquence is second to none.

Director Ryba stated that the ethics Director Alles brings to the conversation and that she has so much gratitude toward him in helping El Camino Hospital disseminate over the last year. She stated Director Alles is a gallant leader and is known across the country for his expertise and leadership.

Director Reeder then commented that the Board discusses El Camino Hospital's finances and investments at the Board meetings and not enough on quality of patient care. Director Reeder suggested spending more time at future meetings discussing quality.

Director Zoglin asked if there were any comments or questions from the Board or the audience.

ADJOURN TO CLOSED SESSION:

Upon motion duly made, seconded, and approved by a vote of five Directors in favor; Directors Cohen and Davis absent; and Director Ryba nonvoting, the Open Session of the meeting was adjourned to Closed Session at 9:20 p.m. pursuant to *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets for development of new services and programs; *Health and Safety Code Section 32106(b)* report involving health care facility trade secrets for development of new services and programs; and *Gov't Code Section 54957* for discussion and report on personnel matters (executive session).

CLOSED SESSION

The Board completed its business of the Closed Session at 9:50 p.m.

RECONVENE OPEN SESSION

The Board reconvened Open Session at 9:52 p.m.

There being no further business, the meeting was adjourned at 9:55 p.m.

_____	_____
John Zoglin	David Reeder
ECH Board Chairman	ECH Board Secretary

Open Study Session Minutes of 11-20-12.doc

EL CAMINO HOSPITAL
BOARD OF DIRECTORS

STUDY SESSION/SPECIAL MEETING

November 20, 2012

MINUTES

The Study Session/Special Meeting of the Board of Directors of El Camino Hospital (the "Hospital") was called to order by Patricia Einarson, MD, Vice-Chair, at 5:30 p.m. on Tuesday, November 20, 2012, in the Medical Staff Conference Room, El Camino Hospital, 2500 Grant Road, Mountain View, California.

Roll call was taken. The Directors present were Neal Cohen, MD; Patricia Einarson, MD; David Reeder; Tomi Ryba; and Nandini Tandon (arrived at 5:40 p.m.) Wes Alles and John Zoglin participated via Webex so they could speak during and hear all proceedings. Director Jeffrey Davis, MD was absent.

POTENTIAL CONFLICT OF INTEREST DISCLOSURES

Director Einarson asked if there was any Board member or anyone in the audience who believes they may have a conflict of interest on any of the items on the agenda. No conflict was stated.

ADJOURN TO CLOSED SESSION

Upon motion duly made, seconded, and approved by a vote of six Directors in favor, Director Davis absent and Director Ryba nonvoting, the Open Session of the meeting was adjourned to Closed Session at 5:35 p.m. pursuant to *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets for the development of new services and programs and *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets for the development of new services and programs

CLOSED SESSION

The Study Session/Special Meeting completed its business of the Closed Session at 8:15 p.m.

RECONVENE OPEN SESSION

The Study Session/Special Meeting reconvened to Open Session at 8:15 p.m.

No action was taken in Closed Session.

There being no further business, the meeting was adjourned at 8:20 p.m.

_____	_____
John Zoglin, Chair	David Reeder, Secretary
ECH Board of Directors	ECH Board of Directors

Board FY13 Period 4 New Format V2 (3).pptx

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Board of Directors
Summary of Financial Operations

Fiscal Year 2013 – Period 4

7/1/2012 to 10/31/2012

EL CAMINO HOSPITAL
EXECUTIVE FINANCIAL SUMMARY
Period Ending October 31, 2012

YTD STATEMENT OF REVENUE AND EXPENSES ($000s)

	Actual	Budget	Var F(U)
Gross Revenue	$808,701	$781,685	$27,016
Deductions from Revenue	(584,704)	(571,470)	(13,235)
Net Patient Revenue	223,997	210,215	13,781
Other Operating Revenue	5,130	5,909	(779)
Total Operating Revenue	**229,127**	**216,124**	**13,003**
Salaries & Wages	116,144	111,610	(4,535)
Supplies	35,576	30,523	(5,053)
Fees & Purchased Services	28,048	29,739	1,691
Other Operating Expense	7,788	8,925	1,137
Total Non Capital Operating Expense	**187,557**	**180,797**	**(6,760)**
OPERATING EBITDA	**41,570**	**35,327**	**6,242**
Interest, Depreciation & Amortization	18,459	18,136	(323)
NET OPERATING SURPLUS	**23,110**	**17,191**	**5,920**
Non Operating Income	7,187	3,321	3,866
TOTAL NET SURPLUS	**30,297**	**20,512**	**9,785**
Yield Percent (NPR / Gross Revenue)	27.7%	26.9%	0.8%
EBITDA Margin	18.1%	16.3%	1.8%
Operating Margin	10.1%	8.0%	2.1%
Total Margin	13.2%	9.5%	3.7%

BALANCE SHEET ($000s)

	Oct 31, 2012	Oct 31, 2011
Cash and ST Investments	452,053	350,509
Non Cash Current Assets	137,846	118,354
Property, Plant & Equipment (Net)	650,081	672,659
Other Assets	75,213	67,371
Total Assets	**1,315,193**	**1,208,893**
Current Liabilities	94,388	72,255
Long-Term Debt	234,442	238,508
Fund Balance/Capital Accounts	986,363	898,130
Total Liabilities & Equity	**1,315,193**	**1,208,893**

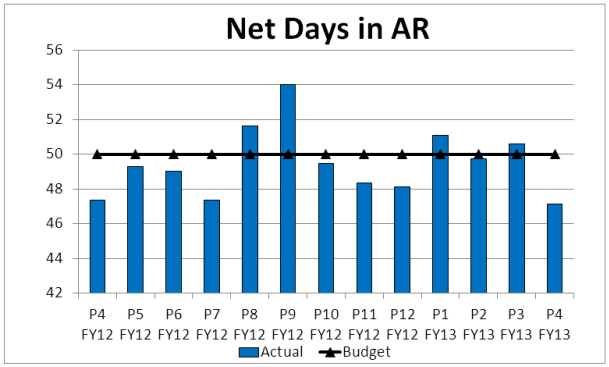
KEY ECH STATISTICS - YTD

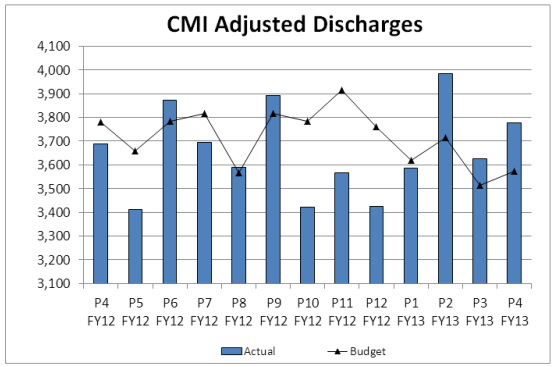
Balance Sheet	Actual	Target (1)
Debt Service Coverage Ratio (MADS)	8.7	1.2
Debt to Capitalization	15.2%	37.5%
Days of Cash	307	229
Net AR Days	47.1	45.3

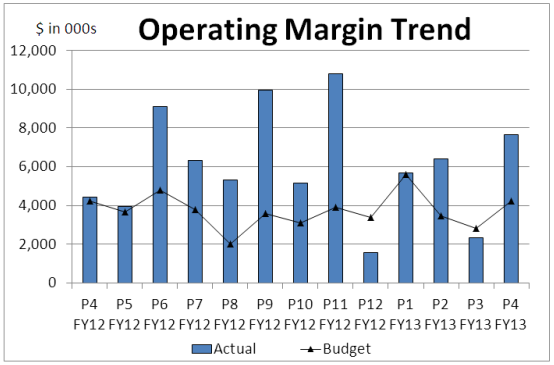
Other	Actual	Budget
Acute Discharges	6,415	6,115
Acute Average Daily Census	221	222
Deliveries	1,866	1,553
Emergency Department Visits	18,177	18,385
Surgical Cases	3,568	3,595
Full Time Equivalent Employees	2,275	2,189
Worked Hrs/CMI Adjusted Discharge	90.89	92.55

(1) For Debt Service Coverage Ratio and Debt to Capitalization, Target represents Bond Convenants
For Days Cash and Net AR Days, Target represents S&P A+ Rated Hospital Medians

Management Commentary







Direction of arrows at top right of each chart indicates desired results

Net Days in AR – Net days in AR decreased to lowest level in the last 12 months due to the strong collections month.

CMI Adjusted Discharges – CMI adjusted discharges were at the 4th highest point in the last 12 months based upon by high surgical cases in the MV campus and deliveries and emergency department visits at both campuses. Total CMI adjusted discharges are 5% above budget year to date due to maternal child and OR patient visits.

Operating Margin – Operating margin was up in the current month related deduction and allowance adjustments from prior periods and patient volumes.

Key Hospital Indicators

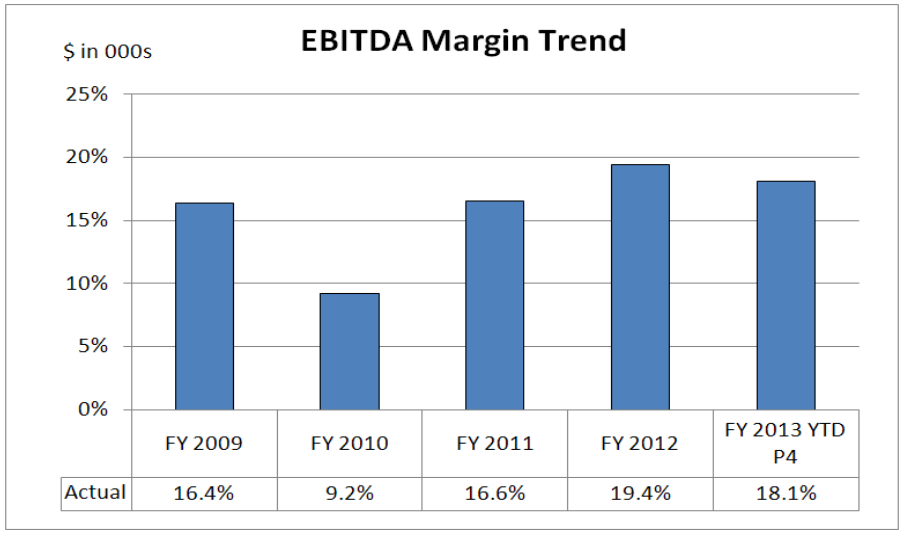
Statistic	FY 2010	FY 2011	FY 2012	FY 2013	Target (1)	+/-
Operating Margin	0.7%	7.9%	10.5%	10.1%	8.0%	
EBITDA Margin	9.2%	16.6%	19.4%	18.1%	16.3%	
Days of Cash	196	250	321	307	229	
Debt Service Coverage Ratio (MADS)	4.3	7.0	7.2	8.7	2.8	
Debt to Capitalization	19.3%	18.9%	15.8%	15.2%	30.9%	
Net AR Days	47.1	48.6	48.1	47.1	45.3	

(1) Target source: Budget for Operating Margin and EBITDA Margin

Target source: S&P A+ Rated Hospital Medians for Debt Service Converage ration, Debt to Capitalization, and Net AR Days

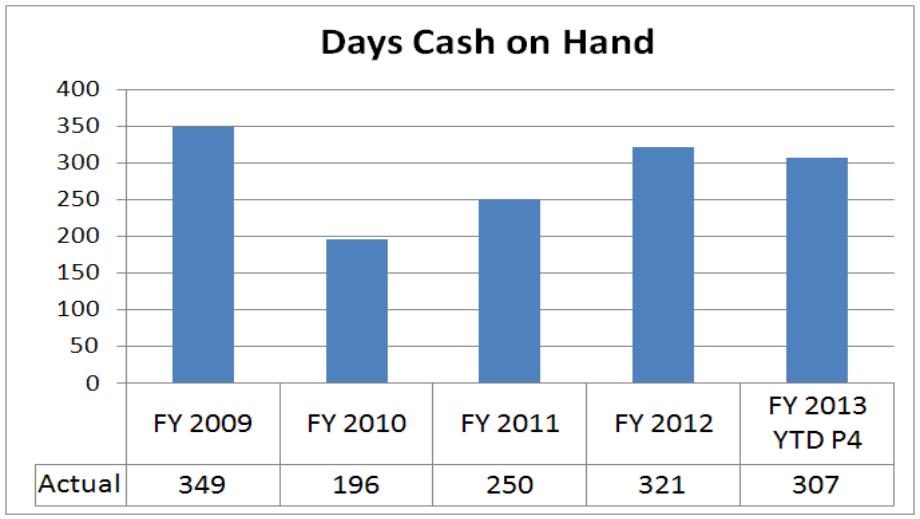
Financial Metrics Trend

Profit_Loss



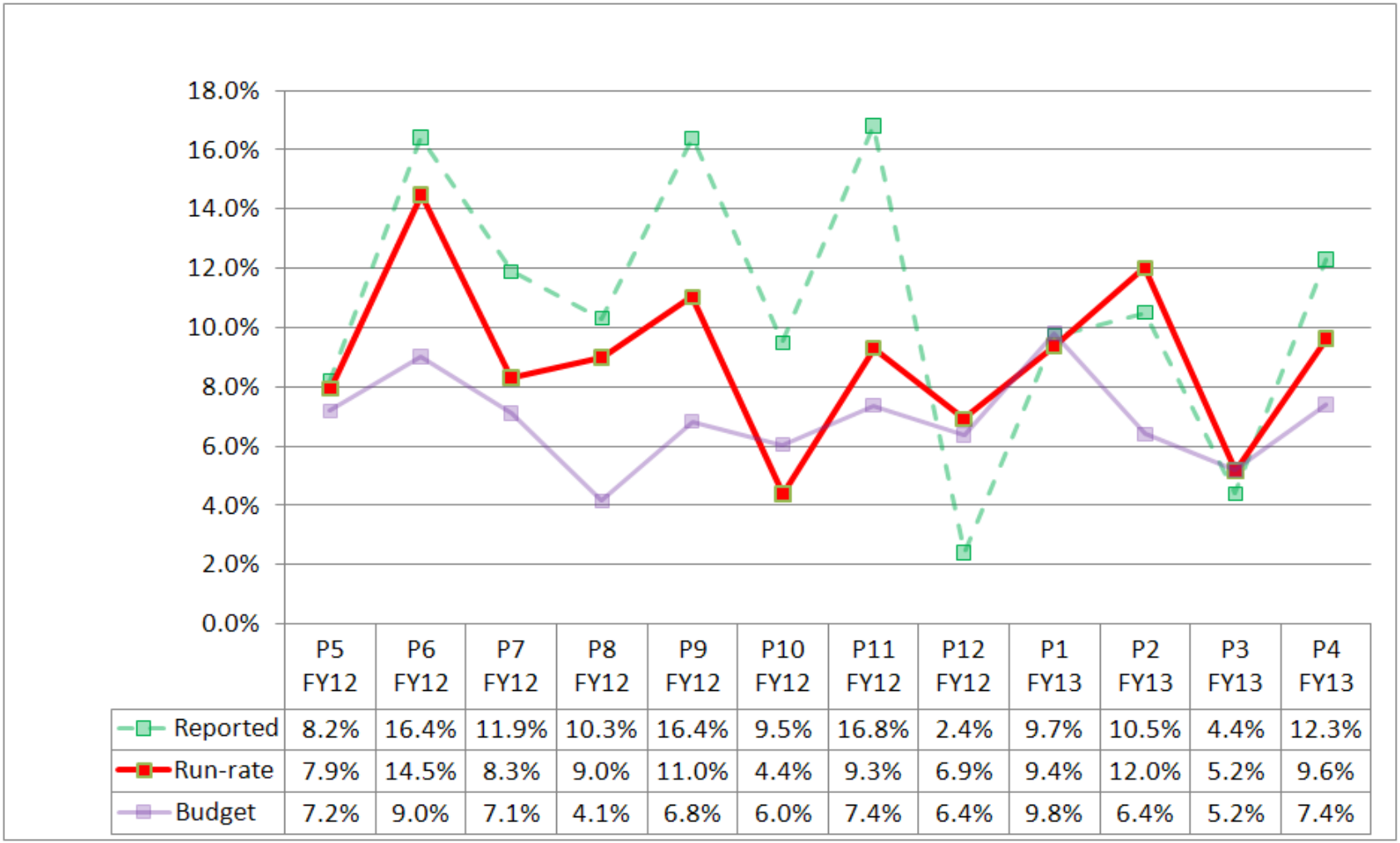
1.8% Favorable to Budget YTD

BAL_SHEET



29 Days Favorable to Budget

ECH Operating Margin



	P5 FY12	P6 FY12	P7 FY12	P8 FY12	P9 FY12	P10 FY12	P11 FY12	P12 FY12	P1 FY13	P2 FY13	P3 FY13	P4 FY13
Reported	8.2%	16.4%	11.9%	10.3%	16.4%	9.5%	16.8%	2.4%	9.7%	10.5%	4.4%	12.3%
Run-rate	7.9%	14.5%	8.3%	9.0%	11.0%	4.4%	9.3%	6.9%	9.4%	12.0%	5.2%	9.6%
Budget	7.2%	9.0%	7.1%	4.1%	6.8%	6.0%	7.4%	6.4%	9.8%	6.4%	5.2%	7.4%

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

ECH Volume Statistics

MOUNTAIN VIEW

	P 4			Year to Date			Prior Year	
	Act	Bud	Var%	Act	Bud	Var%	Act	Var%
Discharges (1)	1,354	1,259	7.5%	5,287	4,994	5.9%	4,980	6.2%
ADC (1)	185	179	3.4%	181	179	1.1%	171	5.8%
Deliveries	393	333	18.0%	1,611	1,322	21.9%	1,378	16.9%
ED Visits	3,783	3,674	3.0%	14,350	14,579	-1.6%	14,187	1.1%
Surgical Cases	558	549	1.6%	2,107	2,177	-3.2%	2,064	2.1%

LOS GATOS

	P 4			Year to Date			Prior Year	
	Act	Bud	Var	Act	Bud	Var	Act	Var%
Discharges (1)	263	283	-7.1%	1,128	1,121	0.6%	995	13.4%
ADC (1)	37	43	-14.0%	40	43	-7.0%	37	8.1%
Deliveries	59	58	1.7%	255	231	10.4%	197	29.4%
ED Visits	984	959	2.6%	3,827	3,806	0.6%	3,668	4.3%
Surgical Cases	324	357	-9.2%	1,461	1,418	3.0%	1,364	7.1%

ECH

	P 4			Year to Date			Prior Year	
	Act	Bud	Var	Act	Bud	Var	Act	Var%
Discharges (1)	1,617	1,542	4.9%	6,415	6,115	4.9%	5,975	7.4%
ADC (1)	222	222	0.0%	221	222	-0.5%	208	6.3%
Deliveries	452	391	15.6%	1,866	1,553	20.2%	1,575	18.5%
ED Visits	4,767	4,633	2.9%	18,177	18,385	-1.1%	17,855	1.8%
Surgical Cases	882	906	-2.6%	3,568	3,595	-0.8%	3,428	4.1%

(1) Excl. Newborn

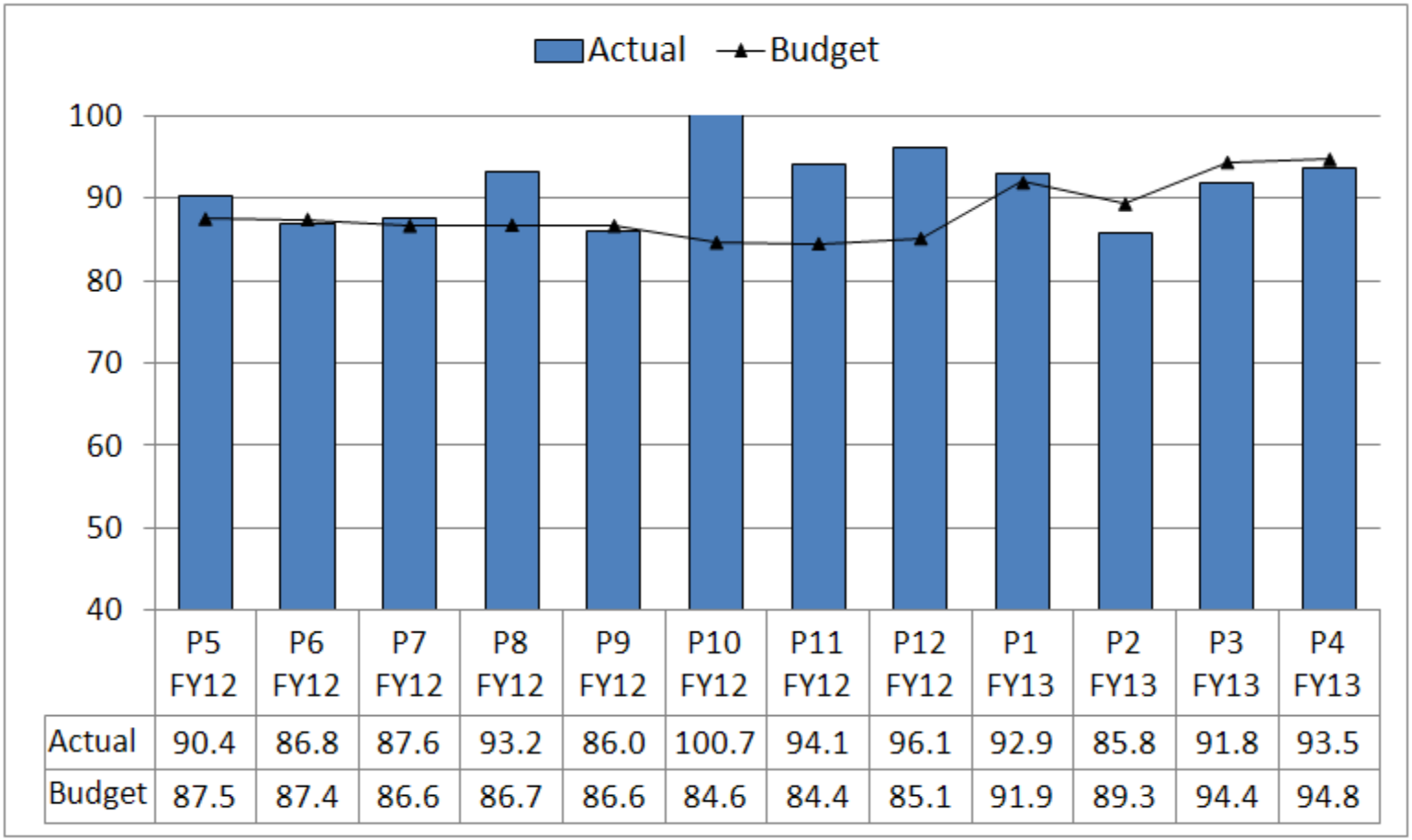
APPENDIX

Summary of Financial Results
$ in Thousands

	Period 4 Actual	Period 4 Budget	Period 4 Variance	YTD Actual	YTD Budget	YTD Variance
El Camino Hospital Income(Loss) from Operations						
Mountain View	6,527	2,294	$4,233	18,499	10,005	$8,494
Los Gatos	1,381	2,185	$(803)	4,611	7,186	(2,574)
Sub Total - El Camino Hospital	**7,908**	**4,479**	**$3,429**	**23,110**	**17,191**	**$5,920**
Operating Margin %	**12.3%**	**7.4%**		**9.4%**	**7.2%**	
El Camino Hospital Non Operating Income						
Investments **	754	1,735	$(981)	9,974	6,940	3,035
Swap Adjustments	222	-	222	432	-	432
Community Benefit	(1,088)	(488)	(600)	(2,618)	(1,950)	(668)
Other	25	(417)	442	(602)	(1,668)	1,067
Sub Total - Non Operating Income	**$(87)**	**830**	**$(917)**	**7,187**	**3,321**	**$3,866**
El Camino Hospital Net Income (Loss)	**7,821**	**5,309**	**$2,512**	**30,297**	**20,512**	**$9,785**
ECH Net Margin %	**13.0%**	**10.7%**		**14.3%**	**10.6%**	
Net Margin All Other Hospital Affiliates	$(168)	$(15)	$(153)	$761	$221	$540
Total Net Margin Hospital & Affiliates	**$7,653**	**$5,294**	**$2,359**	**$31,058**	**$20,733**	**$10,325**

Worked Hours per CMI Adjusted Discharge

P4 YTD: ***1.3 below budget***

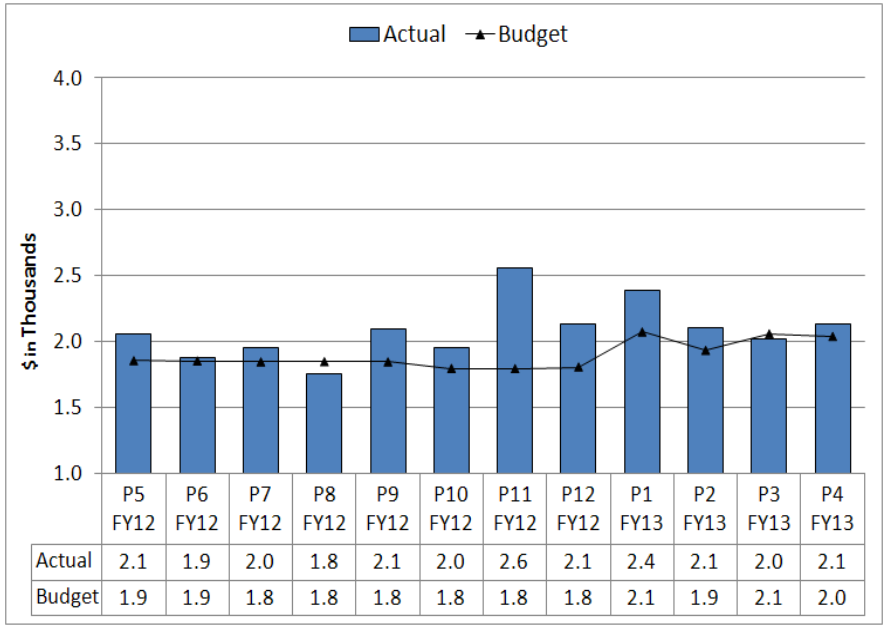


	P5 FY12	P6 FY12	P7 FY12	P8 FY12	P9 FY12	P10 FY12	P11 FY12	P12 FY12	P1 FY13	P2 FY13	P3 FY13	P4 FY13
Actual	90.4	86.8	87.6	93.2	86.0	100.7	94.1	96.1	92.9	85.8	91.8	93.5
Budget	87.5	87.4	86.6	86.7	86.6	84.6	84.4	85.1	91.9	89.3	94.4	94.8

Supply Cost per CMI Adjusted Discharges

YTD P4 : 5.0% above budget

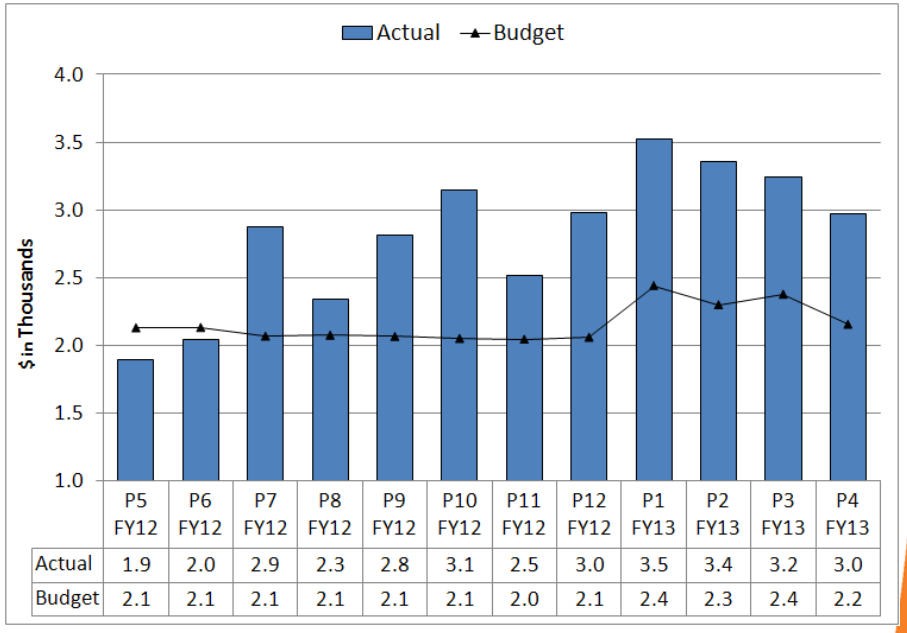
Mountain View



	P5 FY12	P6 FY12	P7 FY12	P8 FY12	P9 FY12	P10 FY12	P11 FY12	P12 FY12	P1 FY13	P2 FY13	P3 FY13	P4 FY13
Actual	2.1	1.9	2.0	1.8	2.1	2.0	2.6	2.1	2.4	2.1	2.0	2.1
Budget	1.9	1.9	1.8	1.8	1.8	1.8	1.8	1.8	2.1	1.9	2.1	2.0

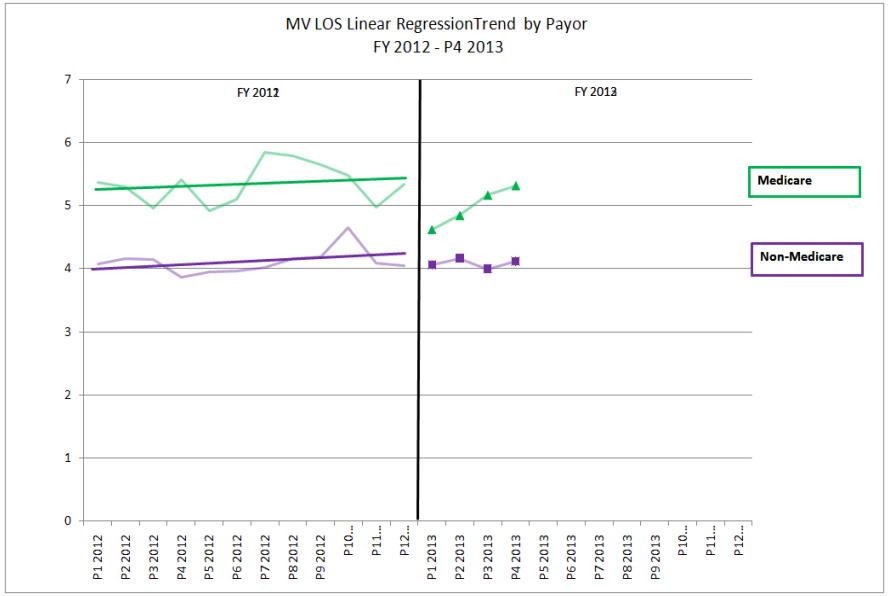
YTD P4 : 36.4% above budget

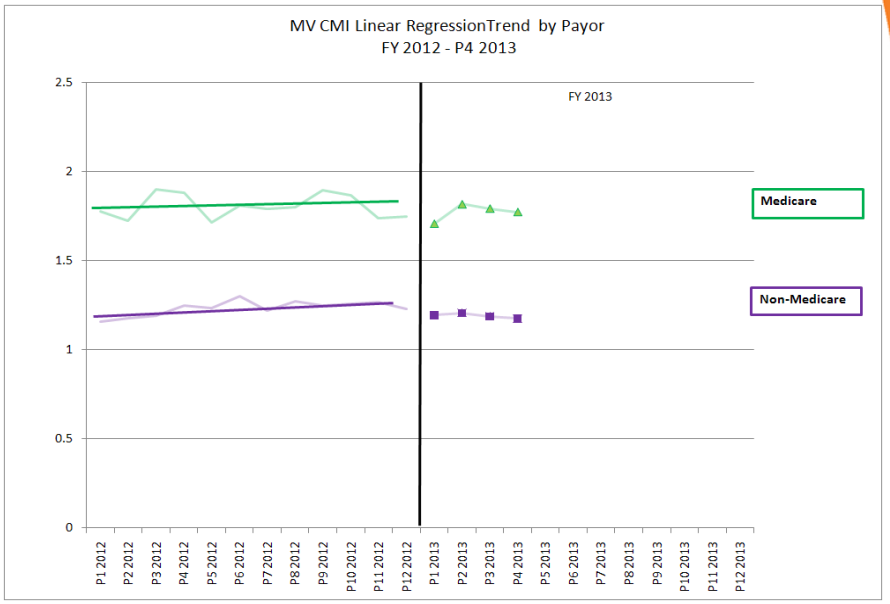
Los Gatos



	P5 FY12	P6 FY12	P7 FY12	P8 FY12	P9 FY12	P10 FY12	P11 FY12	P12 FY12	P1 FY13	P2 FY13	P3 FY13	P4 FY13
Actual	1.9	2.0	2.9	2.3	2.8	3.1	2.5	3.0	3.5	3.4	3.2	3.0
Budget	2.1	2.1	2.1	2.1	2.1	2.1	2.0	2.1	2.4	2.3	2.4	2.2

Mountain View LOS & CMI Trend

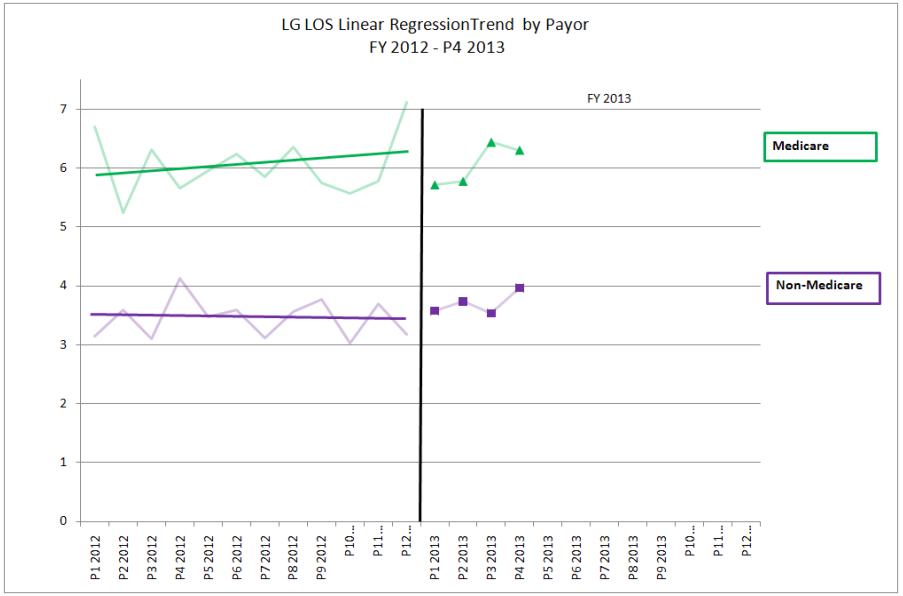


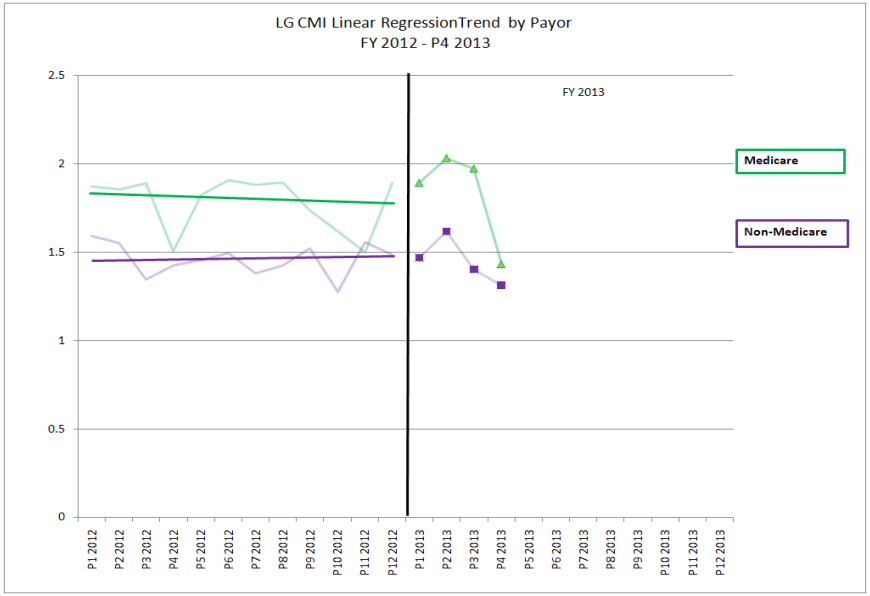


- Medicare: LOS trending up and CMI flat – Unfavorable
- Non-Medicare: Both LOS and CMI are flat – Neutral
- Medicare is a per case reimbursement, and Non-Medicare is mixed.

Payor Mix	YTD P4		Prior Yr	
$ in millions	Gross Chg	Mix %	Gross Chg	Mix %
Government	$290.6	45.0%	$279.6	45.7%
Commercial	327.6	50.8%	$302.1	49.4%
Other	27.3	4.2%	$29.7	4.9%
	$645.5		$611.5	

Los Gatos LOS & CMI Trend





- Medicare: LOS trending up and CMI are trending down – Favorable
- Non-Medicare: LOS trending up and CMI trending down – Favorable
- Medicare is a per case reimbursement, and Non-Medicare is mixed.

Payor Mix	YTD P4		Prior Yr	
$ in millions	Gross Chg	Mix %	Gross Chg	Mix %
Government	$65.9	40.4%	$61.1	42.2%
Commercial	81.6	50.0%	$69.4	48.0%
Other	15.8	9.7%	$14.1	9.7%
	$163.2		$144.6	

El Camino Hospital

Preliminary Results from Operations vs. Prior Year

4 months ending 10/31/2012

$000s	FY 2013	FY 2012	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	808,701	756,022	52,679	7.0%
Deductions	(584,704)	(559,981)	(24,723)	4.4%
Net Patient Revenue	**223,997**	**196,040**	**27,956**	**14.3%**
Other Operating Revenue	5,130	4,792	338	7.1%
Total Operating Revenue	**229,127**	**200,832**	**28,294**	**14.1%**
OPERATING EXPENSE:				
Salaries & Wages	116,144	103,680	12,464	12.0%
Supplies	35,576	28,679	6,898	24.1%
Fees & Purchased Services	28,048	25,952	2,096	8.1%
Other Operating Expense	26,248	26,862	(615)	-2.3%
Total Operating Expense	**206,016**	**185,174**	**(20,843)**	**-11.3%**
Net Operating Income/(Loss)	**23,110**	**15,659**	**7,452**	**47.6%**
Non Operating Income	7,187	(9,339)	16,526	-177.0%
Net Income(Loss)	**30,297**	**6,320**	**23,978**	**379.4%**
Collection Rate	27.7%	25.9%		
Operating Margin	10.1%	7.8%		
Net Margin	13.2%	3.1%		

El Camino Hospital – Mountain View

Preliminary Results from Operations vs. Prior Year

4 months ending 10/31/2012

$000s	FY 2013	FY 2012	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	645,487	611,464	34,022	5.6%
Deductions	(465,944)	(452,575)	(13,369)	3.0%
Net Patient Revenue	**179,542**	**158,889**	**20,653**	**13.0%**
Other Operating Revenue	4,945	4,665	281	6.0%
Total Operating Revenue	**184,488**	**163,553**	**20,934**	**12.8%**
OPERATING EXPENSE:				
Salaries & Wages	96,382	86,448	9,935	11.5%
Supplies	26,049	21,778	4,272	19.6%
Fees & Purchased Services	23,434	21,498	1,936	9.0%
Other Operating Expense	20,123	21,023	(901)	-4.3%
Total Operating Expense	**165,989**	**150,747**	**15,242**	**10.1%**
Net Operating Income/(Loss)	**18,499**	**12,807**	**5,692**	**44.4%**
Non Operating Income	7,176	(9,339)	16,515	-176.8%
Net Income(Loss)	**25,675**	**3,468**	**22,207**	**640.4%**
Collection Rate	27.8%	26.0%		
Operating Margin	10.0%	7.8%		
Net Margin	13.9%	2.1%		

El Camino Hospital – Los Gatos

Preliminary Results from Operations vs. Prior Year

4 months ending 10/31/2012

$000s	FY 2013	FY 2012	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	163,214	144,557	18,657	12.9%
Deductions	(118,760)	(107,406)	(11,354)	10.6%
Net Patient Revenue	**44,454**	**37,151**	**7,303**	**19.7%**
Other Operating Revenue	185	127	57	44.9%
Total Operating Revenue	**44,639**	**37,279**	**7,360**	**19.7%**
OPERATING EXPENSE:				
Salaries & Wages	19,762	17,233	(2,529)	-14.7%
Supplies	9,527	6,901	(2,626)	-38.1%
Fees & Purchased Services	4,614	4,454	(160)	-3.6%
Other Operating Expense	6,125	5,839	(11,964)	-204.9%
Total Operating Expense	**40,028**	**34,427**	**(17,279)**	**-50.2%**
Net Operating Income/(Loss)	**4,611**	**2,852**	**1,759**	**61.7%**
Non Operating Income	11	0	11	100.0%
Net Income(Loss)	**4,623**	**2,852**	**1,771**	**62.1%**
Collection Rate	27.2%	25.7%		
Operating Margin	10.3%	7.7%		
Net Margin	10.4%	7.7%		

El Camino Hospital

Preliminary Results from Operations vs. Budget

4 months ending 10/31/2012

$000s	FY 2013	FY 2012	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	808,701	781,685	27,016	3.5%
Deductions	(584,704)	(571,470)	(13,235)	2.3%
Net Patient Revenue	**223,997**	**210,215**	**13,781**	**6.6%**
Other Operating Revenue	5,130	5,909	(779)	-13.2%
Total Operating Revenue	**229,127**	**216,124**	**13,003**	**6.0%**
OPERATING EXPENSE:				
Salaries & Wages	116,144	111,610	(4,535)	-4.1%
Supplies	35,576	30,523	(5,053)	-16.6%
Fees & Purchased Services	28,048	29,739	1,691	5.7%
Other Operating Expense	26,248	27,061	814	3.0%
Total Operating Expense	**206,016**	**198,933**	**(7,083)**	**-3.6%**
Net Operating Income/(Loss)	**23,110**	**17,191**	**5,920**	**34.4%**
Non Operating Income	7,187	3,321	3,866	116.4%
Net Income(Loss)	**30,297**	**20,512**	**9,785**	**47.7%**
Collection Rate	27.7%	26.9%		
Operating Margin	10.1%	8.0%		
Net Margin	13.2%	9.5%		

El Camino Hospital – Mountain View

Preliminary Results from Operations vs. Budget

4 months ending 10/31/2012

$000s	FY 2013	FY 2012	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	645,487	625,529	19,958	3.2%
Deductions	(465,944)	(458,717)	(7,228)	1.6%
Net Patient Revenue	**179,542**	**166,812**	**12,730**	**7.6%**
Other Operating Revenue	4,945	5,783	(838)	-14.5%
Total Operating Revenue	**184,488**	**172,596**	**11,892**	**6.9%**
OPERATING EXPENSE:				
Salaries & Wages	96,382	92,807	(3,575)	-3.9%
Supplies	26,049	23,620	(2,430)	-10.3%
Fees & Purchased Services	23,434	24,754	1,320	5.3%
Other Operating Expense	20,123	21,410	1,287	6.0%
Total Operating Expense	**165,989**	**162,591**	**(3,398)**	**-2.1%**
Net Operating Income/(Loss)	**18,499**	**10,005**	**8,494**	**84.9%**
Non Operating Income	7,176	3,321	3,855	116.1%
Net Income(Loss)	**25,675**	**13,326**	**12,349**	**92.7%**
Collection Rate	27.8%	26.7%		
Operating Margin	10.0%	5.8%		
Net Margin	13.9%	7.7%		

El Camino Hospital – Los Gatos

Preliminary Results from Operations vs. Budget

4 months ending 10/31/2012

$000s	FY 2013	FY 2012	Variance Fav (Unfav)	Var%
OPERATING REVENUE:				
Gross Revenue	163,214	156,156	7,058	4.5%
Deductions	(118,760)	(112,753)	(6,007)	5.3%
Net Patient Revenue	**44,454**	**43,403**	**1,051**	**2.4%**
Other Operating Revenue	185	125	60	47.6%
Total Operating Revenue	**44,639**	**43,528**	**1,111**	**2.6%**
OPERATING EXPENSE:				
Salaries & Wages	19,762	18,802	(960)	-5.1%
Supplies	9,527	6,904	(2,623)	-38.0%
Fees & Purchased Services	4,614	4,985	371	7.4%
Other Operating Expense	6,125	5,651	(473)	-8.4%
Total Operating Expense	**40,028**	**36,342**	**(3,685)**	**-10.1%**
Net Operating Income/(Loss)	**4,611**	**7,186**	**(2,574)**	**-35.8%**
Non Operating Income	11	0	11	100.0%
Net Income(Loss)	**4,623**	**7,186**	**(2,563)**	**-35.7%**
Collection Rate	27.2%	27.8%		
Operating Margin	10.3%	16.5%		
Net Margin	10.4%	16.5%		

El Camino Hospital

Balance Sheet

	Period Ending October 31	
CURRENT ASSETS	FY 2013	FY 2012
Cash	$30,503	$30,621
Short Term Investments	235,770	100,940
Patient Accounts Receivable, NET	82,408	73,863
Other Accounts and Notes Receivable	3,228	3,079
Intercompany Receivables	1,556	1,278
Inventories and Prepaids	50,654	40,134
Total Current Assets	**404,118**	**249,915**
BOARD DESIGNATED ASSETS		
Plant & Equipment Fund	14,866	48,984
Operational Reserve Fund	100,196	100,989
Community Benefit Fund	2,520	7,845
Workers Compensation Reserve Fund	21,200	18,631
Postretirement Health/Life Reserve Func	15,212	14,898
PTO Liability Fund	17,382	15,425
Malpractice Reserve Fund	2,318	2,318
Catastrophic Reserves Fund	12,087	9,858
Total Board Designated Assets	**185,781**	**218,948**
FUNDS HELD BY TRUSTEE	**9,384**	**9,384**
LONG TERM INVESTMENTS	**40,527**	**31,042**
INVESTMENTS IN AFFILIATES	**20,518**	**21,980**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,002,536	991,312
Less: Accumulated Depreciation	-359,564	-323,397
Construction in Progress	7,108	4,744
Property, Plant & Equipment - Net	**650,081**	**672,659**
DEFERRED COSTS/BOND ISSUE COSTS	4,783	4,964
RESTRICTED ASSETS - CASH	1	0
TOTAL ASSETS	**$1,315,193**	**$1,208,893**

	Period Ending October 31	
CURRENT LIABILITIES	FY 2013	FY 2012
Accounts Payable	$17,540	$12,132
Salaries and Related Liabilities	20,698	17,222
Accrued PTO	17,382	15,425
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	21,123	8,936
Intercompany Payables	519	695
Malpractice Reserves	2,318	2,318
Bonds Payable - Current	2,850	5,379
Bond Interest Payable	2,592	0
Other Liabilities	7,064	7,849
Total Current Liabilities	**94,388**	**72,255**
LONG TERM LIABILITIES		
Post Retirement Benefits	15,212	14,898
Worker's Comp Reserve	18,900	16,331
Other Long-term Obligation (Asbestos Abatement	3,216	3,108
Other Long-term Liabilities (IT/Medical Leases)	2,246	7,718
Bond Payable	194,869	196,453
Total Long Term Liabilities	**234,442**	**238,508**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	800,581	679,181
Board Designated	185,781	218,948
Restricted	1	0
Total Fund Balance & Capital Accounts	**986,363**	**898,130**
TOTAL LIABILITIES AND FUND BALANCE	**$1,315,193**	**$1,208,893**

El Camino Hospital

Capital Spending for the 4 months ended 10/31/2012

Approved Prior Years Projects > $500K	Committed/Approved	Spent in Prior FYs	Spent in Current FY	Remaining	Total
0800 Womens Hospital LDR Expansion	$ 3,810,800	546,132	294,971	2,969,697	841,103
0908 LG Seismic Upgrades	$ 2,670,000	591,711	250,564	1,827,725	842,275
Software - Bedside Medication Administration (KBMA)	$ 1,829,938	577,205	23,939	1,228,794	601,144
Cardiovascular Information System	$ 1,494,500	568,014	5,151	921,335	573,165
Telecom - Los Gatos VoIP Implementation	$ 710,000	342,609	13,954	353,437	356,563
Software - SIS OR Phase 2	$ 628,188	251,982	0	376,206	251,982
eICU CCU intensivist monitoring system	$ 575,000	0	0	575,000	0
Subtotal Projects > $500K	**$ 11,718,426**	**2,877,653**	**588,580**	**8,252,193**	**3,466,233**
Other Projects < $500K	$ 1,098,314	421,014	677,300	0	1,098,314
Total Projects Approved in Prior Years	**$ 12,816,740**	**$ 3,298,667**	**$ 1,265,880**	**$ 8,252,193**	**$ 4,564,547**

Approved Current Year Projects > $500K	Committed/Approved	Spent in Prior FY	Spent in Current FY	Remaining	Total
	0	0	0	0	0
Current Year Total	$0	$0	$0	**0**	**0**
Subtotal Projects > $500K	**$ -**	**0**	**0**	**0**	**0**
Other Projects < $500K	$ 3,383,879	0	2,943,879	440,000	2,943,879
Total Current Year	**$ 3,383,879**	**0**	**2,943,879**	**440,000**	**2,943,879**

Total Capital Spending in Current Year	**$ 4,209,759**

END OF PRESENTATION

2012-19 ECH Resolution Re Measure M Lawsuit_(WEST_32761748_1).docx

RESOLUTION OF THE BOARD OF DIRECTORS
OF THE EL CAMINO HOSPITAL

Resolution 2012-19

WHEREAS, an initiative ("Measure M") purporting to limit "the annual salary and compensation package" of certain employees of the El Camino Hospital District ("District") and the El Camino Hospital ("Hospital") qualified for the November 6, 2012 ballot;

WHEREAS, on December 10, 2012, the El Camino Hospital District declared that Measure M had received a majority of the votes cast;

WHEREAS, the Hospital's staff has concluded, and the Hospital Board agrees, that the Measure M has already impaired, and will continue to impair, the Hospital's ability to attract and retain competent executives, managers, and administrators, and thereby detract from the Hospital's ability to provide the best quality care to the District's residents at the lowest possible price;

WHEREAS, the Hospital Board decided on November 14, 2012, to initiate a lawsuit to obtain a judicial ruling that Measure M is unconstitutional, both on its face and as applied, and to obtain a preliminary injunction precluding the enforcement of Measure M while the lawsuit is being litigated;

WHEREAS, the Hospital executives, administrators and managers whose compensation might also be adversely affected by Measure M wish to join as Petitioners and Plaintiffs in the contemplated lawsuit;

WHEREAS, the Hospital wants to afford the Hospital executives, administrators and managers whose compensation might also be adversely affected by Measure M to join as Petitioners and Plaintiffs in the contemplated lawsuit without fear of incurring liability for attorney's fees and costs;

NOW, THEREFORE, BE IT RESOLVED:

1. The Hospital Board's hereby reaffirms its decision, made on November 14, 2012, to initiate a lawsuit to obtain a judicial ruling that Measure M is unconstitutional, both on its face and as applied.

2. The Hospital requests those Hospital executives, administrators and managers whose compensation might also be adversely affected by Measure M to join as Petitioners and Plaintiffs in the contemplated lawsuit.

3. To accomplish the foregoing, the Hospital will (a) pay the legal fees and costs incurred in initiating and prosecuting the lawsuit challenging the validity of Measure M; and (b) indemnify those Hospital executives, administrators and managers whose compensation might also be adversely affected by Measure M and who join as Petitioners and Plaintiffs in the

contemplated lawsuit against all liability for attorney's fees and costs arising of out their participation in the lawsuit.

PASSED AND ADOPTED at a Regular Meeting held on the __th day of December, 2012, by the following votes:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____

Dave Reeder, Secretary
El Camino Hospital Board

2012-16 Board Resolution for Amendment 3 Delegation of Authority (2).doc

RESOLUTION OF THE BOARD OF DIRECTORS
OF
EL CAMINO HOSPITAL

Resolution 2012-16

WHEREAS, El Camino Hospital (the "Hospital") sponsors the El Camino Hospital Cash Balance Plan, Amended and Restated Effective as of January 1, 2009 (the "Plan"); and

WHEREAS, Section 10.1 of the Plan reserves to the Board of Directors of the Hospital the right to amend the Plan from time to time; and

WHEREAS, the Hospital desires to amend the Plan to delegate certain authorities to amend the Plan to the Retirement Plan Administrative Committee (the "RPAC"), as reflected in the attached Amendment Three to the El Camino Hospital Cash Balance Plan, Amended and Restated Effective as of January 1, 2009 ("Amendment Three").

NOW, THEREFORE, BE IT RESOLVED, the Board of Directors hereby approves Amendment Three as attached hereto.

FURTHER RESOLVED, that the appropriate officers of El Camino Hospital or any appropriate member of the RPAC are authorized and directed to execute Amendment Three and to take any actions they deem appropriate to implement Amendment Three.

FURTHER RESOLVED, that the adoption of Amendment Three is conditioned upon such Amendment Three not affecting the qualified status of the Plan under Section 401(a) of the Internal Revenue Code or the qualified status of the trust for the Plan under Section 501(a) of the Internal Revenue Code.

* * * * *

CERTIFICATE

I, _____, the Secretary of El Camino Hospital, hereby certify that the foregoing Resolution was adopted by the Board of Directors at a meeting held on _____ __, 2012 at the principal offices of El Camino Hospital located in Mountain View, California.

IN WITNESS WHEREOF, I have hereunto set my hand this __day of _____ 2012.

_____
Secretary

2012-17 Board Resolution 2012-17 for Amendment Adjusted Funding Target Percentage.doc

RESOLUTION OF THE BOARD OF DIRECTORS
OF
EL CAMINO HOSPITAL

Resolution 2012-17

WHEREAS, El Camino Hospital (the "Hospital") sponsors the El Camino Hospital Cash Balance Plan, Amended and Restated Effective as of January 1, 2009 (the "Plan"); and

WHEREAS, Section 10.1 of the Plan reserves to the Board of Directors of the Hospital the right to amend the Plan from time to time; and

WHEREAS, the Hospital desires to amend the Plan to satisfy the limitations of Section 436 of the Internal Revenue Code of 1986, as amended, on the accrual and payment of benefits under certain underfunded single employer defined benefit plans, as reflected in the attached Amendment Four to the El Camino Hospital Cash Balance Plan, Amended and Restated Effective as of January 1, 2009 ("Amendment Four").

NOW, THEREFORE, BE IT RESOLVED, the Board of Directors hereby approves Amendment Four as attached hereto.

FURTHER RESOLVED, that the appropriate officers of El Camino Hospital or any appropriate member of the Retirement Plan Administrative Committee (the "RPAC") are authorized and directed to execute Amendment Four and to take any actions they deem appropriate to implement Amendment Four.

FURTHER RESOLVED, that the adoption of Amendment Four is conditioned upon such Amendment Four not affecting the qualified status of the Plan under Section 401(a) of the Internal Revenue Code or the qualified status of the trust for the Plan under Section 501(a) of the Internal Revenue Code.

* * * * *

CERTIFICATE

I, _____, the Secretary of El Camino Hospital, hereby certify that the foregoing Resolution was adopted by the Board of Directors at a meeting held on _____ __, 2012 at the principal offices of El Camino Hospital located in Mountain View, California.

IN WITNESS WHEREOF, I have hereunto set my hand this __day of _____ 2012.

_____
Secretary

2012-18 403(b) Board Reolution - Delegation of Authority (2).doc

RESOLUTION OF THE BOARD OF DIRECTORS
OF
EL CAMINO HOSPITAL

Resolution 2012-18

WHEREAS, El Camino Hospital (the "Hospital") sponsors the El Camino Hospital 403(b) Retirement Plan, amended and restated effective as of January 1, 2011 (the "Plan"); and

WHEREAS, the Hospital desires to delegate the authority to amend the Plan to the Retirement Plan Administration Committee (the "RPAC"), as may be required from time to time due to changes in applicable laws and regulations.

NOW, THEREFORE, BE IT RESOLVED, that the appropriate officers of El Camino Hospital or any appropriate member of the RPAC are authorized and directed to execute any and all Plan amendments required due to changes in applicable laws and regulations and to take any actions they deem appropriate to implement such amendments.

* * * * *

CERTIFICATE

I, _____, the Secretary of El Camino Hospital, hereby certify that the foregoing Resolution was adopted by the Board of Directors at a meeting held on _____ __, 2012 at the principal offices of El Camino Hospital located in Mountain View, California.

IN WITNESS WHEREOF, I have hereunto set my hand this __day of _____ 2012.

_____
Secretary

Slot Ten Step Finanace, 11-26.doc

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Memorandum
Administration

Date: November 16, 2012
To: Board of Directors
From: Ken King, Chief Administrative Services Officer
Re: Facilities Project Preliminary Funding Request - Slot / Data Center

Authority: Capital facilities projects exceeding $500,000 require approval of the Board Finance Committee and the Board of Directors and as the executive responsible for executing facilities projects I am submitting this request for your consideration.

Problem / Opportunity Definition: The "Slot" is a new, seismically compliant, 16,000 square foot, 2-story, shelled- in, hospital building structure that was an early construction phase of the replacement hospital project. (See Attached Diagram) This project proposes to build-out the interior improvements of the Slot building to house functions that are critical to our operations or are required to be in seismically compliant space. These improvements will allow us to relocate the Data Center, the Morgue and Autopsy functions and the Clean and Soiled Linen functions that currently exist in the old main hospital building, which will be classified as non-compliant at the end of 2013.

Process Description: Programming, schematic design and design development phases have been completed. In order to complete construction documents, engage certain contractors and obtain OHSPD plan approval, preliminary funding of $1.4 million is needed. Once the plans and specifications have been through the initial OSHPD review (2-3 OSHPD review cycles are anticipated) we will obtain a Guaranteed Maximum Price (GMP) proposal from BN Builders, the contractor selected to assist in the design and manage the construction of the project. Once a GMP is received a final project budget will be requested. The current estimated cost of the entire project is $17.8 million.

Alternative Solutions: Relocating the Data Center was recommended in the Business Continuity and Disaster Recovery Compliance Audit and relocating the morgue and other functions that must be moved into this seismically compliant building was our only consideration. Other than configuration options, no other viable alternatives exist.

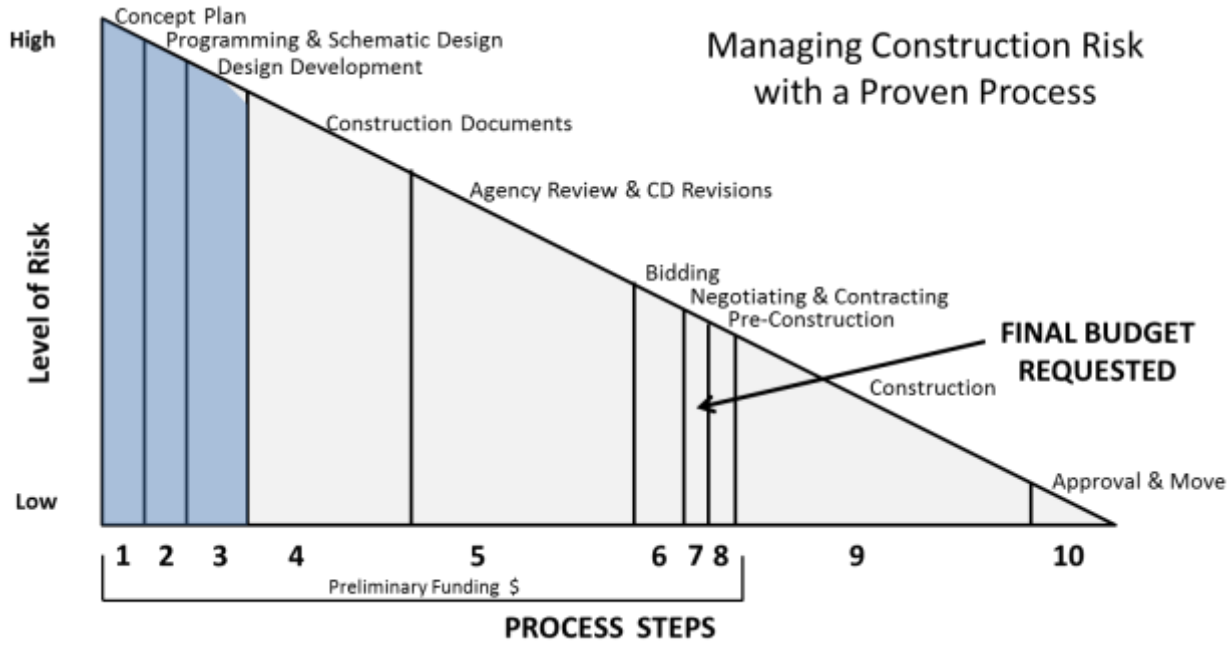
Concurrence for Recommendation: The project is supported by the MV Campus Master Facilities Plan, the IT Leadership, the Pathology and Environmental Services Departments and the Operations Committee. The project is included in the Capital Spending Authority Budget for FY 13 approved by the Board of Directors in June 2012.

Outcome Measures / Deadlines: The target schedule to complete the Construction Documents and obtain OSHPD Plan Approval is June 2013. The request to fund the construction of the project will be submitted prior to the start of construction and the construction is targeted to be completed by the end of 2013.

Legal Review: Design and Construction contracts have been developed and reviewed with the support of Greg Caligari of Cox, Castle and Nicholson.

Compliance Review: None required

Financial Review: The FY 2013 Capital Budget included $17.8 million for the development and construction of the requested improvements. This request for preliminary funding of $1.4 million represents approximately 8% of total estimated cost of the project and it includes the cost of approximately $240,000 committed to date. The graphic below depicts the process steps we follow to manage construction risk while updating the cost estimates along the way. The shaded area on the left indicates where we are in the process for this project. The process provides a critical control point prior to the start of construction to ensure that the scope of work and the cost to complete are fully known and understood before construction funds are authorized.



Recommendation: It is recommended that the Board Finance Committee approve the preliminary funding request not to exceed $1.4 million for the completion of design documents and agency review for the Slot / Data Center project. The final funding of the project to be requested prior to the start of construction.

El Camino Hospital Campus

Current 2012

10 Step_2012_Neurology Call Contract_November 15 2012_OPEN (2).docx

OPEN

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Date: November 16, 2012

To: El Camino Hospital Board of Directors

Subject: Neurology Call Contract – Los Gatos Campus

Authority: Board approval is required for physician on-call contracts where the total cost is greater than 10% above the current cost.

Problem Definition: The Neuroscience Institute at El Camino Hospital continues to focus efforts on the development of key clinical services directed at expanding the continuum of care and enhancing the quality of services offered to the communities we serve. One area that has been underserved is the provision of services to individuals with neurological injuries, specifically those individuals with a stroke who live within the service area of the Los Gatos campus.

In 2006 Santa Clara County implemented a "Stroke Care System" which required patients who exhibited the signs and symptoms of a stroke to be transported to designated stroke centers. El Camino Hospital, Mountain View, a Primary Stroke Center certified by The Joint Commission, was one of the eight hospitals identified as a receiving center for individuals with an acute stroke at that time. At the time of this request, El Camino Hospital, Los Gatos is the only hospital in Santa Clara County that is not part of the "Stroke System of Care" and has not been certified as a Primary Stroke Center.

The decision has been made to have the Los Gatos campus become a "Primary Stroke Center" certified by The Joint Commission. One of the key functions that is required by The Joint Commission, Disease Specific Certification program is the availability of "practitioners experienced in the diagnosis and treatment of stroke" (neurologists), who are available within 15 minutes of a stroke call, twenty-four hours per day, seven days a week. The treatment window for an individual with an acute stroke is limited to a two hundred and seventy minute window from the onset of the stroke. Today, treatment within El Camino Hospitals is limited to the administration of tPA (a clot busting drug) by a highly trained neurologist specializing in the treatment of individuals with a stroke. Early identification and treatment is critical in the care of the individual with a stroke as with each minute that passes, additional brain damage occurs.

Process Description: A business assumption document was developed by Pat Wolfram, Hospital Administrator, Los Gatos campus and presented to The Neuroscience Institute team for review and approval in September 2012. Within the document, Ms. Wolfram described the key business assumptions associated with the development of a Stroke Center which include quality, service, and financial metrics. Additionally, Peter Fung, MD identified the core panel of Neurologists who would be serving the Los Gatos campus. These neurologists include:

- Dr. Paul Singer
- Dr. Lidia Brown
- Dr. Sonya Patel
- Dr. Peter Fung
- Dr. Chien-Ye Liu
- Dr. L Greenwald
- Dr. Andrew Liu, and
- Dr. Amy lee.

Education to the clinical staff in the early identification, diagnosis and treatment is currently being provided.

A letter of intent to become a Primary Stroke Center has been submitted to the Santa Clara County EMS with the intent that ECH Los Gatos be identified as a stroke receiving center on a "provisional" basis by Santa Clara County.

An application for certification by The Joint Commission, Disease Specific Certification program will be submitted in the spring of 2013.

Alternative Solution Which Includes Cost Benefits /SWOT Analysis:

The following are options to a full implementation as a Stroke Receiving Center

1. **Do Nothing**. The option to do nothing would necessitate that patients within the geographic service area of the Los Gatos Campus continue to be transported to other participating hospitals (Good Samaritan, etc). This would prevent the Los Gatos from providing an essential component of care and treatment for neurologically impaired patients.
2. **Telemedicine**. Telemedicine could be implemented as an option to providing care within 30 minutes of the initial stroke call. This option would necessitate the adoption of "remote presence" by the physician team including the Neurologists and Emergency Department practitioners. Although telemedicine is a viable option, the cost and implementation timetables would have a significant impact on our ability to implement the stroke program at the Los Gatos campus. This methodology is a viable option for the future as we see the stroke programs mature.

Outcome Measures and Deadlines:

1. Complete all preparation and education related to stroke care by December 31, 2012
2. Become a "Provisional" Stroke Receiving Center as Designated by Santa Clara County EMS on January 7, 2013.
3. Apply for The Joint Commission Disease Certification as a Primary Stroke Center by May 2013.
4. Become a Certified Primary Stroke Center by September 2013.

10 Step VMOC PSA 11-19-2012 v3.docx

Date: November 19, 2012

To: El Camino Hospital Board of Directors

Subject: **10 Step for a Professional Services Agreement for Medical Oncology Physician Services with Valley Medical Oncology Consultants (VMOC)**

1. **Authority:** According to Administrative Policies and Procedures 51.00, Board approval is required for all new physician agreements.

2. **Problem Definition:** Currently, ECH leases space to Valley Medical Oncology Consultants (VMOC) in the Melchor Pavilion where VMOC operates its outpatient medical oncology clinic. Over the last two years this arrangement, along with several medical directorships, has become problematic and challenged the expansion and growth of the Cancer Center. Shane Dormady, M.D., currently staffs this clinic on behalf of VMOC and has built exceptional relationships with patients, physicians and the community.

   In order to maintain continuity of service to existing patients and to solidify our long term relationship with VMOC, we are converting this program to a hospital based outpatient department with physician services provided under the Professional Services Agreement (PSA). The PSA will compensate the medical group for their services based on productivity with additional quality measure requirements. Special procedures will be put into place to assure that billing is fully compliant and that patients are charged appropriately for their financial responsibility.

3. **Process Description:** Approval is requested for negotiation and execution of a Professional Services Agreement with VMOC for medical oncology physician services.

4. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** Many other alternatives have been reviewed and assessed over the last two years – all without merit of successful implementation. Any other alternative would have jeopardized our infusion services and the degree of integration we seek with our lead physician. This model keeps all program elements integrated and intact and allows fair market value compensation to VMOC for the efforts of their on-site physician. This model also provides ease for expansion of services as needed.

5. **Concurrence for Recommendation:** The Operations Committee and Chief Medical Officer are requesting this change in structure and the associated contracting

modifications.

6. **Outcome Measures and Deadlines:** This transaction will be consummated by March 30, 2013. At a minimum, outcome measures will be based on the following:

    1. Ongoing profitability of the medical oncology program within the Cancer Center
    2. Trended number of medical oncology visits and infusions
    3. Patient satisfaction
    4. Trended cost of professional services as a function of revenues

7. **Legal Review:** The proposed agreement will be a Professional Services Agreement for medical oncology services with VMOC. Legal counsel will review the final agreement prior to execution.

8. **Compliance Review:** Compliance will review and approve the proposed agreement and compensation. To support that review, the Hospital obtained an independent Fair Market Value Opinion from Sullivan Cotter regarding the national and local market for medical oncology services. The recommendation of the reviewer is that ECH pay per wRVU be between the 50^{th} to 75^{th} percentile.

9. **Financial Review**: Compensation appears to be within fair market value limits. The total annual cost of approximately $1.5M appears reasonable and is supported by some offset from expected program reimbursements (both technical and professional) given the importance of our extremely busy and expanding oncology service line and to the future success of ECH.

10. **Recommendation**: We recommend that the Board authorize the CEO to complete the negotiations and the agreement required according to the terms described above.

Date: November 15, 2012

To: El Camino Hospital Board of Directors

Subject: **Approval of Contract for Electronic Intensive Care Unit (eICU) Services from Sutter West Bay Hospitals, dba California Pacific Medical Center**

1. **Authority:** According to Administrative Policies and Procedures 17.00, Board approval is required for contracts exceeding $500,000.

2. **Problem Definition:** In June, 2012, the board took the first step in establishing physician oversight of the Critical Care Unit by approving CCU onsite coverage for ten hours per day by a group of intensivists (named "EC4") organized by the Palo Alto Medical Foundation ("PAMF"). At that time, an early rough estimate of the total cost of providing the full twenty-four hours of daily coverage by adding telemedicine was referenced.

   The second step required to complete the 24 hour day of coverage is to establish the remote telemedicine monitoring of CCU patients during the time that there are no physicians present in the CCU, which is the period from 5 pm to 7 am each day. A contract for those services has been negotiated with a Sutter affiliate in San Francisco that currently provides remote intensivist physician and critical care nursing monitoring to more than ten northern California hospitals, including two that are non-Sutter hospitals. A related Sutter facility in Sacramento provides the same services to ten hospitals near Sacramento.

3. **Process Description:** Approval is requested for the execution of the negotiated agreement with Sutter by the Chief Executive Officer.

4. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** There are no other feasible facilities that can provide the remote clinical monitoring with the State of California.

5. **Concurrence for Recommendation:** The Chief Medical Officer is requesting this added physician coverage for CCU patients. The decision to select the EC4 group for onsite coverage and Sutter for remote monitoring was approved by a committee of practicing physicians and medical staff leaders that spent more than a year reviewing the need for such services and the alternative solutions.

6. **Outcome Measures and Deadlines:** The medical director who provides clinical oversight of the CCU has two quality goals in his contract that incentivize the director to achieve certain quality goals against key metrics. The current goals are as follows:
    a. VTE (venous thromboembolism) prevention measures will be prescribed to all appropriate CCU patients. Minimum: 80% Target: 95% Maximum: 99%
    b. The percentage of patients seen within thirty minutes of telephone request during daytime staffing hours shall meet these goals: Minimum: 80% Target: 90% Maximum: 95%

    Measurement and tracking of these metrics will facilitate care on the unit.

7. **Legal Review:** The negotiated agreement is based on an initial contract template similar to those used for other Sutter client facilities receiving these same services. It was reviewed by the Senior Medical Director for Physician Services and circulated to all key stakeholders with the hospital for review and comment. Changes were negotiated as needed. It was reviewed and edited also by the hospital's Manager, Legal & Contracting Services who also reviewed it with hospital's outside counsel.

7. **Compliance Review:** The Compliance Officer has reviewed and approved the document. The contract is not a physician contract; it is a contract with a division of Sutter Health. However, Sutter will compensate a group of intensivists for some of Sutter's monitoring work, but the compensation must meet fair market value standards according to an independent appraisal, which will be shared with the El Camino Hospital which will have the right to approve it.

8. **Financial Review**: Annual contract costs are within the amount budgeted for this project for the current fiscal year and slightly less for the second year. The term extends from the date of execution through December 31, 2014 and will extend thereafter from month to month until renegotiated.

9. **Recommendation**: Approval is requested for execution of the agreement by the CEO.

10 Step Cardiothoracic Surgery Medical Director - PAMF Dec BD v2 Open Session file.docx

OPEN

Date: November 5, 2012

To: El Camino Hospital Board of Directors

Subject: **Transition the Agreement for the "Medical Director of Thoracic Surgery" to the "Medical Director of Cardiothoracic Surgery – PAMF"**

1. **Authority:** According to Administrative Policies and Procedures 51.00, Board approval is required for all new physician agreements.

2. **Problem Definition:** Currently, ECH MV has two separate arrangements with two separate cardiothoracic surgery teams: Stanford (through its adult hospital, Stanford Hospital and Clinics – or SHC) and Palo Alto Medical Foundation (PAMF). These programs run in parallel with some collaborative participation in peer review activities but are otherwise separately staffed and operated with essentially little sharing of patient responsibilities.

   Since August, 2012, the Stanford program staffed a medical director for cardiothoracic surgery and an on-call agreement for emergencies. The PAMF program staffed a medical director for thoracic surgery and an on-call agreement for emergencies. In an effort to streamline operations and efficiency as well as to reduce the redundant on-call coverage (thoracic surgery and cardiothoracic surgery are essentially a single clinical specialty in training and practice), the PAMF on-call coverage was merged recently with the Stanford on-call coverage. However, the disparate designations of the medical directorships continue to inhibit collaborative work on policies and protocols and reductions in variations in clinical practices and even outcomes.

   A change is proposed to transition the PAMF medical directorship in thoracic surgery to a medical directorship in cardiothoracic surgery for the PAMF program. The total hours allotted to each and the total compensation will be the same for both teams.

3. **Process Description:** Approval is requested for negotiation and execution of an agreement with PAMF using an addendum to its Master Service Agreement that will replace the current medical directorship in thoracic surgery. The title of the Stanford program can either be amended at some future point, including during the opportunity for contract renewal in August 2013.

4. **Alternative Solution which Includes Cost Benefit/SWOT Analysis:** Discussions with PAMF over the past year indicate clearly that the current asynchrony in the two

CT surgery programs is not acceptable to it.

5. **Concurrence for Recommendation:** The Chief Medical Officer is requesting this change in structure and the associated contracting modifications.

6. **Outcome Measures and Deadlines:** This step follows Lean principles in reducing unnecessary processes and activities that should be aligned and coordinated. Synchronization of data collection and outcomes reviews should permit earlier identification and elimination of variations in workflow, equipment use, operations, protocols and best practices. The two programs will share quality goals as to institutional patients, which have already been established as follows:

    1. Maintain 100% compliance with the SCIP (Surgical Care Improvement Project) Core Measures for cardiothoracic surgery with emphasis on each institution's respective program.
    2. Evaluate variability in expense and resource use for cardiothoracic cases.

7. **Legal Review:** The proposed agreement will be a PAMF addendum to its Master Service Agreement that will replace the current medical directorship in thoracic surgery. Legal counsel will review the final agreement prior to execution.

8. **Compliance Review:** Compliance will review and approve the proposed agreement and compensation. To support that review, the Hospital obtained an independent Fair Market Value and Commercial Reasonableness Opinion by HealthWorks of Lafayette, CA, regarding the local market for cardiothoracic surgery services. The recommendation of the reviewer is that ECH can meet fair market value compensation by adjusting the balance between hours worked and hourly compensation in a manner that will put the hourly commitment below the lowest of three other reference points in HealthWork's experience with premier cardiac programs.

9. **Financial Review**: Compensation appears to be within fair market value limits. The total annual cost appears reasonable and will not result in physician expenditures above budget forecasts.

10. **Recommendation**: We recommend that the Board authorize the CEO to complete the negotiations and the agreement required according to the terms described above.

10 Step_Virtural Desktop w Single Sign on_ Fall 2012.doc

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Date: October 15, 2012

To: Board of Directors

From: Greg Walton, Chief Information Officer

Re: Personal Computer (PC) Virtual Desktop Infrastructure (VDI) and Single Sign-on

Authority: The request exceeds the spending authority of the CEO. For this request the FY 2012-2013 Capital account ID 13-84809 is for $ 1,981,464.

Problem Definition: El Camino Hospital personal computer inventory exceeds 2700 devices. This inventory is composed of different makes and models in various stages product life cycles with Dell machines comprising about 1636 with 26 models in service. This inventory diversity can cause different user experiences as well as security risks. In addition, maintaining this hardware and software array is less efficient than best practices. Moreover, the end user community has requested fewer passwords, or basically a single sign-on and password solution. This request is for the funding of a new Personal Computing architecture described as Virtual Desktop Infrastructure (VDI) equipped with end user card swipe Single Sign-On. Described another way we will be implementing an internal Platform as a Service Cloud.

Process Description:

The purpose and goals of the VDI project is to re-design the current desktop environment to allow for:

• Providing physician access to the same virtual desktop both internally and when connecting to ECH network and applications.

• Allowing for simple remote access into hospital applications versus the existing portals which require very specific personal computer requirements.

• Improving user experiences with logging into multiple hospital applications without different usernames and passwords thus increasing end user satisfaction.

• Delivering Constancy across designated desktops.

• Easily and securely ensuring user access to desktops and applications that are up to date with the latest Microsoft security patches.

• Reducing desktop management time by utilizing gold master images to deploy software, installing patches, and implementing other updates centrally versus manually pushing changes.

• Reducing end user downtime by IT being able to rebuild desktops dynamically versus Re-formatting or troubleshooting individual devices.

• Reducing endpoint hardware cost from $900 for a desktop tower to $350 for a Zero client and extending the PC life cycle from 4 to 6 years on average.

•Providing faster desktop provisioning by building new desktops virtually in software versus obtaining and configuring physical hardware.

• Moving the standard desktop operating system from Windows XP to Windows 7. Eliminating the use of generic accounts for general Windows login and individually identify each computer's user.

• Removing the risk of hospital files being saved to local computers by having them centrally stored in the data center where they are protected and backed up.

• Reducing end user downtime when their individual desktop is being rebuilt.

Alternative Solution Which Includes Cost Benefits / SWOT Analysis:

We reviewed several offerings of VDI and determined that our success with server based virtual architecture would best continue with our current partners, extended, as described in our IT plan summer 2012 update[i, ii]. Because this in a virtual architecture it is a shift in how functions are performed. Therefore the alternative to VDI is to leave desktop systems as they currently operate. It is important to note that the systems and technologies outlined in the 10-Step are fully compatible with other major EMR solutions, such as Epic, Cerner or Meditech. Therefore, should ECH change solutions this technology would still have a very long useful life.

We also studied the option of only implementing a Single Sign On (SSO) without a VDI architecture change. We believe the long term benefits are unique to each aspect of this

project and that if approached separately each part will be more costly and take longer to implement. Additionally the possibility of extending these efforts into serial events dramatically reduces the chances that both will ultimately be accomplished. In life, timing is everything and now is the time for both of these projects to be started and well on their way this fiscal year.

Outcome Measures and Deadlines:

>Install the required servers and storage infrastructure to host VDI in as an in-house cloud.
>Install VMware Desktop VCenter product with View Composer (the VDI Builder tool)
>Install and configure VM View connection servers for both internal and external access.
>Install and configure Imprivata hardware appliances for Single Sign-On.
>Create a new Windows 7 Gold Master Image and optimize with Microsoft
>Initially replace 400 legacy desktops due for decommission with Zero Clients, (Zero clients store no data and use less electricity)
> implement VDI in ½ of the eligible clients machines with a priority for machines in patient care areas in the current fiscal year.
>Install 2000 badge readers for single sign-on
>Consume less than 7,500 hours of IT professional time combined from ECH and third parties

The associated costs for this project are as follows:

Total One Time Capital Costs Charged to Capital ID # 13-84809	$ 1,981,464
This includes funding for 9.5% taxes as required on selected items and shipping costs	
Costs Charged to Operations either one time or ongoing	
7500 IT hours (including in the IT Budget)	
License Agreements & Support Year 2 & Year 3	$ 929,958
License Agreements & Support Year 4 and beyond	$ 400,000
Total 5 Year Operating Estimate	$ 1,729,958
Total 5 Years Cost of Ownership	$ 3,711,422
Total 7 Years Cost of Ownership	$ 4,111,422

In these costs we've included more robust servers and more data storage. On the other hand, we expect to reduce spending on devices for around $2mm over 5 years and reduce total annual power consumption for about $250k/year going forward. With assistance and verification from Finance, using a discount rate of 5%, and unique inflation rates for computers and power, it would be logical to conclude that a positive NPV could occur between year 6 or early year 7 with a payback less than year 6.

We are not asserting any quantified time savings because we believe any time saved would be returned to patient care.

Concurrence for Recommendation:

The Executive Council has reviewed this request and supports it.

Legal Review: Legal council's input has been incorporated.

Compliance Review: Compliance has reviewed this effort without challenge.

Financial Review: Completed and concurred

Recommendation: The Board of Directors authorize the CEO to expend the full capital funding of $ 1,981,464 to implement the Personal Computing (PC) architecture described as Virtual Desktop Infrastructure (VDI) equipped with end user card swipe Single Sign-On (SSO).

Tomi Ryba, CEO

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Greg Walton, CIO

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APPENDIX 1
Cost Benefit Analysis and Discussion

Determining precise IT value is often a difficult task and in a health care provider setting it is often impossible. This analysis and discussion is directionally correct but will only yield an opportunity for interpretation and leadership.

Some of the material in this analysis and discussion was taken from the ECH Proof of Concept project. A small sample system has been running on one patient unit for over a month as physicians and nurses have had the opportunity to use this solution with ECH current systems.

Various consultants and hospital providers have made efforts to determine the relative cost- benefits of a Virtual Desktop Infrastructure[iiiiv]. For example, Forrester research conducted a study of a healthcare organization that adopted VMware View, and found an anticipated ROI of 122-128 percent with a net savings of more than USD $2 million over four years. Similarly, IDC Research found that organizations deploying VMware saved on average $610 annually for each supported end user. When combined with Single Sign-on capabilities, the applicable benefits fall into the following categories. For several categories we have provided testimonies from VDI clients and then inserted ECH analysis and discussion.

Quantitative Benefits

1. IMPROVED END USER AND IT PRODUCTIVITY

Norman Regional Health System

- Key Result: Reduce operating expenses for desktop environment. “Going with VMware View for our desktops made more sense from a financial perspective,” says John Meharg (Director Health Information Technology). “With physical desktops, there’s the purchase cost of the PCs, but then there’s also the maintenance contracts on those PCs, hiring people to support those new PCs, and so on. All in all, you’re talking about quite a bit of money. VMware View virtually eliminates those additional costs.”

McCullough-Hyde Memorial Hospital

- Key Result: Reduction of PC rebuild time by 97%, freeing IT staff for higher-value productivity and security projects, and saving the hospital between $30,000 and $40,000 every year.

Overlake Hospital Medical Center

- Key Highlight (page 2): Short-term costs were about equal, but virtualization bested the PC refresh program on long-term benefits and savings. Virtualization also held some unexpected benefits. First, it let the hospital postpone upgrades of 800—850 PCs that were incapable of running Meditech 6.0, yet perfectly capable of running VMware View client. Second, it allowed a "stealth" virtualization of those machines, minimizing the amount of change hospital staff would need to absorb all at once: "We're going to take the current shared workstations and move them into the VMware View environment—so that when people log into them they're not even going to be aware in many cases that they're on a virtual desktop." In the end, the hospital will replace only 200 of the 1200 PCs they had initially planned, and add about 350 Wyse V10L thin clients. Wolfgram estimates that the approach will extend the life of 1000 computers in all: "… maybe only for a year or two, but long enough for me to get a new fiscal year budget to buy more thin clients." He points out that the labor savings were especially significant: "… that was a huge benefit, because a large portion of the PC replacement project is the labor. And I basically paid for our disk drive with what I saved in labor."

Kettering Health Network

Key Point: Kettering's initial goal was to use desktop virtualization to drive parallel benefits within that environment. "We looked at virtualization on the desktop side to help us reduce the cost of our PC deployment," explains Bill Hudson, director of information technology at KHN. This was a pressing concern. To accommodate its caregivers—such as nurses administering medicine and physicians in need of clinical test results—Kettering had installed PCs in "every nook and cranny" across its 60-plus healthcare facilities. But saturating the environment with computing devices meant that some were only lightly used. Kettering wanted a way to reduce overhead costs associated with maintaining all of those machines. Because KHN already had an established relationship with VMware, implementing VMware View was a natural choice. "We were familiar with the VMware technology," Hudson says. "And tying our VMware server infrastructure into a virtualized desktop infrastructure was a big plus for us, because it enabled us to have one product group for all of our virtualization needs."

El Camino Analysis and Discussion

What do we predict will happen to our Microsoft license cost under VDI, and why?

We have the potential to modify our licensing agreements away from physical endpoints (like the number of physical PCs where an application is installed) to the number of virtual desktops or to a concurrent model. With Microsoft we can cut down on the number of Office, Project, Visio, and other such license and only have them available in the virtual desktop pools where the individual users need them. At this point we do not have an estimate on how much it could reduce licensing cost as it will be something we'll apply with our vendors upon our next negotiations.

What will happen to the IT staffing and why?

We expect to save IT person hours from this change. We also expect to reallocate those hours on a range of backlogged activities as well as growing demand. Examples include increased security,

business continuity and disaster recovery, increasing demand and deployment of more mobile devices as well as creating a more balanced supply of service staff with demand. Looking at the Desktop and Mobile device growth since 2005 we have had a 253% increase in 7 years and have gone from 5 members of the Desktop Group (including the Supervisor) to 9. The ratio of devices managed has increased from 226 per technician to 318. Desktop Virtualization does not change this ratio but instead turns the devices into simplified end points connecting to centrally managed and provided virtual desktops. The focus of the Desktop Staff moves away from lower level hardware and operating system tasks to the overall management and improvement of the environment.

What do we suggest will happen to end user device hardware costs?

For near term purchases of end point hardware cost from an average of $900/ desktop tower to $350 for a Zero client, or a reduction of approximately $550 at current cost levels. We also expect to extend the end point hard ware refresh cycle from 4 years to 6 years for all but tablet devices. These changes mean that moving forward the budget to replace all Zero clients every six years will be $140,000 annually. The current cost to replace all PCs on a 4 year cycle is $562,500 each year. This represents a savings of $422,500 per year going forward, over a 5 year period a possible reduction of amounts approaching $2,000,000 with 6 year amounts even greater.

What are your forecasts for changes in server software costs?

This is currently not known. Vendors often attempt to recover cost savings from improvements derived from outcomes of Moore's Law or architectural changes. How they price in the future will depend on how all of the various software applications are licensed. For applications licensed on bed count, that would not change. For licensing Windows, we would only need licenses for the maximum number of concurrent virtual desktops.

What do you predict will happen to storage and server costs?

Included in this project are capital cost $998,900; with ongoing maintenance of $250,000 annually starting in year #4. This represents a net new add to the environment; however, as discussed, this array is one that will be scaled for the next 10-12 years and ultimately replace the existing arrays as they go end of life.

2. ELECTRICITY SAVINGS DRIVEN BY END USER MACHINES THAT ARE MORE EFFICIENT

St Vincent Catholic Medical

- Key Results: Server consolidation gives a major boost to St. Vincent's "green" efforts, and there are significant benefits on the client side, too. Switching from traditional PCs to thin-client devices has resulted in huge power savings: from about 160 watts for a traditional PC to roughly 13 watts on a thin client. That translates into an annual savings of upwards of about $20,000 per 1,000 devices.

- Overall costs savings for hardware, power and cooling are estimated to be $3.4million over the three years.

El Camino Analysis and Discussion

The ECH Facilities team estimates that the change in electricity demand will be a reduction of about $275, 418 per year. Consequently for a total 5 year reduction in power consumed by end user devices the range of savings should be between $1 mm and $1.2mm.[v]

Qualitative Benefits

1. IMPROVED END USER EXPERIENCE

- *Beaufort Memorial Hospital:*

Key Point: "We had a number of goals in mind," recalls Edward Ricks, CIO and vice president of information technology at BMH. "One was to lower our long-term costs. Another was to get rid of the help desk and administrative issues relating to PCs. The primary goal, however, was to drive user engagement—to make our electronic systems easier, faster and more portable for clinicians."

El Camino Analysis and Discussion

The following comments are from the El Camino Hospital Nursing Manager overseeing the VDI proof of concept pilot activity.

"Because the Windows log on in no 24hrs, the RNs are not logging in and out of the PC for use. However, they are logging in and out of ECHO throughout the day. I have one audit sheet for a 8hr per diem RN that shows 14 log ins to ECHO in and 8 hr shift, but the reason I have this report is because I am concerned this nurse is not using the computer at the bedside for medication administration, so I would not rely on that number, I would hope its higher for the average RN.

As for amount of time wasted this morning, I timed a PC at the nurses' station, the ECHO log in windows was not up, so I launched it from the icon that took 12 seconds to get the sign on window. Then, it took me an additional 10 seconds (and I'm pretty fast) to type in my ID and Password and bring up the patient list in ECHO. So that would be a total of about 22 seconds. We also have the VDI Pilot on 3B, so for fun I timed that; 9 seconds! Now, I must be honest, I had already logged in once and the initial log in in the morning takes over a minute to set up the desktop before the PC can be used. But….can you imagine the overall time saving if we had VDI, "follow me PC", in our med rooms and in the patient rooms? Also, if the single sign on was set up with ECHO too? It would really streamline the med pass process for the RNs; hopefully giving them back time to focus on the meds they are giving and they patient they are giving the meds too, rather than logging in."

The Medical Standards for Information Technology Committee (MSIT) serves as the official physician body making recommendations to the Medical Executive Committee (MEC) about a range of issues impacting physicians use, efficiency and effectiveness of Information Technology. At the October 3, 2012 meeting of the MSIT the members had a demonstration of the proposed solution. At that meeting a motion, shown below, was passed and sent to the MEC.

Approved Motion and Recommendation to the Medical Executive Committee
Virtualization of Desktops and Single Sign-On
Recommendation

Situation: El Camino Hospital personal computer inventory exceeds 2700 devices. This inventory is composed of different makes and models in various stages product life cycles with Dell machines comprising about 1636 with 26 models in service. This inventory diversity can cause different user experiences as well as security risks. In addition, maintaining this hardware and software array is less efficient than best practices. Finally, the end user community has requested fewer passwords, or basically a single sign-on and password solution.

Recommendation: This request is for the funding of a new PC architecture described as Virtual Desktop Infrastructure (VDI) equipped with end user card swipe Single Sign-On.

Motion: The Medical Standards for Information Technology (MSIT) supports the acquisition and implementation of the solution for Virtual Desktop Integration (VDI) as demonstrated at the meeting of October 3, 2012.

While ECH has over 250 application systems, most of the clinical community spend their working hours using 3-6. Even with this small subset of systems there is plenty to cause frustration with the amount of passwords and security rules that are required by these different products. Password and sign-on problems are the number one reason physicians call the Help Desk. Under VDI, most clinical users will have 1 ID and password and will be able to use that from fixed and mobile devices, on campus or at home or around the world. While we have not attempted to time study or measure time savings from VDI and SSO we are confident that nursing and physician support is high and these solutions will provide welcomed relief from the current workflow.

2. INCREASED SECURITY BY STORING INFORMATION CENTRALLY

VDI requires that no data are stored on the end user device. This is the case whether the device is within the hospital or anywhere on the planet. Consequently, if a device is lost or destroyed no data are compromised. Given the increased fines for exposure of patient health information the risk reduction value of this architectural change is substantial.

3. IMPROVED BUSINESS CONTINUITY AND DISASTER RECOVERY CAPABILITIES

With all data centrally stored it can be easily moved off site with a single technology. In today's world, end users can place important files within a range of options and some cases directly onto a local storage device. Once stored locally, if the end user does not take the steps to create back-ups the data are at risk. With DVI all data is continually backed up and available for restoration from a risk event. Additionally, the storage used is more cost effective and thus will accommodate the demand for future storage in a very cost effective manner.

Summary

At the opening of this discussion we stated that it would be impossible to precisely demonstrate the value of IT projects. Now you, the reader, must help determine if VDI is a worthwhile effort for El Camino Hospital. We await the opportunity to answer your questions in light of this significant cost and potential benefits of this project and technologies.

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[i] Microsoft offers a VDI solution call RDS (Remote Desktop Services) but it is built for small installations. For larger organizations and enterprises such as ours, Microsoft recommends Citrix Zen Desktop as a front-end to their Hyper-V server virtualization solution. Based on industry evaluation, Citrix Zen Desktop is a respectable competitor to VMware View. El Camino chose VMware View to build off of our existing VMware vSphere server virtualization platform already in production.

[ii] Kovarus is our existing long-standing partner working with us to design, build, and support several Technical Services solutions. Kovarus is our partner and reseller for EMC storage and support, Data Domain backup storage, and all things VMware. Their in depth knowledge of our environment has helped us build solutions that fit not only the immediate need of a new project, but also the long-term roadmap of technologies and ongoing support.

[iii] Forrester, "Total Economic Impact of VM VDI: Healthcare", July 2008
[iv] IDC, "Quantifying the Business Value of VMware View". September 2009

For the details of the savings and calculations please refer to the following file.

VDI Energy Savings.xlsx

END

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10 Step_2012_Electonic Data Warehouse_November 5 2012.docx

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Date: November 14, 2012

To: El Camino Hospital Board of Directors

Subject: Funding Request for Enterprise Data Warehouse (EDW)

Capital Budget ID # 13-84853

Authority: Board funding is required since this request exceeds CIO signing authority

Problem Definition: El Camino Hospital (ECH) began our formalized approach to Business Analytics in 2008 and over the years a great deal of progress has been achieved. Accomplishments include 7 analytics solutions deployed with hundreds of reports, 21 dashboards and 3 registries as well as a great deal of organizational learning. During this time ECH's success with the Electronic Data Warehouse (EDW) has been hindered while the vendor marketplace evolved. Our conclusion is to change both our approach and the vendor supplying our EDW. Consequently, this request is to fund a turnkey Electronic Data Warehouse solution supplied by Healthcare Data Works (HCD).

Business Intelligence (BI) has been informally defined as "the right information to the right person in the right way at the right time" in support of managing a business. A BI solution typically consists of an integrated data repository combined with a business user-facing interface. The Electronic Data Warehouse (EDW) is the repository component -- data from various source systems integrated and organized into subject matter areas and optimized for reporting. Therefore while significant investments in a number of single source BI software solutions have been productive (such as EPSi, Sunrise Clinical Analytics, eTime Business Analytics), and to a limited extent the current EDW (Amalga), we still have challenges. Our limitations include:

- Fragmentation of existing data and end-user access points
- Labor-intensive, time-intensive data mining
- Lack of centralized analytic voice fostering use of the right measurement for the right analysis
- Low user adoption of existing analytic solutions (hard to learn and navigate multiple systems, and to interpret different data displays)
- Existing metrics are loosely linked to performance assessments & job expectations

- Existing technology has provided an "open box" that users have not "filled" in a focused manner – result is doing everything and nothing simultaneously

While the current EDW has strengths, the BI Coordinating Committee investigated several options and concluded that a more structured and vendor-hosted solution would better meet the organization's current needs.

Process Description:

At the conclusion of the Well Spring Partners consulting engagement members of the management team refocused upon the EDW. During the 2010 budget cycle a decision was made to engage a consultant to help reassess our EDW approach, staffing needs and marketplace.

Deliverables from that work included the ECH Business Intelligence Strategic In-Process Review Report, the K.L.A.S. Microsoft Amalga Report, the K.L.A.S. and the Business Intelligence Market Report. These vehicles supported the conclusion that our historical approach would continue to be very labor intensive and that the EDW marketplace had evolved thus introducing new solutions for the very challenges we had encountered.

Using the K.L.A.S. marketplace evaluation reports 5 options were developed including 2 from the existing company and 3 new companies. Each option was measured using a 8 part scoring criteria framework including, 1) company 2) technology 3) implementation approach, philosophy, style, 4) use case execution 5) business and partnership model 6) post activation support, 7)solution comprehensiveness and 8) total cost of ownership.

40 members from various levels of management were invited to participate and score the B.I. use case demonstrations performed by the companies. These events caused each vendor to demonstrate using vignettes or scripted requirements designed by and for the end user community. These included, 1) HVI Service Line Leader 2) Surgical Department Head 3) Orthopedics Clinical Manager 4) Provider Recruitment Director 5) LEAN analyst 6) Heart Failure Clinical Nurse Specialist. The vignettes stressed the aspects and issues ECH is looking for in both a product and a solutions partner.

In addition to this scoring, each solution and company was measured using a capabilities review including, LEAN expertise, types of data, benchmarking, client base, approach, data definition completeness, flexibility, expected end user adoption, greatest value added, greatest constraint, and greatest concern.

Health Care Dataworks' (HCD) product, Knowledge Edge, offers a pre-built health care data model, hardware, software and services as a unified EDW "appliance", including several fully developed executive dashboards that can provide ECH with much greater

speed to value than the earlier approach. This solution does not provide built-in benchmarks, but does support incorporation of benchmarks, such as from our current subscription to Truven Care Discovery (formerly Thomson Reuters) or from Premier Quality Advisor, as well as from other sources.

The conclusion of the Task Force was the recommendation in support of Health Care Data Works (HCD).

The summary of all this effort is shown in the Appendix along with other documents and supporting materials.

Alternative Solution Which Includes Cost Benefits /SWOT Analysis:

The Business Intelligence Coordination Committee (B.I.C.C.) developed and confirmed with the Operations Committee the following EDW conclusions. ECH could,

1. **Do Nothing**. The option to support Lean initiatives, Service Line development and other Quality and Regulatory Compliance requirements using multiple standalone spreadsheets throughout the organization was considered. This option is labor-limited and error prone. It does not address data fragmentation and establishment of a single source of truth.
2. **Ramp Up Amalga**. Even though it builds upon an existing investment, expanding use of the existing Amalga repository is an expensive option, requiring extensive use of third party tools and consultants to build reports and dashboards and a user portal. Earlier attempts to do this were not successful. And because Amalga is an 'open' data repository, all the data quality issues that exist in our source systems are passed through to the repository.
3. **Health Care Dataworks**. (HCD) As noted above, Health Care Dataworks offers an attractive "data warehouse appliance" with pre-configured technology that speeds the organizations time to value. Extensive pre-built content (dashboards and reports) will enable in-house analysts to customize rather than build from scratch.
4. **Healthcare Quality Catalyst**. HCD's strongest competitor. Healthcare Quality Catalyst also offers a hosted data warehouse solution, but one that is less structured, and that the evaluation team felt would require more analyst resource to support.
5. **Premier EDW**. We were impressed with Premier's well-developed clinical and financial benchmarking capability, and its commitment to supporting client networking, their EDW offering is still in a proof of concept stage with two of their large system clients, at the clients' request.

The 5 Year cost and user rankings are shown in the Appendix. Given the turn-key approach HCD uses it is relative less costly than most of the alternatives.

Outcome Measures and Deadlines:

This three-phase project will replace the existing EDW infrastructure with the HCD Knowledge Edge solution, and will result in a set of fully developed quality, service and affordability dashboards that will allow end-users to drill down to investigate and respond to variances.

We anticipate three types of benefits:

User Access:

1. Deliver timely and convenient self-service access to key data.

2. Provide ECH leaders and staff with ready access to key organizational metrics in dashboard/graphical form.

3. Provide this information to different targeted user groups for different levels of the organization (i.e., specific to the enterprise, service line, campus, department, physician group, etc.) so it is focused, relevant and actionable.

Data Consistency:

1. Report key metrics using consistent, well-documented and well-understood definitions and goals.

2. Provide on-line user access to measure definitions to promote and reinforce shared understanding.

3. Establish a permanent Data Governance group to broker the development and documentation of consistent data definitions and business rules for data capture and use across the enterprise.

Analytics Efficiency:

1. Provide a centralized reports portal where, based on security, users can readily access custom reports designed for them for repeated use.

2. Free up analyst resource time to work on other projects (e.g. Lean initiatives, etc.) by moving routine reporting to a self-service mode

3. Develop a 'super user' group (over time) among non-analysts, who become comfortable and get value from independently querying the EDW within their area of expertise.

Acceptance criteria include:

Phase 1

1. Executives, Service Line Leaders and Managers can obtain monthly Enterprise and Campus trend for ALOS, Mortality, 30 Day Readmission Rate, HCAHPS composites and Core Measure composites in dashboard format. They can also drill down to Service Line or Nursing Unit performance as appropriate.
2. Monthly reports are available for 7 day unplanned readmission.
3. Two or more report writers are able to adapt existing reports and create a new report.

Phase 2

1. Executives, Service Line Leaders and Managers can obtain monthly Enterprise and Campus trend for ED Throughput and OR Throughput metrics in report and/or dashboard format.
2. Two or more report writers have intermediate or better skills in developing reports and dashboards. Two to 3 additional report writers have basic skills in adapting existing reports and creating new reports.

Phase 1 will be completed in summer 2013 with Phase 2 planned to complete in the summer of 2014. Ongoing development of the EDW is anticipated, but Phase 3 and beyond activities are out of this project's scope.

Cost

This HCD product will be delivered as a software as a service so the EDW will be operated from another state and in the cloud. The FY 2012 approved capital budget as line it Capital Budget ID # 13-84853 is assigned for the EDW in the amount of $1,000,000.

One Time Capital Costs (Charged to Capital ID#)	**Amount**
Phase 1 Set up and installation	$540,000
Cost of third party software	$205,000
Installation includes 4 initial dashboards and Implementation services will be about 5700 hours total hours for Phase 1	$420,000
HL7 Physician Master Interface into McKesson Star	$25,000
Travel and Living	$125,000
Phase 2	
Project Management Services total hours for Phase 2	
Will be about 550 hours	$92,400
Travel and Living	$26,000
Total	$1,433,000
One Time Cost (Charged to ECH Operations)	**Amount**
Training & Practice will be absorbed from current FY Operations budget	

Three Full Time Equivalent (FTEs) positions are budgeted in the FY 12-13 operating budget for supporting this EDW effort. We estimate the new Phase 1 and Phase 2 full labor annual labor expense for the solution and the 4 dashboards to be about $525,000 or about $2,625,000 over a 5 year term.

The HCD and third party software expense, the network costs, the remote hosting server, storage and support including, database administration, systems administration, back-up, B.I. technical support and Help Desk at the 4 Dashboard level is $62,000 per month or about $3,720,000 over a 60 month agreement. Should ECH elect to purchase additional dashboards, the cost for each will be $2000 per month plus construction (labor) cost. ECH may or may not elect HCD to construct more dashboards.

We estimate the 5 year total cost of ownership at the 4 Dashboard level is about $7.6mm to $7.8mm. However, we expect to expand the solution using the annual budgeting process once Phase 1 & 2 is complete.

The current Information Services FY 2012-2013 total capital budget for all Board approved projects is approximately $13mm. This EDW project has a capital ID approved budget line item of $1mm, thus initial EDW capital exceeds the budgeted amount. Given changes to other projects we do not expect to exceed the total company IT capital amount for all IT projects and thus we are not requesting an IT additional capital allocation.

Concurrence for Recommendation: The Operations Committee supports this request.

Legal Review: Legal counsel input has been incorporated

Compliance Review: Compliance has reviewed this effort without challenge

Financial Review: Completed and concurred

Recommendation: We recommend the Board of Directors authorize the CEO to expend the full capital funding of $1,433,000 and execute the Health Care Dataworks five year agreement for an Enterprise Data Warehouse.

Mick Zdeblick, COO

Greg Walton, CIO

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Tomi Ryba, CEO

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Appendix

These 2 tables reflect the relative rankings of the 5 EDW options.

Summary	Premier (EDW)	HCD	HQC	Amalga Ramped Up	Spreadmart No Amalga
Form:					
Offers good technologic method of storing "single source of truth" (High rank for Technology)	Low	High	Medium	Medium	Low
Offers opportunity to streamline tracking efforts through dashboards (High ranking for Turnkey)	Medium	High	Low	Low	Low
Allows alignment of source data by patient	High	High	High	High	Low
Solves issues of data fragmentation	High	High	High	High	Low
High Ranking for Flexibility	Low - cost, quality, safety are done, but EDW is in infancy	Medium - additional data and dashboards to be developed in house	High	Medium - open architecture	Low - Limited ability to fill full data needs in long run
High Ranking for Experience/Growth in Field	Low	High	Medium	on multiple additional partners to create front end	NA
Function:					
Eases "data scrubbing" requirements (High ranking Time to Implement)	Medium	High	Low	Low	Low - High potential for error
Eases "analytics" by allowing users to generate reports & start analysis in a "click step"	High	High	High	High	Low
Provides a home for benchmarks	Low - Uses own benchmarks only	High - But must purchase benchmarks	purchase benchmarks	High - But must purchase benchmarks	Low - and must purchase benchmarks
Less labor-intensive than current data mining analytics	Low - Estimated 11 FTE	Medium-Estimated 6 FTE	Low - Estimated 9+ FTE	Low - Estimated 13 FTE	Low - Estimated 12 FTE
Strong Vendor Support	Low	High	Medium	Low	NA
Features:					
Eases "analytics" by offering flexibility in adding new data to EDW	Medium	Medium	High	High	Low
Eases "analytic" data mining by centralizing data for analyst use	Multiple Modules with varied development	High - where data is included	High	High	Low
Expect high user adoption (High rank by users)	Low	High	Medium-with analyst assist	to create front end in house	Low - feed dashboards into sharepoint
Affordable	Low	Medium	Medium/Low	Low	Medium

Product	Key Strength	Key Drawback
Premier with EDW	"Join a benchmarking community"	EDW is new & unproven
HCD	"Learning from Others" Well-defined data model, quick to implement Some delivered Dashboards Expect to negotiate more built dashboards as part of contract	Some data source limitations
HQC	"Quality Focus, Lean Linkage" Some data defined Considerable flexibility	Very open structure, reminds us of Amalga
Amalga	"open box"	
'Spreadmart'	Low tech investment Build only what you need	Time & Labor intensive Error prone

This table reflects the relative costs of the 5 EDW options.

	Premier (EDW)	HCD	HQC	Amalga Ramped Up	Spreadmart No Amalga
Costs - 5 year					
Cost - initial		$ 540,000	$ 750,000	$ -	$ -
Cost - recurring (software vendor)	$ 9,100,000	$ 3,570,000	$ 6,630,000	$ 3,750,000	$ 500,000
Cost - recurring (third party software)			$ 575,000	$ 1,250,000	$ 1,250,000
Cost - (professional services)		$ 1,620,000		$ 3,250,000	
Cost - Quality Benchmarks	100,000	100,000	100,000	100,000	100,000
Cost - Cost Benchmarks	100,000	100,000	100,000	100,000	100,000
Additional Products					
Additional Dashboards		$ 120,000			
Recommended internal staffing (FTEs cost IT)	$ 5,400,000	$ 1,800,000	$ 2,700,000	$ 6,300,000	$ 1,800,000
FTEs	*6*	*2*	*3*	*7*	*2*
Recommended internal staffing (FTEs cost analysts)	$ 3,250,000	$ 2,600,000	$ 3,900,000	$ 3,900,000	$ 6,500,000
FTEs	5	4	6	6	10
5 Year Estimated Cost of Ownership	**$ 17,950,000**	**$ 10,450,000**	**$ 14,755,000**	**$ 18,650,000**	**$ 10,250,000**

This table reflects the user scoring of the proposals and scripted demonstrations.

	Premier (EDW)	HCD	HQC	Amalga Ramped Up	Spreadmart No Amalga
Rankings					
User rankings	**3**	1	2		
Technology	**3**	1	2		
Support	**3**	1	2		
Existing set of dashboards -turnkey solution	2	1	**3**		
Time to implement	2	1	**3**		
Flexibility	4	**3**	2		
Company Financial Strength	2	4	**3**		
Company Growth in field	**3**	1	2		
Includes					
Lean expertise	n	n	y	n	n
Will support Lean	**Depends on Data Mined**				
Includes billing data	y	y	y	y	Use Source Systems
Includes ECHO data	n	y	y	y	Use Source Systems
Includes OR data	n	y	y	y	Use Source Systems
Includes CVIS data	n	n	n	y	Use Source Systems
Includes Labor data	n	n	y	n	Use Source Systems
Includes medical supply data	n	y	y	n	Use Source Systems
Includes service survey data	n	y	y	y	Use Source Systems
Contains benchmarks	y	n	n	y	Use Source Systems
Can include benchmarks from external sources	y	y	y	y	Use Source Systems
Includes G/L Financial data	n	n	n	n	Use Source Systems
Clients (EDW)	4	12	8		
Turn-Key Solution	Low	High	Medium	Low	Low
Data Definition Complete (ECH role minimized)	Low	High	Medium	Low	Low
Dashboard Definition Complete (ECH role minimized)	Low	High	Medium	Low	Low
Complete Flexibility to Change as Org Changes	Medium/Unknown	Low	High	High	Medium
Solves Fragmentation	n	n	n	n	n
Helps Low User Adoption	y	y	y	n	Possibly
Solves Data Source Confusion	y	y	y	y	Possibly
Solves Loose Link to Accountability	n	n	n	n	Possibly
Greatest Value Add:	***Available Cohort Group to Provide Benchmarking & "piggy back" learning***	***Available Dashboards and Data Warehouse if we adhere to metrics used often by others***	***Quality Focus - created to allow Lean ad hoc data reporting along with established data set***	***Can do anything - we define what anything means***	***Build as needed using existing sources***
Greatest Constraint:	***Benchmark cohorts must be Premier (ie hard to change to new benchmark)***	***Data is defined - ad hoc tools exist but are limited***	***FTEs to get up and running***	***FTEs to get up and running***	***Working within existing FTE & data mining constraints***
Greatest Concern:	***New product - not clear if EDW will add much over what we have in Amalga***	***Off the shelf dashboard do not offer our Core Measure or Re-admissions dashboards - may need substantial re-writing if we insist on 'our' metrics***	***Teaching us to Fish means we need to define our dashboards, accountability cascade, new data mining, etc - this is what we had a hard time doing for Amalga***	***Internal expertise needed dashboard design, data warehouse design, analysis design AND we need to define accountability etc as with HQC***	***Build as needed means some waiting while new item is built / Use of Spreadmart means front end is less fancy and more analysis done by analyst vs "exec"***

10 Step_iSirona_EMR_to_Medical Device Solution_ Nov_6_2012.doc

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Date: November 14, 2012

To: Board of Directors

From: Greg Walton, Chief Information Officer

Re: iSirona Medical Device to Electronic Medical Record Middleware

Authority: This request exceeds the spending authority of the CEO. For this request the FY 2012-2013 Capital account ID is 13-84809.

Problem Definition: Medical devices in operation at EL Camino Hospital generate enormous amounts of data in their routine use supporting patient care. Information that physicians and nurses want to or that is required to be stored in the Electronic Medical Record (EMR) by and large is manually entered. This is both expensive and opens the door for errors. A good answer to this challenge is to provide a one way data exchange between the medical devices and the EMR. This bridge is referred to as an interface. Nursing are the chief beneficiary of these workflow improvements with the physician and patient gaining from improved speed of data transfer and fewer possibilities of errors.

Process Description: Historically, interfaces between physiological devices and the EMR required development of an interface between each manufacture's unique device and the EMR. The cost of developing interfaces between proprietary devices and the EMR can cause operational and reliability problems, and increased complexity. Additionally, they are expensive. ECH has some experience with medical device interfaces, and along with market improvements we have determined now would be an excellent time to invest in a middleware solution. In this case, middleware is software that operates between the medical device(s) and the EMR making the data transfer interface more cost effective to construct and easier to manage.

The preferred solution, iSirona, is installed in 20 Allscripts hospitals. iSirona is vendor neutral, thus, it is designed to allow creation of an interface between any proprietary device and the Sunrise Clinical Manager EMR and support the day to day management of those interfaces from a centralized location.

Alternative Solution Which Includes Cost Benefits / SWOT Analysis:

After viewing both iSirona and Capsule products, nursing decided that the iSirona product had much better workflow. The workflow with iSirona allows for signing into 1 system (Sunrise Clinical Manager) for equipment and patients to be identified. Then vital signs can be pulled into the patient's flow sheet, again all in one system. Additionally, when we reviewed the details with Capsule, the equipment list required was more than what is required for iSirona and with complexity greater. iSirona reports that they about 143 clients in total and currently have over 60 EPIC hospital installations. Providence in Renton is their largest EPIC installation.

We also have estimated that for each interface for each machine we would expend about 100-125 hours. Each machine is defined as when the company, model or series of a machine is different, thus we would exceed several hundred interfaces. More over the maintaining so many solutions and keeping them safe might be completely impossible.

While we do not have a time a current study of the time and motion or safety issues, we have work when the first solution was tried at ECH. It is shown in the Appendix. That solution has been de-installed because the vendor has since nearly left the business and the product has no longer completely stable.

Outcome Measures and Deadlines:

1. Improve accuracy of patient physiological information entered into Sunrise Clinical Manager.
2. Improve timeliness of patient physiological information entered into Sunrise Clinical Manager.
3. Shorten the development time for interfacing new physiological data devices with the EMR.

4. Provide centralized management for problem solving and maintenance of interfaced patient monitoring data.

5. Reduce 'downtime' of data collection due to interface problems with diverse monitoring equipment by using a centralized console and software platform for interfaces.

The timeline for the project is approximately 6-7 months form contract execution for the first set of medical devices to be interfaced; this should be about 150 to 160 machines. This project timeline, etc. and the associated cost are for Mountain View only.

The associated costs for this project are as follows.

The capital cost for this project is about $ 701k and the operating expenses for 5 years of software maintenance will be $ 394k or about $80k/yr with 134 devices exchanging. The first year operational expense for training is estimated at $40,000 with the total operating cost for the first year estimated at $132k. The Total Cost of Ownership anticipated from this project is expected to range between $ 700k and $2.0mm depending on how many devices ultimately exchange data over a 5 year period. Since the current device fleet exceeds 1300 it is possible all of this these might exchange data thus increasing the annual operating expense to about $373k/year.

The amount originally listed in the capital budget for iSirona is about $560k. This project and 3 other clinical projects that relate to each other now have updated estimates. The table below displays the plan to keep all these within a total acceptable budget limits.

Capital Budget Project	Budget	New Estimate
SCM EMR Feature Pack		$106 k
SCM EMR 6 Upgrade	$210 k	$243 k
Orders Reconciliation	$335 k	
iSirona	$560 k	$701 k
Total	$1,105 mm	$1,034 mm

Concurrence for Recommendation: The Operations Committee has reviewed this request and supports it.

Legal Review: Legal counsel's input has been incorporated.

Compliance Review: Compliance has reviewed this effort without challenge.

Financial Review: Completed and concurred

Recommendation: The Board of Directors authorizes the CEO to expend the full capital funding of $ 701,000 and the first year operating expense of $132,000 to purchase and implement the medical device to Electronic Medical Record middleware solution known as iSirona.

Tomi Ryba, CEO

_____

Greg Walton, CIO

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Appendix

Impact to nursing staff

Pre-Sensitron Nursing Perception Survey 2008 that studied the impact of exchanging data from those devices to the EMR.

Regarding Vital Sign Data

Please circle the answer to the questions below which most closely match your experiences on an average day:

Shift: _____ days _____pms _____nocs

1. How often do you feel vital signs are unavailable to you when you need them?
a. Always
b. Often
c. Sometimes
d. Rarely
e. Never

2. How often do you feel you need to spend time locating vital sign information?
a. Always
b. Often
c. Sometimes
d. Rarely
e. Never

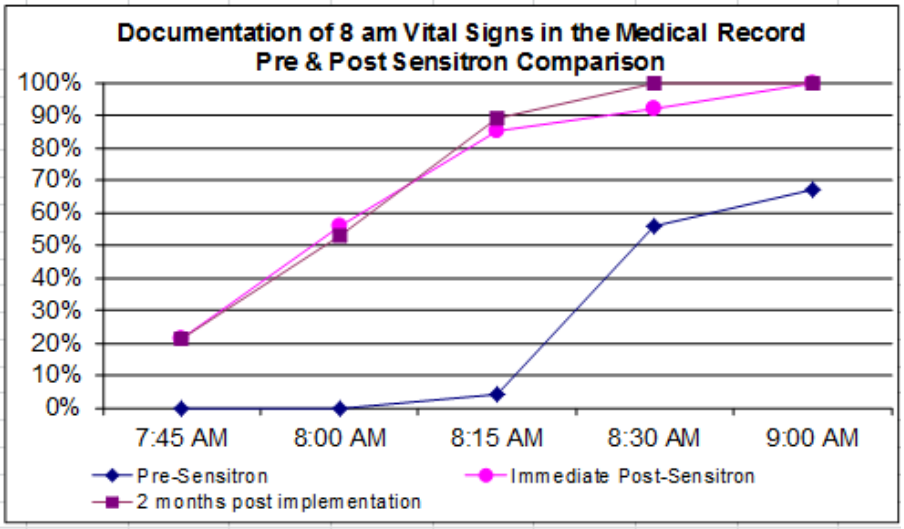
3. How often do you feel vital sign information is unavailable when the patient's physician arrives on the unit?
a. Always
b. Often
c. Sometimes
d. Rarely
e. Never

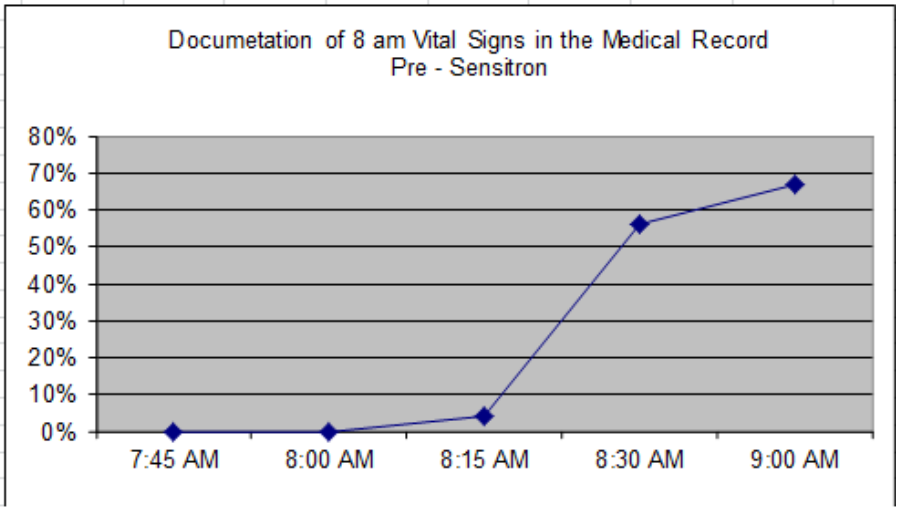
4. How often do you feel there is a delay in your receiving notification of abnormal vital signs?
a. Always
b. Often
c. Sometimes
d. Rarely
e. Never

5. How often have you experienced misinterpretation of abnormal values that caused a delay in notification?

a. Always
b. Often
c. Sometimes
d. Rarely
e. Never

	Documentation of 8 am Vital Signs		
	Pre-Sensitron	Immediate Post-Sensitron	2 months post implementation
45 AM	0%	21%	21%
00 AM	0%	56%	53%
15 AM	4%	85%	89%
30 AM	56%	92%	100%
00 AM	67%	100%	100%





The implications of that study, and of this project is that data are available to the care givers sooner and with less errors. Possible outcomes could be improved quality and a lower length of stay.

IT Impact

Traditional methods for building interfaces are often referred to as 1 to 1. In other words, each interface is hand crafted to exchange the data between 2 machines. This is preferable to no data exchange but is more costly and time consuming that contemporary methods.

While it might be possible to build one or two interfaces and support them going forward, it is not possible, safe, or cost effective to attempt interfaces for many different makes and models of a 1300 medical device portfolio.

Quality charter-11-12-12_cbv_Gov Cte Recs_20121204, 12-5.docx

Quality Committee Charter

(Revised 11-12-12)

Purpose

The purpose of the quality committee is to advise and assist the El Camino Hospital Board of directors in constantly enhancing and enabling a culture of quality and safety at ECH. The committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the El Camino strategic plan related to delivering high quality healthcare to the patients that we serve. High quality care is defined as care that is:

- Culture of safety that mitigates risk and utilizes best practice risk prevention strategies
- Patient-centered
- Delivered in an efficient and effective manner
- Timely
- Delivered in an equitable, unbiased manner

The organization will measure the degree to which we have achieved high quality healthcare using affordability metrics and the CMS value based purchasing program among other measures.

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. In addition, the Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management and quality improvement.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

Membership

- The Quality Committee shall be comprised of two (2) or more Hospital Board members and may include no more than nine (9) external (non-director) members who possess knowledge and expertise in assessing quality indicators, quality processes (e.g., LEAN), patient safety, care integration or medical staff matters, and members who have previously held executive

positions in other hospital institutions (e.g., CNO, CMO, HR). Approval of the full Board is required if more than nine external members are recommended to serve on this committee.

- The Chair of the Committee shall be a Hospital Board director.

Staff Support and Participation

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as senior members of the ECH staff may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chief/Vice Chief of the Medical Staff, VP of Patient Care Services, physicians, nurses, and members from the Community Advisory Councils or the community-at-large.

General Responsibilities

The Committee's primary role is to develop a deep understanding of the organizational strategic plan, the quality plan and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for:

- Ensuring that performance metrics meet the Board's expectations
- Align those metrics and associated process improvements to the strategic plan and organizational goals and quality plan
- Ensuring that communication to the board and external constituents is well executed.

Specific Duties

The specific duties of the Quality Committee include the following:

- Oversee management's development of a multi-year strategic quality plan to benchmark progress using a dashboard
- Oversee management's development of Hospital's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services

- Review reports related to ECH-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
    a. ECH-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan
    b. ECH-wide patient safety goals and hospital performance relative to patient safety targets
    c. ECH-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports and risk management reports
    d. ECH-wide LEAN management activities and cultural transformation work
    e. ECH-wide patient satisfaction and patient experience surveys
    f. ECH-wide risk management and legal activities.
- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to include, but not be limited to, The Joint Commission (TJC), Department of Health and Human Services, and Office of Civil Rights
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements
- Ensure Medical Director and physician agreements abide by hospital policy, align with clinical and strategic priorities, include performance goals (as appropriate), and are based on fair market value
- Review sentinel events and red alerts as per the hospital and board policy
- Oversee organizational performance improvement for both hospital and medical staff activities and ensure that tactics and plans, including large-scale IT projects that target clinical needs, are appropriate and move the organization forward with respect to objectives described in the strategic plan
- Ensure that ECH scope of service and community activities and resources are responsive to community need.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans. Annually, the committee should do a self-evaluation to determine the degree to which we have achieved our specific objectives related to quality of care.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for review and approval.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board and the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

Appointment and Terms

The Board shall appoint the members of the Committee. In accord with the nomination/selection and reappointment process established by the Board, the Governance Committee shall recommend to the Board the appointment or reappointment of external (non-director) members to serve on the Committee. The Committee membership term is for one year, renewable annually.

Quality Committe_FY2013 Goals_20121119_Gov Cte Recs_20121204, 12-5.doc

Quality / Patient Care and Patient Experience Committee
Goals for FY 2013

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Quality Committee helps to assure that exceptional patient care and patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

Staff: Eric Pifer, MD, CMO

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff, VP of Patient Care Services, physicians, nurses, and members from the Community Advisory Councils or the community-at-large. The CEO is an ex-officio of this Committee.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
1. Ensure that the corporate dashboard has cascading metrics in the patient performance improvement, and quality council, continuum of care and patient safety committees.	▪ Q3	▪ Metrics complete with benchmarks on dashboard

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
2. Review annual plans from the following committees: a. Patient Experience b. Patient Safety c. Quality Council d. Lean and Performance Improvement e. Continuum of Care	▪ All plans complete Q3	▪ Plans will have metrics and benchmarks defined and reviewed
3. Review and approve committee charter and goals	▪ Q2	▪ To be complete by December, 2012
4. Oversee the process for red alerts for patient safety	▪ As needed and Annually	▪ At least 1 Board Quality Committee Director will attend each Red Alert debriefing.
5. Provide a forum for patients to share their experiences as overseen by the patient experience committee	▪ Q3 ▪ Quarterly	▪ Plan will be completed on how to and who to invite and what to do with results.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
ELIMINATE 6. Host an annual Quality Summit for the purpose of learning best practices from other institutions.	▪ Q3	▪ Combine the Annual Quality and Strategic Summit ▪ Identify key Quality learning opportunities ▪ Secure a speaker and/or program for the purpose of education ▪ In addition to the Quality Summit education program, seek speakers who can conduct a high level evaluation of the Quality program at ECH
ELIMINATE 7. Develop optimal structure for managing multiple initiatives (as defined in Goal #3) with potential competition for attention.	▪ Q4	▪ A plan will be defined and approved whereby resources are allocated in accordance with the strategic plan.
8. Committee members will participate in educational sessions as appropriate on the following topics: ▪ Vocabulary for Lean Management ▪ ACO and the PPACA ▪ Service Methodologies ▪ Change Management Techniques ▪ Culture Change	▪ Q4	▪ A schedule for educational events will be developed and approved. ▪ At least 2 specific educational opportunities will be presented to committee members.
ELIMINATE 9. Develop vision for patient centered care ▪ Committee will conduct an organizational assessment of family and patient centered care across the two ECH campuses.	▪ Q4	▪ Assessment will be complete ▪ Review will be complete

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
ELIMINATE 10. Recruit additional quality committee member(s), including expertise in patient experience and satisfaction.	▪ Q3	▪ Additional member(s) appointed

Summary of SVMD Proposed Changes (final v2) 11-29-12.DOC

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY
SILICON VALLEY MEDICAL DEVELOPMENT, LLC

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-962-5793
www.elcaminohospital.org

Memorandum

Date: December 4, 2012
To: Governance Committee
Board of Directors
From: Cal James, President
Re: Change of Governance of Silicon Valley Medical Development, LLC ("SVMD")

SVMD provides ambulatory and new venture development; conducts information systems implementation related to health information exchange with community providers; and it serves as a focal point for new business development outside of the Hospital (see attached Power Point slide from June of 2008 for original SVMD mission and purpose). The revenues of SVMD come from Hospital funding. The full purpose and potential of SVMD has yet to be realized, but its value in attracting ambulatory care business talent and its focus outside of the hospital have already provided significant benefit (i.e., Senior Health Center start-up; eClinicalWorks implementations; Dialysis JV with Satellite; and JV of Surgery Center with E3).

The Hospital is the sole member of SVMD. SVMD now has eight employees. It was governed initially by a Board of Managers whose members were Ken Graham, Cal James, John Zoglin, Mariam Manoukian, M.D., Eric Pifer, M.D., and David Katz. After it was established, the role of the Board of Managers decreased as SVMD became focused on operations and long term projects, with overall direction to SVMD being provided by the CEO of the Hospital.

While the potential value of a stand-alone entity dedicated to ambulatory care and physician alignment continues, for the sake of ongoing efficiency of oversight and governance, we believe that SVMD can be best managed by the Member with Tomi Ryba, CEO, acting as the sole Member Representative. The attached documents would change the current governance of SVMD to a Member managed LLC. The activities of the company will be reported to the Board periodically through the CEO's report.

Recommendation: That the Governance Committee recommend that the Board adopt the resolution presented to this meeting authorizing amendment of the SVMD Operating Agreement to establish Member management of SVMD, electing officers Tomi Ryba, Eric Pifer, MD, and Scott Farr, and authorizing submission of required filings to the Secretary of State.

ATTACHMENT 2B Amendment No. 2 to LLC Operating Agreement of Silicon Valley Medical Development LLC.docx

AMENDMENT NO. 2 TO THE

LIMITED LIABILITY COMPANY OPERATING AGREEMENT
OF
SILICON VALLEY MEDICAL DEVELOPMENT, LLC

This Amendment No. 2 (the "Amendment") is made as of November 15, 2012 (the "Effective Date") to the Limited Liability Company Operating Agreement of Silicon Valley Medical Development, LLC dated July 17, 2008, as amended (the "Agreement").

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

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

WHEREAS, the Member wishes to amend the Agreement to provide that the Member shall manage the business of the Company.

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

1. Management

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

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

> 6. Management. The business of the Company shall be managed by the Member. The Member shall have the power to do any and all acts necessary or convenient to or for the furtherance of the purposes described herein, with all powers, statutory or otherwise, possessed by members under the laws of the State of California. The Member designates its chief executive officer as its representative (the "Member Representative") and notwithstanding any other provision of this Agreement, the Member Representative is authorized to execute and deliver any document on behalf of the Company without any vote or consent of any other person and to take any other action of the Member.

2. Officers and Agents

2.1. Reference is made to Section 7 of the Agreement, which provides for the appointment of officers and agents for the Company.

2.2. Section 7 of the Agreement is hereby deleted in its entirety and replaced with the following:

7. Officers and Agents. The Member, through its Member Representative, acting by written instrument, shall have the power to appoint officers and agents to act for the Company, with such titles and holding such powers as may be set forth in such written instrument and consistent with the Act, the Articles and this Agreement. The Member, through its Member Representative, acting by written instrument, may ratify any act previously taken by an agent acting on behalf of the Company. Except as provided in the Act, the Articles and this Agreement, the Member, through its Member Representative, shall have the sole power to bind the Company.

3. Miscellaneous

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

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

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

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

* * *

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

El Camino Hospital,
a California nonprofit public benefit corporation

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

Silicon Valley Medical Development LLC_Action by Sole Member re Restated Articles v2 11-28-12, finalm.DOCX

SILICON VALLEY MEDICAL DEVELOPMENT, LLC

Action of the Sole Member Taken by Written Consent

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

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

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

RESOLVED: That the Limited Liability Company Operating Agreement of the Company (as amended) (the "Operating Agreement") be amended in substantially the form attached hereto as Exhibit B ("Amendment No. 2 to the Operating Agreement") in order to be consistent with the Restated Articles of Organization and provide that the sole Member shall manage the business of the Company and have the sole power to bind the Company.

RESOLVED That the following persons be elected to the office(s) set forth opposite their name below, to serve until the next annual meeting of the Member or until further action by the Member of the Company:

Tomi Ryba	-	Chief Executive Officer
Eric Pifer, MD	-	CMO
Scott Farr	-	VP, Continuum of Care, Venture Development and Physician Relations

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

Dated: November 15, 2012

SOLE MEMBER:

El Camino Hospital,
a California nonprofit public benefit corporation

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

ATTACHMENT 2D Operating Agreement.pdf

Execution Copy

LIMITED LIABILITY COMPANY OPERATING AGREEMENT

OF

SILICON VALLEY MEDICAL DEVELOPMENT, LLC

This Limited Liability Company Operating Agreement (this "Agreement") of Silicon Valley Medical Development, LLC is entered into as of the 17th day of July, 2008, by El Camino Hospital, a California nonprofit public benefit corporation, as the sole member (the "Member").

The Member in order to form a limited liability company pursuant to and in accordance with the California Beverly-Killea Limited Liability Company Act, as amended from time to time (Cal. Corp. Code § 17000, *et seq.*) (the "Act"), hereby agrees with the Company as follows:

1. Name. The name of the limited liability company shall be Silicon Valley Medical Development, LLC (the "Company").

2. Member. The name and the business and mailing addresses of the Member is as follows:

Name	Address
El Camino Hospital	2500 Grant Road Mountain View, CA 94040

3. Initial Agent. The name and address of the initial agent of the Company for service of process on the Company in the State of California, is c/o Corporation Service Company d/b/a CSC-Lawyers Incorporating Service, Suite 100, 2730 Gateway Oaks Drive, Sacramento, California 95833.

4. Articles. The Member, acting through any of its authorized officers, is hereby designated as an authorized person within the meaning of the Act to execute, deliver and file the Articles of Organization of the Company (the "Articles"), and to execute, deliver and file any amendments or restatements of the Articles or any certificate of cancellation of the Articles.

5. Purpose and Powers. The purpose of the Limited Liability Company is to engage in any lawful act or activity for which a limited liability company may be organized under the Act. Such purpose shall include, without limitation, to establish initiatives between independent physicians and El Camino Hospital, to develop and maintain ambulatory ventures outside of the Member facility, and to establish and provide management services to any medical groups in association with the Member. The Company shall have the power and authority to do any and all acts necessary or convenient to or in furtherance of the foregoing purposes, including all power and authority, statutory or otherwise, possessed by, or which may be conferred upon, limited

liability companies under the laws of the State of California. The Company shall not undertake any activity that would jeopardize the Member's status as a tax-exempt entity under the Internal Revenue Code.

6. Management. The business of the Company shall be managed by a Board of Managers, and the persons constituting the Board of Managers, not the Member, shall be the "managers" of the Company for all purposes under the Act.

The initial Board of Managers shall consist of a single manager, who shall be Kenneth D. Graham. Promptly after the formation of the Company, the initial manager shall elect not fewer than six (6) nor more than eight (8) additional managers. Thereafter, the Board of Managers shall consist of not fewer than seven (7) nor more than nine (9) voting managers, subject to increase or decrease by the Member. In addition, the Chief Executive Officer of the Company shall *ex officio* serve as a non-voting member of the Board of Managers.

The Board of Managers will be divided into three classes of approximately equal size, with each class serving for staggered two-year terms (other than the first two classes, which will serve for eight and sixteen months, respectively), such that no more than approximately one-third of the managers' terms shall expire in a given election, held every eight months. Prior to the end of the term of a particular class, the Board of Managers shall elect the class's successors. If a vacancy occurs on the Board of Managers, the Board of Managers shall elect a new manager to fill the vacancy for the remaining portion of the then-current term. The Member has the right to remove any or all managers at any time, with or without cause. If the Member removes the entire Board of Managers, the Member shall then elect a replacement Board of Managers.

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

7. Officers and Agents. The Board of Managers, acting by written instrument, shall have the power to appoint officers and agents to act for the Company, with such titles and holding such powers as may be set forth in such written instrument and consistent with the Act, the Articles, and this Agreement. The Board of Managers, acting by written instrument, may ratify any act previously taken by an agent acting on behalf of the Company. Except as provided in the Act, the Articles, and this Agreement, the Board of Managers shall have the sole power to bind the Company.

8. Indemnification. The Company shall indemnify, defend, and hold harmless the Member and any director, officer, or employee of the Member, each member of the Board of Managers, and any person serving at the request of the Company as a director, officer, employee, partner, trustee, or independent contractor of another corporation, partnership, limited liability company, joint venture, trust, or other enterprise (all of the foregoing persons being referred to collectively as "Indemnified Parties" and individually as an "Indemnified Party") from any liability, loss, or damage incurred by the Indemnified Party by reason of any act performed or omitted to be performed by the Indemnified Party in connection with the business of the Company and from liabilities or obligations of the Company imposed on such Indemnified Party by virtue of such Indemnified Party's position with the Company, including reasonable attorneys' fees and costs and any amounts expended in the settlement of any such claims of liability, loss, or damage; *provided, however*, that if the liability, loss, damage, or claim arises out of any action or inaction of an Indemnified Party, indemnification shall be available only if (a) either (i) the Indemnified Party, at the time of such action or inaction, determined in good faith that its, his, or her course of conduct was in, or not opposed to, the best interests of the Company or (ii) in the case of inaction by the Indemnified Party, the Indemnified Party did not intend its, his, or her inaction to be harmful or opposed to the best interests of the Company and (b) the action or inaction did not constitute fraud, gross negligence, or willful misconduct by the Indemnified Party; *provided, further, however*, that the indemnification provided herein shall be recoverable only from the assets of the Company and not from any assets of the Member. Unless the Board of Managers determines in good faith that the Indemnified Party is unlikely to be entitled to indemnification as provided herein, the Company shall pay or reimburse reasonable attorneys' fees of an Indemnified Party as incurred, provided that such Indemnified Party executes an undertaking, with appropriate security if requested by the Board of Managers, to repay the amount so paid or reimbursed in the event that a final nonappealable determination by a court of competent jurisdiction that such Indemnified Party is not entitled to indemnification as provided herein. The Company may pay for insurance covering liability of the Indemnified Party for negligence in operation of the Company's affairs.

No Indemnified Party shall be liable, in damages or otherwise, to the Company or to the Member for any loss that arises out of any act performed or omitted to be performed by it, him, or her pursuant to the authority granted by this Agreement if (a) either (i) the Indemnified Party, at the time of such action or inaction, determined in good faith that such Indemnified Party's course of conduct was in, or not opposed to, the best interests of the Company or (ii) in the case of inaction by the Indemnified Party, the Indemnified Party did not intend such Indemnified Party's inaction to be harmful or opposed to the best interests of the Company and (b) the conduct of the Indemnified Party did not constitute fraud, gross negligence, or willful misconduct by such Indemnified Party.

Any person who is within the definition of "Indemnified Party" at the time of any action or inaction in connection with the business of the Company shall be entitled to the benefits provided herein as an "Indemnified Party" with respect thereto, regardless whether such person continues to be within the definition of "Indemnified Party" at the time of such Indemnified Party's claim for indemnification or exculpation hereunder.

The Company may in its discretion indemnify any of its officers, authorized agents, employees, consultants, and counsel, each as if an "Indemnified Party." The Company may

enter into an agreement with any Indemnified Party setting forth procedures consistent with applicable law for implementing the indemnities provided herein; however, the Company's failure to enter into any such agreement shall not limit the indemnities provided herein.

9. Reliance by Third Parties. Any person or entity dealing with the Company may rely upon a certificate signed by the Member or the Board of Managers as to: (a) the identity of the Member or the members of the Board of Managers; (b) the existence or non-existence of any fact or facts which constitute a condition precedent to acts by the Member or the Board of Managers or are in any other manner germane to the affairs of the Company; (c) the persons who or entities that are authorized to execute and deliver any instrument or document of or on behalf of the Company; and (d) any act or failure to act by the Company or as to any other matter whatsoever involving the Company, the Member, or the Board of Managers.

10. Capital Contributions. The Member will allocate up to one million three hundred thousand dollars ($1,300,000) as its initial capital contribution to the Company. In its sole discretion, the Member may make, but shall not be required to make, additional capital contributions to the Company.

11. Taxation. The Company shall take steps to be treated as other than a corporation for federal tax purposes.

As set forth herein, the Company shall not undertake any activity that would jeopardize the Member's status as a tax-exempt organization under the Internal Revenue Code. If, in its sole discretion, the Member determines that any activity in which the Company is or proposed to be engaged may jeopardize the Company's status as a tax-exempt organization, the Member may require the Company immediately to modify or terminate such activity in order to preserve the Company's status as a tax-exempt organization.

12. Allocation of Profits and Losses. The Company's profits and losses shall be allocated to the Member.

13. Distributions. Distributions shall be made to the Member at the times and in the aggregate amounts determined by the Member.

14. Dissolution. The Company shall have perpetual existence unless it shall be dissolved and its affairs shall have been wound up upon (a) the vote of the Member or (b) the entry of a decree of judicial dissolution under Section 17351 of the Act. The Member shall have the right to vote to dissolve the Company at any time, in its sole discretion, and without approval of the Board of Managers. The existence of the Company as a separate legal entity shall continue until the cancellation of the Articles as provided in the Act.

15. Assignments. The Member may assign its limited liability company interest to any person, which assignee shall become a Member when the assignee becomes a party to the Agreement.

16. Amendments. This Agreement may be amended or restated from time to time by the Member.

17. Liability of Member. The Member shall not have any liability for any obligations or liabilities of the Company except to the extent provided in the Act.

18. Governing Law. This Agreement shall be governed by, and construed under, the laws of the State of California all rights and remedies being governed by said laws.

* * *

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

El Camino Hospital,
a California nonprofit public benefit corporation

By: Kenneth D Graham
Name: Kenneth D. Graham
Title: Chief Executive Officer, El Camino Hospital

ATTACHMENT 2E opement LLC Restated Articles of Organization.pdf

State of California
Secretary of State

LIMITED LIABILITY COMPANY
RESTATED ARTICLES OF ORGANIZATION

A $30.00 filing fee must accompany this form.

IMPORTANT – Read instructions before completing this form.

This Space For Filing Use Only

1. SECRETARY OF STATE FILE NUMBER
200820010060

2. NAME OF LIMITED LIABILITY COMPANY:
Silicon Valley Medical Development, LLC

3. NAME OF LIMITED LIABILITY COMPANY IF DIFFERENT FROM ITEM 2. (END THE NAME WITH THE WORDS "LIMITED LIABILITY COMPANY" OR "LTD. LIABILITY CO." OR THE ABBREVIATIONS "LLC OR L.L.C.")

4. FUTURE EFFECTIVE DATE, IF ANY:
MONTH: **DAY:** **YEAR:**

5. THE PURPOSE OF THE LIMITED LIABILITY COMPANY IS TO ENGAGE IN ANY LAWFUL ACT OR ACTIVITY FOR WHICH A LIMITED LIABILITY COMPANY MAY BE ORGANIZED UNDER THE BEVERLY-KILLEA LIMITED LIABILITY COMPANY ACT.

6. CHECK THE APPROPRIATE PROVISION BELOW AND NAME THE AGENT FOR SERVICE OF PROCESS

☐ AN INDIVIDUAL RESIDING IN CALIFORNIA. PROCEED TO ITEM 7
☑ A CORPORATION WHICH HAS FILED A CERTIFICATE PURSUANT TO SECTION 1505. PROCEED TO ITEM 8.

AGENT'S NAME: Corporation Service Company which will do business in California as CSC-Lawyers Incorporating Service

7. CALIFORNIA ADDRESS OF THE AGENT FOR SERVICE OF PROCESS. COMPLETE ONLY IF AN INDIVIDUAL.

ADDRESS

CITY STATE: **CA** ZIP CODE:

8. THE LIMITED LIABILITY COMPANY WILL BE MANAGED BY: (CHECK ONE)

☐ ONE MANAGER
☐ MORE THAN ONE MANAGER
☑ ALL LIMITED LIABILITY COMPANY MEMBER(S)

9. OTHER MATTERS TO BE INCLUDED IN THIS CERTIFICATE MAY BE SET FORTH ON SEPARATE ATTACHED PAGES AND ARE MADE A PART OF THIS CERTIFICATE. OTHER MATTERS MAY INCLUDE THE LATEST DATE ON WHICH THE LIMITED LIABILITY IS TO DISSOLVE.

10. TOTAL NUMBER OF PAGES ATTACHED, IF ANY:

11. IT IS HEREBY DECLARED THAT I AM THE PERSON WHO EXECUTED THIS INSTRUMENT, WHICH EXECUTION IS MY ACT AND DEED.

SIGNATURE OF AUTHORIZED PERSON

DATE

El Camino Hospital, sole Member / By: Tomi Ryba its CEO
TYPE OR PRINT NAME AND TITLE OF AUTHORIZED PERSON

12. RETURN TO:

NAME
FIRM
ADDRESS
CITY/STATE
ZIP CODE

ATTACHMENT 2F Silicon Valley Medical Development LLC_SOI Form.pdf

State of California
Secretary of State

L

STATEMENT OF INFORMATION
(Limited Liability Company)

Filing Fee $20.00. If this is an amendment, see instructions.

IMPORTANT — READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

1. **LIMITED LIABILITY COMPANY NAME**

Silicon Valley Medical Development, LLC

This Space For Filing Use Only

File Number and State or Place of Organization

2. SECRETARY OF STATE FILE NUMBER	3. STATE OR PLACE OF ORGANIZATION (If formed outside of California)
200820010060	

No Change Statement

4. **If there have been any changes to the information contained in the last Statement of Information filed with the California Secretary of State, or no statement of information has been previously filed, this form must be completed in its entirety.**

☐ If there has been no change in any of the information contained in the last Statement of Information filed with the California Secretary of State, check the box and proceed **to Item 15.**

Complete Addresses for the Following (Do not abbreviate the name of the city. Items 5 and 7 cannot be P.O. Boxes.)

	CITY	STATE	ZIP CODE
5. STREET ADDRESS OF PRINCIPAL EXECUTIVE OFFICE 2500 Grant Road	Mountain View, CA		94040
6. MAILING ADDRESS OF LLC, IF DIFFERENT THAN ITEM 5 PO Box 7025, 2500 Grant Road	Mountain View, CA		94040
7. CALIFORNIA OFFICE WHERE RECORDS ARE MAINTAINED **(DOMESTIC ONLY)** 2500 Grant Road	Mountain View	**CA**	94040

Name and Complete Address of the Chief Executive Officer, If Any

8. NAME	ADDRESS	CITY	STATE	ZIP CODE
Tomi Ryba	PO Box 7025, 2500 Grant Road	Mountain View, CA		94040

Name and Complete Address of Any Manager or Managers, or if None Have Been Appointed or Elected, Provide the Name and Address of Each Member (Attach additional pages, if necessary.)

9. NAME El Camino Hospital	ADDRESS PO Box 7025, 2500 Grant Road	CITY Mountain View, CA	STATE	ZIP CODE 94040
10. NAME	ADDRESS	CITY	STATE	ZIP CODE
11. NAME	ADDRESS	CITY	STATE	ZIP CODE

Agent for Service of Process If the agent is an individual, the agent must reside in California and Item 13 must be completed with a California address, a P.O. Box is not acceptable. If the agent is a corporation, the agent must have on file with the California Secretary of State a certificate pursuant to California Corporations Code section 1505 and Item 13 must be left blank.

12. NAME OF AGENT FOR SERVICE OF PROCESS
Corporation Service Company which will do business in California as CSC-Lawyers Incorporating Service

13. STREET ADDRESS OF AGENT FOR SERVICE OF PROCESS IN CALIFORNIA, **IF AN INDIVIDUAL**	CITY	STATE	ZIP CODE
		CA	

Type of Business

14. DESCRIBE THE TYPE OF BUSINESS OF THE LIMITED LIABILITY COMPANY
Health care

15. THE INFORMATION CONTAINED HEREIN, INCLUDING ANY ATTACHMENTS, IS TRUE AND CORRECT.

August __, 2012	Tomi Ryba	CEO	
DATE	TYPE OR PRINT NAME OF PERSON COMPLETING THE FORM	TITLE	SIGNATURE

LLC-12 (REV 01/2012)

APPROVED BY SECRETARY OF STATE

Dietary Policy Summary report.docx

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
	New Policies						
	Major Revisions						
	Minor Revisions						
1.01a	Scope of Service						Combined MV and LG polices into one
1.01b	Staffing Pattern – Mountain View Campus Staffing Pattern – Los Gatos Campus (Excel spreadsheets)						Adjusted some MV shift hours
1.01c	Department Organization Chart						Combined MV and LG polices into one
2.08	Storage and Food Handling Procedures						Updated products in attachment
2.08A	Food Handling Expiration Guide						Updated products in attachment
2.10	Food Preparation						Updated internal temp for cooking meat per new FDA Food Code
2.12	Taking Supplies Home						Start trayline 10 minutes early
2.34-MV	Recording of Temperatures - Mountain View Campus						Nourishment refrig temperature by Host
2.38	Outdated Supplies						Added dating of opened spices
2.42	Lead Employees						Lead Ee" changed to "Relief Supervisor"
2.46	Meal Tickets/Gift Cards						Added gift card option

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
3.05	Department Communication - Mountain View Campus						Added Outlook emails
3.14	Day(s) Off Approval						eTime guideline
3.16	Employee Timecards						eTime guideline
4.22	Floorstock Supplies - Mountain View Campus						using NuSOFA
7.19	Waste Handling						Added language for equipment in new kitchen
8.00	Demonstration Kitchen - MV						Added guideline for guest chef to use
	Scheduled Policy Review – No Changes						
1.01a	Scope of Service – Mountain View Campus						
2.00	Purchasing and Receiving of Supplies						
2.01	Compliance with Laws and Regulations						
2.02	Supplies Inventory						
2.02-LG	Supplies Inventory - Los Gatos Campus						
2.03	Hours of Operation – Mountain View Campus						
2.03-LG	Hours of Operation – Los Gatos Campus						
2.04	Ordering Procedures for General Stores						
2.06	Purchasing of Supplies by Department Staff						

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
2.09	Personal Hygiene and Sanitary Food Handling						
2.12	Taking Supplies Home						
2.13	Donations of Surplus Foods						
2.14	Food Production						
2.18	Ice Dispensing						
2.19-LG	Tray Assembly – Los Gatos Campus						
2.20	Pest Control						
2.26	Dishwasher Service Disruption						
2.34-LG	Recording of Temperatures – Los Gatos Campus						
2.36	Preventative Maintenance						
2.40	Appointments with Sales Reps & Brokers - Mountain View Campus						
2.40-LG	Appointments with Sales Reps & Brokers – Los Gatos Campus						
2.43	Meal Analysis and Cost						
2.44	Petty Cash Fund – Mountain View Campus						
2.44-LG	Petty Cash Fund – Los Gatos Campus						
2.48	Sanitizing Dishes						

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
2.50	Department Sanitation						
2.51	Cutting Boards						
3.00	Department Staffing						
3.01	Management Expectations						
3.02	New Employee Orientation & Continuing Education						
3.03	Nutrition Services In-Service Education Hazardous Substance						
3.05-LG	Department Communication - Los Gatos Campus						
3.06	Per Diem Scheduling						
3.10	Scheduled PTO Requests (updated 07/31/09)						
3.18	Employee Dress Code						
3.20	Maintaining a Professional Environment						
3.22-LG	Employee Lockers – Los Gatos Campus						
3.26	Employee Work Expectations						
3.27	Call Back Procedure						
3.30	Employee Meals						
3.36	Hiring of Relatives						

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
3.38	Employee Sick Calls - Mountain View Campus						
3.38-LG	Employee Sick Calls – Los Gatos Campus						
4.00	Nutrition Care Manuel						
4.02	Registered Dietitians						
4.06	Nutritional Screening & Assessment						
4.08	Patient Plan of Care						
4.10	Diet List and Diet Order Processing - Mountain View Campus						
4.10-LG	Diet List and Diet Order Processing – Los Gatos Campus						
4.11	Advance as Tolerated Diet Orders						
4.14	Patient Menus and Menu Selections - Mountain View Campus						
4.14-LG	Patient Menus and Menu Selections – Los Gatos Campus						
4.16	Meal Trays - Mountain View Campus						
4.16-LG	Meal Trays - Los Gatos Campus						
4.18	Nutritional Supplements						
4.20	Patient Nourishments						
4.20-LG	Patient Nourishments - Los Gatos Campus						

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
4.21	Food Brought in to Patient from Outside						
4.21A	Guidelines for Bringing in Food While in the Hospital						
4.22-LG	Floorstock Supplies - Los Gatos Campus						
4.26	24 Hour Availability of Patient Food						
4.26-LG	24 Hour Availability of Patient Food - Los Gatos Campus						
4.28	Patient/Family Education						
4.30	Out-Patient Diet Instructions						
4.32	Early Patient Tray Delivery						
4.34	Enteral Tube Feedings						
4.34A	Enteral Formulary						
4.36	Nutritionally Inadequate Diets						
4.38	Wine and Alcohol						
4.40	Communication and Approval of Nutrition Care Services						
4.42	Patient Satisfaction Survey						
4.46	Counseling for Potential Food/Drug Interactions						
5.00	Cafeteria Operations						

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
5.04	Charging for Meals						
5.06	Guest Trays						
5.08	Vending Machines - Mountain View Campus						
5.12	Catering - Mountain View Campus						
5.12-LG	Catering – Los Gatos Only						
5.14	Vending Services Infection Control						
5.16	Cafeteria Purchases by Check						
5.18	Use of Disposables						
5.20	Cleaning of Hood Filters						
5.22	Cafeteria Cash Register Transaction Procedures						
5.24	Cafeteria Cash Handling - Mountain View Campus						
5.24-LG	Cafeteria Cash Handling - Los Gatos Only						
6.00	Department Safety						
6.01	Department Security						
6.03	Accident Prevention						
6.08	Food and Nutrition Department Disaster Management Program						

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
7.17	Infection Control & Sanitary Handling						
	Scheduled Policy Review – Archived						
1.01A-LG	Scope of Service - Los Gatos Campus						
1.01-LG	Department Organization Chart – Los Gatos Campus						
2.22	Telephone Etiquette						
2.24	Telephone Usage						
3.04	Employee Attendance (see #3.10 below or Human Resources #3.08)						
3.07	Confidentiality of Employee Records						
3.08	Work Schedules (see #3.10 below or Human Resources #3.08)						
3.12	PTO During the Holiday Season						Combined #3.12 into #3.10
3.28	Receiving Phone Calls						
3.34	Tardiness (see #3.10 above) or Human Resources #3.08)						
3.40	Physician Verification of Illnesses						
4.06A	Nutritional Screening & Assessment Tool - Mountain View Campus						
4.06B	Nutritional Screening & Assessment Tool – Los Gatos Campus						

Dietary Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
4.06C	Nutritional Screening & Assessment Tool - NICU						
4.07	Skilled Nursing/Sub Acute Unit Nutritional Assessments						
4.07A	Sub Acute Unit - Nutritional Services						
4.12	Physician Ordered Modified Diet Charges - Mountain View Campus						
4.12	Physician Ordered Modified Diet Charges - Mountain View Campus						
4.27	Patient Confidentiality						
5.08-LG	Vending Machines - Los Gatos Only						*Combined into #5.08
6.08-LG	Food and Nutrition Dept Disaster Management Program – Los Gatos Only						Combined MV & LG

E-Mail Summary and Policy.pdf

El Camino Hospital
Executive Summary

This Policy Applies to: Allied health professionals, Contract services personnel, El Camino Hospital employees, Independent contractors, Partners, Physicians, Registry/temporary agency personnel, Students, Interns and Instructors, Volunteers.	Last Approval Date: June 2009 Next Review Due: June 2013
Name of Policy:	Email policy
Policy Owner (Name, Title & Department):	Greg Walton, CIO
Manual Policy Will Reside In:	Administrative

Brief Policy Statement:

HIPAA Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information.

Summary of Changes:

- ☐ New Policy
- ☐ No Changes
- ☒ Minor Revision
- ☐ Major Revision

(Briefly Specify Changes Below)

Added subject material to be legally correct and include HIPAA requirements.

Legal Review Required?

☒ **Yes** **Date Completed:** 11/30/11

☐ **N/A**

Committee Review History: (List Committees that have reviewed subject policy)

Compliance & Legal	11/11
IT Leadership	03/12
HR	04/12
Executive Committee	Pending
Board of Directors	Pending

19.00 E-mail Policy.docx

EL CAMINO HOSPITAL
ADMINISTRATIVE POLICIES AND PROCEDURES

19.00 E-MAIL POLICY

A. **Coverage**:

All users of the El Camino Hospital (ECH) e-mail system, including but not limited to:

Allied health professionals
Contract services personnel
ECH employees
Independent contractors
Partners
Physicians
Registry/temporary agency personnel
Students, interns and instructors
Volunteers

B. **Reviewed/Revised**

11/00, 05/01, 12/03, 03/05, 11/06, 06/09, 06/12

C. **Governing Laws and Standards**:

HIPAA Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information, 45 C.F.R. Part 160 and Part 164, Subparts A, C and E; Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009), codified at 42 U.S.C. §§300jj et seq.; §§17901 et seq.

D. **Policy Summary**:

The purpose of this policy is to define the criteria for access to e-mail by employees and contract personnel (ECH Email User), as well as to define the guidelines for its acceptable use. ECH e-mail is an important communication resource for ECH employees and related personnel. With the increased capabilities of e-mail, ECH must ensure that all ECH Email Users understand the circumstances in which e-mail communications are appropriate and permitted.

E. **Company Property**:

All ECH computers, e-mail and internet access accounts are ECH property and are to be used solely to facilitate the business of ECH. Upon termination of employment or other business relationship with ECH, no ECH Email User shall remove any data from ECH computers or online databases.

The ECH e-mail network and computers are the property of ECH. ECH management may intercept, monitor, copy, review, or download any communications or files that are sent, received, or stored on the ECH system. Use of passwords or other security measures does not in any way diminish ECH's right to access materials on its systems, or create any privacy rights of the ECH Email User in the messages and files on the systems. All ECH Email Users should expect that all information created, transmitted, downloaded, received or stored in ECH computers or electronic databases may be accessed by ECH at any time without prior notice.

F. **Criteria for ECH E-Mail Access**:

1. All ECH Email Users are required to read ECH's e-mail policy and to follow the guidelines when using e-mail as a representative of ECH.

2. Failure to follow the e-mail policy may lead to disciplinary action, up to and including termination.

G. **Definitions**:

Sensitive Information means any data of which the compromise with respect to confidentiality, integrity, and/or availability could have a material adverse effect on ECH or the disclosure of which would be inconsistent with the reasonable expectations of privacy of any individual.

Protected Health Information (PHI) means information, including demographic information that may identify the patient, that relates to the past, present or future physical or mental health condition of the individual, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual, and identifies, or could reasonably be used to identify, the individual.

Electronic protected health information (EPHI) means individually identifiable health information that is:

- Transmitted by electronic media
- Maintained in electronic media

Electronic media means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

Availability means the property that data or information is accessible and useable upon demand by an authorized person.

Confidentiality means the property that data or information is not made available or disclosed to unauthorized persons or processes.

Integrity means the property that data or information have not been altered or destroyed in an unauthorized manner.

Encryption means the conversion of data into secret, unreadable code. To read encrypted data, a person must have access to a secret key or password that enables them to decrypt (decode) the data. For any e-mail transmitting data consisting of, or containing, individually identifiable health information, encryption is valid only if it conforms to the standards prescribed in the National Institute of Standards and Technology (NIST) Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS) 140-2 validated. The NIST standards may be found at www.csrc.nist.gov.

H. **ECH e-mail Use Requirements**:

1. Always represent yourself as yourself.

2. Adhere to all ECH policies in sending messages, including following the special procedures for the transmission of sensitive or confidential information and EPHI.

3. At no time may ECH Email Users send or receive files or messages that contain material that is defamatory, abusive, obscene, inappropriate, offensive, threatening or disrespectful to others. ECH Email Users encountering or receiving this kind of material should immediately report the incident to the Director of Human Resources.

4. E-mail is to be used for ECH business-related activities only.

5. Additionally, by way of example only, use of e-mail will **not** be used:

   a. For personal gain or profit.
   b. To represent yourself as someone else.
   c. For solicitation of ECH employees.
   d. To provide any information about ECH employees to others.
   e. For commercial solicitations of a non-ECH business enterprise.
   f. When it interferes with your job or the jobs of other employees or contracted personnel.
   g. To access and download or execute games, screen savers or other software via e-mail not approved for use by the Information Services Department.
   h. To send strategic information or otherwise sensitive information without written administrative approval and/or without appropriate encryption protection.
   i. To send patient-specific information, such as EPHI, without appropriate encryption protection and/or without authorization (see EPHI communication requirements, below).
   j. To forward jokes, chain letters and non-business related files.
   k. To transmit, retrieve, download or store messages or images that are offensive, derogatory, defamatory, off-color, sexual in content, or otherwise inappropriate in a business environment.

6. See Administrative Policy 20.00 (Internet Policy) for additional guidelines regarding appropriate access of the internet from ECH systems and/or property.

7. Clearly identify privileged and/or confidential information as such with reference to any applicable legal protection. Extremely sensitive information, including any personally identifiable health,

financial or other information an individual would reasonably deem confidential, must be sent via electronic encryption (see EPHI communication requirements, below).

8. Electronic records are considered part of the organization's business records and should be written in a professional and businesslike manner. Sarcasm, innuendos and derogatory language should be avoided.

9. Each ECH Email User's e-mail portal may only be accessed by the user to which the e-mail portal is registered to. Passwords must not be shared between ECH Email Users. E-mail portals must be secured (i.e., by "logging out") when not in use by the registered user.

10. Consult with your manager if in doubt about any use of e-mail.

11. Vendors and contractors should contact their own management to understand their specific responsibilities with regard to e-mail use and abide by ECH's policies and procedures.

I. **Communication of EPHI via E-Mail**:

1. As a general rule, unencrypted e-mail must not be used to communicate EPHI.

2. EPHI must not be transmitted in the subject line of the e-mail message, however the fact that the e-mail or attachment to the e-mail contains EPHI should be reflected in the subject line of the e-mail message.

3. Every e-mail message containing EPHI must include a confidentiality notice, e.g., "*This electronic message is intended for the use of the named recipient only, and may contain information that is confidential and/or privileged. If you are not the intended recipient of the e-mail message, you are hereby notified that any disclosure, copying, distribution or use of the contents of this message is strictly prohibited. If you have received this message in error, please notify us immediately by contacting the sender at the electronic mail address noted above, and delete and destroy all copies of this message. Thank you*."

4. Before transmitting the e-mail message, ECH Email Users should double-check all information therein to ensure sure the recipient

information is correct and that no unintended information is included.

J. **Violation Reporting**:

Any violation of this policy must be immediately reported to the users immediate supervisor and/or to the Corporate Compliance Officer.

K. **Policy Authority/Enforcement**:

El Camino Hospital's Corporate Compliance Officer, Chief Information Officer, and Chief Information Security Officer are responsible for monitoring enforcement of this policy. Any ECH Email User found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

L. **Renewal/Review**:

This policy is to be reviewed annually to ensure compliance with applicable laws and regulations. In the event that significant related regulatory changes occur, the policy will be reviewed and updated as needed.

M. **Contacts**:

Corporate Compliance Officer
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Chief Information Officer
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Chief Information Security Officer
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040
infosec@elcaminohospital.org

N. Approvals:

Compliance & Legal	12/11
IT Leadership	3/12
HR	4/12
Operations Committee	5/18
Management Staff	6/15
Board of Directors	Pending

HR Summary and Policies.pdf

HUMAN RESOURCES Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
	New Policies						
	none						
	Major Revisions						
3.11	Internal Transfer	9/94	**11/12**				Policy updated to reflect current practice
4.01	Dress Code	6/95	**11/12**				Policy updated to reflect current practices and clarification on what is not acceptable.
5.04	Extended Sick Leave	10/95	**11/12**				Policy updated to reflect current practices and clarification on what is not acceptable.
5.07	Time Away From Work	9/94	**11/12**				Date and policy clarification, Added new leaves that were effective 1/2012 to policy.
5.08	Leave of Absence (LOA)	9/94	**11/12**				Date and policy clarification, Added new leaves that were effective 1/2012 to policy. Clarified how long an employee will remain "employed" when they have exhausted all protected leaves, and their position has been filled by another employee.
6.01	Competency Based Job Description/Performance Evaluation	9/94	**11/12**				Policy updated to reflect current practice, includes changes to the rating scale and comments on does not meet
7.01	Discipline Policy	10/95	**11/12**				Added clarification to difference between oral counselings in absenteeism policy and discipline policy.
17.01	Outside Labor Personnel	5/95	**11/12**				Outlined changes regarding reason to use contract personnel. Added chart summarizing health record and background check requirements.
	Minor Revisions						
1.02	Job Evaluation & Reevaluation	9/94	**11/12**				Date and title updates, no other substantive changes
1.03	Work Status	5/95	**11/12**				Date and policy clarification, no other substantive changes

HUMAN RESOURCES Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
2.05	Electronic Timecard System (eTime)	9/96	**11/12**				Date and policy clarification, no other substantive changes
2.06	Reporting Time Pay	6/95	**11/12**				Date and policy clarification, no other substantive changes
2.07	Employee Referral Program	10/01	**11/12**				Date and policy clarification, no other substantive changes
3.02	Employee Records	9/94	**11/12**				Date and policy clarification, no other substantive changes
3.03	Employment of Relatives	6/95	**11/12**				Date and policy clarification, no other substantive changes
3.09	Rest and Meal Periods	9/94	**11/12**				Date and policy clarification, no other substantive changes
3.13	Staffing	5/95	**11/12**				Date and policy clarification, no other substantive changes
5.01	Benefits Administration	5/95	**11/12**				Date and policy clarification, no other substantive changes
5.02	403b Retirement Plan	9/94	**11/12**				Date and policy clarification, no other substantive changes
5.03	Direct Deposit	6/95	**11/12**				Date and policy clarification, no other substantive changes
5.06	Holiday Pay	6/95	**11/12**				Date and policy clarification, no other substantive changes
13.01	Education Program	1/95	**11/12**				Date and policy clarification, no other substantive changes.
13.02	Tuition Assistance Program	5/95	**11/12**				Date and policy clarification, updated Tuition Assistance Request form, no other substantive changes.
13.03	Employee Education Fund	1/95	**11/12**				Title change (formerly Auxiliary Employee Education Fund) date and policy clarification, no other substantive changes
17.02	Students, Interns and Instructors	5/98	**11/12**				Date and policy clarification, no other substantive changes.

HUMAN RESOURCES Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
16.01	Annual Service Awards Program	9/97	**11/12**				Date and policy clarification, no other substantive changes.
16.02	Employee Farewell Recognition	9/97	**11/12**				Title change (formerly Employee Farewell and Retirement Recognition), date and policy clarification regarding eligibility, no other substantive changes.
	No Changes						
1.01	Position Management System	2/96	**11/12**				Review date changes only
1.04	Assignment to more than one job	9/94	**11/12**				Review date changes only
2.01	Compensation Program	9/94	**11/12**				Review date changes only
2.02	Differentials	1/96	**11/12**				Review date changes only
2.03	Overtime	6/95	**11/12**				Review date changes only
2.04	Returning to work in less than 12 hours	6/95	**11/12**				Review date changes only
2.08	Employee Cash Award Program	7/07	**11/12**				Review date changes only
3.01	Employment Procedures	8/96	**11/12**				Review date changes only
3.04	Hours of Work	6/95	**11/12**				Review date changes only
3.05	Hospital Convenience Time Off	6/95	**11/12**				Review date changes only
3.06	General Hospital Orientation	6/95	**11/12**				Review date changes only
3.07	Provisional Period	9/94	**11/12**				Review date changes only

HUMAN RESOURCES Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
3.08	Absenteeism and Tardiness	9/95	**11/12**				Review date changes only
3.10	Staff Non-Participation Requests	5/95	**11/12**				Review date changes only
3.12	Resignation/Separation of Employment	6/97	**11/12**				Review date changes only
3.14	Lactation Accommodation Policy	12/08	**11/12**				Review date changes only
4.02	Uniform Apparel	6/95	**11/12**				Review date changes only
5.09	Paid Time Off	10/95	**11/12**				Review date changes only
5.10	PTO Pay Down	9/95	**11/12**				Review date changes only
5.12	Retirement Insurance Benefits	9/94	**11/12**				Review date changes only
5.13	Retiree Medical and Dental Insurance Continuation	6/9	**11/12**				Review date changes only
8.01	Pre-Placement Policy	5/95	**11/12**				Review date changes only
8.02	Employees infected with Bloodborne Pathogens	9/94	**11/12**				Review date changes only
8.03	Fitness for Duty Evaluation	9/94	**11/12**				Review date changes only
9.01	Reporting Work Related Injuries	5/95	**11/12**				Review date changes only
9.02	Non-work related injuries	9/94	**11/12**				Review date changes only
9.03	Transitional Work	10/02	**11/12**				Review date changes only

HUMAN RESOURCES Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
10.01	Employee Grievance Procedure	9/94	**11/12**				Review date changes only
11.01	Discrimination in Employment	9/94	**11/12**				Review date changes only
11.02	Harassment	9/94	**11/12**				Review date changes only
12.01	Layoff Reduction in Force/Reorganization	3/96	**11/12**				Review date changes only
13.04	Literacy Assistance	1/08	**11/12**				Review date changes only
14.01	Substance Abuse Policy	9/94	**11/12**				Review date changes only
15.01	Certified, Licensed and Registered Employees	8/96	**11/12**				Review date changes only
17.03	Hospital Volunteers	12/06	**11/12**				Review date changes only

0507 Time Away From Work 2012 (2).doc

5.07 TIME AWAY FROM WORK

A. Coverage:

Full and part-time El Camino Hospital employees. If there is a conflict between the Hospital policy and the applicable **MOU** ~~CBA~~, the **MOU** ~~CBA~~ will prevail.

B. Reviewed/Revised:

9/11/94, 5/1/98, 3/14/01, 11/03, 1/04, 12/13/06, (formerly Human Resources Policy, 5.07,) 12/13/08, 03/09, **11/12**

C. Policy Summary:

This policy is written in recognition of the importance of the need to provide for time away from work for reasons that do not require a Leave of Absence as set forth in Human Resources Policy 5.08, and to assure compliance with federal and state laws governing time away from work.

D. Policy

El Camino Hospital allows for time away from work as it relates to the following circumstances:

1) Jury Duty
2) Legal Appearance as a Witness
3) Voting
4) Victims of Domestic Violence and Sexual Assault
5) Victims of Crime
6) School Activities & Discipline
7) Military and Military Spouse Leave
8) Civil Air Patrol and Civil Volunteer Leave

E. Jury Duty:

1. An employee must notify her/his manager as soon as she/he receives a jury duty notice.

2. An employee will be paid the difference between her/his base salary rate (without shift differential) and the amount received for serving on the jury for each regularly scheduled workday falling within the time of jury duty,

up to a total of 160 hours or 20 days annually, whichever occurs first. Employees may then use their accrued PTO or leave without pay.

3. When reasonable, considering traffic and location of the court, an employee must report to work during standby or periods of extended time off, postponement, or similar delay, when his/her physical presence is not required at the courthouse.

4. An employee on the PM or night shift should be scheduled so she/he does not work on the same day(s) she/he serves on jury duty. If an employee voluntarily works a PM or night shift on a day she/he also serves on jury duty, she/he will be paid at the regular rate for the hours actually worked and jury duty pay will not be deducted from her/his paycheck.

5. An employee must submit jury duty payment verification to her/his manager. The manager will forward the verification to Payroll. Jury duty pay received by the employee will be deducted from the subsequent paycheck.

6. Time spent on jury duty leave is not considered hours worked for calculating overtime, but does count for pension accrual and pension hours.

7. Employees may volunteer for additional days/hours of work on their regular days off or nights in addition to paid jury duty leave. They will be paid all appropriate differentials for any hours worked.

E. Legal Appearance:

1. When an employee appears as a witness at the request of El Camino Hospital, or as a result of activities performed within the normal scope of her/his duties assigned by El Camino Hospital, the employee will be paid at her/his base hourly rate. All other witness duty not arising directly from the performance of duties assigned by El Camino Hospital shall be at the employee's expense or by use of PTO. An employee is not eligible for compensation when she/he has been notified she/he is "on-call" or waiting to be called to appear.

2. If legal appearance is required on a scheduled day off, she/he will be paid for the day at her/his base hourly rate and she/he will be given another day off if scheduling permits as determined by the manager.

3. If the employee is scheduled to work the night prior to legal appearance time she/he will have the night off if scheduling permits as determined by the manager.

4. The manager will determine on an individual basis whether the employee will be required to report to work during the portion of her/his shift not spent in legal appearance time.

5. If the employee is not required to work by the manager (or her/his designee), she/he will be paid for her/his scheduled shift at her/his base hourly rate.

6. There will be no loss of benefits or compensation as a result of legal appearance time, except shift differentials and to the extent the employee is reimbursed for legal appearance services (i.e., witness/subpoena fees). The employee will be required to furnish El Camino Hospital with proof of legal appearance.

7. Legal appearance time constitutes hours worked and applies toward overtime and premium pay.

F. Voting

If an employee does not have sufficient time outside of working hours to vote at a statewide election, the voter may, without loss of pay, take off enough working time that, when added to the working time available outside of working hours, will enable the voter to vote. The employee must give two working days notice that such time is needed. The time away from work will not exceed two hours, and will be granted only at the beginning or end of a shift, and only to the extent necessary when added to the time available outside of work to enable the employee to vote. Employees must use accrued PTO as long as it is available.

G. Victims of Domestic Violence and Sexual Assault

Employees who are victims of domestic assault or domestic violence may be allowed time away from work to obtain relief such as a restraining order or other court assistance, or to obtain services related to domestic violence or sexual assault. If feasible, the employee must provide advance notice and the employee must provide documentation in the form of a police report, court order, medical professional counselor or other domestic violence advocate. The time taken may run concurrently with protected family or medical leave time as set forth in Human Resources Policy 5.08, Leave of Absence.

H. Victims of Crime

An employee who is the victim of certain types of felonies or has an immediate family member or registered domestic partner who is the victim of certain types of felonies may take time away from work to attend judicial proceedings. If feasible, the employee must provide advance notice and the employee must provide documentation from a court or governmental agency, a prosecuting or district attorney's office, or an agency advocating on behalf of the victim that verifies that the employees was attending a judicial proceeding. The time taken may run concurrently with protected family or medical leave time as set forth in Human Resources Policy 5.08, Leave of Absence.

I. School Activities & Discipline

The parent or legal guardian of a child in grades K – 12 who has been suspended from school may take time away from work if he/she needs to appear at the school in connection with that suspension. The parent or guardian of a child in grades K–12, or attending a licensed day care facility, may take up to 40 hours off per calendar year for the purpose of participating in activities of the school or licensed day care facility. However, the time away from work for school activities may not exceed 8 hours per calendar month.

In order to be approved for time away from work for school discipline or school related activities, employees must provide documentation from the school or licensed day care facility as proof that the employee participated in the activity on a specific date and at a specific time. When taking time away from work for school activities or school discipline, employees must use accrued PTO as long as it is available.

J. Military and Military Spouse Leave

Employees who are in service in the uniformed services such as Army, Navy, Air Force, Marine Corps, Coast Guard and the reserves of each of these. Also commissioned corps of the Public Health Service and any other category of people designated by the president in the time of war or national emergency. Service is defined as duty on a voluntary or involuntary basis.

Spouses of military personnel qualify for Military Spouse Leave if they are a spouse of a "qualified" servicemember, work and average of 20 or more hours per week and provide notice to their employer of their intention to take leave, within two business days of receiving official notice that the service member will be on leave from deployment.

K. Civil Air Patrol and Volunteer Civil Service Leaves

To qualify for Volunteer Civil Service Leave you must be required to perform emergency duty. The amount of time an employee can use for volunteer civil service leave is unlimited. Emergency rescue personnel is defined as any person who is an officer, employee or member of a fire department, fire protection or firefighting agency of the federal government, California state government, local government, special district or other public or municipal corporation or political subdivision of California. Also an officer of a sheriff's department, police department or private fire department.

To qualify for Civil Air Patrol Leave, an employee must be a volunteer member of the California Wing of the civilian auxiliary of the U.S. Air Civil Air Patrol, responding to an emergency operation mission. Certification may be required prior to the granting of either of these leaves.

Information on any leave of absence may be obtained through the human resources department or through the State of California Chamber of Commerce.

Comment [SJS1]: Additions to the policy were added by S. Speer.

0508 Leave of Absence 2012.doc

5.08 LEAVE OF ABSENCE (LOA)

A. Coverage:

El Camino Hospital employees. If there is a conflict between the Hospital policy and the applicable **MOU** ~~CBA~~, the **MOU** ~~CBA~~ will prevail.

B. Reviewed/Revised:

9/11/94, 5/1/98, 3/14/01, 11/03, 1/04, 12/13/06, 2/17/09, **11/2012**

C. Policy Summary:

This policy is written in recognition of the importance of time away from work to care for oneself or for family members, for time related to military service of an employee or his or her family members, for civil service, for education, or for such other personal reasons an employee may need, and to assure compliance with federal and state laws governing leaves of absence from employment.

D. Policy

El Camino Hospital provides the following types of leave:

1) Medical Leave for employees
2) Medical Leave to care for an employee's family
3) Birth, Adoption or Placement of a Child though Foster Care
4) Military ~~Family~~ Leave **and Military Spouse Leave**
5) Pregnancy Disability Leave
6) Industrial Injury Leave
7) Personal Medical Leave
8) ~~Military Leave~~ **Organ and Bone Donner Leave**
9) Civil **Air Patrol and Volunteer Civil** Service **Leave**
10) Educational Leave
11) Personal Leave

All terms appearing in italics are defined in the Glossary of Terms at the end of this policy.

E. When You Should Apply for a Leave of Absence

1. All employees who expect to be absent for more than seven (7) consecutive calendar days must apply for a leave of absence (LOA), subject to the guidelines set forth below. This provision is not a substitute for the normal "call-in" procedures required by the department. All employees are expected to communicate with their managers about absences from scheduled work.

2. In order to assure compliance with state and federal law, employees who may be eligible for Medical Leave, Family Medical Leave, Military, Military Spouse, or Pregnancy Disability leave for absences of less than seven days, may also be required to apply for LOA

3. Employees are required to contact the Human Resources Department when requesting a leave of absence. A thorough explanation of the procedure to apply for an LOA appears in section F of this policy.

F. How You Apply For a Leave of Absence

1. Employee must obtain a leave of absence packet from Human Resources. The packet will contain all of the information necessary to apply for a leave. If an employee is not able to pick up a packet, they must call Human Resources and request a packet be mailed to them.

2. At least thirty (30) calendars days prior to the requested start date of a foreseeable leave, employees are required to submit a completed Leave of Absence Request Form, Certification of Physician or Practitioner to the Human Resources Department. If the leave is unforeseen, the required forms must be submitted within 15 days from the date the employee receives the Leave of Absence packet.

3. The completed State Disability form or Paid Family Leave form should be sent to the Employment Development Department.

4. Upon receipt of all applicable information (LOA form, medical certification), the employee will be notified by the Human Resources Department which type of leave they are eligible and been approved for.

G. Your *Eligibility* & The Types of Leave Available

1. MEDICAL LEAVE FOR EMPLOYEES AND FOR THE CARE OF HIS OR HER FAMILY MEMBERS

The Family Medical Care Leave Act (FMLA) and the California Family Rights Act (CFRA) provide for leave for reasons related to the *serious health condition* of the employee or his or her family. An employee will be required to use paid time off.

a. *Eligibility*

An employee who has completed more than 12 months of service, and who has at least 1,250 hours of service during the previous 12-month period, is *eligible* to request up to a total of 12 weeks of *protected leave* in any *12-month period* for Family Care and Medical Leave.

If both parents of a child are El Camino Hospital employees, and both employees request leave for reasons of the birth, adoption, or foster care of the child, or for the employee's parent, then the combined total Family Care and Medical Leave allowed shall not exceed more than 12 weeks in a 12-month period. However, if a parent uses less than 12 weeks allowed, they are eligible for FMLA/CFRA for their own serious health condition or to care for child with a serious health condition.

b. Types of Leave

An employee who is *eligible* may take FMLA/CFRA *protected* leave for the following reasons:

1. Because of a *serious health condition* that renders the employee unable to work;
2. To care for a parent, spouse, child, registered domestic partner or child of a registered domestic partner who has a *serious health condition*;
3. Because of the birth or adoption of a child;
4. Because of the placement of a child with the employee through adoption or foster care.

c. Certification Requirements

The employee must provide certification issued by her/his health care provider or the health care provider of the person requiring the care. For

purposes of providing certification under the policy, it is preferred that the employees use the Certification of Physician or Practitioner Form provided by the Human Resources Department, before the request for leave may be approved.

d. Extensions

A request for an extension of the time originally requested for leave may require additional medical certification. If an employee needs to extend his or her leave beyond the twelve week period allowed by FMLA/CFRA, he or she may qualify for *unprotected* leave as provided for in this policy.

2. MILITARY FAMILY CARE LEAVE

The Family Medical Leave Act (FMLA) provides for *protected leave* to care for family members engaged in military service.

a. *Eligibility*

An employee who has completed more than 12 months of service, and who has at least 1,250 hours of service during the previous 12-month period.

b. Types of Leave

1. Family Military Leave For Medical Care

Eligible employees are entitled to leave to care for the employee's wounded spouse, child, parent or *next of kin* who is a member of the Armed Forces. Employees are entitled to only one twenty-six week leave period and the right does not renew once a new twelve month period begins. The leave may be taken on an intermittent basis but all twenty-six weeks must be used in a single *twelve month period.*

2. Family Military Leave For Qualifying *Exigency*

Eligible employees are entitled to up to 12 weeks leave because of a qualifying *exigency* arising because the spouse, son, daughter, or parent of the employee is on active duty or has been notified of impending call to active duty status.

c. Certification Requirements

The employee must provide certification validating the impending leave of a family member, or certification issued by the health care provider of the person requiring the care. For purposes of providing certification under the policy, it is preferred that the employee use the Certification of Physician or Practitioner Form provided by the Human Resources Department, before the request for leave may be approved.

d. Extensions

A request for an extension of the time originally requested for leave may require additional medical certification. If an employee needs to extend his or her leave beyond the twelve week period allowed by FMLA/CFRA, he or she may qualify for unprotected leave as provided for in this policy,.

3. OTHER MEDICAL RELATED LEAVES

a. Pregnancy Disability Leave

An employee is *eligible* upon hire for up to four months of *protected* Pregnancy Disability leave. This leave applies to employees who are disabled by pregnancy and pregnancy related conditions. An employee must provide physician's certification to qualify for Pregnancy Disability Leave.

b. Industrial Injury Leave

An employee is *eligible* upon hire for leave related to a work related injury. Authorization from Employee Health Service, which may include a separate physician's certification, is required to qualify for Industrial Injury Leave. An employee who is in need of industrial injury leave should refer to Human Resources Policy 9.00 through 9.03, "Industrial Injury Leave" and notify their manager and/or Employee Health. This leave may run concurrently with FMLA/CFRA leave.

c. Personal Medical Leave

An employee is *eligible* upon hire for *unprotected* Personal Medical Leave with a manager's approval. A physician's certification is required to qualify for Personal Medical Leave. The first 12 weeks of Personal Medical Leave does not include any *protected leave* already taken by the employee in the applicable *12-month period*. When ESL usage has exhausted, employees must use accrued PTO as long as it is available.

For purposes of providing certification under the policy, it is preferred that the employees use the Certification of Physician or Practitioner Form provided by the Human Resources Department, before the request for leave may be approved.

4. MILITARY RELATED LEAVE

a. Military Service Leave (Uniformed Services Employment and Reemployment Rights Act)

An employee is *eligible* upon hire for *protected leave* if required to be absent from work due to *service* in the *uniformed services* for up to five years. The employee must provide advance written or verbal notice of the need for leave unless prevented from doing so by military necessity or providing notice would be impossible or unreasonable. Employees must use accrued PTO as long as it is available

b. Military Spouse Leave

An employee is *eligible* for *protected leave* if he or she works for at least 20 hours per week on average, and is the spouse of a deployed member of the United States Armed Forces, National Guard or Reserves on active duty or ordered to active duty. An employee who qualifies will be allowed up to ten days of unpaid leave. Employees must use accrued PTO as long as it is available.

The employee must provide notice to the hospital within two business days of receipt of official notice that his or her spouse will be on leave from deployment. The employee must provide written documentation certifying that the spouse will be on leave from deployment.

5. MISCELLANEOUS LEAVES

a. Volunteer Civil Service

An employee may be granted time off to perform emergency duty as a volunteer firefighter, a reserve peace officer, or emergency rescue personnel. An employee who is a volunteer firefighter is entitled to up to 14 days per calendar year of *protected leave* Employees must use accrued PTO as long as it is available.

b. Educational Leave of Absence

A full-time or part-time employee who has completed two thousand eighty (2080) hours* is *eligible* for Educational Leave not to exceed twelve (12) months. The purpose of Educational Leave is to grant the employee time off for the pursuit of education pertinent to her/his employment with El Camino Hospital. This is *unprotected* leave. Employees must use accrued PTO as long as it is available. The employee may be asked to provide certification validating the educational event before leave may be approved.

c. Personal Leave

A full-time or part-time employee who has completed two thousand eighty (2080) hours is *eligible* for Personal Leave not to exceed three (3) months with manager approval. This leave is *unprotected* and is only available for as long as the employee has PTO. Personal Leaves beyond three (3) months, but not to exceed six (6) months, require Division Vice President's approval. Personal Leaves requested by employees who have not completed 2080 hours may only be taken with manager-level and one level above approval. Employees who do not have adequate PTO may only take unpaid leave with manager-level and one level above approval.

H. TYPES OF PAY RELATED TO LEAVES OF ABSENCE

a. Paid Leaves of Absence

A paid LOA occurs when an employee is absent from work with accrued PTO/ESL to draw upon and has received the required approval for the leave. Except when ESL usage is available and appropriate for the type of leave, employees must use accrued PTO as long as it is available. As long as the employee is on PTO/ESL, she/he will continue to accrue PTO/ESL.

Any ESL accrued prior to the following LOAs will be paid and integrated with other disability benefits (State Disability Insurance, Paid Family Leave, or Workers' Compensation benefits), so that the employee receives pay replacement not greater than 100% of regular base salary. Employees may be eligible to use ESL for all or part of a leave for the following types of leaves:

- Medical Leave for an Employee's *Serious Health Condition*
- Medical Leave for a Family Member's *Serious Health Condition*
- Pregnancy Disability Leave

- Industrial Injury Leave
- Leave to Attend to an Illness of a Family Member

Upon depletion of ESL employees must use their accrued PTO, except that employees are not required to use accrued PTO during a Pregnancy Disability Leave. PTO will be paid until exhausted or until the employee returns to work. Any PTO accrued prior to a Medical Leave for an employee's own *serious health condition* will be paid and integrated with other disability benefits (such as State Disability Insurance or Workers' Compensation) so that the employee receives pay replacement not greater than 100% of regular base salary

For continuation of benefits coverage see the section below entitled "Continuation of Benefits Coverage."

b. Unpaid Leaves of Absence

An unpaid LOA occurs when an employee is absent from work and all PTO/ESL, as applicable, has been exhausted.

During an unpaid LOA the employee will not accrue benefits (PTO/ESL) or seniority. The date upon which the employee's accruals and seniority is based will be advanced by the exact number of days that she/he is on unpaid LOA.

For continuation of benefits coverage see the section below entitled "Continuation of Benefits Coverage."

c. State Provided Pay

1. State Disability Insurance (SDI).

SDI is a short term partial wage replacement benefit for eligible employees who are unable to work due to a non-work related injury or illness. Employees on Medical Leave for an employee's own *serious health condition* or Pregnancy Disability Leave must file for State Disability Insurance benefits, which require a physician's certification.

2. Paid Family Leave (PFL)

PFL is a benefit offered to an eligible employee when he or she is off work to care for a sick family member, or for the birth, adoption or foster placement of a child (eligibility is determined by the state). Any employee is eligible to receive PFL unless he or she is currently entitled to

receive other wage replacement benefits. PFL benefits are available from the state for up to 6 weeks in a 12 month period. An employee who is on leave to care for a sick family member must apply for PFL.

I. Continuation of Benefits Coverage.

1. If the Employee is on paid leave

El Camino Hospital will continue benefits coverage at the same level and under the same conditions in force at the beginning of a paid LOA until the expiration of the LOA, or until PTO/ESL (as applicable) is exhausted, whichever occurs first. El Camino Hospital will continue benefits at the same level and under the same conditions in force at the beginning of the *protected* medical-related leave.

The employee is responsible for maintaining and paying insurance premiums and/or portions of insurance premiums which were the employees responsibility on the date the leave commenced at the same level and under the same conditions in effect at the commencement of the leave. This responsibility is fulfilled through payroll deductions in effect at the commencement of the LOA and which are continued as long as the employee is on paid LOA.

2. If the employee is on unpaid leave:

The employee may select which coverage(s) she/he wants to continue by indicating her/his selections on the form which she/he receives from Human Resources. Discontinued coverage(s) will be discontinued effective the first day of the month following the date of the employees notification of discontinuance and reinstated on the first of the following month when the employee returns to work.

The employee is responsible to pay the required premiums for continued coverage(s) at her/his own expense. Payments are due at the beginning of each month. Coverage may terminate if the employee's premium payment is more than 30 days late and the Hospital has given the employee written notice at least 15 days in advance advising that coverage will cease if payment is not received.

If not coordinated with a *protected* leave, an employee on an unpaid LOA may be responsible for paying her/his portion of the insurance premiums in effect prior to the LOA. The employee is responsible for paying the full

insurance premium for her/his family if family coverage was in effect prior to the LOA.

Any discontinued/terminated coverage(s) will be reinstated on the first of the following month when the employee returns to work. Employees are required to notify the Human resources upon return to work.

The time period for continued coverage is also subject to the terms outlined in the applicable benefit plan document.

J. Return to Work Procedures

Employees returning to work from an LOA are required to notify Human Resources before reporting to their assigned area.

Prior to their scheduled date of return to work, employees returning to work from a Leave pertaining to the employee's own health or medical condition must first schedule an appointment with Employee Health Service and present a signed physician's release statement allowing their return to work.

When an employee has exhausted all "protected" leaves of absence available to them, they will be given 60 days to apply for a position that meets their qualifications and any work restrictions they may have. If at the end of the 60 days, the employee is unable to secure employment at El Camino Hospital, their employment will be voluntarily terminated. The employee can continue to apply for any open positions as external applicants do. ~~Failure to return to work when an LOA, or extension of LOA, expires will be considered a voluntary resignation without notice.~~

GLOSSARY OF TERMS

Eligible or Eligibility – Whether an employee qualifies to apply for certain types of leave. Eligibility does not mean that a leave has been granted and/or approved.

Exigency – In general, it is a situation needing immediate action. A true "exigency" is declared by the appropriate government agency.

Protected – When an employee is on leave within the time frames specified, upon his or her return, under most circumstances, the employee must be placed back into the same position, or a position substantially equivalent to that which the

employee held at the time the leave was sought. When an employee requests an extension beyond the protected time frame, the employee's position may no longer be protected.

Next of Kin – Nearest blood relative of the individual.

Serious Health Condition – An illness, injury, impairment, or physical or mental condition that involves (a) inpatient care in a hospital, hospice, or residential care facility; or (b) continuing medical treatment by a health care provider.

Twelve (12) Month Period – A 12 month period that is determined backward from the time an employees uses such leave.

Unprotected – During the time of leave, the employee is not protected and therefore not entitled to return to the same or equivalent position. The employee's position may be filled at any time during the leave.

Uniformed Service - Army, Navy, Air Force, Marine Corps, Coast Guard, Reserves, National Guard, National Disaster Medical System, U.S. Public Health Service Commissioned Corps, Any other category of persons designated by the President in time of war or emergency.

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6.01 COMPETENCY-BASED JOB DESCRIPTION/PERFORMANCE EVALUATION

A. Coverage

All El Camino Hospital employees. If there is a conflict between the Hospital policy and the applicable **MOU** ~~CBA~~, the applicable **MOU** ~~CBA~~ will prevail.

B. Revised/Reviewed

9/11/94, 6/15/97, 5/1/98, 3/14/01 (replaces 1.02 Job Descriptions, 6.02 Performance Evaluation Program and 6.04 Competency), 11/17/03, 11/17/06, 2/13/09, 6/8/09, **11/12**

Comment [SJS1]: Recommended changes by HR Team.

C. Policy Summary

It is the policy of El Camino Hospital that all jobs will have a competency-based job description/performance evaluation. Competency is defined as the actual performance of skills in a given situation. It describes, through performance, how well an individual integrates the knowledge, attitudes, skills and behaviors in performing to expectations on an ongoing basis. Each employee's competence/job performance shall be evaluated by his/her manager at prescribed times.

The purpose of the competency-based job description/performance evaluation and the performance evaluation discussion is to:

a. Identify essential functions as described in the job specific competencies
b. Set competency and performance expectations.
c. Discuss and document competence and performance.
d. Set performance goals for the coming review period.
e. Assess and evaluate the employee's competence specific to his/her job and for patients' specific age-related and cultural needs.
f. Assess how each employee is continually meeting his/her performance standards.

D. General Requirements

1. Management is strongly urged to complete competency-based performance evaluations at the completion of the employee's provisional period.

2. Management is required to complete competency-based performance evaluations:

   a. At least annually during the designated evaluation period.
   b. At additional intervals during the evaluation period as specified in a developmental action plan.

3. Management is responsible for:

a. Developing job specific competency-based performance standards;
b. Identifying and describing performance criteria for each job; and
c. Communicating these to the employees.

4. All competency-based job description/performance evaluation forms must be in the format outlined in Attachment A of this policy and approved by Human Resources. Any changes to the CBJDPE must be submitted to Director Workforce Planning and Recruiting for approval. If a new job classification is proposed, or there are substantial changes to the major duties, responsibilities, qualification requirements, working conditions and/or job market, the manager should initiate a Job Evaluation request (see HR policy 1.02) to the **Director of** ~~Manager~~ Compensation and Benefits. Job-Specific Competencies are the only standards that can be changed by individual departments.

Comment [SJS2]: HR Recommended changes

5. The annual competency-based performance evaluation cycle corresponds to the employee's anniversary review date. Competency-based performance evaluations should be completed and turned in to the Human Resources Department within 60 days of the end of the performance year.

6. A competency-based performance evaluation may be deferred if the employee is on a leave during the evaluation period. In this case, the competency-based performance evaluation process will be initiated upon the employee's return from leave. Human Resources should be notified that the evaluation is deferred and the reason for the deferral (Medical LOA, Family Leave, etc.)

7. The reviewer and the employee must sign the evaluation. The employee signature indicates that the employee has reviewed the competency-based job description/performance evaluation, that management has discussed the evaluation with the employee and the employee has received a copy; it does not necessarily mean the employee agrees with the rating. In the event that the employee refuses to sign the evaluation, management must obtain the signature of a witness verifying that the employee refused to sign.

8. Competency-based performance evaluation records will be retained as follows:

a. The employee will receive a copy of the evaluation;
b. Management will retain a copy; and
c. The original copy will be filed as a permanent part of the employee's personnel file.

E. Competency Requirements

1. What is evaluated? A department manager, focus group or task force will review specific competency requirements by job and will identify certain job functions/duties for competency evaluation based on one or more of the following factors:

   a. Level of risk;
   b. Level of complexity;
   c. Potential for negative outcomes;
   d. ~~Age related care~~; **Population specific care**
   e. Accreditation standards;
   f. State, federal and/or local requirements.

2. Who and when?

   a. New employees should be evaluated on job-specific and organizational competencies before the conclusion of the Provisional Period.

   b. All employees are evaluated annually on job-specific and organizational competencies, as part of the competency-based performance evaluation.

3. By whom? Competency is evaluated by management, education specialists and staff who have received approval to evaluate competency.

4. By what methods? Methods for evaluating competency are determined by the reviewer and may include one or more of the following:

   a. Direct observation;
   b. Skills demonstration;
   c. Computer based training and testing;
   d. Document review (e.g. chart review, logs, written communication);
   e. By exception (no evidence of inability to meet job competencies).

F. Competency-Based Job Description/Performance Evaluation Form

1. The Competency-Based Job Description/Performance Evaluation Form consists of eight sections:

   a. The cover sheet (which includes the employee's 5-digit ECH Employee ID number, the employee's name, Service Date, Review Date, job code, job title, department ID, department name, FTE status, scheduled hours, and shift) is utilized when the document is being used as a Performance Evaluation.
   b. The Approval Sheet contains the official Job Title, job code, Department Name, FLSA, and reporting relationship. This page

Comment [SJS3]: Recommended changes by HR Team.

also contains signature approval lines for the Department Manager or Director and the Manager, Compensation and Benefits.

c. The El Camino Hospital Mission, the "Basic Purpose" of the position, the "Qualifications", and the "Ages of Patients Served".

d. The Functional and Environmental Evaluation, which includes a description of the physical requirements of the position.

e. The Job-Specific Competencies, which outline the Job Knowledge and Skills required for that particular position – Attachments "B" and "C" contain generic competencies leadership and management competencies for all management positions. Additional job specific manager competencies ~~should be~~ **are** developed for each management position.

f. The Organizational Competencies, which are generic competencies for all positions.

g. The Review of Prior Annual Goals and Objectives, which is used to evaluate the employee's performance on the prior year goals (if applicable for that position).

h. The Goals and Objectives for Next Performance Year, which outline the employee's goals for the following performance year (if applicable for that position).

2. The form is used to conduct the provisional and annual performance evaluation for all employees.

G. Rating Scale

1. Each competency listed in the Job-Specific **and organizational** Competencies section should be rated in one of the following performance categories:

   a. Meets Standards: The employee is meeting the current performance standards.

   b. Does Not Meet Standards: The employee does not meet the current performance standards.

2. Job Specific Competencies also have an "Other" rating category. This category is used to indicate that an employee has "Little or No Experience at this time" or that the competency is "Not applicable at this time or for this position".

3. Each competency listed in the Organizational Competencies section should be rated as "Meets Standards" or "Does Not Meet Standards".

4. If an employee is rated "Does Not Meet Standards" for any Job-Specific or Organizational competency, the reviewer must give an explanation in the

Comment [SJS4]: Changes recommended by HR Team.

"Areas for Growth/Comments" section, indicating the reason for the "Does Not Meet Standards" rating and the plan for improving performance in that category.

Comment [SJS5]: Rating scale moved from "I" to here based on recommendation from HR Team.

3. The completed competency-based performance evaluation is used to determine the overall performance category: "Meets Standards" and "Does Not Meet Standards." If an employee's overall performance rating is Does Not Meet Standards a developmental action plan must be attached to the evaluation with specific dates set for improvement.

   In order for an employee to receive a "Meets Standards" rating in each of the performance categories, he/she must receive the following number of "Meets Standards" in the category:

   a. Job Knowledge – must "Meet Standards" for 90% of the applicable competencies in the category
   b. Critical Thinking – must "Meet Standards" for at least 3 of 4 of the competencies
   c. Interpersonal Relationship Skills – must "Meet Standards" for at least 5 of 6 of the competencies
   d. Work Habits – must "Meet Standards" for at least 8 of 10 of the competencies
   e. Initiative – must "Meet Standards" for at least 2 of 3 of the competencies
   f. Safety/Infection Control – must "Meet Standards" for <u>all</u> competencies.

   If an employee receives a "Does Not Meet Standards" rating in one or more of the above categories, then the overall performance rating must be "Does Not Meet Standards."

H . <u>The Provisional Performance Evaluation</u>

1. During the provisional period, a new, rehired, or reclassified employee will be closely evaluated by his/her manager. Clear expectations will be provided for the employee and the manager will meet with the employee as necessary to keep the employee informed as to how he/she is performing.

2. The Human Resources Department will send a Provisional Competency-Based Job Description/Performance Evaluation cover sheet to the respective manager four weeks prior to the end of the employee's provisional period.

3. Should the manager feel that certain areas of the employee's job performance require additional time to evaluate, the manager may extend the provisional period up to an additional six months (unless otherwise stated in a Collective Bargaining Agreement). **Refer to HR Policy 3.07 on Provisional Period.**

Comment [SJS6]: Changes recommended by HR Team.

4. The employee's manager is strongly urged to conduct a competency- based performance evaluation review prior to the end of the employee's provisional period. The review shall consist of:

   a. A written evaluation completed by the manager; and
   b. A discussion of the evaluation with the employee.

   The provisional evaluation shall be based on job performance relative to baseline job specific and organizational competencies.

I. The Annual Performance Evaluation

1. The Human Resources Department will send a Competency-Based Job Description/Performance Evaluation cover sheet to the manager four weeks prior to the employee's anniversary review due date.

2. The employee's manager shall be responsible for conducting a competency- based performance evaluation discussion with the employee during the evaluation period. The evaluation shall consist of:

   a. A written evaluation completed by the manager; and
   b. A discussion of the evaluation with the employee.

   The evaluation shall be based on job performance relative to job specific and organizational competencies.

3. Delinquent evaluations will be reported to the appropriate **executive** ~~Vice President~~.

4. The Human Resources Department will monitor and audit the Competency- Based Job Description/Performance Evaluation Program

0701 Discipline and Discharge 2012.doc

7.01 DISCIPLINE AND DISCHARGE POLICY

A. Coverage:

El Camino Hospital employees. If there is a conflict between the Hospital policy and the applicable **MOU** ~~CBA~~, the applicable **MOU** ~~CBA~~ will prevail.

B. Reviewed/Revised:

10/11/95, 6/11/97, 2/18/2000, 3/14/01 re-numbered 7.01 (formerly numbered 7.02), 11/03, 7/21/04, 12/4/06, 2/17/09, **11/12**

C. Policy:

It is the policy of El Camino Hospital that a progressive disciplinary process will be used when policies, procedures, or job standards are not met. The objectives of counseling and discipline are to inform employees of deficiencies in conduct and performance, and to correct such deficiencies in order to maintain the integrity of El Camino Hospital operations. Managers will maintain the confidentiality of counseling and discipline, except as may be required by law, or relevant to an investigation conducted by El Camino Hospital, or relevant to the monitoring and enforcement of a written performance improvement plan or probationary period.

This policy outlines standards of conduct and establishes guidelines to outline constructive steps to change or modify employee conduct, and/or improve employee performance. If these efforts are not successful, this policy outlines counseling procedures leading to progressively more severe discipline, including discharge.

D. Verbal Counseling (Documented)

Except in the case of attendance performance issues, most minor conduct offenses and performance problems may be resolved through a verbal counseling session with the employee that will be documented. The verbal counseling session will not be documented if, in the judgement of management, the issues are based entirely on hearsay and/or unsubstantiated allegations. Other misconduct or on-going performance problems will require utilizing the procedure for formal discipline outlined below. **(For performance issues with attendance, refer to HR Policy 3.08 Absenteeism and Tardiness).**

Comment [SJS1]: This brings to the employee attention that the attendance policy is different.

1. Upon determination of a performance problem, or when a policy or procedure has been violated, the management will discuss the problem with the employee in private. It is essential at this point, especially in cases of sub-standard performance, to identify the specific performance problems, explain the required level of performance, and offer the assistance necessary for improvement.

   If the employee has reason to believe that a meeting may result in disciplinary action, she/he may request the presence of a representative. If this occurs, the meeting may be reasonably delayed or rescheduled to the mutual agreement of both parties. Refer to the appropriate CBA if the employee is represented by a union.

2. An appropriate time frame for improvement will be defined (30 day minimum, 6 month maximum), and a method of follow-through outlined in writing. Depending upon the nature of the misconduct, the time frame for improvement may be immediate. In cases of policy or procedure violations, the specific violation will be addressed, identifying the correct procedure or acceptable conduct and/or behavior.

3. Although not part of the formal disciplinary process, all verbal counseling sessions must be documented. Management will do this in memo form to the employee. All documentation will be forwarded to the Human Resources Department and filed in the employee's personnel file.

4. As part of the verbal counseling documentation, it is essential that the employee be specifically warned that if performance does not improve, or if additional violations occur, disciplinary action, up to and including termination, may be necessary.

5. After one year from issuance, a verbal counseling may not form the basis for more severe disciplinary action unless:

   a. The employee has received similar disciplinary actions within the intervening year; or

   b. The employee is involved in the same kind of misconduct within 2 years.

E. Formal Disciplinary Process

1. El Camino Hospital utilizes a progressive disciplinary process. However, in cases of serious or repeated offenses one or more of the progressive steps may be omitted.

2. The progressive steps for formal discipline **other than absenteeism or tardiness,** subsequent to a documented verbal counseling, may be as follows:

   a. First offense: First Written Warning

   b. Second offense: Second Written Warning (or Final Warning prior to Termination)

   c. Third offense: Suspension and/or Probation (or Termination)

   d. Fourth offense: Termination

3. Employees may be placed on probation, not to exceed three (3) months, for performance which falls below the acceptable standards for their position. As with any disciplinary action, contact the Labor Relations Manager for assistance in this process.

4. Depending on the circumstances, previous disciplinary actions may be considered in determining future disciplinary actions.

5. As part of the disciplinary process, management may formally refer the employee (except PRN) to CONCERN: Employee Assistance Program. This may be done by management contacting Concern and completing a formal referral form (Supervisor Referral Form) supplied by CONCERN. Failure by the employee to follow through with required counseling may result in further disciplinary action up to and including possible termination.

F. First Written Warning

The First Written Warning invokes the formal disciplinary process.

Comment [SJS2]: Changes recommended by HR Team.

1. Management must define the specific violation and/or performance problems and outline expectations required for future conduct and/or performance by the employee.

2. The written warning must include an appropriate time frame (30 day minimum, 6 month maximum) for improvement, process for follow-through and closure. Depending upon the nature of the misconduct, the time frame for improvement may be immediate. In cases of policy or procedure violations, the specific violation will be addressed, identifying the correct procedure and/or acceptable conduct. Prior to issuing a formal written warning, contact the Manager, Labor Relations for assistance.

3. After one year from issuance, a written warning may not form the basis for more severe disciplinary action unless:

   a. The employee has received similar disciplinary actions within the intervening year; or

   b. The employee is involved in the same kind of misconduct within 2 years.

4. The following examples include, but are not limited to, those offenses which may be considered cause for discipline (beginning with a written warning and ending in termination if the actions continue):

   - Failure to perform assigned work without just cause.
   - Incompetent, inefficient, or careless performance of duties, including failure to maintain a satisfactory standard of performance or productivity.
   - Negligence, inattention to duties, or attempting to conceal careless work.
   - Interference with the work performance of another employee.
   - Failure to provide appropriate documentation of completion of mandatory training requirements.

- Failure to work assigned overtime without just cause (not applicable to PRN).
- Working overtime without prior approval (except for patient safety reasons when qualified relief is not provided).
- Failure to immediately report a work related injury/illness, or to follow established safety or security rules.
- Failure to observe no smoking regulations.
- Knowingly making false or malicious statements with intent to harm or destroy the reputation of individuals or El Camino Hospital.
- Disrespectful conduct or use of insulting, abusive, or obscene language or gestures.
- Posting or removal of any literature, hand bills, or petition on El Camino Hospital property without administrative authorization (except items posted on approved union bulletin boards designated throughout El Camino Hospital locations).
- Failure to appropriately and accurately complete timecard.
- Failure to comply with departmental or El Camino Hospital dress codes, or failure to wear uniforms when they are provided by El Camino Hospital.
- Excessive absenteeism or tardiness (refer to Human Resources Policies and Procedures 3.08 Absenteeism & Tardiness).
- Traffic citations while in a vehicle owned by El Camino Hospital or any of its entities.
- Excessive parking citations -- at least three (3) in a one (1) year period -- issued by the El Camino Hospital Security Department.

- Improper handling of equipment or supplies which could affect patient diagnosis or treatment.

- Failure to request assistance when available, utilize protective equipment and/or follow established safety procedures.

- Improper usage of El Camino Hospital telephones or equipment (i.e., personal phone calls, correspondence, etc.), or the personal business use of cell phones and other communication devices on work time or in the presence of patients or in patient care areas.

- Other actions, which will result in adverse consequences to El Camino Hospital, the department, other departments, another employee, or the welfare of a patient.

G. Immediate Termination

1. In instances of serious misconduct, immediate termination may be appropriate. In the interest of fairness and consistency, all disciplinary actions must be reviewed with the Manager **of Employee and** Labor Relations prior to issuance.

2. In most cases, however, it may be necessary to suspend an employee pending an investigation of the incident prior to making a decision regarding the appropriate penalty.

3. Some examples of conduct or performance which may necessitate immediate termination include, but are not limited to, the following:

   Fraud, gambling, possessing firearms or weapons (revolvers, knives, *etc.*) or violation of criminal laws on El Camino Hospital premises, including parking areas.

   - Violation of criminal laws relative to any proprietary interest of El Camino Hospital.

   - Insubordination, including improper conduct directed toward a supervisor, other employee, patient, or others, or refusal or delay in carrying out instructions from a superior.

   - Willful or repeated violation of El Camino Hospital Policies and Procedures.

- Refusal to perform job duties without just cause.
- Threatening, fighting, disruptive or disorderly behavior, or other inappropriate conduct.
- Manufacturing, distributing, selling, possessing, using, or being under the influence of alcohol, or of illegal or unauthorized drugs while on duty, on-call, or on El Camino Hospital property; or having the scent of alcohol on the breath while on duty.
- Misuse of prescription or over-the-counter drugs during working hours/on-call.
- Attempting to injure, or threats to harm, others.
- Mistreatment of patients or gross negligence in the performance of duties, which may or may not result in injury or harm to patients, or the reputation of El Camino Hospital.
- Unauthorized removal, misuse or destruction of El Camino Hospital property or the property of another.
- Violation of Human Resources Policies and Procedures 11.01 Discrimination in Employment or 11.02 Harassment.
- Falsification of records, including time cards, or presenting false information in an inquiry.
- Tape recordings of any conversations or meetings without the express knowledge and consent of all individuals involved.
- Unauthorized acquisition or disclosure of patient or employee information.
- Leaving the job without authorization.
- Unauthorized or unexcused absence.

- Feigning illness or the misrepresentation of reasons in applying for a leave of absence or other time off from work.

- Sleeping on the job.

- Failure to follow proper notification procedures prior to taking time off or a leave of absence.

- Failure to obtain, renew, or provide proof of renewal, of required professional license, registration or certification within policy time frames (refer to Human Resources Policies and Procedures 15.01 Licensed and Registered Employees) as required by the applicable job description.

- Failure to comply with specific stipulations (medical and/or job specifications) following a work-related injury; *e.g.*, lifting limitations).

- Unauthorized use of El Camino Hospital vehicles.

- Placing personal long distance telephone calls without reimbursing El Camino Hospital.

- Off-duty misconduct or criminal activities which necessarily harm the employee's ability to perform her/his job duties or which have a demonstrably negative impact on El Camino Hospital's ability to conduct legitimate business activities.

- Other actions, which will result in adverse consequences to El Camino Hospital, the department, other departments, another employee, or the welfare of a patient.

H. Suspension and/or Probation

1. In cases of serious or repeated offenses, suspension from the job may be warranted. Suspension will either be for a definite period of time and/or may be utilized when a period of time is necessary to investigate an offense and determine the appropriate penalty.

2. Depending on the circumstances, an employee may be placed on probation in addition to or in lieu of suspension, not to exceed a period of three (3) months, for performance which falls below the acceptable standards for their position. As with any disciplinary action, contact the Manager, Labor Relations for assistance in this process.

3. In the interest of fairness and consistency, suspensions due to disciplinary actions must be reviewed with the Manager, Labor Relations or the Vice President Human Resources, and PRN (if applicable), prior to issuance.

I. Termination

1. This final step in the disciplinary process is utilized when other attempts to correct behavioral and/or performance issues have failed. However, in instances of serious misconduct, immediate suspension pending investigation and/or termination may be appropriate. See section entitled "**Immediate Termination**" for examples of conduct or performance which may necessitate immediate termination.

2. In the interest of fairness and consistency, terminations due to disciplinary actions must be reviewed with the Manager, Labor Relations or the Vice President Human Resources, and PRN (if applicable), prior to issuance.

J. Miscellaneous

Nothing in these rules shall constitute a waiver of any rights to which RNs and PRN are entitled under the CBA and nothing shall constitute a waiver or limitation on the just cause requirement in the CBA.

1701 Outside Labor Personnel 2012.doc

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

HUMAN RESOURCES POLICIES AND PROCEDURES

17.01 OUTSIDE LABOR PERSONNEL

A. Coverage:

Independent contractors, registry/temporary agency and "traveler" **personnel** companies, and contract service companies that have current **personnel** contracts with El Camino Hospital, **and employees who use these services.**

B. Reviewed/Revised:

5/18/95, 5/5/98 (formerly number/titled 22.00 Registry Personnel), 3/14/01 (formerly numbered 20.04, this policy now includes former policies 20.02 Contract Services Personnel and 20.06 Independent Contractors), 11/19/03, 11/06, 06/09, **11/12**

C. Policy Summary:

Registry/temporary agency and "traveler" personnel **may** ~~will~~ be used to supplement existing staff ~~only~~ when staffing is insufficient to meet department needs and other means of staffing have been exhausted **or to meet seasonal workload fluctuations**. Contract service companies and independent contractors may be employed to perform services that are not performed by existing staff.

Comment [SJS1]: Changes recommended by HR Personnel.

D. Definitions:

1. Registry/temporary agency personnel are available on a per diem basis from agencies that have been approved by Human Resources.

2. "Traveler" personnel are used to staff clinical positions typically for 8 to 13 week assignments.

3. Contract service personnel are employed through an outside company contracting with the Hospital to provide regular ongoing services to or on behalf of the Hospital.

4. Independent contractors are employed to perform services that produce a pre-defined result for a specified cost.

E. Procedure for Requesting Outside Labor Personnel.

1. **A manager requests outside labor staff by submitting a completed Position Requisition form to his/her manager. All positions must be approved by each executive level in the chain of command through the division and by the Vacancy Review Workgroup. Requests for clerical staff who will be utilized for less than three weeks may be approved by the division executive only.**

2. Approved registry/temporary agency or "traveler" companies with current agreements with the Hospital will be used. **Human Resources or Staffing Office will initiate the request for outside labor personnel with the outside labor company.**

2. ~~Contact Human Resources or Staffing Office before initiating request for outside labor personnel to ensure contract is in place and current.~~

3. Refer to Administrative Policies and Procedures ~~20.00~~ **17.00** Signature Authority for instructions regarding contracting with "contract service providers" and "independent contractors."

Comment [SJS2]: Above changes recommended by HR Team.

F. Outside Labor - Company Responsibilities:

Each outside labor company that has a current contract with the Hospital is responsible for maintaining the following documentation for each employee assigned to the Hospital (ECH must be permitted to audit the records of the company to insure compliance):

1. Current certification(s), license(s), and/or registration(s) as required by the position.

2. Evaluation of relevant competencies and the basis upon which the evaluation was conducted.

3. Health records as required by the Hospital (see Section Two of the Infection Control Policy Manual):

   a. Daily Registries must be able to deliver copies to Hospital within 24 hours of receiving a request for health records of staff ~~with direct patient contact~~.

Comment [SJS3]: Changes recommended by HR Team.

b. Direct patient care areas: Temporary traveler agencies, independent contractors and contract service providers must provide copies of health records to Hospital prior to assignment start date.

c. Non-direct patient care areas: Temporary agencies, independent contractors and contract service providers must provide copies of health records to Hospital prior to assignment start date for personnel scheduled for multi-week (3 or more) assignment. Outside agency staff participating in non-clinical assignments of less than 3 weeks are not required to provide documentation of immune status unless patient contact is reasonably anticipated.

d. "Traveler" companies must provide copies of health records to Hospital prior to assignment start date.

4. EHS may provide screening for TB, immunity status assessment and/or vaccination for rubella, measles, mumps and/or chicken pox for outside labor personnel who do not satisfy Hospital immunization requirements. The fee for this service will usually be charged to the outside labor company.

5. Drug testing is required for temporary agency and "traveler" personnel who are scheduled for assignments in patient care areas. The Hospital requires a five-panel drug test through a NIDA-certified lab. *See also* Human Resources Policies and Procedures 14.01 Substance Abuse Policy.

G. Outside Labor Personnel Requirements:

1. Outside labor personnel must follow El Camino Hospital and department-specific policies and procedures and are held accountable for the same standards of performance as regular staff.

2. Prior to the start of the assignment, outside labor traveler personnel must present to the department manager or charge person the original document of current certification, licensure and/or registration (as applicable). Photocopies will be kept in the department file or on the unit. For example:

- Ancillary certificate/license/registration by specialty
- Nursing license/certificate
- Other required professional certification/licenses/registration by area
- Life-saving certifications (e.g. ACLS, BLS) as required by assigned unit

3. Outside labor personnel who are assigned to be on Hospital premises on a multi-week basis must wear Hospital issued Photo I.D. badges.

4. Outside labor personnel must sign a Confidentiality Statement.

H. Competency and Qualification Requirements

1. Outside labor personnel are required to meet the competency and qualification requirements listed in the Competency Based Job Description/Performance Evaluation for the position, as applicable.

2. Competency and qualification requirements will be verified by the Clinical Nurse Specialist, department manager/designee, or hospital supervisor as appropriate.

3. Certification, licensure and registration are verified with the credentialing agency unless the agency does not provide such verification. Life-saving certifications (e.g. BLS, ACLS, PALS, NRP, etc) are considered verified when the employee presents a current certification card.

I. Orientation

1. Outside labor personnel will be oriented to the unit or department by the manager, charge person or designee prior to commencing their shift. Each individual orientation will be documented and will include where to find reference manuals, policies and procedures, safety procedures, along with expectations for performance (see attached Department Orientation Summary and Competency-Based Performance Evaluation).

2. Assignments less than ~~3~~ **2** months and non-clinical assignments:

- Outside labor personnel must complete the applicable Life Safety Review form, one for clinical and one for non-clinical personnel (see attached), prior to the start of the first shift and submit the completed form to her/his manager. Life Safety Review forms are available on the Toolbox.

- The manager must review the applicable Life Safety Review form with the registry/temporary agency person and file the completed form in the department.

3. Assignments of ~~3~~ **2** months or more:

- Each outside labor employee must complete the mandatory education modules available via computer assisted instruction or attend an orientation covering those materials (arrangement can be made through the Education Department).

- Managers are responsible for requiring "traveler" RNs, **and** LVNs ~~and CNAs~~ to complete appropriate nursing orientation through the Nursing Education Department.

Comment [SJS4]: Above changes were recommended by the HR Team.

J. Performance Evaluations (See Attached)

1. The person supervising the outside labor personnel will prepare the Outside Labor Competency-Based Performance Evaluation and forward the evaluation to the manager who will review for final approval.

2. Outside Labor Competency-Based Performance Evaluation will be approved by the manager, or designee, for outside labor personnel upon completion of the first shift and annually if the individual returns.

3. Performance evaluations will be kept in the unit file or in the department file for each outside labor employee assigned to that unit/department.

4. Outside Labor Competency-Based Performance Evaluations may also be completed by the manager, charge person or designee, for outside labor personnel with extended assignments (3 months or more) upon completion of the assignment.

5. El Camino Hospital reserves the right to restrict or dismiss any outside labor personnel at any time for unprofessional conduct, negligent or improper patient care, or failure to comply with standards, policies, and/or procedures of El Camino Hospital or the department.

For a summary of outside labor requirements, refer to the attached chart.

K. Timekeeping

1. Traveler personnel are required to record worked time in the hospital electronic time keeping system in addition to their agency time sheets.

Comment [SJS5]: Changes were recommended by HR Team.

L. Termination of Assignment:

Outside labor personnel must return Hospital property prior to assignment termination, including photo ID badge, equipment, binders, books, keys and software.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Outside Labor Personnel

Dept. Orientation Summary & Competency-Based Performance Evaluation (Direct/Non-Direct Patient Care Areas)

NAME	OUTSIDE LABOR≅ COMPANY NAME
DEPARTMENT/UNIT	MANAGER
POSITION SHIFT	DESCRIBE TYPE OF Γ CERTIFICATION Γ LICENSE Γ REGISTRATION
DATE	CERTIFICATION / LICENSE / REGISTRATION NO.

DEPARTMENT ORIENTATION SUMMARY – Manager/Supervisor - complete w/ individual prior to start of assignment.

- ☐ Confidentiality Statement, signed and placed in file
- ☐ Disaster Plan
- ☐ Documentation System
- ☐ Emergency Procedures
- ☐ Equipment
- ☐ Identification Badge from Registry/Temp. Agency w/ ECH sticker
- ☐ Photo ID Badge required for assignments of specified duration.
- ☐ Medication Administration
- ☐ ECHO
- ☐ Outside Labor Orientation/Annual Review Form – Clinical
- ☐ Outside Labor Orientation/Annual Review Form – Non-Clinical
- ☐ Policies, Procedures, Protocols
- ☐ Reference Manuals
- ☐ Supplies
- ☐ Telephone System
- ☐ Other:

COMPETENCY-BASED PERFORMANCE EVALUATION - Manager – file in separate file per individual.

☐ Direct Patient Care Area	☐ Non-Direct Patient Care Area	YES	NO	N/A
A. Job Knowledge/Skills 1. Administering medications and IVS. 2. Patient assessment and problem identification. 3. Using tools and technology in unit 4. Delivering treatments and procedures. 5. Documenting and reporting. 6. Explains procedures in terms patient can understand. 7. Reflects the nursing/therapeutic process and patient response to nursing/therapeutic interventions in documentation and plan of care.	1. Demonstrates skills necessary to perform job functions. 2. Demonstrates ability to assess work and establish priorities.	1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐ 7. ☐	1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐ 7. ☐	1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐ 7. ☐
B. Critical Thinking 1. Assesses situation, considers alternatives & chooses appropriate course of action. 2. Maintains patient, employee, client, confidentiality and uses discretion when discussing such information. 3. Proactively seeks information/resources/assistance needed to complete tasks successfully.		1. ☐ 2. ☐ 3. ☐	1. ☐ 2. ☐ 3. ☐	1. ☐ 2. ☐ 3. ☐
C. Interpersonal Relationship Skills 1. Treats patients, visitors, co-workers and other ECH staff with dignity, courtesy and respect. 2. Reports observations to RN/MD in charge (or manager) appropriately and timely. 3. Asks questions when necessary. Accepts feedback and demonstrates efforts to apply it. 4. Accessible to patients and/or co-workers. 5. Good communication and comprehension skills. 6. Professional demeanor (calm, helpful, cooperative, accepted direction).		1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐	1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐	1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐
D. Initiative 1. Performs duties with minimal direct supervision.		1. ☐	1. ☐	1. ☐

E. Work Habits 1. Punctual re start time, returning from breaks, responding to requests, etc. 2. Completes assignments on time and within a reasonable amount of time. 3. Professional appearance (I.D. Badge, appropriate attire) 4. Accessible and promptly responds to needs (concerns, questions, call lights) 5. Respects the privacy of patients, employees and hospital information.	1. ☐ 2. ☐ 3. ☐	1. ☐ 2. ☐ 3. ☐	1. ☐ 2. ☐ 3. ☐

Comments:	
Evaluator Name (print)	Signature Date
Company notified if **DO NOT RETURN**? ☐ Yes ☐ No	Manager Signature Date

Approved: 06/10
C:\utilities\distiller\temp\1DODD_QVDV6F-73B20B38C0A80BA4501B2CB902DC82AE.doc~~C:\Documents and Settings\pamela_m\Desktop\December Hospital Meeting\1701 Outside Labor Personnel 2012.doc~~E:\2012 ~~HR Policies for Review\1701 Outside Labor Personnel 2012.doc~~U:\~~HR Policies and Procedures\Joint Commission\1701 Outside Labor Personnel 2012.doc~~

HS = HealthStream LSF = Life Safety Form Conf = Confidentiality Statement SC = Safety Card 12/M = If here 12 months	Less than 3 Weeks								More than 3 Weeks							
	Fit Testing	Background Check	Health Screening	Drug Test	Orientation Type	Competency Assessment/Orie	Performance Eval - Annually	Other	Fit Testing	Background Check	Health Screening	Drug Test	Orientation Type	Competency Assessment/Orie	Performance Eval - Annually	Other
Traveler (Clinical)																
Patient Care/Contact:	Y	Y	Y	Y	GHO	Y	Y	CONF	Y	Y	Y	Y	GHO	Y	12/M	CONF
Patient Interaction	Y*	N	N	N	LSF	N	N	CONF	Y*	Y	Y	Y	LSF	Y	12/M	CONF
No Patient Interaction:	**See Temporary/Agency (clerical-administrative)**															
Daily Registry (independent contractor)	Y*	Y	Y	Y	LSF	Y	Y	CONF	Y*	Y	Y	Y	LSF	Y	Y	CONF
Temporary/Agency (clerical-administrative)																
Patient Contact:	**See Traveler (clinical)**															
Patient Interaction	Y*	Y	Y	N	LSF	Y	N/A	CONF	Y	Y	Y	Y	LSF	N	N	CONF
No Patient Interaction:	N	N	N	N	LSF	Y	N/A	CONF	N	Y	Y	Y	LSF	N	N	CONF
Contracted Service (valet, security, bldng contractor, IS, PICC, Audiology)																
Patient Care/Contact:	Y*	Y	Y	Y	LSF	Y	Y	CONF	Y*	Y	Y	Y	LSF	Y	Y	CONF
Patient Interaction	Y*	N	N	N	LSF	N	N	CONF	Y*	Y	Y	Y	LSF	N	N	CONF
No Patient Interaction:	N	N	N	N	LSF	N	N	CONF	N	Y	Y	N	LSF	N	N	CONF
Student																
Patient Care/Contact:	Y*	Y	Y	Y	HS	N	N	CONF	Y	Y	Y	Y	HS	Y	N	CONF
Patient Interaction	Y*	N	N	N	LSF	N	N	CONF	Y*	Y	Y	Y	LSF	Y	N	CONF
No Patient Interaction:	N	N	N	N	LSF	N	N	CONF	N	Y	Y	Y	LSF	N	N	CONF
Job Shadow in patient care area	**Contact the Education Department before commiting to this activity**															
Volunteer																
Patient Care/Contact:																
Patient Interaction	N	Y	Y	N	LSF	N	N	CONF	N	Y	Y	N	LSF	Y	Y	CONF
No Patient Interaction:	N	N	N	N	LSF	N	N	CONF	N	Y	Y	N	LSF	Y	Y	CONF
Volunteer - Roadrunner									N	Y	Y	Y	LSF	Y	N	CONF
Retail (non-ECH employee)																
No Hands On Contact	N		Y		LSF				N		Y		LSF			
Hands on contact w/ customers (i.e massage)									Y	Y	Y	Y	LSF	N	N	CONF
Contact with Inpatients (i.e. pharmacists)									Y*	Y	Y	Y	LSF	N	N	CONF
Forensic: (i.e. Ambulance, surveyor, police)																
Patient Care/Contact:	N	N	N	N	SC	N	N	N	N	N	N	N	SC	N	N	N
Patient Interaction:	N	N	N	N	SC	N	N	N	N	N	N	N	SC	N	N	N
No Patient Interaction:	N	N	N	N	SC	N	N	N	N	N	N	N	SC	N	N	N

*If will be entering isolation rooms

HR 0401 Dress Code 2012.doc

EL CAMINO HOSPITAL
HUMAN RESOURCES POLICIES AND PROCEDURES

4.01 DRESS CODE

A. Coverage:

El Camino Hospital employees, students, interns, contracted employees and temporary staff in patient care areas and non patient care areas ("covered personnel).

B. Reviewed/Revised:

6/18/95, 5/1/98, 8/99, 3/01 (formerly numbered 4.00), 11/03, 12/06, 05/10, **11/12**

C. Policy Summary:

It is the purpose of this policy to help define dress and grooming guidelines that are appropriate to the work situation. In general, dress and appearance should reflect a professional image to patients and the public. It is also the purpose of this policy to regulate certain aspects of dress and grooming as they relate to covered personnel and patient safety, infection control, and to abide by any related state or federal laws or any department specific policies that are in place.

D. Policy:

El Camino Hospital expects all covered personnel **who are in an El Camino hospital facility on work-related business,** to follow policy and maintain a professional appearance to patients and the public in the areas of general appearance, skin and nails, perfumes, colognes and makeup, jewelry, hospital identification and attire. All covered personnel are expected to abide by any department specific policies addressing dress codes. This policy is applicable to whenever any covered personnel are acting in any official capacity as a representative of El Camino Hospital, **including attending meetings on their own time**. Exceptions may be made on a case by case basis for medical, safety, religious, or cultural reasons.

Comment [SJS1]: Changes to this paragraph were requested by the nursing management.

1. General Appearance

It is expected that all covered personnel in every department will present with a clean and well-groomed appearance, and will maintain good personal hygiene, and cleanliness.

a. Hair
1) Hair shall be worn with a clean, neat and well-groomed appearance.
2) Hair dyed or highlighted in colors such as blue, green, pink or purple is not allowed.
3) Hair should be pulled back or restrained as appropriate for safety and infection control in the work area.
4) Beards, sideburns and moustaches are to be kept neat and trimmed.
5) No hats, bandannas, sweatbands or headgear, including earphones, auditory media, etc., may be worn unless required for medical, safety, religious or cultural reasons, or as part of a uniform or for work duties, or as is otherwise issued by the hospital.

b. Skin and Nails
1) Hands and fingernails are to be clean with nails neatly trimmed.
2) Artificial nails are not to be worn by any personnel providing direct patient care.

c. Perfumes, Colognes and Scented Lotions

1) Perfumes, scented after-shave and colognes are prohibited.
2) Other scented materials (lotions, laundry additives, scented deodorants etc.) should be used conservatively and in a manner that is considerate of coworkers, patients, and to the public.

d. Jewelry
1) Jewelry worn should be professional and should compliment the covered personnel's wearing apparel.
2) Promotional buttons with wording are discouraged unless professionally related.
3) Jewelry should not compromise direct patient care activities or the covered personnel's job duties. Patient care providers may not wear bracelets, (except Medical Alert bracelets), or large hoop earrings and are limited to two rings worn on fingers.
4) Visible body piercing jewelry in areas other than the ear are not allowed.

e. Hospital Identification

1) All personnel required to wear a badge in accordance with Environment of Care Policy 2.14, Identification of Patients, Staff, Vendors & Contractors, such as employees, volunteers, contractors, students, clinical instructors and bargaining unit representatives are required to wear the picture identification badge issued by the Security Department and to follow the policy restrictions as set forth in this section. (See EOC ((Safety)) Policies 2.12, Access Control, and.2.14 Identification of Patients, Staff, Vendors & Contractors).
2) The identification badge must be worn face up, above the waist, and should be clearly visible to patients, covered personnel and visitors.
3) Identification badges are to be worn at all times while on duty, including entering and leaving the facility before or after a shift, or while acting in any official capacity requiring the identification badge to be worn. **Identification badges that are unreadable due to wear and tear are to be replaced by security.**
4)
5) Any covered personnel, volunteer, contractor, vendor, student, medical staff or bargaining unit representative who refuses to present their identification badge upon request will not be allowed access to the facility until such time that it is presented. Refusal to present an identification badge may result in corrective action being taken up to and including termination, or other action such as barring future access to the facility in an official capacity.
6) Badges shall not be defaced by placing any material over the identification features of the badge.

Comment [SJS2]: Requested change by Clinical Managers.

f. Pagers and Cell Phones

Pagers and cell phones, including hands free devices (except Vocera), must be worn where they are not visible and must be maintained in a silent or vibrate mode only so as not to be audible by anyone else. Phones in hip holsters may be worn in non patient care areas. These devices shall not be used, including texting, for personal business while covered personnel are on shift except during break times.

g. Tattoos or Body Art

Tattoos or body art should be covered for covered personnel who come into contact with patients, families, or visitors.

2. Attire

Clothing/Uniforms/Scrubs should fit properly, be freshly laundered or cleaned, and should not show excessive wear. Attire should be appropriate

for the work that is performed and for the area in which the covered personnel works. Attire with large lettering, logos or slogans is discouraged unless professionally related. The following is intended as guidelines for determining what is or is not acceptable.

a. Uniforms and scrubs provided and maintained by El Camino Hospital shall not be worn to and from work, but shall remain on El Camino Hospital premises unless specifically provided otherwise in Section E of this Policy, "Addendum Department Guidelines".
b. Pants/Skirts: Jeans or denim skirts are not permissible unless approved for special occasions by a member of management. Short pants or short skirts for covered personnel working **or attending any hospital meeting or educational training,** in patient care areas are not allowed.
c. Shirts: Sweatshirts, T-shirts, midriff/crop or short tops and/or tight fitting or revealing tops are not permissible unless otherwise covered by scrubs or other acceptable outerwear. **This includes not wearing ball caps or hoods on a sweatshirt while working.**
d. Footwear: 1) Any covered personnel who handles/comes into contact with/ or works directly with blood or body fluids, or who performs work related tasks in patient care areas must wear hosiery or socks. In addition, outer footwear must cover the foot with the exception of the heel and must adequately protect covered personnel's safety. Outer footwear that is not deemed acceptable includes any shoes with holes in them (whether by design or wear and tear, this includes Crocs), no sandals or flip-flops. 2) Covered personnel who does not handle/come into contact with/ or work directly with blood or body fluids, or who performs work related tasks in patient care areas is expected to wear footwear that is clean and in good condition and is consistent with the purpose of this policy.

Comment [SJS3]: Changes to this paragraph were requested by nursing management.

Comment [SJS4]: Changes to this parapgraph were requested by nursing management.

E. Addendum Departmental Guidelines:

Since work locations and conditions vary, individual managers may develop and implement an addendum to the general guidelines set forth in this policy. Addendum departmental guidelines will be developed where operational necessity, or where covered personnel or patient safety and welfare necessitates special grooming or attire by departmental personnel. Addendums to the Dress Code Policies and Procedures require review and approval of a member of management.

F. Responsibility:

1. It is the responsibility of the Manager and the appropriate Director to assure that this policy, as well as the addendum departmental guidelines are observed by covered personnel in the department.

2. Upon approval of the addendum department guidelines, the manager will review such guidelines with covered personnel to assure understanding and to provide clarification of any area subject to interpretation.
3. Guidelines will be reviewed by the manager with all new covered personnel during the orientation and provisional period.

4. Managers will give a copy of the addendum departmental guidelines to each new covered personnel.

G. Procedure:

If covered personnel reports for work dressed or groomed in violation of this policy, the supervisor may direct the covered personnel to return home to change clothes or take other appropriate corrective action. The covered personnel will not be compensated during such time away from work, and repeated violations of this policy will be cause for disciplinary action. See Human Resources Policies & Procedures 7.01 Discipline and Discharge Policy.

HR Extended Sick Leavejjedits 2012, 12-5.doc

HUMAN RESOURCES POLICIES AND PROCEDURES

5.04 EXTENDED SICK LEAVE (ESL)

A. Coverage:

El Camino Hospital full-time and part-time employees. If there is a conflict between the Hospital policy and an applicable **MOU** ~~CBA,~~ the **MOU** ~~CBA~~ will prevail.

B. Reviewed/Revised:

10/11/95, 5/1/98, 3/14/01 (formerly numbered 5.10), 11/03, 1/04, 12/13/06, 03/09, **11/12**

C. Policy Summary:

In addition to Paid Time Off (PTO), benefit-eligible employees earn Extended Sick Leave (ESL). ESL is provided to complement PTO and integrate with State Disability Insurance (SDI) or Workers' Compensation in the event of an extended illness. ESL is not intended as a substitute for PTO. In addition, an employee may use his or her annual ESL accrual for time off to care for an ill family member.

D. ESL Accrual:

1. Employees classified as full-time and part-time accrue ESL on the basis of work status **FTE**. A full-time employee accrues five (5) days per year, accrued in equal amounts throughout the year. A part-time employee accrues a prorated amount in accordance with her/his work status **FTE** Temporary and per diem employees do not accrue ESL.

2. There is no limit to the number of ESL hours that may accrue.

E. ESL Utilization:

Comment [SJS1]: Recommended changes by HR Team.

1. Although eligible employees accrue ESL from the date of employment, it may not be utilized until the employee completes her/his initial provisional period. **(Refer to HR Policy 3.07 Provisional Period.**

2. ESL hours are required to be used as follows:

   a. After the employee has been sick for more than four (4) calendar days as verified in writing by a physician. Lost work time during the first four (4) calendar days of illness are charged to PTO; or

   b. Immediately:

      (1) If the employee is admitted to a hospital; or

      (2) If the employee is admitted to an Ambulatory Surgery Center **or has outpatient surgery performed by licensed medical/dental practitioner**; or

      (3) If the employee has a documented work related injury and is eligible for Workers' Compensation benefits. In this case the ESL will integrate with Workers' Compensation benefits; or

      (4) ~~During the first four (4) calendar days if the employee receives SDI benefits. After the eighth calendar day of disability, ESL will be substituted for PTO and the employee's PTO level will be retroactively adjusted; or~~

      (5) If the manager will not allow the employee to work during the incubation period following an on-the-job exposure to a communicable disease. This applies to the waiting period for Workers' Compensation only. At the completion of the incubation period the employee will return to work if the disease does not develop or will be covered by Workers' Compensation if the disease does develop.

3. An employee may use the annual ESL accrual for time off to care for an ill child, parent, spouse, domestic partner or child of a domestic partner, **ESL**

Comment [SJS2]: Recommended changes by HR Team.

Comment [SJS3]: Recommended changes by HR Team.

Comment [SJS4]: Recommended changes by HR Team

hours may be used immediately if the dependent is admitted to a hospital or has outpatient surgery and requires care by the employee.

Comment [SJS5]: Recommended changes by HR Team.

4. ESL hours may not be used when the manager will not allow the employee to work during the incubation period following an off-the-job exposure to a communicable disease. In this case, the employee will be required to use PTO.

5. PTO hours must be used when ESL hours have been exhausted, except that the employee is not required to use PTO during a Pregnancy Disability or Personal LOA.

6. ESL **hours** may not be converted to cash or PTO hours.

7. ESL hours are eliminated when the employee terminates employment except for sick time accruals converted to ESL at the inception of the PTO Plan (January 1978). If the employee converted sick time accruals to ESL at that time, she/he is entitled to a thirty percent (30%) redemption of those hours at her/his current base hourly rate upon termination. Any ESL taken since January 1978 must be deducted from this old accrual before any redemption may be paid.

Comment [SJS6]: Question as to why this language is still needed…it still applies to 5 people

8. **ESL hours accrued are zeroed out when an employee transfers from a benefit eligible to a per diem position. If the employee later transfers from a per diem position to a benefit eligible position, they will start accruing from a zero balance.**

Comment [SJS7]: Change recommended by HR Team.

F. Return to Work

An employee who is returning to work from ESL following a medically related leave must present a physician's certification of their ability to return to work and limitations, if any. The employee will present the medical documentation to Employee Health Services and must be cleared by EHS before he/she can return to work

Internet Summary and Policy.pdf

El Camino Hospital
Executive Summary

This Policy Applies to: Allied health professionals, Contract services personnel, El Camino Hospital employees, Independent contractors, Partners, Physicians, Registry/temporary agency personnel, Students, Interns and Instructors, Volunteers.	Last Approval Date: June 2009 Next Review Due: June 2013
Name of Policy:	Internet policy
Policy Owner (Name, Title & Department):	Greg Walton, CIO
Manual Policy Will Reside In:	Administrative

Brief Policy Statement:

HIPAA Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information.

Summary of Changes:

- ☐ New Policy
- ☐ No Changes
- ☒ Minor Revision
- ☐ Major Revision

(Briefly Specify Changes Below)

Added subject material to be legally correct and include HIPAA requirements.

Legal Review Required?

☒ **Yes** **Date Completed:** 12/11/11

☐ **N/A**

Committee Review History: (List Committees that have reviewed subject policy)

Compliance & Legal	12/11
IT Leadership	03/12
HR	04/12
Executive Committee	Pending
Board of Directors	Pending

20.00 Internet Policy.docx

EL CAMINO HOSPITAL
ADMINISTRATIVE POLICIES AND PROCEDURES

20.00 COMPUTER AND INTERNET POLICY

A. **Coverage**:

All users of the El Camino Hospital (ECH) computer and internet access system, including but not limited to:

Allied health professionals
Contract services personnel
El Camino Hospital employees
Independent contractors
Partners
Physicians
Registry/temporary agency personnel
Students, interns and instructors
Volunteers

B. **Reviewed/Revised**:

11/00, 05/01, 12/03, 03/05, 11/06, 06/09, 06/12

C. **Governing Laws and Standards:**

HIPAA Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information, 45 C.F.R. Part 160 and Part 164, Subparts A, C and E; Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009), codified at 42 U.S.C. §§300jj et seq.; §§17901 et seq.

D. **Policy Summary**:

The purpose of this policy is to define the criteria for Internet access by employees and contract personnel (ECH Internet User) as well as to define the guidelines for its acceptable use. The Internet is a rapidly growing and important resource that can provide a critical competitive advantage in the form of information gathering, improved external communications and increased customer responsiveness. With the increased capabilities of the Internet, ECH must ensure that employees understand the circumstances in which Internet communications are appropriate and permitted.

E. **Company Property**:

All ECH computers and internet access accounts are the property of ECH and are to be used solely to facilitate the business of ECH. Upon termination of employment or other business relationship with ECH, no ECH Internet User shall remove any data from ECH computers of online databases.

The ECH internet network and computers are the property of ECH. ECH management may intercept, monitor, copy, review or download any communications or files that are sent, received, or stored on the ECH system. User of passwords or other security measures does not in any way diminish ECH's right to access materials on its systems. All ECH Internet Users should expect that all information created, transmitted, downloaded, received or stored on ECH computers or electronic databases may be accessed by ECH at any time without prior notice.

E. **Criteria for Internet Access**:

1. ECH employees are required to read the ECH Internet policy before accessing any Internet via an ECH system and to follow the guidelines when using the Internet as a representative of ECH.

F. **Specific Use Requirements**:

1. Always represent yourself as yourself.

2. Material that would be considered defamatory, abusive, obscene, inappropriate, offensive, threatening or disrespectful to others will not be accessed or stored.

3. Internet use will be limited to ECH business-related activities only.

4. Internet browsing will be confined to business-related articles, information and purposes.

5. Additionally, by way of example only, the Internet will not be used:

   a. For personal gain or profit.
   b. To represent yourself as someone else.
   c. For solicitation purposes.
   d. To provide information about ECH employees to others.
   e. For commercial purposes relating to a non-ECH business enterprise.
   f. When it interferes with your job or the jobs of other employees or contracted personnel.
   g. To inappropriately transmit or comment on ECH confidential information.
   h. To download or execute games, screen savers or other software not approved for use by Information Services Department management.

i. To inappropriately and/or without authorization store or retain any information that contains ECH restricted, ECH confidential, or regulated material such as patient-specific information or other personally identifiable health, financial, or other information that an individual would reasonably deem confidential.
j. To send strategic, proprietary or otherwise confidential information without written administrative approval.
k. To send patient-specific information which would allow identification of the patient to be sent over unsecured data lines.
l. To send sensitive ECH information over unsecured data lines.
m. To forward jokes, chain letters and non-ECH business related files.
n. Gambling of any kind, monitoring sports scores, or playing electronic games.
o. Using the Internet or any social media to recount descriptions of events that occur in the workplace that relate in any way to medical services rendered by ECH or to any ECH patient.

6. Any individually identifiable health information, as defined in the HIPAA rules at 45 C.F.R. § 160.103, will not be transmitted through or uploaded to the Internet unless it is encrypted in accordance with the standards prescribed in the National Institute of Standards and Technology (NIST) Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS) 140-2 validated. The NIST standards may be found at www.csrc.nist.gov. See Administrative Policy 19.00 (E-Mail Policy) for additional guidelines regarding appropriate transmission of individually identifiable health information.

7. Internet downloads will be kept to a minimum as downloaded files may contain viruses and impact ECH system's capacity. Users who wish to download files for business purposes should ensure the following: (a) receive files only from reputable sources such as vendors with which ECH does business; (b) ensure that an updated virus control program that is approved and supported by ECH protects their system; and (c) that they are not infringing on copyright or intellectual property agreements by downloading or using the material they receive.

8. Streaming media such as videos, movies and radio will not be accessed unless for a valid business reason, *e.g.*, for training purposes.

9. Consult with your manager if in doubt about any use of the Internet.

10. Vendors and contractors will contact their own management to understand their specific responsibilities with regard to ECH Internet use.

11. For related information, see Administrative Policy 19.00 (E-Mail Policy).

G. **Violation Reporting**:

Any violation of this policy must be immediately reported to the user's immediate supervisor and/or to the Corporate Compliance Officer.

H. **Policy Authority/Enforcement:**

El Camino Hospital's Corporate Compliance Officer, Chief Information Officer, and Chief Information Security Officer are responsible for monitoring enforcement of this policy. Any workforce member found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

I. **Renewal/Review:**

This policy is to be reviewed annually to determine if the policy complies with applicable laws and regulations. In the event that significant related regulatory changes occur, the policy will be reviewed and updated as needed.

J. **Contacts:**

Corporate Compliance Officer
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Chief Information Officer
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Chief Information Security Officer
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040
infosec@elcaminohospital.org

K. Approvals:

Compliance & Legal	12/11
IT Leadership	3/12
HR	4/12
Operations Committee	5/18
Management Staff	6/15
Board of Directors	Pending

Administrative Summary and Policies.pdf

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
	New Policies						
	none						
	Major Revisions						
43.00	Leadership Policy	11/12	**11/12**	**11/12**			Added description of Chief Operating Officer, a role new to the organization. Reorganized policy to reflect changes in titling structure (i.e. Some positions formerly designated as VP were re-title to Chief). Updated other minor title changes to reflect current convention.
51.00	Physician Contract Review		**11/12**	**11/12**			Updated checklist utilized when complting contract
34.00	Service Animals for Disabled Patients or Visitors		**8/12**	**8/12**			Added new procedure for accomodating request for service dogs, notification to risk management when access is denied, exclusion for behavioral health units
58.10	Visitors Policy		**8/12**	**8/12**			CMS changed visitation regulations that require visitation standards to apply to outpatient settings, to include clinical justifications for restriction of visitation
	Minor Revisions						
11.00	Management Organization	5/98	**11/12**	11/12			Minor word change to clarify meaning. Note: Organization Charts that are attachments to this policy are updated frequently as changes occur.
23.00	Solicitation and Distribution	9/94	**11/12**	11/12			Minor word changes to reflect language (ex. Chief vs VP)
09.00	Complaint Management	4/89	**8/12**	**8/12**			Added statement for Breast Care complaints to be compliant with Radiology mandates

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
01.00	Policy & Procedure Formulation, Approval, Distribution and Review	6/98	**8/12**	**8/12**			Changed of titles to reflect current nomenclature; clarification of workflow
36.00	Business Courtesies to Non-Referral Sources		**10/12**	**10/12**			MISSING INFO?
02.00	Confidentiality: (Refer to HIPAA Section)		**10/12**	**10/12**			MISSING INFO?
12.00	Animal Visitation		**8/12**	**8/12**			Added language for service animals, added Inpatient Rehabilitation, added areas where visitation is restricted and language when the animal can be reomved from the facility
46.00	Adverse Event Reporting to the California Department of Health Care Services		**8/12**	**8/12**			Changed title of staff involved in reporting process
27.00	Disclosure of Unanticipated Outcome Information						Changing to wording- no changes to content
30.00	Patient Safety Plan		**8/12**	**8/12**			Restructuring of this policy however the content has not changed
14.00	Quality Review Report - Unusual Occurrence Policy (QRR)		**8/12**	**8/12**			Changes to wording- no changes to content
08.00	Serious Reportable Event (Sentinel Event)						Changed title of staff involved in reporting process
8.06	Hand Off Communication		**9/12**	**9/12**			Added language on bedside INTROS and "pit crew"
	Scheduled Policy Review – No Changes						
2.24	Workers Compensation Use and Disclosure of Protected Health Information	4/03	**11/12**				.

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
56.00	Locker Policy	10/09	**11/12**				
11.00	Management Organization		**10/12**				
58.00	Patient Responsibilities		**10/12**				
69.00	Administrative and Board of Directors or Events Scheduling		**10/12**				
06.00	Forms and Print Management		**10/12**				
21.00	Meeting Room Use		**10/12**				
21.00a	Outside Meeting Facilities (off-campus)		**10/12**				
21.00b	Outside Group Meeting Room Request Form		**10/12**				
21.00c	Café Catering Sign-in Form		**10/12**				
37.00	Business Courtesies to Referral Sources		**10/12**				
48.00	Charitable Donations to Outside Organizations		**10/12**				
03.00	Code of Ethics		**10/12**				
02.01	Confidentiality Statements – FORMS		**10/12**				
04.00	Conflict of Interest		**10/12**				

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
24.00	Corporate Compliance Hotline		**10/12**				
57.00	Direct Patient Care Services Contractual Agreement		**10/12**				
40.00	Gifts from Patients / Families		**10/12**				
25.00	Government Investigations		**10/12**				
52.00	Identity Theft/Patient Misidentification Prevention		**10/12**				
26.00	Internal Investigations		**10/12**				
10.00	Receipt of Summons and Complaint and Legal Documents		**10/12**				
59.00	Social Network Mediums		**10/12**				
59.00a	Social Medium Guidelines for the Public		**10/12**				
32.00	Advanced Beneficiary Notices		**10/12**				
55.00	Adverse Events, Not Billing for		**10/12**				
49.00	Business Corporate Credit Card		**10/12**				
	Business Corporate Credit Card Agreement		**10/12**				
67.00	Business Plan Policy		**10/12**				

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
33.00	Cash Balance		**10/12**				
53.00	Cash Collections Incentive Plan		**10/12**				
07.00	Cash Discount		**10/12**				
64.00	Chargemaster Policy		**10/12**				
48.00	Charitable Donations to Outside of Organization		**10/12**				
35.00	Charity Care / Financial Need Discount Policy		**10/12**				
66.00	Clinical Trials Policy		**10/12**				
44.00	Construction-in-Progress Accounting Policy		**10/12**				
18.00	Employee Emergency Loan Fund		**10/12**				
18.01a	Employee Emergency Loan Fund (Promissory Note)		**10/12**				
54.00a	Mileage Reimbursement (FORM)		**10/12**				
54.00	Mileage Reimbursement in Between Sites		**10/12**				
68.00	Monthly Financial Review and Plan of Action		**10/12**				
60.00	Pricing Policy		**10/12**				

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
69.00	Quality of Earnings Nonrecurring Expenses Report		**10/12**				
05.00	Reimbursement of Business, Education and Travel Expe		**10/12**				
71.00	Revenue Cycle Redundant Back-Up Policy		**10/12**				
70.00	Revenue Recognition		**10/12**				
17.00	Signature Authority		**10/12**				
17.01a	Signature Authority Limits at a Glance		**10/12**				
17.01b	Use of CEO's Signature Stamp for Check Signing		**10/12**				
16.00	Surplus Cash Investment Policy		**10/12**				
39.00	Capital Equipment Requisition Policy		**10/12**				
42.00	Physician Recruitment Program Policy		**10/12**				
42.00a	Appendix A – Income Guarantee		**10/12**				
42.00b	Appendix B - PHYSICIAN RECRUITMENT PROGRAM		**10/12**				
42.00c	Appendix C - PHYSICIAN REIMBURSEMENT REQUEST		**10/12**				

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
45.00	Financial Policy		**10/12**				
72.00	Value Analysis		**10/12**				
50.00	Purchase Services (Formerly Vendor) Payment Policy		**10/12**				
38.00	Donor Recognition & Naming Opportunities Policy		**10/12**				
02.02	Accounting of Disclosures		**10/12**				
02.03	Accounting of Disclosures Request – Form		**10/12**				
02.13	Acknowledgement of Receipt of Notice of Privacy Practices – Form		**10/12**				
02.05	Amend PHI Request – Form		**10/12**				
02.04	Amendment of Protected Health Information		**10/12**				
02.15	Authorization to Release Protected Health Information (PHI) – Form		**10/12**				
02.06	Complaints Regarding Privacy Practices		**10/12**				
02.00	Confidentiality Policy		**10/12**				
02.01	Confidentiality Statements – FORMS		**10/12**				
02.07	Fundraising Uses or Disclosures of Protected Health Information		**10/12**				

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
02.08	Limited Data Sets of Protected Health Information		**10/12**				
02.09	Marketing Uses or Disclosures of Protected Health Information		**10/12**				
02.10	Minimum Necessary Use and Disclosure of Protected Health Information		**10/12**				
02.11	Mitigation of Privacy Complaints		**10/12**				
02.12	Notice of Privacy Practices – Form		**10/12**				
02.14	Obtaining Authorization of Release of Protected Health Information		**10/12**				
02.15	Authorization to Release Protected Health Information Forms English & Spanish		**10/12**				
	Authorization to Release Protected Health Information Forms (with expiration of authorization dates) English & Spanish		**10/12**				
02.17	Opportunity is Not Required to Agree or Object to Uses or Disclosures of Protected Health Information		**10/12**				
02.16	Opportunity is Required to Agree or Object to Uses or Disclosures of Protected Health Information		**10/12**				

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
02.18	Patient Access to Protected Health Information		**10/12**				
02.22	Request for Restriction on the Manner or Method of Confidential Communications – Form		**10/12**				
02.20	Request to Restrict Use on Disclosure of Protected Health Information – Form		**10/12**				
02.21	Restricting Confidential Communications		**10/12**				
02.19	Restricting Use or Disclosure of Protected Health Information		**10/12**				
02.23	Retention and Destruction of Records		**10/12**				
02.25	Data Transmission Security (also under Technology/IS)		**10/12**				
02.26	Password Management (also under Technology/IS)		**10/12**				
02.27	Security Awareness Training (also under Technology/IS)		**10/12**				
02.28	Workstation Use (also under Technology/IS)		**10/12**				
13.01	Master Services Agreement		**10/12**				
65.00	Clinical Documentation Improvement Program		**10/12**				
27.00	Disclosure of Unanticipated Outcome Information		**10/12**				
2.25	Data Transmission Security (also under HIPAA)		**10/12**				

Administrative Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
15.00	ECHO User Access Code		**10/12**				
61.00	Information Security Risk Analysis & Assessment		**10/12**				
62.00	Information Stewardship		**10/12**				
63.00	Media Control Policy		**10/12**				
02.26	Password Management (also under HIPAA)		**10/12**				
47.00	Responsible Use of Portable Technology Resources & Information		**10/12**				
28.00	Responsible Use of Technology Resources & Information		**10/12**				
2.26	Security Awareness Training (also under HIPAA)		**10/12**				
41.00	Vocera Communications System Policy		**10/12**				
2.28	Workstation Use (also under HIPAA		**10/12**				

43 00 Leadership Policy doc, 12-5.doc

EL CAMINO HOSPITAL
ADMINISTRATIVE POLICIES & PROCEDURES

43.00 LEADERSHIP POLICY

A. **COVERAGE:**

El Camino Hospital Leadership

B. **REVIEWED/REVISED:**

11/06, 06/09, 10/12

C. **POLICY:**

It is the policy of the Board of Directors of El Camino Hospital that leadership's role and accountability be clearly established in writing and reviewed at least every three years.

LEADERSHIP:

Leadership begins with establishing the organization's mission, then defining and communicating the organization's vision. Building on the vision, leadership defines the values of the organization. The organization's leaders provide the framework for planning the health care services to be provided by the organization. Leadership has the authority and responsibility to carry out the four processes of leadership: (1) planning, (2) directing, (3) implementing and coordinating, and (4) improving services. These functions are inherent throughout standards that describe operations at El Camino Hospital. Leaders help create an environment that enables the hospital to fulfill its mission and meet or exceed its goals. Within this environment the leadership:

- Supports the Board of Directors in developing, regularly updating, and implementing the strategic mission, vision, values and goals for the organization;
- Coordinates the development and implementation of strategic plans to achieve the vision, including the annual quality improvement plan and the annual budget;
- Nominates, screens, and selects improvement projects;
- Assigns teams to projects;
- Ensures that teams have the resources and support necessary to accomplish their objectives, including appropriate staff, time, materials, team leaders, training, follow up, and incentives;
- Monitors progress against objectives, including budget monitoring;
- Establishes organizational standards consistent with the applicable accrediting regulatory and licensing agencies;
- Implements strategies to improve organizational performance;
- Defines the organizational structure and facilitates effective implementation of operation standards;
- Serves as role models and promotes shared values.

The leadership philosophy and practice includes periodic self-assessment and communicates with leadership and medical staff to ensure:

- Alignment with organizational goals;
- Optimism;
- Consistency;
- A sense of diligence, persistence and urgency.

Effective leadership develops other leaders to help fulfill the vision, mission, and goals of the organization. The El Camino Hospital Board of Directors (Board) supports the process for orienting, forming and developing management as committed leaders who are effective communicators, who have appropriate competencies, perform well in their positions, and whose actions reflect El Camino Hospital's leadership philosophy, vision, mission, and values to all members of the organization and the communities it serves.

D. PROCEDURE

SECTION I: Governance

Subject to Bylaws, the Board shall have and exercise full power and authority to perform all actions necessary and expedient in the governance, management, and control of the business and affairs of the organization, including adopting policies to guide its operation. This authority is defined in the El Camino Hospital Bylaws. The Board may appoint standing or special committees, and designate their function and responsibility, as it may deem appropriate and desirable. Other standing committees may be created at the discretion of the Board. Each committee has an established charter that outlines the scope of responsibilities, an authority to act on behalf of the Board, and delineates its reporting relationships. The power of such committees shall be limited to the extent provided by Title 22.

SECTION II: Executive Leadership

1. President and CEO

The Board has appointed a President and Chief Executive Officer (CEO) who is qualified for this position by education, certification, and relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for the organization. The CEO has the ultimate responsibility for the management and leadership of the organization as defined in the El Camino Hospital Bylaws. The President and CEO appointed an Executive Team, consisting of the various Chiefs, Officers, Presidents and Vice-Presidents to lead the organization.

2. Chief Operating Officer (COO)

El Camino Hospital's CEO has appointed a Chief Operating Officer (C0O) who is an individual qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible. The Chief Operating Officer (COO) provides leadership, direction, and administration of specific hospital operational and functional areas including all clinical service lines, nursing operations, and the Performance Improvement Office (PIO). Utilizing Lean Performance Improvement methodologies, the COO leads change management initiatives across the enterprise to achieve cultural and operational effectiveness in improving outcomes, reducing waste (variability), reducing costs, and increasing satisfaction.
The COO builds and refines the Performance Improvement Office, which is comprised of all entities related to driving improvements in performance, processes, and clinical effectiveness through leveraging such functionalities as the Enterprise Data Warehouse, Utilization Management, and Data Analytics.

~~2~~3. Chief Medical Officer (CMO)

El Camino Hospital's CEO has appointed a Chief Medical Officer (CMO) who is a physician qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible. The CMO provides leadership and overall strategic and operational direction for patient safety, quality and patient and physician satisfaction initiatives through the enhancement, expansion, and ongoing refinement of medical care and clinical information systems. The CMO is responsible for the clinical effectiveness department and identifies key performance indicators to measure and communicate the effectiveness of physician quality and initiatives. S/he is responsible for medical director/physician contracts and effectively manages relationships with key stake holders including the medical staff department heads, medical staff members and physicians in the hospital community. The CMO collaborates with the Chief Information Officer to align IS strategic planning to develop, implement and monitor effectiveness of clinical information systems, web and business intelligence services. The CMO develops and implements physician outreach initiatives to improve clinical practices and physician satisfaction with the Hospital as a place to practice medicine. This executive has through either direct or matrix reporting relationships, the authority and responsibility to establish standards of operations, composition of the staff and to establish minimum criteria for education and licensure. In consultation with the medical staff the CMO, with the executive team, shall determine important aspects of patient care and support service delivery. The medical staff executive committee will provide input to the annual evaluation to the incumbent in this position.

4. Nurse Executive: Chief of Clinical Operations/ Chief Nursing Officer

El Camino Hospital's CEO has appointed a Chief of Clinical Operations/Chief Nursing Officer (CCO/Nurse Executive) who is a registered nurse qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible. The CCO/Nurse Executive has, through either direct or matrix reporting relationships, the authority and responsibility to establish the plan for patient care, to define the philosophy of patient care, to establish interdisciplinary standards of clinical practice, to establish the composition of the patient care delivery team, to promote patient, employee, and physician satisfaction and to establish minimum criteria for clinical education, licensure, and competency throughout the hospital. The CCO/Nurse Executive and/or designee represents patient care delivery concerns at Board, Medical Staff, and Hospital committees and meetings. In consultation with the medical staff, the CCO/Nurse Executive, with the Executive Team, determines important aspects of patient care and services and outcome measurements to determine the quality, safety and effectiveness of patient care and support service delivery and the patients' experience of care.

5. Chief Information Officer (CIO)

El Camino Hospital's CEO has appointed a Chief Information Officer (CIO) who is qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible. The CIO provides strategic leadership and operational direction for the Information Services Division, including Health Information Management Services, information technology, computer support services, network communications, telecommunications, clinical engineering, intranet and internet services, copy center and all printers, fax machines, scanners, and the integration of business and clinical applications to accomplish Hospital goals and objectives. The CIO is responsible for data integrity, and security. The CIO oversees web services and collaborates with the Chief Medical Officer for clinical applications. The CIO develops and implements initiatives to evaluate the effectiveness of information systems and practices and ensure end user competence. This executive manages both internal and outsourced IS resources to meet organizational IS requirements.

6. Chief Financial Officer

El Camino Hospital's CEO has appointed a Chief Financial Officer (CFO) who is qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible. The CFO provides sound financial analysis and a balanced financial perspective to support the executive leadership and the Board in conducting strategic thinking and planning by demonstrating expertise in budgeting, capital planning and financial forecasting. The CFO is responsible for financial management and reporting and ensures that the finance function is responsive to the

needs of its customers and that services are provided in a timely and effective manner.

The scope of the CFO's responsibilities include general and cost accounting, accounts payable and receivable, payroll, budgeting, revenue management, productivity reporting, reimbursement, Medicare cost reports, patient registration and financial counseling, patient accounting and billing, health information management, materials management,treasury, investments, tax, audit and capital financing.

In addition, the CFO supports sound financial management, including the analysis and reporting the current financial operations of the hospital and development and implementation of standardized financial reporting systems. Other major areas of focus include: cash collections, pricing analysis, deployment of resources across the system, effectively preserving financing and allocating capital to support long-term system viability and growth. The CFO maintains current knowledge of economic and industry trends and their potential impact on the Hospital's financial and cash positions and advises management, executives, and the Board on the feasibility and potential return from prospective ventures and investments.

7. Chief Human Resources Officer

.El Camino Hospital's CEO hasappointed a Chief Human Resources Officer (CHRO)who is an individual qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible.Leads and directs the planning, development, implementation, and administration of Human Resources programs and policies and is a business partner to other senior leaders in the hospital. S/he serves on the executive leadership team to identify and develop key human resource initiatives to support the achievement of strategic plan objectives and critical imperatives and the cultural transformation needed to accomplish them. This Chief serves as a strategic business and tactical partner to the senior leadership team and is a strong executive leader for the human resources team. The functional areas of responsibility include employee/labor relations, benefits, compensation, HRIS, organizational development, education and training, talent management, recruitment and retention, workforce planning, internal employee communications, hospital volunteers, and employee occupational health and safety. This Vice President plans and directs the development of human resources policies and procedures that are consistent with overall organizational strategies and initiatives.

8. Chief Administrative Services Officer

El Camino Hospital's CEO has appointed a Chief Administrative Services Officer (CAO) who is an individual qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for which s/he is responsible. This position is responsible for the planning, development, construction, management, and

operations of facility assets operated by El Camino Hospital. This Vice President is accountable for effective and efficient planning, organizing, developing and directing the operations of all hospital owned and leased facilities. Specific responsibilities include real estate acquisition, sales, leasing and development of land, buildings and equipment, master facilities planning and implementation, facility design and construction projects, plant operations, plant maintenance, landscaping and grounds maintenance, clinical engineering, security and parking, PBX operators and physician answering service, imaging services, nutrition services, environmental and laundry services. This Chief serves as the liaison with local and state authorities having jurisdiction over various elements of plant and facility operations, property development, and construction projects.

9. Presidents

A President is a senior executive position reporting to the CEO of El Camino Hospital or directly to a board whose directors include at least two members or their designees of the El Camino Hospital Board of Directors (Board).

A President is the chief executive of a subsidiary organization or affiliated healthcare facility who develops, promotes, and directs all aspects of the subsidiary's policies, objectives, and initiatives approved by the parent organization. A President will have profit and loss accountability, oversee operations of the subsidiary/healthcare facility, and ensure strategic alliance with strategic goals and initiatives of the El Camino Hospital. A President will oversee business development, clinical operations, and ancillary and administrative activities for the subsidiary organization or facility.

A subsidiary organization or affiliated healthcare facility will typically have a separate board of directors or advisory board. A President will effectively manage and leverage relationships with the Board, advisors, medical staff, and/or community members to achieve the affiliate's mission and vision and position the organization for long term sustainability.

The President title is assigned to leadership positions of the Auxiliary, Concern:EAP, El Camino Hospital, El Camino Hospital Foundation, ~~El Camino Hospital Los Gatos,~~ El Camino Surgery Center and Silicon Valley Medical Development.

a. **President, El Camino Hospital Foundation** – The President, El Camino Hospital Foundation is responsible for planning, developing, implementing and evaluating all aspects of the El Camino Hospital Foundation to achieve its financial growth goals.The President directs the Hospital's fundraising efforts, campaigns, and programs to meet specific operational and capital needs of the Hospital as well as fund community benefit programs. The President oversees the Foundation's board of directors and committees, directs the development of

Foundation policies and procedures which are consistent with overall organizational strategies and initiatives. This Hospital vice-president oversees the services provided by the Auxiliary and its funded programs and is responsible for external affairs that include government relations. This position may be responsible for planning, developing, implementing, and evaluating programs that are funded or potentially funded through Foundation donations or grants such as the Center for Technology Integration and Genomics initiatives.

b. President, Silicon Valley Medical Development, LLC and Chief, Strategy and Business Development

The President of Silicon Valley Medical Development, LLC (SVMD) provides leadership, strategic and operational direction for planning, development, implementation and management of Hospital-sponsored ventures relating to community, physician, and ambulatory site development. The position serves as President of a separate corporation established by El Camino Hospital for these purposes. Duties include managing new ventures with the Independent Physicians of El Camino Hospital (IPECH), Palo Alto Medical Foundation, the Menlo Clinic, and other community medical groups and independent practice associations; creation and direction of management service organization (MSO) and practice management support for these organizations; syndication of facility ventures with community physicians; evaluation, development and management of retail ambulatory ventures, including embedded convenience clinics and employee health centers; and physician network development.

10. Vice Presidents

Leadership for the organization is provided by Vice Presidents who are qualified by education, licensure, and relevant experience that includes management and leadership skills to effectively direct enterprise-wide functions and operations. The Vice Presidents have, through either direct or matrix reporting relationships, the authority and responsibility to establish standards of operations and composition of the staff, and to establish minimum criteria for education, licensure, and competency. The Vice Presidents are accountable for comprehensive management of their function(s) including:

- Clinical Quality and Safety;
- Compliance with laws, regulations, and accreditation standards;
- Compliance with Hospital policies;
- Development and implementation of division strategy;
- Achievement of patient, employee and physician satisfaction goals;
- Continuity of services;
- Quality, service and productivity process improvement;

- Achievement of Hospital volume growth goals;
- Budget compliance;
- Staff development and supervision;
- Communication with staff, physicians, public and business associates;
- Management of human and material resources;
- Support the Hospital's mission to improve the health and well being of the communities we serve.

The Vice Presidents represent clinical and support services at Board, Medical Staff, and Hospital committees and meetings. The Vice Presidents determine important aspects of patient care and support service delivery, and outcome measurements to determine their effectiveness.

a. Vice- President, El Camino Hospital, Los Gatos

El Camino's CEO has appointed a Vice-President for the Los Gatos Campus who is qualified for this position by education, certification, and/or relevant experience and possesses the management and leadership skills to effectively direct the delivery of services for the Los Gatos Hospital. The vice-president sets objectives and manages a multi-disciplinary team of individuals through direct and matrix relationships and is responsible for achieving the objectives of the El Camino Hospital: Los Gatos. Vice Chief Clinical Operations at Los Gatos. The Vice-President is responsible for effectively managing the financial, service, and quality goals of the Los Gatos Division. The Vice-President establishes annual goals for areas of responsibility that support the strategic plan. The Vice-President identifies business opportunities for providing new services or enhancing existing services. The Vice-President serves as a patient care advocate and collaborates with Administrative Leadership, Medical Staff Leadership, and Hospital Board Leadership in meeting the care needs of Los Gatos Division and El Camino customers. The following departments or functions report to the Vice-President, Los Gatos: Inpatient and Emergency Services which includes Critical Care and Medical/Surgical/Telemetry, Maternal/Child, Pediatric, Patient Care Resources, Emergency Department, Rehabilitation, Respiratory Therapy, Operating room, Clinical Laboratory, Nutrition Services, Environmental Services, Pharmacy and Imaging Services. The Vice-President reports to the Chief Operating Officer for operational issues and reports to the Chief Clinical Operations/Chief Nursing Officer regarding nursing practice.

b. Vice President, Marketing and Corporate Communications – Responsible for overall direction and serves as the primary resource for activities related to ~~strategic planning, business development, physician relations,~~ marketing, planning, and external communications for El Camino Hospital. The Vice President of ~~Business Development~~Marketing/Communications ensures a coordinated approach to all hospital ~~development,~~ marketing, ~~physician relations~~ activities. This vice president is responsible for the Hospital's image, internal and external communications and media

relations.

c. Vice President, Corporate and Community Health Services and President, CONCERN: Employee Assistance Program (EAP) – This Vice President is responsible for the strategic direction, program and business development, leadership, service quality and financial accountability for the Corporate and Community Health Services including but not limited to: CONCERN: EAP, Camino Counseling Services (CCS), Health Resource Center (HRC), Health Library, RotaCare Clinic, Road Runners, Retail Services, South Asian Heart Center, Healing Arts Program, community outreach and hospital-wide initiatives to enhance the patient experience. This vice president is responsible for the development, implementation and evaluation of effectiveness of the Hospital's community benefit initiatives and programs that support the mission of the Hospital to improve the health and well being of the communities served. This Vice President serves as the President of CONCERN: EAP with responsibility for business strategy, revenue growth, oversight of its board of directors and committees and maintaining compliance with all DMHC/Knox -Keene regulations.

d.Vice President, Payor Relations – Responsible for acquiring an retainingmarket share for El Camino Hospital under financially favorable terms through contracts with managed care payers and health plans. This Vice President is responsible for overseeing and evaluating contract negotiations for all payers including financial arrangements, contract language, financial and utilization data to support contracting relationships with payers, and develops effective processes to administer the hospital-wide contracts. Responsible for administering all capitated risk arrangements and managing risk for all capitated plans. This Vice President evaluates and makes recommendations to Hospital leadership regarding managed care contract issues including contract strategy and contract administration for the hospital.

SECTION III: Service Line and Division/Department Leadership

1. Service Line Leadership

a. **Service Lines** are designated by executive leadership as a means of increasing clinical excellence, enhancing the patients' experience of care, and revenue and services growth through collaboration among physicians (different groups, different specialties), clinical and support staff.

b. **Executive Directors of Service Lines** are responsible for the effective development, program direction, marketing, revenue and expense management, clinical quality and patient experience of the service line. This is accomplished in collaboration with staff in finance, business

development and clinical operations. The service line includes a Medical Advisory Committee and a Fundraising Committee of the Hospital Foundation that is dedicated to the service line and may include an optional Community Advisory Committee.

2. Department/Division Leadership

El Camino Hospital's leadership through managers and other staff implement systems, processes, integration of functions, staff performance development to enhance patient care.

a. Vice Chief of Clinical Operations, Mountain View–Responsible for providing operational direction to implement the strategic imperatives and goals for all clinical and patient care activities on the Mountain View campus, insuring high quality, cost efficient patient care. This position is responsible for employee and patient satisfaction, promoting teamwork among and between nursing, patient care and other hospital and medical staff. Serves as a patient care advocate and collaborates with executive leadership, medical staff leadership, and the Hospital Board leadership to meet the care needs of El Camino Hospital's patients. The Vice Chief of Clinical Operations is responsible for in-patient, critical care, emergency department, maternal-child health, behavioral health and dialysis nursing services; Respiratory Medicine, Rehabilitation Services, and oversees clinical nutrition through a matrix reporting relationship.

b. Directors-- Responsible for the organization's success in achieving annual organizational goals. Directors either have large and/or complex and financially significant areas of operational responsibilities or responsibility for driving direction and strategy for an area of expertise across the organization. Directors may have responsibility and accountability for multiple departments and/or provide direction to outside consultants or services to achieve annual goals and objectives. Directors may have managers reporting to them based on the scope and complexity of their area of responsibility. Directors who do not have managers reporting to them also fulfill the manager responsibilities for their area of responsibility.

i. Senior Directors—Senior directors have a broad organization-wide responsibility involving a high level of accountability due to a higher level of risk for the activities s/he oversees. In addition, they may serve in the role of an operational or functional director as described in the following sections.

ii. **Operational Directors--** Operational Directors are responsible for insuring the link between El Camino Hospital's mission, vision, values, goals, strategic plan and organizational goals, and the department goals. They are directly

accountable, either personally or through delegation, for their area(s) of responsibility to:

- **Accomplish organizational goals, operational expectations, and departmental growth targets in their area.** Operational Directors work collaboratively with Strategic Planning and Business Development to develop strategies and growth plans for their area of responsibility. Additionally, Operational Directors work collaboratively with functional departments for support and expertise in Quality, Human Resources, Finance, Compliance, Materials Management, etc.
- **Provide effective, efficient, and financially sound department operations.** This includes meeting or exceeding budget and productivity targets, and staffing their area with competent and trained staff.
- **Assure patient safety and accreditation and regulatory compliance.**
- **Assure patient, employee, and physician satisfaction.**

iii. **Functional Directors--** Functional Directors are responsible for staff functions that support the entire organization. Functional Directors have expertise in areas such as Strategic Planning, Business Development, Financial Analysis, Human Resources, Materials Management, etc. Functional Directors are responsible for providing organizational expertise and direction across the organization plus directing the operations of their area. They may achieve results through matrix management or outside services and providers.

3. Managers

Managers are assigned areas of responsibility more specifically defined than those of Directors but the functions are relatively similar in nature and scope. In general, Managers have a smaller scope and focus than Directors. Managers are responsible for planning, organizing, hiring, and controlling the work in assigned areas of responsibility. Managers translate overall goals set by executive leaders into individual and team goals, develop plans for accomplishing goals, and direct and review progress.

Managers are responsible for their department's results where success is measured through departmental indicators. Managers communicate goals and accomplish results through delegation to staff.

a. Operational Managers

Operational Managers are responsible and accountable for their area to provide:

- **Effective, efficient and financially sound department operations.** This includes meeting or exceeding budget and productivity targets, and staffing their area with competent and trained staff.
- **Assure accreditation and patient safety and regulatory compliance.**
- **Assure patient, employee and physician satisfaction.**
- **Assess employee competency and conduct performance evaluations.**
- **Provide orientation, training and education to their staff.**
- **Communicate relevant organizational information to employees.**

b. Functional Managers

Functional Managers are responsible for functions that support the entire organization. These managers have expertise in areas that include Marketing, Training and Development, Process Improvement, Clinical Effectiveness, Finance, etc. Managers are responsible for providing organizational expertise and direction across the organization plus managing the operations of their area. Functional Managers have a more focused area of responsibility and scope than Functional Directors.

SECTION IV: Officers

1. **Hospital Safety Officer** – The Hospital Safety Officer (HSO) develops, implements and monitors the effectiveness of El Camino Hospital's Safety Management plan. The HSO along with Hospital Leadership and members of the Central Safety Committee ensure compliance with The Joint Commission's Environment of Care, Life Safety Management and Emergency Management standards and the requirements of the Cal/OSHA Injury and Illness Prevention Program (IIPP). This is accomplished through an ongoing effort of establishing performance standards; measuring and reviewing key performance indicators in each of the components of the Safety Management Plan and implementing actions to correct deficiencies and improve the effectiveness of the program to manage the environment of care. The HSO regularly reports on findings, recommendations, actions taken and results of measurement of safety management issues to the El Camino Hospital Board, CEO and Department Managers. The HSO is also authorized to intervene whenever conditions exist that pose an immediate threat to life or health, or pose a threat of damage to equipment or buildings.

2. **Patient Safety Officer** -The Patient Safety Officer has primary oversight of the facility-wide **patient** safety program. This leadership role directs others within the facility towards process improvement that will support the reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes. This practitioner provides leadership for safety assessments, coordinates the activities of the patient safety committee, educates other practitioners on the system-based causes for medical error, consults with

management and staff, and communicates literature-based ideas regarding effective patient safety strategies to others within the organization.

3. **Corporate Compliance Officer** - The Compliance Officer provides direction and oversight of the Compliance Programs in conjunction with the Corporate Compliance and Internal Audit Committee. The Compliance Officer is responsible for identifying and assessing areas of compliance risk for the hospital; communicating the importance of the Compliance Program to all employees, the executive management and the Hospital Board of Directors; preparing and distributing the written Code of Conduct, setting forth the ethical principles and polices which are the basis of the Compliance Program; developing and implementing education programs addressing compliance and the Code of Conduct; implementing a retaliation-free internal reporting process, including an anonymous telephone reporting system; and collaborating with executive management to effectively incorporate the Compliance Program within system operations and programs.

4. **Privacy Officer** – The Privacy Officer oversees all ongoing activities related to the development, implementation, maintenance of and adherence to the organization's polices and procedures covering the privacy of and access to, patient health information in compliance with federal and state laws and the healthcare organization's information privacy practices. The Privacy Officer monitors activities and performs privacy risk assessments and works with HIM Directors in overseeing patient rights to inspect, amend, and restrict access to protected health information when appropriate. The Privacy Officer works in coordination with organization management, administration, the Corporate Compliance and Internal Audit Committee and legal counsel.

SECTION V: Delegation of Authority

The Hospital Supervisor has responsibility for the operations of the hospital during times when other leadership are not on the premises and has the authority to initiate whatever administrative or emergency measures may be necessary to preserve the safety of the hospital and individuals. As appropriate, the Hospital Supervisor notifies the "Administrator On-Call" or appropriate leader in the chain of command.

There are established lines of authority and accountability within the organization. As "Administrator On-Call" the Hospital's executives rotate responsibility for remaining accessible to the hospital via telephone or pager in the event administrative direction or assistance is needed by on-site supervision. The Board maintains authority and responsibility for the overall operations of the organization.

- The President and CEO delegates authority and responsibility for all aspects of the organization including both hospital sites and all service locations.

- Leadership including Executives, Officers, Chiefs, Directors and Managers delegate responsibility for operations of their assigned areas of responsibility.

SECTION VI: Management Rights and Responsibilities

There are established rights and responsibilities of hospital management in fulfilling hospital objectives. Labor agreements and mandatory subjects of bargaining may necessitate negotiations to bargain the effect of management decisions. As such, El Camino Hospital leadership management staff has the right to exercise the customary functions of management including, but not limited to, the rights to:

- Manage and control the premises and equipment;
- Select, hire, train/develop, promote, suspend, dismiss, assign, supervise, and discipline staff;
- Determine and change starting times, quitting times and shifts;
- Transfer staff within departments or into other departments and other classifications;
- Determine and change the size, composition and qualifications of the work force;
- Adopt, establish, change, and abolish operational standards, rules and procedure;
- Determine and modify job descriptions, job evaluations, and job classifications;
- Determine and change methods and means of operations, as needed, for efficient and effective delivery of services;
- Assign duties to staff in accordance with needs and requirements, as determined by hospital management;
- Carry out all ordinary functions of management;
- Plan, organize, staff, lead, control, train, review and budget.

SECTION VII: Methods of Work/Analysis

1. TEN-STEP PROCESS

El Camino Hospital leadership will use the ten-step process outlined below when submitting recommendations in writing to the El Camino Hospital Board and El Camino Hospital District Board. This is in the form of a memo or cover letter; in certain situations the request will also require a business plan. Inherent in the completion of the ten-step process is the involvement of stakeholders, including medical staff, staff, and peers. The ten steps are:

1. Authority (who asked you to develop this?)
2. Problem definition (what are you trying to solve?)
3. Process description (how do you plan to solve the problem?)

4. Alternative solutions that you considered and may include cost benefit/SWOT analysis (strengths, weaknesses, opportunities, threats)
5. Concurrence for recommendation (who has agreed with your information and who else needs to?)
6. Outcome measures/deadlines (what are the success criteria and timeline?)
7. Legal Review: has this been reviewed/approved by Legal Counsel?
8. Compliance Review: has this been reviewed/approved by the Internal Compliance Department?
9. Financial Review: has this been reviewed/approved by the Finance Department?
10. Recommendation (what do you want people to approve?)

2. QUALITY and PROCESS IMPROVEMENT

El Camino Hospital's quality and process improvement methodology is based on the Plan, Do, Study, Act model. Developing outcome measures, conducting process flow, creating process redesign, and establishing continuous monitoring of outcomes are core components of this methodology.

3. REPORTS / INFORMATION

There are established communication channels among hospital leadership, management staff, and all hospital employees, volunteers and physicians. The availability of and access to information to assist in the task of providing leadership and decision-making is critical. Information used by leaders comes in a variety of formats ranging from written data and information to verbal information presented through formal or informal channels.

Leadership at all levels has an obligation to appropriately and routinely report on operational activities and progress of goals. Leadership also has an obligation to inform and enroll front line staff in the organization's mission, vision, values, goals and operational plans and to report the results of organizational and team efforts to them.

Examples of such data and information are:

a. Written Reports
- Monthly financial responsibility summary
- Monthly financial variance reports
- Daily and bi-weekly productivity reports
- Patient, physician and employee satisfaction survey results
- Quality indicator reports
- Payroll and Accounts Payable reports

b. Structured Meetings

- Board and Board Committee meetings
- Leadership meetings
- Departmental staff meetings
- Joint practice committees
- Organizational committees
- Medical Staff committees

c. Electronic Information

- Voice mail
- Email
- Internal databases
- External databases
- Knowledge-based information (e.g., internal access, medical information search services, journals, etc.)

- ~~d.~~ Leadership Rounds—Employee rounding for outcomes by leadership is the conscious effort to connect with staff at regular intervals to develop relationships, build trust, acknowledge accomplishments and address operational needs and problems.

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

ADMINISTRATIVE POLICIES AND PROCEDURES

51.00 PHYSICIAN CONTRACT REVIEW

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ADMINISTRATIVE POLICIES AND PROCEDURES

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New 6/08, 06/09; 8/12

C. Policy Summary:

The purpose of this policy is to establish administrative standards and guidelines that should be observed ~~relative to~~ anytime the Hospital enters into an arrangement ~~the Hospital is engaging~~ with an individual physician, with a physician group, other organizations representing a physician, or into an indirect arrangement ~~relationship~~ with a physician. All such arrangements must be evidenced by a written contract timely executed by each party before the arrangement begins. It is the policy of the Hospital that all contracts involving physicians, including but not limited to, ~~M~~medical ~~D~~director, ~~C~~consulting, ~~O~~on-~~C~~call ~~A~~arrangements, ~~S~~service ~~A~~agreements, ~~R~~recruitment, or ~~E~~equipment or ~~R~~real ~~E~~estate ~~L~~leases ~~arrangements~~, will be in accordance with Stark, Anti-Kickback, and all other Federal and State Laws. For example, a physician may not begin services under a medical director agreement until the agreement has been reduced to writing and signed by both parties. No payments will be made for services performed before such date. A physician may not begin using real estate or equipment leased to such physician until the written agreement is prepared and is signed by both parties.

D. Administrative Guidelines

1. All contracts (except leases) should contain language regarding the Hospital's charitable purpose of serving the needs of the uninsured and underinsured members of the community.

2. The contract must be in writing.

3. The contract must be timely signed by the affected parties and can only be executed by the CEO for the Hospital and follow Hospital's signature authority policy 17.00 (except for real estate and equipment leases with physicians, which may be signed by the Chief Administrative Services Officer). The arrangement cannot begin until the contract has been executed by both parties.

4. The contract must contain terms and termination without cause provisions (except for real estate and equipment leases). The term of the contract shall be for at least one year. ~~and contain terms and termination without cause provisions.~~ Contracts which give an exclusive right to hospital-based physicians to perform services may not exceed five years. If the contract is terminated in less than one year, then the parties may not enter into a new contract or arrangement with the same physician/group covering the same arrangement ~~cannot be created~~ until 12 months after the execution date of the original contract.

5. Any compensation paid to or remuneration received by physician must be set prior to negotiations and reflect fair market value. Compensation cannot exceed the seventy-fifth percentile (75%) of fair market value without Board approval. Medical Director Agreements should utilize national market data and On-Call agreements should utilize local market data to determine 75% of FMV. Compensation cannot be revised or modified during the first 12 months of the contract. If the compensation is revised thereafter, it must be evidenced by a written amendment to the contract of at least one year, ~~-~~signed by both parties before the increase in compensation is to take effect. For example, if the increase in compensation is to take effect on April 1, the amendment must be signed by both parties on or after April 1. The compensation cannot be changed after such amendment until 12 months following the effective date of such amendment.

6. In order to support reasonableness of compensation or remuneration, supporting fair market data documentation must accompany the contract and show compensation paid by similar situated organizations and/or independent compensation surveys by nationally recognized independent firms.

7. The compensation or remuneration available to the physician under the contract shall not vary based on the volume or value of services referred or business otherwise generated by the physician.

8. Potential conflicts of interest involving the physician will need a completed conflict of interest form and must be reviewed by the compliance officer prior to developing a contract. The conflict must be addressed and referenced in the contract.

9. The overall arrangement must be commercially reasonable. The contract must have details that reflect the work or activities to be performed. The work or activities to be performed must ~~and does~~ not duplicate work that is detailed in other current agreements ~~with the proposed contract party or others prior to negotiations~~. A set number of administrative hours to be performed must be stated in a medical director contract. The total aggregate of services contracted for may not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement. If there are multiple contracts for one physician they must cross-reference each other (or the contract may cross-reference a master list of contracts that is updated centrally and is maintained in a manner that preserves the historical record of contracts) and be reviewed for potential overlap commitments prior to negotiating additional agreements.

10. All Medical Director contracts must require monthly completion of a Physician Time Study Report which must be set for the duration of the contract before the services begin and the contract is signed.

11. All new Medical Director Contracts and upon renewal of current Medical Director contracts, shall incorporate into the duties and responsibilities at least two (2) annual quality incentive goals that will support the Hospital's strategic initiatives. For contracts greater than $100,000 in compensation per year, at least 20% of the total compensation will be held at risk based on the completion of the quality incentive goals. For contracts between $50,000 to $99,999 per year, at least 10% of the total compensation will be held at risk based on the completion of the goals. For contracts between $30,000 to $49,999 per year, at least 5% of the total compensation will be held at risk based on the completion of the goals and for contracts less than $30,000 in compensation per year, 0% of the total compensation will be held at risk.

12. Contracts involving physician's relocation to the Hospital service area must comply with the physician recruitment guidelines issued by the IRS and the Hospital's physician recruitment program policy 42.00.

13. Contracts where physicians are using real estate must comply with fair market value standards. Real estate agreements must be for at least one year, executed by both parties before use begins and payments must be received from physician on a monthly basis.

14. All contracts involving a physician shall be scanned into the Meditract system.

15. Performance under contracts deemed to not meet the administrative guidelines shall be suspended until the contract can be remedied.

16. All contract renewals should be signed before the expiration of the term of the existing contract.

E. Approval of Physician Contracts:

1. Attached to the final version of a contract prior to CEO (or CASO) execution should be a completed "Physician Arrangement Review Checklist" and signed "Contract Certification" (Appendix A).

2. Corporate Compliance will verify the checklist, certification, and documentation accompanying all contracts prior to execution by the CEO (or CASO). Incomplete or missing checklist and certifications will be considered a violation of the policy.

3. All contracts lacking the appropriate documentation shall be returned to the originator for completion. No services may be performed under the arrangement until the contract is signed.

F. Exceptions:

1. There are no exceptions to this Board policy unless approved by the Board.

G. Review and/or Modification:

The CEO along with the Corporate Compliance Officer shall be responsible for reviewing guidelines as conditions warrant but at a minimum at least annually.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

APPENDIX A

Contract Cover Sheet and Summary of Terms

Name of Physician or Group party to agreement:

Type of Arrangement (Medical Dir., Consulting, Recruitment, Service, On-Call, Lease, Other):

Hospital Service Area Affected:

Contract Owner and/or individual negotiating:

Name and title of person responsible for monitoring whether the physician performs the terms of the agreement and taking steps in the event of default:

New Contract: ☐ Date of Board Approval:	Renewal Contract: ☐ If fee increase 10%+ Date of Board Approval:	Addendum to Existing Contract: ☐

Proposed Effective Date: Proposed Expiration Date: Business Associate Agmt: ___

Approvals

Compliance : Date:

Legal : Date:

Please articulate the need for this arrangement:

Please articulate why this person or group was chosen for the position:

How did you calculate how many hours this position would require:

How did you calculate the rate of compensation? How did you calculate the amount of incentive pay, if any?

What is the total cost over the entire term of this Agreement:

Compliance Checklist

Yes ☐ No ☐ 1. Has the amount of compensation been determined based on the volume or value of any actual or anticipated referral by the physician or other business generated by the parties?
Yes ☐ No ☐ 2. Do aggregate services contracted exceed those that are reasonable and necessary for legitimate business purposes of the arrangement?
Yes ☐ No ☐ 3. Are any payments made in consideration of, or to obtain, referrals?
Yes ☐ No ☐ 4. Do the services to be furnished involve counseling or promotion of any arrangement or other activity that violates any state or federal law?
Yes ☐ No ☐ 5. Has the Hospital paid the physician and/or an immediate family member any amount of money within the last 12 months?
Yes ☐ No ☐ 6. Were any loans or loan guarantees made to the physician?
Yes ☐ No ☐ 7. Will there be any non-monetary compensation to the physician?
Yes ☐ No ☐ 8. Has this contract been executed, terminated or modified, or has it expired within the last 12 months?
Yes ☐ No ☐ 9. Has another contract at the Hospital been executed with similar duties & responsibilities?
Yes ☐ No ☐ 10. Does the contract automatically renew?
Yes ☐ No ☐ 11. Were any of the form agreement's standard terms modified? If yes, attach a copy marked to show changes
Yes ☐ No ☐ 12. Does the physician currently have any other compensation arrangement with the Hospital?
Yes ☐ No ☐ 13. If yes, are the other arrangements identified in the current contract, or on a list?
Yes ☐ No ☐ 14. Has the physician filled out a conflict of interest disclosure form?
Yes ☐ No ☐ 15. The services are needed by the Hospital to carry out its tax-exempt mission?
Yes ☐ No ☐ 16. Has a fair-market value (FMV) analysis been completed?
Yes ☐ No ☐ 17. Do all of the services contracted for meet reasonable FMV?
Yes ☐ No ☐ 18. Is the analysis attached? Who completed the FMV analysis?
Yes ☐ No ☐ 19. Was the amount ECH was willing to pay determined before negotiations with the physician?
Yes ☐ No ☐ 20. Does the contract clearly detail the scope of work, all the services, duties and responsibilities and/or deliverables to be furnished by the physician?
Yes ☐ No ☐ 21. Are all the referenced documents (attachments or exhibits) complete and submitted with the final contract and certification?
Yes ☐ No ☐ 22. Have "quality outcome goals" been included in the contract?
Yes ☐ No ☐ 23. If Medical Director Agreement, has Medical Executive Committee approved? Date Approved by Medical Executive Committee
Yes ☐ No ☐ 24. Is the term of the arrangement for at least one year?
Yes ☐ No ☐ 25. Is it possible to cancel/terminate the contract for failure to perform?
Yes ☐ No ☐ 26. If needed, have confidentiality and/or business associate contracts been signed by all parties of the contract?
Yes ☐ No ☐ 27. Has a legal firm reviewed this specific contract?
Name of legal firm that reviewed contract
Yes ☐ No ☐ 28. Was an approved standard hospital template used to create this contract?

Contract Certification

I, _____ of El Camino Hospital hereby certify that to the best of my knowledge,
(responsible party negotiating)

the following matters are true for the attached contract by and between El Camino Hospital and _____
_____
(Physician) dated _____ (the "Arrangement").

1) There are no other arrangements, written or oral with the physician except set forth in the Arrangement;

2) No payment has been or will be made to the physician referenced herein outside of the terms and condition of the arrangement unless such outside payment is also consistent with El Camino Hospital's policies;

3) The contract is in compliance with Administrative Policy 51.00 guidelines.

4) All of the statements above are complete and correct.

Date: _____ Signature: _____
_____ (Hospital responsible party negotiating)

Date: _____ Signature: _____
_____ (Party responsible for monitoring physician, if different from party negotiating)

Date: _____ Signature: _____
_____ (Immediate supervisor of responsible party)

~~Physician Contract Review Checklist~~

~~Name of Physician or Group party to agreement: _____~~

~~Type of Arrangement (Medical Dir., Consulting, Recruitment, Service, On-Call, Lease, Other):~~
_____

~~Hospital Service Area Affected: _____~~

~~Contract Owner and/or individual negotiating: _____~~

~~New Contract _____ Renewal Contract: _____ Addendum to Existing Contract: _____~~

~~Proposed Effective Date: _____ Proposed Expiration Date: _____~~

~~Contract Owner Responses~~

~~Yes __ No __ 1. The services are needed by the Hospital to carry out its tax-exempt mission?~~

Yes __ No __ 2. Has the amount of compensation been determined based on the volume or value of any actual anticipated referral by the physician or other business generated by the parties?

Yes __ No __ 3. Do aggregate services contracted exceed those that are reasonable and necessary for legitimate business purposes of the arrangement?

Yes __ No __ 4. Are any payments made in consideration of, or to obtain, referrals?

Yes __ No __ 5. Do the services to be furnished involve counseling or promotion of any arrangement or other activity that violates any state or federal law?

Yes __ No __ 6. Has the Hospital paid the physician and/or an immediate family member any amount of money within the last 12 months?

Yes __ No __ 7. Has the physician filled out a conflict of interest disclosure form?

Yes __ No __ 8. Were any loans or loan guarantees made to the physician?

Yes __ No __ 9. Will there be any non-monetary compensation to the physician?

Yes __ No __ 10. Does the physician currently have any other compensation arrangement with the Hospital?

Yes __ No __ 11. If yes, are the other arrangements identified in the current contract?

Yes __ No __ 12. Has a fair market value (FMV) analysis been completed?

Yes __ No __ 13. Do all of the services contracted for the physician meet reasonable FMV?

Yes __ No __ 14. Is the analysis attached? Who completed the FMV analysis? _____

Yes __ No __ 15. Was the amount ECH was willing to pay determined before negotiations with the physician?

Yes __ No __ 16. Does the contract clearly detail the scope of work, all the services, duties and responsibilities and/or deliverables to be furnished by the physician?

Yes __ No __ 17. Are all the referenced documents (attachments or exhibits) complete and submitted with the final contract and certification?

Yes __ No __ 18. Have "quality outcome goals" been included in the contract?

Yes __ No __ 19. If Medical Director Agreement, has Medical Executive Committee approved? Date Approved by Medical Executive Committee _____

Yes __ No __ 20. Is the term of the arrangement for at least one year?

Yes __ No __ 21. Has this contract been executed, terminated or modified, or has it expired within the last 12 months?

Yes __ No __ 22. Has another contract at the Hospital been executed with similar duties & responsibilities?

Yes __ No __ 23. Does the contract automatically renew?

Administrative Policies and Procedures
51.00 Standards of Physician Contracts:

Yes __ No __ 24. Is it possible to cancel/terminate the contract for failure to perform?
Yes __ No __ 25. If needed, have confidentiality and/or business associate contracts been signed by all parties of the contract?
Yes __ No __ 26. Has a legal firm reviewed this specific contract?
Name of legal firm that reviewed contract _____
Yes __ No __ 27. Was an approved standard hospital template used to create this contract?
Yes __ No __ 28. Were any of the standard terms modified? If yes, attach a copy marked to show changes
Yes __ No __ 29. Within 5 days after final execution, the contract will be forward for scanning into Meditract?

30. Name of person and title responsible for monitoring whether the physician performs the terms of the agreement and taking steps in the event of default:

Name :_____

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Lease Contract Review Checklist

Yes __ No __ 1. Is the term of the lease agreement for at least one year?
Yes __ No __ 2. Does the agreement describe what is being leased and all services that will be included?
Yes __ No __ 3. Are the Tenant Improvements incorporated into the lease?
Yes __ No __ 4. Has fair-market value (FMV) rates been calculated based at time of signing?
Yes __ No __ 5. Does the lease rate include and inflator value for future FMV?
Yes __ No __ 6. Is the Physician using the space prior to the execution of the contract?
Yes __ No __ 7. Will all applicable property taxes be paid by the physician?
Yes __ No __ 8. Were any loans or loan guarantees made to the physician?
Yes __ No __ 9. Was the approved standard hospital template used to create this contract?
Yes __ No __ 10. Were any of the standard terms modified? If yes attach a copy marked to show changes.
Yes __ No __ 11. Within 5 days after final execution, the contract will be forward for scanning into Meditract?

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Contract Certification

I, _____ of El Camino Hospital hereby certify that to the best of my knowledge,

(responsible party negotiating)

the following matters are true for the attached contract by and between El Camino Hospital and _____

(Physician) dated _____. (the "Arrangement")

1) There are no other arrangements, written or oral with the physician except set forth in the Arrangement;

2) No payment has been or will be made to the physician referenced herein outside of the terms and condition of the arrangement unless such outside payment is also consistent with El Camino Hospital's policies;

3) The contract is in compliance with Administrative Policy 51.00 guidelines.

4) All of the statements above are complete and correct.

Date: _____ Signature: _____

(Hospital representative named in item 30)

Date: _____ Signature: _____

(Hospital responsible party negotiating if not named in item 30)

Date: _____ Signature: _____

(Immediate supervisor of responsible party)

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Service Animals for Disabled Patients Visitors_34 00, 12-5.doc

EL CAMINO HOSPITAL
ADMINISTRATIVE POLICIES AND PROCEDURES (Draft, approved by PCMC pending Board approval 9/12)

34.0 SERVICE ANIMALS FOR DISABLED PATIENTS OR VISITORS

I. Coverage

This policy applies to all inpatients, outpatients and visitors of El Camino Hospital using a service animal. For employees who require a service animal while at work, please consult with Human Resources. Physicians who require a service animal while at work should consult with the Medical Staff office.

II. Reviewed/Revised Dates

9/09, 108/12

III. Policy Summary

It is the policy of El Camino Hospital to comply with the requirements of the Americans with Disability Act and other state and federal regulations to provide access to individuals with disabilities who present with service animals. This policy ~~will provide~~will provide guidelines on how to provide access for the service animal while preserving ~~a safe~~a safe environment in the Hospital. Except as specified below, a person using a service animal shall generally be afforded the same access to the Hospital as that afforded the public in general. Any questions about this policy should be directed to the Manager of Risk Management.

IV. DEFINITIONS

A. Disability:

A disability is defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual, including but not limited to walking, talking, breathing, hearing or caring for oneself.

B. Service Animal

A *service animal* is defined as a dog ~~or miniature horse~~ trained to work or perform tasks for the benefit of an individual with a disability. For sight impaired patients who are allergic to dogs, a miniature horse (usually not more than 26 inches in height or more than 100 pounds) may be used as a

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service animal. However, the miniature horse must be trained to provide assistance to the individual with a disability and must be house broken. The work or tasks performed by a service animal must be directly related to the individual´s disability. This includes but is not limited to the following: guiding individuals with impaired vision, alerting individuals with impaired hearing to sounds, providing minimal protection.

C. **Direct Threat.** A direct threat is defined as a significant risk to the health or safety of others that cannot be eliminated or mitigated by a modification of policies and procedures or by the provision of auxiliary aids/services. The Hospital shall make an individual assessment based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence to ascertain the presence of a direct threat posed by a service animal.

V. **Procedure**

A. In general, a service animal shall be permitted in any area of the Hospital that is unrestricted to inpatients, outpatients or visitors such as lobbies, cafeterias and patient rooms provided that the service animal does not pose a Direct Threat to the health and safety of others and would not require a fundamental alteration in the Hospital's policies and procedures. **Any decision to exclude a service animal from a particular area of the Hospital shall be made pursuant to the guidelines below and shall be made by competent medical personnel based on an individual assessment.**

1. Restricted Access Areas. Areas that are considered restricted where service animals will not be allowed include areas where the general public is not permitted. Additional areas may be identified on a case-by-case basis to protect the health and safety of patients, visitors and employees of El Camino Hospital. These areas include but are not limited to:
   a. Procedural and interventional areas including the operating room, ~~l~~ cath labs, endoscopy and the PACU.
   b. Patient units where a patient is immunocompromised
   c. Patients who are placed in isolation for respiratory, enteric or infectious precautions.
   d. Behavioral Health Units. The presence of a service animal on the inpatient BHU poses a fundamental alteration to the services provided to patients on the unit.

2. If a patient with a service animal is located in an area with restricted access, efforts must be made to accommodate the patient's disability.

3. Risk Management/Clinical Effectiveness shall be notified before a patient is denied access to an area with his/her service animal.

4. The patient will be informed about the decision to allow/deny the service animal, the reasons why, and what accommodations will be made for his/her disability and documentation will be in the medical record.

B. Any service animal in attendance of a patient or visitor will be recognized as an animal trained to assist a disabled person and will not be viewed as a "pet". If any El Camino Hospital employee has a concern that an animal is a "pet" rather than a service animal, the employee may ask the following questions and consult with Risk Management.

a) If the animal is a service animal required because of a disability
b) What work/task has the service animal been trained to perform

If the person answers "No" to either of the questions above, then the animal is not considered a service animal and the staff member should refer to the Animal Visitation Policy for further guidance about allowing the animal to visit with the patient. The staff member should document this interaction in the patient's medical record. If the patient answers yes to the questions, the service must be allowed unless it is in a restricted area.

2. Staff must not ask for information about the person's disability, require medical documentation regarding the service animal, ~~require~~and require a special identification card or training documentation for the service animal.
~~animal~~

C. Procedure for Managing Requests for Service ~~Animalss~~Animals. The following general guidelines apply when a patient requests access for his/her service animal.

1. Notify Hospital supervisor and clinical manager of unit that patient has a service animal.
2. Hospital supervisor will place patient in a private room unless in a restricted area.
3. Notify Risk Management.
4. Service Animals must appear healthy, clean and be well behaved. The service animal must not have visible fleas or skin lesions. The clinical manager or house supervisor shall visually evaluate the appearance of the service animal and document the request for the service animal, any communications with the patient/visitor and the overall health status of the animal. The owner of the service animal may provide documentation that the animal is in good health which should be part of the patient's medical record. However, staff should not ask that these records be provided. If there are questions or concerns about the visual appearance of the animal, contact the Risk Manager and Infection Control via Vocera
5. The patient shall be informed of the following:

   a. The hospital is not responsible for caring for the service animal. The patient is responsible for making arrangements for caring for

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the service animal. If the physician determines the patient is not able to care for the animal while admitted, the patient shall make arrangements for another person to care for the service animal. If no other person is available to care for the service animal, the service animal may have to be removed from the hospital. El Camino Hospital is not required to supervise or care for any service animal. All obligations to feed, groom, exercise, or care in other ways for the animal must be arranged and paid for by the disabled person/patient or by that person's representative.

If the service animal must be separated from the disabled person/patient, it is the responsibility of the disabled person/patient to arrange for the care and supervision of the animal during the period of separation.

b. Leashing/kenneling:

(1) Service animals in patient rooms shall not be required to be leashed or kenneled unless it is established that the unleashed service animal posses a risk to the health, safety, or well being of the disabled person/patient or others. In the event that it is determined that the unleashed service animal poses a risk to the health, safety, or well being of the disabled person/patient or others, leash control or kenneling in the patient room will be required.

(2) If, after leashing or kenneling, the service animal continues to pose a risk to the health, safety, or well being of the disabled person/patient, or others, the service animal may be restricted or excluded from the premises.

~~(2)~~(3)

(3) ~~(3)~~ Service animals shall be leashed in all public areas unless leashing will interfere with the services that the animal is intended to provide.

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c. Contact Concerns

(1) The disabled person/patient must prevent the animal from coming in contact with any patient's non-intact skin (surgical sites drainage tubes, wounds, etc.).

(2) Service animals should not have direct contact with a patient in isolation. Arrangements should be made for the animal to wait by the door or in another appropriate location.

(3) If medical justification shows that the presence or use of a service animal would pose a significant health risk to the disabled person or to surrounding patients and/or

employees of El Camino Hospital, the service animal may be restricted or excluded from the premises.

(4) If the roommate of a disabled person utilizing a service animal or patient frequently visited by a disabled person utilizing a service animal, is allergic to the service animal, or otherwise objects to the service animal, either the disabled patient or the roommate shall be assigned to a different room, subject to availability of appropriate accommodations.

(5) If the animal's presence or behavior adversely affects or compromises a person's physical or emotional well being, including the disabled person/patient (e.g., allergies of staff and/or patients, interference with therapies, noise disruption, etc.), the disabled person/patient will be asked to make alternative arrangements for the animal.

D. Additional issues

1. Hand Cleansing
Hands should be washed or cleansed after direct contact with the service animal, its equipment, or other items with which it has been in contact.

2. Education
Education may be required for roommates and visitors, as well as disabled person/patient, regarding limiting interactions with the service animal. Health system personnel will be responsible for providing this education utilizing the contents of this procedure as a guide.

VI. CROSS REFERENCE DOCUMENTS

A. Americans with Disabilities Act of 1990
B. Chang H. Miller, H. Watkins, N., Arduino, M., Midgley, G., Aguero, S. Pinto-Powel, R., von Reyn, C.F., Edwards, W., McNeil, M., Jarvis, W., Pruitt, R. "An Epidemic of Malassezia pachydermatis in an Intensive Care Nursing Associated with the Colonization of Health Care Workers' Pet Animals," New England Journal of Medicine, March 12, 1998, vol. 338, no. 11, pp. 796-711.
C. Hardy, Glenna: "The seeing-eye animal: an infection risk in hospital?" Canadian Medical Association Journal, March 15, 1981, vol. 124, pp. 698-700.
D. Houghtalen, R., Doody, J.I., "After the ADA: Service Animals on Inpatient Psychiatric Units," Bull American Academy Psychiatry Law, vol. 23, no. 2, 1995.
E. Mayhall, C.G.., Epidemiology and Prevention of Nosocomial Infection Associated with Animals in the Hospital, Hospital Epidemiology and Infection Control, 1996 Williams & Wilkins, chapter 85.
F. Olmsted, R., APIC Infection Control and Applied Epidemiology, Principles and Practice, 1996, Mosby, chapter 97.
G. Reuter, "Pet Study Warns of Many Diseases Transfer to Humans," The Washington Post, September 22, 1997

VII. Approvals
Patient Care Management Council, 8/12 (MV and LG)
Medical Executive Committee
Board of Directors

Visitors Policy_ 58 10, 12-5.DOC

EL CAMINO HOSPITAL
ADMINISTRATIVE POLICY

58.10 VISITORS POLICY

A. Coverage:

El Camino Hospital Staff, Employees, Volunteers

B. Reviewed/Revised:
New 8/2011, 10/12

C. Policy Summary:

To ensure that all visitors of inpatients and outpatients at El Camino Hospital enjoy equal visitation privileges consistent with patient preferences and any of the hospital's justified clinical restrictions. ~~**The Centers for Medicare & Medicaid Services (CMS) mandates a new regulation for equal patient visitation rights. This applies to all hospitals that accept Medicare and Medicaid reimbursement. The Joint Commission is in agreement with this revised requirement. This policy addresses patient visitation rights, including** any clinically necessary or reasonable restrictions or limitation. The hospital will respect, protect and promote patient visitation rights. Designated visitors may be included in the Advance Directive (such as Durable Power of Attorney (DPA), guardian, and Healthcare proxies. If the patient lacks decision-making capacity, the DPA, guardian, healthcare proxies, and any persons living in the patients' household may make the determination as to who may visit.~~

D. Definitions

1. Justified Clinical Restrictions mean any clinically necessary or reasonable restriction or limitation imposed by the Hospital on a patient's visitation rights which may be necessary to provide safe care to patient or other patients, and as necessary in order to conduct hospital operations. These justified clinical restrictions may include, but are not limited to, to the following:
    a. A patient's medical condition
    b. The family's health and safety
    c. Any court order limiting or restraining contact

d. Behavior disruptive to functioning of the patient care unit
e. Behavior presenting a direct risk or threat to the patient, hospital staff or others in the immediate environment
f. Patient's risk of infection by the visitor
g. Visitors' risk of infection by the patient
h. Substance abuse treatment protocols requiring restricted visitation
i. Patient's need for privacy or rest, including during the immediate post procedural period in the PACU area
j. Need for privacy or rest by another individual in the patient's shared room
k. When a patient is undergoing clinical intervention/procedure and the practitioner believes it is necessary to limit visitation (e.g., requires sterile environment)
l. Extraordinary protections due to a pandemic or infectious disease outbreak

2. Patient means anyone admitted as an inpatient or receiving outpatient treatment.

3. Support Person means a family member, friend or other individual who is present to support the person during the course of the patient's stay or treatment.

E. Policy

1. The hospital offers our patients and visitors an open visiting policy for both the Mountain View and Los Gatos campuses. However, the hospital reserves the right to limit the number of visitors for any one patient during a specific period of time as well as to establish minimum age requirements for child visitors based on the clinical needs of the patient or other patients and operation of unit,

~~1. The hospital will inform the patient and/or support person, when appropriate of his or her visitation rights~~Prior to care being provided, patients (or their designated support person) are informed of visitation rights and any potential clinical restrictions. ~~.~~
~~2. Patients will be provided a written copy of the visitation rights in advance of~~
~~3.~~ ~~providing treatment. This~~ Visitation information will be provided via the hospital's "Hello

~~4.~~2. ~~——~~Goodbye Folder" which is provided to every patient admitted to the ~~hospital~~hospital and is posted and available in the Visitor's guide in outpatient areas.~~.~~

~~Every attempt will be made to provide information to patients with limited English proficiency in a manner and language that the patients can understand.~~

3. Visitation rights include the right to receive the visitors designated by the patient, including but not limited to, a spouse, a domestic partner (including a same-sex domestric partner), another family member, or a friend, and his/her right to withdraw or deny such consent at any time.

~~d.~~

a. If the patient is incapacitated or otherwise unable to communicate his/her wishes and the patient has designated a support person, the hospital is to provide the required notice to this support person and allow that support person to exercise the patient's visitation rights.

b. If the patient is incapacitated as defined above and has not designated a support person in advance, but a support present asserts that s/he is the patient's support person, the hospital can rely on this assertion.

4. The hospital prohibits discrimination in visitation based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, gender, sexual orienation, and gender identity or expression.

~~5. The hospital has the right to withdraw or deny such consent at any time.~~

5. The hospital has the right to rescind or restrict the visitation hours and rights based upon the safety and welfare of the patient and the hospital staff, and as necessary in order to conduct normal hospital operations by imposing Justified Clinical Restrictions as defined above. ~~.~~ The reasons for the clinical restrictions or limitation must be explained to the patient and family.

~~The reasons may include:~~
~~A patient's medical condition~~
~~The family's health and safey~~
~~A patient's wish for privacy or uninterrupted rest time~~
~~A non-private room~~
~~The need for a sterile environment~~
~~Any court order limiting or restraining contact~~
~~Behavior presenting a direct risk or threat to the patient, hospital staff, or others in the immediate environment~~

~~Behavior disruptive in the function of the patient care unit~~
~~Patient's risk of infection by the visitor~~
~~Visitor's risk of infection by the patient~~
~~Extraordinary protections due to a pandemic or infectious disease outbreak~~
~~Substance abuse treatment protocols requiring restricted visitation.~~

6. The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of the inpatient or outpatient hospital stay.

7. The hospital allows for the presence of support individual of the patient's choice unless the presence infringes on others' rights, safety, or is medically or therapeutically contraindicated.

8. All visitors designated by the patient should enjoy the same visitation privileges as immediate family would enjoy.

~~6.~~9. ~~enjoy (not more restrictive).~~Hospital staff who are involved with managing and controlling visitor access will be trained on these policies.

F. Approvals:
Patient Care Services (Mountain View and Los Gatos): 8/2011,9/12
Executive Council: 1/2012, 9/12
Medical Excecutive Committee: 2/12,9/12
Board of Directors: 3/12, pending

Finance Committee OPEN Minutes 10-2-12 - MRK.docx

EL CAMINO HOSPITAL
FINANCE COMMITTEE OF THE BOARD
Tuesday, October 2, 2012

MINUTES

The Finance Committee of the Board of Directors of El Camino Hospital (the "Hospital") was called to order by David Reeder, Chairman, at 5:36 p.m. on Tuesday, October 2, 2012 in Conference Room B, ground floor, El Camino Hospital, Mountain View.

OPEN SESSION

CONFLICT OF INTEREST DISCLOSURES: Mr. Reeder asked if any Committee member may have a conflict of interest on any of the items on the agenda. No conflict was stated.

CONSENT CALENDAR: A motion was made, seconded, and approved by a vote of three members in favor, none opposed, to approve the minutes of the September 5, 2012 Finance Committee of the Board of Directors meeting.

FY 2011/2012 DRAFT FINANCIAL AUDIT: Mr. Chris Pritchard of Moss Adams presented the El Camino Hospital District Report of Independent Auditors. Mr. Brian Conner of Moss Adams was present to discuss the new accounting standards and policies, and it was noted that Mr. Conner will be replacing Mr. Pritchard next year as engagement partner.

A motion was made, seconded, and approved by a vote of three members in favor, none opposed, to recommend the Board approve the financial audit.

IT REPORTS: Greg Walton, Chief Information Officer, presented post-activation reports for two projects, the Cardiovascular Picture Archiving System and McKesson Document Imaging.

403B PARTICIPANT FEE REDUCTION: Michael King, Chief Financial Officer, provided information regarding a proposed fee reduction for the corporation's 403(b) plan and requested that the Committee make a recommendation to the Board in support of management renegotiating reduced fees with Fidelity. Mr. Juelis asked about the fee arrangement for separated employees. Mr. King will look into the arrangement. A motion was made, seconded, and approved by a vote of three members in favor, none opposed, to recommend the Board authorize renegotiating reduced fees with Fidelity.

ADJOURN TO CLOSED SESSION: Upon motion duly made, seconded and approved by the members of the Committee, the Open Session of the meeting was adjourned to Closed Session at 6:17 p.m. pursuant to *Gov't Code Section 54957.6.*

CLOSED SESSION

The Committee completed its business of the Closed Session at 7:40 p.m.

RECONVENE OPEN SESSION:

The Committee reconvened Open Session at 7:40 p.m.

CLOSED SESSION REPORTS:

El Camino Surgery Center: A motion was made, seconded, and approved by a vote of three members in favor, none opposed, to recommend the Board authorize the sale and contribution of ECSC assets to the new joint venture surgery center company and to execute the appropriate legal documents on behalf of the Hospital.

IT Sourcing: A motion was made, seconded, and approved by a vote of three members in favor, none opposed, to recommend the Board authorize termination of the current Allscripts contract and to negotiate and execute a new agreement with Allscripts to continue the provision of software maintenance and other services.

Physician Contracts: A motion was made, seconded, and approved by a vote of three members in favor, none opposed, to recommend that the Board approve negotiation and execution of the following physician contracts: 1) Modification of Thoracic Surgery Medical Directorship; 2) Addition of Radiology Administrative Services in support of Cancer Center tumor boards, and 3) Addition of new Urology On-Call Panel for Mountain View.

CFO REPORT: Michael King, Chief Financial Officer, presented the Fiscal Year 2013, Period 2 Financial Statements for discussion.

FEDERAL TAX RETURN: Mr. King provided the Committee with an overview of the history regarding the organization's prior decision to prepare, but not file, the federal tax return called *Return of Organization Exempt From Income Tax*, also known as "Form 990". He noted that the hospital is not required to file the Form 990 and has not done so for many years, but has continued preparing the form because people used to request it. He stated there have been no requests for the document for at least two years and noted that the corporation's decision a few years ago to provide the salaries of its executives to the public was likely the reason that no requests have been made. He stated that he would like for the Committee to consider whether it might be more prudent to prepare only the salary-related schedules in the future, and discontinue the practice of preparing the entire document. Mr. Reeder and Mr. Hobbs requested a copy of the one page which consists of executive salaries. Mr. King will provide a copy of the entire document to the Committee members.

It was recommended that completion of Form 990 be discussed with the entire Board, noting that the Committee members supported that completion of Form 990 be discontinued except for the portion which provides salary information.

PUBLIC COMMENT: There was no public comment.

ADJOURNMENT: There being no further business, the meeting adjourned at 8:05 p.m.

_____

David Reeder
Chair, Finance Committee

Quality Open Minutes 10 15 2012.docx

Minutes of the Open Session
Quality, Patient Care and Patient Experience Committee
of El Camino Hospital
October 15, 2012

The Open Session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order by Chair Patricia Einarson, M.D., at 5:31 p.m. on **Monday, October 15, 2012,** Conference Room G, at El Camino Hospital, 2500 Grant Road, Mountain View, California.

I. Call to Order. Roll call was taken. Committee members present were Patricia Einarson, M.D., Lisa Freeman, Cary Hill, M.D., Don Nielsen, M.D., Robert Pinsker, M.D., and David Reeder. Katie Anderson, M.P.H., and Neal Cohen, M.D., M.P.H., were absent.

II. Potential Conflict of Interests Disclosures. Dr. Einarson asked if any Committee member or anyone in the audience believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.

III. Consent Calendar. The Committee reviewed the minutes from the April 30, 2012 and August 25, 2012 meetings.

Action: Mr. Reeder asked that the minutes of April 30, 2012 be removed from the consent calendar for discussion.

A motion was made and seconded by Committee members present to approve the following items on the consent calendar: Minutes of August 25, 2012 Committee meeting.

Mr. Reeder asked that the April 30, 2012 minutes be revised by replacing the word "Contract" with "Credentials" in the Board Quality Committee Goals. A motion was made and seconded by Committee members present to approve the April 30, 2012 meeting minutes with the amendments proposed by Mr. Reeder.

IV. Introduction – Mick Zdeblick. Dr. Einarson welcomed Mick Zdeblick, the Hospital's new Chief Operating Officer.

V. Adjourn to Closed Session. A motion was made, seconded and approved by Committee members present, to adjourn the Open Session to Closed Session at 5:36 p.m. pursuant to *Gov't Code Section 54957.2* and pursuant to *Health and Safety Code Section 32106 (b)* for report involving Health Care Facility Trade Secrets.

Closed Session:

The Committee completed its business of the Closed Session at 5:48 p.m.

VI. Reconvene Open Session. The Board reconvened Open Session at 5:49 p.m.

VII. Informational and Possible Motion Items:

A. Review Committee Charter, Committee Goals and Hospital Committee Structure. Dr. Einarson provided an overview of the Committee charter. The Committee discussed the importance of creating a uniform understanding of "quality" and patient-centered care. The Committee will continue its discussion of the Committee Charter at its next meeting and will spend additional time reviewing the sections pertaining to General Responsibilities, Specific Duties and Committee Effectiveness to ensure they are linked to the Hospital's vision, strategy and organizational goals. Dr. Pifer will present the final revisions to the Charter for approval at the next Committee meeting.

Dr. Pifer provided an overview of the FY2013 Committee goals and described the process undertaken to develop the goals. The Committee discussed minor revisions to the existing goals as well as adding an educational goal. Dr. Pifer will present final revisions to the goals for approval at the next Committee meeting.

Dr. Pifer presented the proposed Quality Committee Structure and asked the Committee to provide feedback on how medical issues should get escalated to the Board. The Committee discussed a number of options and agreed to a brief discussion at a later time. The Committee also discussed alignment and coordination between committees, linkage to the Hospital's strategic plan and strategies to reduce gaps in oversight or duplication of effort across committees. Dr. Pifer will present the final revisions to the proposed Quality Committee structure for approval at the next Committee meeting.

Action: A motion was made and seconded by Committee members present, to approve the addition of an education goal to conduct educational sessions, as appropriate, on the following topics: vocabulary for LEAN management, ACO and PPACA, Service Methodologies, Change Management techniques, Culture Change.

B. Review ECH Organizational Goals and Discuss. Dr. Pifer stated that a primer on strategy will be presented at the next Committee meeting which will provide additional context on how the organizational goals were developed. The Committee reviewed the Committee Goals and stressed the importance of including patient satisfaction and patient experience goals and metrics.

Action: A motion was made and seconded by Committee members present, to recommend the FY2013 Organizational Goals to the El Camino Hospital Board of Directors. The Committee also agreed to add an organizational goal on patient experience in FY2014.

C. Review ECH Corporate Scorecard Quality Elements and Discuss Targets. Dr. Pifer presented the Corporate Scorecard. He stated that the primary focus is to monitor the highest impact indicators and therefore the existing targets and measures will continue to evolve.

Action: A motion was made and seconded by Committee members present, to recommend the existing FY 2013 Corporate Scorecard to the El Camino Hospital Board of Directors.

D. FY2013 Calendar. Dr. Einarson presented the final Committee meeting schedule.

Action: A motion was made and seconded by Committee members present, to approve the FY 2013 Meeting Calendar.

E. Closing Comments and Summary Call Out of Deliverables. Dr. Einarson highlighted the primary commitments from the meeting: feedback would be incorporated into the charter and goals and will be presented at the next Committee meeting for final Committee review and approval; the Committee will add a patient-centered goal in FY2014; the FY 2013 organizational goals and scorecard will be recommended to the Board as presented to the Committee, and a patient experience goal and measure will be added to the organizational goal and scorecard in FY 2014; the FY 2013 calendar will be published; the Chiefs of Staff and Vice Chiefs of Staff will be invited to future meetings as appropriate.

There being no further business, the meeting was adjourned at 7:39 p.m.

_____

Patricia Einarson, M.D.
Chair, ECH Quality, Patient Care and
Patient Experience Committee

Governance Open Minutes of 11-8-12 (2).doc

EL CAMINO HOSPITAL
Governance Committee of the Board
November 8, 2012

MINUTES

The meeting of the Governance Committee of the Board of El Camino Hospital (the "Hospital") was called to order by John Zoglin at 5:30 p.m. on **Thursday, November 8, 2012** in Conference Room C, El Camino Hospital, 2500 Grant Road, Mountain View, California.

Roll call was taken. The Committee members present were John Zoglin, Gary Kalbach and Mark Sickles (by speaker phone so he could speak during and hear all proceedings). Peter Moran arrived at 5:40 p.m. and Patricia Einarson, MD arrived at 5:50 p.m.

CONFLICT OF INTEREST DISCLOSURES: Mr. Zoglin asked if any Committee member has a conflict of interest regarding any of the items on the agenda. No conflict was stated.

CONSENT CALENDAR: A motion was made, seconded, and approved by a vote of three Committee members in favor, Mr. Moran and Dr. Einarson absent, to recommend approval to the Board of Directors of the minutes of the October 2, 2012 Governance Committee meeting.

BOARD AND COMMITTEE CONTINUING EDUCATION POLICY:

Ms. JoAnn McNutt of Nygren Consulting discussed the Board and Committee Continuing Education Policy. She stated that it was simplified with added language that provides delegated authority to the committee chairs and removal of language from of the main body of the policy and put into an appendix that would make it easier to amend the policy. Ms. McNutt also stated that the policy states that the Hospital Directors would be allowed to select their own education fund up to a certain limit without needing approval from the Governance Committee.

Mr. Zoglin asked if there were any questions or comments on this document.

Mr. Zoglin stated that he wanted defined in the policy the budget parameters for onboarding of new committee members. He also requested a different phrase for "Return on Investment", which will be made by Ms. McNutt.

After considerable discussion, a redraft of the policy will be sent to Mr. Zoglin for review and then submitted to the November 14, 2012 Board for approval.

Mr. Zoglin also requested under Budget and Delegated Authority more explanation be added.

The total annual training budget for Board and Committees was then discussed which included $50,000 per annum, $2500 for Hospital Directors and $2500 per committee. Mr. Moran stated that the committees should be encouraged not to use their full allotted amount this year because of their participation in Estes Park.

Action: Upon motion duly made and seconded by the Committee members, the Continuing Education Policy was recommended, pending revisions, to be submitted to the Board on November 14, for approval.

SUMMARY COMPARISON OF COMMITTEE CHARTER AND GOALS (Interdependencies):

Ms. Christine Bassarab provided a summary comparison of the FY 2013 charters and goals. She stated that that all the committee charters were reviewed, focusing on the areas where there were potential overlaps and/or lack of clarity. She then provided a matrix across all the different committees to see where there might be confluence, gaps, or a need for greater coordination. She recommended that groups have risk thresholds within each of their areas of oversight, as well as enterprise risks. After review and discussion the following changes were recommended on the document by the committee:

- Regulatory oversight be moved to the Quality Committee
- IT enabling
- Medical Director agreements be reviewed quarterly by the Quality Committee

This document will be brought back to the committee in December for approval and recommendation to the Board.

Action: Upon motion duly made and seconded by the committee members, the charters received were approved as presented. The Quality, Patient Care and Patient Experience Committee charter will be reviewed in December.

BOARD/MANAGEMENT COMPACT:

Ms. JoAnn McNutt stated that last May David Nygren facilitated a session with the Board and management. Twelve principles were derived from that meeting. The feedback received was that the compact needed to be more specific. Using the Virginia Mason compact as a guide, a five dimension compact was created.

- Strategic Thinking
- Constructive Partnership
- Results-Oriented
- Transparency and Accountability
- Continuous Learning

Ms. McNutt stated that this document will be incorporated into the evaluation process. A recommendation was made to add an appendix to the compact with core value definitions. This document, with revisions, will be brought back to the December meeting for review, approval and recommendation to the Board.

PUBLIC COMMUNCATIONS: None.

ADJOURN TO CLOSED SESSION: Upon motion duly made, seconded, and approved by a vote of Committee members in favor, the Open session of the meeting was adjourned to Closed Session at 6:42 p.m. pursuant to *Gov't Code Section 54957.2* to consider the Closed Session minutes of the

Governance Committee meeting (October 2, 2012) and Board Pacing Plan and *Health and Safety Code Section 32106(b)* for report involving health care facility trade secrets.

CLOSED SESSION

The Committee completed its business of the Closed Session at 8:00 p.m.

RECONVENE OPEN SESSION

The Committee reconvened open session at 8:02

CLOSED SESSION REPORTS:

Mr. Zoglin reported on the following actions taken in Closed Session, which are required to be disclosed in Open Session:

Closed Session Minutes of October 2, 2012
The Board reviewed and approved the Closed Session minutes of October 2, 2012, as presented, by a vote of five Committee members in favor.

There being no further business, the meeting was adjourned at 8:03 p.m.

_____
John Zoglin, Chair
Governance Committee

Auxiliary Report and Data.pdf

El Camino Hospital Auxiliary

Board Report

December 12, 2012

Strategic Planning Committee

The Strategic Planning Committee continues to meet approximately every two weeks. We are currently in the process of assessing all of the Auxiliary's services to determine if there are issues that need to be addressed or if the service is running smoothly. For example; are all shifts being covered, is it meaningful work and are the volunteers happy and satisfied. Is there adequate communication and partnership between staff and volunteers and does staff understand the responsibilities of the volunteers and why they're on that unit? Is there more the volunteers can do to help staff, patients and visitors? Is this a necessary service or should we pull volunteers and deploy them elsewhere? Auxiliary priorities are bubbling to the surface and we're are dealing with critical issues as necessary and gathering information to attend to in order of importance. It's an interesting process and the committee is engaged and excited as things evolve.

Patient Safety Volunteers

The Auxiliary is expanding our Patient Safety Volunteers to cover all 5 units. This service provided by all Junior volunteers is primarily a "falls prevention" program. Our volunteers round on patients designated to be fall risks and check to make sure all safety measures are in place. They verify that call lights are within reach, bed alarms are plugged in and remind them to call for a nurse if they need to get out of bed, etc. These volunteers up to now have rounded on 2C, 3B and 3C and will now add 4A and 4B to their rounds.

Customer Service Workshop

The Auxiliary is starting to plan a Customer Service Workshop in January for all volunteers who work Information Desk, Greeters, Surgery Liaison and Escort. We are bringing in an outside facilitator to lead these sessions that will motivate and inspire our volunteers to go the extra mile in serving the public and each other. While these first workshops will be for the aforementioned services, we hope to eventually roll them out to all Auxiliary services. So far we have 3 dates scheduled for Mountain View volunteers and 2 for Los Gatos. It promises to be educational and fun for all!

Auxiliary ECHA Data Report December.pdf

El Camino Hospital Auxiliary

Board Report

December 12, 2012

Combined Data as of October 31 for Both Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members -	525	
Dues Paid Inactive -	147	(Includes Associates & Patrons)
Leave of Absence -	32	
SUBTOTAL	**704**	

Resigned in Month-	23
Deceased in Month-	0

Junior Members

Active Members -	222
Leave of Absence -	2
SUBTOTAL	**224**

Total Membership **928**

COMBINED AUXILIARY HOURS FROM INCEPTION (as of Oct 31): **5,227,794**

El Camino Hospital Auxiliary

Board Report

December 12, 2012

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Foundation Report 11-28-12.docx

El Camino Hospital® Foundation
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Park Pavilion, Mailstop PAR116
Mountain View, CA 94040-4378
Phone: 650-940-7154
Fax: 650-940-7144
www.elcaminohospital.org/foundation

Memorandum

Date: November 28, 2012
To: El Camino Hospital Board of Directors
From: Claudia Coleman, Chair, El Camino Hospital Foundation Board of Directors
Larry Feder, President, El Camino Hospital Foundation Board of Directors
Re: Report on Foundation Activities

El Camino Hospital Foundation's strategic plan focuses on three general areas: building a culture of philanthropy throughout the hospital and the community; broadening and effectively managing the pipeline of donors; and raising revenue at a best practices cost of fundraising. As the year draws to a close, we reflect on the steps we are taking toward fulfilling these goals.

Building a Culture of Philanthropy

"Inspire the community to embrace El Camino Hospital Foundation as a compelling philanthropic enterprise."

In order to strengthen the culture of philanthropy, the Foundation is working on supporting and strengthening the Foundation lay leadership, developing a hospital-wide understanding of and commitment to philanthropy, and focusing on its donor stewardship program.

- **Strengthening and Supporting Lay Leadership**
  - **Board of Directors** - El Camino Hospital Foundation is pleased to announce that Roger S. Borovoy has joined the Board of Directors. Roger is Of Counsel in the Silicon Valley office of Fish & Richardson P.C., where he focuses primarily on patent infringement and licensing. Prior to beginning his private practice, he was part of the venture capital partnership that started Compaq Computer Corporation (now part of HP) and Lotus Development (now part of IBM). In his venture capital work he raised and invested $60,000,000 in high technology electronics start-up companies and served on six boards of directors of those companies. Roger previously served as vice president, general counsel and secretary at Intel Corporation and was patent counsel at the Fairchild Camera

Instrument Corporation.

- **Board of Ambassadors** – The Foundation has established a new organization for emeritus lay leaders, providing an avenue to keep them involved and engaged in philanthropic activities on behalf of the hospital. Past board and campaign cabinet members attended a launch reception at Los Altos Golf and Country Club on October 30, where they learned about the roles and responsibilities of the new group, heard a hospital update from CEO Tomi Ryba, and received a report on the new Senior Health Center from Dr. Eric Pifer. The new ambassadors will have special opportunities throughout the year to stay informed about the latest happenings at El Camino Hospital. They, in turn, are charged with helping the Foundation widen its circle of friends and supporting the Foundation's events and special programs.

- **Annual Foundation Leadership Dinner** – The Foundation hosted its annual leadership dinner at Los Altos Golf and Country Club on November 8. It was an occasion for members of the board and Los Gatos Leadership Committee and their spouses to socialize, and for the Foundation to thank them for their commitment. Six outgoing board members, Robert Adams, Mishy Balaban, Marla de Broekert, Phyllis Dorricott, Girish Shah, and Pamela Taft received plaques in gratitude for their service. The board voted to renew the terms of office of returning board members Bernis Kretchmar, Lane Melchor, Dr. Anil Singhal, Dr. Frederick St. Goar, and Lynn Telford.

Hospital Engagement

- **Employee Giving** - El Camino Hospital Foundation's two-week 2013 Employee Giving Campaign officially concluded on November 13 but we are continuing to accept enrollment forms until December 7. As of November 23, 614 employees had contributed $131,532 to the campaign and more forms remain to be processed. Eighteen departments thus far have reached 100% participation. "Where the need is greatest" continues to be the most popular designation for gifts, with the RotaCare Clinic a close second. The Cancer Center and Nursing Research and Innovation fund also received many donations. Ted Prairo of the shipping and receiving department explained his support for the campaign this way: "The El Camino Hospital Foundation defines what a true collaboration between a hospital and community is all about: an

outstanding outreach consisting of medical professionals, employees, and a caring public for the healthy advancement of all. I'm always eager to support an organization that continues to put the progress of people first. ECH FOUNDATION – CARING and SHARING for the Betterment of ALL!"

- **Circle of Caring –** Since being launched at the end of September, 30 grateful patients and family members have honored a hospital caregiver by making a donation to El Camino Hospital Foundation through this program. In addition to enclosing Circle of Caring brochures in each patient packet, the Foundation, with the help of Auxiliary volunteers, is now mailing a brochure to each patient within one or two weeks of discharge. The honored caregivers receive a special pin and are acknowledged in the internal hospital publication Spotlight.

- **Donor Stewardship**
  - **Holiday Card Mailing** – The Foundation mailed Thanksgiving cards to 2,700 donors to thank them for their support this year.

  - **Friends of the Foundation** – In the month of November, concierge Mary Dybdahl touched 50 patients by making hospital visits, providing assistance, and delivering comforting gifts, as well as through contact by phone and via mail. Since the program launched one year ago, she has offered care and comfort to more than 550 patients.

Broadening the Donor Pipeline

"Maximize solicitation opportunities within an enriched pipeline."

The Foundation is focusing on broadening its donor base and identifying major donors for solicitation in 2013.

- Within the first four months of the fiscal year we already have 1,061 donors toward our strategic goal of 2,700.

  - **Maecenas Dinner** – El Camino Hospital Foundation hosted an intimate dinner for 18 prospective major donors to the Cancer Center in the demonstration kitchen on November 13. This is the third in a series of such evenings organized by volunteers Michele Kirsch and Maria Constantino Roelandts. The attendees had the opportunity to meet and

hear from CEO Tomi Ryba and Cancer Center physicians Shyamali Singhal, Shane Dormady and Robert Sinha. The Foundation is now following up with the guests.

- **Allied Professional Seminar** – The Planned Giving department is organizing its annual Allied Professional Seminar, which will be held at Palo Alto Hills Golf and Country Club on February 6. One hundred estate planning professionals are expected to attend the program, which is an important way to keep them informed about El Camino Hospital and the Foundation's planned giving program so they can help their clients who might be interested in making a bequest. This is a major project of the Foundation's Planned Giving Council who are members of the estate planning community and volunteer their time to the Foundation. They assist with all aspects of the planned giving program and serve as valued ambassadors of our work. The main topic of the seminar will be, "Charitable Gifts of Difficult Assets: Creating a 'Win-Win' for Clients and Charities." The talk will be given by Claudia B. Sangster, director, philanthropy, estate and trust services and the Harris Charitable Fund Program, Harris myCFO.

- **Harris Connect** – The Foundation has finished its first round of calls and follow-up letters through this donor acquisition program, which to date has brought in 444 new donors. Harris Connect targeted its fundraising efforts primarily on grateful patient donor prospects and a smaller number of past donors who have given cumulatively $250 or less. Further research is being done on this donor pool to assess their future gift potential. The Foundation will analyze and compare these results to those of past direct mail programs to determine whether or not to re-engage Harris Connect in 2013.

Raising Revenue

"Achieve El Camino Hospital Foundation revenue goals with cost of fundraising consistent with industry best practices."

On October 10, Moss Adams presented the Auditor's report to the Foundation Finance Committee. The Audit result was "unqualified opinion," which is the best possible. In particular they praised our "significant accounting policies."

Efforts to raise revenue include major donor solicitations, planned giving, signature and special events, grants, and annual giving. Many of the programs that are designed to activate a culture of philanthropy also raise revenue for the Foundation and have been discussed above, including employee giving, Circle of Caring, and planned giving.

- **Signature Events**
  - **Sapphire Soirée –** The gala committee is meeting monthly to plan every detail of the Foundation's signature event, a benefit for the Cancer Center that will be held at the Menlo Circus Club in Atherton on April 27. Sponsorship and program book advertising efforts are moving forward. The Foundation is collaborating with the marketing department on the publicity plan.

- **Special Events**
  - **Norma's Literary Luncheon** – Even though invitations have not yet been mailed, all but three tables have already been committed for the February 7 fundraiser on behalf of the Women's Hospital. Because the event is being underwritten by a generous gift from the Melchor family, all ticket sales and sponsorships will directly benefit the hospital.

- **Annual Giving**
  - The Foundation is preparing an end of year appeal letter to send to all donors who have given in the range of $250-$4,999 within the past three years (but have not made a recent gift) and major donors who gave in 2011 but not yet in 2012. The letter will be mailed the first week of December.

- **Major Giving**
  - **Dedicating the Norma Melchor Heart and Vascular Institute** – In gratitude for the Melchor family's multi-million dollar gift commitment to create an endowment that supports the lifesaving clinical programs and research of the Heart and Vascular Institute, El Camino Hospital will formally rededicate it as the Norma Melchor Heart and Vascular Institute. The Foundation is organizing the ceremony and a celebration reception, which will be held on Thursday, December 20 from 5:00 – 7:00 p.m. in the hospital's conference center. A formal invitation will be mailed the first week of December. The entire extended Melchor family is expected to attend along with family friends and Foundation and hospital leadership and supporters. The Foundation is working with the marketing department to coordinate a publicity and communications

plan about the gift including media advisories, press releases and internal publications.

- **Planned Giving**
  - In April we reported the Foundation received notification that it was the beneficiary of a bequest of property with an estimated value of $2 million. The property was recently sold for $400,000 more than expected and the Foundation will soon receive the proceeds, which are directed to be used “where the need is greatest.”

Medical Staff Board Open Session 12-12-12.pdf

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
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Board of Directors Open Session (December 12, 2012)

To: El Camino Hospital Board of Directors

From: Vivien D'Andrea, Chief of Staff

Date: November 29, 2012

RE: REPORT FROM THE MEDICAL STAFF EXECUTIVE COMMITTEE

This report is based upon the Medical Staff Executive Committee meeting of **December 15, 2012**.
Approval is requested for the following items:

Patient Care Policy/Procedures (Summaries pp. 7-14)

- **New Policies – Emergency Management**
  - Emergency Conditions & Basic Staff Response (pp. 15-16)
  - Employee, Physician, & Volunteers Recall, Notification & Reporting Plan (pp. 17-18)
  - Volunteer Credentialing Policy for Use in Major Disaster (pp. 19-22)
  - Physicians Response Role in Major Disaster (p. 23) – Physicians should report to the Medical Staff Office unless destroyed and then they should report to the labor pool. Revision to clarify what a labor pool is. This would be useful to new physicians – add policy to the New Physician Orientation handouts.
- **Infection Control Policies with major revisions (Summaries pp. 24-29)**
  - Airborne Precautions (pp. 30-33)
  - TB Exposure Control Plan (pp. 34-56)
  - Infection Control and Exposure Plan (pp. 57-75)

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
	New Policies						
EM 1.03.01	EMERGENCY CONDITIONS & BASIC STAFF RESPONSE		8/2012				Policies are not new to the organization, however have never been reviewed by medical staff and to meet TJC requirements – need MS review and approval
EM 01.42	Employee, Physician, & Volunteers Recall, Notification & Reporting Plan		8/2012				Policies are not new to the organization, however have never been reviewed by medical staff and to meet TJC requirements – need MS review and approval
EM 01.43	Volunteer Credentialing Policy for Use in Major Disaster		8/2012				Policies are not new to the organization, however have never been reviewed by medical staff and to meet TJC requirements – need MS review and approval
EM 01.44	Physician Response Role in Major Disaster		8/2012				
	Major Revisions						
	NONE						
	Minor Revisions						
HIM 7.10	Physician Suspension Process (includes ECH Administrative Policy)						Added language: The suspension process is consists of a two-week cycle with specific tasks occurring during weeks one and two with the purpose of reminding practitioners to complete records within 14 days after patient discharge to remain in comply with State and Federal regulations, Hospital policy and to prevent suspension.

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
17.02	Abuse, Elder, or Dependent Adult (including hospitalized patient		6/12				Added For incidents of suspected abuse, assault or inappropriate touching occurred while the **patient is hospitalized** the following actions should be taken (a). If a staff member witnesses or is informed by the patient thatan assault has occurred they are required to IMMEDIATELY contact the Department Manager, Risk Manager, or Hospital Supervisor. (b). If the staff member is currently assigned to patient care, the manager or hospital supervisor will immediately remove the staff member who is suspected of committing the abuse, assault, or inappropriate touching from his/her direct patient care assignment and reassign it to the charge nurse, break nurse, or lead therapist. If the staff member does not have a patient care assignment (such as housekeeper or transporter) the manager or hospital supervisor will immediately remove the staff member to a non-patient care area (c). The staff member is to remain on site, until released by the manager or house supervisor. (d) The manager or hospital supervisor will IMMEDIATELY contact the Mountain View Police Department (650-903-6395) or Los Gatos Police Department (408-354-8600) to report the event and request an officer come to interview the patient as soon as possible (e). The Police Officer will interview the patient and will confirm or deny the allegations of abuse. (f). If the abuse cannot be confirmed, the employee can resume care of their patients with the exception of the patient who made the allegation. The patient that made the allegation of abuse will be assigned to another nurse. (g). If the abuse IS confirmed or further investigation is required, the employee will be immediately suspended and actions will be taken by following HR policy 07.01 Discipline and Discharge.

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
21.00	PROCEDURE: Acetaminophen, Administration of, to an adult in the ED		2012				Changed dosage from 1000 mg to 650 mg if last dose was given greater than 4 hours, for fever > 101
21.02	Procedure: Acetaminophen, Administration Of To Pediatric Patients In The Emergency Department	4/95	2012				Added competency section 1. Registered Nurses in the Emergency Department will utilize Standardized procedure. 2. Periodic educational opportunities will be provided for all E staff during advertised times or during competency classes o Pneumonia. Standardized Policies will be reviewed each ye all RNs. 3. The RN preceptor will validate the new nurse's initial compe during orientation. The competency will be re-verified on a basis by the nurse manager through feedback from colleague physicians, and chart review, or during competency classes. 1. Follow-Up: Areas requiring increased proficiency as determined by evaluation will be reevaluated by the manager at appropriate intervals until acceptable skill level is achieved
21.03	Procedure: Admission Of Outpatients To Labor & Delivery, Management Of		2012				Changed from 20 weeks to 16 weeks gestation
21.04	Procedure: Anaphylaxis, Patient Management, Adult		2012				Added **EPIPEN 0.3 mg. IM, inject into the high thigh,MV Only or epinephrine 0.3 mg. subcutaneous upper arm.**

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
21.06 f	Procedure: Cardiopulmonary Resuscitation (Cpr), Emergency Neonatal – Mountain View		2012				Added **Targeted preductal SPO_2 after birth per NRP Protocol 2012**
21.06 g	Procedure: Cardiopulmonary Resuscitation (Cpr), Code White Response Emergency Pediatric Team (Mountain View Campus)		2012				Added 1. Code White Response, Pediatric Team refers to all areas serving pediatric patients with the exception of the Emergency Department and the Mother Baby Unit who respond to their own Code White situations.
21.13	Procedure: Peripherally Inserted Central Catheter (Picc) Insertion, Except The		2012				Updated to add more specifics to perfroming the procedure
21.14	Procedure: Peripherally Inserted Central Catheter (Picc) Insertion In The Neonate		2012				Deleted from indications for use **Premature infants weighing < 1500gm, GI disorders, cardiac disorders,**
21.17	Procedure: Hypovolemic And Hemorrhagic Shock, Patient With Management, Adult		2012				Added language to contact MD for orders for blood; place patient on cardiac mnitor,

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
21.18	Procedure: Tetanus Prophylaxis In The Emergency Department		2012				Added language The Advisory Committee on Immunization Practices (ACIP) recommends a single Tdap dose for persons aged 11 through18 years who have completed the recommended childhood diphtheria, tetanus toxoids pertussis/diphtheria, and tetanus toxoids and acellular pertussis (DTaP) vaccination series. DTP vaccines are no longer given by pediatricians in the US. For adults aged 10 through 64 years there are two Tdap vaccines available in the United States. Boostrix (GlaxoSmithKline Biologicals, Rixensart, Belgium) is licensed for use in persons aged 10 through 64 years, and Adacel (Sanofi Pasteur, Toronto, Canada) is licensed for use in persons aged 11 through 64 years. Both Tdap products are licensed for use at an interval of at least 5 years between the tetanus and diphtheria toxoids (Td) and Tdap dose. The prevention of Pertussis has become an imperative component of tetanus prophylaxis, because it is a highly contagious respiratory tract infection. Although most children are protected against pertussis by vaccination, immunity wanes over time and leaves adults and a adolescents unprotected. In U.S, the estimated number of pertussis cases among adults 19-64 years of age is 600,000 per year. Added competencies
21.19	Procedure: Labor & Delivery: Ultrasound, Limited Obstetrical, By RN (Mountain View Only)		2012				Added language RNs who have undergone 16 hours of didactic instructions in ultrasound physics and instrumentation including sound wave frequencies, transducers, resolution, and imaging techniques in addition to a minimum of eight (8) procedures under direct supervision of a qualified preceptor*, with an MD's order,
21.20	Procedure: Pneumonia, Adult Patient Management In The Emergency Department		2012				Added Request order for blood gases for patient with decrease or change level of consciousness, severe respiratory distress, or history of Chronic Obstructive Pulmonary Disease (COPD)

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
21.12	Procedure: Stroke / Transient Ischemic Attack (Tia), Patient Management In Emergency Department		2012				Added When t-PA is to be administered more than 3 hours after the onset of stroke symptoms, a consent is required.
21.24	Procedure: Nitroglycerin, Sublingual, To An Adult In The Cardiopulmonary Wellness Center (Cpwc) Department		2012				Added **Precautions and complications: *Do NOT* administer nitroglycerin:** (1) In presence of systolic blood pressure less than 90 mmHg systolic or greater than or equal to 30 mmHg below baseline (2) In presence of severe bradycardia less than 50 beats per minutes (3) Do not administer if patient has used a Phosphodiesterase Enzyme (PDE) inhibitors for erectile dysfunction Sildenafil (Viagra ™) within 24 hours Tadalafil (Cialis ™) within 48 hours and Vardenafil (Levitra™) within 24 hours. **May cause severe refractory hypotension. Note:** Patients with other medical conditions such Pulmonary Hypertension may be taking PDE inhibitors.
21.35	Standardized Procedure: Ibuprofen, Administration Of, To Adult Patients In The Emergency Department		2012				Added Research indicates the use of a multimodal approach to pain management is a best practice method. The use of nonsteroidal anti-inflammatory drugs (NSAIDS) in conjunction with opioids can assist in better pain management with less adverse effect. Consideration should be given to patients for optimal pain control
	Scheduled Policy Review – No Changes						
21.06e	Bls & Acls Cardiopulmonary Resuscitation (Cpr) Code Blue, Adult		**2012**				

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
21.06LG	PROCEDURE: CARDIOPULMONARY Resuscitation (CPR), EMERGENCY NEONATAL (LOS GATOS)		2012				
21.12	Standardized Procedures For Nurse Practitioners		2012				
21.15	Procedure: Symptomatic Premature Ventricular Contractions (Pvcs) : , Patient Management		2012				
21.16	Procedure: Seizures, Patient Management, Adult		2012				
21.25	Procedure: Oxygen Administration		2012				
21.26	Procedure: Admission of Normal Newborn to Mother Baby		2012				
21.29	Standardized Procedure: Mrsa Nares Screening Of Patients		2012				
21.31	Human Immunodeficiency Virus (Hiv) Positive Patient In Labor & Delivery, Treatment Of		2012				

Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
21.32	Procedure: Chest Pain Or Anginal Equivalent Symptoms, Management Of The Adult Patient With: Mountain View Campus Only (The Following Areas Are NOT Covered By This Standardized Procedure. Call 911 For Emergency Care: Melchor Pavilion; Park Pavilion, PPI, Oak Pavilion Dialysis; Willow Pavilion, Radiation Oncology, And Cyberknife)		2012				
21.34	Procedure: Diagnostic Testing For Pre-Anesthesia Work-Up		2012				
21.36	Standardized Procedure: Behavioral Health Disorders, Patient Management, In Emergency Department - Mountain View		2012				
21.39	Standardized Procedure: Cardiac Rehab Screening Of Patients		2012				
EM 1.03.01	EMERGENCY CONDITIONS & BASIC STAFF RESPONSE		2012				
EM 01.42	Employee, Physician, & Volunteers Recall, Notification & Reporting Plan		2012				

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El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

1.03.1 EMERGENCY CONDITIONS & BASIC STAFF RESPONSE

Mountain View and Los Gatos Campuses - Dial "55" to report emergencies
Off Campus - Dial 9-911.

(See Emergency Management Reference Guide, Safety Program Manual and unit policies for more information.)

Problem	Description	Initial Response	Secondary Response	Follow-Up
Bomb Threat ***"CODE YELLOW"***	Notification of a bomb on hospital property, usually by an outside caller.	• When receiving the call, obtain as much information as possible. Complete the Bomb Threat Checklist in the Code Yellow section of the Red Safety Binder.	• Report all information to your supervisor.	When Code Yellow is paged, discreetly begin a visual search of your area for a suspicious item. **Do not touch it if found.** Report anything suspicious.
Large Earthquake **"CODE TRIAGE"**	Significant shaking of the building causing internal and or external damage.	• **Duck, Cover & Hold.** Protect self by taking a step or two to improve safety. Get under a table, move away from objects likely to fall or break, protect head.	• Assess yourself for injury, survey the damage near you, take appropriate defensive action. • Follow your department specific Code Triage response plan.	Report problems to department director and or supervisor.
Evacuation – Immediate Area ***Situation A, B or C***	Situation A – Evacuate immediate area. Situation B – Evacuate extended area or floor (horizontal) Situation B – Evacuation building (vertical and horizontal)	• Evacuate an area when remaining may be hazardous to life, health, or safety. • Notify all in area of the need to evacuate. • Evacuate ambulatory, wheelchair, and then bed ridden. • Take records if safety permits. • Listen to announcement over Fire Alarm System as to the evacuation assembly location	• Report to designated assembly area and account for all who were in area that was evacuated. • Follow your department specific Code Triage response plan.	Report evacuation status to supervisor. Identify any personnel unaccounted for.
Fire ***"CODE RED"***	Fire, smoke or smell of something burning.	Remove those in immediate danger (if safe to do so). Alarm and Dial 55. Confine the fire (close doors and windows). Extinguish fire ONLY if safe to do so.	Use extinguisher to put out the fire: Pull the pin. Aim the nozzle. Squeeze the handle. Sweep by spraying at the base of the fire.	Evacuate to designated area, if appropriate, and report evacuation status to a supervisor. Identify any unaccounted staff.
Hazardous Materials Spill or Release **Radioactive Incident** ***"CODE ORANGE"***	Any hazardous materials spill, release or radioactive incident, which may present a hazard to people, the environment, or the effects of the spill are unknown.	• Isolate the spill area and evacuate if doing so does not spread the contamination. • Deny entry to others. • Notify your supervisor. • Obtain MSDS (if possible) for Code Orange Response Team.	• Seek / coordinate medical treatment of decontaminated victim with ED (if not an employee) or Employee Health Services (if an employee). • If incident is Radioactive, coordinate response with Nuclear Medicine.	Complete incident report.
Person with a weapon or hostage situation	A person is reported in building carrying a weapon. and/or	• Clear the area to avoid others from becoming a hostage or victim. • Dial 55 and have a Code Silver paged. The Call Center will dial	• Report all pertinent information to a supervisor and others in charge of response. • Wait for the police.	Complete incident report.

1.03.1

SYSTEMS FAILURE & BASIC STAFF RESPONSE

(See department policies and procedures for additional details)

Failure of:	What to Expect:	Who to Contact:	Responsibility of User:
Computer Systems	System down.	Information Systems.	Use backup manual/paper systems.
Electrical Power Failure - Emergency Generators Work	Many lights are out. Only RED outlets or those labeled "EMERGENCY" will work.	Facilities Engineering	Ensure that life support systems are on emergency power (red outlets). Ventilate patients by hand as necessary, complete cases in progress ASAP. Re-set ventilators as needed. Use flashlights.
Electrical Power Failure - Total	Failure of all electrical systems.	Facilities Engineering & Respiratory Therapy.	Use flashlights & lanterns, hand ventilate patients, manually regulate IV's, don't start new cases.
Elevators Out of Service	All vertical movement will be by stairwells.	Facilities Engineering & all directors/managers	Review fire & evacuation plans, establish services on 1st floor, use carry teams to move critical patients and equipment to other floors.
Elevator stopped between floors	Elevator alarm bell sounding.	Facilities Engineering & Security	Keep verbal contact with persons still in elevator and let them know help is on the way.
Fire Alarm System	No fire alarms or sprinklers.	Facilities Engineering	Institute Fire Watch; minimize fire hazards, use phone or runners to report fire.
Medical Gases	Gas Alarms, no O_2 or medical air or Nitrous Oxide (NO_2).	Facilities Engineering, Respiratory Therapy.	Hand-ventilate patients: transfer patients if necessary, use portable O_2 and other gasses; call Facilities for additional portable cylinders.
Natural Gas; Failure or Leak	Odor, no flames on burners, etc.	Facilities Engineering	Open windows to ventilate, turn off gas equipment, don't use any spark producing devices, electric motors, switches, etc.
Nurse Call System	No patient contact.	Facilities Engineering, Pt. Care directors/managers	Use bedside patient telephone, if available; move patients; use bells, send a rover to check patients.
Patient Care Equipment/Systems	Equipment/system does not function properly.	Clinical Engineering	Remove equipment from service. Replace and tag defective equipment.
Sewer Stoppage	Drains backing up.	Facilities Engineering and Infection Control	Do not flush toilets and do not use water. Set up red bag toilets/commodes. Obtain waterless hand wash supplies form General Stores.
Telephones	No phone service.	Information Systems, Telecommunications, directors/managers	Use paging, Vocera, pay phones, back up phones and runners as needed.
Ventilation	No ventilation; no heating or cooling	Facilities Engineering	Open windows, if possible, (institute Fire Watch) or obtain blankets if needed; restrict use of odorous/ hazardous materials.
Water	Sinks and toilets inoperative.	Facilities Engineering, Infection Control and Central Services.	Institute Fire Watch; conserve water; use bottled water for drinking, be sure to turn off water in sinks, use RED bags in toilet, and use waterless hand wash supplies.
Water Non-Potable	Tap water unsafe to drink.	Facilities Engineering, Infection Control, Food Service and all directors/managers	Place Non-potable Water - Do Not Drink signs at all drinking fountains and washbasins. Label ice machines "Not for Human Consumption". Bottled water will be acquired.

Phone Numbers: Mountain View

Facilities	7085
Clinical Engineering	7314
Central Services	7090
Dietetic/Nutrition Services /7112	7188
Information Systems	8000/7273
Respiratory Services	7075
Safety Officer	7569
Security	7614
Telecommunications	7999/202

Phone Numbers: Los Gatos

Facilities	4190
Clinical Engineering	4174
Central Services	4108
Dietetic/Nutrition Services	4026
Information Systems	8000
Respiratory Services	4162
Safety Officer	7569
Security	3887
Telecommunications	3838

El Camino Hospital
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EL CAMINO HOSPITAL
EMERGENCY MANAGEMENT POLICIES AND PROCEDURES

01.42 Employee, Physician, & Volunteers Recall, Notification & Reporting Plan

A. Coverage:

El Camino Hospital employees, medical staff, and volunteers.

B. Reviewed/Revised:

12/97, 6/98, 02/01, 11/03, 07/06, 06/09, 08/12

C. Policy Summary:

In the event of a disaster which requires additional off-duty staff be called in to assist, the following procedures shall apply.

D. Policy and Procedure:

1. Purpose
   a. To ensure there is adequate staff to care for patients during an emergency/disaster event.
2. Procedure
   a. In the event phone services are not available, employees, medical staff and auxiliary staff can tune into KCBS 740 AM to hear the staffing needs of El Camino Hospital.
   b. Hospital Employees
      1) Each department shall maintain a disaster recall list that identifies staff by name, title and home phone number. Departments will be responsible for notifying the department director and staff that may be needed.
      2) In patient care departments, staff should report to their regular work area. The Personnel Tracking Manager may reassign extra staff.
      3) In non-patient care departments, staff report to the Labor Pool.
      4) Each department shall report the number of staff available for reassignment to the Labor Pool.
   c. Medical Staff
      1) Responding physicians are to report to the Medical Staff Office (or in the event the Medical Staff Office is non-operational, physicians will report to the Labor Pool) for credentialing and to receive assignments.
      2) The Labor Pool & Credentialing Unit Leader will respond to requests for numbers and specialties of physicians.

d. El Camino Hospital Volunteers

1) The Auxiliary President(s) will be contacted by the Support Branch Director or their designee and will be requested to initiate their disaster recall.

2) Volunteers will report to the Labor Pool and sign in for assignment.

e. Other Volunteers

1) Report to Labor Pool, sign-in, receive nametag and assignment.

E. Approvals:

Emergency Management Work Group 09/2012

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
EMERGENCY MANAGEMENT POLICIES AND PROCEDURES

01.43 Volunteer Credentialing Policy for Use in Major Disaster

A. Coverage:

El Camino Hospital employees, medical staff, allied health practitioners and volunteers.

B. Reviewed/Revised:

12/97, 6/98, 02/01, 11/03, 07/06, 03/07, 06/09, 08/12

C. Policy Summary:

1. In the event a State of Emergency has been declared by the Director of the Emergency Medical Services Authority, physician and allied health practitioner volunteers from another state may be authorized to work at El Camino Hospital.
2. If a State of Emergency does not exist, out-of-state licensed health care practitioners who volunteer may assist with non-licensed activities.
3. In the event of a disaster, which overwhelms the response capabilities of El Camino Hospital care practitioners, the following procedure will be followed to ensure the credentials of the volunteer professional staff have been verified.

D. Policy and Procedure:

1. Purpose
   a. To check and document the licensure of professional personnel volunteering at El Camino Hospital.
2. Procedure
   a. All volunteer RN, LVN, CNA, Respiratory Therapy, and Radiology Tech staff reports to the Labor Pool and present the following:
      1) Photo ID
      2) Current professional license
      3) Specialty Certification
   b. All physician and allied health practitioner volunteers report to the Medical Staff Office. In the event the Medical Staff Office is non-operational, physicians will report to the Labor Pool. Credentialing of practitioners during disaster events will follow the Medical Staff Disaster Policy 6.6 -6.7. See attached document below.
   c. This information will be collected by Labor Pool & Credentialing Unit Leader using form "HICS-253 - Volunteer Staff Registration Form".

1) A copy of this form will be sent to Safety and Security Officer.
2) All volunteers will wear a temporary El Camino Hospital nametag while working in the facility.

Approvals:

Emergency Management Work Group 09/2012

ATTACHMENT 1:

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Purpose:

To ensure that physicians and allied health practitioners (hereinafter referred to as "practitioner"), who do not possess medical staff or practice privileges, may be accepted to work at El Camino Hospital during a disaster, when Code Triage has been activated (Emergency Management Plan located in Hospital Safety Manual).

These disaster privileges are granted only when the following two conditions are present:

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

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 CEO (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.

El Camino Hospital
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EL CAMINO HOSPITAL
EMERGENCY MANAGEMENT POLICIES AND PROCEDURES

01.44 Physician Response Role in Major Disaster

A. Coverage:

El Camino Hospital employees, medical staff, and volunteers.

B. Reviewed/Revised:

12/97, 6/98, 02/01, 11/03, 07/06, 06/09, 08/12

C. Policy Summary:

In the event of a disaster that overwhelms the capabilities of the staff of the hospital, a Code Triage will be called, activating HICS (Hospital Incident Command System). Upon implementation of HICS, a staff member of the Medical Staff Office will assume the role Medical Staff Specialist.

Refer to Policy 6.2-2 "Privileging Licensed Independent Practioners during Disaster Events," located in the Medical Staff Policy and Procedure Manual, for more specific information.

D. Policy and Procedure:

1. Purpose
   a. To ensure the safety and continued care of patients.
2. Procedure
   a. All physicians/volunteers report to Medical Staff Office. In the event the Medical Staff Office is non-operational, physicians will report to the Labor Pool.
   b. The Medical Staff Specialist will be responsible for calling in physicians for emergency patients.
   c. Keep a record of physicians who volunteer and their location.
   d. Issue temporary privileges to physicians from other areas that volunteer. Temporary privileges may be issued after a State of Emergency has been declared.

E. Approvals:

Emergency Management Work Group 09/2012

INFECTION CONTROL Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
	New Policies						
	Major Revisions						
5.02	Airborne Precautions	1/12	10/12				1. HEPA filter is not to be substituted for an appropriate negative pressure room is one is available in the hospital. Only in event that the hospital is devoid of any available negative pressure rooms, a private room with a HEPA filter can be used temporarily. 2. Nurse to contact facilities before patient is placed in negative pressure room. Facilities will check the room for negative pressure via a puffer test or other acceptable measure. 3. Facilities will perform daily puffer test and document the results accordingly. 4. PAPR's shall be worn by all persons when entering the room.
4.00	TB Exposure Control Plan	6/11	10/12				1. Discontinuation of isolation: Diagnosis of TB no longer suspected: (All criteria must be met) 1. Patient has 3 consecutive negative AFB sputum smears, collected in 8-24 hour intervals (at least one being an early morning specimen). Specimen must be induced if necessary to produce an adequate specimen and 2. Patient is NOT on TB treatment regimen Criteria for Patients to Be Considered Noninfectious (must meet all three criteria) 1. Patient has 3 consecutive negative AFB sputum smears, collected in 8-24 hour intervals (at least one being an early morning specimen). Specimen must be induced if necessary to produce an adequate specimen. 2. Patient symptoms have improved clinically (Example: they are coughing less and they no longer have a fever). 3. Patient has completed 2 weeks or longer of TB medication treatment.

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INFECTION CONTROL Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
1.04	Infection Control and Prevention Plan	4/11	10/12				Changes based on Evaluation of the Infection Prevention and Control Plan FY 2012 Annual Report and the outcome data from the IC Risk Assessment from July 2011 – June 2012. **D. Policy and Procedure.** (2) Objectives: (page 1-3) b. Reduce hospital onset Clostridium difficile infection rate to **<8.20 (MV); < 7.30 (LG)**/ 10,000 patient days. c. Reduce hospital onset MRSA infection rate to **< 1.7 (MV); 0.67 (LG)**/ 10,000 patient days. e. Reduce hospital onset MDRGNR infection rate to **<1.51 (MV); <0.66 (LG).** l. Maintain Oak Dialysis CLABSI rate at **< 0.40**/ 100 patient months. m. Reduce Evergreen Dialysis CLABSI rate to **< 2.5** / 100 patient months. n. Maintain Rosegarden Dialysis CLABSI rate at, **2.06**/ 100 patient months. r. Reduce BBP exposure rate to **< 1.72 (MV and LG).** s. Maintain Urinary Tract Infection rate at **< 0.25 (MV) and 0.00 (LG).** **Surgical Site Infection Surveillance** **a. Specific SSI surveillance in accordance with CDPH Senate Bill 1058 requirements shall be monitored and reported to NHSN on a monthly basis. Surveillance activities include: daily census review of admission diagnosis and post discharge surveillance letter to surgeons.** **b. Targeted SSI surveillance selected by IC Committee based on annual Risk Assessment is monitored and reported quarterly to the IC Committee. (same surveillance activities as above).** **Environmental Conditions** **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 instruction for use.** **d.** Endoscopes shall be monitored each cycle by Steris/Medivators quality indicators **according to current best practice guidelines and manufacturer's recommended instructions for use.** **e.** All probes and TEE scopes shall be monitored each use by Cidex OPA quality indicators **according to current best practice guidelines and manufacturer's recommended instructions for use.** **f.** Water used to prepare dialysis fluid shall be tested **according to current AAMI standards.**

INFECTION CONTROL Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
1.04	Infection Control and Prevention Plan (continued)						IC Plan Grid FY 13 New Events: Sterile Processing: Rank 7; Goal: Prevent procedure deficiencies Operating Room: Rank 6; Goal: Prevent procedure deficiencies Endoscopy: Rank 4; Goal: Prevent procedure deficiencies
	Minor Revisions						
8.10	Infection Control Procedures for Ancillary Departments: EEG/EKG	4/07	9/12				The patient cable , lead wires and electrodes are cleaned with a "hospital approved germicide" (delete Sani-cloth)
6.01	Patient Care Equipment Cleaning	8/09	9/12				If equipment needs to be used before it can be sent to Central Processing, nursing shall clean item with Sani cloth **changed to "hospital approved germicide."** • **Frequency of Cleaning** for the following changed from Weekly to Between patients: • BP Cuffs (Cardiac Rehab) • Scales, Nursery • Neuro/geri chairs • Patient Lifts Equipment • Walkers **Frequency of Cleaning** for Gurney/Wheelchairs; Ice machine added **"when visibly soiled"** **All patient care equipment will be cleaned and disinfected according to the equipment's recommended "Manufacturer's Instructions for Use" (IFU) with a hospital approved germicide.**
	Scheduled Policy Review – No Changes						
3.08a	Appendix A: Employees: What to do if You Have Exposure to Blood or Body Fluids	12/08	9/12				
3.01	Bloodborne Pathogen Exposure Control Plan	12/08	9/12				

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INFECTION CONTROL Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
3.01a	Appendix A: Job Classifications with Reasonably Anticipated Risk of Exposure to Blood or Body Fluids (BBF) (part of 3.01)	12/08	9/12				
3.01b	Appendix B: Tasks and Procedures Involving Potential Occupational Exposure for Appendix A ..... Job Classification Personnel (part of 3.01)	12/08	9/12				
3.01c	Appendix C: Sharps Injury Log	12/08	9/12				
3.01d	Appendix D: Definitions (part of 3.01)	12/08	9/12				
Protocol	*Clostridium difficile*, Preventing Transmission & Infection of (Protocol)	12/10	9/12				
5.12	Cohorting Isolation Patients	12/10	9/12				
8.88	Department of Respiratory Medicine Guidelines for Protection of Self	12/06	9/12				
2.01	Employee Health Service: Infection Control Program	3/09	9/12				
2.03	Guidelines for Immunization Administration (EHS)	3/09	9/12				
2.03a	Guidelines for Meningococcal Vaccine Administration	3/09	9/12				
3.13	Guidelines for Physicians Exposed to Blood or Body Fluids	12/10	9/12				
3.04	Handling of Sharps	3/10	9/12				

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INFECTION CONTROL Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
3.06	Hepatitis B Vaccine Program	3/09	9/12				
7.01	Infection Control for Auxiliary	12/06	9/12				
2.06	Infection Control for Pregnant Healthcare Workers	3/09	9/12				
2.06a	Table: Information on Communicable Diseases for Pregnant Health Care Workers (Part of 2.06)	3/09	9/12				
2.06b	Table: Pregnant Health Care Personnel: Pertinent Facts to Guide Management of Occupational ..... Exposures to Infectious Agents (Part of 2.06)	3/09	9/12				
7.17	Infection Control and Sanitary Food Handling	7/06	9/12				
7.24	Infection Control for Transportation	12/06	9/12				
8.08	Infection Control Practices for Behavioral Health Services	5/07	9/12				
2.04c	Influenza Exposure Guidelines	3/09	9/12				
2.04	Management of Exposure to Infectious Disease	3/09	9/12				
3.09	Management of Medical Waste	3/09	9/12				
8.55a	Management of Patients with Creutzfeldt-Jakob Disease	6/07	9/12				
8.203	Management of Scabies Outbreak	5/07	9/12				

INFECTION CONTROL Summary of Policies and Policy Changes

Policy Number	Policy Name	Original Date	Review Date	Revision Date	New Policy Date	Delete Policy Date	Summary of Policy or Changes
1.05	Outbreak Investigation /	3/10	9/12				
6.35	Room Cleaning - Occupied Patient	8/09	9/12				
6.36	Room Cleaning - Patient Discharge	4/09	9/12				
6.37	Room Cleaning - Unoccupied Patient	4/09	9/12				
2.04a	Table: Basic Information Regarding Agents that Cause Most Nosocomial Exposures	3/09	9/12				
6.39	Transportation and Handling of Soiled Linen	1/09	9/12				

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
INFECTION CONTROL DEPARTMENT POLICIES AND PROCEDURES

5.02 AIRBORNE PRECAUTIONS

A. Coverage:

El Camino Hospital staff

B. Reviewed/Revised:

10/12, 1/12 8/07 1/01
7/09 12/06 1/98
3/09 4/04

C. Policy Summary:

In addition to standard precautions, airborne precautions shall be used for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small particles, 5 micrometers or less in size, of evaporated droplets that may stay suspended in the air for long periods of time) or dust particles containing the infectious agent.

D. Policy and Procedure:

1. Purpose

a. To reduce the risk of airborne transmission of epidemiologically important pathogens within the hospital.

2. Procedure

a. PATIENT PLACEMENT

(1) Contact Infection Control (IC) to notify them that a patient has been placed in Airborne Isolation. If patient is in airborne isolation for TB, contact IC before removing patient from isolation (guidelines for discontinuation of isolation are listed in the TB Exposure Control Plan).

(2) Patient shall be placed in a room that has monitored negative air pressure room in relation to the surrounding areas. A

HEPA filter is not to be substituted for an appropriate negative pressure room if one is available in the hospital.

(3) Only in the event that the hospital is devoid of any available negative pressure rooms, a private room with a HEPA filter can be used temporarily. A HEPA filtration unit can be used to increase the number of air exchanges per hour. HEPA units are ordered from Central Services (Mountain View) and ordered from Facilities (Los Gatos). A The HEPA filter must be checked daily by nursing personnel an attached diagram on the unit indicates the placement of the unit in relation to the patient's head.

(4) Nurse to contact facilities before patient is placed in negative pressure room. Facilities will check the room for negative pressure via a puffer test or other acceptable measure. (In Mountain View, A facilities staff member is available 24 hours/day at ext. 7085).Facilities in Los Gatos is not staffed 24 hours, and after regular staffed hours for Facilities, the Nurse will check room for negative pressure via a puffer test or other acceptable measure and document. The Nurse will contact facilities to perform daily check and document accordingly.

(5) Nurse to turn key to the "Infectious Isolation, Negative Pressure" position. This will alert facilities to monitor the room on a daily basis for verification of negative pressure; it also activates the "alarm" mechanism. (Mountain View)

(6) Facilities will perform daily puffer tests and document the results accordingly. (NO longer nursing responsibility in Mountain View).

(7) Respiratory protection PAPR (Positive Air Purifying Respirator) shall be worn by all persons when entering the room.

(8) The door shall be closed at all times, and the patient shall remain in the room.

(9) When a private room is not available, the patient shall be placed in a room with a patient who has active infection with the same microorganism but with no other infection.

b. RESPIRATORY PROTECTION

(1) Respiratory protection PAPR's shall be worn by all persons when entering the room of patient with suspected or known pulmonary tuberculosis.

(2) Susceptible persons shall not enter the room of patients with rubeola (measles) or varicella (chickenpox) if other immune care givers are available. If not immune, respiratory protection shall be worn.

(3) Persons immune to measles or chickenpox, including pregnant women, need not wear respiratory protection.

c. PATIENT TRANSPORT

(1) The movement and transport of the patient shall be limited to essential purposes only.

(2) If transport of the patient from the room is necessary, a surgical mask shall be placed on the patient to minimize dispersal of droplet nuclei.

(3) Personnel in the area to which the patient is taken shall be notified of the impending arrival of the patient and of the precautions to be used to reduce the risk of transmission of infectious microorganisms.

(4) Patient must be accompanied by staff when leaving the unit.

(5) Patient shall be informed of ways by which they can assist in preventing the transmission of their infectious microorganisms to others.

E. References:

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation

Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007

F. Approvals:

Infection Control Committee:	4/21/04, 12/06, 9/07, 4/14/09, 7/31/09, 1/27/12, 10/12
Medical Executive Committee:	5/6/04, 4/26/07, 10/25/07, 5/28/09, 8/27/09, 2/23/12
Board of Directors:	6/2/04, 5/9/07, 11/14/07, 6/10/09, 9/9/09, 3/14/12

El Camino Hospital
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EL CAMINO HOSPITAL
INFECTION CONTROL DEPARTMENT POLICIES AND PROCEDURES

4.00 TB EXPOSURE CONTROL PLAN

A. Coverage:

El Camino Hospital staff

B. Reviewed/Revised:

10/12, 6/11, 7/09, 4/09, 1/07, 7/03, 10/02, 6/02, 5/01, 1/01, 1/99, 1/98, 1/97, 2/96, 4/93

C. Policy Summary:

The risk for transmission of *Mycobacterium tuberculosis* within El Camino Hospital shall be minimized through the use of administrative, engineering, and respiratory control measures.

D. Policy and Procedure:

1. PURPOSE

a. To ensure early identification, diagnostic evaluation, isolation, and effective treatment of patients with suspected or confirmed infectious TB.

b. To provide prompt triage for and appropriate management of patients with suspected or confirmed infectious TB in all outpatient settings.

c. To promptly initiate and maintain TB isolation for patients with suspected or confirmed infectious TB who have been admitted to inpatient setting.

d. To effectively plan for the discharge of patients with infectious TB.

e. To maintain and evaluate ventilation and other engineering controls to reduce the potential for airborne exposure to *M. tuberculosis*.

f. To develop, implement, maintain, and evaluate a respiratory protection program.

g. To provide training and education for HCWs about TB and effective methods for preventing transmission of tuberculosis.

h. To routinely screen HCWs for active and latent TB infection.

i. To screen new employees for active and latent TB infection.

2. PROCEDURE

a. Assignment of Responsibility

(1) The Infection Control Committee shall be responsible for the implementation and enforcement of the TB Exposure Control Plan.

(2) The makeup of the committee shall include persons with expertise in infection control, employee health, engineering, respiratory medicine, endoscopy, and education.

b. Periodic Risk Assessment and Update of TB Program

(1) A review of Santa Clara County's annual TB report which includes our community's TB profile shall be done each year by the Epidemiology Coordinator.

(2) A review and analysis of the number of TB patients treated in each area of the hospital and the drug susceptibility patterns of TB isolates of these patients shall be done each year by the Epidemiology Coordinator.

(3) Employee's and volunteer's conversion rates in each area of the hospital shall be analyzed, and a comparison among the areas with occupational risk and those without risk or less risk shall be done by the EHS to determine each area's risk for TB exposure.

(4) The TB Risk Assessment shall be reviewed annually and the TB Exposure Control Plan updated, if indicated, based upon all the collected data.

c. Identification, Evaluation, and Treatment of TB Patients

(1) Patients shall be promptly screened for signs and symptoms of active TB at or before time of admission to hospital or on initial encounter in Emergency Department or outpatient setting.

(2) A suspected diagnosis of tuberculosis shall be considered for any patient meeting the following criteria:
- (a) A lasting cough for >3 weeks with one or more of the following symptoms:
- (b) Bloody sputum or chest pain
- (c) Fever or night sweats
- (d) Unexplained weight loss or anorexia lasting 2 weeks or more.

(3) Risk factors that increase suspicion of tuberculosis include the following:
- (a) Foreign born persons from areas with high rate of TB (Asia, Africa, Latin & Central America)
- (b) Close contacts of infectious TB cases (i.e. family member)
- (c) HIV infection known or suspected
- (d) IV drug users
- (e) The homeless
- (f) Immunosuppressive therapy (equivalent to 15mg prednisone / day for at least one month)
- (g) Residents of long-term facilities
- (h) Correctional facility inmates
- (i) History of prolonged chronic illness, greater than or equal to 1 year; e.g., poorly controlled diabetes, chronic renal failure, silicosis.
- (j) Fibrotic lesions, thickening or calcified granulomas on chest x-rays consistent with possible previous TB.
- (k) Prior positive TB skin test.
- (l) Children < 6 years of age.
- (m) Malnutrition (<10% IBW)
- (n) History of hematologic malignancies, head/neck cancers, gastrectomy.

(4) Diagnostic measures for identifying TB in suspected patients shall include medical history, physical exam, TST skin test or Quantiferon blood test chest X-ray, microscopic exam and culture of sputum or other appropriate specimens.
- (a) Prompt laboratory results are crucial to proper treatment of the TB patient and to early initiation of infection control.
- (b) Results of AFB smears shall be available within 24 hours after specimens are received by outside laboratory.

(5) Patients with confirmed active TB or who are highly suspicious of having active TB shall be started promptly on appropriate treatment.

(6) Patients suspicious of TB must be reported immediately to the appropriate public health department if:
- (a) Smear from any anatomic site is positive for AFB.
- (b) Nucleic acid amplification test (e.g., Amplicor®, Genprobe®) result suggests *M. tuberculosis*.
- (c) Culture is positive for *M. tuberculosis*.
- (d) Patient started on 2 or more anti-TB meds for treatment of suspected or confirmed active TB.
- (e) Patient is suspected of having active TB based on clinical and/or radiological data whether or not anti-TB medication has been started.

d. Management of Patients with Possible TB in Ambulatory Settings and Emergency Departments.

(1) Employees who are the first points of contact in facilities that serve populations at risk for TB shall be trained to ask questions that will help to identify patients with signs and symptoms of TB.

(2) TB precautions in ambulatory-care setting shall include:
- (a) Placing patients known or suspected of having TB in a separate area from other patients.

(b) Giving these patients surgical masks to wear while in health care system.

(c) Giving these patients tissues and instructing them to cover their mouths and noses with the tissues while sneezing and coughing.

(d) Employees wearing N95 Respirator protection when working with patients with known or suspected TB.

(3) TB precautions shall be followed for patients who are known to have active TB and who have not completed therapy until a determination is made that they are no longer infectious.

e. Managing Inpatients Who Have Possible Infectious TB

(1) Initiation of isolation

(a) In the inpatient setting all patients with suspected or diagnosed active pulmonary or laryngeal TB must be admitted to, or transferred to an airborne isolation room that has monitored negative air pressure in relation to the surrounding areas. A HEPA filter is not to be substituted for an appropriate negative pressure room if one is available in the hospital.

(b) The final decision for Airborne Isolation Precautions is made by the attending physician in consultation with the Epidemiology Coordinator, if necessary.

(c) Notify Infection Control when patient is placed in airborne isolation.

(2) TB isolation practice

(a) Patient shall be placed in a negative pressure room with door closed at all times. Only in the event that the hospital is devoid of any available negative pressure rooms, a private room with a HEPA filter can be used temporarily. HEPA filter units are ordered from Central Services

(Mountain View) and ordered from Facilities (Los Gatos).

(b) All personnel entering room shall wear a PAPR (Positive Air Purifying Respirator).

(c) If possible, all diagnostic and treatment procedures shall be done in patient's room. If patient needs to leave room for treatment etc., a surgical mask shall be worn by the patient during transport.

(d) Patients shall be educated about the transmission of TB and the reasons for their isolation. They shall be instructed to cover their mouth and nose with tissue while coughing and sneezing even in an isolation room.

(4) TB isolation room

(a) Room shall be maintained under negative pressure at all times (Refer to engineering controls)

(5) Discontinuation of isolation

(a) Call Infection Control before removing a patient from Airborne isolation.

(b) DC isolation:
1. Diagnosis of TB is no longer suspected or
2. Patient is considered noninfectious.
(Refer to charts below for criteria).

Diagnosis of TB no longer suspected: (All criteria must be met)
1. Patient has 3 consecutive negative AFB sputum smears, collected in 8-24 hour intervals (at least one being an early morning specimen). Specimen must be induced if necessary to produce an adequate specimen **and**
2. Patient is NOT on TB treatment regimen

Criteria for Patients to Be Considered Noninfectious (must meet all three criteria)
1. Patient has 3 consecutive negative AFB sputum smears, collected in 8-24 hour intervals (at least one being an early morning specimen). Specimen must be induced if necessary to produce an adequate specimen.
2. Patient symptoms have improved clinically (Example: they are coughing less and they no longer have a fever).

3. Patient has completed 2 weeks or longer of TB medication treatment.

(6) Discharge planning

(a) Before a TB patient is discharged from the hospital, the facility and the public health department shall collaborate to ensure continuation of therapy. A TB discharge form completed by the patient's physician, care coordinator and Epidemiology Coordinator shall be faxed to the Public Health Department at least 48 hours before the patient is to be discharged for approval by the TB Control Officer at Public Health Department.

(b) Patients who are infectious at time of discharge shall only be discharged to facilities that have isolation capability or to their homes. A TB patient cannot be discharged from a facility before the discharge is approved and signed by the TB Control Officer at Santa Clara County Public Health Department.

f. Engineering Controls

(1) Health care facilities shall have a qualified engineer with expertise in ventilation.

(2) Negative pressure shall be maintained to control the direction of airflow between the room and adjacent areas, thereby preventing contaminated air from moving from the room into other areas within the facility. To be effective in reducing the concentration of droplets, TB isolation and treatment rooms shall have an airflow of >6 ACH. If feasible, this shall be increased to >12 ACH with the use of HEPA filters.

(3) The negative pressure in a room shall be monitored continuously when the room is being used for TB isolation by a differential pressure-sensing device that provides a visible and an audible warning signal when the air pressure is low, signals when pressure is in the

negative range and alarms when pressure is not negative. The room sensors shall be monitored monthly by facilities staff. Negative pressure should be verified at least once a month when the room is not being used for isolation. Nurse to contact facilities before patient is placed in negative pressure room. Facilities will check the room for negative pressure via a puffer test or other acceptable measure. (In Mountain View, A facilities staff member is available 24 hours/day at ext. 7085).Facilities in Los Gatos is not staffed 24 hours, and after regular staffed hours for Facilities, the Nurse will check room for negative pressure via a puffer test or other acceptable measure and document. The Nurse will contact facilities to perform daily check and document accordingly.

(4) Portable HEPA filtration units shall be used to increase the effectiveness of room airflow. The placement of the unit within each room shall ensure that most of the air is recirculated through the HEPA filter. Instructions for the placement and use of the HEPA filter are located on each filtration unit.

(5) Air from TB isolation rooms and treatment rooms shall be exhausted directly to the outside of the building away from air-intake vents.

(6) Negative pressure room locations (see attached documents)

g. Respiratory Protection

(1) PAPR's (Positive Air Purifying Respirator) shall be used by:

(a) All persons entering rooms in which patients with known or suspected infectious TB are isolated.

(b) Persons present during cough-inducing or aerosol-generating procedures performed on such patients.

(c) Persons in other settings where engineering controls are not present i.e., most ambulatory settings.

(2) Respiratory devices used in healthcare settings for protection against *M. tuberculosis* shall meet OSHA standards.

(3) PAPR training is required of select employees having direct patient contact. Proper use and instructions on donning, fit checking, and removal of PAPR's shall be included in employee orientation. Select N-95 fit testing and shall be done during initial clinical orientation and annually in specified departments. (See Respiratory Protection Policy 4.04)

(4) The TB risk assessment shall be completed annually by the Epidemiology Coordinator and EHS (See section 2.b.). Employee Health (EHS) shall coordinate PAPR training and N95 fit testing (select departments) of employees, maintain all training and fit testing records, and annually update the program, if needed.

(5) Clinical managers shall ensure that required fit testing is completed. They shall identify and notify employees who will require fit testing and training, provide EHS with the names of employees, schedule time for the employee(s) to participate, and provide replacement respirators for employees as necessary.

(6) In select departments who are not using PAPR's; each employee requiring annual fit training/testing shall complete an annual fit test and notify Employee Health for fit test sooner if there is change in health status or facial structure that affects fit (see Respiratory Protection Policy 4.04.

h. Education and Training

(1) The basic concepts of *M. tuberculosis* transmission, pathogenesis, diagnosis, and treatment shall be presented during general orientation of all staff.

(2) PAPR training and additional information regarding respiratory protection shall be presented during general orientation of all staff.

(3) Training shall be reviewed at least once a year and updated as needed.

i. TB Surveillance Program

(1) The Tuberculosis Surveillance Program, a TB screening and prevention program for employees and volunteers, shall be established to prevent transmission of the TB bacilli from employees to patients; to identify TB transmission to employees and offer consultation, treatment, and referral as indicated. Refer to EHS Policy and Procedure for specific policies and procedures.

(2) Pre-placement TB screening shall be done for all prospective employees. This includes a 2-step TST or Quantiferon blood test unless the employee has documentation of a positive TST or a previous TST done within 12 months of hire date. The first TST is applied at the time of the pre-placement evaluation; the second TST shall be applied at least one week and no more than three weeks after the first. A prospective employee shall complete all TB screening within 30 days of start date. Prospective employees with a positive TST shall complete a TB Questionnaire and have a chest x-ray, unless one was done within the past 6 months and results are available for review. S/he will be referred to her/his personal health care provider or previous employer for possible INH chemoprophylaxis as indicated. A prospective employee with a positive chest x-ray or signs/symptoms of TB shall not work until medical clearance is completed.

(3) Annual or periodic TB screening as determined by the annual TB exposure risk assessment shall be mandatory for all hospital employees and volunteers. Departments are scheduled for TB screening according to a monthly schedule. See Policy & Procedure 4.01 Appendix A-

TB Screening Schedule for the annual schedule. Physicians practicing at El Camino Hospital are asked to obtain an annual TST and maintain a record of their results. Employee Health Services is available to perform TST testing as needed for physicians. Clinical contractor staff must provide documentation of TB screening to Employee Health Services.

(a) EHS applies and reads TSTs during daily scheduled open clinic hours, by appointment and as otherwise arranged. TSTs are read 48-72 hours later by EHS clinician or by department designated readers. Hospital department's nursing staff (registered nurses) who have completed a competency test given by Employee Health Services may apply and read TSTs as arranged by EHS. If a designated reader feels a TST is positive, she/he must refer employee to Employee Health Services for final TST reading and further evaluation.

(b) TST conversion from a negative to a positive is defined as an increase in tuberculin reaction > 10 mm, from less than 10 mm in diameter to 10 or more mm in diameter, within 24 months from a documented negative to a positive TB skin test. Employees with skin test reactions of 5 mm or more of induration (regardless of the change since prior testing) shall be considered positive if they: are known to be HIV positive or have risk factors for HIV with unknown HIV status, are requiring insulin, long-term use of corticosteroid or other immunosuppressive medication, and/or have had close contact with cases of infectious tuberculosis. Quantiferon conversion is when the test result goes from negative to positive.

(c) Employee with prior documented positive TST or Quantiferon test shall complete a TB questionnaire annually.

j. Guidelines for Follow up of Potential TB Exposure.

"Exposure Incident" is an event in which an employee sustains substantial exposure to a confirmed infectious TB case, or to a suspect infectious TB case who is determined to have been an infectious TB case at the time of the incident, without the benefit of all applicable exposure control measures. To determine whether the event involves substantial exposure, the following factors shall be taken into account: the infectiousness of the exposure source, proximity of the employee to the exposure source, the extent to which the employee was protected from exposure, and the length of the exposure event.

(1) Exposed employees shall be identified by the Epidemiology Coordinator and the clinical manager.

(2) Physicians who believe they have recently been exposed can come to Employee Health Services for post-exposure TST or Quantiferon screening and follow-up as per TB Surveillance Policy 4.01.

(3) EHS will determine if exposed employees will need a baseline TST or Quantiferon testing.

(4) Exposed employees shall have a TB screening done 10-12 weeks post exposure or within 30 days of notification. Clinical managers and employees shall be notified by EHS. TB screening is mandatory. Employees who do not complete required testing and follow up shall not be scheduled to work until TB screening is completed.

k. Coordination with the Public Health Department

(1) As soon as a patient, employee or volunteer is known or suspected to have active TB, a report shall be made to the public health department according to current procedures by Employee Health, or Infection Control, as appropriate.

(2) Results of all AFB positive sputum smears, cultures positive for *M. tuberculosis*, and drug susceptibility results on *M. tuberculosis* isolates shall be reported to

EHS and the public health department by Epidemiology Coordinator as soon as results are available.

E. Regulations:

County of Santa Clara, Public Health Department Tuberculosis Prevention and Control Program, Employment Tuberculosis Screening for Employees/volunteers, January 25, 2001.

County of Santa Clara Public Health Department, Disease Control and Prevention, Employment Tuberculosis Screening for Employees and Volunteers of Health care Facilities, January 25, 1999.

Cal/OSHA, Interim Tuberculosis Control Enforcement Guidelines. July 1, 1995.

F. References:

CDC "Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection". *MMWR* Vol. 49, no. RR-6 (2000)

DHS/California Tuberculosis Controllers Association, *Joint Guidelines for the treatment of Tuberculosis and Tuberculosis Infection for California,* April 2002.

CDC "Guideline for Infection Control in Health Care Personnel", *Federal Register,* September 8, 1997, pp.47288-9.

CDC "Guidelines for Preventing the Transmission of *Mycobacterium Tuberculosis* in Health Care Facilities, 1994." *MMWR* 43, no. RR-13 (1994): 1-106.

CDC, "Guidelines for Preventing the Transmission of *Mycobacterium Tuberculosis* in Health Care Settings, 2005.

G. Approvals:

Infection Control Committee: 2/12/03, 3/3/07, 4/14/09, 7/31/09, 10/28/11, 10/23/12
Medical Executive Committee: 7/3/03, 4/26/07, 5/28/09, 8/27/09, 11/17/11
Board of Directors: 7/9/03, 5/11/07, 6/10/09, 9/9/0, 12/14/11

NEGATIVE PRESSURE ROOM LOCATIONS

APRIL 2011

BUILDING	LOCATION OF ROOM	SYSTEM CURRENTLY IN PLACE FOR MONITORING	DOCUMENTATION
New Main	See Attached Site Plans for Room Locations	Monitored from the Central Plant	Available Upon Request
Oak		No rooms in Oak. Dialysis are enclosed	N/A
Old Main	See Attached Site Plan for Room Locations	Local Only	No reports available from Facilities
Women's Hospital	See Attached Site Plan for Room Locations	2 Rooms – Local only (MBU) 2 Rooms – BAS to CUP (MBU) 1 Room – Local and BAS to CUP in NICU	No reports available from Facilities No reports available from Facilities Available Upon Request
Los Gatos	See Attached Site Plan for Room Locations	2 Rooms – Endoscopy Exam 1 & 2 1 ICU Room 1075 1 Medical Room 1023 1 Cardio Pavilion Room 1023 4 Rooms – Emergency Rooms 5,6,7 & 8	Available Upon Request

MBU = Mother Baby Unit
BAS = Building Automation System
CUP = Central Utility Plant

Negative Pressure Room Locations 2011

Daily Negative Pressure Room Check

Document room check DAILY for all negative pressure rooms before 8:15AM.
Perform "Flutter test" ONLY if Negative Pressure is in use

Process for Documentation of Check
Initial one (1) of the four columns listed on the Daily Negative Pressure Room Check for each of the 4 rooms on Maternity

Column #1 Room is Not Occupied or patient is Not in Airborne Precautions. No need to do test. Just initial in column under room number
Column #2 Room is Occupied and in Negative Pressure mode- Airborne Precautions [perform "Flutter test"]
Column #3 Negative Pressure Initialed- document Time "Flutter test" PASSED
Column #4 No Negative Pressure "Flutter test" FAILED Immediately notify Facilities

Directions for how to perform a "flutter test"

Rip small corner off of a Kleenex and drop in front of closed door in Negative Pressure.

Negative pressure PASSED if Kleenex corner is sucked into the room.
Negative pressure FAILED if Kleenex corner blows back toward you. REPORT to Facilities Immediately.

Send Completed form to Infection Control at [redacted] IC 3206 MV IC 1335 LJ

Daily Negative Pressure Room Check

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Unit: _____ Month: _____

Date	Not Occupied or No Precautions Required				Negative Pressure Present Occupied / Airborne Precaution				Negative Pressure Initiated: Time				No Negative Pressure Facility Notified			
Room #	148	149	168	167	148	149	168	167	148	149	168	167	148	149	168	167
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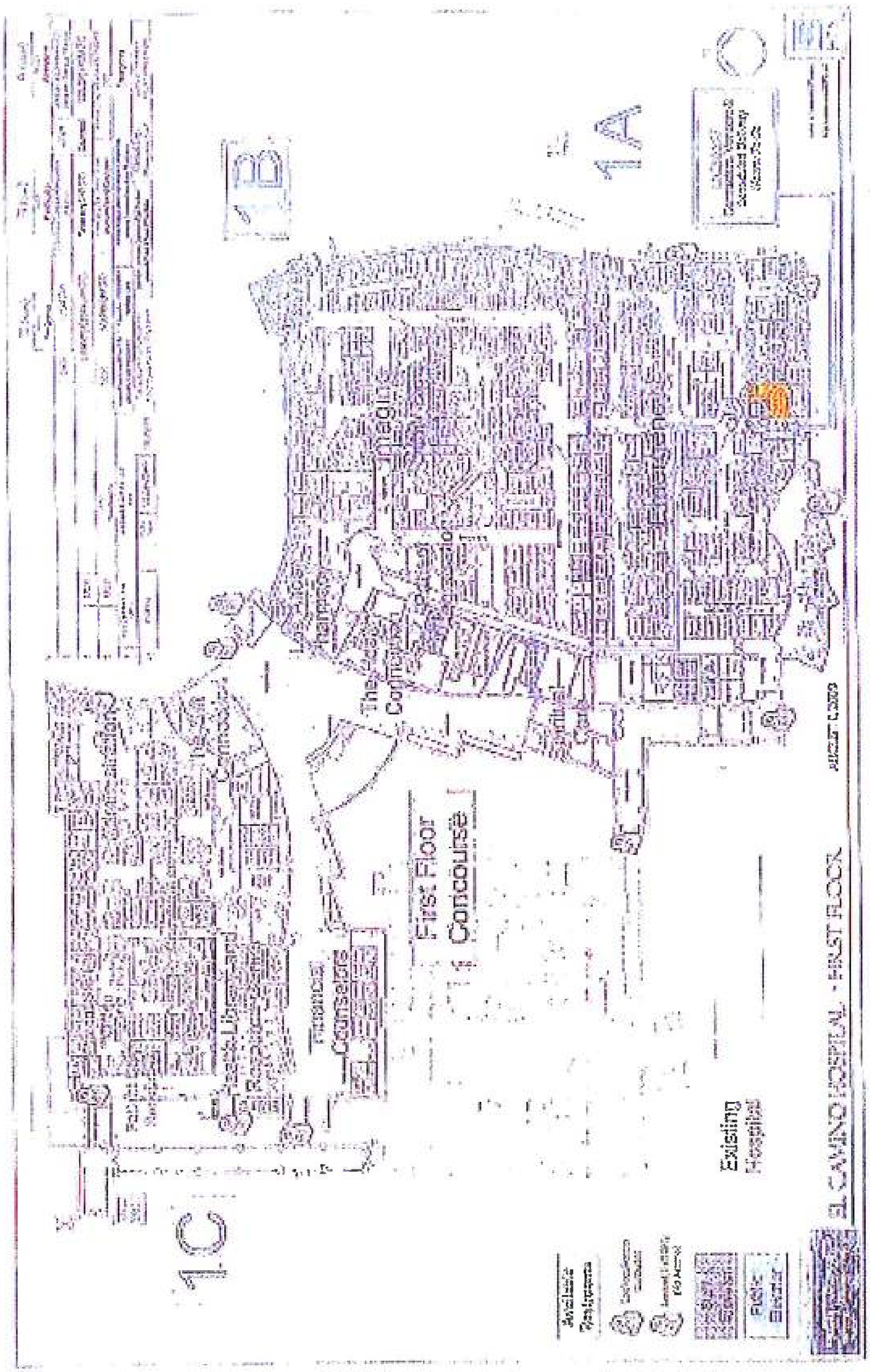
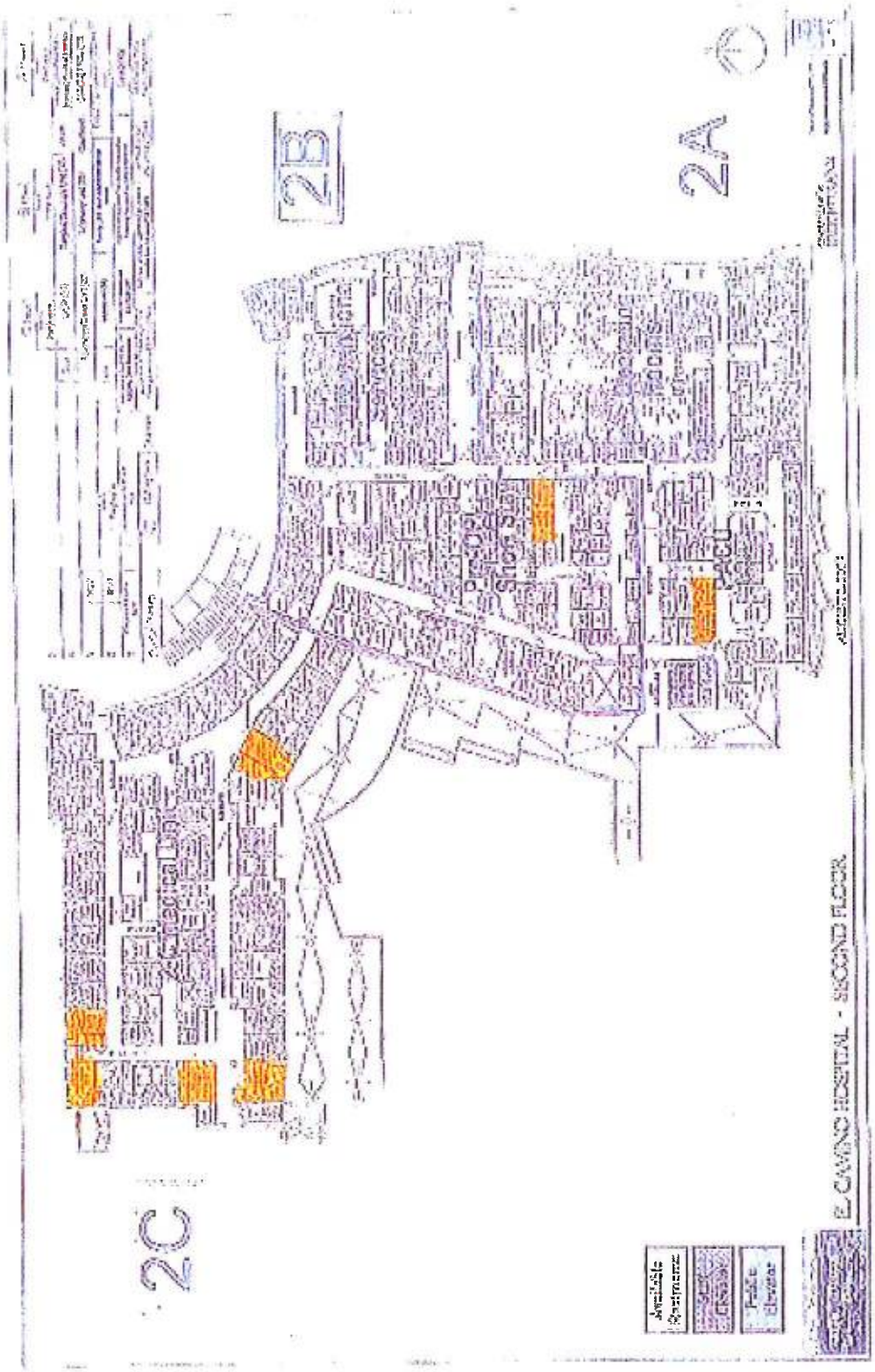
Initial Daily Check Completed Before 8:30AM

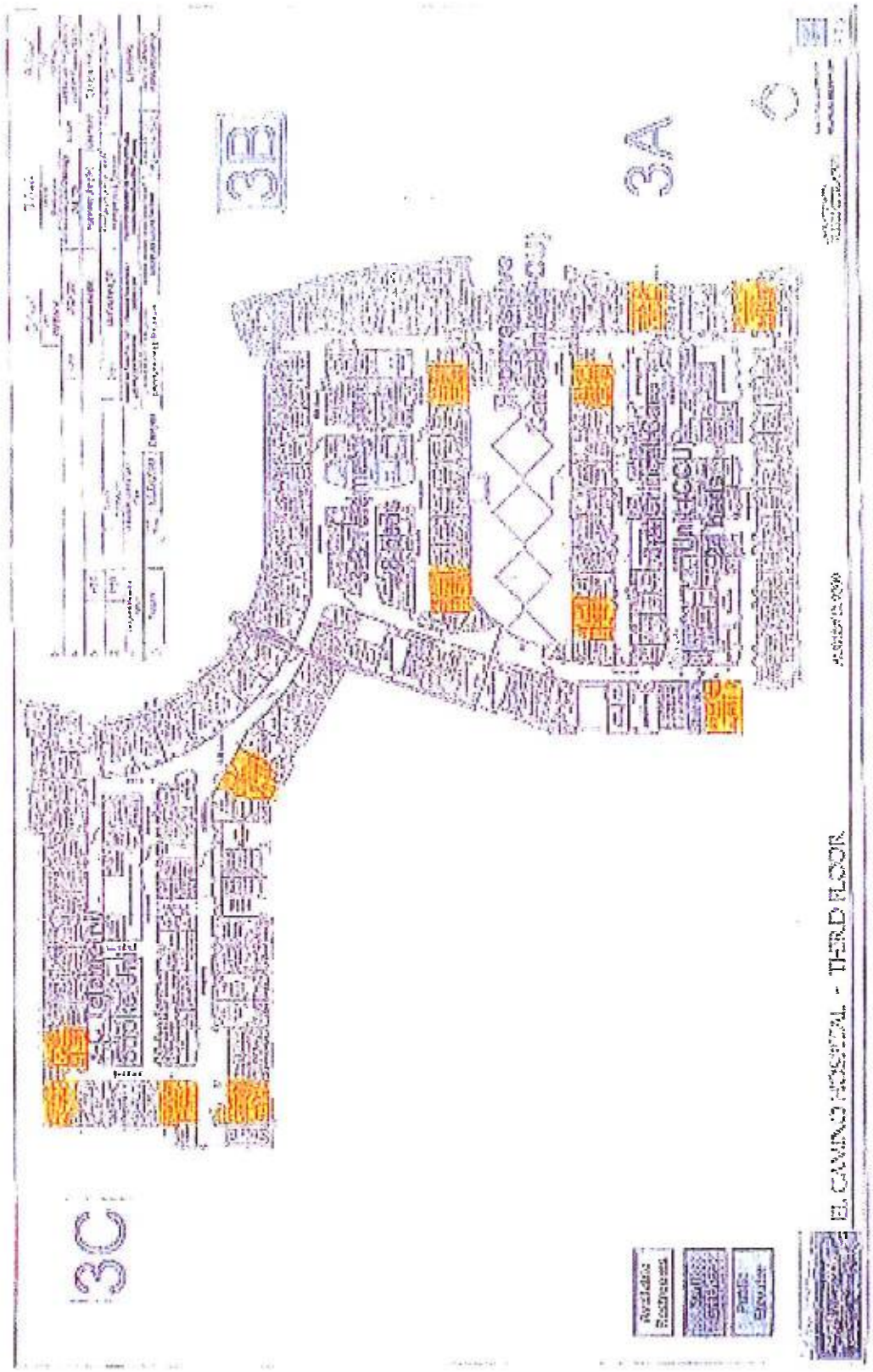
-50-



New Main 1st Floor

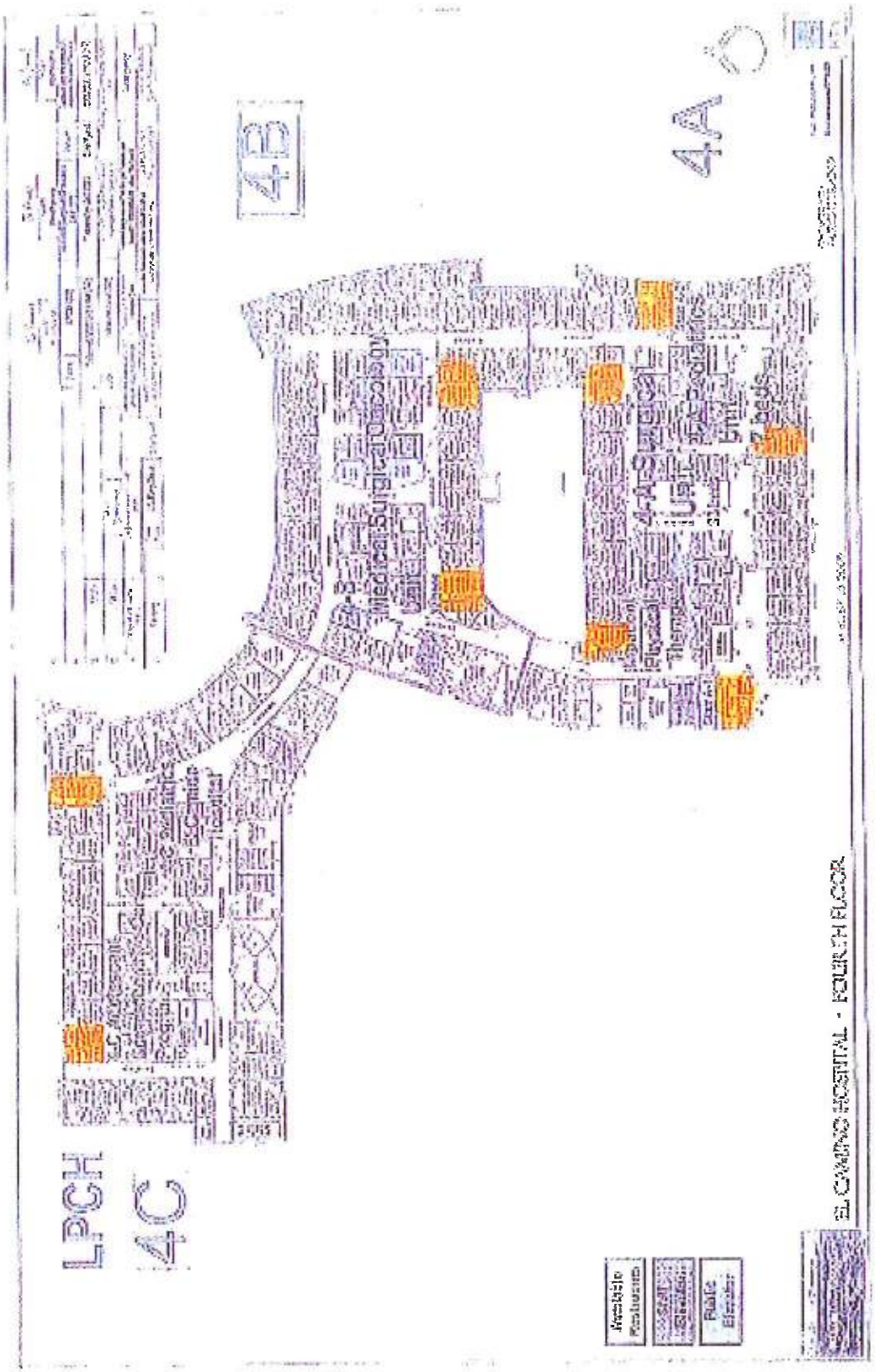


New Main 2nd Floor



New Main 3rd Floor

App



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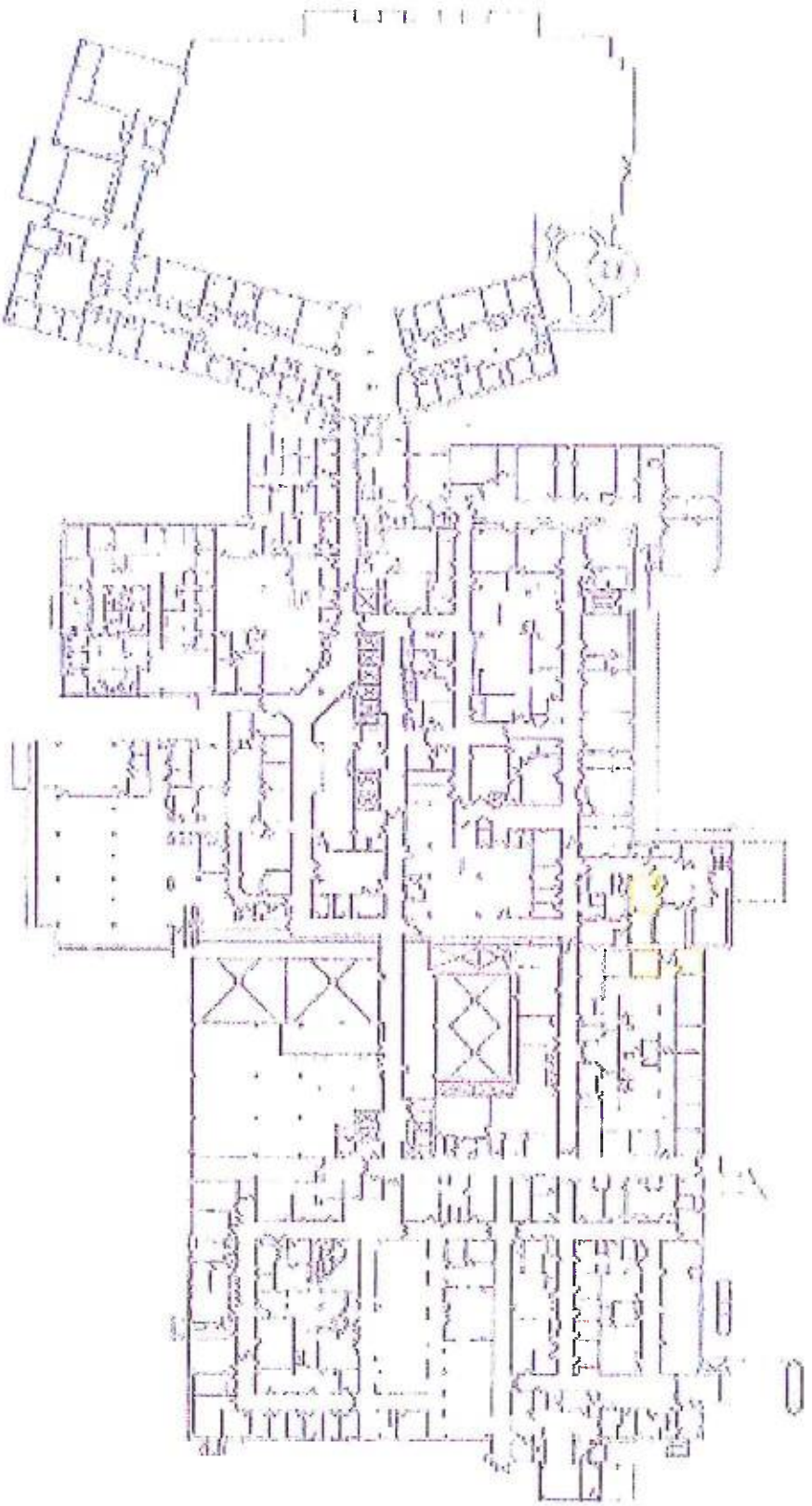
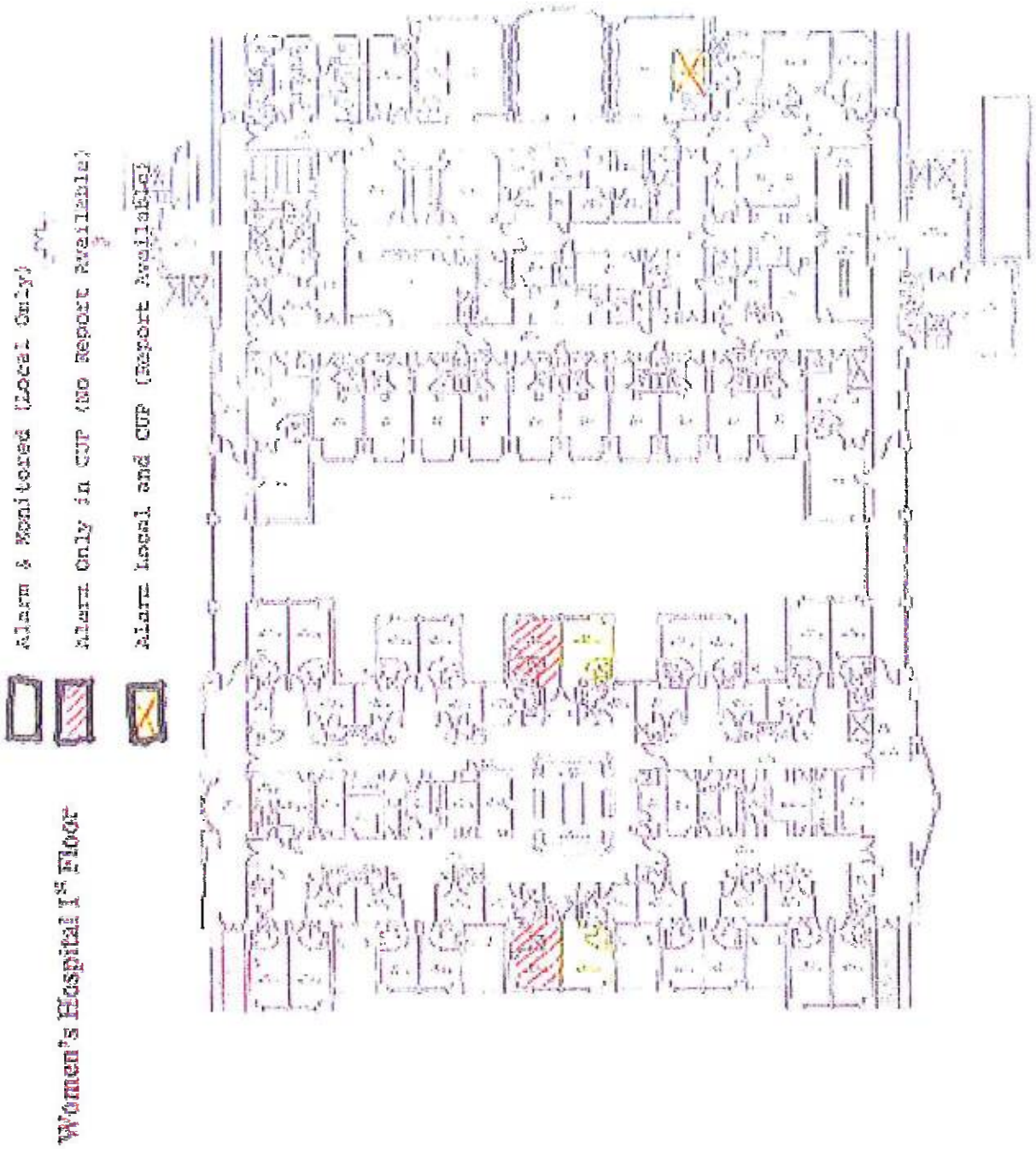
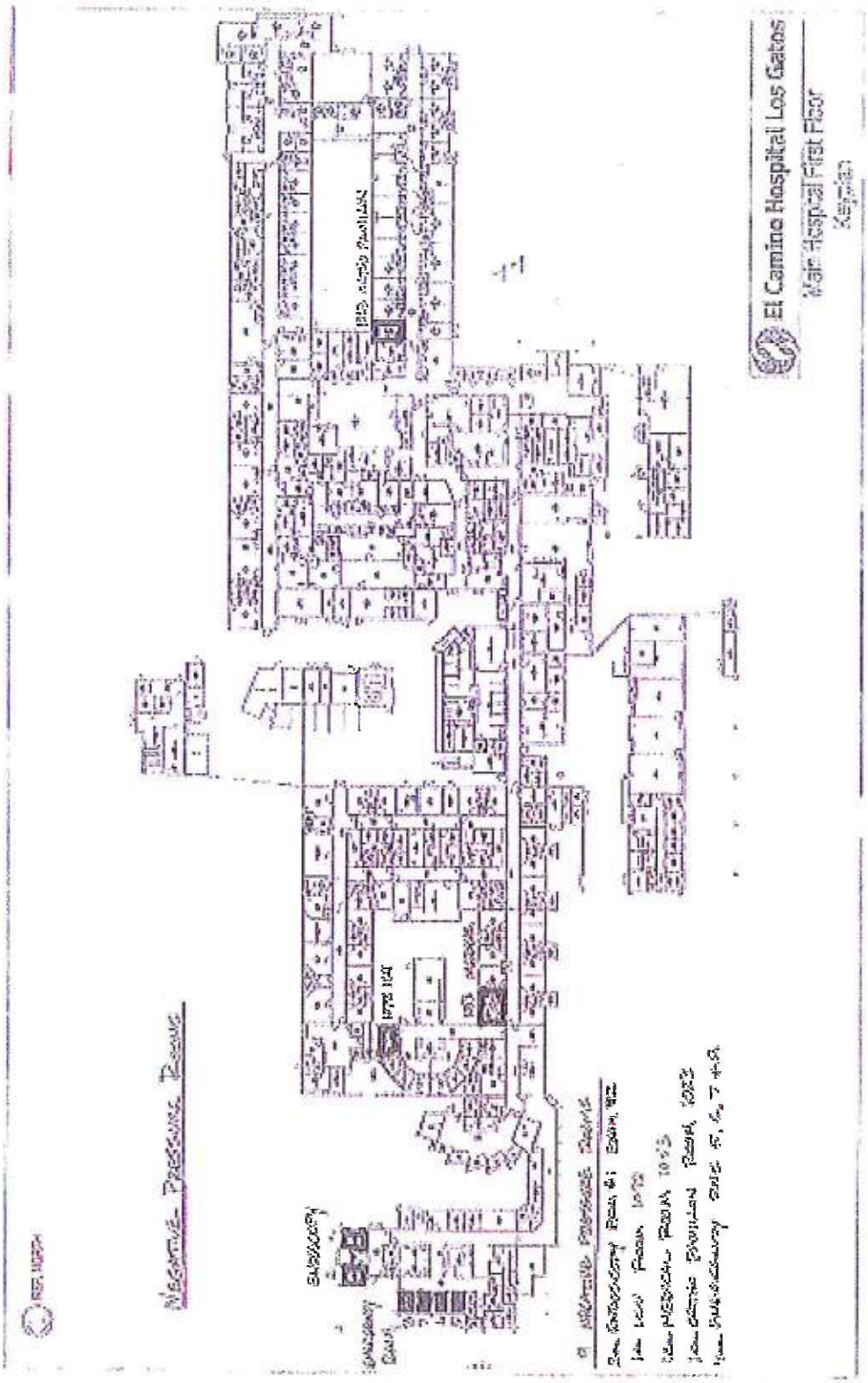


Old Main 1st Floor




El Camino Hospital Los Gatos
Main Hospital First Floor
Keynan

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
INFECTION CONTROL DEPARTMENT POLICIES AND PROCEDURES

1.04 INFECTION CONTROL AND PREVENTION PLAN

A. Coverage:

El Camino Hospital Los Gatos and Mountain View

B. Reviewed/Revised:

10/12	**4/11**	5/09	12/05	5/03	1/98
1/10	12/08	8/05	4/02	1/97	
7/09	11/06	1/05	2/01	1/96	

C. Policy Summary:

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. 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 or expert consensus. At least annually, and whenever risks significantly change, an evaluation of the effectiveness of the infection prevention and control plan will be done. This evaluation will include a review of the prioritized risks, the goals, objectives, and the infection prevention strategies. The results of the evaluation will be used to make revisions to the plan. The revised plan will be communicated to the organization.

D. Policy and Procedure:

1. **Purpose**

a. To plan, coordinate and monitor policies, procedures and practices related to the identification, control and prevention of hospital associated infections.

b. 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. Achieve 95% compliance rate with CLIP organization-wide.
   (1) Maintain CLABSI rate at 0.00 in CCU and ICU.
   (2) Maintain CLABSI rate in NICU at 0.00 for all weight categories.

b. Reduce hospital onset *Clostridium difficile* infection rate to ≤ **8.20 (MV); <7.30 (LG)** /10,000 patient days.

c. Reduce hospital onset MRSA infection rate to ≤ **1.7 (MV); <0.67 (LG)** /10,000 patient days.

d. Increase MRSA screening compliance rate to 90% or more.

e. Reduce hospital onset MDRGNR infection rate to ≤ **1.51 (MV); < 0.66 (LG)**/10,000 patient days.

f. Maintain CABG SSI rate at or below NHSN Rates/Risk of SIR <1.00 (see Risk Assessment). (MV campus).

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

h. Reduce Total Hip Surgical Site Infection rate to at or below NHSN Rates/Risk of SIF <1.0 (see Risk Assessment). (MV and LG campus).

i. Reduce laminectomy surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (see Risk Assessment) (LG campus).

j. Reduce spinal fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR < 1.00 (see Risk Assessment). (LG campus).

k. Reduce spinal re-fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (see Risk Assessment). (LG campus).

l. Maintain Oak Dialysis CLABSI rate at ≤ **0.40** /100 patient months.

m. Reduce Evergreen Dialysis CLABSI rate to ≤ 2.5/100 patient months.

n. Maintain Rosegarden Dialysis CLABSI rate at ≤ 2.06/100 patient months.

o. Maintain hand hygiene compliance at ≥ 95%.

p. Maintain PPE compliance at ≥ 95%.

q. Utilize all influenza vaccine that is available.

r. Reduce BBP exposure rate to **≤ 1.72 (MV and LG).**

s. Maintain Catheter Associated Urinary Tract Infection rate at ≤ **0.25 (MV) and maintain 0.00 (LG)** / 1000 cath days.

3. Goals

a. Recommend methods for early identification of infections and the appropriate therapy when infections do occur.

b. Analyze practices that have the potential to affect hospital onset infection rates and to recommend changes in practice, if necessary.

c. Support Employee Health Services, Clinical Effectiveness, Safety and Case Management using epidemiological and scientific methodologies.

d. Facilitate compliance with reporting requirements of hospitals to various public health agencies, National Healthcare Safety Network (NHSN), California Department of Public Health (CDPH), CMS Hospital In patient Quality (IQR), Santa Clara County Health Department and the state of California.

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

f. Monitor infection control practices of healthcare workers. Provide feedback with recommendations for improvement (if necessary).

g. Provide general orientation in infection prevention and control for all employees.

h. Review and revise infection control policies every three years, or as needed. Provide input into patient care, product evaluation and selection, and approve written policies and procedures that describe the role and scope of participation of each department in infection control and prevention activities.

i. Recognize and maintain an awareness and working knowledge of guidelines and recommendations that are published by Centers for Disease Control, Occupational Safety and Health Administration, The Joint Commission and Association of Professionals in Infection Control and Epidemiology that impact infection control. Maintain and enhance own knowledge of infection control and epidemiology.

j. Provide documentation of recognition and compliance with appropriate regulatory and accrediting agencies. Review/revise yearly Bloodborne Pathogens and TB Exposure Control Plans to reflect changes in regulatory requirements.

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

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

4. **Infection Control Committee**

a. The responsibility for monitoring the Infection Control Program is invested in the Infection Control Committee. The committee has the authority to institute any appropriate control measures or studies when the situation is reasonably felt a danger to any patient, HCW or visitor, or in the event of an infection control crisis situation (See Appendix A). The committee functions as the central decision and policymaking body for infection control. The Infection Control Committee shall meet not less than quarterly.

b. The Infection Control Committee shall be a multi-disciplinary committee consisting of representatives from at least the medical staff, nursing, administration and the epidemiology coordinator. The Chairman shall be a physician with knowledge of and special interest in infectious disease. Representatives from key hospital departments such as but not limited to Facilities Services, Environmental Services, Pharmacy, Central Services, Operating Room and Employee Health shall be available on a consultative basis when necessary.

c. The Infection Control Committee shall develop a hospital-wide program and maintain surveillance over the program.

d. The Infection Control Committee shall develop a system for reporting, identifying and analyzing the incidence and cause of all hospital onset infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.

e. The Infection Control Committee shall 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.

f. The Infection Control Committee shall develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.

g. The Infection Control Committee shall identify new indicators and thresholds of diseases, recommend and assess corrective measures based upon the analysis of relevant data, and communicate its findings and interventions to the appropriate departments.

h. The Infection Control Committee shall act upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, the departments, other medical staff and hospital committees.

i. The Chairman of the Infection Control Committee is responsible for medical direction and decisions as required for the review, analysis and presentation of data to the Medical Staff.

j. The committee minutes shall be reviewed by the Medical Executive Committee, the Chief Executive Officer, Vice President of Patient Care Services, and the Medical Director, Quality Assessment.

5. Infection Preventionist

a. The Infection Preventionist(s) is responsible for the supervision and coordination of infection control activities throughout the organization, including outpatient dialysis units. The preventionist(s) is also responsible for the development, implementation, and evaluation of the performance improvement activities, ensuring that they are based upon accurate data collection, analysis, and interpretation.

b. Qualifications for Infection Preventionist are:

1) Baccalaureate degree from an accredited college or university. A current California license as a registered nurse.
2) Certification by Certification Board of Infection Control (CBIC) and recertification every five years. In the absence of certification by CBIC, three to five years experience in infection control and completion of the Association for Professionals in Infection Control and Epidemiology (APIC) Beginning Infection Control Practitioners Course within one year.
3) Knowledge of current infection control standards and practices and requirements, regulations and recommendations of federal and state/county regulatory bodies (Joint Commission, OSHA, and Center for Disease Control) in order to perform duties listed above.

c. Provides input and assistance in the revision, updating and formulation of policies and procedures related to infection control.

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

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

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

g. Notifies California Department of Public Health, either verbally or by written notification, of all reportable diseases occurring either within the hospital or in the community.

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

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

6. Scope of Services

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 Infections

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) Both 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 infections while others may be considered inevitable.
3) Strict criteria shall be used for assessment in regard to targeted hospital onset infections. Not all hospital onset infections in the hospital shall be counted and presented for statistical analysis. The type of data collection to be used and analyzed shall be determined by the Infection Control Committee (ICC) based upon the annual Risk Assessment.
4) The criteria written by the Center for Disease Control and Prevention (CDC) shall be used when calculating infection rates for statistical analysis. (See Infection Control Policy and Procedure 1.06, Hospital Infections.)

c. Surveillance Activities

1) Active infection surveillance within the hospital shall be an ongoing observation of the occurrence and distribution

of disease or disease potential and of the conditions that increase or decrease the risk of disease transmission.

2) The surveillance of patients, staff and environment shall ensure appropriate patient placement, initiation of appropriate isolation or special precautions, identification of patient care problems associated with hospital infection control, prevention of targeted hospital onset infections in high risk, high volume procedures, facilitation of data collection for selected quality indicators and the collection of required information for reporting to the Public Health Department.

3) Daily laboratory reports, utilization review reports and verbal communications with staff shall be reviewed routinely by the Epidemiology Coordinator. Surveillance shall be a blend of routine physical presence in all areas of the facility and the use of clinical and laboratory computer information systems.

4) The amount of time spent on infection surveillance, control and prevention activities is based upon the following:
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: 542
- FTE Staff: 2100
- Department Resources:
  - 2.0 FTE RNs as Epidemiology Coordinators
  - 1/2 FTE for administrative support
  - Equipment: computer, printer, fax
- Patient Population:
  - Various ages, ethnic, socio-economic backgrounds
- Risk factors of the population:
  - Infectious agents related to construction
  - Tuberculosis
  - MRSA
  - VRE
  - MDRGNRs
  - *Clostridium difficile*
- Complexity of the services provided:
  - Critical Care- adult and NICU
  - Emergency Services

- Women's Services
- Medical / Surgical
- Surgery (including Bariatrics)
- Dialysis-inpatient and outpatient
- Oncology – inpatient and outpatient
- Behavioral Health
- Cardiac Cath Lab
- Nuclear medicine, radiology, diagnostic imaging
- Rehab Services
- Community Outreach Programs

5) The selection of clinical indicators is determined by the Infection Control Committee and is based upon the assessment of problem prone, high risk/high volume services provided. Results of these measures are reported in rates rather than raw numbers using valid epidemiological methods. Results are evaluated annually using data trend analysis generated by surveillance activities during the year and shall reflect changes in the hospital's assessed needs.

7. **Surgical Site Infection Surveillance**

a. Specific surgical site infection surveillance in accordance with California Department of Public Health Senate Bill 1058 requirements shall be monitored and reported to NHSN on a monthly basis. Surveillance activities include: daily census review of admission diagnosis and post discharge surveillance letters to surgeons

b. Targeted surgical site infection surveillance selected by Infection Control Committee based on annual Risk Assessment is monitored and reported quarterly to the Infection Control Committee. Surveillance activities include: daily census review of admission diagnosis and post discharge surveillance letters to surgeons.

8. **Targeted Surveillance Indicators for upcoming Calendar Year based upon the annual evaluation of the IC plan**
(Other indicators may be added as problems are identified)

Epidemiologically significant microorganisms

a. Plan: Use *Clostridium difficile* and MRSA infection rates as quality indicators to evaluate the effectiveness of compliance with transmission-based precautions and decontamination protocols. Goal is to reduce hospital onset infections of each microorganism as noted in Objectives (page 2).

b. Do: (1) Determine number of new *C. difficile* cases per 10,000 patient days. (2) Determine staff / MD compliance with Contact Precautions and hand hygiene.

c. Do: (1) Determine number of new MRSA (colonization and infection) cases per 10,000 patient days. (2) Determine compliance with MRSA nares screening of targeted patients or specific units. (3) Determine staff/MD compliance with Contact Precautions and hand hygiene.

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

e. Act: ***(Clostridium difficile)*** – Cleanse hands of patients with soap and water before each meal. Place patient on Contact Precautions. Provide education to patient and family on *Clostridium difficile* infection. Bathe patient daily. Change linens daily or when soiled. Clean/disinfect patient room with bleach product upon transfer/ discharge or clearance. Provide education to staff, physicians, patients, and families.
(MRSA) – Place patient on Contact Precautions. Provide education to patient and family on MRSA. Cleanse hands of patients with soap & water or gel before each meal. Perform MRSA nares screening on targeted patients. Provide education to staff, physicians, patients, and families.

Targeted Surgical Site Infection Surveillance

a. Plan: Use NHSN definitions of SSI's according to NHSN. Total knee, total hip, CABG, and spine surgeries are high-risk cases with potential for adverse patient outcome. Goal for all SSIs is to maintain SSI SIR rate < 1.00.

b. Do: Determine number of total knee, total hip, CABG, and spine surgery infections.

c. Study: Monitor indicator rates for SSIs over time and compare to NHSN benchmarks. Statistically analyze data to determine if appropriate interventions are needed. Review and analyze data on a quarterly basis to identify trends and potential high-risk areas.

d. Act:
   1. Perform MRSA nares swabs on targeted patients before surgery.
   2. Instruct targeted patients to shower with CHG on night and morning of surgery.
   3. Perform preop scrub with CHG on targeted patients upon admission to unit.
   4. Ensure antibiotics are given within recommended time prior to incision.
   5. Follow all SSI Core Measures.

Central Line Associated Bloodstream Infection (CLABSI)

a. Plan: Use NHSN definition of CLABSI. These are high-risk patients with documented additional lengths of stay due to infection. Goals are to maintain CLIP compliance at or above 95%, to maintain all critical care CLABSI rates at 0.00/1000.

b. Do: 1) Determine number of CLABSI's in critical care patients/1000 CCU central line days, 2) Determine number of CLABSI's in NICU patients stratified by birth weight/1000 NICU central line days.

c. Study: Data are reviewed and analyzed quarterly to identify trends and potential high-risk areas.

d. Act: Implement CLIP for all central lines. Provide staff, patient, and family with education regarding care and maintenance of lines. Implement a necessity of line protocol. Provide biopatch dressing in all Central Line kits.

Employee Exposures to Blood/Body Fluid (Employee Health)

a. Plan: Use data from Employee Health Services (EHS) as collected on form entitled "Report of Employee Accident Injury or Exposure." Identify types of exposures (sharps and blood/body fluid), devices used if any, and interventions to prevent exposure from happening again. Goal is to decrease employee exposures by at least 5% annually.

b. Do: Determine number of exposures per 100 Full Time Employees (FTEs).

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

d. Act: Continue to contribute to efforts of the Sharps Safety Work Group to improve availability and use of safety-engineered sharps. Work with managers and EHS to increase compliance with policies and procedures (i.e., use of personal protective equipment).

Influenza Vaccinations for Staff

a. Plan: Use data on the number of staff that are eligible to receive the influenza vaccination and the number of staff that receive (or sign declination to receive) influenza vaccine to determine vaccination rate. Goal is to administer all vaccine that is available during each flu season and to track vaccination rate.

b. Do: Determine amount of vaccine that was administered. Determine number of staff that receive or decline influenza vaccine.

c. Study: Review and analyze data on an annual basis to determine vaccination rate (vaccinations + declinations / total eligible employees). Determine amount of vaccine not administered (if any).

d. Act: EHS will continue to offer vaccinations at scheduled clinics to all eligible employees and physicians. EHS will continue to go to specific units to provide vaccinations at their

site. Individual employees and physicians may schedule a specific time for their vaccination with EHS.

9. Data Collection Methods

All identified cases related to targeted infections and communicable diseases will be maintained in a database.
Specific methods used by infection control to obtain surveillance data include daily lab reports, patient census reports, daily serological reports, patient charts, referred cases from case managers and verbal communication with staff and physicians.

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

10. Investigation of Disease Clusters (Outbreak Control)

The Infection Control Committee shall have ultimate authority and responsibility for investigating epidemic/outbreak situations and implementing appropriate interventions in order to prevent and to control further disease and to identify factors that contributed to the outbreak. (See Infection Control Policy and Procedure 1.05, Outbreak Investigation).

11. Reporting to Outside Agencies

a. Specified communicable diseases (in accordance with Title 17, California Code of Regulation) identified at El Camino Hospital shall be reported to the Santa Clara Department of Public Health (SCDPH) in the required timelines to prevent the spread of certain communicable diseases to the public at large. (See Infection Control Policy and Procedure 1.08, Communicable Diseases).

b. El Camino Hospital shall provide follow-up management for pre-hospital caregivers who may have been exposed to a communicable disease during the performance of their duties and reporting of these exposures to the proper authorities. (See Infection Control Policy and Procedure 1.09, Pre-hospital Communicable Disease Exposure).

c. El Camino Hospital shall report to NHSN the following:
- Hospital Onset MRSA BSI's

- Hospital Onset VRE BSI's
- Hospital Onset CRE-Klebsiella BSI's
- All Hospital cases of *Clostridium difficile* infections
- CLABSI's in CCU, ICU and NICU (MV campus)
- Hospital Wide CAUTI's
- Operative procedures identified by CDPH as consistent with meeting the requirements of Health and Safety Code Section 1288.55 for reporting SSI's.

12. Education

a. Orientation for all hospital employees shall include general information on potential infection risks, transmission routes, and 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 (HealthStream) and tracked by the Education Department.

c. Department specific education shall be done as deemed necessary by the Medical Director of Infection Control and/or the Infection Preventionist(s), working in conjunction with department managers.

d. Training material in all areas of education shall be kept current and conform to current information pertaining to the prevention and control of infectious diseases. Infection Preventionist(s) shall attend annual hospital-funded continuing education programs to maintain current in principles of epidemiology.

13. Research

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.

14. Liaison

a. Provide ongoing expert advice and consultation as appropriate to other departments including but not limited to Microbiology Laboratory, Employee 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 Health Services, Pharmacy Services, and Environmental Services.

c. Function as a liaison to the Santa Clara Public Health Department and other agencies.

d. Function as a liaison to other Infection Control Programs at other hospitals and long-term care facilities.

15. Policy Formation

a. Policies and procedures shall be reviewed on a regular basis with changes made as new guidelines and information become available.

b. Standard Precautions shall be practiced in all areas of the hospital and are the basic standard of care for all patients.

c. Additional transmission-based precautions shall be used in addition to standard precautions for specific diseases or organisms

to prevent their transmission. (See Section 5 of the Infection Control Manual.)

d. Infection control departmental policies are found on the toolbox. Copies of policies are located in IC and other specified areas.

16. Quality Improvement

a. Provide ongoing evaluation and assessment of the goals and accomplishments of the Infection Control Program to ensure that it meets the needs of the hospital, employees, physicians, patient population, and visitors.

b. Evaluation of the Infection Control Plan shall be done at least annually or when a change in the scope of the Infection Control Program or in the Infection Control risk analysis occurs. Assessment of Infection Control strategies shall also be evaluated for their effectiveness at preventing infections.

17. Environmental Conditions

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

b. Routine microbiological surveillance of the inanimate hospital environment or of personnel, with the exception of research purposes, shall be done on an as needed basis (to be determined by the Infection Preventionist).

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 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 shall be monitored each use by Cidex OPA 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 200 microorganisms per ml. The dialysate at end of dialysis shall be tested once a month and shall contain less than 2000 microorganisms per ml. ml.

18. Reporting Mechanisms

a. Patients admitted with a reportable or communicable disease or who develop such a disease while hospitalized shall be reported to Infection Control by admitting staff, care coordinators, case managers or direct care providers.

b. Physicians shall be encouraged to report infections that occur after discharge that could be related with a recent hospitalization.

c. Suspected exposure of pre-hospital care providers to infectious diseases shall be reported to infection control by emergency department staff or by the designated officer of the pre-hospital care giver. Each case shall be evaluated and exposure confirmation determined. The proper forms shall be sent to the designated officer and to the Public Health Department. (See Policy & Procedure 1.09, Pre-hospital Communicable Disease Exposure.)

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.

E. References:

1. Deborah Yokoe et al. Compendium of Strategies to Prevent Hospital Acquired Infections in Acute Care Hospitals ICHE 2008:29; S12-S21.

2. Jonas Maschall et al. Strategies to Prevent Central Line Associated Blood Stream Infections in Acute Care Hospitals ICHE 2008:29; S22-S30.

3. Susan Coffin et al. Strategies to Prevent Ventilator Acquired Pneumonia in Acute Care Hospitals ICHE 2008:29; S31-S60.

4. Deverick J. et al. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals ICHE 2008:29; S51-S61.

5. David Calfee et al. Strategies to Prevent Transmission of Methicillin Resistant *Staphylococcus aureus* in Acute Care Hospitals ICHE 2008:29; S62-S80.

6. Erik Dubberke et al. Strategies to Prevent *Clostridium difficile* Infection in Acute Care Hospitals ICHE 2008:29; S81-S92.

F. Approved By:

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 10/12
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
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

CEO Report 12-12-12 Closed.docx

Date: December 12, 2012
To: El Camino Hospital Board of Directors
From: Tomi Ryba, CEO
Re: CEO Report - Closed Session

FY13 Corporate Goals

Organizational Goal	Performance Measurement Minimum	Target	Maximum	Weight	Evaluation Timeframe	FYTD through Oct
Regulatory Compliance						
Joint Commission Accreditation	*Full Accreditation*			Threshold	FY	Met
Financial Viability						
Budgeted Operating Margin	*90% of Budgeted*			Threshold	FY	Met
Operating Margin re Budget	meet	0.5%	1.0%	15%	FY	2.1%
Quality and Patient Safety						
Core Measures % of 100 Possible Performance Points	84%	86%	90%	20%	Apr-Jun 2013	pending 82% Apr-Jun
Rate of Patient Falls	1.96	1.87	1.81	20%	Apr-Jun 2013	1.76
Service						
Meet the averaged performance for the 3 Service metrics on the Corporate Scorecard: - Improve Staff Communication to 75% - Improve Medication Communication to 60% - Improve Staff Responsiveness to 64%	65.3%	66.3%	67.3%	15%	June 2013	64.8%
Efficiency						
Minutes from ED Arrival to Admit to Unit	301	286	275	15%	Apr-Jun 2013	300
Continuum of Care						
7 Day Unplanned Readmission after Discharge	2.45%	2.28%	2.15%	15%	Apr-Jun 2013	2.38%

Operations

- Fair market valuation of the El Camino Surgery Center for both lease rate and assets is complete and accepted by E3. Detailed transaction documents are being prepared by our legal counsel. We are still hoping to have executed documents within the next three weeks.

- Site selection for the new joint venture facility in Los Gatos with Satellite Dialysis is complete, and we are amending the Master Agreement to account for the slightly longer distance of the facility from the Los Gatos campus (2.6 miles versus 2 miles).

The City of Los Gatos has been supportive of this project and the referring physicians are enthusiastic about its potential. The new facility is scheduled to open in Q4, 2013. Since this is a net new facility and does not require that we close any of our existing operations, it will not require any transition of our current dialysis staff, but may provide an employment opportunity for these staff. Met with Kaiser to discuss dialysis transition planning; they had sent a notice that they were going to move patients, and we updated them on our progress with the Satellite affiliation in an attempt to stop them from moving their patients. Their intent remains unclear.

Meetings with Outside Organizations

The Board has asked that I prioritize time to spend with the community. Here is a calendar of meetings over the last 60 days so the Board has a view of who I am meeting with in the market.

Date	Person	Organization
10/2/12	J Logan	City of Los Altos
10/5/12	Mr. Kimura	Mitsubishi and Kobayashi Medical
10/9/12	Board Meeting	Silicon Valley Leadership Group
10/9/12	Barbara Burgess	Pathways
10/10/12	Breakfast Club	Los Altos Town Crier
10/10/12	Bob Adams	
10/15/12	John Kirsten Kraft, MD	Santa Clara Co IPA
10/15/12	John Freidenberg	Marin General Hospital
10/17/12	Michelle Lew	ACCI
10/22/12	Dr. Langston Peter Savas Ken Rice	Alseres Parkinson's Institute
10/23/12	Gary Luebbers	City of Sunnyvale
10/23/12	Martin Fenstersheib	Santa Clara County Public Health Department
10/24/12	Dan Rich	City of Mt View
10/24/12	Noboru Ohrui	Mitsubishi
10/29/12	Father Engh	Santa Clara University
10/29/12	J.C. Moran	Applied Materials
10/30/12	Dave Anderson	City of Saratoga
10/31/12	Nancy Farber	Washington Hospital
11/5/12	Cheryl Cartney	Grant Cuesta
11/5/12		Los Gatos Town Council
11/6/12		Hospital Council CEOs & SNFs
11/7/12	Melinda Deckerd	ManorCare
11/7/12		Saratoga City Countil
11/8/12	Gay Krause	Mt View Challenge Team
11/8/12	Jane Rozanski	Camarillo Healthcare
11/12/12	Charlotte Dickson	Active Living
11/14/12	Gordon Ringold	UC Santa Cruz, Silicon Valley Initiatives

11/21/12	Greg Larson	City of Los Gatos
11/28/12	Jackie Ballinger	Physically Focused
11/29/12	Bob Adams	Rotary

Finance

- Developed detailed financial model in support of affiliation discussions.

- Achieved orthopedic implant cost reduction of approx. $700k annually by working with medical staff to reduce per-item costs.

- Reduced average collection time (Accounts Receivable days) by 3.5 days, increasing our cash level by $6.2m.

- Received three Medicare settlements totaling $281k, dating back as far as FY 2008.

Personnel Matter

Diana Russell, Chief Nursing and Chief Clinical Officer has met with me privately and expressed her plans to retire as early as January, 2013. It is in the best interest of the organization that we retain Diana Russell and defer this retirement to July 1, 2013 due to the following factors:

- The Joint Commission
- Recertification process for Magnet
- Diana Russell is the Executive Sponsor for the Organizational Goal for Efficiency
- Allows adequate time for a smooth transition before a national search can be conducted

I have the delegated authority to make this decision and have worked with Julie Johnston and Sullivan & Cotter to make sure the retention dollar value is appropriate and supportable. We are offering the following:

- Diana Russell will be eligible for the FY13 Executive Incentive Program if employed July 1, 2013, subject to Board approval in October timeframe, 2013.
- Diana Russell will be paid the retention amount of $25,000 July 1, 2013.
- If Diana voluntarily resigns before July 1, 2013, she waives the rights to the retention bonus and is not eligible for severance or the Executive Incentive Program for FY13.
- If Diana involuntarily leaves the organization prior to July 1, 2013, she will receive the amount of $40,000 since she has extended her service at ECH, however would not be eligible for the FY13 Executive Incentive Program, nor severance.

ATTACHMENT 8 ECH - Statement Regarding Committee Chair Appointment - Dec 5 2012_v2 doc, 12-6.docx

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Committee Chair Appointment

The Governance Committee recommends that the Board Chair take the following criteria into consideration when deliberating on the appointment of committee chairs.

- **Leadership –** the candidate demonstrates effective leadership skills, particularly in communication, consensus-building and meeting facilitation skills.

- **Experience –**the candidate possesses prior experience in leading a hospital committee or committees in the same or similar functional area.

Based on these criteria, the Governance Committee strongly recommends to the Board Chair that the vacant chair seats are filled by the following individuals:

- Executive Compensation Committee: Nandini Tandon

- Corporate Compliance/Privacy and Audit Committee: Dave Reeder

Following our processes, the Chair in consultation with the CEO and Governance Committee will review the committee chair assignments at the end of the fiscal year and make changes to the appointments as appropriate – reflecting evolving committee composition and increased depth of institutional and industry knowledge and experience by Hospital Directors.

Committee Composition – Proposed New Appointments

	Chair	Board	Committee
Compliance/ Audit	*Dave Reeder*	*Dennis Chiu*	Sharon Anolik Shakked Ramy Houssaini Christine Sublett *Wes Alles*
Executive Compensation	*Nandini Tandon*	Dave Reeder *Dennis Chiu*	Teri Eyre Jing Liao Bob Miller Prasad Setty
Finance	Dave Reeder	*Nandini Tandon* *Julia Miller*	Bill Hobbs Rich Juelis
Governance	John Zoglin	Patty Einarson *Julia Miller*	Gary Kalbach Pete Moran Mark Sickles
Investment	John Zoglin	Jeff Davis	Nicki Boone Ethan Cohen-Cole Brooks Nelson
Quality	Patty Einarson	Dave Reeder Neal Cohen	Katy Anderson Lisa Freeman Cary Hill Don Nielsen Rob Pinsker

Proposed New Appointment

ATTACHMENT 8 ECH Board-Management Compact - December 5 2012 (Submitted for Board Approval).doc

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

ECH Board-Management Compact

Last Updated: December 5, 2012

Introduction

This document codifies five core principles critical for effective health care governance. This compact is *an agreement between the board and management for how they will work together to build a high-performing culture based on mutual respect, honesty and professionalism.* The agreements herein shall guide the working relationship and normative behaviors between and among the board and management. This document should be reviewed, discussed and agreed upon on a regular basis by the hospital board, committees and management team, and be referenced in moments when it is believed an agreement is not being adhered to. To maintain accountability, the core principles and behaviors described in the compact will be incorporated into the annual performance assessments of the board, committees and management.

Board-Management Compact

Core Principle	The Board Agrees to…	The Management Team Agrees to…
1. Strategic Thinking *The generation and application of unique business insights and opportunities to create competitive advantage for the organization and ensure its long-term sustainability.*	▪ Partner with management to create a compelling future direction for the organization. ▪ Use intentionally ECH's mission, vision, values and strategic direction to guide the board's decisions. ▪ Provide effective oversight and guidance by focusing on strategic direction and organizational capabilities, versus actually executing the plan. ▪ Achieve consensus on the future direction of ECH and speak with one voice, fully supporting the management in the execution of the strategic plan. ▪ Safeguard the interests of the organization and community by effectively overseeing risk and innovation.	▪ Engage the board at the appropriate times to benefit from its perspective on strategic matters. ▪ Convey how organizational goals, priorities and opportunities support ECH's mission, vision, values, and strategic direction. ▪ Provide timely updated metrics versus detailed summary of accomplishments. ▪ Be open to innovation and informed thinking and encourage innovation in others. ▪ Balance risk and innovation in developing strategic initiatives. ▪ Provide the board with strategic-level information and high-level analyses to equip the board in making informed decisions.
2. **Constructive Partnership** *A model of shared leadership that promotes collaboration, group cohesion, and role clarity.*	▪ Model professional behavior in all interactions by listening attentively, speaking respectfully, and respecting others' differing points of view. ▪ Seek input from committees, management, physicians, and other stakeholders on appropriate matters before making decisions. ▪ Maintain clear boundaries between governance and operations. ▪ Challenge traditional thinking and be willing to ask management tough questions.	▪ Demonstrate regard for and consideration towards board and committee members who volunteer their time to the organization. ▪ Actively seek out board members' input to leverage their expertise and experience. ▪ Communicate effectively with the board and committees in a timely fashion. ▪ Be open and responsive to questions and challenges from the board.

Core Principle	The Board Agrees to…	The Management Team Agrees to…
3. Results-Oriented *Directing organizational strategy toward the achievement of objectives, producing desired outcomes, and delivering to the required time, cost, and quality.*	▪ Ensure the board's work is value-added, meaningful, and produces solutions that advance the goals of the board and the organization. ▪ Be a champion of change by supporting management's effort to effectively carry out their plan and reach their objectives. ▪ Commit to building a culture of excellence that is driven by results and evidence-based practices. ▪ Advocate for system improvements that maintain quality and reduce variability in the delivery of health care services.	▪ Assess the efficiency, effectiveness, and impact of strategic initiatives and programs. ▪ Regularly update the board on the progress of strategic efforts against milestones. ▪ Ensure implementation of the highest clinical standards. ▪ Make patient safety a given, not a priority in competition with other priorities for limited resources and new programs.
4. **Accountability and Transparency** *Taking responsibility for one's actions; demonstrating openness; two-way communication; integrity.*	▪ Understand and adhere to the Brown Act. ▪ Advocate for ECH and have the community's best interest in mind. ▪ Conduct oneself with the utmost level of confidentiality and professionalism. ▪ Speak openly and honestly with respect toward others. ▪ Take ownership and responsibility of one's actions.	▪ Keep the board informed on significant issues, concerns or incidences that may potentially have a negative impact on the organization. ▪ Communicate openly and directly with staff and board/committee members. ▪ Speak openly and honestly with respect toward others. ▪ Take ownership and responsibility of one's actions.
5. Continuous Learning *Growth through ongoing learning events and experiences.*	▪ Pursue continuing education opportunities inside and outside the board room. ▪ Stay up-to-date on the healthcare industry and take advantage of educational opportunities provided by the hospital. ▪ Assess itself annually to evaluate its effectiveness and the value it adds to the organization. ▪ Provide honest, constructive feedback to improve performance and teamwork.	▪ Be receptive to the board's feedback to improve performance and processes where appropriate. ▪ Keep the board and committees informed of learning opportunities to enhance board members' understanding of ECH and the healthcare environment. ▪ Assess performance annually and engage in educational opportunities to advance learning and effectiveness.

Normative Behaviors

In addition to the principles identified in the compact, we agree to the following normative behaviors that shape our desired culture:

1. Presume good intent
2. Implement and continuously update compliance plan
3. Communicate directly and openly with one another
4. Engage in constructive debate over ideas, data and analysis to ensure due diligence
5. Speak with one voice once decisions are made
6. Seek feedback to continuously grow and learn

ATTACHMENT 4 Board Retreat Planning_20121126.pptx

Board Retreat Planning

Date Options:

- End of February/early March
- Saturday 8:30 – 2:30 pm
- Friday 12:00 – 6:30 pm

Proposed Attendees:

- ECH Hospital Board
- CEO, COO, CMO, CFO, CNO, Interim VP of HR, Julie Johnston, Diane Wigglesworth

Proposed Topics:

- Current performance against strategy
- Clinical Program Update
- Affiliation Discussion

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ERM and Policy Oversight

To: ECH Hospital Board

Date: November 20, 2012

From: David Nygren, PhD, and JoAnn McNutt, PhD

Subject: Enterprise Risk Management and Policy Oversight

The following articles establish the context with which we are proposing the recommendations outlined in this memo regarding the ECH Hospital Board's oversight role of enterprise risk management and policy:

- "A Guide to the Board's Compliance Oversight Duties": Written by Michael Peregrine, an attorney with whom David Nygren has co-published several articles, this article draws a clear linkage between a health care organization's exposure to risk and its compliance procedures and responsibilities. Given our trust in his expertise, our longstanding working relationship with him, and the research he presents here, we believe that ECH's Corporate Compliance, Privacy, and Audit Committee is the best entity through which enterprise risk management should be overseen by the board.
- "A Model for Enterprise Risk Management within a Healthcare Organization": This article discusses how ERM is related to compliance readiness and the Sarbanes-Oxley Act for health care organizations.
- "Sarbanes-Oxley Impetus for ERM": Sarbanes-Oxley has numerous implications for non-profit organizations, and this article covers its application to a risk management enterprise context.

Enterprise Risk Management

As cited in the first two articles listed above, it is clear that there needs to be institutional commitment to an effective compliance plan to mitigate exposure to potential risks affecting the most senior levels of the organization. It is necessary, however, to situate the compliance plan within a broader framework that enables the hospital to identify, evaluate, and respond to all risks across function areas while maintaining patient safety. Given that the board has explicit fiduciary requirements with respect to the implementation and operation of compliance, board members should be fully aware of their responsibilities in this area, as that can positively impact the organization's risk profile.

As cited in the third article listed above, it is widely recognized among non-profit health institutions that there is value in incorporating the principles of the Sarbanes-Oxley Act into compliance procedures. Nonprofit organizations are not bound legally to the specific

requirements of this law in the same way for-profit companies are, which allows non-profits some flexibility in implementation. Health care organizations can capitalize on this by taking a risk-based approach to Sarbanes-Oxley implementation, which allows hospitals and health systems to address the processes and controls that are most important or vulnerable.

Because compliance and risk oversight are so closely intertwined, at ECH, to develop a broader view of risk management across the enterprise, the Corporate Compliance, Privacy and Audit Committee is well-positioned to ensure the organization's compliance plan is aligned with the areas that require greatest attention. That said, each committee assumes some level of risk oversight in the areas they govern. For example, the Quality Committee is more able to effectively oversee risk involved in patient safety and quality of care. With that in mind, any approach to enterprise risk management inherently encompasses the full range of organizational functions, which we believe can be centralized within the scope of work of the Compliance Committee. The board should ensure that communication processes between each committee, the Compliance Committee, and the board facilitate the sharing of critical information related to risk management.

Policy Oversight

Similarly, the Corporate Compliance, Privacy, and Audit Committee is the logical entity to oversee policy. In general, a board committee is responsible for the policies it sponsors; policy oversight is not typically centralized. That said, the Compliance Committee can review developing and proposed policies and various committee initiatives for the purpose of providing input both to the committees and the board with regard to some specific perspectives. Those perspectives include the degree to which specific proposals address policy goals relevant to ECH and whether initiatives/policies are sufficiently evidence-based, where appropriate. The goal of the committee's work with respect to policy oversight should be to ensure that ECH initiatives, regardless of sponsoring committee, are reviewed and evaluated with a standard set of perspectives. The Compliance Committee can oversee policy planning for ECH and make recommendations to the full board on major policy issues affecting the hospital and its capacity to carry out its mission.