El Camino Health

AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, April 15, 2020 – 5:30pm
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-866-365-4406, MEETING CODE: 9407053#

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Lanhee Chen, Board Chair		**5:30 – 5:31pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information 5:31 – 5:32**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.* b. Written Correspondence	Lanhee Chen, Board Chair		**information 5:32 -5:35**
4.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair; Mark Adams, MD, CMO	*public comment*	**possible motion 5:35 – 5:55**
5.	**FY20 PERIOD 8 FINANCIALS** **ATTACHMENT 5**	Michael Moody, Interim CFO	*public comment*	**possible motion 5:55 – 6:05**
6.	**APPROVAL OF RESOLUTION 2020-02: Declaring a Local Emergency** **ATTACHMENT 6**	Mary Rotunno, General Counsel; Cindy Murphy, Director of Governance Services	*public comment*	**possible motion 6:05 – 6:20**
7.	**ADJOURN TO CLOSED SESSION**	Lanhee Chen, Board Chair	*public comment*	**motion required 6:20 – 6:26**
8.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information 6:26 – 6:27**
9.	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair		**motion required 6:27 – 6:29**
	Approval *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board Meeting (3/11/2020) b. Minutes of the Closed Session of the Executive Compensation Committee Meeting (11/7/2019) ***Information*** *Health & Safety Code Section 32155:* c. Enterprise Quality Council Minutes			

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	Gov't Code Section 54956.9(d)(2): ***Reviewed by the Finance Committee and Compliance and Audit Committees:*** d. Summary of Physician Financial Arrangements			
10.	*Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Report	Imtiaz Qureshi, MD, Enterprise Chief of Staff; Linda Teagle, MD, Los Gatos Chief of Staff		**motion required** **6:29 – 6:44**
11.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets and *Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - COVID-19 – Impact on Organizational Prioritization	Dan Woods, CEO; Jim Griffith, COO; Mark Adams, MD, CMO; Cheryl Reinking, RN, CNO		**discussion** **6:44– 7:39**
12.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: - Physician Contracts a. Enterprise Telestroke Agreement; b. Neurology Inpatient Consult Panel	Jim Griffith, COO; Mark Adams, MD, CMO		**discussion** **7:39– 7:49**
13.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets and *Gov't Code Section 54956.9(d)(2)* – conference with legal counsel – pending or threatened litigation: - SVMD Update	Dan Woods, CEO; Bruce Harrison, President, SVMD; Mary Rotunno, General Counsel		**discussion** **7:49– 8:34**
14.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets; Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: - CEO Report on New Programs	Dan Woods, CEO		**discussion** **8:34 – 8:39**
15.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: - Executive Session	Lanhee Chen, Board Chair		**discussion** **8:39 – 8:59**
16.	**ADJOURN TO OPEN SESSION**	Lanhee Chen, Board Chair		**motion required** **8:59 – 9:04**
17.	**RECONVENE OPEN SESSION/ REPORT OUT**	Lanhee Chen, Board Chair		**information** **9:04 – 9:05**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
18.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair	*public comment*	**motion required** **9:05 – 9:07**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	Approval a. Minutes of the Open Session of the Hospital Board Meeting (3/11/2020) ***Reviewed and Recommended for Approval by the Medical Executive Committee*** b. Medical Staff Report c. Proposed Revised Medical Staff Bylaws ***Reviewed and Recommended for Approval by the Executive Compensation Committee*** d. Proposed Revised Policies: - Executive Comp Philosophy - Base Salary Admin Policy - Executive Performance Incentive Plan Policy e. Minutes of the Open Session of the Executive Compensation Committee Meeting (11/7/2019) ***Reviewed and Recommended for Approval by the Finance Committee*** f. FY20 Period 7 Financials g. Urology On-Call Panel (MV) h. Urology On-Call Panel (LG) i. Infection Control Medical Director Hours Increase ***Reviewed and Recommended for Approval by the Governance Committee*** j. Proposed FY20 Board and Committee Self-Assessment Tools			
	Information k. Progress on FY20 Board Action Plan l. Update on Major Capital Projects in Progress m. Finance Committee Approvals			
19.	**PHYSICIAN CONTRACTS** a. Enterprise Telestroke Agreement b. Neurology Inpatient Consult Panel **ATTACHMENT 19**	Jim Griffith, COO; Mark Adams, MD, CMO	*public comment*	**possible motion(s) 9:07 – 9:09**
20.	**RESOLUTION 2020-03: Approving Neurology Inpatient Consult Panel Agreement for Peter C. Fung, MD** **ATTACHMENT 20**	Mark Adams, MD, CMO	*public comment*	**possible motion 9:09 – 9:11**
21.	**CEO REPORT** **ATTACHMENT 21**	Dan Woods, CEO		**information 9:11 – 9:14**
22.	**BOARD COMMENTS**	Lanhee Chen, Board Chair		**information 9:14 – 9:15**
23.	**ADJOURNMENT**	Lanhee Chen, Board Chair	*public comment*	**motion required 9:15pm**

Upcoming Regular Meetings: May 5, 2020; May 20, 2020; May 26, 2020*; June 10, 2020
*Joint Meeting with Finance Cmte

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Julie Kliger, MPA, BSN, Quality Committee Chair
Mark Adams, MD, CMO
Date: April 15, 2020
Subject: Quality, Patient Care and Patient Experience Committee Report

Purpose:

To inform the Board of the work of the Quality Committee, and to obtain approval of the proposed Quality/Performance Improvement and Patient Safety Plan, which the Quality Committee voted to recommend.

Summary:

1. Cheryl Reinking, RN, CNO, provided an update on survey data related to patient experience based on HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) data. The three areas of opportunities for improvement are discharge information, responsiveness of staff, and likelihood to recommend. Specific interventions for each area were presented. For example, “commit to sit” and call light attention are designed to improve responsiveness. “Help at Home” initiative and post-discharge phone calls enhance discharge instructions. Frequent rounding and service recovery are configured to improve likelihood to recommend. On a positive note, the FY20 goal that 80% of all HCAHPS metrics score above the national 50th percentile was achieved.

2. Mark Adams, MD, CMO, presented the proposed Quality/Performance Improvement and Patient Safety Plan (traditionally known as the QAPI—quality assurance and process improvement). This provides a framework for the quality and safety performance improvement activities of the organization. This links the mission, vision, and values to efforts designed to improve quality and reduce risk. This also satisfies regulatory requirements including the Joint Commission and CMS. Two major additions to this plan this year compared to previous versions are the concept of high reliability (HRO) and the STEEEP (safe, timely, effective, efficient, equitable, and person centered care) definition of quality and safety. Highlights include introducing Patient Safety Oversight and Root Cause Analysis Oversight committees, introducing a Serious Safety Event Classification system, application of LEAN methodology, and defining corrective action auditing methodology. Following robust discussion, the Committee voted to recommend adoption of this plan by the Board.

3. Mark Adams, MD, CMO, presented the results of the annual CMS Value Based Purchasing Program. CMS scores each qualifying healthcare organization in four sectors: clinical care, patient experience, safety, and efficiency. Each organization starts with a 2% withhold and can then “earn back” the withhold and possibly earn a “bonus” up to 2% based on performance. Based on a measurement period that ended in December of 2019, El Camino will experience a 0.0022% reduction on future FFY21 Medicare PPS (prospective payment system) payments. Based on estimated projected Medicare revenue, this amounts to a roughly $196,000 penalty. We scored very well in clinical care, average in safety and patient experience, and poorly in efficiency which is Medicare beneficiary per year spending.

4. The Quality Committee goals were reviewed and approved which will now include review of the effectiveness of the new Board quality dashboard.

5. The committee reviewed the proposed FY21 organizational goals pertaining to quality, safety, and patient experience. The goals selected include reduction of readmission index, reduction of the SSER (serious safety event rate), improvement in HEDIS (healthcare effectiveness data information set), and likelihood to recommend. Each goal was evaluated based on the following principles and corresponding questions:

a. Does it support our mission and impact the patient?
b. Does it affect many different categories of patients?
c. Is it easily understood?
d. Is it used in the public domain as a quality proxy?
e. Does it have financial impact?
f. Can we reliably measure it and compare it to a benchmark?

After considerable discussion, the committee approved recommending adoption of these FY21 organizational goals to the Board.

List of Attachments:

1. Quality Dashboard
2. Proposed Quality/Performance Improvement and Patient Safety Plan

Suggested Board Discussion Questions: None.

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

February 2020 (Unless otherwise specified)

Month to Board Quality Committee: April, 2020

Quality	FY20 Performance: Latest month	FY20 Performance: FYTD	Baseline FY19 Actual	FY 20 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Months Average
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: February 2020*	0.77 (1.62%/2.11%)	0.69 (1.35%/1.94%)	0.97	0.90	UCL: 1.36; Target: 0.90; LCL: 0.56	FY20 Target; Mortality Rolling 12 month average
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: January 2020*	0.94 (8.17%/8.68%)	1.01 (7.97%/7.92%)	0.99	0.96	UCL: 1.20; Target: 0.96; LCL: 0.85	FY20 Target; Readmission Rolling 12 month average
3	**Patient Throughput-Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Date Period: February 2020*	MV: 306 min LG: 240 min Enterprise: 273 min	MV: 288 min LG: 229 min Enterprise: 259 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)	UCL: 353; Target: 266; LCL: 218	FY20 Target; ED Throughput Rolling 12m avg for MV; ED Throughput Rolling 12m avg for LG; ED Throughput Rolling 12m avg Enterprise

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Mortality Index (Observed/Expected)	The number of deaths increased in February, the observed was sill less than expected. Better physician documentation on the patient's major and co-morbid conditions increases the index expected value. FYTD we are well below target @ 0.69.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
Readmission Index - All Patient All Cause Readmit (Observed/Expected)	Readmissions were reduced in January, and with the use if the Conversa Chat box for the Pneumonia population, in February, we hope to see a continued reduction. .	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
Patient Throughput-Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients and Newborns)	This org goal is renamed as, "Arrival to ED Departure" given the process change in ED that went live on Feb 11th, 2020. Like last month, teams have continued to keep their throughput performance trending in the right direction compared to the high surge season last fiscal year. In addition, there was a process change implemented in mid-February to help address some billing and compliance issues that will impact the measurement of the end point of this metric. Instead of patients being pulled into their bed in Epic once they reach the unit, they will be placed into their bed by the ED staff as they depart the Emergency room. This will remove the physical transportation time once we get to 100% compliance with the new process. Meanwhile, both campuses are working on sustaining other process improvements and elements of their daily management systems.	Cheryl Reinking, Dolly Mangla	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *LCL is set to '0' if value is less than or equal to zero.*	**iCare Report: ECH ED Arrival to Floor**

FY 20 Organizational Goal and Quality Dashboard Update

February 2020 (Unless otherwise specified)

Month to Board Quality Committee: April, 2020

	Service	FY20 Performance: Latest month	FY20 Performance: FYTD	Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
4	* Organizational Goal **HCAHPS Discharge Information** **Top Box Rating of Always** *Date Period: February 2020*	89.5	87.7	86.7	87.3	UCL 90.2; Target: 87.3; LCL: 83.9 (Oct-18 to Feb-20)	FY20 Target; Discharge Information Rolling 12 month average (Mar-19 to Feb-20)
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: February 2020*	63.0	66.3	65.7	67.1	UCL: 70.7; Target: 67.1; LCL: 60.2 (Oct-17 to Feb-20)	FY20 Target; Responsiveness Rolling 12 month average (Mar-19 to Feb-20)
6	*Organizational Goal **HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: February 2020*	83.8	83.3	83.5	84.2	UCL: 87.6; Target: 84.2; LCL: 79.1 (Oct-18 to Feb-20)	FY20 Target; Likelihood to Recommend Rolling 12 month average (Mar-19 to Feb-20)

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	• Discharge Information – this metric is above target for the quarter and year to date. Strong improvements have been made in Inpatient / Mother baby especially in Los Gatos. Continued work is being done on implementing the proven best practice of post discharge phone calls. "Help at Home" signs are up on all units in order to help foster the discharge discussion. Committee continues to work with low scoring nursing units and has seen improvements.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero..*	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	• Staff Responsiveness – this metric is below target for the quarter and year to date. Committee focusing on units with the lowest scores and high volume. Mother/Baby 'commit to sit' where nurses commit to sit daily in order to make a connection and/or address concerns has seen has seen an improvement in Responsiveness scores for MV MCH. Call light system malfunctions have been reported to facilities and repaired. Continue to submit requests for system as needed. Proposal for replacement is in the works. Working with Admin Support (AS) to assure best practices, "words that work", and call light escalation/response structure is in place and utilized. Hourly rounding /purposeful rounding program is being reviewed in order to improve its efficacy Communication training for the non-clinical staff has been placed on Hold.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Press Ganey Tool**
HCAHPS Likelihood to Recommend Top Box	• HCAHPS: Likelihood to Recommend – Likelihood to Recommend is our loyalty score and the industry standard of measuring experience. Although not quite at target, ECH continues to have strong LTR scores and high percentile (88th%tile) compared with others in the nation. Continued emphasis on leader rounding, updating and reinvigorating our service standards, will contribute to this metric. Leader-patient rounding will continue by Nurse Leaders and was recently restructured for non-nursing leaders to focus rounding on staff. Questions were updated in Vocera rounding tool.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Press Ganey Tool**

Current Status: *Draft*	**PolicyStat ID:** *7725923*

Origination:	*05/2018*
Effective:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Catherine Carson: Senior Director Quality*
Area:	*Quality, Risk & Patient Safety*
Document Types:	*Plan*

Quality/Performance Improvement & Patient Safety Plan (QAPI)

PURPOSE

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

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ORGANIZATION OVERVIEW

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

The ECH Medical Staff includes 1606 active, courtesy or provisional physicians/independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

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

El CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

El CAMINO HEALTH VALUES

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

Compassion: We care for each individual uniquely with kindness, respect and empathy.

Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

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

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

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

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

HIGH RELIABILITY

El Camino's 2020 vision for quality includes a high reliability journey leading to zero preventable harm. Safety is a well-defined science and can be improved through attention to reliability culture (expectations, behaviors, teamwork, etc.) and processes (intuitive design, mistake proofing, etc.). Camino will form a steering committee to implement these high reliability practices. Implementation will include training and case-based learning, multi-disciplinary interactions to improve communication, tools, job aids, and newsletters. Real-time change management will include simulations, moments for safety before meetings, red "no interruption zones," and a cascade of safety huddles that focus on patient and team member risk assessment and mitigation. Additional support for cultural transformation will include leader rounding, safety coaches on each unit, policy changes, tools, on-line resources, and rewards/recognition.

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

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

DEFINITIONS

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

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.

- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

SERVICES/PROGRAMS

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

Acute Inpatient Services:	**Emergency Services**	**Outpatient Services**
Intensive & Critical Care Unit	Basic Emergency	Behavioral Services – Outpatient
Progressive Care Unit (PCU) (Step-down)		Cancer Center
Operating Room (OR)		Cardio Pulmonary Wellness Center
Post-Anesthesia Care Unit (PACU)		Outpatient Surgical Unity
Telemetry/Stroke		Endoscopy
Medical/Surgical/Ortho		Interventional Services
Pediatrics		Pre-op/ Short Stay Unit (2B)
Ortho Pavilion		Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI)
Labor and Delivery (L&D)		Radiation Oncology
Mother/Baby		Rehabilitation
Neonatal Intensive Care Unit (NICU) Le Level II and Level III		Infusion Services
Mental Health and Addictive Services (Inpatient) Psychiatry)		Nuclear Medicine
Acute Rehabilitation		Wound Care Clinic
Cardiac Catheterization Services		Occupational Therapy/Physical Therapy
Cardiovascular Surgery		Speech Therapy

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OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.

5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.
6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of performance improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

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A. Governing Board

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

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

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

Other specific responsibilities with regard to performance improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the Governing Board.

B. Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.14, the Medical Executive Committee is responsible for the quality and efficiency of patient care rendered by members of the Medical Staff and for the

medico-administrative obligations of the medical staff.

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

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

C. Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of a combination of campus-specific departments and enterprise departments. Enterprise departments are those departments that serve constituency at all campuses (including Mountain View – MV and Los Gatos- LG). All departments report to an Enterprise Medical Staff Executive Committee.

Other specific responsibilities with regard to performance improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A.

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D. Leadership and Support

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

1. Adopt an approach to performance improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities
2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. Establish priorities for performance improvement and safety giving priority to high-volume, high-risk, or problem- prone processes for performance improvement activities and reprioritize performance improvement activities in response to changes in the internal and external environment
4. Participate in interdisciplinary and interdepartmental performance improvement and safety improvement activities in collaboration with the medical staff
5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
6. Assure that staff is trained in performance improvement and safety improvement approaches and methods and receives education that focuses on safety and quality
7. Continuously measure and assess the effectiveness of performance improvement and safety improvement activities, and implement improvements for these activities

E. Medical Staff, Employees, and Contracted Services

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

F. Enterprise Quality & Patient Safety Committees: Enterprise Quality Council and Patient and Employee Safety Committees (See Flow of Information Appendix A)

The Medical Staff Bylaws describe the composition and duties of the Enterprise **Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments and information on medical record review, transfusion, tissue and autopsy review. The Quality and Safety Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues.

The Enterprise **Patient and Employee Safety Committee** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Ulcers, Hospital-acquired Infections A3 Teams (CAUTI, CLABSI, C. Diff, and Hygiene), National Patient Safety Goals, Safety/Security, Antibiotic Stewardship, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene and the Grievance Committee. The Committee also reviews reports from Culture of Safety Surveys and works with the medical staff and hospital administration to develop action plans in response to the results. The Director of Risk Management also conducts risk assessments regarding the safety of patient care including Failure Mode Effects Analysis (FMEA) for new or changed hospital services. The Director of Risk Management/Patient Safety Officer provides data on the Quality Review Reports (QRR), ECH's Online System for adverse event reporting) and the adequacy of the reporting process, including updates on the number and type of QRRs, serious safety events and RCAs (root cause analyses). Updates are also provided on the performance improvement teams that are chartered through this committee and as a result of RCAs or Intensive Analyses. This Committee uses the Management of Serious Safety Events policy to outline the process for categorizing patient safety events, including serious safety events, defining those events that reach the level of a Red Alert, ensuring compliance with all regulatory requirements for oversight of adverse events and to outline the procedure for notifying ECH leadership and the ECH Board of serious safety events.

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

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The Quality Readmission and Mortality Performance Improvement Teams is a sub teams and will report to the Readmission and Mortality Steering Committee and then reports to the Enterprise Quality Council. The Quality Readmission and Mortality Performance Improvement Teams consist of a multidisciplinary approach to addressing identified trends and or patterns which have increase the readmission and or mortality rates. The teams will work on specific tasks, processes to streamline care and ensure the patients are receiving quality of care and maintaining patient safety initiatives.

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

G. Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and performance improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Quality, Safety and Risk Management Department staff serves as an internal resource for the development and evaluation of performance improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including the 10 teams addressing the Quality goals of Mortality Index and Readmission Index, ERAS Team, and the Surgical Site Infection Task Force and the HAI Teams. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

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The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of performance improvement activities from all sources
2. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
3. Managing the peer review process and the peer review data base for the medical staff and providing data and reports for the OPPE and FPPE process of the medical staff
4. Providing clinical and provider data from hospital and external registry data bases as needed for performance improvement
5. Maintaining a performance improvement and patient safety reporting calendar and communicating it to all groups responsible for performance improvement activities
6. The Director of Risk Management leads efforts to manage risk and the Quality Review Reporting (QRR) (Online System for adverse event reporting). This also includes conducting Root Cause Analyses and Intense Analyses as responses to adverse events and near misses
7. Facilitating a failure mode and effectiveness analysis (FMEA) at least every 18 months through the leadership of both the Director of Risk Management & Patient Safety and the Director of Accreditation & Public Reporting
8. Performance improvement teams that are commissioned as a result of findings of Root Cause Analyses or Intense Analyses are led by the department's Performance Improvement Coordinator
9. Working with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"

10. Supporting Infection Prevention efforts within the hospital, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
11. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
12. Providing data as requested to external organizations, see List with data provided in Appendix B
13. Providing oversight for the hospital's participation in Clinical Registries, see Appendix C for current list
14. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, managing NSQIP Registry and quality improvement, the MBSAQIP, and all Transfusion review and data

H. Improving Organizational Performance

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

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

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of performance improvement, patient safety and risk reduction activities
3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)
4. Accreditation and/or regulatory requirement(s) of TheJoint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix B.

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A deviation from generally accepted performance standards (GAPS) that...

SEC SAFETY EVENT CLASSIFICATION
HPI PRESS GANEY

Serious Safety Event
- Reaches the patient
- Results in moderate to severe harm or death

Precursor Safety Event
- Reaches the patient
- Results in minimal harm or no detectable harm

Near Miss Safety Event
- Does not reach the patient
- Error is caught by a detection barrier or by chance

Serious Safety Events

Precursor Safety Events

Near Miss Safety Event

Table 1. HPI SEC Levels of Harm

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	SSE 1	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	PSE 1	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	NME 1	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch

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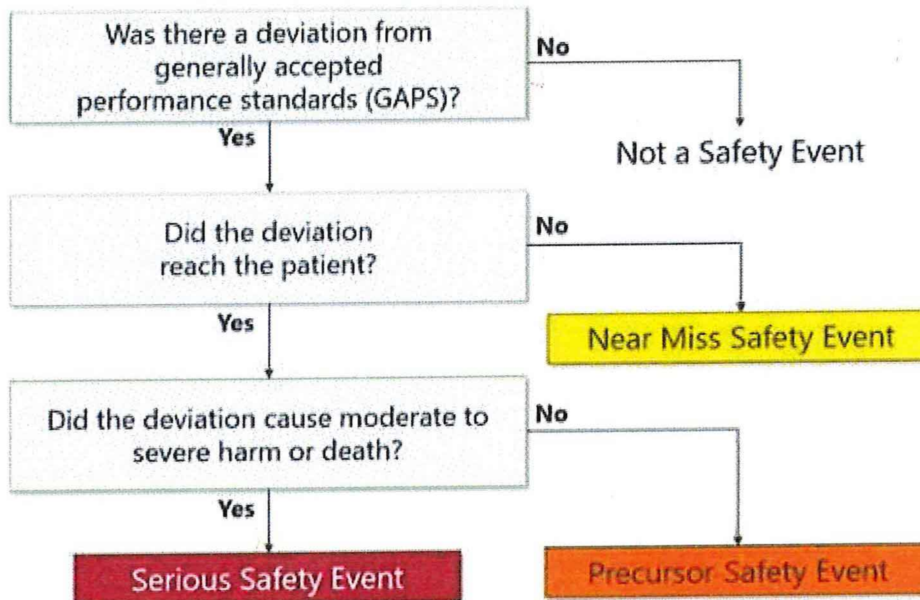


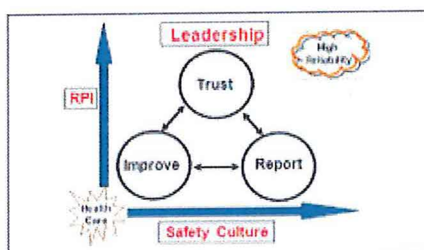
I. Performance Processes

1. **Design**

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

2. **Patient Safety**

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



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

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

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

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

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

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

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

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

a. Performance varies significantly and undesirably from that of other organizations;
b. Performance varies significantly and undesirably from recognized standards;
c. When a sentinel event occurs;

d. Blood Utilization to include confirmed transfusion reactions;
e. Significant adverse events and drug reactions;
f. Significant medication errors, close calls, and hazardous conditions;
g. Significant adverse events related to using moderate or deep sedation or anesthesia;

J. Improvement Model And Methodology

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

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

The model has two parts:

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

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

2. ***The Plan-Do-Study-Act (PDSA) Cycle***
    The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.
    Step 1: Plan
    Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
    Step 2: Do
    Try out the test on a small scale. What did we observe that was not a part of our plan?
    Step 3: Study
    Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
    Summarize and reflect on what was learned.
    Step 4: Act

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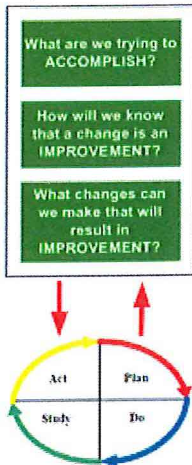
Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.

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



3. Goal Setting and Auditing Methodology
   a. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
      The acronym stands for:
      S – Specific
      When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
      Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
      What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
      When – You'll get more specific about this question under the "time-bound" section of defining S.M.A.R.T. goals, but you should at least set a time frame.
      Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
      Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."
      Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

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M – Measurable

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

A – Achievable

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

R – Relevant

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

T – Time-Bound

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

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

    - Sample all cases for a population size of fewer than 30 cases
    - Sample 30 cases for a population size of 30–100 cases
    - Sample 50 cases for a population size of 101–500 cases
    - Sample 70 cases for a population size of more than 500 cases
    - Sample 100 cases for a population greater than 500 cases
      To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

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K. Lean Improvement Methodology:

ECH has applied the use of Lean methodology and principles to the process of performance improvement. The Performance Improvement Department provides resources to the organization in deploying Lean strategies and tools. This Department provides trained A3 team facilitators and education to the organization on Lean principles. For FY 2020, the Performance Improvement Department is focusing on using Lean tools to address Through-put involving patient flow beginning in the Emergency Departments.

Lean is a set of concepts, principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. Lean organizations deliver exactly what is needed, at the right time, in the right quantity without defects, and at the lowest possible cost. The currency of lean is value.

As you take out "muda" (i.e., waste) in the process, you take out time. Waste is anything other than the minimum amount of equipment, materials, technology, space, and a colleague's time that are essential to add value to the product or service. Lean is a long term strategy in that it takes time to change. Testing turnaround time and OR utilization are classic examples. Lean thinking specifies value from the standpoint of the customer.

Systems critical to the success of lean include reward and recognition, education and training, idea generation, communication, and engagement. Lean behaviors require everyone to be a problem-solver, managers solicit ideas from colleagues and encourage continuous improvement, everyone is treated with respect and challenged to grow professionally and personally, and everyone is transparent about results and areas for improvement. Lean leadership guiding principles require a belief that problems are "treasures" and that you will go to the "gemba" (i.e., the actual workplace) to see the actual situation for understanding.

1. **Lean Principles**

   The five-step thought process for guiding the implementation of lean techniques is easy to remember, but not always easy to achieve:

   a. Specify value from the standpoint of the end customer by product family.
   b. Identify all the steps in the value stream for each product family, eliminating whenever possible those steps that do not create value.
   c. Make the value-creating steps occur in tight sequence so the product will flow smoothly toward the customer.
   d. As flow is introduced, let customers pull value from the next upstream activity.
   e. As value is specified, value streams are identified, wasted steps are removed, and flow and pull are introduced, begin the process again and continue it until a state of perfection is reached in which perfect value is created with no waste.

   Lean practices are the actions that enable the lean process. They are tactical. Improvements are the result of their repeated execution. Examples of lean practices are many and include the 5S model, standardization, visual management, and problem solving.

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L. Performance Improvement Link With Organizational Goals

ECH's Performance Improvement & Patient Safety Plan focuses on specific quality measures in three areas: quality/safety, service and efficiency. For FY 2019 and FY 2020 the Organizational Goals are:

FISCAL YEAR	QUALITY	SERVICE	EFFICENCY	PEOPLE
FY 2019	Mortality Index (Observed/ Expected Readmission Index (Observed/ Expected)	HCAHPS: Nurse Communication Responsiveness Cleanliness	Patient Throughput ED Door to Patient Floor	Employee Engagement Press Ganey Overall Engagement Score
FY2020	Mortality Index	HCAHPS: Discharge	Adjusted	Employee Engagement

FISCAL YEAR	QUALITY	SERVICE	EFFICENCY	PEOPLE
	(Observed/ Expected Readmission Index (Observed/ Expected)	Communication and Staff Responsivenesss	Discharges	Press Ganey Overall Engagement Score

M. Commitment to Person-Centered Care

ECH has embraced Person-Centered Care and believes that its goal is to create partnerships among health care practitioners, patients and families that will lead to the best outcomes and enhance the quality and safety of health care. As a result, ECH has implemented a Patient and Family Advisory Council as a formal mechanism for involving patient and families in performance improvement efforts, policy and program decision making. The patient and family advisors act as champions of the ideal patient experience, and ensure its implementation across ECH. They are involved in reviewing communication to patients and families to ensure that it builds on patient and family strengths and engages them in a partnership in health care services and serve as members of some hospital committees. As needed, the advisors make recommendations to senior leaders for improvements in service quality.

N. Allocation of Resources

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

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O. Confidentiality

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

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

P. Annual Evaluation

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

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

I. Cross References:

1. Management of Serious Safety Events and Red Alert Procedure
2. Medical Staff Peer Review Policy

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

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Attachments

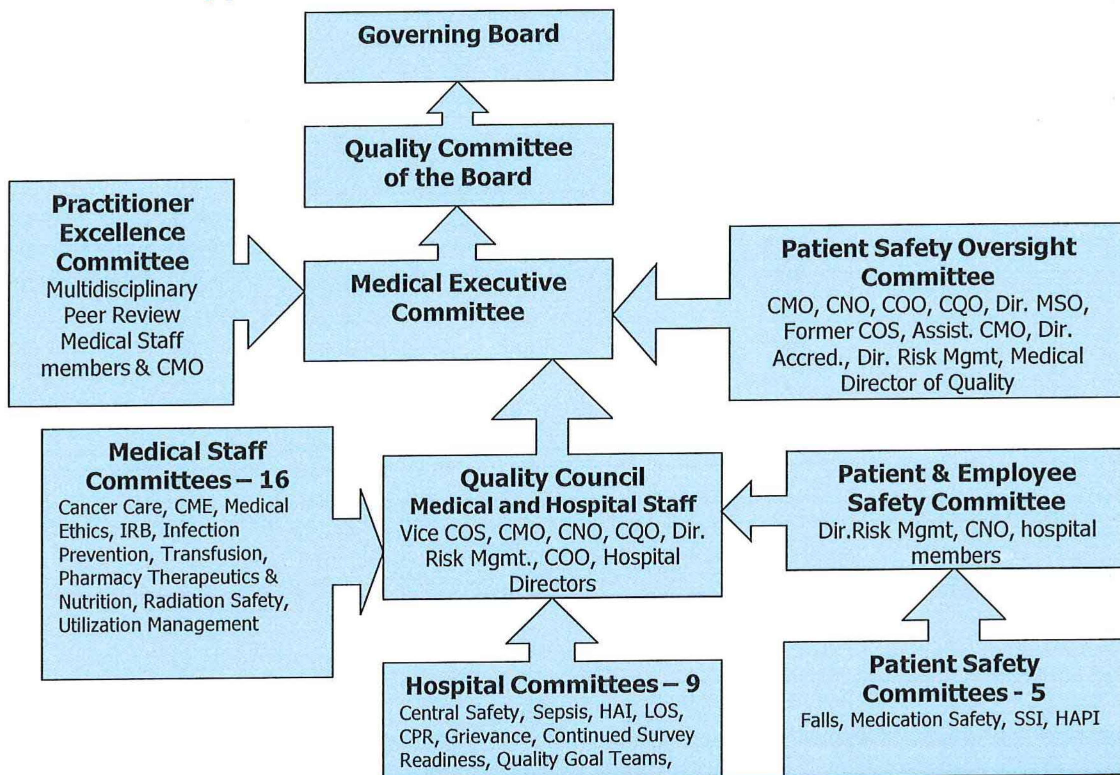
Appendix A - Information flow QA-PI-PS Plan
Appendix B- External Regulatory Compliance Indicators/Measures
Appendix C - El Camino Hospital Data Registries
Data Registries.JPG

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES
Appendix B

<table>
<tr><th>Indicator Name</th><th>Indicator Description</th><th>Regulatory/Accreditation source</th></tr>
<tr><td colspan="3">Chart-Abstracted Clinical core measures
Hospital Inpatient and Outpatient:</td></tr>
<tr><td>OP-18:</td><td>Median Time from ED Arrival to ED Departure for Discharged ED Patients</td><td rowspan="2">Hospital Outpatient Quality Reporting (OQR) Program</td></tr>
<tr><td>OP-23</td><td>Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke</td></tr>
<tr><td>PCB-05</td><td>Exclusive Breast Milk Feeding</td><td rowspan="5">TJC ORYX Performance Measurement Program</td></tr>
<tr><td>PCB-06.0</td><td>Unexpected Complications in Term Newborns - Overall Rate</td></tr>
<tr><td>PCB-06.1</td><td>Unexpected Complications in Term Newborns - Severe Rate</td></tr>
<tr><td>PCB-06.2</td><td>Unexpected Complications in Term Newborns - Moderate Rate</td></tr>
<tr><td>PCM-02a</td><td>Cesarean Birth</td></tr>
<tr><td>PCM-01</td><td>Elective Delivery</td><td>Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program</td></tr>
<tr><td>SEP-1</td><td>Early Management Bundle</td><td rowspan="5">Hospital Inpatient Quality Reporting (IQR) Program</td></tr>
<tr><td>SEP-3T</td><td>Sepsis Treatment 3-Hour Window</td></tr>
<tr><td>SEP-6T</td><td>Sepsis Treatment 6-Hour Window</td></tr>
<tr><td>SHK-3T</td><td>Septic Shock Treatment 3-Hour Window</td></tr>
<tr><td>SHK-6T</td><td>Septic Shock Treatment 6-Hour Window</td></tr>
<tr><td colspan="2">HBIPS – Hospital-based Inpatient Psychiatric</td><td rowspan="6">TJC ORYX Performance Measurement Program</td></tr>
<tr><td>IMM-2</td><td>Influenza Immunization</td></tr>
<tr><td>HBIPS-5a</td><td>Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate</td></tr>
<tr><td>SUB-2</td><td>Alcohol Use Brief Intervention Provided or Offered</td></tr>
<tr><td>SUB-2a</td><td>Alcohol Use Brief Intervention</td></tr>
<tr><td>SUB-3</td><td>Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge</td></tr>
</table>

SUB-3a	Alcohol and Other Drug Use Disorder Treatment at Discharge	
TOB-2	Tobacco Use Treatment Provided or Offered	
TOB-2a	Tobacco Use Treatment	
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge	
TOB-3a	Tobacco Use Treatment at Discharge	

Electronic Clinical Quality Measures (<u>eCQM</u>): Name and description	**Regulatory/Accreditation source**
eVTE-1 Venous Thromboembolism Prophylaxis	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
eVTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis	
eSTK-2 Discharged on Antithrombotic Therapy	
eSTK-6 Discharged on Statin Medication	
ePC-05 Exclusive Breast Milk Feeding	
eED-2 Median Admit Decision Time to ED Departure Time for Admitted Patients	


Performance Improvement & Patient Safety Plan
Appendix A: Flow of Information
Governing Board
Quality Committee of the Board
Practitioner Excellence Committee
Multidisciplinary Peer Review Medical Staff members & CMO
Medical Executive Committee
Patient Safety Oversight Committee
CMO, CNO, COO, CQO, Dir. MSO, Former COS, Assist. CMO, Dir. Accred., Dir. Risk Mgmt, Medical Director of Quality
Medical Staff Committees – 16
Cancer Care, CME, Medical Ethics, IRB, Infection Prevention, Transfusion, Pharmacy Therapeutics & Nutrition, Radiation Safety, Utilization Management
Quality Council
Medical and Hospital Staff
Vice COS, CMO, CNO, CQO, Dir. Risk Mgmt., COO, Hospital Directors
Patient & Employee Safety Committee
Dir.Risk Mgmt, CNO, hospital members
Hospital Committees – 9
Central Safety, Sepsis, HAI, LOS, CPR, Grievance, Continued Survey Readiness, Quality Goal Teams,
Patient Safety Committees - 5
Falls, Medication Safety, SSI, HAPI
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY
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El Camino Hospital Data Registries - February 2020 Appendix C

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
1	CathPCI Registry®	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the characteristics, treatments and outcomes of cardiac disease patients who receive diagnostic catheterization and/or percutaneous coronary intervention (PCI) procedures	Indication (appropriateness): Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate. Process: Proportion of STEMI patients receiving immediate PCI w/in 90' . Outcome: PCI in-hospital risk adjusted mortality (all patients); Composite: Proportion of PCI patients with death, emergency CABG, stroke or repeat target vessel revascularization; PCI in-hospital risk adjusted rate of bleeding events (all patients)	HVI	Quarterly
2	Chest Pain-MI Registry®-(old ACTION)	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients AMI process and patient care	AMI/ACS process performance: Overall AMI performance composite; STEMI performance composite; NSTEMI performance composite	HVI	Quarterly
3	ACC Patient Navigator Program Focus MI	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	This is a national program specifically designed to enhance the care and outcomes for myocardial infarction patients.	National benchmarks, with comparison data to reduce AMI patient readmission for quality improvement project	HVI	Quarterly
4	STS/ACC TVT RegistryTM	STS (Society of Thoracic Surgeons) ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Monitors patient safety and real-world outcomes related to transcatheter valve replacement and repair procedures – emerging treatments for valve disease patients. With 30day and 1 year follow-up	Process: Length of Stay (TAVR & MitraClip)– Median Post Procedure (days) and outcome (TAVR & MitraClip): In Hospital, 30 day observed and 3-year risk adjusted mortality. Risk adjusted Stroke rate	HVI	Quarterly
5	LAAO RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Captures data on left atrial appendage occlusion (LAAO) procedures to assess real-world procedural outcomes, short and long-term safety, comparative effectiveness and cost effectiveness.	Process: Proportion of patients undergoing a LAAO procedure per CMS indications; Proportion of LAAO procedures successful and medication stredegy and outcome: Proportion of patients with a major complication either intra or post procedure and prior to discharge	HVI	Quarterly
6	AFib Ablation RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the prevalence, demographics, acute management and outcomes of patients undergoing atrial fibrillation (AFib) catheter ablation procedures.	Process: Proportion of patients undergoing procedure per indications; and outcome: complication rate	HVI	Quarterly
7	STS®- Adult cardiac Surgery	STS (Society of Thoracic Surgeons)	National quality measures and quality improvements with more than 5.8 million records.	Risk adjusted Mortality for isoCABG, isoAVR and MV procedures. Composite quality rating (star rating) for isoCABG, isoAVR and MV procedures	HVI	Quarterly
8	Centers for Medicare & Medicaid Services (CMS) Hospital IQR program	IBM Watson	CMS Required eCQM Core Measures	Quality indicators	Quality	Quarterly

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
9	National Healthcare Safety Network (NHSN)	CDC, CALNOC, CDPH, Leapfrog	Quality Measures, CDC's data registry for infection data	Quality indicators: Patient Safety Module: SSI Surveillance on 29 ICD10s Facwide/IRF Surveillance: MDRO's: CDIF; MRSA; CRE; VRE Device Associated Surveliace: CLABSI, CAUTI, CLIP Compliance Bundle Healthcare Personnel Safety Module: HCP Influenza Vaccination Data	Quality; Nursing EW&HS	monthly Yearly
10	Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP)	American College of Surgeons	Nationwide accreditation and quality improvement program for metabolic and bariatric surgery. MBSAQIP centers are accredited in accordance with nationally recognized MBS standards.	Risk adjusted, mortality and complication based on 30-day, 6 month, and 1 year follow-up. Follow-up extends through 5 years.	Quality	Rolling continuous data abstraction
11	PVI RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Provide national banchmarks and risk adjusted outcome of carotid artery stent, carotid endarterectomy and low extremity peripheral artery intervention procedures.	Assesses the prevalence, demographics, management and outcomes of patients undergoing lower extremity peripheral arterial catheter-based interventions and includes carotid artery stenting (CAS) and carotid endarterectomy (CEA).	HVI	Quarterly
12	National Stroke Registry	Get with the Guidelines (GWTG)	Nationally all Primary Stroke Centers report data for comparisons	Quality Indicators	Quality; Neuro	Quarterly
13	EMS Quality Committee	Santa Clara County	Key Stroke data submitted by all county hospitals	Quality indicators	Quality; Neuro	quarterly
14	The Joint Commission Disease Specific Certification Primary Stroke	The Joint Commission	Recertification as a Primary Stroke Center		Quality; Neuro	PRN
15	Association for Behavioral Healthcare	AABH	Outpatient behavioral Health	Patient satisfaction	Behavioral Health	Quarterly
16	BASIS 24 BASC-3	MacLean	Outcomes behavioral Health	Outcomes	Behavioral Health	rolling submission
17	California Maternity Quality Care Collaborative (CMQCC)	Hospital Collaborative	Outcomes Obstetric; California Quality Maternal Child Collaborative (maternal and neonatal data)	Outcomes	Obstetrics	Monthly
18	California Perinatal Quality Care Collaborative (CPQCC)	Hospital Collaborative	Perinatal Outcomes	Outcomes	Perinatal	Monthly
19	California Alliance for Nursing Outcomes	CALNOC	Actionable information and reearch on nursing sensitive quality indicators	Nursing indicators	Nursing	Quarterly
20	National Database of Nursing Quality Indicators	NDNQI	National data base that provides quarterly and annual reporting of structure, process and outcome indicators to evaluate nursing care at the unit leel	Nursing indicators	Nursing	Quarterly
21	National Surgical Quality Improvement Program (NSQIP)	American College of Surgeons	Leading nationally validated program to measure and improve the quality of surgical care. Provides opportunity to prevent complications, save lives, and reduce costs.	Risk adjusted, case-mix adjusted mortality and complications based on 30 day outcomes.	Quality	Rolling continuous data abstraction
22	American Joint Replacement Registry	American Association of Orthopedic Surgeons	Hip and Knee Replacement Case Profile data, Risk Assessment data, and Outcomes data	Case data including implants, comorbidities, hospital complications. Patient reported outcomes Survey data fro HOOS JR, KOOS JR, and PROMIS-10	Ortho Director	Rolling submission with PRO data drawn
23	The Joint Commission - Disease-Specific Certification for Total Joints, Hip Fracture, Spinal Fusion	The Joint Commission	Disease-specific (Total Joint, Hip Fracture, Spinal Fusion)		Ortho	Every two years

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
24	CCORP	CA state OSHA	California state mandated, any adult cardiac surgery related to CABG	Outcome (part of STS) risk adjusted mortality and stroke rate. Comparison with all other CA hospitals	HVI	biannually
25	Santa Clara County-AMI and Cardiac Arrest	Santa Clara County	Santa Clara county mandated. AMI and cardiac arrest patient	EMS process and outcome. Biannually County meeting	HVI	Quarterly
26	National Cancer Data Base	American College of Surgeons and the American Cancer Society	Information on patients with malignant neoplastic diseases, their treatments, and outcomes. Data submitted for accreditation application and used for quality benchmarking	Outcomes	Cancer Registry	Annually
27	State Registry/SEER	CA Cancer Registry	California state mandated, any reportable cancer cases.	New cancer cases	Cancer Registry	Monthly
28	HCAHPS	Press Ganey	Patient satisfaction survey required by CMS	Patient satisfaction	Patient Experience	2X a week Mon and Thurs
29	Hospital Based Inpatient Psychiatrics Services Core Measures, Hospital IQR program	CMS	HBIPS is just one set of core measures for TJC and CMS	Psychiatric clinical measures	Quality	Quarterly
30	MIRCal for inpatient, emergency room and ambulatory surgery coded data	Office of Statewide Health Planning and Development (OSHPD)	OSHPD state mandated report for IP, ED and AD coded cases on semiannual and quarterly basis.	Data statistics for coded/reported diagnoses, procedures and associated charges.	HIMS Coding	Semiannual for inpatient data and quarterly for ED and ambulatory data
31	Parkinsons Registry	California Department of Public Health			HIMS Coding	Every month
32	Quarterly Tracking of Birth Defects - Neural Tube Defects and Chromosomal Abnormalities	California Department of Public Health Genetic Disease Screening Program	Coded cases for neural tube defects and/or chromosomal abnormalities found in fetus or infants less than one year of age.	Identifying fetus or infants less than one year with neural tube defects for clinical research.	HIMS Coding	Quarterly

El Camino Health

Summary of Financial Operations

Fiscal Year 2020 – Period 8
7/1/2019 to 2/29/2020

Financial Overview - February

Financial Performance

- Operating Margin favorable variance was $6M. Driven by:
  - Patient Revenue was favorable to budget $10.8M (14%)
    - Both Inpatient and Outpatient charges were favorable to budget driven by high patient volumes
  - Operating Expense was unfavorable to budget by $4.8M (6%)
    - Operating Expense per CMI Adjusted Discharge was 5% favorable to budget indicating solid cost control during period of high growth
- Non Operating Income saw a sharp decline due to investment market conditions.

Hospital Patient Volume

- Adjusted Discharges (AD) favorable to budget 365 ADs (13.6%) and favorable to prior year by 10%
  - Mountain View: Favorable to budget by 251 ADs (11.4%) and favorable to prior year by 9%
  - Los Gatos: Favorable to budget by 123 ADs (25%) and favorable to prior year by 14%

Payor Mix

- Commercial payor mix was favorable to budget by 1.3% in February.

Financial Overview – February Year to Date

Financial Performance

- Strong outpatient volumes and solid inpatient volumes drive year to date operating margin favorable variance, $14M (29%). Despite continued higher volumes, expenses continue to increase at a lower rate than revenue
  - Patient Revenue favorable to budget by $27.2M (4.2%)
  - Operating expense unfavorable to budget by $14.9M (2.3%)
    - Supplies are higher than budget due to continued high mix of procedural volume growth
- Non Operating Income is at budgeted level with the anticipation of significant future movement due to recent market conditions

Hospital Volume

- Adjusted Discharges (AD) continues to be favorable to budget 1,945 ADs (8%) and favorable to prior year by 12%. Overall Procedural volume favorable to budget by 3.0%. Favorable by 6% excluding budgeted LG Infusion volumes.
  - Mountain View: Favorable to budget by 1,395 ADs (7%) and favorable to prior year by 10%
    - Procedural Volume favorable to budget by 900 cases (4.9%)
    - Infusion encounters favorable to budget by 558 encounters (11%) - extended hours and increased productivity
    - Heart & Vascular procedures up 74 cases (4%)
  - Los Gatos: Favorable to budget by 550 ADs (13%) and favorable to prior year by 20%
    - Excluding budgeted Infusion volumes, procedural volume favorable to budget by 434 cases (11%)
      - Orthopedics & Spine surgeries favorable to budget by 239 cases (34%) due to high producing ortho/spine surgeons
      - General Surgery favorable to budget by 128 cases (17%) driven by Ophthalmology
      - General Medicine favorable to budget by 43 cases (10%) driven by Endoscopy

Payor Mix

- Payor mix continues at budget year to date

Productivity

- Year to date FTEs are at targeted levels

Dashboard - as of February 29, 2020

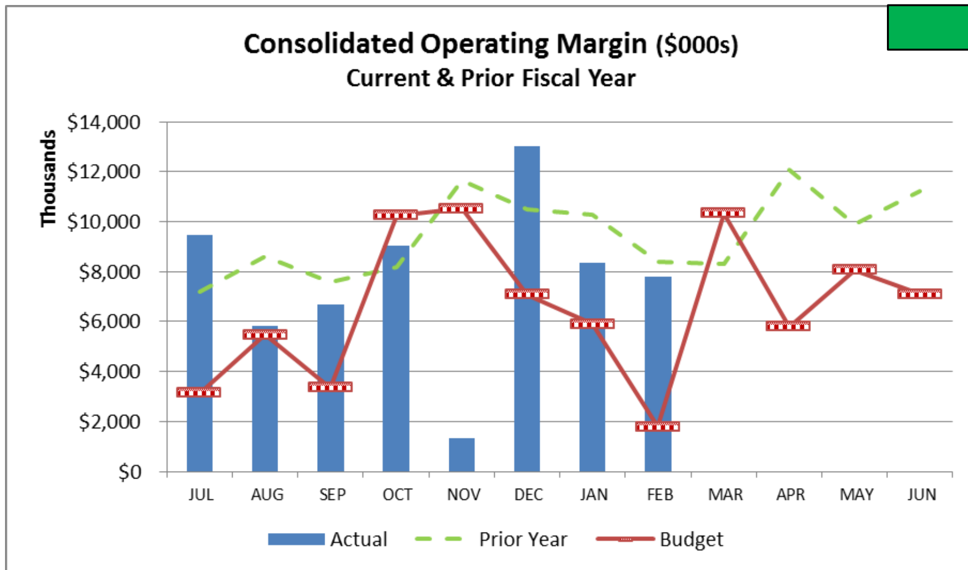
	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Consolidated Financial Perf.								
Total Operating Revenue	77,096	91,172	80,324	10,848	637,054	720,831	692,011	28,820
Operating Margin $	8,396	7,783	1,787	5,996	72,353	61,440	47,483	13,958
Operating Margin %	10.9%	8.5%	2.2%	6.3%	11.4%	8.5%	6.9%	1.7%
EBIDA %	17.2%	15.4%	10.6%	4.8%	17.2%	14.0%	13.3%	0.7%
Hospital Volume								
Licensed Beds	443	443	443	-	443	443	443	-
ADC	258	259	236	23	237	240	238	2
Utilization MV	71%	71%	64%	6.8%	65%	66%	64%	1.3%
Utilization LG	32%	33%	31%	2.1%	29%	30%	32%	(1.5%)
Utilization Combined	58%	59%	53%	5.3%	54%	54%	54%	0.4%
Total Discharges (Excl NNB)	1,576	1,611	1,501	110	12,742	13,577	13,003	574
Hospital Payor Mix								
Medicare	52.9%	50.8%	49.9%	0.9%	48.3%	49.3%	48.5%	0.7%
Medi-Cal	8.2%	7.0%	8.3%	(1.3%)	8.1%	7.4%	8.1%	(0.7%)
Total Commercial	36.5%	40.5%	39.3%	1.3%	41.1%	41.0%	41.0%	(0.0%)
Other	2.5%	1.7%	2.5%	(0.8%)	2.4%	2.3%	2.3%	(0.0%)
Hospital Cost								
Total FTE	2,719.0	2,891.6	2,873.1	(18.5)	2,648.6	2,801.3	2,797.5	(3.8)
Productive Hrs/APD	30.2	29.6	32.4	2.8	30.6	30.8	31.9	1.2
Consolidated Balance Sheet								
Net Days in AR	49.4	52.0	49.0	(3.0)	49.4	52.0	49.0	(3.0)
Days Cash	510	452	435	17	510	452	435	17

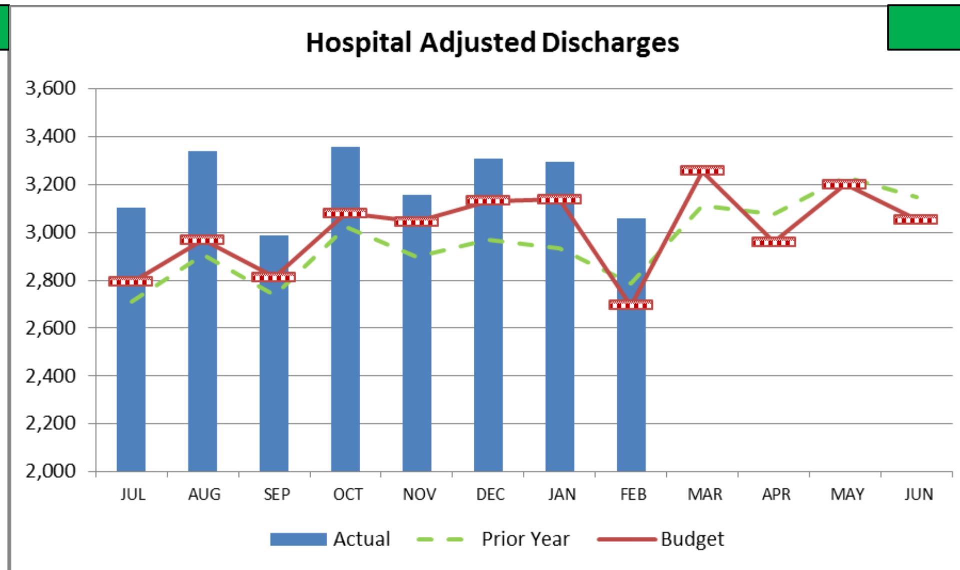
Consolidated Statement of Operations ($000s)

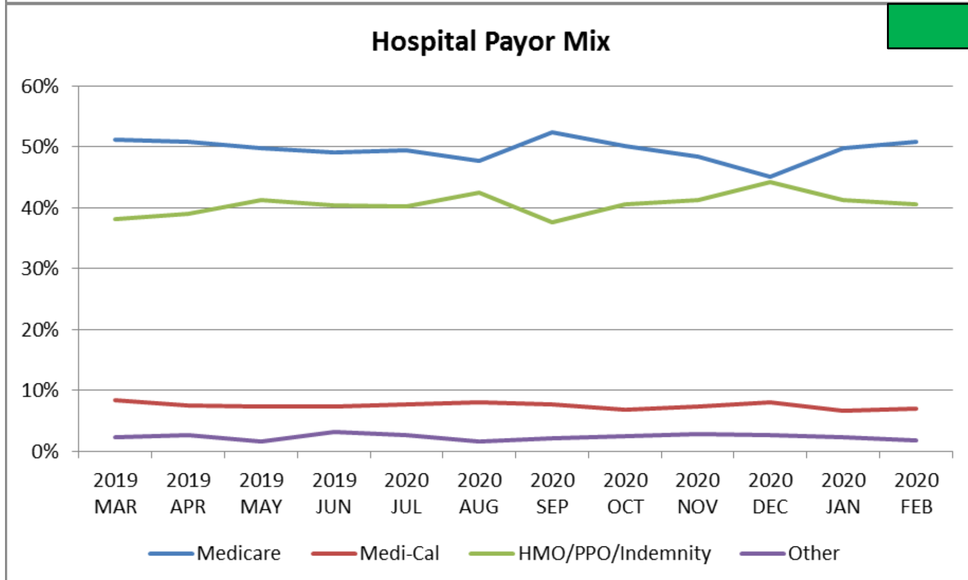
Period ending 02/29/2020

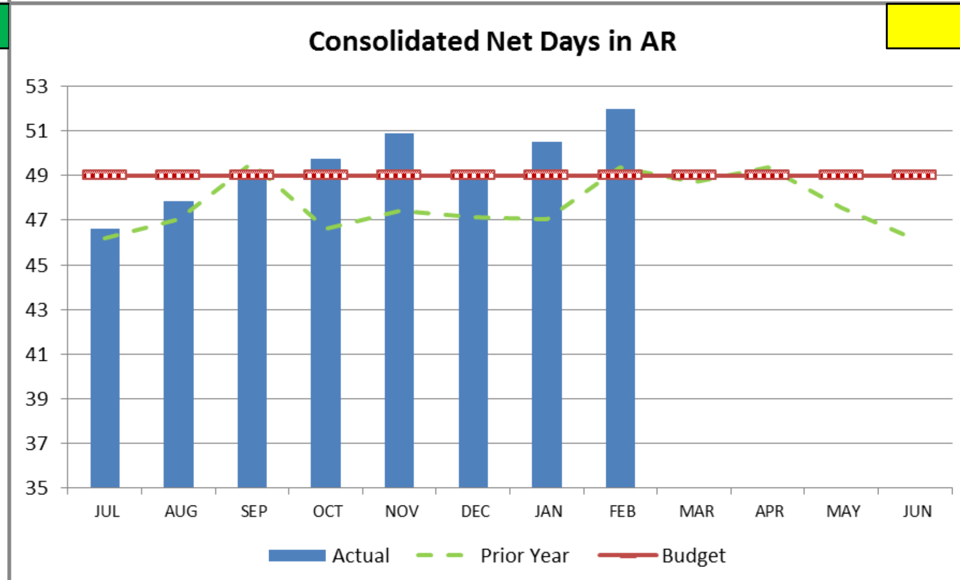
Period 8 FY 2019	Period 8 FY 2020	Period 8 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
286,320	325,932	292,375	33,557	11.5%	**Gross Revenue**	2,300,279	2,603,852	2,521,039	82,814	3.3%
(212,259)	(239,489)	(216,472)	(23,017)	(10.6%)	**Deductions**	(1,690,668)	(1,919,864)	(1,864,717)	(55,147)	(3.0%)
74,061	**86,443**	**75,903**	**10,540**	**13.9%**	**Net Patient Revenue**	**609,611**	**683,988**	**656,321**	**27,667**	**4.2%**
3,035	4,729	4,421	308	7.0%	**Other Operating Revenue**	27,443	36,843	35,690	1,153	3.2%
77,096	**91,172**	**80,324**	**10,848**	**13.5%**	**Total Operating Revenue**	**637,054**	**720,831**	**692,011**	**28,820**	**4.2%**
					OPERATING EXPENSE					
40,728	46,497	44,313	(2,185)	(4.9%)	**Salaries & Wages**	336,225	369,822	368,297	(1,525)	(0.4%)
10,739	12,903	11,301	(1,602)	(14.2%)	**Supplies**	87,875	106,240	95,859	(10,381)	(10.8%)
9,636	14,080	12,595	(1,485)	(11.8%)	**Fees & Purchased Services**	82,017	113,084	104,117	(8,967)	(8.6%)
2,759	3,669	3,589	(80)	(2.2%)	**Other Operating Expense**	21,066	30,090	31,546	1,456	4.6%
468	1,458	1,428	(30)	(2.1%)	**Interest**	2,965	4,227	6,226	1,999	32.1%
4,369	4,781	5,310	529	10.0%	**Depreciation**	34,553	35,928	38,484	2,556	6.6%
68,700	**83,388**	**78,537**	**(4,852)**	**(6.2%)**	**Total Operating Expense**	**564,701**	**659,391**	**644,529**	**(14,862)**	**(2.3%)**
8,396	**7,783**	**1,787**	**5,996**	**335.6%**	**Net Operating Margin**	**72,353**	**61,440**	**47,483**	**13,958**	**29.4%**
17,241	(28,424)	3,327	(31,751)	(954.4%)	**Non Operating Income**	9,527	24,461	24,996	(535)	(2.1%)
25,637	**(20,641)**	**5,114**	**(25,755)**	**(503.6%)**	**Net Margin**	**81,880**	**85,901**	**72,479**	**13,422**	**18.5%**
17.2%	15.4%	10.6%	4.8%		**EBITDA**	17.2%	14.1%	13.3%	0.8%	
10.9%	8.5%	2.2%	6.3%		**Operating Margin**	11.4%	8.5%	6.9%	1.7%	
33.3%	-22.6%	6.4%	(29.0%)		**Net Margin**	12.9%	11.9%	10.5%	1.4%	

Monthly Financial Trends









INVESTMENT SCORECARD AS OF DECEMBER 31, 2019

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY20 Budget	Expectation Per Asset Allocation
Investment Performance		**4Q 2019**		**Fiscal Year-to-date**		**7y 2m Since Inception (annualized)**		**FY 2020**	**2019**
Surplus cash balance*		$1,087.8	--	--	--	--	--	--	--
Surplus cash return		3.9%	4.2%	4.8%	4.9%	5.9%	5.8%	4.0%	5.6%
Cash balance plan balance (millions)		$293.8	--	--	--	--	--	--	--
Cash balance plan return		5.3%	5.1%	5.6%	5.7%	8.1%	7.4%	6.0%	6.0%
403(b) plan balance (millions)		$548.4	--	--	--	--	--	--	--
Risk vs. Return		**3-year**				**7y 2m Since Inception (annualized)**			**2019**
Surplus cash Sharpe ratio		1.14	1.11	--	--	1.09	1.08	--	0.34
Net of fee return		7.8%	7.4%	--	--	5.9%	5.8%	--	5.6%
Standard deviation		5.2%	5.1%	--	--	4.7%	4.7%	--	8.7%
Cash balance Sharpe ratio		1.16	1.09	--	--	1.17	1.12	--	0.32
Net of fee return		9.6%	8.5%	--	--	8.1%	7.4%	--	6.0%
Standard deviation		6.6%	6.1%	--	--	6.2%	5.8%	--	10.3%
Asset Allocation		**4Q 2019**							
Surplus cash absolute variances to target		9.4%	< 10%	--	--	--	--	--	--
Cash balance absolute variances to target		7.4%	< 10%	--	--	--	--	--	--
Manager Compliance		**4Q 2019**							
Surplus cash manager flags		9	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		11	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$53 mm), District assets (~$38 mm), and balance sheet cash not in investable portfolio. Includes Foundation (~$35 mm) and Concern (~$13 mm) assets. Budget adds back in current Foundation and Concern assets and backs out current debt reserve funds.

Consolidated Balance Sheet

(in thousands)

ASSETS

CURRENT ASSETS	February 29, 2020	Audited June 30, 2019
Cash	90,044	124,912
Short Term Investments	186,424	177,165
Patient Accounts Receivable, net	151,571	132,198
Other Accounts and Notes Receivable	7,638	5,058
Intercompany Receivables	45,471	8,549
Inventories and Prepaids	68,643	64,093
Total Current Assets	**549,791**	**511,976**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	16,236	16,895
Plant & Equipment Fund	175,270	171,304
Women's Hospital Expansion	22,430	15,472
Operational Reserve Fund	148,917	139,057
Community Benefit Fund	18,742	18,260
Workers Compensation Reserve Fund	19,389	20,732
Postretirement Health/Life Reserve Fund	29,579	29,480
PTO Liability Fund	25,622	26,149
Malpractice Reserve Fund	1,860	1,831
Catastrophic Reserves Fund	18,673	19,678
Total Board Designated Assets	**476,718**	**458,857**
FUNDS HELD BY TRUSTEE	**40,563**	**83,073**
LONG TERM INVESTMENTS	**384,449**	**375,729**
CHARITABLE GIFT ANNUITY INVESTMENTS	**571**	**602**
INVESTMENTS IN AFFILIATES	**34,365**	**38,532**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,336,091	1,692,693
Less: Accumulated Depreciation	(658,809)	(622,877)
Property, Plant & Equipment - Net	**1,154,297**	**1,069,816**
DEFERRED OUTFLOWS	33,401	33,876
RESTRICTED ASSETS	27,420	24,279
OTHER ASSETS	946	1,036
TOTAL ASSETS	**2,702,521**	**2,597,775**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	February 29, 2020	Audited June 30, 2019
(Accounts Payable	46,065	38,390
Salaries and Related Liabilities	11,719	30,296
Accrued PTO	25,797	26,502
Third Party Settlements	12,489	11,331
Intercompany Payables	46,079	8,464
Bonds Payable - Current	9,128	8,630
Bond Interest Payable	2,135	12,775
Other Liabilities	1,192	14,577
Total Current Liabilities	**158,703**	**150,966**
LONG TERM LIABILITIES		
Post Retirement Benefits	30,204	29,480
Worker's Comp Reserve	19,972	18,432
Other L/T Obligation (Asbestos)	4,054	3,975
Bond Payable	511,543	507,531
Total Long Term Liabilities	**565,773**	**559,417**
DEFERRED REVENUE-UNRESTRICTED	1,777	1,113
DEFERRED INFLOW OF RESOURCES	13,268	13,715
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	1,745,840	1,389,510
Board Designated	189,904	458,839
Restricted	27,256	24,215
Total Fund Bal & Capital Accts	**1,963,000**	**1,872,563**
TOTAL LIABILITIES AND FUND BALANCE	**2,702,521**	**2,597,775**

El Camino Health

APPENDIX

Non Operating Items and Net Margin by Affiliate

$ in thousands

	Period 8- Month			Period 8- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	11,424	2,830	8,594	76,922	57,072	19,849
Los Gatos	8	1,027	(1,020)	12,303	11,758	546
Sub Total - El Camino Hospital, excl. Afflilates	**11,432**	**3,857**	**7,574**	**89,225**	**68,830**	**20,395**
Operating Margin %	**13.2%**	**5.2%**		**13.0%**	**10.6%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**(28,834)**	**2,887**	**(31,722)**	**19,423**	**21,497**	**(2,074)**
El Camino Hospital Net Margin	**(17,403)**	**6,744**	**(24,147)**	**108,648**	**90,327**	**18,321**
ECH Net Margin %	**-20.0%**	**9.1%**		**15.9%**	**14.0%**	
Concern	407	98	309	856	660	196
ECSC	978	0	978	949	3	947
Foundation	(979)	171	(1,150)	1,779	1,124	655
Silicon Valley Medical Development	(3,644)	(1,900)	(1,744)	(26,331)	(19,635)	(6,696)
Net Margin Hospital Affiliates	**(3,238)**	**(1,631)**	**(1,607)**	**(22,747)**	**(17,848)**	**(4,899)**
Total Net Margin Hospital & Affiliates	**(20,641)**	**5,114**	**(25,755)**	**85,901**	**72,479**	**13,422**

El Camino Health

El Camino Hospital – Mountain View ($000s)

Period ending 2/29/2020

Period 8 FY 2019	Period 8 FY 2020	Period 8 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
233,158	259,677	228,828	30,849	13.5%	**Gross Revenue**	1,884,004	2,070,047	1,988,738	81,309	4.1%
(171,466)	(188,013)	(170,535)	(17,479)	(10.2%)	**Deductions**	(1,383,260)	(1,521,073)	(1,479,451)	(41,621)	(2.8%)
61,692	**71,664**	**58,293**	**13,371**	**22.9%**	**Net Patient Revenue**	**500,744**	**548,974**	**509,286**	**39,688**	**7.8%**
1,614	1,494	1,774	(280)	(15.8%)	**Other Operating Revenue**	15,996	14,579	15,989	(1,409)	(8.8%)
63,306	**73,158**	**60,067**	**13,091**	**21.8%**	**Total Operating Revenue**	**516,739**	**563,554**	**525,275**	**38,279**	**7.3%**
					OPERATING EXPENSE					
33,533	36,982	35,261	(1,721)	(4.9%)	**Salaries & Wages**	276,053	292,794	291,285	(1,510)	(0.5%)
8,761	10,083	8,416	(1,668)	(19.8%)	**Supplies**	71,218	84,523	73,510	(11,012)	(15.0%)
5,582	6,926	5,672	(1,253)	(22.1%)	**Fees & Purchased Services**	50,015	54,993	46,622	(8,371)	(18.0%)
2,204	2,560	2,160	(400)	(18.5%)	**Other Operating Expense**	16,941	21,160	20,232	(928)	(4.6%)
468	1,458	1,428	(30)	(2.1%)	**Interest**	2,965	4,227	6,226	1,999	32.1%
3,526	3,725	4,300	575	13.4%	**Depreciation**	28,094	28,935	30,328	1,392	4.6%
54,073	**61,734**	**57,237**	**(4,497)**	**(7.9%)**	**Total Operating Expense**	**445,286**	**486,632**	**468,203**	**(18,429)**	**(3.9%)**
9,233	**11,424**	**2,830**	**8,594**	**303.7%**	**Net Operating Margin**	**71,453**	**76,922**	**57,072**	**19,849**	**34.8%**
15,567	(28,834)	2,887	(31,722)	(1098.7%)	**Non Operating Income**	(1,677)	19,423	21,497	(2,074)	(9.6%)
24,799	**(17,411)**	**5,717**	**(23,128)**	**(404.5%)**	**Net Margin**	**69,776**	**96,345**	**78,569**	**17,775**	**22.6%**
20.9%	22.7%	14.2%	8.5%		**EBITDA**	19.8%	19.5%	17.8%	1.7%	
14.6%	15.6%	4.7%	10.9%		**Operating Margin**	13.8%	13.6%	10.9%	2.8%	
39.2%	-23.8%	9.5%	(33.3%)		**Net Margin**	13.5%	17.1%	15.0%	2.1%	

El Camino Hospital – Los Gatos ($000s)

Period ending 2/29/2020

Period 8 FY 2019	Period 8 FY 2020	Period 8 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
51,718	59,023	54,828	4,196	7.7%	**Gross Revenue**	409,246	475,292	460,977	14,315	3.1%
(39,794)	(45,714)	(40,643)	(5,071)	(12.5%)	**Deductions**	(302,756)	(356,906)	(341,846)	(15,060)	(4.4%)
11,923	**13,310**	**14,185**	**(875)**	**(6.2%)**	**Net Patient Revenue**	**106,490**	**118,387**	**119,132**	**(745)**	**(0.6%)**
315	377	271	106	39.1%	**Other Operating Revenue**	2,343	3,063	2,170	893	41.1%
12,239	**13,687**	**14,456**	**(769)**	**(5.3%)**	**Total Operating Revenue**	**108,833**	**121,450**	**121,301**	**148**	**0.1%**
					OPERATING EXPENSE					
6,595	7,479	7,037	(442)	(6.3%)	**Salaries & Wages**	55,162	59,974	58,536	(1,438)	(2.5%)
1,934	2,360	2,517	157	6.2%	**Supplies**	16,223	18,261	19,179	919	4.8%
2,615	2,711	2,682	(30)	(1.1%)	**Fees & Purchased Services**	21,281	21,885	21,875	(10)	(0.0%)
315	359	377	18	4.8%	**Other Operating Expense**	2,494	2,700	3,322	622	18.7%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
789	769	815	46	5.6%	**Depreciation**	6,081	6,326	6,632	305	4.6%
12,247	**13,679**	**13,429**	**(250)**	**(1.9%)**	**Total Operating Expense**	**101,242**	**109,146**	**109,544**	**398**	**0.4%**
(9)	**8**	**1,027**	**(1,020)**	**(99.3%)**	**Net Operating Margin**	**7,591**	**12,303**	**11,758**	**546**	**4.6%**
0	0	0	0	0.0%	**Non Operating Income**	0	0	0	0	0.0%
(9)	**8**	**1,027**	**(1,020)**	**(99.3%)**	**Net Margin**	**7,591**	**12,303**	**11,758**	**546**	**4.6%**
6.4%	5.7%	12.7%	(7.1%)		**EBITDA**	12.6%	15.3%	15.2%	0.2%	
-0.1%	0.1%	7.1%	(7.1%)		**Operating Margin**	7.0%	10.1%	9.7%	0.4%	
-0.1%	0.1%	7.1%	(7.1%)		**Net Margin**	7.0%	10.1%	9.7%	0.4%	

El Camino Health

Silicon Valley Medical Development ($000s)

Period ending 2/29/2020

Period 8 FY 2019	Period 8 FY 2020	Period 8 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
1,445	7,232	8,720	(1,488)	(17.1%)	Gross Revenue	7,029	58,513	71,324	(12,810)	(18.0%)
(999)	(5,762)	(5,295)	(467)	(8.8%)	Deductions	(4,652)	(41,886)	(43,420)	1,534	3.5%
446	**1,470**	**3,425**	**(1,955)**	**(57.1%)**	**Net Patient Revenue**	**2,377**	**16,627**	**27,903**	**(11,276)**	**(40.4%)**
0	2,076	1,614	462	28.6%	Other Operating Revenue	39	13,466	11,434	2,032	17.8%
446	**3,546**	**5,038**	**(1,493)**	**(29.6%)**	**Total Operating Revenue**	**2,417**	**30,093**	**39,337**	**(9,244)**	**(23.5%)**
					OPERATING EXPENSE					
144	1,576	1,514	(62)	(4.1%)	Salaries & Wages	1,002	13,439	14,334	895	6.2%
36	456	356	(100)	(28.2%)	Supplies	340	3,372	3,068	(304)	(9.9%)
1,045	4,210	3,896	(314)	(8.1%)	Fees & Purchased Services	6,283	33,327	32,641	(686)	(2.1%)
129	664	980	316	32.3%	Other Operating Expense	1,035	5,640	7,423	1,783	24.0%
0	0	0	0	0.0%	Interest	0	0	0	0	0.0%
51	284	193	(92)	(47.6%)	Depreciation	350	646	1,505	859	57.1%
1,405	**7,190**	**6,939**	**(251)**	**(3.6%)**	**Total Operating Expense**	**9,010**	**56,424**	**58,972**	**2,548**	**4.3%**
(959)	**(3,644)**	**(1,900)**	**(1,744)**	**91.8%**	**Net Operating Margin**	**(6,593)**	**(26,331)**	**(19,635)**	**(6,696)**	**34.1%**
1,000	0	0	0	0.0%	Non Operating Income	7,810	0	0	0	0.0%
41	**(3,644)**	**(1,900)**	**(1,744)**	**91.8%**	**Net Margin**	**1,217**	**(26,331)**	**(19,635)**	**(6,696)**	**34.1%**
-203.4%	-94.8%	-33.9%	(60.9%)		EBITDA	-258.3%	-85.4%	-46.1%	(39.3%)	
-214.9%	-102.8%	-37.7%	(65.1%)		Operating Margin	-272.8%	-87.5%	-49.9%	(37.6%)	
9.2%	-102.8%	-37.7%	(65.1%)		Net Margin	50.4%	-87.5%	-49.9%	(37.6%)	

El Camino Health

ECH Hospital Operating Margin

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

	CY	A	S	O	N	D	J	F	M	A	M	J
Reported	$12,172	$9,996	$10,434	$11,915	$5,232	$16,466	$11,579	$11,432	$0	$0	$0	$0
Run-rate	$12,033	$9,863	$10,965	$11,760	$5,096	$14,320	$11,438	$11,302	$0	$0	$0	$0
Budget	$6,129	$8,672	$6,243	$13,026	$12,853	$9,835	$8,215	$3,857	$12,692	$8,305	$10,473	$9,642

FY 2020 Actual Run Rate Adjustments (in thousands) - FAV / <UNFAV>										
Revenue Adjustments		J	A	S	O	N	D	J	F	YTD
	Mcare Settlmt/Appeal/Tent Settlmt/PIP	129	129	210	137	129	194	129	129	1,188
	RAC Release	-	-	(746)	-	-	-	-	-	(746)
	PRIME Incentive	-	-	-	-	-	1,944	-	-	1,944
	Various Adjustments under $250k	9	4	5	18	6	8	12	-	62
	Total	**138**	**133**	**(531)**	**155**	**136**	**2,146**	**141**	**129**	**2,447**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mary Rotunno, General Counsel; Cindy Murphy Director of Governance Services
Date: April 15, 2020
Subject: Resolution 2020-02 Declaring A Local Emergency

Recommendation:

To approve Resolution 2020-02: Declaring a Local Emergency.

Summary:

1. Situation: The Santa Clara County Public Health Department reported its first known case of COVID-19 on January 31, 2020. As of April 7, 2020, the County had reported a total of 1285 cases and 43deaths. On February 3, 2020, the County of Santa Clara Public Health Officer proclaimed a local health emergency and on February 10, 2020 the Board of Supervisors ratifed it. On March 10, 2020, the Board of Supervisors extended it until April 9, 2020. Because the number of new COVID-19 cases over the last week (April 1 – April 7, 2020) remains fairly steady at an average of 54 new cases per day, we expect the County will further extend its declaration of local health emergency. As well, the number of COVID-19+ hospitalized patients across the County continues to increase (277 as of Apirl 7, 2020). Due to COVID-19, the El Camino Hospital Corporation and its affiliated healthcare facilities (collectively, "the Corporation") are exposed to an increase in costs to address the disease.

2. Authority: Declaration of a local emergency will support the Corporation's cost recovery of the Corporation's emergency related expenditures from federal and state sources,

3. Background: The purpose of an emergency declaration by the Corporation, in concert with those already declared by the state, county and other healthcare entities, is to make available recovery and response resources to protect our ability to provide comprehensive health and hospital services to the community during the COVID-19 pandemic. Federal and state funding through FEMA, the CARES Act and other programs, is being offered to hospitals to partially mitigate the extraordinary costs of pandemic-related services, supplies, equipment and labor, and necessary suspension of normal hospital operations during the COVID-19 pandemic. The declaration facilitates the Corporation's timely application to these programs and coordination with relevant county, state and federal emergency response agencies.

4. Assessment: Approval of Resolution 2020-02 will enhance the Corporation's ability to recover costs of any of the Corporation's emergency related expenditures from federal and state sources.

5. Other Reviews: The CEO, CFO and COO support this request. It has not been reviewed by any of the Board's Advisory Committees.

6. Outcomes: Potential cost recovery of emergency related expenditures from federal and state sources.

List of Attachments:

1. Draft Resolution 2020-02: Declaring a Local Emergency

Suggested Board Discussion Questions: N/A

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RESOLUTION NO. 2020-02

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPIATL

DECLARING A LOCAL EMERGENCY

WHEREAS, El Camino Hospital (the "Corporation"), is a nonprofit public benefit corporation organized under the laws of the State of California. The Corporation operates hospitals, outpatient clinics, and other healthcare facilities.

WHEREAS, conditions of disaster or of extreme peril to the health and safety of persons and property have arisen both internationally and within the United States as a result of the introduction of the novel coronavirus ("COVID-19"), a novel communicable disease which led to California Governor Gavin Newson, to proclaim a State of Emergency for California on March 4, 2020; and

WHEREAS, currently COVID-19 has spread globally, infecting hundreds of thousands of persons and causing fatalities worldwide. Due to the expanding list of countries with widespread transmission of COVID-19, and increasing travel alerts and warnings for countries experiencing sustained or uncontrolled community transmission issued by the Centers for Disease Control and Prevention ("CDC"), COVID-19 has created conditions that are likely to be beyond the control of local resources and require the combined forces of other political subdivisions to combat this virus; and

WHEREAS, a local health emergency was proclaimed by the County of Santa Clara] Public Health Officer on February 3, 2020, ratified by the Board of Supervisors on February 10, 2020, and thereafter extended on March 10, 2020 until April 9, 2020; and

WHEREAS, the CDC confirmed person-to-person transmission of COVID-19 in the United States, raising the possibility of community transmission occurring in the general public, and on March 13, 2020, President Donald Trump declared a Federal Declaration of National Emergency; and

WHEREAS, the Corporation's ability to mobilize local resources, accelerate procurement of vital supplies, use mutual aid, and seek future reimbursement by state and federal governments will be critical to successfully responding to COVID-19; and

WHEREAS, these conditions warrant and necessitate that the Corporation declare the existence of a local emergency; and

WHEREAS, the State Public Assistance Program allows certain private nonprofit organizations to receive an allocation of funds under the California Disaster Assistance Act;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of El Camino Hospital as follows:

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1. That the Board of Directors of the Corporation hereby declares the existence of a local emergency as a result of COVID-19 and directs the Corporation staff to take the necessary steps for the protection of life, health and safety.

2. During the existence of said local emergency, the powers, functions, and duties of the Corporation shall be those prescribed by state law and by policies and procedures of the Corporation . The Corporation's Chief Executive Officer or his/her designee (the "Authorized Officer") is hereby authorized to implement the Corporation's existing policies and procedures for emergency operations.

3. To the extent that there are federal or state government work or procurement policies and procedures that must be complied with to receive reimbursement for emergency expenditures, and the Corporation seeks such reimbursement, the Corporation shall comply with such procedures.

4. The Corporation's Authorized Officer may commit or expend the Corporation's non-budgeted funds for emergency purposes during this state of emergency and the Corporation's Authorized Officer shall take all reasonable steps to recover such costs from aid or reimbursement available from all sources, including state and federal agencies.

5. The Corporation's Authorized Officer may suspend the performance of any Corporation contracts as required to comply with public health orders during this period of emergency.

6. The Corporation's Authorized Officer is hereby authorized to implement on behalf of the Corporation and the Corporation Board any suspension of any existing law or regulation ordered by federal, state or local governments that are ordinarily applicable to Corporation operations or governance.

7. The Corporation shall track costs for staffing, supplies, and equipment related to COVID-19 preparation and prevention and forward that information to the Corporation's Authorized Officer.

8. The Corporation's Authorized Officer is authorized and directed to take all measures to seek and recover disaster relief funding from all sources, including state and federal agencies.

9. The Corporation shall coordinate Corporation-wide planning, preparedness and response efforts regarding COVID-19 with the Santa ClaraCounty Office of Emergency Services.

10. The Corporation's Authorized Officer shall enter into supply, equipment purchase, and/or physician contracts needed to respond to the declared emergency. Such contracts shall comply with applicable laws, regulations and exceptions allowed during the declared emergency.

11. Actions taken by the Corporation's Authorized Officer prior to the effective date of this Resolution in response to threats posed by COVID-19 are hereby ratified.

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12. The recitals set forth above are incorporated herein and made an operative part of this Resolution.

13. This Resolution shall take effect immediately.

ADOPTED this 15th day of April 2020.

AYES:

NOES:

ABSTAIN:

ABSENT

____
Julia E. Miller
Secretary/Treasurer

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Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, March 11, 2020
2500 Grant Road, Mountain View, CA 94040
Conference Rooms F&G (ground floor)

Board Members Present	**Board Members Absent**	**Members Excused**
Lanhee Chen, Chair** **Peter C. Fung, MD**** **Gary Kalbach** **Julie Kliger**** **Julia E. Miller,** Secretary/Treasurer **Jack Po, MD, PhD**** **Bob Rebitzer**** **George O. Ting, MD** **Don Watters**** **John Zoglin**, Vice Chair**	None **via teleconference	None

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30pm by Chair Chen. A verbal roll call was taken. Directors Kalbach, Miller, and Ting were physically present at the meeting. Directors Chen, Fung, Po, Watters, and Zoglin participated via teleconference from within the boundaries of the El Camino Healthcare District. Directors Kliger and Rebitzer participated via teleconference from outside the District. Director Rebitzer joined the meeting via teleconference at 5:31pm during Agenda Item 3: Public Communication. A quorum was present.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. PUBLIC COMMUNICA-TION	Cindy Murphy, Director of Governance Services, read a written communication from Bruce Harrison, President of Silicon Valley Medical Development (SVMD), to the Board regarding the public comments from the February 12, 2020 Hospital Board meeting. The communication outlined SVMD's governance and operational structure. In his letter, Mr. Harrison noted that at this time, there has been no determination by the California Public Employment Relations Board (PERB) or the National Labor Relations Board (NLRB) or any other entity that El Camino Hospital and SVMD are a single or joint employer; there is a complaint pending before PERB, but a hearing has not been scheduled, and no determination or order has been made. Mr. Harrison's communication further described SVMD's voluntary recognition of SEIU-UHW as the representative of SVMD clinic workers in certain job classifications, tentative agreements reached, and the status of bargaining sessions. Mr. Harrison commented that the purpose of his letter is to correct the record.	
4. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 5:35pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (2/12/2020); pursuant to *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Enterprise Quality Council Minutes; pursuant to *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report.	***Adjourned to closed session at 6:21pm***

	Movant: Miller **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
5. AGENDA ITEM 9: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 5:42pm by Chair Chen. Agenda items 5-8 were addressed in closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (2/12/2020), and the Medical Staff Report, including the credentials and privileges report, by a unanimous vote in favor of all members present and participating by phone (Directors Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Watters, and Zoglin).	
6. AGENDA ITEM 10: CONSENT CALENDAR	Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. Director Miller requested that Item 10e: Community Benefit Mid-Year Metrics be removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting (2/12/2020); Approval of the Outpatient Behavioral Clinic Relocation; Medical Staff Report; and for information: FY20 Period 7 Financials. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None Barbara Avery, Director of Community Benefit, provided an overview of the Community Benefit Mid-Year Metrics. **Motion:** To approve the consent calendar: for information: Community Benefit Mid-Year Metrics. **Movant:** Kalbach **Second:** Kliger **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None At the request of the Chair, Dan Woods, CEO, provided an update on El Camino Health's preparedness related to COVID-19.	***Consent calendar approved***
7. AGENDA ITEM 11: ADJOURNMENT	**Motion**: To adjourn at 6:01pm. **Movant:** Kalbach **Second:** Po **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Watters, Zoglin **Noes:** None	***Meeting adjourned at 6:01pm***

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	Abstentions: None **Absent:** None **Recused:** None	

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

____
Lanhee Chen
Chair, ECH Board of Directors

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Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services
Sarah Rosenberg, Contracts Administrator/Governance Services EA

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El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Imtiaz Qureshi, MD, Enterprise Chief of Staff
Linda Teagle, MD Chief of Staff Los Gatos
Date: April 15, 2020
Subject: Medical Staff Report – Open Session

Recommendation:

To approve the Medical Staff Report, including Policies and Scopes of Service identified in the attached list.

Summary:

1. Situation: The Medical Executive Committee met on March 26, 2020.

2. Background: MEC received the following informational reports.

a) Quality Council – The Quality Council met on March 4, 2020. Reports and performance dashboards were reviewed and approved from the following ECH Departments/Service Lines:

i. Annual Reporting Calendar
ii. Patient Blood Management
iii. Acute Rehab
iv. Sterile Processing
v. Sepsis

b) Leadership Council – Leadership Council met on March 10, 2020:

i. Reviewed the function and future of the Leadership Council
ii. Discussed the voting progress of the proposed Bylaws
iii. Suspension Policy: Dr. Marfatia presented and discussed his revisions to the current policy:
   1. Revised policy designed to be clear
   2. Remove fines
   3. Suggest four (4) periods of time where notifications are made leading up to suspension (third phase) and possibly loss of privileges (fourth phase)
iv. Policy approval process: Dr. Marfatia suggested the following:
   1. Divide the policies into two categories – patient care and non-patient care
   2. Patient care policies should be vetted by the appropriate physician leaders (chairs and medical directors) who are conversant with the content before a policy is forwarded to MEC
   3. Non-patient care policies should be vetted by the appropriate individuals who can speak to the policy content before forwarding to the MEC
   4. Combine those polices which are duplicative

c) The CEO Report was provided and included the following updates:

i. Drive-through COVID-19 screening in place for patients with physician order by Friday, March 27
ii. Surge plans are in place for both El Camino Health hospitals
iii. Accelerated Care Unit (Tent) outside the ED at Mountain View Campus. Still in process at Los Gatos Campus
iv. Elective Surgeries and Procedures still limited at both campus, following CDC and CDPH guidelines

d) CMO/CNO Report was provided and included the following updates:

i. A comprehensive update was presented regarding COVID-19 including the symptoms, how these symptoms compare to the common cold, allergies and the flu
ii. Reviewed and discussed El Camino's experience
iii. A comprehensive review of supplies on hand was presented
iv. How to prevent the spread of COVID-19

3. Other Review**:**

a) The MEC approved the Quality Performance Improvement and Patient Safety Plan ("QAPI")

List of Attachments:

1. The QAPI is attached to the Quality Committee Report for Board approval.

Suggested Board Discussion Questions: None; this is a consent item

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Imtiaz Qureshi, MD, Enterprise Chief of Staff
Linda Teagle, MD, Los Gatos Chief of Staff
Date: April 15, 2020
Subject: Approval of Revised Medical Staff Bylaws

Recommendation:

To approve the Revised El Camino Hospital Medical Staff Bylaws

Summary: The revised bylaws provide a blueprint for transforming the Medical Staff into a Contemporary Medical Staff Model with the fundamental aim of reducing silos and improving quality within the organization.

1. Situation: At our retreat in September 2019, the Medical Executive Committee decided that the Medical Staff should be transformed as described above. To that end, we created a Medical Staff Reorganization Taskforce comprised of eleven physician leaders, including the Medical Staff Chiefs and Vice Chiefs as well as Board member George Ting, the CEO, the CMO, and the COO. The Taskforce, moderated by a group of nationally recognized experts, met a number of times over the last several months and made the recommendations reflected in the revised bylaws.

2. Authority: Any revision to the Medical Staff Bylaws must be approved by the governing body.

3. Background: Proposed Changes:

- Article 9.2: Creation of three Enterprise Departments (Medicine, Surgery, and Maternal Child Health) (Article 9.2). The Departments shall be led by elected Department Chairs and campus-specific Vice-Chairs. The Department Chair will lead quality improvement efforts throughout the enterprise and shall work with Medical Directors in each department. This provides, for the first time, a forum to collaboratively work and have no silos between the elected Medical Staff Officers and the appointed Medical Directors.
- Article 11.9: The Department Chairs and the Medical Directors will also serve on the Hospital's Quality Council to lead quality improvement in the enterprise. Members of the Hospital Administration including but not limited to the CMO, CQO, and CNO shall also serve on the Departmental Executive Committees, which further strengthens the departments.
- Article 11.10: Campus-Specific Operations Committees have been created and will be led by the Chief of Staff. The Chief of Staff at each campus will have the ability to appoint various physician leaders from each campus as deemed necessary. The Committee gives voice to each campus pertaining to local campus issues not just limited to operations.
- Article 11: Medial Staff Committee Composition - The most essential committees have been named in the bylaws including MEC, Leadership Council, Practitioners Excellence Committee (PEC), Credentials Committee, Quality Council, Physician Health and Well Being Committee, and IDPC. The details of all committees except MEC and Leadership Council are described in the Rules and Regulations Document.

- Article 11.5: Medical Executive Committee: The MEC shall be composed of elected Medical Staff leaders, Department Chairs, elected at-large members from both campuses and members of Hospital administration.
- Article 10.3-5: Roles of Department Chairs and Vice-Chairs: The Department Chair shall be responsible for the department with focus on quality improvement.
- Article 10.3-6: The Department Vice-Chairs for each campus shall be responsible for initial credentialing evaluations and recommendations, behavior interventions, and participation in the campus-specific operations committee.
- Article 10.3-3: Department Chair and Vice-Chair Term: The terms of the elected officers shall increase from two to three years (Article 10.3-3). The longer terms enable officers to meaningfully execute improvement efforts and reduce frequent turnovers.
- Article 4: The Medical Staff categories have been reduced to three main categories and have been redefined.

4. Assessment: We believe that these changes will position the Medical Staff to lead quality improvement efforts and break the existing silos within the organization. If the changes are approved, the new structure will go a long way towards transforming the Medical Staff for the better.

5. Other Reviews: The Medical Staff voted to approve the proposed revisions to the Medical Staff Bylaws.

6. Outcomes: As above.

List of Attachments:

1. Proposed Revised Medical Staff Bylaws

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

MEDICAL STAFF BYLAWS

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DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~14.~~

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

regulations or policy of the Medical Staff.

ARTICLE 1
NAME

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

ARTICLE 2
PURPOSES

2.1 ORGANIZATION

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

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

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

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

Overseeing all of this is the Medical Executive Committee, comprised of the elected officials of the Medical Staff, Hospital-based ~~Division Chiefs~~Department Chairs, and others as noted in the Medical Staff Executive Committee composition, Article 11.5.

2.2 PURPOSES OF THIS ORGANIZATION

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

Through its governance structure, the Medical Staff Organization will:

(a) Assure that physician clinical activities strive for high professional standards, are efficient, effective and ethical.
(b) Assure that practitioners have and maintain competencies for their clinical activities.
(c) Assure that opportunities for providing care are fair and accessible to all qualified members.
(d) Promote clinical quality improvement and the environment of a learning organization through Continuing Medical Education and communication.
(e) Emphasize caring and compassion towards patients.

2.3 PURPOSES OF THESE BYLAWS

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

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

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

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

ARTICLE 3
MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

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

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) During the past seven (7) years, the practitioner **<u>may not</u>**:

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

(i) Once the applicant qualifies as noted above and an application has been received, additional qualifications to meet include:

1. Documentation of adequate experience, education, and training, current professional competence, good judgment, and current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to fulfill the responsibilities of the Medical Staff membership and/or specific privileges requested and that patients treated by them can reasonably expect to receive quality medical care.
2. Applicant agrees to:
    1. adhere to the ethics of their respective profession;
    2. work cooperatively with others so as not to adversely affect patient care;
    3. keep as confidential, as required by law, all information or records received in the physician-patient relationship;
    4. participate in and properly discharge those responsibilities determined by the Medical Staff; and
    5. maintain in force professional liability insurance covering the exercise of all requested privileges, in not less than one million per occurrence and three million annual aggregate or such other amount as may be determined and approved by the Board of Directors and

Medical Staff Executive Committee from time to time.

3.2-2 PARTICULAR QUALIFICATIONS

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

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

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

3.2-3 EXCEPTIONS FOR BOARD CERTIFICATION OF INITIAL APPLICANTS:

Board certification may become a compounded matter due to the number of multiple boards and specialties, certificates of added qualifications and maintenance of board certification requirements. The Medical Staff Executive Committee recognizes that situations may arise when meeting board deadlines is not easy to fulfill and therefore will consider the following:

(a) Initial applicants who were previously board certified whose board certification has lapsed may be allowed two (2) years to regain board certification as long as the certifying body allows for board eligibility.

(b) Exceptions to the requirement for board certification must be substantiated by appropriate medical education and training, extraordinary experience and reputation, and additional evidence of current competency that is endorsed by the Department Chief and presented, in writing, for consideration through the Credentials Committee for recommendation to the MEC and Governing Board.

3.2-4 WAIVER OF MINIMUM QUALIFICATIONS

Insofar as is consistent with applicable laws, the Board of Directors has the discretion to deem an applicant to have satisfied a qualification, upon recommendation of the Medical Staff Executive Committee, if it determines that the applicant has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of El Camino Hospital. There is no obligation to grant any such

waiver and applicants have no right to have a waiver considered and/or granted. An applicant who is denied waiver or consideration of a waiver shall not be entitled to any procedural hearing and appellate review rights provided for in the Fair Hearing Plan in these Bylaws.

3.3 EFFECT OF OTHER AFFILIATIONS

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

3.4 NONDISCRIMINATION

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

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

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

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

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

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

(e) abiding by the lawful ethical principles of the California Medical Association and the member's specialty board, if any; aiding in any Medical Staff, department, or division approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;

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

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

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

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

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

(k) discharging such other staff obligations as may be lawfully established from time to

time by the Medical Staff or Medical Staff Executive Committee; and

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

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

3.6 DURATION OF APPOINTMENT

Except as otherwise provided in these bylaws; initial appointments and reappointments to the Medical Staff shall be for a period up to two (2) years.

3.7. HARASSMENT/DISRUPTIVE/INTIMIDATING BEHAVIOR PROHIBITED

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

ARTICLE 4
CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

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

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

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

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

(a) Have 11+ patient contacts per year at this facility (defined below *)

(b) A practitioner who wishes to serve on the ER call panel or otherwise participate in medical staff functions may request that the Medical Staff Executive Committee appoint him/her to the Active Staff for this purpose. Active Staff membership may be granted by the Medical Staff Executive Committee for as long as the practitioner is involved in medical staff functions.

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

4.2-2 PREROGATIVES

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

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

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

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

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

4.2-3 RESPONSIBILITIES

Each Active Medical Staff member shall:

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

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

(c) Participate in such emergency service coverage or consultation panels as may be determined by the Medical Staff.

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

4.3 PROVISIONAL STAFF

4.3-1 QUALIFICATIONS

(a) The Provisional Staff shall consist of practitioners who meet the qualifications specified for members of the Medical Staff set forth in Section 3.2, except that they have not yet satisfactorily completed the focused professional practice evaluation (FPPE) requirements specified in Section 6.3; have been Medical Staff members for less than six (6) months; and/or have not fulfilled such other requirements as may be set forth in these Bylaws, the Medical Staff and department guidelines, or Hospital policies.

(b) A practitioner may remain a Provisional Staff member for a ~~maximum~~ minimum period of twelve (12) months. At the conclusion of the provisional period~~12 months~~, an activity profile will be generated and the practitioner will be advanced to the appropriate staff category based on the level of patient contacts (see definition under section 4.2-1). If ~~-~~Focused Professional Practice Evaluation (FPPE) requirements have not yet been satisfied at the end of 12 ~~-~~month period, the privileges that still require proctoring will be relinquished. A provisional staff member may request an extension for proctoring with a plan to increase activity to meet proctoring requirements to the Department Chief for recommendation to the Credentials Committee. Proctoring cannot be extended beyond 24 months from time of initial appointment. If privileges are terminated or suspended based upon failure to complete proctoring, the member shall not be entitled to any procedural hearing and appellate review rights provided for in the Fair Hearing Plan in these Bylaws.

~~(b)~~

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4.3-2 PREROGATIVES

The prerogatives of a Provisional Staff member shall be to:

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

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

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

4.3-3 RESPONSIBILITIES

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

4.4 ~~COURTESY~~ CONSULTANT STAFF

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4.4-1 QUALIFICATIONS

The ~~Courtesy~~ Consultant Staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2

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

the Active Staff.

~~(b)~~(c) Are Active Staff Status members in good standing ~~and who has Active Staff Status~~ at another hospital in California

4.4-2 PREROGATIVES

The prerogatives of a ~~Courtesy~~ Consultant Staff member shall be to:

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

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

~~(a)~~

~~(b)~~(c) Attend meetings of the Medical Staff and ~~the~~ assigned Department ~~of which he/she is a member with vote.~~ as a voting member. A ~~Courtesy~~ Consultant Staff member may not hold office in the Medical

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Staff or in the department of which he/she is a member.

(d) May not v~~V~~ote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws. May not serve as committee chair of a medical staff committee.

~~(e)~~

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4.4-3 RESPONSIBILITIES

Each ~~Courtesy~~ Consultant Staff member shall meet the basic responsibilities set forth in Section 3.5.

~~**4.5 ACTIVE COMMUNITY STAFF**~~

~~4.5-1 QUALIFICATIONS~~

~~The Active Community Staff shall consist of members who:~~

~~(a) Meet qualifications set forth in Section 3.2~~

~~(b) Is active in the medical community and refers patients to El Camino Hospital.~~

~~4.5-2 PREROGATIVES~~

~~Active Community Staff members hold no clinical privileges. The prerogatives of an Active Community Staff member shall be to:~~

~~(a) Attend meetings of the Medical Staff and the Department of which he/she is a member.~~

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

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

~~4.6~~4.5 AFFILIATE STAFF

4.5~~6~~-1 QUALIFICATIONS

The Affiliate Staff shall consist of practitioners who maintain a clinical practice in the hospital service area and wish to be able to follow the course of their patients when admitted to the hospital . Members of this category will not manage patient care at the hospital or make notations in the medical record.

~~do not have a hospital practice but regularly provide professional services for patients in the community served by El Camino Hospital.~~

4.5~~6~~-2 PREROGATIVES

Affiliate Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. Members of this category will not manage patient care at the hospital or make notations in the medical record. They may gain access to the patient record with permission (read only).

The prerogatives of an Affiliate Staff member shall be to:

(a) Attend meetings of the Medical Staff and the Department of which he/she is a member in a non-voting capacity, except within committees when the right to vote is specified at the time of appointment; CME functions and social events.~~.~~ An Affiliate

Staff member may not hold office in the Medical Staff or in the department and committees of which he/she is a member.

(b) May not vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws. May not serve as committee chair of a medical staff committee.

~~(a)~~

~~(b) An Affiliate Staff member may not vote on any Medical Staff matter, except as specified in 4.6-2(a).~~

4.5~~6~~-3 RESPONSIBILITIES

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

4.6 HONORARY AND EMERITUS STAFF

~~**4.7**~~

4.6~~7~~-1 QUALIFICATIONS

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

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

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

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

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

4.67-2 PREROGATIVES

(a) The prerogatives of an Honorary or Emeritus Staff member shall be to aAttend meetings of the Medical Staff and his/her department/division.

:

(b) Serve on Medical Staff committees and vote on such committees.

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

4.67-3 RESPONSIBILITIES

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

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

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

4.78-1 CONTRACTED PHYSICIANS.

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

4.78-2 MEDICAL DIRECTOR REVIEW/RECOMMENDATIONS.

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

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~~4.9~~4.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be

subject to limitation by special conditions attached to a particular membership, by other Sections of these Bylaws, or by the Medical Staff Rules and Regulations. The staff shall be limited to those for which they can demonstrate the possession of the requisite licensure, education, training, experience, and current competence.

~~4.10~~4.9 EXCEPTIONS TO PREROGATIVES

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

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

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

~~4.11~~4.10 MODIFICATION OF MEMBERSHIP

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

ARTICLE 5
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

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

5.2 APPLICATION FOR APPOINTMENT

5.2-1 CONTENT

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

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

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

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

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

contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

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

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

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

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

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

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

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

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

5.2-2 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff each applicant:

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

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

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

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

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

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

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

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

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

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

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

5.3 PROCESSING THE APPLICATION

5.3-1 APPLICANT'S BURDEN

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

5.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Medical Staff Services Office, which shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Services Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. The Hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant (or member). The resulting report shall be placed in the applicant's/member's credential file. An applicant whose application is not completed within six (6) months after it was received

by the Medical Staff Services Office shall be automatically removed from consideration for staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, has been resubmitted.

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

5.3-3 DEPARTMENT ACTION

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

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

5.3-4 CREDENTIALS COMMITTEE ACTION

The recommendations of the Department Chairs shall be sent to the Credentials Committee. The committee shall review the entire application along with departmental recommendations and resolve any outstanding issues that might remain. The Credentials Committee shall then make their recommendation on each application which shall then be transmitted to the MEC.

5.3-5~~4~~ MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

The Medical Staff Executive Committee shall consider the department ~~chief's~~ Chair's and the Credential Committee's recommendations, and such other relevant information as may be available. The committee shall then forward to the ~~Administrator/~~ Chief Executive Officer or designee, for transmittal to the Board of Directors, its written report and recommendations, prepared in accordance with Section 5.3-5. The Committee may also defer action on the application pursuant to Section 5.3-8~~7~~(a).

5.3-6~~5~~ APPOINTMENT REPORTS

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

5.3-7~~6~~ BASIS FOR APPOINTMENT

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

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

5.3-87 EFFECT OF EXECUTIVE ACTION

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

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

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

5.3-98 ACTION BY THE BOARD OF DIRECTORS

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

(b) Without Benefit of Medical Staff Executive Committee Recommendation: If the Board of Directors does not receive a Medical Staff Executive Committee recommendation within the time period specified in Section 5.3-11, it may, after notifying the Medical Staff Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Board of Directors. If the recommendation is one of those set forth in Section 8.2, the Administrator/ Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2; and the applicant shall be entitled to the procedural rights as provided in Article 8 before any final adverse action is taken.

(c) After Procedural Rights: In the case of an adverse Medical Staff Executive Committee recommendation pursuant to Section 5.3-7(c) or an adverse Board of Directors recommendation pursuant to Section 5.3-8(a) or (b), the Board of

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

5.3-10~~9~~ NOTICE OF FINAL DECISION

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

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

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

5.3-11~~0~~ REAPPLICATION AFTER WITHDRAWAL/ADVERSE DECISION/OMISSION BY APPLICANT

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

5.3-12~~1~~ TIME PERIODS FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this Section 5.3-12. The Medical Staff Services Office shall transmit an application to the Department Chief within thirty (30) days after all information collected and verification tasks are completed and all relevant materials have been received. In the event the relevant materials are not received within ninety (90) days after the application is received, the applicant shall be notified and the application shall remain pending until either the materials are received by the Medical Staff Services Office or the expiration of six (6) months after receipt shall automatically be removed from consideration as specified in Section 5.3-2. The applicable department chiefs shall act on an application within thirty (30) days after receiving it from the Medical Staff Office. The Medical Staff Executive Committee shall review the application and make its recommendation to the Board of Directors within forty-five (45) days after receiving the department report. The Board of Directors shall then take final action on the application within forty-five (45) days. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his/her application process within those periods.

5.4 REAPPOINTMENTS

5.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

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

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

5.4-2 VERIFICATION OF INFORMATION

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

5.4-3 DEPARTMENT ACTION

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

(b) The following applies to the review of information in the Medical Staff member’s

credentials file at the time of reappraisal or reappointment.

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

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

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

4. However, if ~~an investigation~~ further information needs to be gathered and/or adverse recommendation on reappointment is warranted, the Department Executive Committee shall so inform the Medical Staff ~~Executive~~ Credentials Committee and shall proceed gathering such appropriate information~~ly with such investigation~~ as part of the reappointment process.

~~4.~~ 5.4-4 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review recommendations of the Department Chair and any relevant supporting information in the reapplication. Any outstanding issues shall be resolved. The Credentials Committee shall make their recommendations, either favorable or adverse, and transmit these recommendations to the MEC.

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5.4-5~~4~~ MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

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

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

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

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

5.4-65 REAPPOINTMENT REPORTS

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

5.4-76 BASIS FOR REAPPOINTMENT
Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.5, and met all of the standards and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession, with the Medical Staff Bylaws and Rules and Regulations and Hospital policies, rendition of services to his/her patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, and his/her competency and qualifications.

5.4-87 FAILURE TO FILE REAPPOINTMENT APPLICATION
If the member fails to submit an application for reappointment completed as required, he/she shall be deemed to have resigned his/her membership and privileges in the Medical Staff, effective on the expiration date of his/her appointment.

5.5 LEAVE OF ABSENCE

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

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

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

5.5-4 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave (which may be waived by the Medical Staff Executive Committee), or at any earlier time, the Medical Staff member may

request reinstatement of his/her privileges and prerogatives by submitting a written notice to

that effect to the Administrator and to the Medical Staff Executive Committee. If so requested by the Medical Staff Executive Committee or the Administrator/ Chief Executive Officer, the staff member shall submit a written summary of his/her relevant activities during the leave. The Medical Staff Executive Committee shall recommend whether to approve the member's request for reinstatement of his/her privileges and prerogatives. Thereafter, the procedure set forth in Sections 5.3-7 through 5.3-11 shall be followed.

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

ARTICLE 6
CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

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

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 REQUESTS

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

6.2-2 BASIS FOR PRIVILEGES DETERMINATION

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

6.2-3 PROCEDURE

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

6.2-4 GENERAL CONDITIONS

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

6.3 PROFESSIONAL PRACTICE EVALUATION

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

information regarding FPPE process, see Medical Staff Policy 13.5.1

(a) FOR INITIAL APPOINTMENTS

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

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

(b) MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

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

(c) TERM OF PROCTORING PERIOD

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

(d) FOR PHYSICIAN PERFORMANCE ISSUES

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

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

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

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

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

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

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

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

6.5 TEMPORARY PRIVILEGES

6.5-1 CIRCUMSTANCES

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

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

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

(b) Temporary Privileges to Meet an Important Patient Care Need (Care of Specific Patient in physician database): Upon receipt of an application for specific temporary privileges, a practitioner may be granted temporary privileges for the care of up to six (6) specific patients in any one calendar year, for the term of their hospitalization. Practitioners

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

6.5-2 CONDITIONS

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

6.5-3 TERMINATION

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

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

6.5-4 RIGHTS OF THE PRACTITIONER

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

6.6 EMERGENCY PRIVILEGES

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

no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are either not requested or denied, the patient shall be assigned to an appropriate member of the staff by the chief of staff or his/her designee.

6.7 PRIVILEGING LICENSED INDEPENDENT PRACTITIONERS DURING DISASTER EVENTS

(a) Purpose: To ensure that physicians and allied health practitioners (hereinafter referred to as "practitioner"), who do not possess medical staff or practice privileges, may be accepted to work at El Camino Hospital during a disaster, when Code Triage has been activated (Emergency Management Plan located in Hospital Safety Manual).

These disaster privileges are granted only when the following two conditions are present:

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

(b) Procedure:

1. A practitioner may present to the hospital to volunteer to provide services during a disaster. The scope of services provided must be within the practitioner's scope of practice as outlined by their state board.
2. All staff will be alerted to direct the practitioner to the hospital triage officer or the medical staff office to process disaster privileges.
3. The practitioner must produce his/her pocket license to practice medicine, a photo ID, the name of his/her malpractice insurance carrier, and the name of a hospital where he/she currently has privileges or has recently practiced. If possible, copies should be made of the license and photo ID.
4. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed with 72 hours from the time the volunteer practitioner presents to the organization. The medical staff office will keep the name, title, and license number of the volunteer practitioner on file for future reference if needed.

IN THE EVENT THESE CALLS CANNOT BE COMPLETED, DISASTER PRIVILEGES MAY STILL BE GRANTED UPON RECEIPT OF THE KEY IDENTIFICATION DOCUMENTS NOTED ABOVE.

5. The Chief of Staff (or designee) may grant these disaster privileges. If the Chief of Staff (or designee) is not available, the Administrator/ Chief Executive Officer (or designee) may grant disaster privileges.
6. The practitioner granted disaster privileges must be paired with a credentialed practitioner currently on staff who has a similar specialty. This pairing should be recorded along with the licensing information. Within 72 hours a decision will be made (based on information obtained regarding the professional practice of the volunteer) related to the continuation of the disaster privileges initially granted.
7. The practitioner will wear a temporary El Camino Hospital nametag issued by Security, while working in the facility.
8. A practitioner's privileges, granted under this situation, may be terminated at any time without reason or cause.
9. Termination of these privileges will not give rise to a hearing or review.

6.8 POST-DOCTORAL PRACTITIONER LIMITED PROCEDURAL TRAINING

Privileges may be granted to practitioners to pursue a limited period of clinical training and education in a particular area of their specialty. Upon submission of a written application,

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

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

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

6.9 LOCUM TENENS PRIVILEGES

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

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

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

6.10 HISTORY & PHYSICAL – PRIVILEGES AND TIMEFRAMES

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

1. MD/DO

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

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

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

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

6.11 TELEMEDICINE PRIVILEGES

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

(b) Scope:

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

(c) Definitions:

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

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

1. El Camino Hospital may fully privilege and credential the practitioner according to Joint Commission standards and its medical staff processes and requirements.
2. The practitioner may be privileged at El Camino Hospital using

credentialing information from the distant site if the distant site is a Joint

Commission accredited organization. The Board of Directors of grants privileges based on ECH medical staff recommendations.

3. Regardless of the privileging procedure utilized (d. 1-2 above), each LIP must possess those qualifications for LIP utilization of privileges at El Camino Hospital (e.g. California licensure, professional liability insurance, education, training, etc).

ARTICLE 7
CORRECTIVE ACTION

7.1 ROUTINE CORRECTIVE ACTION

7.1-1 CRITERIA FOR INITIATION

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

7.1-2 INITIATION

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

7.1-3 INVESTIGATION

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

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

7.1-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

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

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

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

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

7.1-5 PROCEDURAL RIGHTS

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

7.1-6 INITIATION BY BOARD OF DIRECTORS

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

7.2 SUMMARY SUSPENSION

7.2-1 CRITERIA FOR INITIATION

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

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

7.2-2 INITIATION BY BOARD OF DIRECTORS

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

7.2-3 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

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

7.2-4 PROCEDURAL RIGHTS

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

7.3 AUTOMATIC SUSPENSION

7.3-1 LICENSE

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

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

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

(d) Suspension: Whenever a practitioner's license authorizing him/her to practice in this state is suspended, his/her staff membership and clinical

privileges shall be automatically suspended effective upon, and for at least the term of, the suspension.

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

7.3-2 DRUG ENFORCEMENT ADMINISTRATION

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

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

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

7.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

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

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

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

7.3-5 PROCEDURAL RIGHTS – MEDICAL RECORDS

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

7.3-6 MALPRACTICE INSURANCE

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

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

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

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

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

7.3-11 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS
Whenever a practitioner’s privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner, the Medical Staff Executive Committee, the Administrator/ Chief Executive Officer, pertinent hospital staff/departments, and the Board of Directors. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner is terminated by the automatic suspension, his/her patient(s) shall be assigned to another practitioner by the department ~~chief~~ Chair or Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

7.4 INTERVIEWS

Interviews shall neither constitute, nor be deemed, a "hearing," as described in Article 8, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Staff Executive Committee shall be required, at the practitioner's request, to grant him/her an interview. In the event an interview is granted, the practitioner shall be informed of the general nature of the circumstance leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

ARTICLE 8
HEARINGS AND APPELLATE REVIEWS

8.1 PREAMBLE AND DEFINITIONS

8.1-1 INTRAORGANIZATIONAL REMEDIES

The remedies, hearing and appellate review procedures provided for in this Article are strictly quasi-judicial in structure and function. Accordingly, the Article 8 Judicial Review Committee process shall have no power or authority to make determinations as to the substantive validity of bylaws, rules or regulations.

Notwithstanding the foregoing, the Board of Directors may entertain challenges to the substantive validity of bylaws, rules or regulations and in all proper cases shall hear and decide such challenges. Where the substantive validity question is the sole issue, the petitioner shall be permitted a direct appeal in the first instance, before the Medical Staff Executive Committee, under procedures which it shall determine. The Medical Staff Executive Committee shall make a decision regarding the issue and transmit its decision, together with any record it has compiled to the Board of Directors for final decision. Utilization of this process shall be a condition precedent to the petitioner's right to seek judicial review in a court of law.

8.1-2 EXHAUSTION OF REMEDIES

If an adverse ruling is made concerning a practitioner, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust any remedies provided by these Bylaws before resorting to legal action. The exclusive procedure for obtaining judicial review shall be by Petition of Writ of Mandate pursuant to Part 3, Title 1, Chapter 2 of the California Code of Civil Procedure.

8.1-3 DEFINITIONS

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

(a) "Body" whose decision prompted the hearing" refers to the Medical Staff Executive Committee in all cases where the Medical Staff Executive Committee or authorized officers, members or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing being requested.

(b) "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his/her or its address as it appears in the records of the Hospital and pursuant to Section 8.3-4.

(c) "Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 8.3 of these Bylaws.

(d) "Date of Receipt" of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 8.1-3.

8.2 GROUNDS FOR HEARING

8.2-1 GROUNDS

Any one or more of the following actions or recommended actions shall constitute grounds for a hearing if such action requires a report under California Business & Professions Code

Section 805:

(a) Denial of Medical Staff membership;

(b) Denial of requested advancement in staff membership status (except that a refusal to advance a Provisional Staff member before the conclusion of the permissive twelve (12) month proctoring period shall not constitute grounds for a hearing);

(c) Denial of staff reappointment;

(d) Demotion to lower staff category or membership status;

(e) Suspension of staff membership for a certain time period or until completion of specific conditions or requirements;

(f) Summary suspension of staff membership during the pendency of corrective action hearing and appeals procedures;

(g) Expulsion from staff membership;

(h) Denial of requested privileges (not including temporary privileges);

(i) Reduction in privileges;

(j) Suspension of privileges until completion of specific conditions or requirements;

(k) Summary suspension of privileges (including temporary privileges);

(l) Termination of privileges;

(m) Requirement of consultation;

(n) Monitoring requirements for other than investigational purposes (excluding monitoring incidental to Provisional Staff status);

(o) Any other actions which require a report be made to the Medical Board of California under the provisions of Section 805 of the California Business and Professions Code and the National Practitioner Data Bank.

Recommendation of any one of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws.

8.2-2 FINAL ACTION

Adverse recommendations shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Hospital Board of Directors.

8.3 REQUEST FOR A HEARING

8.3-1 NOTICE OF ACTION

In all cases in which actions have been taken or recommendation made which give rise to rights of appeal under Section 8.2 of the Bylaws, the person or body responsible for such action or recommendation shall give the affected practitioner: (i) written notice of the recommendation or final proposed action, (ii) notice that the action, if adopted, shall be taken and reported pursuant to California Business and Professions Code Section 805 and the National Practitioner Data Bank, (iii) notice of his or her right to request a hearing pursuant to section 8.3-2 (iv) notice that such hearing must be requested within thirty (30) days, and (v) a summary of the hearing and appeal rights under these Bylaws.

8.3-2 REQUEST FOR HEARING

The affected practitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing. Said request shall be effected by notice to the Chief of Staff with a copy to the Administrator/ Chief Executive Officer. In the event the affected practitioner does not request a hearing within the time and in the manner herein above set forth, he or she shall be deemed to have accepted the recommendation, decision, or action involved and it shall there upon become the final recommendation of the Medical Staff.

Such final recommendation shall be considered by the Board of Directors within forty-five (45) days.

8.3-3 TIME AND PLACE OF HEARING
Upon receiving a request for a hearing, the Chief of Staff shall schedule and arrange for a hearing which will commence within sixty (60) days after receipt of the request for the hearing unless such time period is otherwise extended as permitted under these Bylaws.

The Chief of Staff shall give notice to the affected practitioner of the time, place and date of the hearing not less than thirty (30) days before the commencement of the hearing.

8.3-4 NOTICE OF CHARGES
Together with the notice stating the place, time and date of the hearing, the chief of staff, on behalf of the Medical Staff Executive Committee, shall state the reasons for the final proposed action, including the acts or omissions with which the affected practitioner is charged and a list of the charts in question, where applicable.

8.3-5 JUDICIAL HEARING BODY
When a hearing is requested, it shall be held before a Judicial Hearing Committee appointed by the Medical Staff Executive Committee, consisting of at least three (3) individuals, and alternates as appropriate.

The Judicial Hearing Committee shall be composed of individuals who gain no direct financial benefit from the outcome of the hearing, who have not acted as accusers, investigators, fact finders or initial decision makers in the matter at any previous level and shall include, where feasible, and an individual practicing in the same specialty as the affected practitioner. Preferably, the members of the Judicial Hearing Committee shall be members of the Medical Staff.

When a Judicial Hearing Committee is appointed, the Chief of Staff shall designate a chair who shall preside in the manner described in section 8.4-3 and who shall handle all pre-hearing matters and preside until a Hearing Officer, as described in Section 8.4-4 below is appointed.

8.3-6 FAILURE TO APPEAR OR PROCEED
Failure without good cause of the affected practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved. Such final recommendations shall be considered by the Board of Directors within forty-five (45) days.

8.3-7 CONTINUANCES
Continuances shall be granted upon agreement of the parties or by the hearing officer on a showing of good cause.

8.3-8 DISCOVERY
(a) The affected practitioner shall have the right to inspect and copy at his or her expense any documentary information relevant to the charges which the Medical Staff has in its possession or under its control as soon as practicable after receipt of the request for a hearing. The Medical Staff Executive Committee shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the affected practitioner has in his or her possession or control as

soon as practicable after receipt of the request for a hearing. Any request for inspection of documentary information relevant to the charges must be submitted in writing. The failure by either party to provide access to such information at least thirty (30) days before the hearing shall constitute good cause for continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the affected practitioner under review. The hearing officer appointed pursuant to Section 8.4-4 shall consider and rule upon any request for access to information and may impose any safeguard as the protection of the peer review process and justice requires. When ruling upon requests for access to information and determining the relevance thereof, the Hearing Officer shall, among other factors, consider the following: (i) whether the information sought may be introduced to support or defend the charges; (ii) the exculpatory or inculpatory nature of the information sought, if any; (iii) the burden imposed on the party in the possession of the information sought, if access is granted, and (iv) any previous requests for access to any information submitted or resisted by the parties to this same proceeding.

(b) If either side to the hearing requests in writing a list of witnesses, each party shall furnish to the other within fifteen (15) days of such request a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Failure to disclose the identity of a witness at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance. Requests for a list of witnesses shall be submitted in writing to the other party.

(c) At the request of either side, the parties shall exchange copies of all documents expected to be introduced at the hearing. Failure to produce copies of all such documents at least ten (10) days before commencement of the hearing shall constitute good cause of continuance. A request for all documents expected to be introduced at the hearing shall be submitted in writing to the other party.

8.4 HEARING PROCEDURE

8.4-1 PREHEARING PROCEDURE

It shall be the duty of the petitioner and the body whose decision prompted the hearing to raise objections regarding procedural issues and the composition of the hearing committee as soon as such objections are or should have been known. For these purposes, all such objections should be submitted in writing to the presiding officer identified in Section 8.4-3 at least seven (7) days before the scheduled hearing. Objections to any prehearing decisions concerning procedural issues and committee composition shall be raised at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing which, thereafter, might be requested.

8.4-2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. The member shall be entitled to representation by legal counsel at his or her expense in any phase of the hearing, should he/she so choose. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney-at-law, and the Medical Staff Executive Committee shall not be represented by an attorney-at-law if the affected practitioner elects not to be so represented.

8.4-3 THE PRESIDING OFFICER

The presiding officer at the hearing shall be a hearing officer as described in Section 8.4-4, or if no such hearing officer has been appointed, the chair of the Judicial Hearing Committee shall preside over the hearing. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He/she shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He/she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence. He/she shall also have discretion to make all rulings necessary to assure a timely, efficient and orderly hearing process.

8.4-4 HEARING OFFICER

The Medical Staff Executive Committee shall appoint a hearing officer to preside with respect to pre-hearing issues and at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, however, an attorney regularly utilized by the hospital, the Medical Staff or the individual Medical Staff member or applicant for membership, for legal advice regarding its affairs and activities shall not be eligible to serve as a hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have an reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and arguments during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence including those which arise prior to the hearing. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Hearing Committee, the hearing officer may participate in the deliberations of such a committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

8.4-5 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by such person lawfully authorized to administer such oath.

8.4-6 RIGHTS OF THE PARTIES

At a hearing both sides shall have the following rights to ask Judicial Hearing Committee members and the hearing officer questions which are directly related to determine whether they are impermissibly biased and challenge the impartiality of any member or hearing officer, to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issued, and otherwise to rebut evidence, and to be provided with all information made available to the Judicial Hearing Committee. The affected practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. Any challenge directed at one or more members of the committee or hearing officer shall be ruled on by the hearing officer.

8.4-7 BURDENS OF PRESENTING EVIDENCE AND PERSUASION

(a) The Medical Staff Executive Committee shall have the initial duty to present evidence which supports the charge(s) or recommended action.

(b) When the hearing involves an applicant, and his or her Medical Staff membership, the applicant shall bear the burden of persuading by a preponderance of the evidence of his or her qualifications by producing information which allows for adequate information and resolution of reasonable doubts concerning his or her current qualifications for staff privileges, membership or employment. Initial applicants shall not be permitted to introduce information not produced upon request of the Medical Staff Executive Committee during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided for initial applicants in paragraph (b) above, the Medical Staff Executive Committee shall bear the burden of persuading by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

8.4-8 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement to be filed following the conclusion of the presentation of oral testimony. The Judicial Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

8.4-9 BASIS OF DECISION

If the Judicial Hearing Committee should find the charge(s) or any of them to be true, it shall impose such form of discipline as it shall find warranted, provided, however, that such form of discipline shall not be more stringent than that recommended by the body whose decision prompted the hearing. The decision of the Judicial Hearing Committee shall be based on the evidence produced at the hearing. Such evidence may consist of the following:

(a) Oral testimony of witnesses.
(b) Briefs or written statements presented in connection with the hearing.
(c) Any material contained in the Hospital or Medical Staff personnel files regarding the petitioner, which shall have been made a part of the hearing record.
(d) Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.
(e) Any other evidence admissible hereunder.

8.4-10 ADJOURNMENT AND CONCLUSION

The hearing officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Both parties shall have the right to submit written statements at the close of the hearing. Upon conclusion of the presentation of oral and written evidence and argument and written statements, if any, the hearing shall be closed. The Judicial Hearing Committee shall there upon, outside the presence of any persons, except the hearing officer, conduct its deliberations, and render a decision and accompanying report.

8.4-11 DECISION OF THE JUDICIAL HEARING COMMITTEE
Within thirty (30) days after final adjournment of the hearing, the Judicial Hearing Committee shall render a decision which shall be accompanied by a report in writing and which shall be delivered to the Medical Staff Executive Committee. If the affected practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the affected practitioner, the Administrator/ Chief Executive Officer, and the Board of Directors. The report shall contain a precise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached.

Both the affected practitioner and the Medical Staff Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Hearing Committee shall be subject to the right of appeal to the Board of Directors as provided in 8.5-4.

8.5 APPEALS TO THE BOARD OF DIRECTORS

8.5-1 TIME FOR APPEAL
Within thirty (30) days after the date of receipt of the Judicial Hearing Committee decision, either the petitioner, or the body whose decision prompted the hearing may request an appellate review by the Board of Directors. Said request shall be delivered to the Administrator/ Chief Executive Officer in writing either in person, or by certified or registered mail, return receipt requested, and it shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Directors within forty-five (45) days, but shall not be binding on the Board of Directors.

8.5-2 REASONS FOR APPEAL
The reasons for appeal from the hearing shall be: (a) substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny petitioner of fair hearing; (b) the lack of substantive rationality of a Medical Staff bylaw, rule or regulation relied upon by the Judicial Hearing Committee in reaching its decision; and/or (c) action taken arbitrarily, unreasonably or capriciously.

8.5-3 TIME, PLACE AND NOTICE
When appellate review is requested pursuant to the preceding subsection, the Board of Directors shall, within thirty-five (35) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Board of Directors shall give the petitioner notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Board of Directors, or appeal board (if any).

8.5-4 APPEAL BOARD

When an appellate review is requested, the Board of Directors may sit as the appeal board or in its sole discretion it may appoint a hearing officer who shall conduct the appellate hearing and make recommended findings, conclusions and a decision which may be adopted, modified or rejected by the Board of Directors. If a hearing officer is appointed, he/she shall be an attorney at law, admitted to practice in California for at least ten (10) years, shall not be legal counsel to the Hospital and shall not act as a prosecuting officer, an advocate for the Hospital, the practitioner, the Board of Directors or any other body whose action prompted the proceeding. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board or hearing officer, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this Section, participating in an initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter.

8.5-5 BOARD OF DIRECTORS APPEALS PROCEDURE
The proceedings by the Board of Directors shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Hearing Committee, provided that the Board of Directors may accept additional oral or written evidence, subject to the foundational showing that such additional evidence could not have been made available to the Judicial Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Hearing Committee hearing; or may remand the matter to the Judicial Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his or her position on appeal, the right to present a written statement in support of his or her position on appeal, the right to appear and respond, and the right to be represented by an attorney or any other representative designated by the party. At the conclusion of oral argument, the Board of Directors may there upon conduct, at the time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Board of Directors shall have the option of having legal counsel present during the appeal and their deliberations to advise them in questions relating to the conduct of the appellate review. The legal counsel's role shall be limited to that of an advisor.

8.5-6 ACTION BY A HEARING OFFICER
If the Board of Directors has appointed a hearing officer, he/she shall prepare findings of fact and a proposed decision in such form that it may be adopted as the decision of the Board of Directors. The findings of fact and proposed decision shall be filed by the hearing officer with the Board of Directors within fifteen (15) days after conclusion of the hearing, and a copy thereof shall be served at the same time on all parties to the action. Within ten (10) days after the filing of such findings and proposed decision with the Board of Directors by the hearing officer, the practitioner or the chairman of the committee whose decision prompted the hearing may file a request to present oral or written argument directly to the Board of Directors. No later than the next regular meeting of Board of Directors, a time shall be fixed for hearing of such arguments by the Board of Directors, which shall not be more than thirty (30) days after the filing of the hearing officer's findings and proposed decision. At the time so fixed, such arguments shall be presented and heard by the Board of Directors. In such event, no member of the Board of Directors shall vote on the final decision who is not present at oral argument, or who did not read written argument.

8.5-7 FURTHER REVIEW OF FINDINGS AND RECOMMENDED DECISION

After the hearing officer's findings and recommended decision have been filed with the Board of Directors, if the findings and recommended decision are at material variance with

the recommendations of the Medical Staff, or if Board of Directors deems that there are matters raised by the hearing officer's findings and recommended decision which the Board of Directors believes were not considered in the Medical Staff proceedings, or if Board of Directors proposes to render a decision at variance with the recommendations of the Medical Staff or the hearing officer, Board of Directors may refer the findings and proposed decision to the Judicial Hearing Committee or any other body or person for further review and recommendation. If the matter is so referred for further review and recommendation, that committee or person shall, within thirty (30) days after such referral, conduct its review and make its further recommendations to the Board of Directors in accordance with the instructions given by the Board of Directors.

8.5-8 DECISION

Within ten (10) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision in writing. The Board of Directors may affirm, modify or reverse the Judicial Hearing Committee decision or, at its discretion, remand the matter for further review and recommendation by the Judicial Hearing Committee or any other body or person. The decision shall be in writing and shall specify the reasons for the action taken, and shall be forwarded to the affected practitioner, the Medical Staff Executive Committee, and the Administrator/ Chief Executive Officer.

8.5-9 RIGHT TO ONE HEARING

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one judicial, evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Medical Staff Executive Committee or the Board of Directors (whether or not in conjunction with a hearing officer) or by both.

8.6 EXCEPTIONS TO HEARING RIGHTS

(a) The Medical Staff Executive Committee shall review and make written recommendations to the Board of Directors regarding quality of care issues related to exclusive arrangements for physician services, prior to any final Board decision being made to execute an exclusive contract in a previously open department or service. In such cases, the Medical Staff Executive Committee's recommendation shall be made within a reasonable time in light of the Hospital's need to execute such an exclusive contract, as determined by the Board of Directors in its sole discretion. Regarding Board decisions (i) to renew or modify an exclusive contract in a particular department or service, or (ii) to terminate an exclusive contract in a particular department or service, the Board shall consult with the Medical Staff Executive Committee regarding quality of care issues related to such decisions prior to taking final action on the contracts, unless the Board decides, in its sole discretion, that such prior consultation would subject the Hospital's business interests or its patients to a risk of imminent harm. In cases in which the Board decides it must proceed without such prior consultation, the Board shall, within thirty (30) days of taking action, inform the Medical Staff Executive Committee of the reasons for its decision, excluding confidential financial information.

(b) The hearing and appellate review rights of any physician whose Medical Staff membership or privileges are adversely affected by decision by the Board of Directors falling within the provisions of 8.1 and 8.2-1 ~~7.6-1~~ shall be governed by Article 8~~7~~ of these Bylaws. The hearing rights of Article 8~~7~~, however, shall apply only to the extent that an action is taken or a recommendation is made which, when final, must be reported to the Medical Board of California under Business and Professions Code section 805 and to the extent that Medical Staff membership status

or clinical

privileges which are independent of the practitioner's contract are also removed or suspended.

8.7 REPORTS

The Chief of Staff or Authorized Representative shall provide the affected Practitioner with a copy of any Section 805 and/or National Practitioner Data Bank report filed with respect to him/her.

ARTICLE 9
CLINICAL DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

The unified El Camino Medical Staff will be comprised of three Enterprise departments which are thosea ~~combination of campus-specific departments and enterprise departments. Enterprise departments are those departments~~ that serve their constituency at all campuses (including MV & LG). All departments shall ultimately report to a unified Medical Staff Executive Committee. Each Department shall be organized as a separate part of the Medical Staff and shall have a ~~Chief~~ Chair and twoa ~~Vice Chiefs~~Vice Chairs, one from MV and one from LG, who are elected and have the authority, duties, and responsibilities specified in Article 10. ~~Each Division of a Department shall be organized as a specialty subdivision within a Department, shall be directly responsible to the Department within which it functions, and shall have a Division Chairman who has the authority, duties, and responsibilities specified in Article 10.~~

~~Do we need divisions? I thought we eliminated them~~

9.2 DESIGNATION

The current departments ~~and divisions~~ are:

~~Campus Departments:~~

~~MV Medicine, Obstetrics/Gynecology, Surgery~~

~~LG Medicine, Obstetrics/Gynecology, Surgery~~

~~Enterprise Departments~~

~~Family Medicine, Orthopedics, Pediatrics, Psychiatry~~

~~Divisions: Divisions reporting to Medical Department – Emergency Medicine, Radiology, Hospitalists~~

~~Divisions reporting to Surgical Department – Pathology, Anesthesia~~

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Medicine- to include Radiology, Emergency Medicine, Hospitalists, Psychiatry, Family Medicine

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Surgery- to include Pathology, Anesthesia, Orthopedics, Gynecologic Oncology, Otolaryngology, Opthalmology, Plastic Surgery, Neurosurgery, General Surgery, Urology, Cardiothoracic Surgery, Vascular Surgery

Maternal Child Health- to include Obstetrics/Gynecology~~, Gynecology~~, Pediatrics, Neonatology-

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~~I added orthopedics above. We had eliminated Hospitalists as a~~

~~division few months ago~~

9.3 ASSIGNMENT TO DEPARTMENTS ~~AND DIVISIONS~~

Each practitioner will declare his/her primary campus and shall be assigned membership in one Department~~ and/or Division within such Department within that campus~~. The exercise of privileges within each Department ~~and Division~~ shall be subject to the Rules and Regulations thereof and to the authority of the Department Chair~~ief and Division Chairman.~~

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9.4 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each Department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by the members of the Department.

To carry out this responsibility, each Department shall:

(a) Conduct patient care reviews for the purpose of analyzing and evaluating the quality of care and appropriateness of treatment provided to patients by the members of the Department. Such reviews shall be conducted in accordance with such procedures ~~as~~ that may be adopted by Medical Staff Executive Committee in consultation with other appropriate committees. Each Department shall review all clinical work performed under its jurisdiction, whether or not the particular person whose work is subject to such review is a member of that Department. The criteria to be used in such review shall be objective and reflect current knowledge and clinical experience. Each

Department shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the effectiveness of actions which have been taken in resolving such problems.

(b) Prepare written reports for submission to the Medical Staff Executive Committee concerning:

1. findings of the Department's review, evaluation, and monitoring activities, conclusions, actions taken thereon, and the results of such action; and
2. recommendations and actions taken for maintaining and improving the quality of care provided in the Department and the Hospital.

(c) Meet as necessary for the purpose of receiving, reviewing, and considering patient care review findings and for the performance or reception of reports on other Department and Staff functions.

(d) Establish criteria for the granting of clinical privileges within the Department for approval by the Medical Staff Executive Committee.

(e) Submit to the Medical Staff Executive Committee the recommendations required under Articles 5 and 6 regarding the clinical privileges each member or applicant should be authorized to exercise.

(f) Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and regarding findings of review, evaluation, and monitoring activities.

(g) Take appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

(h) Coordinate the patient care provided by the Department's members with nursing and ancillary patient care services and with administrative support services.

(i) Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

9.5 FUNCTIONS OF DIVISIONS

Each Division, upon the approval of the Medical Staff Executive Committee, shall perform the functions assigned to it by the Department Chief. Such functions may include, without limitation, the continuous monitoring of patient care practices, credentials review and privileges delineation, and continuing education programs. The Division shall transmit regular reports to the Department Chief on the conduct of its assigned functions.

Do we need divisions? They are in the proposed model being led by Medical Directors and not elected officers

9.6 9.5 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Medical Staff Executive Committee and the Board of Directors, by their joint action, may suggest to the administration on the creatione, the eliminatione, subdivide, further subdivideor the creation of clinical, or combine departments, divisions, and/or clinical services. Divisions and/or Clinical Services will be managed by a Medical Director.

All Medical Directors appointed by the CMO will be subject to approvalrecommendations by the Medical Executive Committee. Any dismissal of a Medical Director shall likewise be subjected to MEC approval.

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Comment [EC1]: Delete or revise since this is not in compliance with TJC

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Creation of Subdivision: If (i) a sufficient number of practitioners are available for

(a) **, appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and relevant Rules and Regulations adopted pursuant hereto; and, (ii) the patient or service activity to be associated with the new component is substantial enough to warrant imposition on the members thereof the responsibility to accomplish such functions, a subdivision may be created.**

(b) **Eliminations: If the number of members available is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions on the members of such subdivision, a subdivision may be**

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eliminated.

(c) Combination: If the union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions, and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions on the members of such combined components, subdivisions may be combined. In all instances of modification, the Hospital's written plan of development, as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall also be considered.

9.7 FUNCTIONS OF HOSPITAL BASED DIVISIONS

Each Hospital Based Division shall be organized as part of the Medical Staff and have a Medical Director who is appointed by Hospital Administration. Members of the individual Hospital Based Divisions (Emergency Services, Radiology, Pathology, Anesthesia, and Hospitalists), shall have the following authority and duties: They shall meet independently as necessary; review on-going care of patients; review morbidity and mortality of these patients; attend the Medical Staff Executive Committee and Quality Council; and report on their activity to Medical Staff Executive Committee. Radiation Therapy physicians shall act as a subdivision of Radiology. One representative from Radiology, Emergency Medicine, and Hospitalists shall be a member of the Medicine Department Executive Committee. One representative from Anesthesia and one representative from Pathology shall be a member of the Surgery Department Executive Committee.

I think it can be deleted, as we are changing the MEC composition. Also Hospitalist is no longer a division

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ARTICLE 10
OFFICERS

10.1 GENERAL OFFICERS OF THE MEDICAL STAFF

10.1-1 IDENTIFICATION

The general officers of the Medical Staff shall be the MV Chief of Staff (MVCOS), the MV Vice-Chief of Staff (MVVCOS), Immediate Past MV Chief of Staff (IPMVCOS), and the LG Chief of Staff (LGCOS), the LG Vice-Chief of Staff (LGVCOS), and Immediate Past LG Chief of Staff (IPLGCOS). The MV Chief of Staff will serve as Chair of the Medical Executive Committee and will act as Enterprise Chief of Staff ~~and the President of the Medical Staff~~..

10.1-2 QUALIFICATIONS

General officers must be members of the Active ~~or Active Community~~ Staff and must be board certified or qualified in his/her primary specialty at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 NOMINATIONS

The Medical Staff election shall be held tri~~bi~~-annually. The ~~Nominating Committee shall consist of the past Chiefs of each Department. The Immediate Past Chief of Staff shall Chair the Committee.~~Leadership Council shall serve as the Medical Staff Nominating Committee. The Nominating Committee shall nominate one or more nominees for Chief and Vice-Chiefs for each campus. The Nominating Committee's nominees shall be presented to the Medical Staff.

~~The Leadership Council is the nominating committee.~~

Further nominations may be made for any Medical Staff or Department office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least 10% of the Medical Staff/Department members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the nominating committee as soon as reasonably practicable, but at least five (5) days prior to mailing of the written ballots under Section 10.1-4. Candidates nominated by this procedure shall have their names included on the written ballot mailed to eligible voting members of the Medical Staff/Department.

10.1-4 ELECTION

Voting shall be by: (1) Secret written mail ballot, as defined in Article 14, Section 14.9, which shall be mailed to eligible voting members of the Medical Staff during the first week of March of an election year and must be returned to the Medical Staff Office within two weeks of receipt of the ballot or (2) Electronic vote, with the voting method to be determined by the Medical Staff Executive Committee. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote, a runoff election shall be arranged promptly between the two candidates receiving the highest number of votes. Elected officers shall be announced to the entire Medical Staff, method of communication to be determined by the Medical Executive Committee.

~~This year elections are going to be late. Cant happen in March~~

10.1-5 IMMEDIATE PAST CHIEF OF STAFF PROVISIONS

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Sections 10.1-4 and 10.1-5 shall not apply to the office of Immediate Past Chief of Staff. The Chief of Staff shall, upon completion of his/her term of office in that position, immediately succeed to the office of Immediate Past Chief of Staff.

10.1-6 TERM OF ELECTED OFFICERS

Each officer shall serve a three (3) ~~/twowo~~ year term, commencing on the first day of the Medical Staff year following election. Each officer shall serve until the end of this term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

Comment [EC3]: To discuss

10.1-7 REMOVAL OF ELECTED OFFICERS

Except as otherwise provided in these Bylaws, grounds for dismissal of an elected officer may be initiated by the Medical Staff Executive Committee or upon the written request of twenty percent (20%) of the members eligible to vote for officers. Such removal may be effected by a two-thirds (2/3) vote of the members eligible to vote for officers. Voting on removal of an elected officer shall be by secret written mail ballot, as defined in Article 14, Section 14.9.

The written mail ballots shall be sent to each voting member at least two weeks before the voting date and the ballots shall be counted by the Immediate Past Chiefs of the Medical Staff (MV and LG) (except when he/she is the subject of the balloting, in which case the Chief of Staff shall count the ballots) and the Vice Chief of Staff and, in the case of a petition by members, a representative of the petitioners and the officer subject to recall or his/her designee.

Grounds for removal of an officer are as follows:

- (a) Failure to remain a member in good standing of the Active or Active Community Staff.
- (b) Failure to perform his/her duties in a timely or appropriate manner.
- (c) Subjection to corrective action (as defined in Article 7).
- (d) Subjection to a summary suspension, imposed pursuant to Article 7, which remains in effect for fourteen days (14) or longer.
- (e) Declaration that the officer is of unsound mind by order of court or convicted of a felony.
- (f) Evidence that the officer has acted in a fraudulent or dishonest way or has grossly abused authority or discretion with reference to the Medical Staff or Hospital.

10.1-8 VACANCIES IN ELECTED OFFICES

Vacancies in office, other than that of Chief of Staff, shall be filled by the Medical Staff Executive Committee. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term and shall then serve as Chief of Staff for the following term. A vacancy in the office of Immediate Past Chief of Staff need not be filled, except that the Medical Staff Executive Committee may appoint qualified successors to serve as the Chief of, or as a member of, any committee that the Immediate Past Chief of Staff is automatically appointed to pursuant to these Bylaws.

10.1-9 COMPENSATION

The amount and source of compensation of Medical Staff Officers shall be determined annually by the Medical Staff Executive Committee. ~~in consultation with the Board of Directors.~~

10.2 DUTIES OF GENERAL OFFICERS

10.2-1 CHIEF OF STAFF

The MV and LG Chiefs of Staff shall serve as the Chief Executive Officer of the Medical Staff members of his/her primary campus. He/she shall:

(a) Act in coordination and cooperation with the Administrator in all matters of mutual concern within the Hospital where consistent with these Bylaws.
(b) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
(c) The MV Chief of Staff will serve as Chairman of the Enterprise Medical Staff Executive Committee.
(d) Serve as an ex officio member of all other Staff committees without vote, unless his/her membership in a particular committee is required by these Bylaws.
(e) Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations, for the implementation of sanctions where indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
(f) Appoint, with Medical Staff Executive Committee approval, committee members to all standing and special Medical Staff committees, except where otherwise provided by these Bylaws or by Medical Staff Rules and Regulations.
(g) Serve as a member of the Board of Directors in such capacity as may be permitted or required by the Hospital's corporate Bylaws.
(h) Represent the views, policies, needs, and grievances of the Medical Staff to the Board of Directors and to the Administrator/Chief Executive Officer.
(i) Interpret the policies of the Board of Directors to the Medical Staff.
(j) Serve as a spokesperson for the Medical Staff in external professional and public relations.
(k) Perform such other functions as may be assigned to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee or by the Board of Directors and where consistent with these Bylaws.

10.2-2 VICE CHIEF OF STAFF
The MV and LG Vice-Chiefs of Staff, in the absence of the Chief of Staff shall assume all duties and authority of the Chief of Staff; shall be a member of the Medical Staff Executive Committee; perform such other supervisory duties as the Chief of Staff may assign to him/her; ~~safeguard and be accountable for all funds of the Medical Staff~~ and carry out such other functions as may be delegated to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee, or by the Board of Directors. He/she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.

10.2-3 IMMEDIATE PAST CHIEF OF STAFF
~~The Immediate Past Chief of Staff shall be the Chairman of the Nominating, Bylaws and Capital Expenditure Committees;~~
The Immediate Past Chief of Staff shall act as Medical Staff Treasurer, perform such ~~other~~ supervisory duties as the Chief of Staff may assign him/her, and carry out such other functions as may be delegated to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee or by the Board of Directors.

10.3 DEPARTMENT OFFICERS

10.3-1 QUALIFICATIONS
Each Department Chair~~ief~~ and Campus specific Department ~~Vice Chief~~Vice Chair(MV and LG) shall be a member of the Active ~~or Active Community~~~~Consultant~~ Staff, shall be certified by the appropriate specialty board or have affirmatively demonstrated comparable ability, through the credentialing process, in at least one of the clinical areas covered by the

Comment [m4]: No active community category

Department, and be willing and able to faithfully discharge the functions of the office.

10.3-2 SELECTION

The Department Chairief and the Department Vice ChiefVice Chairs shall be elected by the eligible voting staff members of the Department. Each Department shall appoint a Department Nominating Committee consisting of three (3) Active or Active Community Staff members who are members of the Department. The Committee shall be appointed not later than January of each election year. The Nominating Committee recommendations for one or more nominees for Department Chairief and the two Department Vice ChiefVice Chair–s shall be reported to the members of each Department prior to the election. Nominations will also be accepted from the floor in the manner described in 10.1-3. The Department officers may be elected at the Department meeting. Eligible voting members of the Department may vote. All department members shall vote on the Department Chair. The members of the appropriate campus shall vote for the campus Department Vice-Chair-Chief. If a member exercises privileges at both campuses, then they are eligible to vote for both Chief positions. If more than one candidate is proposed, voting shall be conducted by written ballot or by electronic methods, as determined by the current Department Chairief.

Comment [m5]: No floor

10.3-3 TERM OF OFFICE

Each Department Chairief and Department Vice-ChiefVice Chairs shall serve a three/twotwo year term commencing on their appointment. They shall serve until the end of the Medical Staff year and until their successors are chosen, unless either shall sooner resign or be removed from office.

Comment [EC6]: To discuss at MEC

10.3-4 REMOVAL

Removal of a Department Chairief and/or Vice Chief Vice Chair from office may be initiated by the Medical Staff Executive Committee or by written request from twenty percent (20%) of the members of the Chief's Chair's or Vice-Chief's Chair's Department who are eligible to vote. Grounds for removal shall be consistent with those listed in 10.1-7 in this section. Such removal may be effected by a majority vote of the Medical Staff Executive Committee members or by a majority vote of the Department members eligible to vote on departmental matters. All voting shall be conducted by written secret mail ballot, as defined in Article 14, Section 14.9, which shall be sent to those eligible to vote within forty-five (45) days after the initiation of removal, pursuant to this Section. The ballots must be received no later than two weeks days after they are mailed and shall be counted by the Chief of Staff, Vice Chief of Staff, and Medical Staff Coordinator and the officer subject to recall or his/her designee. No removal shall be effective unless and until it is ratified by the Medical Staff Executive Committee.

10.3-5 DUTIES OF DEPARTMENT CHAIR

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Each Department Chair ief shall have the following authority, duties, and responsibilities, and the Vice ChiefVice Chairs, in the absence of the Chairief, shall assume all of them and shall otherwise perform such duties as may be assigned to him/her:

(a) Be accountable to the Medical Staff Executive Committee and to the Chief of Staff for all clinical and administrative activities within his/her department, and particularly for the quality of patient care rendered by members of his/her department and for the continuous assessment and improvement of the quality of care, treatment, and services provided by his/her department and the maintenance of quality control programs as appropriate.

(b) Develop, implement and evaluate departmental programs in cooperation with the Chief of Staff, and/or Quality Assessment/Utilization Management Director for

monitoring and evaluation of patient care, credentials review, privileges delineation, medical education and utilization management.

(c) Be a member of the Medical Staff Executive Committee, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions to the Medical Staff Executive Committee and the Medical Staff, as

appropriate regarding his/her own Department including, but not limited to, criteria for clinical privileges in the department.

(d) Provide oversight for theMaintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report thereon to the Medical Staff Executive Committee.

(e) Provide to the Medical Staff Executive Committee his or her recommendations concerning appointment and classification, completion of FPPE requirements, reappointment, delineation of clinical privileges, and corrective action with respect to practitioners in his/her department. Provide input to the Hospital and/or the Interdisciplinary Practice Committee, as appropriate, regarding the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

(f) Enforce the Hospital and Medical Staff Bylaws, rules, regulations, and policies within his/her department, including initiation of corrective action and investigation of clinical performance and ordering of consultations to be provided or sought when necessary.

(f) Specifically, participate, when they are required, in interventions with department members regarding inappropriate behavior and report findings and further recommendations to the MEC.

(g) Participate in the integration of the department into the primary functions of the hospital in cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, space and other resources, supplies, special regulations, standing orders and techniques, and assessing and recommending sources for needed patient care services not provided by the department or organization.

(h) Be involved in orientation and continuing education of all persons in the department.

(i) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her Department as may be required by the Medical Staff Executive Committee or the Board of Directors.

(j) Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Chief of Staff, the Medical Staff Executive Committee, or the Board of Directors and where consistent with these Bylaws.

(k) Department Vice Chiefs Chairs shall be a member s of the Quality Council; and perform other duties as ordinarily pertain to that office or as may be assigned from time to time by the Department CChief of Staffhief.

The Immediate Past Department Chairief shall be a member of the Capital Expenditure Committee.

10.3-6 DUTIES OF DEPARTMENT CHIEFSVICE CHAIRS

(l)

Each Department Vice Chair shall have the following authority, duties, and responsibilities:

(a) In the absence of the Department Chair, the Department Vice Chair shall assume all duties, authority and responsibility of the Department Chair.

(b) Shall participates in interventions with Department members regarding inappropriate behavior and report findings and further recommendations to Leadership Council and/or MEC when required.

(c) Shall perform the primary implementation by campus of FPPE as required as well as OPPE for the campus department members on a regular basis and report recommendations

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to the Department Chair.

(d) Shall carry out any further duties assigned to them by the Department Chair

(a) Specifically, participate, when they are required, in interventions with department members regarding inappropriate behavior and report findings and further recommendations to the MEC.

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10.4 DIVISION CHIEFS

10.4-1 QUALIFICATIONS

Each Division Chief shall be a member of the Active or Active Community Medical Staff and a member of the Division which he/she is to head, shall be qualified by training, experience, interest, and demonstrated current ability in the clinical area covered by the Division, and shall be willing and able to discharge the administrative responsibilities of his/her office.

10.4-2 SELECTION

Each Division Chief shall be elected by the Division.

10.4-3 TERM OF OFFICE

Each Division Chief shall serve a one year term, commencing on his/her appointment. He/she shall serve until the end of the succeeding Medical Staff year and until his/her successor is chosen, unless he/she shall sooner resign or be removed from office. A Division

Chief may be removed by majority of the Board of Directors, the Medical Staff Executive Committee, the Department Executive Committee or the members of the Division. Grounds for removal shall be consistent with those listed in 10.1-7.

10.4-4 DUTIES

Each Division Chief shall:

(a) Account to his/her Department Chief and to the Medical Staff Executive Committee for the effective operation of his/her Division.

(b) Develop and implement, in cooperation with his/her Department Chief, and/or the Quality Assessment/Utilization Management Director, programs to carry out the quality review, evaluation, and monitoring functions assigned to his/her Division.

(c) Exercise general supervision over all clinical work performed within his/her Division.

(d) Conduct investigations and submit reports and recommendations to his/her Department Chief regarding the clinical privileges to be exercised within his/her division by members of, or applicants to, the Medical Staff.

(e) Act as presiding officer at all Division meetings.

(f) Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by his/her Department Chief, the Chief of Staff, the Medical Staff Executive Committee or the Board of Directors.

No person shall occupy two of the following offices, General Officer, Department Officer, or elected Division Chief at the same time. He/she shall resign one or the other position.

ARTICLE 11 COMMITTEES

11.1 GENERAL

There will be enterprise committees (those serving all campuses, including MV and LG campuses) and campus-specific committees. The enterprise committees are designated as such – all others are campus-specific. Enterprise committees will have appropriate representation from members of both campuses.

11.1-1 DESIGNATION AND SUBSTITUTION

The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the members of such committees and the chairman of such committees shall be appointed by the MV or LG Chief of Staff if the committee is a campus-specific committee; by the Enterprise Chief of Staff if an enterprise committee and is subject to Medical Staff Executive Committee approval. Unless specified, non-Medical Staff committee members shall be appointed by the Chief Executive Officer or his/her designee, subject to approval by the Medical Staff Executive Committee. Medical staff committees shall be responsible to the Medical Staff Executive Committee.

In addition, special committees may be created by the Medical Staff Executive Committee on an ad hoc basis to perform specified tasks. The members of special committees shall also be appointed by the Enterprise, MV, or LG Chief of Staff as appropriate, and is subject to the Medical Staff Executive Committee's approval.

11.1-2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a committee member shall be appointed for a term of one (1) year and shall serve until the end of this period and until his/her successor is appointed, unless he/she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Enterprise, MV, or LG Chief of Staff as appropriate may be removed by a majority vote of the Medical Staff Executive Committee. Any committee member who is appointed by the Department ~~Chief~~ Chair may be removed by a majority vote of the Department Executive Committee or the Medical Staff Executive Committee. The removal of any committee member who is automatically assigned to a committee because he/she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official pursuant to Article 10, Section 10.1-7.

11.1-3 VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

11.1-4 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article 12.

11.1-5 VOTING

Practitioners in all categories may vote on committees to which they have been appointed.

11.2 CARE REVIEW COMMITTEEPRACTITIONER EXCELLENCE COMMITTEE (PEC)

11.2 – Enterprise Committee

11.2-1 COMPOSITION OF COMMITTEE

The committee shall be a multidisciplinary peer review committee and shall include voting and non-voting members. This is further described in the PEC Policy and Procedures document.

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Voting Members shall consist of the following:

(a) The Chairperson. The Chairperson must have been a past chief of staff or past department chief and will be appointed to an initial three (3) year term by the current Enterprise Chief of Staff and subject to Medical Staff Executive Committee approval. The chair may serve subsequent three (3) year terms with approval of the Chief of Staff and MEC.

(b) Members. The Immediate Past Chiefs of Staff from the MV and LG campuses and Immediate Chiefs of all Medical Staff Department and Divisions will serve on the committee. If appropriate, a physician from the department or division may be appointed to the committee by majority vote of the Department/Division Chief, Enterprise Chief of Staff and Chair of the Care Review Committee.

(c) Members At Large. At large members will be rotating to provide consistency, with representation from MV and LG campuses.

The At-large members shall be appointed by the CRC chair, with Enterprise Chief of Staff approval, to a three (3)-year term. The At-large member may serve subsequent three (3) year terms with approval of the CRC chair and Enterprise Chief of Staff. There will be a maximum of three (3) at large members.

Non-voting Members may include:
(d) Medical Director of Quality and Patient Safety
(e) Director Risk Management
(f) Chief Medical Officer
(g) Chief Nursing Officer
(h) Associate Chief Medical Officer

11.2-2 MEETINGS
(a) Committee shall meet monthly, or as needed, at the discretion of the chairperson.
(b) The chair shall report to the Medical Staff Executive Committee monthly as a standing report.

11.2-23 DUTIES
(a) The duties of the PEC are described in the PEC Policy and Procedures document.
(b) The Chair of the PEC shall be an ex-officio member of the MEC. The other members of the PEC cannot hold any other position that gives membership to the MEC.

11.2-3 MEETINGS
(a) The meetings and requirements are described in the PEC Policy and Procedures document.
The Care Review Committee shall perform the following duties:
(a) Perform peer review. Cases will be referred to the committee from:
1. Department Chiefs
2. QA/UR Medical Directors
3. Leadership Council
4. Credentials Committee
(b) Provide oversight and review of Medical Staff departmental peer review processes for consistency.

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(c) ~~Identify hospital systems problems in the course of peer review.~~

(d) ~~Identify cases with educational value, in liaison with the Medical Director of continuing education, for presentation to continuing medical education program.~~

(e) ~~Act as ad hoc committee in the event that indications for surgical or other invasive procedures are questioned and intervention needs to be considered. The Medical Staff Executive Committee will act as the body to which an~~

appeal may be presented.

(f) Decide which data elements/indicators do not require physician review (informational letter only).

(g) Review determinations from prior levels of review
1. Quality Department
2. Leadership Council
3. Department Chiefs

If the Care Review Committee disagrees with the prior level of review, it may:
1. Send the matter back to Leadership Council or Department Chief with questions or concerns and/or ask that matter be reconsidered.
2. Refer the matter to an individual Medical Staff member, another Medical Staff Committee or hospital department for review.
3. Review the matter itself.

(h) Determine who presents cases before the Care Review Committee
1. Presenter of the case may be:
   i. Department Chief
   ii. Assigned Reviewer
   iii. Appropriate Care Review Committee member
2. Obtain additional clinical expertise if necessary
   i. Internal
   ii. External

(i) Develop Performance Improvement Plans (PIP) when warranted. A PIP may consist of (but is not limited to):
1. Additional education/CME
2. Prospective monitoring/review of a specific number of cases
3. Second opinions/consults
4. Concurrent proctoring
5. Participation in formal evaluation/assessment program
6. Additional training
7. Educational LOA

Other

8. No this is the old CRC language and needs to be deleted. I do also think that PEC should be in here? Lets discuss

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11.3 CREDENTIALS COMMITTEE – *Enterprise Wide*

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11.3-1 COMPOSITION

(a) The chairperson of the Credentials Committee will be appointed to an initial three (3) year term by the current Enterprise Chief of Staff, subject to Medical Staff Executive Committee approval. The chair may serve subsequent three (3) year terms with approval of the Chief of Staff and subject to MEC approval.

(a) The credentials committee shall consist of the Vice Chiefs of Staff from LG and MV, Vice Chiefs of each medical staff department/division and the chair of the Interdisciplinary Practice Committee and up to three (3)all Department Vice Chiefshairs, The Chair of the Interdisciplinary Practice Committee (IDPC) and a number of 4 sufficient members- at-large as needed to ensure balanced representation from both campuses.

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Comment [m9]: No number

(b) Further details shall be found in the Credentials Policy and Procedure Document, with at least one(1) member-at-large from each campus, Los Gatos and Mountain View.

(b)

(c) The At-large members shall be appointed by the Credentials Committee chairperson, with Enterprise Chief of Staff approval, to a three (3) year term. The At-large members may serve subsequent three (3) year terms with approval of the chairperson and Enterprise Chief of Staff.

The at large members are selected to ensure a balance of specialties and campus representation

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11.3-2 DUTIES

(a) The duties of the credentials committee shall:are described in the Credentials Policy and Procedure document.

(b) The Chair of the Credentials Committee shall be an ex-officio member of the MEC.

11.3-3 MEETINGS

The meetings and requirements are described in the CredentialsPEC Policy and Procedures document.

(a)

(a) Review all recommendations from departments and divisions and provide recommendations to the Medical Staff Executive Committee regarding all applications for medical staff and allied health professional appointments, reappointments and privilege requests.

(b) Review any question of appointment or privilege where there is a dispute between departments or divisions, or when a credentials committee review has been specifically requested.

(c) Assist in development of privileging standards to ensure that credentialing and privileging are based on a consistent standard of care within the medical staff.

(d) Recommend delineation of privilege forms and criteria, review and revision of privileging forms and processes, and review and approve credentialing policies and procedures.

(e) Ensure focused professional practice evaluation (FPPE) of each practitioner applying for initial membership, privileges or modification of privileges is consistently implemented in accordance with the criteria defined by the Medical Staff's Policy.

(f) Review the recommendation of the Department Chief to determine when each FPPE has been adequately completed and report to the MEC and Governing Board. The Credentials Committee and the Department Chief have the right to extend or shorten FPPE as needed.

(g) Approve Ongoing Professional Practice Evaluation (OPPE) data elements and Focused Professional Practice Evaluation (FPPE) indicators recommended by departments.

(h) Review recommendations from the Interdisciplinary Practice Committee on Advanced Practice Providers.

(i) Review and report on matters referred by the Chief of Staff or Medical Staff Executive Committee regarding the qualifications, competence, conduct or professional character of any applicant or medical staff member during reappointment.

(j) Submit monthly reports and recommendations to the Medical Staff Executive Committee.

11.3-3 MEETINGS

The committee will meet monthly, but may convene more frequently or be canceled as determined by the Chairperson. The committee may also meet electronically, as needed.

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11.4 DEPARTMENT EXECUTIVE COMMITTEES – *Campus-Specific*

11.4-1 COMPOSITION

Each department designated in Article 9 shall have a campus specific Department Executive Committee including but not limited to the Department's Chief Chair and Campus appropriate Vice-ChiefChair. The Department Chief Chair will select members that are representative of the specialties and sub-specialties within the department whenever possible. The Department Chief Chair may designate the department as a whole to act as the Department Executive Committee. The Department Chief Chair shall act as Chairman of the Department

Comment [m10]: Negated by the creation of the campus specific operating committees

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Executive Committee. The peer review portion of the Department Executive Committees will be attended by physicians, dentists, and/or podiatrists of the committee.

11.4-2 DUTIES
Each Department Executive Committee shall assist the Chief Chair of the Department to carry out the functions described in Article 9.

11.4-3. MEETINGS
As often as necessary but at least quarterly.

11.4 LEADERSHIP COUNCIL
11.5 Enterprise Committee

11.45-1 COMPOSITION
The Leadership Council shall be comprised of the Chiefs of Staff from MV and LG campuses, Vice Chiefs of Staff from MV and LG campuses, and Immediate Past Chiefs of Staff from MV and LG campuses. The, Chief Medical Officer shall be an ex officio member. , Associate Chief Medical Officer (ex-officio, no vote), Medical Director of Quality and Patient Safety (ex officio, no vote), other members for clinical expertise as needed (ex-officio, no vote). Support personnel will include the Director, Medical Staff Services (ex-officio, no vote), and the Supervisor the DirectorManager of the, Medical Staff Services (ex-officio, no vote).

11.45-2 CHAIR
The committee will be chaired by the Enterprise Chief of Staff (Chief of Staff MV).

(a) 11.45-3 DUTIES

(b) Performs prompt, initial review of complex* cases and handles matter if possible. Cases will be brought to the Leadership Council through the QRR process, or individuals with concerns may refer cases to the Leadership Council for review and disposition.

- No further review or action
- Address through alternate policy
- Educational letter
- Collegial intervention

The above will be reported to CRC.

(c) Determines appropriate avenue for full review if needed

- Further review is required, refer as appropriate, to:
  - Department Executive Committee
  - Expert reviewer of case, expert chosen in consultation with department chief
  - Care Review Committee – refer cases that are defined as complex
  - Medical Staff Executive Committee – requires immediate disciplinary action
- Leadership Council will provide oversight of the cases that are referred until they are concluded.

(d) Review new technology/procedures – refer to Care Review Committee if additional expertise is necessary.

(e) Serve as the Nominating Committee for the Medical Staff Officer Elections. Submit nominations for MV and LG Chiefs of Staff and MV and LG Vice Chiefs of Staff as required by these Bylaws.

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(a) Serve as the Nominating Committee for the Medical Staff Officer Elections. Submit nominations for MV and LG Chiefs of Staff and MV and LG Vice Chiefs of Staff as required by these Bylaws

~~Review new technology/procedures – refer to the Credentials Committee if additional expertise is necessary.~~

~~(f)~~(b) Review the Bylaws and the rules, regulations, procedures, and forms promulgated in connection therewith as necessary.

~~(g)~~(c) Submit recommendations to the Medical Staff Executive Committee and to the Board of Directors for changes in these documents as necessary to reflect current medical staff practices.

~~(h)~~(d) Receive and consider all matters ~~specified in subparagraph (a)~~ referred to this body as may be referred by the Board of Directors, the Medical Staff Executive Committee, the Departments, the Chiefs of Staff and the ~~Administrator/~~Chief Executive Officer or designee.

~~***Definition of a complex issue:**~~

- ~~Requires immediate or expedited review~~
- ~~Involves practitioners from two or more departments or specialties~~
- ~~Involves department chief~~
- ~~Involves possible conflicts of interest~~
- ~~Involves professional conduct, disruptive practitioner behavior~~
- ~~Involves possible health issue~~
- ~~Pattern has developed despite prior interventions~~
- ~~Prior PIP; recurrence of issues~~
- ~~EMTALA violations~~
- ~~Serious Safety Event – if referred to Leadership Council due to need for peer review or medical staff input.~~

~~Should this complex case stuff language be here at all?~~

~~Should LC be doing Peer review at all??~~

11.4~~5~~-4 MEETINGS
Leadership Council will meet as needed which could be as often as monthly ~~or as needed~~ (determined by the chair).

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

11.5 MEDICAL STAFF EXECUTIVE COMMITTEE (MEC) – *Enterprise Committee*
~~**11.6**~~

11.5~~6~~-1 COMPOSITION
The Medical Staff Executive Committee members shall consist of:

~~(a)~~• The general officers of the Medical Staff as listed in Section 10.l-1; The Chair of Medical Staff Executive Committee will be the MV Chief of Staff who is designated ~~. The Chair of~~

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Medical Staff Executive Committee will act as the Enterprise Chief of Staff.

- The department chief(s)chairs of the threeall Medical Staff Departments. If the department chief chair is unable to attend a Medical Staff Executive Committee , a Department Vice Chairmeeting, the immediate past chief or vice-chief may attend and vote in both General and Executive Sessions.

(b)

- The Chief of each Hospital Division (Emergency, Radiology, Pathology, Hospitalist, and Anesthesia) or designee approved by the Enterprise Chief of Staff.There will be up to four (4) at-large members appointed by the Enterprise Chief of Staffelected by the Medical Staff to ensure balanced -of representation of both campuses.s and specialties as needed. Two (2) at-large members will be elected from the Mountain View Campus and two (2) from the Los Gatos Campus.

(c)

In addition, the following may attend General and Executive Sessions without vote:
The following shall be ex-officio non-voting members of the MEC:

(a) The Chief Executive Officer (CEO);
(b) The Chief Medical Officer (CMO);
(c) Associate Chief Medical Officer;
(d) The Medical Director of Psychiatric Services;
(e) Medical Director of Quality and Patient Safety;
(f)(c) The Chair of the Care Review CommitteePractitioner Excellence Committee;

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Comment [EC11]: Ex officio members

(d) The Medical Director of Neonatology Intensive Care UnitChair of the Credentials Committee;

(g) The Chief Operating Officer (COO)

(e) The Chief Nurs

(h)(f) The Chief Nursing ing Officer (CNO);

(g) The Sr. Quality Director/Chief Quality Officer (CQO).

(i)(h) The Chair of the Quality Council

The following may attend the General Session (without vote). Executive Session attendance will be by invitation in order to discuss specific pertinent issues:

(a) The Hospital Administrator of El Camino Hospital Los Gatos Campus;
The Santa Clara County Medical Association Councilor.
(b) Should this continue?

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

11.56-2 DUTIES

The duties of the Medical Staff Executive Committee (MEC) shall be to:

(a) Represent and to act on behalf of the organized medical staff in the absence of a general staff meeting, subject to such limitations as may be imposed by these Bylaws.

(b) The Medical Staff Executive Committee shall recommend Bylaws amendments to the organized medical staff for approval in accordance with Article 15 of these Bylaws.

(c) The Medical Staff Executive Committee shall formulate, review, and propose to the Board of Directors any medical staff rule, regulations, policies/procedures, and amendments as needed and in accordance with Article 15 of these Bylaws.

(d) Coordinate the activities and general policies of the Medical Staff not otherwise established as the responsibility of the Departments.

(e) Receive and act upon Department, Division, and committee reports and requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.

(f) Implement policies of the Medical Staff not otherwise the responsibility of the Departments.

(g) Provide liaison between the Medical Staff and the Administrator/ Chief Executive Officer and the Board of Directors.

(h) Recommend action to the Administrator/ Chief Executive Officer/ Board of Directors on matters of a medico-administrative nature.

(i) Make recommendations on Hospital management matters, such as long-range planning, to the Board of Directors through the Administrator/ Chief Executive Officer.

(j) Fulfill the Medical Staff's responsibility of accountability to the Board of Directors for the medical care rendered to patients in the Hospital.

(k) Assure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.

(l) Review the credentials of applicants through Department Chief reports and make recommendations to the Board of Directors for staff membership, assignments to

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departments, delineation of clinical privileges, disciplinary actions, —and terminations.

(m) Review periodically all information available regarding the performance and clinical competence of staff members, other practitioners, and allied health practitioners with practice privileges, and as a result of such review, make recommendations for reappointments and renewals or changes in clinical or practice privileges.

(n) Take all reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and allied health practitioners including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

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

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

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

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

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

(t) Monitors the quality of medical histories and physical examinations.

11.5~~6~~-3 MEETINGS

Monthly or at the discretion of the chair.

11.6 PHYSICIAN HEALTH & WELL-BEING COMMITTEE – ***Enterprise Committee***

~~**11.7**~~

11.6~~7~~-1 COMPOSITION

The committee will at least be composed of licensed independent practitioners~~ (LIPs) from the clinical specialties of Anesthesia, Surgery, Addiction Medicine and Emergency Medicine and representatives from Behavioral Health~~. There will be a Chair and four (4) at-large members. Further details may be found in the Medical Staff Committee Policy and Procedures.~~Except for initial appointments, each member shall serve a term of at least three years and the term shall be staggered as deemed appropriate by the Medical Staff Executive Committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment committees while serving on the committee.~~

11.6~~7~~-2 DUTIES

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

~~(a) Receipt of Reports, Evaluation and Referrals: Receive reports related to the physical or mental health, well-being or impairment of LIPs, including reports of self- referrals or referrals by other organizational staff, and as it deems appropriate, evaluate such reports. For matters involving individual LIPs, the committee shall evaluate the credibility of a complaint, allegation, or concern and provide such advice, counseling, or referral to an appropriate internal or external professional resource for evaluation, diagnosis, and treatment of the condition or concern.~~

~~(b) Confidentiality: The activities of this committee shall be confidential except as limited by law, ethical obligation, or when the health and safety of a patient is threatened. The Committee shall have no investigatory or disciplinary responsibility or any role in the corrective action process under these Bylaws.~~

~~(c) Reporting: If information received by the Committee~~

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demonstrates that the LIP is providing unsafe treatment, that information shall be referred to the organized medical staff leadership for consideration of initiating an investigation under Section 8.1-2 of these Bylaws.

(d) Monitoring: Review and monitor a LIP's progress in and adherence to any treatment program and the safety of patients until rehabilitation is complete and periodically thereafter, if required. Provide recommendations to other appropriate committees or officers regarding reasonable safeguards concerning a LIP's

continued practice in the Hospital while undergoing treatment, rehabilitation or during any disciplinary process. Appropriate actions will be initiated if a LIP fails to complete the required rehabilitation program.

(e) Education: Consider general matters related to the health and well-being of the LIP, including educational programs about illness and impairment recognition issues specific to LIPs or related patient safety in coordination with other appropriate committees.

(f) Policy Setting: Establish guidelines for the management of licensed individual practitioners thought to be acting under the influence of chemical agents (reference Medical Staff Policy 7.1-2, Impaired Physicians, and Physician Health & Well-Being Committee Guidelines).

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11.67-3 RECORDS/REPORTING

The details of records and reporting may be found in the Medical Staff Committees Policy and Procedure.

The committee shall maintain such records of its proceedings as it deems advisable, and shall report on its activities on a quarterly basis to the Medical Staff Executive Committee and the Board of Directors. Any records regarding individual licensed individual practitioners shall be kept strictly confidential and maintained independently from the general records of the committee and the affected licensed individual practitioner's credentials file, subject to any need for disclosure to protect patients.

11.67-4 MEETINGS

At least quarterly, or more often if necessary.

11.7 11.8 QUALITY COUNCIL – *Enterprise Committee*

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11.78-1 COMPOSITION

The committee shall be composed of vice chiefs of Medical Staff Departments, Medical Director of Quality and Patient Safety, Senior Director of Quality and Patient Safety, , and other members as appointed by the Chief of Staffthe Chair, the Enterprise Department Chairs, and the appropriate Service Line leaders as determined by the Committee and the Enterprise Chief of Staff. The Enterprise Chief of staff will appoint at large members to ensure balanced representation of campuses. Ex-officio members shall include the Chief Medical Officer and the Chief Quality Officer, and Chief Nursing Officer.

11.8-2 TERMS

The with a limit of six (6) years total. The remaining members terms are determined by fulfillment of position with no term limits.

11.78-2 DUTIES

The details regarding duties of the Quality Council may be found in the Medical Staff Committees Policy and Procedures.

(a) Review information on clinical path variances.

(b) Assure uniform standards of care and heightened awareness of resource allocation in all Medical Staff and hospital departments. Optimal outcomes management will be emphasized.

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~~(c) Identify certain projects that require multidisciplinary action, hear results and follow-up on these actions.~~

11.8 ~~11.8-3 MEETINGS~~

~~**At least quarterly, or more often if necessary.**~~

THE INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC) – ***Enterprise Committee***

11.8~~9~~-1 COMPOSITION

The details may be found in the Medical Staff Committee Policy and Procedures.

~~**11.9-2 TERMS**~~

~~The details may be found in the Medical Staff Committee Policy and Procedures.~~

11.8~~9~~-3 DUTIES

The details may be found in the Medical Staff Committee Policy and Procedures.

11.9 DEPARTMENT EXECUTIVE COMMITTEES – ***Enterprise Committee***

11.9-1 COMPOSITION

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

11.9-2 DUTIES

Each Department Executive Committee shall assist the Chair of the Department to carry out the functions described in Article 9.

11.9-3. MEETINGS

As often as necessary but at least quarterly.

11.10 ~~10~~ CAMPUS SPECIFIC OPERATIONS COMMITTEES (MVOC AND LGOC)

11.10~~10~~-1 COMPOSITION

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

~~**11.10-2 TERMS**~~

As determined by term of position holder or, in the case of the members at large, annual appointment by the Chair.

11.91100-3 DUTIES

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

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

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ARTICLE 12
MEETINGS

12.1 MEETINGS

12.1-1 GENERAL MEDICAL STAFF ANNUAL MEETING

There shall be an annual meeting of the Medical Staff members in June. The meeting shall be chaired by the Enterprise Chief of Staff – see Article 10, Officers of the Medical Staff. The Enterprise Chief of Staff, or such other officers as the Enterprise Chief of Staff or Medical Staff Executive Committee may designate, shall present a summary report on events of the preceding year and matters believed to be of interest and value to the membership. Notice of this meeting shall be given to the membership at least thirty (30) days prior to the meeting.

12.1-2 REGULAR MEETINGS

Regular meetings of the medical staff shall be held as determined by the Medical Staff Executive Committee and will be chaired by the Enterprise Chief of Staff. The date, place and time of the regular meetings shall be determined by the Medical Staff Executive Committee, and adequate notice shall be given to the members. The annual meeting shall count as a regular meeting of the Medical Staff.

12.1-3 AGENDA

The order of business at a regular meeting shall be determined by the Enterprise Chief of Staff. The agenda may include:

(a) Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
(b) Administrative reports from the Administrator/ Chief Executive Officer, the Chief of Staff, the departments and committees.
(c) Reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of the other required staff functions.
(d) Recommendations for improving patient care within the Hospital.
(e) Old business.
(f) New business.

12.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Enterprise Chief of Staff and shall be called at the request of the Board of Directors, the Medical Staff Executive Committee, or ten percent (10%) of the eligible voting members. The meeting must be called within thirty (30) days after receipt of such request and notice must be given at least ten (10) days prior to the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Committees and departments, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. The Chairs shall make every effort to ensure that the meeting dates are disseminated to the members.

12.2-2 SPECIAL MEETINGS
A special meeting of any committee or department may be called by, or at the request of, the Chairman thereof, the Medical Staff Executive Committee, the Chief of Staff or by one-third of the group's current members eligible to vote, but not less than three (3) members.

12.3 NOTICE OF MEETINGS

Written notice stating the place, day, and hour of any regular or special committee or Department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than seven (7) days before the date of such meeting, in the manner specified in Section 14.8, hereof. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

12.4-1 STAFF/COMMITTEE MEETINGS
A quorum for any regular or special meeting of the general medical staff shall consist of the presence of ten (10) percent of those eligible to vote. A quorum of fifty (50) percent of the voting members shall be required for Medical Staff Executive Committee meetings. For other Committees, a quorum shall consist of the majority of those present and voting.

12.4-2 IRB MEETINGS
At IRB meetings, a majority of the total membership must be present to transact business, one member to be a lay person.

12.5 MANNER OF ACTION

Except as otherwise specified; the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone/electronic conference which shall be deemed to constitute a meeting for the matters discussed in that conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

12.6 MINUTES

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the resultant conclusions, recommendations and actions taken on each matter. The minutes shall be signed by the presiding officer. Each Committee and Department shall maintain a permanent file of the minutes of each meeting in the Medical Staff Office.

12.7 ATTENDANCE REQUIREMENTS

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance may be used by the Executive Committee in evaluating Medical Staff members at the time of reappointment.

12.8 SPECIAL APPEARANCE

Whenever an apparent or suspected deviation from standard clinical practice is involved, notice shall be given at least fourteen days (14) days prior to the meeting and shall include the time and place of the meeting, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to

which he/she was given such notice, unless excused by the Medical Staff Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Staff Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Staff Executive Committee, as provided in Section 7.3-4.

12.9 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, minor technical failures to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE 13
CONFIDENTIALITY, IMMUNITY, AND RELEASES

13.1 AUTHORIZATIONS AND CONDITIONS

By applying for or exercising clinical or practice privileges within this Hospital, a health practitioner:

(a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing on his/her professional ability and qualifications.

(b) Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such health practitioner to the Hospital and its Medical Staff.

(c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

(d) Acknowledges that the provisions of this Article are express conditions to his/her application for or acceptance of Medical Staff membership and the continuation of such membership, or to his/her exercise of clinical privileges at this Hospital, or to his/her application for or acceptance of approval and exercise of practice privileges at this Hospital.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under Article 14, and meetings of special or ad hoc committees created by the Medical Staff Executive Committee or by departments and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the peer review discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff bylaws, and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Staff Executive Committee may undertake such corrective action as it deems appropriate.

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and hospital shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff, hospital or El Camino Hospital District.

13.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or hospital concerning such person who is, or has been, an applicant to or member of the staff

or who did, or does, exercise clinical privileges or provide services at this hospital.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) application for appointment, reappointment, or clinical privileges;
(b) corrective action;
(c) hearings and appellate reviews;
(d) department, or division, committee, or Medical Staff activities conducted in executive sessions; and
(e) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

13.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities, as long as such activities are subject to a privilege afforded by State or Federal law. These activities include, but are not limited to, (1) as a member of or witness for a Medical Staff department, service, committee or hearing panel, (2) as a member of or witness for the hospital board or any hospital task force, group, or committee, and (3) as a person providing information to any Medical Staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant. The Medical Staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff or member sees fit, and concurrently or in such sequence as the Medical Staff or member may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the hospital's indemnification obligations hereunder.

ARTICLE 14
GENERAL PROVISIONS

14.1 RULES AND REGULATIONS

14.1-1 MEDICAL STAFF RULES AND REGULATIONS
The Medical Staff Rules and Regulations may be adopted, amended or repealed by the Medical Staff Executive Committee subject to approval of the Board of Directors, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Rules and Regulations.

14.1-2 DEPARTMENT GUIDELINES
Subject to approval of the Medical Staff Executive Committee, each Department shall formulate and approve its own guidelines, each Clinical Service shall formulate and approve its own protocols, and each committee its own standing orders.

Such guidelines, protocols and standing orders shall not conflict with these Bylaws, the rules and regulations of the Medical Staff, or other policies of the Staff and Hospital. When adopted and approved by the Medical Staff Executive Committee, the guidelines, protocols and standing orders shall have the same force and effect as these Bylaws.

14.2 DUES

Active, Provisional, ~~Courtesy, Active Community,~~ Consultant and Affiliate Staff members are required to pay annual dues. A failure to pay such dues shall result in those actions specified in Section 7.3-8. The Medical Staff Executive Committee shall have the authority to set the amount of annual dues, if any, for each category of Medical Staff membership and the amount of the processing fee for initial applications, and to determine the manner of expenditure of funds received.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

14.4 AUTHORITY TO ACT

Action of the Medical Staff in relation to any person other than the members thereof shall be expressed only through the Chief of Staff or the Medical Staff Executive Committee, or his/her or its designee, and they shall first confer with the Administrator. Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Staff Executive Committee or Board of Directors may deem necessary.

14.5 ACCEPTANCE OF PRINCIPLES

All members of whatever class or category, by application for membership in this Medical Staff, do thereby agree to be bound by the provisions of these Bylaws, a copy of which shall be delivered to each member on his/her initial appointment, and a copy of each amendment thereto, promptly after adoption. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Staff Executive Committee or Board of Directors shall direct.

14.6 DIVISION OF FEES

The practice of the division of professional fees under any guise whatsoever is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

14.7 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested.

In the case of notice to hospital, Board of Directors, Medical Staff or officers or committee thereof, the notice shall be addressed as follows:

El Camino Hospital
2500 Grant Road
Mountain View, CA. 94039-7025

In the case of a notice to a practitioner, Allied Health Practitioner, or other party, the notice shall be addressed to the address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery, and if mailed as provided for above, such notice shall be effective two (2) days after it is placed in the mail. Any party may change its address, as indicated above, by giving written notice of such change to the other party in the manner as above indicated.

14.8 SECRET WRITTEN BALLOT

Whenever these Bylaws require voting by secret, written mail ballot, the mail ballots shall be returned in an unmarked envelope, which shall be placed inside a properly identified return envelope on which the staff member has printed and signed his/her name, and their participation shall be confidential. The staff member's name shall be verified against the Medical Staff records. Whenever electronic voting is utilized, appropriate safeguards for confidentiality shall be implemented as determined by the Medical Staff Executive Committee.

14.9 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chief, or the Medical Staff Executive Committee shall, at least 5 days prior to the date of election or appointment, disclose in writing to the Medical Staff Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Such disclosures shall also be made during physician's term as they occur.

ARTICLE 15
ADOPTION AND AMENDMENT OF MEDICAL STAFF DOCUMENTS

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15.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review, adopt and propose to the Board of Directors the Medical Staff documents and amendments thereto which shall be effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. The medical staff exercises this responsibility regarding Bylaws through direct vote of its medical staff members who are eligible to vote. The medical staff exercises this responsibility regarding Rules and Regulations and Policies/Procedures through its elected and appointed leaders via the Medical Staff Executive Committee. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board of Directors and with the Community.

15.1-1 MEDICAL STAFF DOCUMENTS

Medical Staff documents consist of the following:

(a) Medical Staff Bylaws
(b) Medical Staff Rules & Regulations – attached to these Bylaws
(c) Medical Staff Policies/Procedures – located in Medical Staff Policy Binder
(d) Allied Health Professionals Policy Manual – located in Medical Staff Policy Binder

15.2 PROCEDURE FOR AMENDMENTS/ADOPTION MEDICAL STAFF DOCUMENTS

~~15.2~~

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(a) Medical Staff Bylaws: Amendments to the Bylaws occur through direct vote of the medical staff members. Proposed amendments occur in one of the following ways:

1. Upon the request of (i) the Medical Staff Executive Committee (MEC), (ii) the Chief of Staff or Bylaws Committee after approval by the Medical Staff Executive Committee.
2. The organized medical staff (OMS) has the ability to adopt medical staff bylaws, rules, regulations, and policies, and amendments thereto, and to propose them directly to the Board of Directors. Proposed amendments to the Bylaws or Rules and Regulations may be originated by the Medical Staff Executive Committee or by a petition signed by twenty-five percent (25%) of the voting members of the medical staff. Any amendments proposed by this procedure must be in writing and accompanied by a written description of the reasons for the amendment. Proposals received in this manner will then follow the usual and customary method of voting for an amendment prior to the proposal being forwarded to the Board of Directors for approval.
   - When proposed by the Medical Staff Executive Committee, there will be communication of the proposed amendment to the OMS before a vote is taken by the OMS.
   - When proposed by the OMS, there will be communication of the proposed amendment to the Medical Staff Executive Committee before a vote is taken by the OMS.

(b) Medical Staff Rules and Regulations: The OMS delegates authority for amendments to the Rules and Regulations to the Medical Staff Executive Committee. Proposed amendments to these Rules and Regulations may be originated by the Medical Staff Executive Committee or by a petition signed by twenty-five percent (25%) of the

voting members of the OMS.

1. When proposed by the Medical Staff Executive Committee, there will be communication of the proposed amendment to the OMS before a vote is taken by the Medical Staff Executive Committee.
2. When proposed by the OMS, there will be communication of the proposed amendment to the Medical Staff Executive Committee. If the Medical Staff Executive Committee does not pass the proposed amendment to the Rules and Regulations, the OMS can ask for a medical staff vote using the mechanisms noted in the conflict resolution process (Article 15.2-1).

(c) The Medical Staff Executive Committee and Board of Directors may adopt such provisional amendments to these Rules and Regulations that are in the Medical Staff Executive Committee's and Board's judgments necessary for legal or regulatory compliance without first communication to the OMS. After adoption, these provisional amendments to the Rules and Regulations will be communicated to the OMS for their review. If the OMS does not approve of the provisional amendment, this will be resolved using the conflict resolution mechanism noted in Article 15.2-1. If a substitute amendment is then proposed, it will follow the usual approval process.

(d) Medical Staff Policies/Procedures – Allied Health Procedures: The OMS delegates authority for amendments to the Policies/Procedures to the Medical Staff Executive Committee. When the Medical Staff Executive Committee adopts a policy or amendment thereto, there will be communication of the policy or amendment to the OMS.

15.2-1 CONFLICT RESOLUTION (Between OMS and the MEC)

Any conflict between the OMS and the Medical Staff Executive Committee will be resolved using the mechanisms noted below:

(a) Each medical staff member eligible to vote may challenge any rule or policy established by the Medical Staff Executive Committee through the following process:

1. Submission of written notification to the Enterprise Chief of Staff of the challenge and the basis for the challenge, including any recommended changes to the rule or policy.
2. At the meeting of the Medical Staff Executive Committee that follows such notification, the Medical Staff Executive Committee shall discuss the challenge and determine if any changes will be made to the rule or policy.
3. If changes are adopted, they will be communicated to the OMS, at such time each medical staff member eligible to vote may submit written notification of any further challenges(s) to the rule or policy to the Enterprise Chief of Staff.
4. In response to a written challenge to a rule or policy, the Medical Staff Executive Committee may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.
5. If a task force is appointed, following the recommendations of such task force, the Medical Staff Executive Committee will take final action on the rule or policy.
6. Once the Medical Staff Executive Committee has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member may submit a petition signed by twenty-five percent (25%) of the medical staff members eligible to vote requesting review and possible change of a rule, regulation, policy, or procedure. Upon

~~p~~presentation of such a petition, the adoption procedure outlined in Article 15.2 will be followed.

(b) If the OMS votes to recommend directly to the Board an amendment to the Bylaws, Rules and Regulations, or Policy/Procedure that is different from what has been recommended by the Medical Staff Executive Committee, the following conflict resolution process shall be followed:

1. The Medical Staff Executive Committee shall have the option of appointing a task force to review the differing recommendations of the Medical Staff Executive Committee and the medical staff, and recommend language to the Bylaws, Rules and Regulations or Policy/Procedure that is agreeable to both the OMS and the Medical Staff Executive Committee.

2. Whether or not the Medical Staff Executive Committee adopts modified language, the medical staff shall still have the opportunity to propose directly to the Board of Directors the alternative language. If the Board receives differing proposals for amendments for Bylaws, Rules and Regulations, or a policy from the Medical Staff Executive Committee and the OMS, the Board shall also have the option of appointing a task force of the Board to study the basis of the differing recommendations and to recommend appropriate Board action. Whether or not the Board appoints such a task force, the Board shall have final authority to resolve the difference between the OMS and the Medical Staff Executive Committee.

(c) At any point in the process of addressing a disagreement between the OMS and the Medical Staff Executive Committee regarding the Bylaws, Rules, Regulations, or Policy/Procedures, the OMS, the Medical Staff Executive Committee, or the Board of Directors shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed in so doing, is the responsibility of the Board of Directors.

~~(c)~~

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15.3 METHODOLOGY

Neither the Board of Directors nor the Medical Staff may unilaterally amend the Medical Staff Bylaws. Medical Staff Bylaws may be adopted, amended or repealed by the following combined action:

15.3-1 STAFF MEMBERS

(a) The affirmative vote of a majority of the medical staff members eligible to vote Staff Members voting on this matter by secret written ballot, or

(b) By the affirmative vote of a majority of those eligible staff members voting by electronic voting, method to be determined by the Medical Staff Executive Committee.

(c) The method of voting will be determined by the Medical Staff Executive Committee and at least fourteen (14) days prior written notice, accompanied by the proposed Bylaws and/or amendments, will be provided to Staff Members eligible to vote.

~~(c)~~

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15.3-2 BOARD OF DIRECTORS

Amendments will be approved by the affirmative vote of a majority of the Board of Directors. If approval is withheld, the reason for doing so shall be so specified by the Board of Directors in writing and shall be forwarded to the Medical Staff Executive Committee and Bylaws Committee.

ADOPTED by the Medical Staff	**APPROVED by the Board of Directors**
on: December 28, 2018	**on: January 16, 2019**

Previous approvals: 8/2015; 1/2016; 4/2017; 10/2018

EL CAMINO HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

Appendix I

A. ADMISSIONS/DISCHARGES

1. Patients shall be admitted only under the care of a qualified member of the Medical Staff. The attending physician must be available to the admitted patient at all times or must arrange such coverage.

   Allied health practitioners may initiate arrangements for admission and complete charts and forms pertinent to the admission and the medical record if privileged to do so within their scope of practice and under the supervision of the attending physician (if applicable).

2. Except in an emergency, patients shall not be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.

3. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary or appropriate to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

4. According to policy of Medical Staff (see Operating Room Committee policy), pre-operative lab work shall be ordered at the discretion of the admitting surgeon. If pre-op lab work is ordered, the attending surgeon will be responsible for either including a copy of the lab work in the chart or in the dictated H&P or the admission note in the progress notes.

5. Potassium levels shall be obtained within 72 hours of surgery for all patients on potassium depleting diuretics.

6. All laboratory procedures, for patients being investigated or treated within the Hospital, shall be done in the Hospital except in those circumstances where the Hospital refers laboratory work outside the Hospital.

7. Decisions concerning the use of reference laboratories for studies not performed in the Hospital shall be delegated to the director of the medical laboratory services.

8. Each patient on admission shall be provided with a wristband unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient and the Hospital admission number.

9. Patients shall not be routinely admitted to a distinct part of the Hospital unless it is appropriate for the level of care required by those patients.

10. Patients with critical burns shall be treated in a Burn Center unless transfer of the patient to the center is contraindicated in the judgment of the attending physician.

11. Any outpatient psychotherapist arranging for inpatient psychiatric care of his/her patient at El Camino Hospital will share with the ECH treatment team all

information relevant to the patient's treatment. When the outpatient therapist is not the admitting psychiatrist, a special effort should be made to inform the admitting psychiatrist of all relevant treatment issues. This communication is for purposes of ensuring optimal short-term patient care. Information must be held in strict confidence within the treatment setting, but the availability of relevant information to the treatment team is essential to provide adequate and appropriate therapy.

12. A mentally competent adult shall not be detained in the Hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where the law permits an unemancipated minor to contract for medical care without the consent of his/her parent or guardian, he/she shall not be detained in the Hospital against his/her will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the Hospital in his own interest nor the detention of a mentally disordered patient for the protection of himself or others under the applicable provisions of the Welfare and Institutions Code, Section 5000, et seq., until transfer to an appropriate facility can be arranged.

13. Patients shall not be transferred or discharged for purposes of effecting a transfer from the Hospital to another health facility unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or after reasonable attempts have been made to notify the responsible person. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.

14. A minor shall be discharged only to the custody of his or her parent or to his legal guardian or custodian, unless such parent or guardian shall otherwise direct. This provision shall not be construed to preclude a minor legally contracting for medical care from assuming responsibility for himself upon discharge.

15. Patients may only be discharged upon the order of a Medical Staff member.

16. In the event that a hospitalized patient refuses treatment by a physician, the affected physician will:
    a. Communicate with the patient with regard to what he/she needs (tests, follow-up care, etc).
    b. Ask a physician in his/her call group or specialty to take over care of the patient ***or.***
    c. Ask the chief of department or chief of staff for assistance in assigning another physician to care for the patient.

If the affected physician is acting as a consultant, the primary physician will find another consultant, absent an emergency situation. The primary physician is always responsible for the patient's care in the immediate emergency situation absent the patient's direct wishes to not be cared for in the interim.

17a. Prior to initiation of definitive therapy at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, it is strongly recommended that review and report of the findings must be documented by an ECH pathologist.

17b. Prior to initiation of definitive therapy for breast cancer at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, review and report of the findings must be documented by an ECH pathologist.

B. RECORDS

The responsible staff member shall be accountable for the preparation of a complete medical record for each patient. Unless otherwise provided in standing orders, protocols, or guidelines, a record shall include (a) identification data; (b) chief complaint; (c) details of present illness; (d) relevant past, social, and family histories; (e) inventory of body systems; (f) complete physical examination; (g) provisional diagnosis; (h) consultation reports; (i) reports from laboratory, i.e., pathology, radiology, etc.; (j) progress notes detailing medical-surgical treatment that reflect any change in condition and results of treatment; (k) reports of procedures (also see below), e.g., nuclear medicine, radiology, anesthesia; (l) principal & secondary diagnosis(es); (m) discharge summary, discharge instructions; (n) follow-up plans; and (o) appropriate consents; and (p) autopsy results, if applicable. All entries shall be dated, timed, and authenticated by the appropriate practitioner. Any entries made for the practitioner (fellow, resident, physician assistant, etc.) must be dated, timed, and counter-signed by the practitioner, except emergency department (ED) reports. ED assessments may be dictated and signed by the responsible nurse practitioner or physician's assistant, and must include the name of the supervising ED physician. The ED physician must document in the ED record that he/she has reviewed the assessment and care provided.

Medical Records may be authenticated by a computer key code, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who has possession of the key code and the only person who will use the key code. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice.

History & Physical (H&P)

1. H&P must be completed by a practitioner privileged to perform H&Ps – these are defined as:
   a. MD/DO
   b. DDS/DMD
   c. DPM
   d. Nurse Practitioner – must be countersigned by supervising practitioner within 14 days of the patient's discharge.
   e. Certified Nurse Midwife
   f. Physician Assistant – must be countersigned by supervising practitioner within 14 days of the patient's discharge.

2. H&P must be completed and documented for each patient no more than 30 days before or ***within*** 24 hours ***of*** admission ***or registration***, but prior to surgery or procedure requiring anesthesia services.

   At a minimum, the following systems must be included in the H&P:
   a. Heart and lungs
   b. Abdomen
   c. General appearance and orientation
   d. Vital signs (including blood pressure, heart rate, respiratory rate, and temperature – afebrile is acceptable) or reference to vital signs obtained

elsewhere in the admission process

e. Major integumentary

f. Musculoskeletal or sensory systems when problems such as blindness, deafness, missing limbs, or open sores and wounds exist

g. Rectal/pelvic examinations are recommended when pertinent to the admission diagnosis

h. Salient features of the case

i. Drug tolerances

j. Pertinent positive and negative findings that relate to the reason for admission.

Outpatients receiving local anesthesia or conscious sedation require, as a minimum, a current statement of present illness, a statement of absence of infection or intercurrent disease, a description of cardiorespiratory status, known allergies, current medications, and a preoperative diagnosis.

Obstetrical records should include all pertinent and significant prenatal information. A durable, legible original or reproduction of the office or clinical prenatal record is acceptable. The report of the physical examination shall reflect a comprehensive current physical assessment

ECT Patients – For patients receiving a series of ECT treatments, the history and physical must be within thirty (30) days prior to the initial treatment. For subsequent treatments within the same series, an update to the H&P will be required (the update must include auscultation of the lungs and heart and any significant change in condition or absence of any significant change). This may be documented on the anesthesiologist pre-anesthesia assessment form.

3. **Updates**: When the H&P is conducted within 30 days of admission (inpatient or outpatient), an updated examination, including any changes in the patient's condition, must be completed and documented by a qualified practitioner (see #1 in this section) within 24 hours of admission (inpatient or outpatient) or registration, but prior to surgery or a procedure requiring anesthesia services when the H&P was completed within the previous 30 days.

   a. The update must include review of the H&P, updated examination including auscultation of the lungs and heart, and any significant change in condition or absence of any significant change from the previous report. If the patient is an inpatient, the update may be documented in the progress note or on the 'Procedure Notes' form.

4. If the reviewing practitioner finds the H&P incomplete, inaccurate, or otherwise unacceptable, he/she may disregard the H&P and perform a new H&P within 24 hours or prior to surgery/procedure as noted above.

Other Medical Record Documentation:

1. Pre-Anesthetic and Post-Anesthetic Notes

   There shall be pre-anesthetic and post-anesthetic notes documented in the medical record which include the anesthesiologist's pre-anesthetic evaluation, the patient's condition upon admission to the Post Anesthesia Care Unit, a description of the post-operative course, a description of any anesthesia complications, and a description of the patient's condition upon discharge from the Post Anesthesia Care

Unit.

2. Operative Reports

The immediate post-operative note must be entered in the medical record before the patient is transferred to the next level of care. This documentation includes the name(s) of the primary surgeon and assistants, procedures performed and a description of each procedure finding, estimated blood loss, specimens removed, and complications, if any; condition at the end of the case, and postoperative diagnosis. This documentation must be documented in the electronic medical record on the 'post procedure note'. Downtime paper forms may be used when the EMR is not functional.

The comprehensive operative report describing techniques, findings, and tissues removed or altered must be written or dictated within 24 hours of surgery and signed by the surgeon.

- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

3. Progress notes shall be written/dated/timed/signed on each day of the hospital stay and within 24 hours of discharge by the attending physician, his/her associate, or his/her designated PA or NP with El Camino Hospital privileges.

4. Orders for treatment and tests must be entered into the computer system by the Medical Staff member or authorized person at the direction of the staff member. When ordering diagnostic CT, MRI, PET, or nuclear medicine imaging exams, the practitioner should consider the patient's age and recent imaging exams. Drug and treatment orders must be appropriately signed within forty-eight (48) hours. All other orders must be signed within seventy-two (72) hours or prior to the discharge or transfer of the patient. Telephone orders shall immediately be recorded and then read back to the staff member for confirmation, shall be signed by the person to whom dictated with the name of the Medical Staff member per his own name, and shall be signed by the Medical Staff member within the prescribed time limits.

Persons authorized to accept orders defined: Persons to accept and transcribe orders at the direction of Staff Member shall include the nursing staff, pharmacists, and those persons designated by department guidelines or service protocols in conformity with applicable statutory provisions.

Orders and patient referrals for outpatient services shall be accepted from any member of the El Camino Hospital Medical Staff or Allied Health Professional Staff who holds a current, unrestricted California license and is privileged to do so.

Practitioners (physicians, podiatrists, dentists, and other allied health professionals) who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order outpatient services and refer patients for outpatient services in accordance with the provisions and condition set forth below.

a. If the ordering practitioner is not a member of the El Camino Hospital Medical Staff or Allied Health Professional Staff, verification that the practitioner is licensed and acting within his/her scope of practice in the State in which he/she sees the patient shall be obtained by the outpatient department(s) prior to performing or providing the test, study, or outpatient service. The license shall be verified via the appropriate website or by obtaining verbal verification from the appropriate licensing board by the department providing the service. In addition, a telephone number for the ordering practitioner will be verified by the outpatient department(s) prior to performing or providing the test, study, or outpatient service.
b. Orders for outpatient services must include the name of the patient, the date of the order, the test or treatment to be performed, and the reason for the test or treatment to be performed (symptoms or diagnosis). Orders for outpatient diagnostic tests (i.e., laboratory, radiology exams, EKG, etc.) may be submitted on a requisition form, a prescription/order form from the practitioner's office, or may be telephoned to the appropriate department by the practitioner's office staff with follow-up written orders.
c. Results shall be directly sent to the ordering practitioner unless otherwise requested by the ordering practitioner.
d. Practitioners who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order or refer patients for all outpatient services provided by El Camino Hospital except for chemotherapy orders.

Verbal or telephone orders must be signed/authenticated, dated and timed by the author within 48 hours. Faxed or electronic signatures may be used to authenticate a verbal or telephone order. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice. Verbal or telephone orders should be limited to those situations in which it is impossible for the prescriber to enter it into a computer.

In the case of an incorrect order, the practitioner must document in the medical information system or on the Unsigned Orders Summary, that the order was entered incorrectly.

5. A Record of Newborn must be completed for each normal newborn. The Admission Examination must be completed within twenty-four (24) hours of birth by the attending physician.

6. Medical Screening Exams (as defined under the Emergency Medical Treatment and Labor Act) shall be performed and documented in the Emergency Department and Labor and Delivery. Medical Screening Exams shall be performed by a credentialed MD, DO, certified nurse midwife, Emergency Department physician assistants under appropriate supervision and within scope of practice, or, in the case of a patient

presenting with pregnancy and/or signs and symptoms of labor, RNs who have demonstrated current competence (per hospital policy) in assessing the laboring patient.

7. A discharge summary is required on all stays over forty-eight (48) hours, except for uncomplicated obstetrical cases and normal newborns. Discharge summaries are also required for patients who are transferred to another acute care facility or who die within forty eight (48) hours, and shall be written or dictated at the time of discharge, transfer or death.

   A discharge summary should briefly recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, medications, and any specific instructions given to the patient and/or family regarding follow-up care.

   For stays less than forty-eight (48) hours, a final progress note may be completed in lieu of a discharge summary unless the patient is transferred or dies. If a discharge summary is not required, the following information must be included in the final progress note: diagnosis, condition of the patient, diet, activity, medications, and follow-up instructions (if not covered with a preprinted form).

8. Discharge instructions are required on all hospital stays, including short-stay and cancelled surgeries. Discharge instructions must include the following elements: 1) Discharge medication reconciliation; 2) discharge diet; 3) follow-up appointments; 4) activity level; 5) signs/symptoms to watch for.

9. In the event of a death, a discharge summary should be added to the record which the physician must authenticate. The final summary should indicate the reason for admission, the findings, course in the hospital including significant conditions (present on admission and comfort care), and immediate cause of death.

10. When a necropsy is performed, the provisional anatomic diagnosis should be recorded on the medical record within seventy-two (72) hours and a final completed report shall become a part of the record.

11. The records of discharged patients will be completed within 14 days following discharge.

12. All forms designed to become a part of the medical record must be approved by the Medical Records Committee and by the Medical Staff Executive Committee.

13. Procedures for making changes or amendments to record entries:
    a. Any individual who discovers an error or omission of his or her own shall immediately upon discovery correct it and do so in accordance with the procedures in this section.
    b. Simple corrections may be made during the actual writing of a record entry and shall be lined through (not obliterated), initialed and dated/timed.
    c. Errors or omissions discovered at a later time shall be corrected by a separate entry to the appropriate portion of the record. The original entry shall be lined out (not obliterated).

14. Physician Review of Medical Records

A physician may request to review a chart only when he/she is actively involved in that patient's care or if reviewing the case for official peer review or quality assessment purposes. Any abuse of this privilege may result in disciplinary action.

15. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Act, as implemented by the HIPAA Privacy Regulation (42 CFR Parts 160 and 164) requires that El Camino Hospital implement policies and procedures to protect the privacy and security of "protected health information" and to afford patients certain rights with regard to their information. "Protected health information" includes any health-related information that identifies or could be used to identify an individual, including patient medical and billing records. HIPAA applies both to the Hospital and to the members of the Medical Staff

a. El Camino Hospital has adopted privacy practices for the use and disclosure of patient information within the Hospital. These privacy practices are summarized in the Hospital's Notice of Privacy Practices, which is furnished to patients and posted at the Hospital's facilities.

b. The Notice of Privacy Practices applies to all patient health information created or received in the course of providing health care or conducting business operations at any hospital operated location. The Notice is given jointly on behalf of the Hospital and the members of the Medical Staff. It does not, however, apply to patient health information at other locations, such as a Medical Staff member's private office.

c. Each member of the Medical Staff shall abide by the terms of the Notice of Privacy Practices and with the Hospital's policies and procedures for health information privacy and security, as amended from time to time. Medical Staff members must adopt their own notice of privacy practices at their private offices as necessary to comply with the Privacy Regulations.

C. REMOVAL OF ORIGINAL RECORDS FROM THE HOSPITAL

Original records may be removed from the Hospital's custody only pursuant to court order, subpoena or statute, with exception of x-rays and other images, tracings, recordings and clinical and anatomical pathological materials which are sought for purposes of continuing care of the patient.

D. AUTOPSIES

Every member of the Medical Staff shall try to secure permission for autopsy when appropriate. No autopsy shall be performed without the written consent of the appropriate party. All autopsies shall be performed by the hospital pathologist(s) or by a physician to whom he may delegate the duty. In all cases where any doubt exists regarding the legal status of death, the coroner shall be notified and request for an autopsy made. (Indications for autopsy are found in the Pathology Department Policy "Autopsies for QA – Indications for Autopsy".)

E. CONSULTATIONS

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

The Consultant shall document the fact that all available, pertinent past medical records were examined.

F. MANDATORY CONSULTATIONS

Mandatory consultation(s); in specific, urgent or critical clinical conditions; may be imposed at the discretion of a Medical Staff officer, department or division chief or their designees with concurrence of a Medical Staff officer. Mandatory consultations may be imposed on any staff member in a specific urgent clinical management problem and/or as an overall continuing requirement in all similar types of clinical management cases.

Mandatory consultations may be imposed by departments or division guidelines for all staff members or classes of members in specific clinical conditions, subject to approval of the Medical Staff Executive Committee.

The consultant in a specific urgent or critical situation may or may not be a staff member, but must be a practitioner with acknowledged expertise. Temporary privileges, if necessary, may be granted at the discretion of an appropriate Department Chief, Chief of Staff, and Hospital Administration and are subject to Sections 6.5-1 and 14.2 of the Bylaws.

The imposition of mandatory consultation requirements on a member in a specific, urgent or critical clinical condition, or such imposition on all members or a class of members, does not constitute a reduction in privileges. Mandatory consultation requirements constitute a reduction in privileges of a member when the requirement is imposed on the individual member and as a continuing requirement in all similar cases.

Patients who have attempted suicide prior to or during their hospitalization, or who have suicidal ideation identified following hospitalization, must be evaluated for suicidal risk prior to discharge. Such evaluation is to be done by a psychiatrist or by a member of the Behavioral Health Services staff who must then review the case with a psychiatrist prior to discharge.

If an inpatient is on an involuntary psychiatric hold (i.e. 5150 or 5152); then a psychiatrist must evaluate the patient directly prior to such a hold being released.

G. PATIENT COVERAGE

Each staff member is responsible to respond to an emergency involving a member's patient or have a substitute staff member respond. In case of failure to respond, the Medical Staff officers or department executive officers of the appropriate department or service shall have the authority to request emergency services from any staff member. When a staff member finds a substitute for coverage of his practice that substitute physician must be a member in good standing of the El Camino Hospital Medical Staff with similar scope of privileges and will assume all duties of the primary physician.

H. HOSPITAL SERVICES

Outpatient diagnostic or therapeutic services may be performed only on request of a Medical Staff member with clinical privileges or practitioners who by training, practice, and California licensure would otherwise qualify for Medical Staff membership or if approved by the Medical Staff Executive Committee.

I. PROCEDURE FOR CREATION OF NEW MEDICAL STAFF DEPARTMENTS

Existing services or divisions of the Medical Staff may be considered for provisional department status if:

1. This is mandated by Joint Commission or Hospital Board of Directors, and
2. A majority of the members of the considered service or division approve, and

3. The considered service or division has at least 15 Medical Staff members.

Procedure for obtaining provisional department status:
Following approval by a majority of its members, a written request shall be forwarded to the Medical Staff Executive Committee. If the Medical Staff Executive Committee grants provisional departmental status, it shall be bound to review the performance of this provisional department after one year. At this review, the Executive Committee may grant full department status or mandate an additional six month provisional period. If an additional six month provisional period is mandated, the Medical Staff Executive Committee will again review the performance of this provisional department at the end of this time and will either grant full department status or will return it to its prior division or service level.

Responsibilities of a provisional Medical Staff department shall include:
1. The establishment of regular meetings at the frequency of not less than quarterly, which must be attended by not less than 50% of its members.
2. The maintenance of minutes that reflect concurrent review of appropriateness of care provided by its members consistent with the Quality Assessment program of the Medical Staff.
3. The review and recertification of its members' privileges in accord with established guidelines.
4. The development of departmental guidelines which are to be submitted to the Medical Staff Executive Committee within three months.
5. The development of member privileging criteria which are also to be submitted for approval to the Medical Staff Executive Committee within three months.

The Chief and Vice-Chief may sit on the Medical Staff Executive Committee during the provisional period, but may not vote until the department has been granted full status.

J. FEES
An applicant to the Medical Staff shall be required to pay $300 as a processing fee.

K. RESIDENTS
1. Nature of Affiliation: Residents engaged in patient care at El Camino Hospital must be post-doctoral trainees (residents or fellows) in training programs of approved teaching institutions which have a contract with El Camino Hospital. Residents must be licensed by the Medical Board of California. They may be authorized to perform clinical duties consistent with their training program, and as outlined in the contract between El Camino Hospital and the residency program and the Medical Staff Guidelines for Supervision of Residents (Medical Staff Policy/Procedure, Section 9). The contracting teaching institution must provide professional liability insurance for residents to cover the performance of all clinical duties at El Camino Hospital. The Medical Staff Executive Committee and Board of Directors shall approve the residency contract. Authorization to perform clinical duties will cease at the completion of an individual physician's rotation or under the terms of the contract. Residents are required to comply in all respects with the Medical Staff Bylaws and Rules and Regulations, departmental or service rules and regulations as well as applicable policies and procedures.

   Residents do not enjoy the due process rights afforded Medical Staff members. Moreover, the Medical Staff retains the right to require the immediate suspension or withdrawal of any resident if such action is deemed warranted in order to protect

patients or other individuals.

2. Supervision: All clinical care provided by residents shall be under the supervision of a member of the Medical Staff. Guidelines for supervision can be found in the ECH Medical Staff Policies and Procedures, Section 9. All policies related to supervision of residents shall be approved by the Medical Staff Executive Committee.

2. Authorized Activities: A resident may make entries in the patient's medical record as delineated in the Medical Staff Guidelines (Medical Staff Policy/Procedure, Section 9). The extent to which the resident may otherwise participate in patient care services and make entries in the medical record shall be determined by the Supervising Physician and Training Program and shall be consistent with the applicable Guidelines.

L. ALLIED HEALTH PROFESSIONALS

Allied Health Professionals ("AHPs") are covered in the Medical Staff policy regarding these practitioners.

M. DEA Certification Waiver

Exemption may be granted upon written attestation of the physician that the physician will not prescribe controlled substances in the hospital. The Department Chief and Medical Staff Executive Committee need to concur that a DEA is not required based on the physician's attestation.

EL CAMINO HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

Appendix II

A. CANCER CARE COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Committee shall consist of at least one Board certified physician representative, from Surgery, Gyn Oncology, Medical Oncology, Radiation Oncology, Radiology and Pathology, and all other representatives as required by the current American College of Surgeons/Commission on Cancer Standards.

2. DUTIES

The Committee shall:

(a) develop and evaluate annual goals and objectives for clinical, educational and programmatic activities related to cancer;
(b) promote a coordinated, multi-disciplinary approach to patient management;
(c) coordinate educational and consultative cancer conferences to cover all major sites and related issues;
(d) monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes;
(e) promote clinical research;
(f) supervise the Cancer Registry and ensure accurate and timely abstracting, staging and follow-up reporting;
(g) perform quality control of registry data;
(h) encourage data usage and regular reporting;
(i) uphold medical ethical standards; and
(j) annually provide a summary quality management report to the Medical Staff Executive Committee.

3. MEETINGS

The committee shall meet at least quarterly and will submit an annual report to the Medical Staff Executive Committee.

B. CAPITAL EXPENDITURE COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The committee will be interdisciplinary and at least composed of physicians from Surgery, Medicine, Radiology, Pathology, Obstetrics/Gynecology, Family Practice and Orthopedics. Additionally, there will be a representative from Finance, OR, Nursing Administration, Ancillary Services and Administration. The committee will be co-chaired by the MV and LG Vice Chiefs of Staff.

2. DUTIES

(a) Participate in the selection of patient care equipment/instrumentation.
(b) Review and approve recommendations from clinical departments or divisions.
(c) Participate in the review of equipment evaluation.
(d) Submit recommendations to the Medical Staff Executive Committee.

3. MEETINGS

As necessary.

C. CARDIOVASCULAR/PERIPHERAL VASCULAR SERVICES (CPVS) COMMITTEE – *MV Campus*

1. COMPOSITION

Committee members may include healthcare professionals involved in the diagnosis and treatment of cardiovascular and peripheral vascular disease including interventional cardiologists, vascular surgeons, vascular medicine surgeons, interventional radiologists, interventional neuroradiologists, interventional nephrologists. Nonvoting members may include support staff from the Cardiac Catheterization Laboratory, Angiography and Interventional Radiology Services, Non invasive Imaging and Surgery. The peer review portion of the Cardiovascular/Peripheral Vascular Services Committee will be attended by physicians of the committee.

2. DUTIES

(a) Conduct multidisciplinary review of coronary and peripheral vascular intervention procedures performed at El Camino Hospital.

(b) Develop recommendations and/or criteria for clinical privileges for percutaneous endovascular procedures.

(c) Develop protocols for a registry of cases performed at El Camino to include indications and outcomes statistics to ensure consistent quality of care

(d) Promote teaching and education amongst the healthcare professionals involved in the evaluation, combined percutaneous surgical diagnostic and therapeutic endovascular procedures.

(e) Review selected cases identified via medical staff approved criteria and refer cases for secondary peer review to the appropriate department executive committee.

3. MEETINGS

The committee shall meet as often as necessary, but at least quarterly.

D. CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The continuing medical education/library committee shall be composed of physician members and other health professionals of the Medical Staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The chairperson shall be the MV Director of Medical Education, who shall serve for at least two years, the Medical Librarian, and committee members selected by the MV Director of Medical Education who shall serve staggered terms in order to assure continuity. The LG Director of Medical Education will serve as assistant chair.

2. DUTIES

The continuing medical education/library committee shall perform the following duties:

(a) plan, implement, coordinate and promote educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital for the Medical Staff. This includes:

1. identifying the educational needs of the Medical Staff;

2. formulating clear statements of objectives for each program;
3. assessing the effectiveness of each program;
4. choosing appropriate teaching methods and knowledgeable faculty for each program; and
5. documenting staff attendance at each program.

(b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.

(c) establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.

(d) maintain close liaison with other hospital Medical Staff and department committees concerned with patient care.

(e) make recommendations to the Medical Staff Executive committee regarding library needs of the Medical Staff.

(f) advise administration of the financial needs of the continuing medical education program.

3. MEETINGS

At least quarterly. It shall maintain minutes of the program planning discussions and report to the Medical Staff Executive committee.

E.* INFECTION CONTROL COMMITTEE – *Campus-Specific

1. COMPOSITION

The Infection Control Committee shall be a multi disciplinary committee consisting of the Infection Control Officer and representatives from the Medical Staff departments as needed: the departments of medicine, surgery, obstetrics/gynecology, pediatrics, pathology, nursing, Administration, and the Nurse Epidemiologist, nursing, Administration and the Nurse Epidemiologist. The Chairman shall be a physician with knowledge of and special interest in Infection Control. Representatives from key hospital departments such as but not limited to Facilities Services, Environmental Services, Pharmacy, Central Services, Operating Room and Employee Health.

2. DUTIES

The Infection Control Committee shall:

(a) Develop a hospital-wide infection program and maintain surveillance over the program.

(b) Develop a system for reporting, identifying and analyzing the incidence and cause of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow up action.

(c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques. Such techniques shall be defined in written policies and procedures.

(d) Develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.

(e) Act upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, the departments, and

other Medical Staff and Hospital committees.

3. MEETINGS
The Committee and subcommittees (if any) shall meet at least quarterly. It shall maintain a record of its proceedings and shall submit quarterly reports to the Medical Staff Executive Committee.

F. INTERDISCIPLINARY PRACTICE COMMITTEE – ***Enterprise Committee***

1. COMPOSITION
The Committee shall be a multi-disciplinary committee consisting of at least eight (8) members, including, as the minimum, the Chief Nursing Officer, the Administrator/ Chief Executive Officer or his/her designee, and an equal number of physicians appointed by the Medical Staff Executive Committee and of registered nurses appointed by the Chief Nursing Officer.
(a) The committee shall be responsible for appointment and reappointment of all allied health practitioners in approved categories.
(b) The committee shall review quality assessment issues pertaining to allied health practitioners at the time of reappointment as needed.

2. DUTIES
(a) The Committee shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:
1. Provision for securing recommendations from Medical Staff members in the medical specialty or clinical field of practice under review, and from persons in the appropriate non medical category who practice in the clinical field or specialty under review.
2. Methodology for the approval of standardized procedures in accordance with Section 2725 of the Business and Professions Code, which requires affirmative approval of the procedures by the Administrator/ Chief Executive Officer or his/her designee, a majority of the physician members, and a majority of the registered nurse members after consultation has been obtained from medical and nursing staff members practicing in the medical and nursing specialties under review.
3. Provision for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the Medical Staff for medical services in the Hospital.
4. Provision for securing approval for each recommendation of the Committee from the Medical Staff Executive Committee and, if so approved, the Board of Directors.
(b) Registered Nurses: The Committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in the Hospital. These policies and procedures will be administered by the Committee, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.
(c) Standardized Procedures for Registered Nurses: The Committee shall be responsible for:

1. Identifying the functions and/or procedures which required the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the Hospital, and initiating the preparations of such standardized procedures in accordance with this Section.
2. The review and approval of such standardized procedures covering practice by registered nurses in the Hospital.
3. Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee or by delegation to the Director of Patient Care Services.

(d) Each standardized procedure approved by the Committee shall:

1. Be in writing and set forth the date it was approved by the Committee.
2. Specify the standardized procedures which registered nurses are authorized to perform and under what circumstances.
3. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.
4. Specify any experience, training or special education requirements for performance of the standardized procedures.
5. Establish a method of initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedures.
6. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedures.
7. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedures; for example, if the standardized procedure is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.
8. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
9. State any limitation on settings or departments within the Hospital where the standardized procedure may be performed.
10. Specify any special requirements for procedures relating to patient record keeping.
11. Provide for periodic review of the standardized procedure.

3. MEETINGS

As necessary.

G. INSTITUTIONAL REVIEW BOARD – *Enterprise Committee*

1. COMPOSITION

The Institutional Review Board ("IRB") shall be composed in a manner which meets the requirement of the federal Health and Human Services ("HHS") and Food and Drug Administration ("FDA") regulations for the protection of human subjects. The

IRB shall have at least five (5) members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted in the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members' backgrounds, including consideration of the racial and cultural backgrounds of members and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to possessing the professional competence necessary to review specific research activities, the IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB shall, therefore, include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a vulnerable category of subjects, including but not limited to subjects covered by specific regulations, the IRB shall include one or more individuals who are primarily concerned with the welfare of these subjects.

The IRB may not consist entirely of men or entirely of women, or entirely of members of one profession. It shall include at least one (1) member whose primary concerns are in nonscientific areas (for example: lawyers, ethicists, members of the clergy), and at least one (1) member who is not otherwise affiliated with the institution or part of the immediate family of a person who is affiliated with the institution. No member may participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

2. DUTIES

(a) The IRB must adopt and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, including procedures for:

1. Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and to the institution.
2. Determining which projects require review more often than annually, which projects need verification from sources other than the investigators, and that no material changes have occurred since previous IRB review.
3. Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject.
4. Assuring prompt reporting to the IRB of unanticipated problems involving risks to subject or others.
5. For research subject to HHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.
6. Assuring timely reporting to the appropriate institutional officials of any serious or continuing noncompliance by investigators with the

requirements and determinations of the IRB. For research subject to the HHS and FDA regulations, these reports must also be made to HHS, or to the FDA, as appropriate.

(b) Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one (1) member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth in Paragraph (c) below. In order for the research to be approved it must meet the criteria set forth in California law and federal regulations and it must receive the approval of a majority of those members present at the meeting. Research which is approved by the IRB may be subject to further appropriate review and approval or disapproval by officials of the institution, but such review is not required. However, those officials may not approve any research subject to the California law and/or federal regulations referenced herein if it has not been approved by an IRB.

(c) The Institutional Review Board shall:

1. Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by HHS, FDA, or California law and regulations.
2. Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The IRB may require that information, in addition to that specifically mentioned in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.
3. Require documentation of informed consent or waive documentation in accordance with the provisions of applicable law or regulations.
4. Notify the investigator in writing of its decision to approve or disapprove a proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.
5. Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research.
6. Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and appropriate regulatory authorities.

3. MEETINGS

At least quarterly.

H.* JOINT CONFERENCE COMMITTEE – *Enterprise Committee

1. COMPOSITION:

Chief Executive Officer or designee, Chiefs of Staff, Vice Chiefs of Staff, Immediate Past Chiefs of Staff, Board of Directors' representative, Medical Director of Quality Assessment/Utilization Management, Chief Nursing Officer, Senior Director of Quality and Patient Safety.

2. DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and Medical Staff policy, practice and planning, conflict resolution, and a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Staff Executive Committee or the Board of Directors. The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

3. MEETINGS:

As needed.

I.* MEDICAL ETHICS COMMITTEE – *Enterprise Committee

1. COMPOSITION

The committee will be multi-disciplinary with at least representatives from Medical Staff and Patient Care Services. It may also include members of other professions or the public.

2. DUTIES

(a) Provide counsel to physicians, hospital staff, administration in the understanding, delineations and clarification of medical ethical dilemmas.

(b) Provide regular educational activities on medical ethical dilemmas to the institution.

(c) Assist in the development of ethical guidelines where appropriate.

(d) Submit recommendations to the department executive committee or Medical Staff Executive Committee as appropriate.

3. MEETINGS

As needed and no less than annually.

J.* MEDICAL STANDARDS FOR INFORMATION TECHNOLOGY (MSIT) COMMITTEE – *Enterprise Committee

1. COMPOSITION

The MSIT Committee shall be chaired by the. Members will consist of physicians selected by the Chief of Staff and one representative each from nursing, the Health Information Management Department, Administration, and Information Systems.

2. DUTIES

The duties of the MSIT shall include:

(a) Review and evaluation of the electronic medical record, or a representative sample, to determine whether they: 1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and

treatment rendered; and 2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital;

(b) Review and make recommendations for Medical Staff and hospital policies, rules and regulations relating to the electronic medical record, including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement;

(c) Provide liaison with hospital administration and Health Information personnel in the employ of the hospital on matters relating to practices involving the electronic medical record;

(d) Incorporate Medical Staff input into information systems planning and decisions, such as internet, intranet, e-mail, software applications, and Medical Information Systems (MIS) development, maintenance and upgrade, and other clinical data systems;

(e) Review the hospital-wide Information Management Plan on an annual basis and recommend additions or revisions as may be warranted based upon clinical needs assessment;

(f) Review the Medical Staff clinical data collections applications and recommend changes or upgrades as may be warranted.

3. MEETINGS

Will meet at the discretion of the chair and report annually to the Medical Staff Executive Committee.

K.* PERFORMANCE IMPROVEMENT (PI)/SAFETY COMMITTEE – *Enterprise Committee)

1. COMPOSITION

The Performance Improvement/Safety Committee shall be composed of the Chief Nursing Officer, Chief Medical Officer, Senior Director of Quality and Patient Safety, Physician members of the Medical Staff, Nurse Managers, Infection Control Practitioner, Manager of QI/PI, Safety Management Specialist, and the Risk Manager.

2. CHAIRS

The committee will be co-chaired by the Chief Nursing Officer and one of the physician members (to be determined by the Chief of Staff).

3. DUTIES

(a) Oversee PI/Safety Teams

(b) Assess goals and monitor performance of the PI/Safety Teams

(c) Ensure PI/Safety Teams have adequate resources

(d) Identify gaps in hospital safety and performance – set targets for improvement

4. MEETINGS

The committee shall meet quarterly, or at the discretion of the chairs.

L.* PERINATAL COMMITTEE – *Enterprise Committee

1. COMPOSITION

This committee will be multi-disciplinary and at least composed of representatives from Pediatrics, OB/GYN, Neonatology, Anesthesia, Care Coordinator and Chief Nursing Officer.

2. DUTIES

(a) Review the ongoing care of patients in Labor and Delivery, NICU, Maternity, and the Nursery.

(b) Establish guidelines for the care of patients in Labor and Delivery, NICU, Maternity, and Nursery.

(c) Submit recommendations/concerns to Pediatric Department Executive Committee, OB/GYN Department Executive Committee, or Maternal Child Health Department Executive Committee as appropriate.

3. MEETINGS

Monthly, or at the discretion of the chair.

M.* PHARMACY AND THERAPEUTICS COMMITTEE – *Enterprise Committee

1. COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of at least five (5) representatives from the Medical Staff. Additional voting members shall include one (1) pharmacist, the Chief Nursing Officer or his/her representative, and Administrator or his/her representative.

2. DUTIES

The Pharmacy and Therapeutics Committee shall:

(a) Assist in the formulation of broad professional policies regarding the procurement, evaluation, selection, storage, distribution, dispensing, use, safety procedures, administration and all other matters relating to drugs and diagnostic testing materials in the Hospital.

(b) Advise the Medical Staff and the Hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs and review all significant untoward drug reactions.

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(d) Develop and review periodically a formulary or drug list for use in the Hospital.

(e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(f) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(g) Perform an annual review of all Standing Orders.

(h) Perform such other duties as assigned by the Chief of Staff or the Medical Staff Executive Committee.

3. MEETINGS

At least quarterly.

N.* QUALITY STEERING COMMITTEE – *Enterprise Committee

1. COMPOSITION

The Quality Steering Committee shall be composed of the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, two members of the Board of Directors (including the Chairman of the Board), Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Associate Chief Medical Officer, Medical Director of Quality and Patient Safety, Senior Director Clinical Quality and Patent Safety,

Manager QA/PI, Director Medical Staff Services

2 CHAIRS
The committee will be co-chaired by the Chief of Staff and the Chairman of the Board.

3. DUTIES
(a) Set overall direction for QI activities at El Camino Hospital
(b) Align medical staff and hospital QI activities
(c) Align service line development and hospital growth initiatives with medical staff and hospital QI activities
(d) Continually review committees and reporting structures to ensure collaboration and teamwork with regard to QI activities.

4. MEETINGS
The committee shall meet quarterly, or at the discretion of the chairs.

O.* RADIATION SAFETY COMMITTEE - *Enterprise Committee

1. COMPOSITION
The Committee shall consist of members from the departments of Medicine and Surgery, Radiology, a physician experienced in the safe handling of radioisotopes and in determining radioisotope dosage for various patients, studies or treatments. Other members should include a Radiation Safety Officer, Nuclear Medicine Supervisor and Administration.

2. DUTIES
(a) Establish radiation safety guidelines for staff and patients at El Camino Hospital.
(b) Review ongoing activities relative to radiation safety.
(c) Review proposals for diagnostic and therapeutic uses of unsealed radio nuclides.
(d) Review regulations for the use, transport, storage and disposal of radioactive materials used in Nuclear medicine
(e) Recommend remedial action when there is a failure to observe protection recommendations, rules and regulations.

3. MEETINGS
Meet every six months.

P.* SPECIAL SERVICES COMMITTEE – *MV Campus

1. COMPOSITION
The committee shall be multi-disciplinary and shall be composed of at least the physician representatives from Medical Staff, Care Coordinator and Chief Nursing Officer.

2. DUTIES
(a) Establish guidelines for care of patients on the critical care units
(b) Perform ongoing review of patient care on the critical care units
(c) Review of cases as brought to the Committee by the Medical Director or any member. Refer as appropriate to the Care Review Committee or the Department Executive Committee.

(d) Participate in evaluation and selection of equipment purchases.
(e) Review cases referred from other medical/staff committees as requested.

3. MEETINGS
As least quarterly.

Q.* TISSUE REVIEW FUNCTION – *Enterprise Committee

The tissue review function shall include review of surgical cases in which a specimen (tissue or non tissue) is removed, as well as from those cases in which no specimen is removed. In the latter case, however, a screening mechanism based upon pre established criteria may be established. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre operative and post operative (including pathologic) diagnosis. The Medical Staff Executive committee may describe a system by which the tissue review function shall be coordinated with departmental surgical case review.

A report will be made to the Medical Staff Executive Committee as needed, but at least annually.

R.* UTILIZATION REVIEW COMMITTEE – *Enterprise Committee

1. COMPOSITION
The utilization review committee shall consist of a sufficient number of members to afford fair representation. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate.

2. DUTIES
The duties of the utilization review committee shall include:
(a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Staff Executive committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;
(b) establishing a utilization review plan which shall be approved by the Medical Staff Executive committee; and
(c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

3. MEETINGS
The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a quarterly report of its activities and recommendations to the Medical Executive Committee.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Bob Miller, Chair, Executive Compensation Committee
Date: April 15, 2020
Subject: Review Executive Compensation Policies

Recommendation(s): (Possible Motion)

To approve the proposed revised to Executive Compensation Philosophy, Executive Base Salary Administration, and Executive Performance Incentive Plan policies.

Summary:

1. Situation: The Committee periodically reviews the policies and may make recommended changes to the Board for approval. Language in the policies needs to be updated for consistency across the policies and with the Committee's charter as amended on June 13, 2018.

2. Authority: The Committee's Charter defines the role of the Committee and the Board in the oversight and governance of Executive Compensation.

3. Background: The Committee reviewed and discussed changes at its November 7, 2019 and April 2, 2020 meetings. The changes discussed at the meeting have been made to the attached documents. With the launching of the "El Camino Health" brand, additional changes were made in the policy when referring to leadership roles, goals, and measurements. Per the governance structure underlying the El Camino Health brand, El Camino Hospital is used when referring to the Board of Directors or the Executive Compensation Committee.

4. Assessment: The recommended changes to the policies are not material and do not affect plan design.

5. Other Reviews: The Executive Compensation Committee recommended these proposed revised policies for approval at its April 2, 2020 meeting.

6. Outcomes: The language changes will be shared with plan participants.

List of Attachments:

1. Executive Compensation Philosophy
2. Executive Salary Administration Policy
3. Executive Performance Incentive Policy

Suggested Board Discussion Questions:

1. Do the proposed changes create any concerns or issues that need to be addressed before approval?

El Camino Health ital
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EL CAMINO HOSPITAL
BOARD OF DIRECTORS POLICIES AND PROCEDURES
EXECUTIVE COMPENSATION COMMITTEE RECOMMENDATIONS TO BOARD
REVISED 4-2-20

03.01 EXECUTIVE COMPENSATION PHILOSOPHY

A. Coverage:

The Chief Executive Officer ("CEO") of El Camino Hospital and Health System ("El Caminothe Hospital") and those executives reporting directly to the CEO and approved participants. Participation in the plan is subject to approval by the Hospital Board of Directors (see Attachment A).

B. Reviewed/Revised:

New: 2/08, 6/09, 12/08/10; 8/10/11, 2/13/13, 6/11/14, 10/12/16, 1/10/18, 2/14/18, 2/13/19, 2/12/20

C. Policy Summary:

The compensation philosophy is the official statement of El Camino Hospital's Board of Directors regarding the guiding principles and objectives upon which executive compensation decisions are based, and the general parameters and components for accomplishing these objectives.

The executive compensation program encompasses both cash compensation (salary, incentive pay, and other cash compensation) and non-cash compensation (employer provided benefit plans and perquisites) which in whole, represent total compensationremuneration.

The program is governed by the Board of Directors and the Executive Compensation Committee which advises the Board to meet all applicable legal and regulatory requirements as it related to executive compensation and their effectiveness in attracting, retaining, and motivating executives.

The target competitive positioning for executive remuneration is:

- Base Salary – Executive base salaries are targeted on average at the 50th percentile of market data plus the geographic differential.
- Total Cash Compensation - Base Salary plus actual performance incentive payouts is targeted, on average, at the 50th percentile and up to the 75th percentile of market data, dependent upon individual and organizational performance

- Total Remuneration - Total Cash plus the value of benefits is targeted, on average, between the 50th and 75th percentile of market data, dependent upon individual and organizational performance

D. Executive Compensation Philosophy:

The philosophy describes the guiding principles and objectives of the executive compensation program. Executive compensation decisions will be made using the following guiding principles and objectives:

1. Support the Hospital'sEl Camino's ability to attract, retain, and motivate a highly-talented executive team teamwith the ability and dedication to manage the Hospital accordingly.

2. Support the El Camino'sHospital's mission and vision and achievement of of short and long-term strategic goals and stewardship of the health system mission.

3. Encompass a total compensation remuneration perspective in developing and administering cash compensation and benefit programs.

4. Considers the El Camino'sHospital's financial performance and ability to payfund. which shall be balanced with the Hospital's ability to attract, retain and motivate executives.

5. Govern the executive compensation programs to comply with state and federal laws.

E. Components:

The three key components of the executive compensation program are base salary, performance incentive compensation, and benefits.

1. Base Salary. Each executive position will be assigned a salary range that is competitive with comparable hospitals organizations and accounts for the higher cost of labor in Silicon Valleythe San Francisco Bay Area.

2. Performance Incentive Compensation. Each executive will be eligible for a goal-based performance incentive compensation program. An executive's performance incentive payout will be based on their performance against pre-defined organizational and individual goals and objectives measurements aligned with the Hospital'sEl Camino's mission, vision, and strategic goals.

3. Executive Benefits and Perquisites. El Camino The Hospital may provide executives with supplemental benefits as described in the executive benefits policy. It is the El Camino'sHospital's practice to minimize the use of perquisites in total executive compensation.

F. Roles and Responsibilities:

1. The Executive Compensation Committee shall recommend and maintain written policies and procedures regarding the administration of each component.

2. The Hospital Board of Directors will approve all policy changes and approves all components of CEO compensation and benefits.~~.~~

~~1.~~3. The CEO has the authority to approve retention bonuses and hiring bonuses, relocation and housing assistance (including home loans) for other participants. The decisions will be reported to the Executive Compensation Committee.

G. Definitions

Comparable ~~Hospital~~ Organizations – To measure the competitiveness of the executive compensation program, ~~the Hospital~~ El Camino will use, in general, compensation information from tax-exempt independent hospitals and health systems from across the United States comparable in size and complexity ~~to the Hospital. The hospitals will be comparable in size and complexity~~ based upon net operating revenues.

Competitive Position – A determination of where the ~~Hospital~~ El Camino places executive salaries, incentives, and benefits relative to comparable ~~hospitals~~ organizations nationally. El Camino's ~~Hospital's~~ competitive position for base salaries is the market median plus a geographic differential for the ~~Silicon Valley~~San Francisco Bay A~~a~~rea.

Geographic Differential – Recognizes the significantly higher cost-of-labor in the~~Silicon Valle~~ San Francisco Bay Area ~~y.~~ The Committee will periodically analyze data to ensure the geographic differential is appropriate and accurately projecting the El Camino ~~Hospital~~ median.

El Camino ~~Hospital~~ Median – Reflects the median base pay of the comparable hospitals plus the geographic differential for a particular position. ~~The Hospital increases the data by 25% to calculate the El Camino Hospital median.~~

Other Cash Compensation – Other cash compensation excludes base salary and incentive pay but may -include~~s a hiring and~~ retention and hiring bonuses and relocation ~~reimbursement~~and housing assistance.

Salary Range - A range established as 20% below to 20% above the salary range midpoint, resulting in a maximum amount that is 150% of the minimum amount.

Salary Range Midpoint - The midpoint of the salary range for each executive position will be set at the El Camino ~~Hospital~~ Median. However, the Committee may elect to not adjust salary ranges.

Total Cash Compensation – includes base salary plus annual incentive compensation (and other cash) paid to an executive.

Total ~~Compensation~~ Remuneration – Total cash compensation plus the cost of employee and executive benefit programs.

ATTACHMENT A:
APPROVED PARTICIPANTS IN EXECUTIVE COMPENSATION PROGRAM
Effective 4/15/20 (if Board approves change)

Job Title	Name
Chief Admin Svcs Officer	Kenneth K. King
Chief Executive Officer	Daniel J. Woods
Chief Financial Officer	~~Iftikhar Hussain~~Vacant
Chief Human Resources Officer	Kathryn M. Fisk
Chief Information Officer	Deborah A. Muro
Chief Medical Officer	Mark C. Adams, MD
Chief Nursing Officer	Cheryl L. Reinking
Chief Operating Officer	James D. Griffith
Chief Quality Officer	Vacant
Chief Strategy Officer	Vacant
General Counsel	Mary Lynn Rotunno
President Foundation	Andrew Cope
President, Silicon Valley Medical Development	Bruce A. Harrison
VP Corp & Comm Hlth Svcs/President Concern	Cecile S. Currier *
VP Payor Relations	Joan M. Kezic*

*E~~These e~~executive~~s~~ is~~are~~ considered a grandfathered participant~~s~~ and shall continue to be eligible for the Executive Compensation Program as long as the individual remains in an executive position with El Camino~~ Hospital.~~. Executive has been deemed a non-disqualified person.

Note: Executives hired on an interim basis are not eligible for the Executive Compensation and Benefits Program.

El Camino Health ~~pital~~
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EL CAMINO HOSPITAL
BOARD OF DIRECTORS POLICIES AND PROCEDURES
EXECUTIVE COMPENSATION COMMITTEE RECOMMENDATION TO THE BOARD
REVISED 4-2-20

03.02 EXECUTIVE BASE SALARY ADMINISTRATION

A. Coverage:

The Chief Executive Officer ("CEO") of El Camino Hospital and Health ("~~the Hospital~~El Camino") and those executives reporting directly to the CEO and those in other approved positions. ~~or COO~~. Participation in the plan is subject to approval by the Hospital Board of Directors

~~C.~~B. Reviewed/Revised:

New 9/15/09, 12/08/10, 2/13/13, 6/11/14, 10/12/16, 2/14/18

~~D.~~C. Policy Summary:

Base salary is one component of the executive total ~~compensation~~ remuneration program which includes benefits, performance incentive pay, and other cash compensation. This policy defines how a salary range is established and provides guidelines for determining an individual's placement in the range. The program is governed by the Board of Directors and administered by the Executive Compensation Committee ("the Committee").

~~E.~~D. General Provisions:

1. **Salary Range** – Each executive position at El Camino ~~Hospital~~ will have a salary range with minimum and maximum, determining the lowest and highest pay for that job.

   a. ~~The salary range midpoint reflects the 50th percentile or median base pay of the comparable hospitals plus the cost-of-labor adjustment (known as the El Camino Median).~~ The midpoint of the salary range for each executive position will be set at the El Camino Median. ~~However, the Committee may elect not to adjust salary ranges.~~

b. The salary range will be from 20% below to 20% above the salary range midpoint, resulting in a maximum amount that is 150% of the minimum amount.

c. Salary ranges ~~will~~ may be updated annually based on competitive market data and/or executive increase market trends. ~~The Executive Compensation Committee reserves the right to recommend lower base salary ranges or to freeze salary ranges and recommend freezing or lowering base salaries (for example, when financially prudent) for Board approval.~~ However, the Committee may elect not to adjust salary ranges.

1. **Placement in the Salary Range** includes initial placement of a new hire, adjustments when there is a change in job scope, and periodic salary increases or decreases. An individual's placement in the range will be determined based on a combination of the following factors: paying competitively, rewarding performance, and recognizing competence, credentials, and experience.

   The guidelines for placement in range are:

   - ***Pay at 80% to 90% of Midpoint*** may be appropriate for an individual with limited experience in a comparable position, or for an individual who has recently been promoted and needs developmental time in the position. This may be a new hire or internal promotion. An individual may be eligible for higher percentage increases, aligned with performance, when positioned at this level.

   - ***Pay at 90% to 110% of Midpoint*** may be appropriate for a fully experienced individual with a demonstrated record of successful performance. ~~The Hospital~~El Camino -manages base salary increases so that upward movement in salary reflects individual performance and demonstrated proficiency.

   - ***Pay at 110% to 120% of Midpoint*** may be appropriate for a highly experienced individual with demonstrated record of consistently exceeding performance expectations or in roles which are particularly critical for the achievement of strategic objectives or in roles with a highly competitive labor market. ~~The Hospital~~ El Camino compares base salary levels above market with competitive market data to verify that individual base salary is reasonable.

   - The Hospital Board of Directors can approve salaries outside the normal salary range or guidelines for hard-to-recruit positions or positions deemed critical to the success of the organization. El Camino ~~The Hospital~~ compares salary levels above market with competitive market data to verify that the individual base salary and total compensation is reasonable.

~~F.~~E. Roles and Responsibilities

1. The El Camino Hospital Board of Directors shall approve the CEO's base salary. ~~executive base salaries.~~

2. The Executive Compensation Committee Charter defines the responsibilities delegated by the Hospital Board such as selecting consultants and approval of the salary ranges and base salaries of executives other than the CEO. ~~.~~ The Committee may recommend exceptions to policy to the Board for their approval

3. The CEO recommends the salary range and base salary for those executives reporting to the CEO to the Committee.

4. The Chief Human Resources Officer and/or Director Total Rewards are responsible for implementing salary ranges and base salaries.

El Camino Health

EL CAMINO HOSPITAL
BOARD OF DIRECTORS POLICIES AND PROCEDURES
DRAFT 1-22-20

03.04 EXECUTIVE PERFORMANCE INCENTIVE PLAN

A. Coverage:

The Chief Executive Officer ("CEO") of El Camino Hospital and Health ("El Camino~~the Hospital~~") and those executives reporting directly to the CEO and those in other approved positions. Participation in the plan is subject to approval by the Hospital Board of Directors~~ (reference Attachment A of the Executive Compensation Philosophy)~~.

B. Reviewed/Revised:

New: 9/15/09, 12/08/10, 2/13/13, 6/11/14 (eff 7/1/14), 10/14/15, 10/12/16, 1/10/18, 2/14/18, 5/8/19

C. Policy Summary:

The Performance Incentive Plan is one component of the executive total remuneration program which includes base salary, benefits, and other cash compensation. The Performance Incentive Plan is an annual goal-based compensation program designed to motivate and reward performance toward key strategic goals of ~~the Hospital~~El Camino.

D. General Provisions:

The target amount for incentive pay will be competitive with those at comparable ~~hospitals~~organizations. An executive's incentive payout will be based on their performance against pre-defined organizational and individual goals and measures aligned with ~~the Hospital~~El Camino's mission, vision, and strategic goals.

1. Eligibility – Participants hired after December 31 will not be eligible for the program until the beginning of the next fiscal year on July 1. However, employees promoted into an executive position at any time during the fiscal year will be eligible for executive performance incentive pay on a prorated basis. ~~Incentive compensation will be pro-rated for executives with at least six months, but less than one year in the position at the end of the fiscal year.~~ Written performance goals and measures will be determined within the first 60 days of employment.

2. Criteria – ~~the Hospital~~El Camino has established two criteria for payout:

a.~~1)~~ the individual executive must "meet expectations" or higher on their performance review; and

b.~~2)~~ ~~the Hospital~~El Camino ~~-~~must meet the threshold financial measure.

There will be no performance incentive payout to an executive unless both criteria are met.

~~2.~~3. Organizational Goals – each fiscal year ~~the Hospital~~El Camino will define organizational goals that support the strategic/business plan upon which at least 50% of performance incentive pay will be based. In addition, ~~the Hospital~~El Camino may establish one to three threshold measures that must be achieved for there to be any payout. ~~Whenever possible,~~E~~e~~ach goal will have annual performance ~~measures~~ metrics for threshold, target, and stretch~~maximum~~ levels that can be scored ~~and payouts will be~~ on a continuum. The organizational goals will include a threshold financial measure (i.e., net margin) that must be achieved for any participant to receive incentive pay.

~~3.~~4. Executive Individual Goals (excluding CEO) – each fiscal year ~~the Hospital will define~~ individual goals will be defined for each executive that support the strategic/business plan Whenever possible, each goal will have performance measures for threshold, target, and stretch with metrics that can be scored~~(levels and scores will be~~ on a continuum. The individual score will be based on the executive's achievement against approved goals with the CEO having the discretion to modify for individual score ranging from 0% to 150%~~)~~.

~~4.~~5. Weighing Organizational and Individual Goals – the weight of organizational, individual and discretion vary by job as shown below.

Job	Organizational Weight	Individual Weight	Discretion
CEO	90%	N/A	10% at Board's discretion
Presidents (Concern:EAP; Foundation; and SVMD)	50%	50%	CEO has discretion to modify individual score from 0% to 150%
Other Participants	70%	30%	CEO has discretion to modify individual score from 0% to 150%

~~5.~~6. Amount of incentive pay – the amount of incentive pay is based on the executive's base salary as shown below:

Job	Threshold	Target	Maximum or Cap
CEO	15%	30%	45%
Other Participants	10%	20%	30%

The amount of incentive pay is prorated for new participants hired after July 1 and those. employees who transfer into an executive position during the fiscal year. Incentive pay is prorated based on the number of calendar days. If a management employee is promoted into an executive position during the fiscal year, the executive's bonus payout will be prorated based on the length of their participation in the management and executive performance incentive plans.

7. Performance Incentive Payout – Incentive compensation will be paid within 30 days of approval of the organizational score and the payout amounts. In order to receive incentive compensation, executives must be actively employed in an executive position at the time the incentive compensation is paid.

8. Exceptions – Provision allows for additions, deletions, and changes to approved organizational and individual goals, metrics, and weighting.

   a. Timing – The CEO is to initiate a request as soon as a change is known and within the fiscal year. Recommendations for changes will be made at the next scheduled Executive Compensation Committee meeting for individual goals and at the next scheduled Hospital Board meeting for organizational goals.

   b. Organizational Goals – The CEO may recommend changes to the goal statement or metrics based on unforeseen events beyond the control of executive leadership including removing a goal and reweighting other approved goals/metrics. The CEO will notify the Board and Committee chairs of the need for change. Recommendations will be made to the Executive Compensation Committee (ECC) or to the ECC Chair prior to the exception request going the Hospital Board of Directors. If the recommendations go to the ECC first, the ECC will make the recommendation to the Board. If the Board meets first, the Board's decision will be reported at the next ECC meeting.

   c. Individual Goals - The CEO may recommend additions, deletions, and changes to approved individual goals, metrics, and weighting. Such changes may occur based on unforeseen events beyond the control of the executive. The CEO will make recommendation to the ECC who has the authority to approve the changes. Changes will be reported to the Board.

E. Roles and Responsibilities

1. The El Camino Hospital Board of Directors shall approve the plan design including positions eligible; organizational goals, ~~measurements~~metrics;~~,~~ and scoring; and the CEO’s discretionary score and performance incentive payout. In addition, the Board approves any exceptions recommended by the Executive Compensation Committee.

2. The Executive Compensation Committee shall approve individual goals, ~~measurements~~ metrics, and scores, and non-CEO executive performance incentive payouts. In addition, the Committee will review and recommend organizational goals, policy and plan design changes, and report its decisions to the Board.

3. The CEO recommends the individual goals, scores, and incentive payout amounts to the Committee and the organizational goals to the Committee and Board.

4. The Chief Human Resources Officer and/or Director Total Rewards are responsible for overseeing administration of the program and implementing actions approved by the Committee and the Board.

Minutes of the Open Session of the
Executive Compensation Committee
of the El Camino Hospital Board of Directors
Thursday, November 7, 2019
El Camino Hospital | Conference Room A (ground floor)
2500 Grant Road, Mountain View, CA 94040

Members Present	**Members Absent**
Teri Eyre	None
Jaison Layney	
Julie Kliger, Vice Chair	
Bob Miller, Chair	
George Ting, MD	
Pat Wadors	
John Zoglin	

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Executive Compensation Committee of El Camino Hospital (the "Committee") was called to order at 4:00pm by Chair Bob Miller. A silent roll call was taken. Mr. Zoglin joined the meeting at 4:01pm during Agenda Item 4: Consent Calendar. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Miller asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. PUBLIC COMMUNICATION	None.	
4. CONSENT CALENDAR	Chair Miller asked if any member of the Committee or the public wished to remove an item from the consent calendar. Chair Miller requested and the Committee agreed to update the following metrics for the FY20 ECC Goals: 1. For goal #2, "Evaluate the effectiveness of the independent compensation consultant and the Committee": the Committee Chair rather than the Board Chair reviews the cost/value of the consultant. 2. For goal #3, "Review Leadership Development/Succession Planning": the first metric should read "Committee completes review of the CEO review process and makes recommendation(s) to the Board." Ms. Kliger requested that materials related to the CEO Evaluation clearly explain what "the tool" is: the assessment form completed by Board members, which includes a few questions specifically for the District Board. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Executive Compensation Committee Meeting (9/19/2019); and for information: Progress Against FY20 ECC Goals (as updated above); FY20 CEO Performance Assessment Timeline (as modified above); FY20 Organizational Goal Update; Article of Interest. **Movant:** Ting **Second:** Layney **Ayes:** Eyre, Kliger, Layney, Miller, Wadors, Ting, Zoglin **Noes:** None **Abstentions:** None	***Consent calendar approved***

	Absent: None **Recused:** None	
5. REPORT ON BOARD ACTIONS	Chair Miller referred to the recent Board approvals as further detailed in the packet, including the approval of the FY20 CEO Base Salary. Dan Woods, CEO, reported that Bob Rebitzer and Julie Kliger were re-appointed to the El Camino Hospital Board at the October 22, 2019 District Board meeting.	
6. LETTER OF REBUTTABLE PRESUMPTION OF REASONABLENESS	Lisa Stella from Mercer reported that the purpose of the letter is to document for IRS purposes the process, data used, and actions taken by the Board and the Committee (acting with delegated authority) related to executive compensation for certain executives. She noted that there is no new information in the letter; it is a summary of the last year. In response to questions, Ms. Stella and Chair Miller described the calculation of the geographic differential using Economic Research Institute data between the local area and the national market. Ms. Stella reported that the current differential is 28% for Mountain View and Silicon Valley (average across several cities in Santa Clara County), and ECH applies a 25% differential to its salary data, per policy approved by the Committee and the Board. She noted that the annual review ensures that the geographic differential applied continues to be appropriate. Ms. Eyre suggested using more regional (*i.e.*, San Francisco Bay Area) rather than hyper-local numbers. Ms. Eyre suggested that the Committee look holistically at compensation and consider 1) what are the critical roles for the organization and are we compensating those roles accordingly and 2) to what degree are we using compensation tools in service of our succession strategy? Chair Miller requested that survey sources and range of revenue sizes for compensation surveys be included in the narrative part of the letter, mirroring the language for the benefits section. He also requested that the letter include two exhibits, one for the executive team and one for the CEO separately to be presented to the Board. **Motion:** To adopt and recommend that the Board approve the Letter of Rebuttable Presumption of Reasonableness with changes described above. **Movant:** Wadors **Second:** Layney **Ayes:** Eyre, Kliger, Layney, Miller, Wadors, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Letter of Rebuttable Presumption of Reasonableness recommended for approval***
7. ASSESS EFFECTIVENESS OF DELEGATION OF AUTHORITY	The Committee discussed the effectiveness of delegation of authority to the Committee, including 1) encouraging the Board to review this area as well, 2) the level of comfort with the work, and 3) how the Committee is a better forum for deeper discussion with subject matter experts. The Board members on the Committee described the differing views of delegations of authority on the Board and the general level of comfort with the process. Mr. Zoglin commented that the Board should not be accepting 100% of recommendations from Committees.	

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<td>8. REVIEW EXECUTIVE COMPENSATION POLICIES</td>
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Executive Compensation Philosophy
Ms. Kliger suggested additional threshold criteria for executive incentive payouts related to quality or other critical organizational functions. Ms. Johnston explained that the organization previously used accreditation by the Joint Commission (a triennial survey) as a threshold goal. Ms. Stella noted that most organization use “triggers” in their performance incentive plan rather than in their compensation philosophy; the majority of hospitals use a goal related to financial stewardship and only 20-30% use a quality threshold goal. The Committee and staff discussed 1) the inclusion of additional criteria for corporate stewardship, like labor disputes, significant CMS fines, quality goals, or other “third rail” events that would pre-empt incentive payment, 2) utilizing an exception/adjustment clause in the incentive plan to cover unforeseen circumstances, 3) language regarding a Code of Conduct (which is covered by the employment agreements) and forfeiture of payments, and 4) whether or not to articulate institutional (rather than individual) failure points in the philosophy.
In response to Ms. Eyre’s question, Ms. Johnston explained that for the Executive Performance Incentive Plan (EPIP), executives must “meet expectations” overall on their performance review.
Mr. Woods explained that there are long-term strategic organizational goals, which were established in FY18 through FY22. He noted that there currently is no long-term incentive plan. Ms. Kliger suggested that there should be clarity around the methodology for how the short-term goals are milestones for the longer-term (3-5) year goals.
The Committee requested the following revisions:

Refer consistently to “health system” rather than “Hospital” where appropriate, but coordinate with Legal/Governance Services on the appropriate nomenclature.
<u>Section D(1)</u>: remove “with the ability and dedication to manage the Hospital accordingly.”
<u>Section D(2)</u>: “Support the Hospital’s mission and vision, achievement of long and short-term goals, and stewardship of the health system mission” [addition of language in bold].
<u>Section D(4)</u>: substitute “ability to fund” for “ability to pay.”
<u>Section E(2)</u>: remove reference to a discretionary component and amended and restate the second sentence as follows: “An executive’s performance incentive payout will be based on their performance against individual and organizational goals.”
<u>Section G (Comparable Hospital)</u>: “comparable in size and complexity to the Hospital based on net operating revenue.”
<u>Section G (El Camino Hospital Median)</u>: remove the specific reference to the 25% differential (the second sentence).
<u>Section G (Other Cash Compensation)</u>: remove specific reference to home loans and say relocation “assistance” rather than “reimbursement,” which could include home loans.
<u>Section G (Salary Range Midpoint)</u>: substitute “adjust” for “increase” to cover movement of salary ranges in both directions; amended and restated as “The Committee may elect not to adjust salary ranges when financially prudent.”

The Committee agreed not to hardwire the 25% geographic differential in the philosophy.
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The Committee requested clarification on "El Camino Health" and how it should be used in these documents.

Mr. Woods explained that the financial trigger for the FY20 goals is based on the consolidated enterprise financials, which includes SVMD, not just the Hospital's standalone financials.

The Committee expressed no concerns with the rest of the proposed changes for the Philosophy.

*Generally, the Committee requested that all changes be made consistently across all of the policies.

Salary Administration

1. Section D(1)(a): substitute "adjust" for "increase" to cover movement of salary ranges in both directions; amended and restated as "The Committee may elect not to adjust salary ranges when financially prudent."*

The Committee expressed no concerns with the rest of the proposed changes for this policy.

Executive Performance Incentive Plan

1. Section C: Remove discretionary reference
2. Section D(1)(a): Clarify and simplify the proration of an incentive bonus for a promoted individual; amended and restated as "If an employee is promoted into an executive position during the fiscal year, the executive's bonus payout will be prorated based on the length of their participation in the management and executive performance incentive plans."
3. Section D(4): Remove reference to the "Hospital will define goals.." and instead state that "each fiscal year, **individual goals will be defined for each executive** that support the strategic/business plan…"
4. Section D(5): Notate the table with an example of the weighting of the individual goals, and showing that these numbers are percentages (of achievement) of a percentage (of base salary) to determine payout.
5. Section D(6): In the chart, change the header "Minimum" to "Below Threshold."
6. New subsection in Section D (between 6 and 7): Add a separate exception clause to allow for changes based on unusual or unforeseen circumstances. The Committee would have the authority to approve individual goals/metrics changes and make recommendation to the Board for changes to organization goals/metrics. Under the proposed change, the Board would approve any changes to the organization goals/metrics. In addition, add a clause that the Committee can recommend and the Board can approve adjustment and/or suspension of payouts.

The Committee further discussed the process for modifying individual goals or establishing them for new executives. They voiced support that the Chair of the Committee would provide recommendations to the CEO on proposed revisions to an individual executive's goal. Ms. Wadors and Ms. Eyre expressed concerns about the responsiveness of the process and commented that the CEO should be empowered and delegated authority to make goal adjustments. Other members commented that revisions should be approved by either the Committee or the Board to ensure oversight.

The Committee suggested that the process be as follows: 1) CEO reviews

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The Committee discussed the Committee's review of the organizational goals, reviewing the structure while the Quality and Finance review content.

Motion: To approve in concept the proposed changes be made to the Executive Compensation Philosophy, Salary Administration Policy, and Executive Performance Incentive Plan policies and to direct staff to bring back revised drafts of the policies for the Committee's review and approval at the Committee's next meeting.

Movant: Wadors
Second: Layney
Ayes: Eyre, Kliger, Layney, Miller, Wadors, Ting, Zoglin
Noes: None
Abstentions: None
Absent: None
Recused: None

Ms. Johnston explained that Mercer will be conducting a benefits review and the Benefits Policy will be reviewed at the Committee's next meeting.</td><td></td></tr>
<tr><td>9. ADJOURN TO CLOSED SESSION</td><td>Motion: To adjourn to closed session at 5:49pm.

Movant: Zoglin
Second: Kliger
Ayes: Eyre, Kliger, Layney, Miller, Wadors, Ting, Zoglin
Noes: None
Abstentions: None
Absent: None
Recused: None</td><td>Adjourned to closed session at 4:22pm</td></tr>
<tr><td>10. AGENDA ITEM 14: RECONVENE OPEN SESSION/ REPORT OUT</td><td>Open session was reconvened at 5:37pm. Agenda items 10-13 were addressed in closed session. Ms. Kliger and Ms. Wadors left the meeting during the closed session.

During the closed session, the Committee approved the Minutes of the Closed Session of the Executive Compensation Committee Meeting (9/19/2019) by a unanimous vote in favor of all members present (Eyre, Kliger, Layney, Miller, Wadors, Ting, Zoglin) and the Proposed FY20 President, Foundation Goals, and the Proposed Revised FY20 General Counsel Goals by a unanimous vote in favor of all members present (Eyre, Layney, Miller, Ting, Zoglin). Ms. Kliger and Ms. Wadors were absent.

Ms. Stella clarified that the revisions to the Letters of Rebuttable Presumption of Reasonableness include:
- Separate exhibits for the CEO and executive data
- Specific revenue cuts for each of the compensation surveys
- Removal of a comment in the methodology section on including general industry benefits data

These edits will be incorporated into the version presented to the Board for approval.</td><td></td></tr>
</table>

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	Ms. Stella left the meeting and Mr. Woods discontinued participation in the meeting.	
11. AGENDA ITEM 15: 6-MONTH EXECUTIVE COMPENSATION CONSULTANT REVIEW	The Committee discussed the timing of an RFP for next year and requested more information on this topic (dates of the original contract, the dates of the extension recommended and approved by the Committee, and next steps/pacing). The Committee and staff also reviewed the effectiveness of the executive compensation consultant.	***Staff to provide more information regarding RFP***
12. AGENDA ITEM 16: FY20 PACING PLAN	The Committee requested adding a meeting in January/February 2020 for the benefits review and to finalize the policy revisions from this meeting.	
13. AGENDA ITEM 17: CLOSING COMMENTS	Chair Miller thanked the Committee for the work in this meeting.	
14. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 6:20pm. **Movant:** Zoglin **Second:** Kliger **Ayes:** Eyre, Layney, Miller, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Kliger, Wadors **Recused:** None	***Meeting adjourned at 6:20pm***

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

____
Bob Miller
Chair, Executive Compensation Committee

____
Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Sarah Rosenberg, Contracts Administrator/Governance Services EA

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El Camino Health

Summary of Financial Operations

Fiscal Year 2020 – Period 7
7/1/2019 to 1/31/2020

Financial Overview – January Year to Date

Financial Performance

- Strong outpatient volumes continue to drive year to date operating margin favorable variance, $8.0M (17%). Despite the higher volumes, expenses continue to remain near budgeted levels
  - Patient Revenue favorable to budget by $17.1M (3%)
  - Operating expense is near budget level
    - Supplies are higher than budget due to continued strong procedural volume growth
- Non Operating Income favorable variance due to favorable Investment performance

Hospital Volume

- Adjusted Discharges (AD) continues to be favorable to budget 1,580 ADs (8%) and favorable to prior year by 12%
  - Mountain View: Favorable to budget by 1,152 ADs (7%) and favorable to prior year by 10%
    - Infusion Volumes favorable to budget by 502 encounters (11%) - extended hours and increased productivity
    - Overall procedural volume favorable to budget by 716 cases (4%)
  - Los Gatos: Favorable to budget by 428 ADs (11%) and favorable to prior year by 21%
    - Excluding budgeted Infusion volumes, procedural volume favorable to budget by 382 cases (11%)
    - Orthopedics & Spine surgeries favorable to budget by 195 cases (32%) due to high producing ortho/spine surgeons)
    - General Surgery – Ophthalmology 92 cases
    - Endoscopy – 97 cases

Payor Mix

- Payor mix continues at budget year to date

Productivity

- Year to date FTEs are in line with targets

El Camino Health

Financial Overview - January

Financial Performance

- Operating Margin favorable variance was $2.5M (42%). Driven by:
  - Patient Revenue was favorable to budget $5.0M (6%)
  - Operating Expense was unfavorable to budget by $2.4M (3%)
- Non Operating Income continues to be favorable due to positive Investment results

Hospital Volume

- Adjusted Discharges (AD) continue to be favorable to budget for January 155 ADs (5%) and favorable to prior year by 12%
  - Mountain View: Favorable to budget by 145 ADs (5.7%) and favorable to prior year by 11%
  - Los Gatos: Favorable to budget by 10 ADs (2%) and favorable to prior year by 18%

Payor Mix

- Commercial payor mix is favorable to budget by 2% in January.

Dashboard - as of January 31, 2020

	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Consolidated Financial Perf.								
Total Operating Revenue	85,042	94,280	89,428	4,853	559,958	629,659	611,687	17,972
Operating Margin $	10,275	8,362	5,891	2,471	63,956	53,657	45,696	7,961
Operating Margin %	12.1%	8.9%	6.6%	2.3%	11.4%	8.5%	7.5%	1.1%
EBIDA %	17.6%	15.9%	14.2%	1.7%	17.3%	13.8%	13.7%	0.2%
Hospital Volume								
Licensed Beds	443	443	443	-	443	443	443	-
ADC	259	264	252	12	234	237	238	(1)
Utilization MV	71%	74%	69%	5.6%	64%	65%	64%	0.5%
Utilization LG	32%	29%	33%	(3.7%)	29%	30%	32%	(2.0%)
Utilization Combined	59%	60%	57%	2.6%	53%	54%	54%	(0.3%)
Total Discharges (Excl NNB)	1,680	1,787	1,750	37	11,166	11,966	11,502	464
Hospital Payor Mix								
Medicare	53.0%	49.9%	48.9%	1.0%	47.7%	49.0%	48.4%	0.7%
Medi-Cal	8.3%	6.6%	8.5%	(1.9%)	8.1%	7.5%	8.0%	(0.6%)
Total Commercial	36.2%	41.3%	40.4%	0.9%	41.8%	41.1%	41.3%	(0.2%)
Other	2.5%	2.3%	2.2%	0.0%	2.4%	2.4%	2.3%	0.1%
Hospital Cost								
Total FTE	2,692.3	2,838.7	2,889.7	50.9	2,638.5	2,788.3	2,779.0	(9.3)
Productive Hrs/APD	29.5	28.9	31.0	2.0	30.7	30.9	31.9	0.9
Consolidated Balance Sheet								
Net Days in AR	47.1	50.5	49.0	(1.5)	47.1	50.5	49.0	(1.5)
Days Cash	498	460	435	25	498	460	435	25

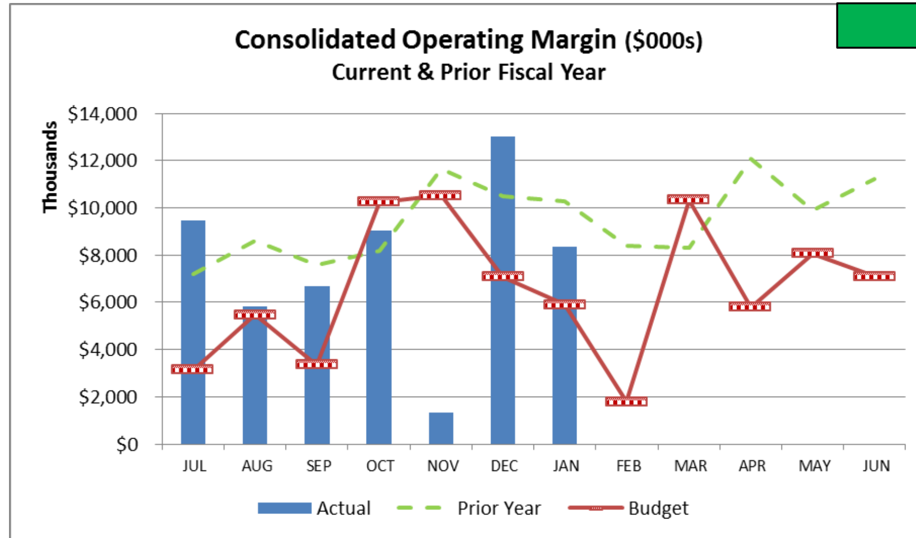
El Camino Health

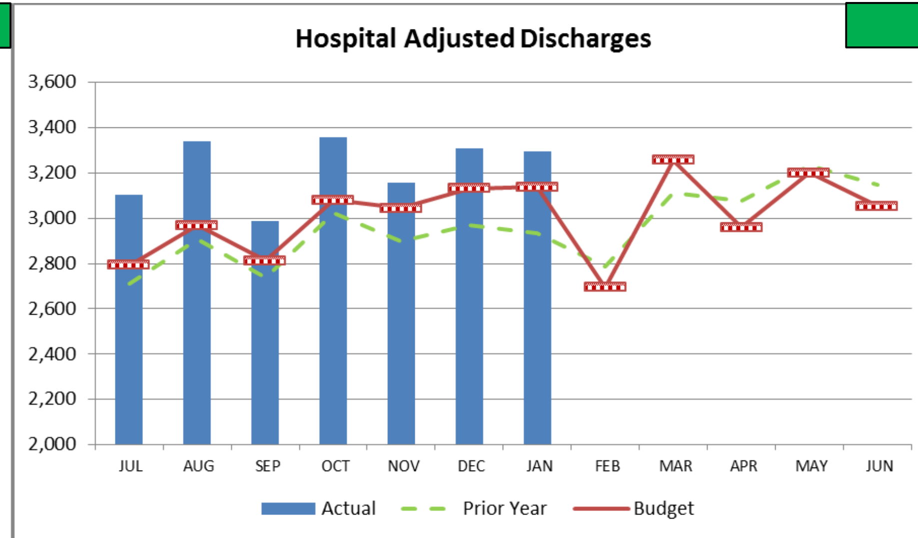
Consolidated Statement of Operations ($000s)

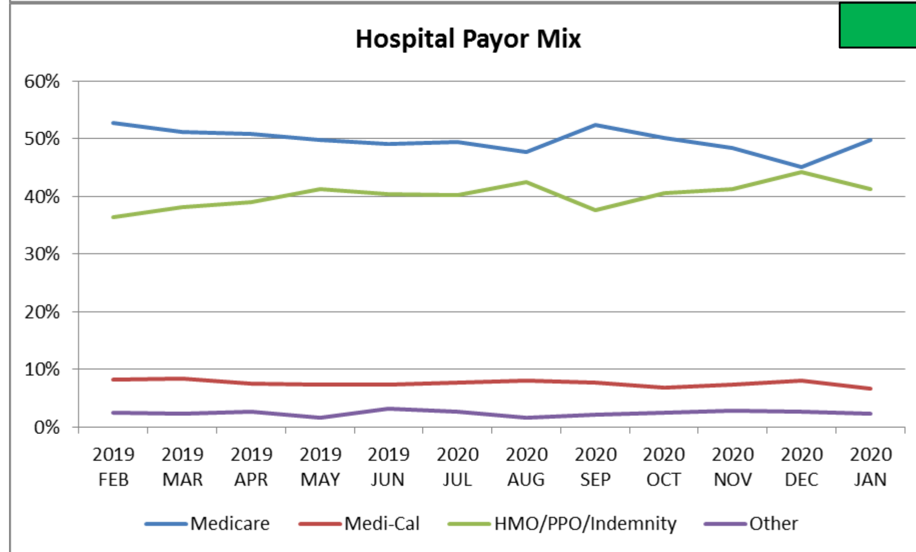
Period ending 01/31/2020

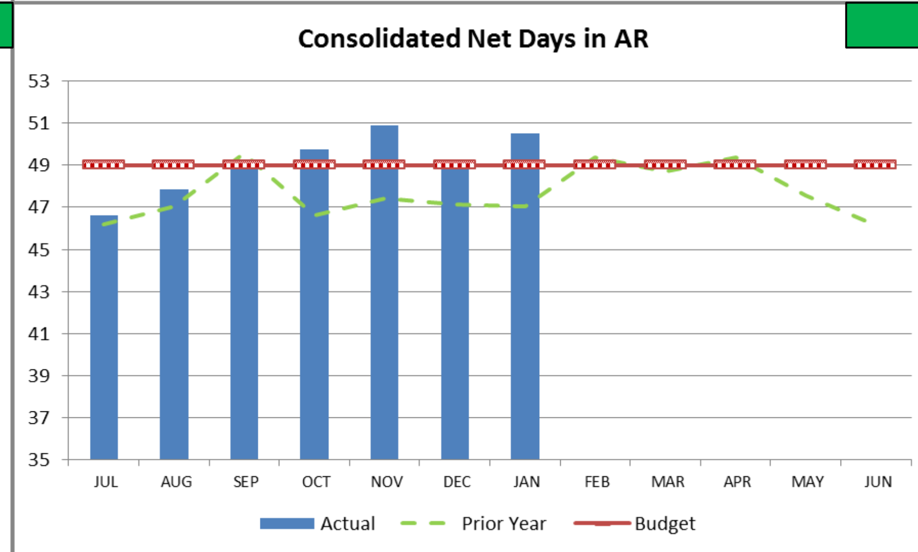
Period 7 FY 2019	Period 7 FY 2020	Period 7 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
305,591	346,412	327,742	18,670	5.7%	**Gross Revenue**	2,013,959	2,277,920	2,228,664	49,257	2.2%
(223,495)	(256,441)	(242,797)	(13,644)	(5.6%)	**Deductions**	(1,478,409)	(1,680,375)	(1,648,245)	(32,130)	(1.9%)
82,096	**89,972**	**84,945**	**5,026**	**5.9%**	**Net Patient Revenue**	**535,550**	**597,545**	**580,418**	**17,127**	**3.0%**
2,946	4,309	4,482	(174)	(3.9%)	**Other Operating Revenue**	24,408	32,114	31,269	845	2.7%
85,042	**94,280**	**89,428**	**4,853**	**5.4%**	**Total Operating Revenue**	**559,958**	**629,659**	**611,687**	**17,972**	**2.9%**
					OPERATING EXPENSE					
44,771	48,046	47,798	(249)	(0.5%)	**Salaries & Wages**	295,498	323,325	323,984	659	0.2%
11,575	12,923	12,294	(629)	(5.1%)	**Supplies**	77,135	93,337	84,557	(8,779)	(10.4%)
11,074	14,682	13,132	(1,550)	(11.8%)	**Fees & Purchased Services**	72,381	99,004	91,522	(7,483)	(8.2%)
2,687	3,655	3,525	(129)	(3.7%)	**Other Operating Expense**	18,307	26,421	27,957	1,536	5.5%
269	1,552	1,428	(124)	(8.7%)	**Interest**	2,497	2,769	4,798	2,029	42.3%
4,392	5,059	5,359	300	5.6%	**Depreciation**	30,184	31,146	33,173	2,027	6.1%
74,767	**85,918**	**83,537**	**(2,382)**	**(2.9%)**	**Total Operating Expense**	**496,002**	**576,003**	**565,992**	**(10,011)**	**(1.8%)**
10,275	**8,362**	**5,891**	**2,471**	**41.9%**	**Net Operating Margin**	**63,956**	**53,657**	**45,696**	**7,961**	**17.4%**
23,190	4,510	3,300	1,210	36.7%	**Non Operating Income**	(7,713)	52,885	21,669	31,216	144.1%
33,466	**12,872**	**9,191**	**3,680**	**40.0%**	**Net Margin**	**56,243**	**106,542**	**67,365**	**39,177**	**58.2%**
17.6%	15.9%	14.2%	1.7%		**EBITDA**	17.3%	13.9%	13.7%	0.2%	
12.1%	8.9%	6.6%	2.3%		**Operating Margin**	11.4%	8.5%	7.5%	1.1%	
39.4%	13.7%	10.3%	3.4%		**Net Margin**	10.0%	16.9%	11.0%	5.9%	

Monthly Financial Trends









El Camino Health

INVESTMENT SCORECARD AS OF DECEMBER 31, 2019

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY20 Budget	Expectation Per Asset Allocation
Investment Performance		**4Q 2019**		**Fiscal Year-to-date**		**7y 2m Since Inception (annualized)**		**FY 2020**	**2019**
Surplus cash balance*		$1,087.8	--	--	--	--	--	--	--
Surplus cash return	Green	3.9%	4.2%	4.8%	4.9%	5.9%	5.8%	4.0%	5.6%
Cash balance plan balance (millions)		$293.8	--	--	--	--	--	--	--
Cash balance plan return	Green	5.3%	5.1%	5.6%	5.7%	8.1%	7.4%	6.0%	6.0%
403(b) plan balance (millions)		$548.4	--	--	--	--	--	--	--
Risk vs. Return		**3-year**				**7y 2m Since Inception (annualized)**			**2019**
Surplus cash Sharpe ratio	Green	1.14	1.11	--	--	1.09	1.08	--	0.34
Net of fee return	Green	7.8%	7.4%	--	--	5.9%	5.8%	--	5.6%
Standard deviation	Green	5.2%	5.1%	--	--	4.7%	4.7%	--	8.7%
Cash balance Sharpe ratio	Green	1.16	1.09	--	--	1.17	1.12	--	0.32
Net of fee return	Green	9.6%	8.5%	--	--	8.1%	7.4%	--	6.0%
Standard deviation	Green	6.6%	6.1%	--	--	6.2%	5.8%	--	10.3%
Asset Allocation		**4Q 2019**							
Surplus cash absolute variances to target	Green	9.4%	< 10%	--	--	--	--	--	--
Cash balance absolute variances to target	Green	7.4%	< 10%	--	--	--	--	--	--
Manager Compliance		**4Q 2019**							
Surplus cash manager flags	Green	9	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags	Green	11	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$53 mm), District assets (~$38 mm), and balance sheet cash not in investable portfolio. Includes Foundation (~$35 mm) and Concern (~$13 mm) assets. Budget adds back in current Foundation and Concern assets and backs out current debt reserve funds.

Consolidated Balance Sheet

(in thousands)

ASSETS		
		Audited
CURRENT ASSETS	January 31, 2020	June 30, 2019
Cash	82,115	124,912
Short Term Investments	257,733	177,165
Patient Accounts Receivable, net	145,322	132,198
Other Accounts and Notes Receivable	6,200	5,058
Intercompany Receivables	40,724	8,549
Inventories and Prepaids	69,226	64,093
Total Current Assets	**601,319**	**511,976**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	17,567	16,895
Plant & Equipment Fund	182,210	171,304
Women's Hospital Expansion	22,430	15,472
Operational Reserve Fund	148,917	139,057
Community Benefit Fund	18,729	18,260
Workers Compensation Reserve Fund	-	20,732
Postretirement Health/Life Reserve Fund	-	29,480
PTO Liability Fund	-	26,149
Malpractice Reserve Fund	1,838	1,831
Catastrophic Reserves Fund	20,605	19,678
Total Board Designated Assets	**412,296**	**458,857**
FUNDS HELD BY TRUSTEE	**42,035**	**83,073**
LONG TERM INVESTMENTS	**403,319**	**375,729**
CHARITABLE GIFT ANNUITY INVESTMENTS	**573**	**602**
INVESTMENTS IN AFFILIATES	**35,442**	**38,532**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,334,954	1,692,693
Less: Accumulated Depreciation	(654,021)	(622,877)
Property, Plant & Equipment - Net	**1,156,372**	**1,069,816**
DEFERRED OUTFLOWS	33,451	33,876
RESTRICTED ASSETS	27,686	24,279
OTHER ASSETS	976	1,036
TOTAL ASSETS	**2,713,469**	**2,597,775**

LIABILITIES AND FUND BALANCE		
		Audited
CURRENT LIABILITIES	January 31, 2020	June 30, 2019
(Accounts Payable	47,087	38,390
Salaries and Related Liabilities	10,190	30,296
Accrued PTO	25,294	26,502
Third Party Settlements	12,477	11,331
Intercompany Payables	41,627	8,464
Bonds Payable - Current	9,128	8,630
Bond Interest Payable	460	12,775
Other Liabilities	1,490	14,577
Total Current Liabilities	**151,851**	**150,966**
LONG TERM LIABILITIES		
Post Retirement Benefits	29,579	29,480
Worker's Comp Reserve	19,754	18,432
Other L/T Obligation (Asbestos)	4,044	3,975
Bond Payable	509,576	507,531
Total Long Term Liabilities	**562,953**	**559,417**
DEFERRED REVENUE-UNRESTRICTED	1,560	1,113
DEFERRED INFLOW OF RESOURCES	13,268	13,715
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	1,766,481	1,389,510
Board Designated	189,950	458,839
Restricted	27,405	24,215
Total Fund Bal & Capital Accts	**1,983,837**	**1,872,563**
TOTAL LIABILITIES AND FUND BALANCE	**2,713,469**	**2,597,775**

APPENDIX

Non Operating Items and Net Margin by Affiliate

$ in thousands

	Period 7- Month			Period 7- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	9,968	6,561	3,407	65,498	54,242	11,255
Los Gatos	1,612	1,654	(42)	12,296	10,730	1,566
Sub Total - El Camino Hospital, excl. Afflilates	**11,579**	**8,215**	**3,364**	**77,793**	**64,973**	**12,821**
Operating Margin %	**13.0%**	**9.9%**		**13.0%**	**11.4%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**5,156**	**2,860**	**2,296**	**48,257**	**18,610**	**29,648**
El Camino Hospital Net Margin	**16,736**	**11,076**	**5,660**	**126,051**	**83,582**	**42,469**
ECH Net Margin %	**18.7%**	**13.3%**		**21.1%**	**14.6%**	
Concern	323	78	245	448	562	(113)
ECSC	(1)	0	(1)	(29)	2	(31)
Foundation	(1,056)	122	(1,179)	2,758	953	1,805
Silicon Valley Medical Development	(3,131)	(2,085)	(1,045)	(22,687)	(17,734)	(4,952)
Net Margin Hospital Affiliates	**(3,864)**	**(1,885)**	**(1,980)**	**(19,509)**	**(16,217)**	**(3,292)**
Total Net Margin Hospital & Affiliates	**12,872**	**9,191**	**3,680**	**106,542**	**67,365**	**39,177**

El Camino Health

El Camino Hospital – Mountain View ($000s)

Period ending 1/31/2020

Period 7 FY 2019	Period 7 FY 2020	Period 7 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
251,909	276,262	258,398	17,865	6.9%	Gross Revenue	1,650,846	1,810,370	1,759,910	50,460	2.9%
(184,993)	(203,698)	(192,665)	(11,033)	(5.7%)	Deductions	(1,211,795)	(1,333,059)	(1,308,917)	(24,143)	(1.8%)
66,916	**72,564**	**65,732**	**6,832**	**10.4%**	**Net Patient Revenue**	**439,052**	**477,311**	**450,993**	**26,317**	**5.8%**
1,474	1,446	1,782	(336)	(18.9%)	Other Operating Revenue	14,382	13,085	14,215	(1,129)	(7.9%)
68,390	**74,011**	**67,515**	**6,496**	**9.6%**	**Total Operating Revenue**	**453,433**	**490,396**	**465,208**	**25,188**	**5.4%**
					OPERATING EXPENSE					
36,833	38,210	37,951	(258)	(0.7%)	Salaries & Wages	242,520	255,812	256,024	212	0.1%
9,590	10,154	9,362	(791)	(8.5%)	Supplies	62,457	74,439	65,095	(9,345)	(14.4%)
6,737	7,467	5,790	(1,676)	(29.0%)	Fees & Purchased Services	44,433	48,067	40,950	(7,117)	(17.4%)
2,113	2,434	2,086	(348)	(16.7%)	Other Operating Expense	14,737	18,600	18,072	(529)	(2.9%)
269	1,554	1,428	(125)	(8.8%)	Interest	2,497	2,769	4,798	2,029	42.3%
3,533	4,226	4,336	110	2.5%	Depreciation	24,568	25,211	26,028	817	3.1%
59,076	**64,043**	**60,953**	**(3,090)**	**(5.1%)**	**Total Operating Expense**	**391,213**	**424,898**	**410,965**	**(13,933)**	**(3.4%)**
9,314	**9,968**	**6,561**	**3,407**	**51.9%**	**Net Operating Margin**	**62,221**	**65,498**	**54,242**	**11,255**	**20.7%**
20,772	5,156	2,860	2,296	80.3%	Non Operating Income	(17,243)	48,257	18,610	29,648	159.3%
30,086	**15,124**	**9,422**	**5,702**	**60.5%**	**Net Margin**	**44,977**	**113,755**	**72,852**	**40,903**	**56.1%**
19.2%	21.3%	18.3%	3.0%		EBITDA	19.7%	19.1%	18.3%	0.8%	
13.6%	13.5%	9.7%	3.7%		Operating Margin	13.7%	13.4%	11.7%	1.7%	
44.0%	20.4%	14.0%	6.5%		Net Margin	9.9%	23.2%	15.7%	7.5%	

El Camino Health

El Camino Hospital – Los Gatos ($000s)

Period ending 1/31/2020

Period 7 FY 2019	Period 7 FY 2020	Period 7 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
52,391	61,662	59,936	1,726	2.9%	Gross Revenue	357,528	416,269	406,150	10,119	2.5%
(37,595)	(46,773)	(44,417)	(2,356)	(5.3%)	Deductions	(262,961)	(311,192)	(301,203)	(9,989)	(3.3%)
14,796	**14,889**	**15,520**	**(631)**	**(4.1%)**	**Net Patient Revenue**	**94,567**	**105,077**	**104,947**	**131**	**0.1%**
349	374	272	102	37.5%	Other Operating Revenue	2,027	2,686	1,899	787	41.4%
15,145	**15,264**	**15,792**	**(529)**	**(3.3%)**	**Total Operating Revenue**	**96,594**	**107,763**	**106,845**	**918**	**0.9%**
					OPERATING EXPENSE					
7,213	7,598	7,642	44	0.6%	Salaries & Wages	48,567	52,495	51,499	(996)	(1.9%)
1,946	2,418	2,531	113	4.5%	Supplies	14,290	15,901	16,662	762	4.6%
2,741	2,572	2,749	177	6.5%	Fees & Purchased Services	18,666	19,173	19,193	20	0.1%
264	285	388	104	26.7%	Other Operating Expense	2,179	2,341	2,945	603	20.5%
0	0	0	0	0.0%	Interest	0	0	0	0	0.0%
805	780	828	49	5.9%	Depreciation	5,293	5,557	5,816	259	4.5%
12,969	**13,652**	**14,138**	**486**	**3.4%**	**Total Operating Expense**	**88,995**	**95,467**	**96,115**	**648**	**0.7%**
2,176	**1,612**	**1,654**	**(42)**	**(2.6%)**	**Net Operating Margin**	**7,599**	**12,296**	**10,730**	**1,566**	**14.6%**
0	0	0	0	0.0%	Non Operating Income	0	0	0	0	0.0%
2,176	**1,612**	**1,654**	**(42)**	**(2.6%)**	**Net Margin**	**7,599**	**12,296**	**10,730**	**1,566**	**14.6%**
19.7%	15.7%	15.7%	(0.1%)		EBITDA	13.3%	16.6%	15.5%	1.1%	
14.4%	10.6%	10.5%	0.1%		Operating Margin	7.9%	11.4%	10.0%	1.4%	
14.4%	10.6%	10.5%	0.1%		Net Margin	7.9%	11.4%	10.0%	1.4%	

Silicon Valley Medical Development ($000s)

Period ending 1/31/2020

Period 7 FY 2019	Period 7 FY 2020	Period 7 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
1,292	8,488	9,408	(920)	(9.8%)	**Gross Revenue**	5,584	51,281	62,604	(11,323)	(18.1%)
(908)	(5,970)	(5,715)	(255)	(4.5%)	**Deductions**	(3,653)	(36,124)	(38,125)	2,001	5.2%
384	**2,518**	**3,693**	**(1,175)**	**(31.8%)**	**Net Patient Revenue**	**1,931**	**15,157**	**24,478**	**(9,321)**	**(38.1%)**
4	1,815	1,665	149	9.0%	**Other Operating Revenue**	39	11,390	9,820	1,570	16.0%
388	**4,333**	**5,359**	**(1,026)**	**(19.1%)**	**Total Operating Revenue**	**1,970**	**26,547**	**34,298**	**(7,751)**	**(22.6%)**
					OPERATING EXPENSE					
206	1,826	1,674	(152)	(9.1%)	**Salaries & Wages**	858	11,863	12,820	957	7.5%
35	350	388	38	9.8%	**Supplies**	303	2,916	2,713	(204)	(7.5%)
1,034	4,300	4,209	(92)	(2.2%)	**Fees & Purchased Services**	5,238	29,117	28,745	(372)	(1.3%)
234	936	980	44	4.5%	**Other Operating Expense**	906	4,976	6,443	1,467	22.8%
0	(1)	0	1	0.0%	**Interest**	0	0	0	0	0.0%
51	52	193	141	73.2%	**Depreciation**	299	362	1,312	950	72.4%
1,560	**7,463**	**7,444**	**(19)**	**(0.3%)**	**Total Operating Expense**	**7,604**	**49,234**	**52,033**	**2,799**	**5.4%**
(1,172)	**(3,131)**	**(2,085)**	**(1,045)**	**50.1%**	**Net Operating Margin**	**(5,634)**	**(22,687)**	**(17,734)**	**(4,952)**	**27.9%**
1,000	0	0	0	0.0%	**Non Operating Income**	6,810	0	0	0	0.0%
(172)	**(3,131)**	**(2,085)**	**(1,045)**	**50.1%**	**Net Margin**	**1,176**	**(22,687)**	**(17,734)**	**(4,952)**	**27.9%**
-289.1%	-71.1%	-35.3%	(35.8%)		**EBITDA**	-270.7%	-84.1%	-47.9%	(36.2%)	
-302.3%	-72.3%	-38.9%	(33.3%)		**Operating Margin**	-285.9%	-85.5%	-51.7%	(33.8%)	
-44.4%	-72.3%	-38.9%	(33.3%)		**Net Margin**	59.7%	-85.5%	-51.7%	(33.8%)	

ECH Hospital Operating Margin

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

FY 2020 Actual Run Rate Adjustments (in thousands) - FAV / <UNFAV>									
Revenue Adjustments		J	A	S	O	N	D	J	YTD
	Mcare Settlmt/Appeal/Tent Settlmt/PIP	129	129	210	137	129	194	129	1,059
	RAC Release	-	-	(746)	-	-	-	-	(746)
	PRIME Incentive	-	-	-	-	-	1,944	-	1,944
	Various Adjustments under $250k	9	4	5	18	6	8	12	62
	Total	**138**	**133**	**(531)**	**155**	**136**	**2,146**	**141**	**2,318**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, Chief Medical Officer
Date: April 15, 2020
Subject: MV Urology On-Call Panel

Recommendation: To approve delegating to the Chief Executive Officer the authority to execute a two-year renewal of the Mountain View (MV) Urology On-Call Panel agreements at an increased rate of $1,200/day.

Summary:

1. Situation: The Hospital has separate urology call panels at each campus where urologists respond when needed for emergency evaluations and surgical interventions for patients in the emergency departments and for inpatient urology consults at the existing rate of $930/day.

The MV urology on-call panel includes three (3) Palo Alto Medical Foundation ("PAMF") physicians and four (4) Urological Surgeons of Northern CA ("USNC") physicians. The current agreements expire April 30, 2020.

In December 2019, PAMF urologists requested an increase to $1,200/day upon renewal of their MV Urology On-Call Panel agreement. ECH countered at $940/day (75th percentile). PAMF and USNC declined the offer, claiming they receive $1,300/day from a local hospital for the same service.

ECH countered with an increase to $1,100/day. USNC declined the offer and PAMF declined to respond until USNC and ECH reached an agreement.

After review of the MV urology on-call events over the last year (320) compared to that of LG urology on-call events (161), ECH decided to offer USNC and PAMF $1,200/day to provide continued coverage at the MV campus. Both USNC and PAMF accepted the offer and a renewal term of two years with USNC and PAMF at the increased per diem rate of $1,200/day is being requested.

2. Authority: According to Administrative Policies and Procedures 51.00, Finance Committee review and Board approval is required prior to the Chief Executive Officer signature of physician agreements that are greater than a 10% increase in compensation and exceed the 75th percentile for fair market value.

3. Background: USNC and PAMF urologists have provided urology call coverage services at the MV campus since December, 2012.

4. Assessment:

Alternative Solutions:

- ECH discussed the possibility of contracting with USNC to provide enterprise urology call coverage at both campuses for a single, negotiated, increased rate, and USNC was not interested in that option.

- There is a lack of independent urologists on ECH's medical staff and, without the participation of urologists with USNC and PAMF, ECH would be forced to transfer urology patients that come through the MV ED to another hospital.
- ECH could employ four (4) urologists to cover the MV campus 24/7/365 that would cost the Hospital approximately $1.5 million/year.

Fair Market Value: Compensation will be increased to $1,200/day, which is greater than the 90th percentile according to the 2019 MD Ranger San Francisco Bay Area report for Urology Call Coverage (90th percentile is $1,060/day). A renewal term of two years will be proposed.

5. Other Reviews: Legal and Compliance will review the renewal amendments and compensation terms prior to CEO execution. The Finance Committee reviewed and recommended this proposal for approval at its March 23, 2020 meeting.

6. Outcomes: Physicians will participate in the peer review process for consultations related to urology call coverage.

List of Attachments: N/A

Suggested Board Discussion Questions: N/A

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, Chief Medical Officer
Date: April 15, 2020
Subject: LG Urology On-Call Panel

Recommendation: To approve delegating to the Chief Executive Officer the authority to execute a two-year renewal of the LG Urology On-Call Panel agreement at an increased rate of $1,100/day; $401,500/year.

Summary:

1. Situation: The Finance Committee on January 27, 2020 approved delegating to the Chief Executive Officer the authority to execute a two-year renewal of the LG Urology On-Call Panel agreement at the existing rate of $930/day and $339,450/year. However, after approval Urological Surgeons of Northern CA ("USNC"), the sole provider of urologists that provide LG campus urology call coverage, refused to continue providing services unless they receive $1,300/day, which they claim a local hospital pays them for the same service.

ECH countered with an increase to $940/day (75th percentile). USNC declined and countered with their original request of $1,300/day.

After many discussions with Hospital leadership and USNC, ECH and USNC reached an agreement of $1,100/day upon renewal.

2. Authority: According to Administrative Policies and Procedures 51.00, Finance Committee review and Board approval is required prior to the Chief Executive Officer signature of physician agreements that are greater than a 10% increase in compensation, exceed $250,000 in annual compensation, and exceed the 75th percentile for fair market value.

3. Background: USNC physicians have provided sole urology call coverage services at the LG campus since 2010. Urologists with Palo Alto Medical Foundation ("PAMF") and USNC are both contracted to provide urology call coverage at the MV Campus. USNC participation is essential to provide sufficient urology call coverage at both campuses.

4. Assessment:

Alternative Solution: ECH discussed the possibility of contracting with USNC to provide enterprise urology call coverage at both campuses for a negotiated, increased rate, and USNC was not interested in that option. If USNC does not participate in urology call coverage at the LG campus, ECH will be forced to transfer urology patients that come through the LG ED to another hospital.

Fair Market Value: Compensation will be increased to $1,100/day, $401,500 per year, which is greater than the 90th percentile according to the 2019 MD Ranger San Francisco Bay Area report for Urology Call Coverage (90th percentile is $1,060/day). A renewal term of two years will be proposed.

5. Other Reviews: Legal and Compliance will review the renewal amendment and compensation terms prior to CEO execution. The Finance Committee reviewed this proposal and recommended it for approval at its March 23, 2020 meeting.

6. Outcomes: Physicians will participate in the peer review process for consultations related to urology call coverage.

List of Attachments: N/A

Suggested Board Discussion Questions: N/A

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Board of Directors

From: Mark Adams, MD, Chief Medical Officer

Date: April 15, 2020

Subject: Enterprise Infection Control Medical Director Increase in Hours

Recommendation: To approve delegating to the Chief Executive Officer the authority to execute an amendment to the Enterprise Infection Control (IC) Medical Director Agreement for an additional 204 hours per year, which is an increase of $34,680 per year, for a total of 792 hours/year, not to exceed an annual compensation of $134,640.

Summary:

1. Situation: The Hospital is taking actions to ensure that staff, patients, visitors and physicians remain safe and protected to mitigate the impact of COVID-19.

   The expertise of our infectious disease medial director is required above and beyond her contracted maximum allowed hours in support of the Hospital's efforts to provide the safest possible environment for ECH employees, visitors and patients in response to COVID-19.

   The IC Medical Director will be required to provide additional administrative services during the months of March 2020 through June 2020 in response to COVID-19.

2. Authority: According to Administrative Policies and Procedures 51.00, Finance Committee review and Board approval is required prior to the Chief Executive Officer signature of physician agreements that are greater than a 10% increase in compensation and exceed the 75th percentile for fair market value.

3. Background: A PAMF Infection Disease specialist has been the Hospital's IC Medical Director for the past 19 years. On June 12, 2019, the Board approved a 2-year renewal at an increased hourly rate and additional hours for a total not to exceed maximum annual compensation of $99,960.

4. Fair Market Value Assessment: The $170/hour rate is at the 90th percentile according to 2019 MD Ranger SF Bay Area data for Infection Control Medical Direction and between the 75th percentile ($160) and 90th percentile ($170) according to 2019 MD Ranger All Facilities for Infection Control Medical Direction (*approved by ECH Board of Directors on June 12, 2019*). The proposed increase in hours and total compensation of $134,640 is between the 75th percentile ($118,888) and 90th percentile ($155,302), according to 2019 MD Ranger Infection Control Medical Direction benchmark report for facilities with general acute care beds 300 and over, using the multi-facility calculation.

5. Other Reviews: Legal and Compliance will review the renewal amendment and compensation terms prior to CEO execution. The Finance Committee reviewed this proposal and recommended it for approval at its March 23, 2020 meeting.

6. Outcomes: Due to the outstanding efforts and the coordinated response to COVID-19, the Hospital received special commendation from the Centers for Disease Control (CDC), the Santa Clara County Public Health Department (SCCPHD), and the California Department of Public Health (CDPH). The expertise, leadership, and guidance will be required by the IC Medical Director more than usual over the next four months to ensure the safety of our patients and employees amid COVID-19.

List of Attachments: N/A

Suggested Board Discussion Questions: N/A

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Peter, C. Fung, MD, Governance Committee Chair
Date: April 15, 2020
Subject: 2020 Board and Committee Self-Assessment Survey Questionnaires

Recommendation(s):

To approve the 2020 El Camino Hospital (ECH) Board and Committee Self-Assessment survey questionnaires and process with the caveat that the Board Chair, in consultation with the Governance Committee Chair and CEO, has the option of delaying the survey launch if there is a conflict with other Board and/or operational priorities related to ECH's response to the COVID-19 pandemic.

Summary:

1. Situation: At the February 4, 2020 and March 31, 2020 ECH Governance Committee meetings, members discussed the proposed 2020 Board and Committee Self-Assessment survey questionnaires and provided feedback.

2. Authority: In accordance to ECH policies/practices, the Governance Committee is tasked with reviewing and recommending Board approval of the assessment tools used in the annual Board and biennial Committee Self-Assessment Process.

3. Background: Via has been engaged to design and facilitate a comprehensive board and committee self-assessment process for the ECH Board. The process is planned to include two online surveys completed by all board and committee members in June 2020. Responses will be used to develop customized assessment reports and recommendations specific to the board and each of its six committees.

The results of the board assessment will be presented and discussed at a board meeting to be scheduled in late summer 2020. The committee reports will be provided to the committees for discussion. The intent is to have the board and each committee identify a limited number of desired actions for further strengthening ECH's governance in the next year.

4. Assessment: As distinguished from last year's Board assessment tool, the two surveys have been revised to include (1) a section exploring specific ongoing education topics and preferred modalities was added to the board survey questionnaire and (2) a statement regarding the effectiveness of communication from the board to the committees was added to the committee survey questionnaire.

5. Other Reviews: At its March 31, 2020 meeting, the Governance Committee reviewed and voted to recommend approval of 2020 El Camino Hospital (ECH) Board and Committee Self-Assessment survey questionnaires and process.

6. Outcomes: Final versions of the tools will be loaded into Survey Monkey and distributed to all ECH board and committee members as part of the 2020 Board and Committee Self-Assessment process in June 2020. The exact date is to be determined, and could be delayed as described above.

List of Attachments:

1. Draft Proposed 2020 ECH Board Self-Assessment Survey Questionnaire
2. Draft Proposed 2020 ECH Committee Self-Assessment Survey Questionnaire

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

Introduction

Welcome to the El Camino Health 2020 Board Self-Assessment questionnaire. Responses to this survey will be used in conjunction with board member and executive leadership interviews conducted by Via Healthcare Consulting to develop an assessment report and recommendations for board consideration. The report and recommendations will be discussed at the [*Date to be Determined*] Board session. Please note, your individual answers will be seen by Via Healthcare Consulting *only*.

Instructions to Board Members Completing the Survey

Completing the survey will take approximately 20-30 minutes. Your candid responses are a key part of continued enhancement and improvement for the board; we encourage you to be honest and direct. Individual responses *will not* be shared with other directors or management; information gathered will be used in the aggregate only.

Do not hesitate to indicate you "Don't Know" to any question if in fact you don't know. Also use the "Don't Know" response if it is not clear to you how the board handles the practice. If a question refers to a practice that the board does not follow, please indicate "Not Applicable." When in doubt about your choice, select the more conservative response (e.g. if your response falls somewhere between "Strongly Agree" and "Agree," select "Agree.") Be sure to respond to all the questions.

Use the "Comments" sections to explain your answers (especially for those which you answered "Neutral", "Disagree", "Strongly Disagree" or "Don't Know.") Written comments will be kept anonymous, as well.

If you have any questions, please contact Erica Osborne (760-271-0557, eosborne@viahcc.com) or Connie Serna (909-373-7661, cserna@viahcc.com) at **Via Healthcare Consulting**. Thank you in advance for your time and thoughtful responses.

This survey is broken down into the following areas of board responsibilities/activities:

Section I **Mission and Planning Oversight: Setting Strategic Direction**
Section II **Quality Oversight: Monitoring Performance Improvement**
Section III **Management Oversight: Enhancing Board-Executive Relations**
Section IV **Legal and Regulatory Oversight: Ensuring Organizational Integrity**
Section V **Finance and Audit Oversight: Following the Money**
Section VI **Board Effectiveness: Optimizing Board Functioning**
Section VII **Ongoing Governance Education**

Section I Mission and Planning Oversight: Setting Strategic Direction

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Not Applicable
1. The ECH Board receives adequate education on strategic, external and internal environmental issues and trends throughout the year.	5	4	3	2	1	DK	NA
2. The ECH Board spends sufficient time during board and relevant committee meetings discussing strategy.	5	4	3	2	1	DK	NA
3. The ECH Board is appropriately involved in in establishing the organization's strategic direction (e.g. creating a long-range vision, setting strategic priorities, and developing/approving the strategic plan).	5	4	3	2	1	DK	NA
4. The ECH Board regularly reviews the organization's performance against community health care needs to ensure it is meeting its obligations as a not-for-profit organization.	5	4	3	2	1	DK	NA
5. The ECH Board and its committees uses the Mission and Vision statements to guide its decision-making.	5	4	3	2	1	DK	NA

Mission and Planning Oversight Comments Section:

Section II Quality Oversight: Monitoring Performance Improvement

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don’t Know	Not Applicable
6. All ECH Board members receive adequate education on the board’s responsibilities for quality oversight and/or ECH’s quality metrics throughout the year.	5	4	3	2	1	DK	NA
7. The ECH Board receives adequate information regarding performance improvement programs undertaken at ECH.	5	4	3	2	1	DK	NA
8. The ECH Board is well-informed about the quality, safety and patient experience provided by ECH.	5	4	3	2	1	DK	NA
9. The ECH Board has sufficient expertise and competencies in the area of quality and patient safety.	5	4	3	2	1	DK	NA
10. The board oversees the setting of annual goals for the organization’s performance on quality, safety and service.	5	4	3	2	1	DK	NA
11. The ECH Board requires corrective action in response to under-performance on the quality and service goals.	5	4	3	2	1	DK	NA

Quality Oversight Comments Section:

Section III Management Oversight: Enhancing Board-Executive Relations

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Not Applicable
12. All ECH Board members understand and respect the distinction between the role of the board and the role of management.	5	4	3	2	1	DK	NA
13. The ECH Board currently has a productive working relationship with the CEO.	5	4	3	2	1	DK	NA
14. The ECH Board currently has a productive working relationship with the executive leadership team.	5	4	3	2	1	DK	NA
15. The ECH Board has a clear process in place for setting the CEO's annual goals.	5	4	3	2	1	DK	NA
16. The full ECH Board participates in the annual evaluation and review of the CEO's performance.	5	4	3	2	1	DK	NA
17. The full board is knowledgeable about all elements of the CEO's compensation.	5	4	3	2	1	DK	NA

Management Oversight Comments Section:

Section IV Legal and Regulatory Oversight: Ensuring Organizational Integrity

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Not Applicable
18. The ECH Board members apprise themselves of all reasonably-available and relevant information before taking action on any significant issue.	5	4	3	2	1	DK	NA
19. ECH Board and committee members recuse themselves from involvement in any activity or decision that might be a conflict of interest.	5	4	3	2	1	DK	NA
20. All ECH Board members keep closed-session board discussions confidential.	5	4	3	2	1	DK	NA
21. The ECH Board has sufficient processes in place to ensure all members of the executive compensation committee are 'independent' (i.e. free from any conflicts of interest).	5	4	3	2	1	DK	NA
22. The ECH Board is knowledgeable about the organization's compliance performance.	5	4	3	2	1	DK	NA

Legal and Regulatory Oversight Comments Section:

Section V Finance and Audit Oversight: Following the Money

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Not Applicable
23. The ECH Board establishes realistic financial goals and objectives for the organization.	5	4	3	2	1	DK	NA
24. The ECH Board regularly monitors the organization's financial and operational performance compared to plans and relevant industry benchmarks.	5	4	3	2	1	DK	NA
25. The ECH Board requires corrective action in response to under-performance on the financial and capital plans.	5	4	3	2	1	DK	NA
26. The ECH Board members demonstrate a good understanding of ECH's business via discussions of key issues.	5	4	3	2	1	DK	NA
27. The ECH Board has sufficient knowledge and processes in place to effectively oversee organization-wide risk (i.e., financial, business, and operational risks).	5	4	3	2	1	DK	NA
28. The ECH Board has sufficient processes in place to ensure all members of the committee that oversee audit are 'independent' (i.e. free from any material conflicts of interest).	5	4	3	2	1	DK	NA

Finance and Audit Oversight Comments Section:

Section VI Board Effectiveness: Optimizing Board Functioning

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Not Applicable
29. ECH Board members understand the reserved powers held by the sole member, the El Camino Healthcare District Board.	5	4	3	2	1	DK	NA
30. ECH Board members understand the roles and responsibilities of the hospital board.	5	4	3	2	1	DK	NA
31. The ECH Board has an appropriate mix of skills, experience and backgrounds.	5	4	3	2	1	DK	NA
32. ECH Board members receive sufficient orientation and on-going education to do their job effectively.	5	4	3	2	1	DK	NA
33. The ECH Board meeting frequency and duration are appropriate.	5	4	3	2	1	DK	NA
34. Board meetings are effective, efficient and promote generative discussion.	5	4	3	2	1	DK	NA
35. ECH Board members ask appropriately challenging questions of the CEO and senior management.	5	4	3	2	1	DK	NA
36. ECH Board members exhibit a willingness to challenge status quo thinking.	5	4	3	2	1	DK	NA
37. The ECH committee structure is appropriate to the current responsibilities of the board.	5	4	3	2	1	DK	NA
38. The ECH board receives sufficient information and context regarding the process committees follow in developing recommendations to the board.	5	4	3	2	1	DK	NA

39. Committee reports provide the full board with sufficient information to make informed decisions.	5	4	3	2	1	DK	NA
40. Board and committee meeting materials/presentations are not overly duplicative of each other.	5	4	3	2	1	DK	NA

Board Effectiveness Comments Section:

Section VII Ongoing Governance Education

41. Which of the following major education topic(s) do we need to focus on in the coming year? Please check all that apply.

- ☐ Governance Effectiveness (vs Management), Board Roles and Fiduciary Responsibilities
- ☐ Quality, Patient Safety and Engagement
- ☐ Physician Credentialing
- ☐ Understanding Systemness and Promoting Health System Alignment
- ☐ Organizational Integrity and the Board’s Role in Compliance
- ☐ Workforce Issues/Addressing Provider Burnout
- ☐ Technology and Cybersecurity
- ☐ Legislative Updates
- ☐ Community Health
- ☐ Market Disruptors and the Impact
- ☐ Board’s Role in Crisis Management

42. Please list any topics you are interested in receiving education on that do not fall within the categories listed above:

____

____

43. How would you like to receive continuing education in the future? Please check all that apply.

- ☐ Presentation during board or committee meetings
- ☐ Special education sessions conducted by outside expert
- ☐ Educational session at annual retreat
- ☐ External educational conferences
- ☐ Webinars
- ☐ Articles

44. Please list any other learning modalities you would be interested in that were not included above:

____

____

Additional Comments Section: Please note these comments (as well as this entire questionnaire's responses) will be kept confidential and anonymous.

Conclusion:

Thank you for your contributions and commitment to El Camino Health. Your time, dedication, and experience serving El Camino Health's mission are tremendously valued. Thank you also for taking the time to complete this survey.

If you have any questions about the survey questions or the process, please contact Erica Osborne (760-271-0557, eosborne@viahcc.com) or Connie Serna (909-373-7661, cserna@viahcc.com) at Via Healthcare Consulting. Thank you again.

Introduction

Welcome to the El Camino Health 2020 Committee Self-Assessment questionnaire. Responses to this survey will be used to develop individual committee assessment reports and recommendations for the committees to consider. The reports and recommendations will be discussed at future committee meetings. Please note, your individual answers will be seen by Via Healthcare Consulting *only*.

Instructions to Board Members Completing the Survey

Completing the survey will take approximately 15-20 minutes. Your candid responses are a key part of continued enhancement and improvement for the committee; we encourage you to be honest and direct. Individual responses *will not* be shared with other members or management; information gathered will be used in the aggregate only.

Do not hesitate to indicate you "Don't Know" to any question if in fact you don't know. Also use the "Don't Know" response if it is not clear to you how the board handles the practice. If a question refers to a practice that the committee does not follow, please indicate "Not Applicable." When in doubt about your choice, select the more conservative response (e.g. if your response falls somewhere between "Strongly Agree" and "Agree," select "Agree.") Be sure to respond to all the questions.

Use the "Comments" sections to explain your answers (especially for those which you answered "Neutral", "Disagree", "Strongly Disagree" or "Don't Know.") Written comments will be kept anonymous, as well.

If you have any questions, please contact Erica Osborne (760-271-0557, eosborne@viahcc.com) or Connie Serna (909-373-7661, cserna@viahcc.com) at **Via Healthcare Consulting**. Thank you in advance for your time and thoughtful responses.

1. Name:____

2. Committee you are responding to the survey about: _________________________

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Not Applicable
3. Committee members understand their roles and responsibilities as specified in the committee charter.	5	4	3	2	1	DK	NA
4. The committee efficiently and effectively carries out responsibilities outlined in its charter or as delegated by the board.	5	4	3	2	1	DK	NA
5. Committee members receive adequate orientation on their committee responsibilities.	5	4	3	2	1	DK	NA
6. The committee receives sufficient information and context to understand and assess the issues under discussion.	5	4	3	2	1	DK	NA
7. The committee maintains focus on important strategic and policy issues.	5	4	3	2	1	DK	NA
8. The committee has an appropriate mix of skills, experience, and backgrounds to meet its responsibilities.	5	4	3	2	1	DK	NA
9. The committee meeting frequency and duration are appropriate.	5	4	3	2	1	DK	NA
10. The number of meeting agenda topics allows for enough time to thoughtfully address all issues.	5	4	3	2	1	DK	NA

11. Committee meeting agendas are designed around strategic priorities and committee responsibilities.	5	4	3	2	1	DK	NA
12. Committee meetings are effective, efficient, and promote generative discussion.	5	4	3	2	1	DK	NA
13. Committee meeting agendas are organized to ensure there is an effective balance between report outs and discussion.	5	4	3	2	1	DK	NA
14. The committee chair provides effective leadership and direction to the committee.	5	4	3	2	1	DK	NA
15. Committee work results in appropriate recommendations to the board.	5	4	3	2	1	DK	NA
16. The committee effectively communicates information to the board that supports the achievement of board goals and organizational strategy.	5	4	3	2	1	DK	NA
17. The committee regularly receives feedback and information from the board that informs its work.	5	4	3	2	1	DK	NA

18. How can the committee improve its performance in support of the ECH Board?

19. What additional education would you like to receive?

Additional Comments Section: Please note these comments (as well as this entire questionnaire's responses) will be kept confidential and anonymous.

Conclusion:

Thank you for your contributions and commitment to El Camino Health. Your time, dedication, and experience serving El Camino Health's mission are tremendously valued. Thank you also for taking the time to complete this survey.

If you have any questions about the survey questions or the process, please contact Erica Osborne (760-271-0557, eosborne@viahcc.com) or Connie Serna (909-373-7661, cserna@viahcc.com) at Via Healthcare Consulting. Thank you again.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Cindy Murphy, Director of Governance Services
Date: April 15, 2020
Subject: Board Action Plan Review

Purpose:

To provide the Board with information about the progress towards completion of the 2019-2020 El Camino Hospital (ECH) Board Action Plan (following review by the Governance Committee).

Summary:

1. Situation: Attached is the 2019-2020 ECH Board Action Plan, which was developed based on the results of the 2019 Board Self-Assessment (BSA). It is broken down into the four areas of focus including quality oversight, meeting effectiveness, ongoing education/training, and board culture.

2. Authority: In accordance with its Charter, the Governance Committee is tasked with overseeing implementation of the annual Board Action Plan and providing a report.

3. Background: Via Healthcare conducted a comprehensive BSA process for the ECH Board in the summer of 2019. The process included an online survey completed by all Board members as well as interviews with Board members and executive leadership. The results of the assessment and a set of recommendations were developed and presented to the ECH Board in August 2019. At the August 21, 2019 ECH Board meeting, Board members discussed the findings, identifying and prioritizing a list of enhancement actions the Board could undertake to improve its effectiveness over the next year. The Board approved the attached action plan on November 6, 2019 and it represents the agreed upon actions that the full Board decided to pursue.

4. Assessment: Progress in the 4 areas is noted below:

A. Quality Oversight – The Board held a joint meeting with the Quality Committee in October. The Quality Committee is in process of developing a Dashboard for the Board to facilitate quality oversight using the STEEEP methodology. Additional work in other areas was delayed pending the arrival of ECH's Chief Quality Officer which has now also been delayed.

B. Meeting Effectiveness –

i. There has been more consistent use of cover memos, but making them effective continues to be a challenge.

ii. Board members completed meeting evaluation surveys for September – February meetings. The survey form and results are attached. Challenges include less than 100% participation and some Board members only responding to questions 1, 5 and 6.

iii. Board meetings are temporarily being conducted remotely which may have some impact on the effectiveness of the meetings.

C. Ongoing Education/Training - The Board approved an education plan and staff has stepped up efforts to keep Board members informed about educational opportunities. Unfortunately, the April 22nd Board and Committee Education Session has been cancelled due to State of California shelter in place and social distancing orders. At its March 31, 2020 meeting the Governance Committee suggested encouraging Board and Committee members to participate in the planned self-learning materials and follow-up with discussion at their upcoming May and June committee meetings. Board staff will communicate that suggestion to the Executive Sponsors and Committee Chairs.

As well, for the same reasons, the Governance Institute cancelled a late April conference with a focused quality oversight track that several Board, Committee and Staff members were planning to attend.

D. Board Culture – The Board held two social gatherings in FY20. In August, Board members, Board staff, and their guests participated in a pasta making class and enjoyed dinner together. This event was very well attended. In December, Board members and their guests enjoyed a meal out together. This event was less well attended due to scheduling difficulties. A third event was planned for May 5th. That day is now being held for an additional Board meeting and we will look for a back-up date in June or July for a social gathering.

5. Other Reviews: The Governance Committee reviewed and discussed the progress at its March 31, 2020 meeting.

6. Outcomes: Some progress has been made. Recent shelter in place and social distancing orders are impeding progress on completing some planned activities in the areas of education, meeting effectiveness and culture.

List of Attachments:

1. 2019-2020 El Camino Hospital Board Action Plan
2. Board Meeting Evaluation Form
3. Board Meeting Evaluation Results

Suggested Board Discussion Questions: None. This is an informational item on the consent calendar.

Approved by the Hospital Board 11/6/2019

Board Action Plan

	What	Who	By When	Current Status
Quality Oversight				
	Adopt a customized, actionable approach to effective quality. • Review and discuss available approaches to quality oversight. Frameworks to consider might include IHI Framework for Governance of Health System Quality, AHRQ High Reliability Organizations, and LEAN Six Sigma among others. • Identify and incorporate aspects from the different frameworks to create a customized approach to quality oversight at ECH.	Quality Committee Chair, CMO	End Q1 2020	
	Hold an educational meeting or series of meetings focused on quality oversight. These sessions will provide: • Additional education on the board's role in quality oversight including information on quality goals, indicators and how to interpret data. • An opportunity to discuss how ECH defines quality and what the organization's approach should be.	Quality Committee Chair, CMO	Scheduled for October 23, 2019	
Meeting Effectiveness				
	Restructure board meeting presentations to improve focus and promote dialogue.	CEO, Dir Gov Services	December 2019	
	Implement a board meeting evaluation to assess quality of materials, mechanics and results of the meeting.	Board Chair, CEO	September 2019	
Ongoing Governance Education/Training				
	Develop an intentional, multi-year strategy for ongoing board education. The intent would be to identify topics and modalities that would enhance the governance competencies and engagement of the ECH Hospital Board.	Governance Committee	December 2019	
Enhancing Board Culture				
	Convene board members outside the typical board meeting structure to facilitate greater cohesiveness and teamwork on a quarterly or bi-annual basis.	Board Chair, CEO, Dir Gov Services	Ongoing	

El Camino Hospital
Board of Directors
Meeting Evaluation Form
Date: December 11, 2019

		Exceed Expectations	**Meets Expectations**		**Below Expectations**	
1)	Overall, the meeting agenda was clear and included appropriate topics for Board consideration	5	4	3	2	1
2)	The following agenda items did not warrant spending Board time (please circle) Quality Committee Report FY20 Period 4 Financials El Camino Health Enterprise Structure Revised SVMD, LLC Operating Agreement Investment Committee Report Medical Staff Report Los Gatos Plan Update Consent Calendar: Letters of Rebuttable Presumption, Report on Educational Activity, Update on Major Capital Projects CEO Report					
3)	The Board materials for the following agenda items ***were not*** at a "governance level" (please circle) Quality Committee Report FY20 Period 4 Financials El Camino Health Enterprise Structure Revised SVMD, LLC Operating Agreement Investment Committee Report Medical Staff Report Los Gatos Plan Update Consent Calendar: Letters of Rebuttable Presumption, Report on Educational Activity, Update on Major Capital Projects CEO Report					
4)	The Board materials for the following agenda Items ***were*** at a "governance level" and an appropriate number of pages. (please circle) Quality Committee Report FY20 Period 4 Financials El Camino Health Enterprise Structure Revised SVMD, LLC Operating Agreement Investment Committee Report Medical Staff Report Los Gatos Plan Update Consent Calendar: Letters of Rebuttable Presumption, Report on Educational Activity, Update on Major Capital Projects CEO Report					
5)	There was enough time on the agenda for discussion and the Board used its time for relevant and productive discussion	5	4	3	2	1
6)	The Board kept its discussion focused on governance level issues of quality, strategy and policy	5	4	3	2	1

Please provide further feedback here, particularly on any items you rated 3 or lower:

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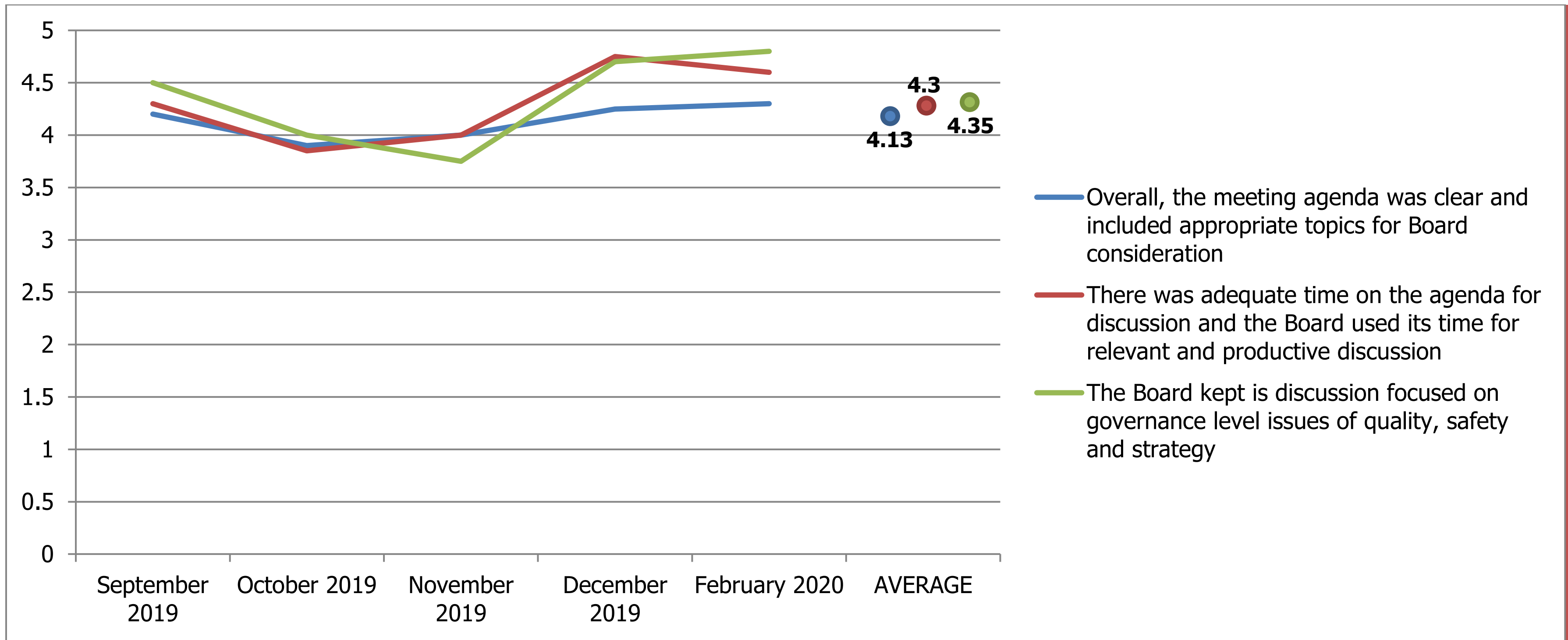
____

Board Meeting Evaluation



El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Ken King, CASO
Date: April 15, 2020
Subject: Major Projects Update – For Information

Purpose:

To keep the Finance Committee and the Board informed on the progress of major capital projects in process

Summary

1. Situation/Status: **Taube Pavilion** (aka BHS) construction is substantially complete and the OSHPD occupancy issue that has delayed the opening of the building has reached a resolution. Senior OSHPD officials agreed with our proposed plan to maintain the occupancy classification as previously approved with modifications that ensures full compliance with the NFPA 101 Life Safety Code for a new healthcare building. The specific plans were submitted for review and approval on March 11th and we have been promised an expedited review. At the same time we have directed the General Contractor to proceed with the release of material orders and contracts to execute the revisions. As all of this effort is taking place, we are working to schedule final OSHPD inspections so that "Beneficial Occupancy" can be granted. Once Beneficial Occupancy is received by CDPH, then our Licensing Certification inspection will be scheduled sometime within six weeks of their receipt. A specific target move in date has not yet been established in light of the current COVID-19 situation and the notice that OPSHD site visits have been suspended.

We continue the process of negotiating the contract close out change order requests and we expect to complete the project within the approved budget.

Sobrato Pavilion (aka IMOB) construction is substantially complete with only the final phase of work to be completed in the hospital connector area. The issues that delayed occupancy were successfully resolved and on February 21st we received "Temporary Occupancy" for the Sobrato Pavilion from the City of Mountain View. This allowed us to move our first Tenant into the building over the weekend so that patients could be seen on Monday, February 24th. The Final Occupancy will be received when the work on the Grant Road right turn lane is complete.

As of today, we have moved several non-clinical departments into the new building and once we get past the current COVID-19 situation, we will request our CDPH Licensing Certification inspection, which is needed before we can relocate the clinical services into the new building.

Final contract change orders are being negotiated and we expect to complete the project within the approved budget.

Women's Hospital construction documents labeled OSHPD Back Check #1 were submitted to OPSHD on March 6th. We anticipate at least one and possibly two more rounds of plan review with OSHPD before a building permit is received.

As we contemplate that current cost estimates received by the major subcontractors, we continue to evaluate qualified sub-contractors to bid on the project. The recent events may have a positive impact on construction pricing in the Bay Area and our plan is to use the OSHPD Back Check #2

documents for bidding and negotiating the GMP agreement with the General Contractor sometime this coming summer.

M.V. Campus Completion Project (Phases 1 and 2) received approval from both the Hospital Board and the District Board. We have received the first comments on Phase 1 from OSPHD and we expect to resubmit Back Check #1 plans by the end of March. Phase 2 plans have been submitted to OSPHD and are currently under review. The target date for obtaining the Phase 1 permit is now June 2020 and the start of demolition is currently being reevaluated.

Phase 3 development options are under development, however we have pushed the date to present these options to the May meeting of the Finance Committee.

2. Authority: This memo is to keep the Finance Committee and the Board informed of the progress towards completion of the major development projects within the Mountain View Campus Development Plan.

3. Background: The Board of Directors approved the Mountain View Campus Development Projects which consist of the following:

Step I:	Status
North Parking Garage Expansion -	Complete
Behavioral Health Services Building -	Substantially Complete – Not Occupied
Integrated Medical Office Building -	Substantially Complete – Occupied
Central Plant Upgrades -	Complete
Step II:	
Women's Hospital Expansion -	Plan Review/Permit
Demolition of Old Main Hospital -	Plan Review/Permit Phases 1&2

4. Assessment: In addition to the construction activities, all impacted departments are working on the activation, training, move planning and budgeting for the future state of operations.

5. Other Reviews: The Finance Committee received this update at its March 23, 2020 meeting.

6. Outcomes: The primary objective continues to be completing the projects within the approved budgets and to safely transition into the new building environments.

Finance Committee Approvals Report to the Board – April 15, 2020

In accordance with the Corporate Compliance: Physician Financial Arrangements Policy, the following agreement was approved by the Finance Committee at its March 23, 2020 meeting.

Clinical Area	Campus	Agreement Type	Hourly or Per Diem Rate	Hours	Not-to-Exceed	FMV Assessment	Statement of Need
Orthopedic and Spine Surgery	Enterprise	Co-Management Agreement Expansion	$300/hour	1000 hours/ Year	NTE $560,000 annually: $300,000 for hourly work plus up to aggregate bonus potential of $260,000. Covers 26 physicians across Orthopedic and Neurosurgery Specialties	Below 75th percentile	Expand Orthopedic Co-Management work by: 1) expanding participation to include all active spine surgeons at both campuses, which will allow for emphasis on spine surgery to develop a Joint-Commission certified Spine program at Mountain View and improving the performance at Los Gatos. The co-management arrangement work has potential to result in numerous advantageous outcomes, including (1) decrease IV narcotics for total joint replacements, (2) supply, implant, equipment and medication savings of $2.4 million annualized.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, CMO & Jim Griffith, COO
Date: April 15, 2020
Subject: Enterprise Telestroke/Teleneurology Program and Enterprise Neurology Inpatient Non-Emergency Consult Panel Physician Services Agreements

Recommendation(s):

To approve delegating to the CEO the authority to:

1. Execute a two-year enterprise Neurology Telemedicine Services Agreement between El Camino Hospital and CEP AMERICA-NEUROLOGY, PC, a California professional corporation d/b/a Vituity Neurology Inc. to be effective April 20, 2020 with the following core terms:
- Base Compensation: Per diem of $650 per 24 hours
- Payment Formula: 24/7/365 coverage
- Not-to-Exceed Annual Compensation: $237,250 per year, plus a one-time $9,900 implementation fee.

2. Execute a two-year enterprise neurology inpatient consultation non-emergency coverage agreement between El Camino Hospital and local neurologists for combined enterprise call for non-urgent in-person consults. This agreement would have the following core terms:
- Base Compensation: Per diem up to $1,640 maximum.
- Payment Formula: Per diem payment for a 24-hour shift as scheduled each month.
- Response Time for Consultation: Phone call response within 15 minutes; in-person as requested within 12 hours.
- Not-to-Exceed Annual Compensation: $598,600 per year

Summary:

1. Situation: Due to COVID-19 neurology provider shortages, ECH is moving-up the already planned conversion of the current stroke/neurology on-call Emergency Department and inpatient coverage panel at each campus with combined compensation of $1,664 per diem for 24-hour coverage to a tele-neurology program with 24/7 tele-stroke/neurology coverage for acute/emergency events and a non-urgent call panel for in-person follow-up consultation for admitted patients.

Shifting these agreements will improve patient outcomes as follows:

- Improve timeliness of care for emergent acute stroke from up to 30 minutes to an average of 5 minutes.
- Improves care and reduces physician turnover by reducing use of locum tenens (substitute) physicians.
- Reduces overall expense for stroke program.
- Total annual savings estimated at $8,793 (minimum) due to reduction in Locum Tenens costs

2. Authority: According to Administrative Policies and Procedures 51.00, Board approval is required prior to the CEO signature of physician agreements with compensation that exceeds the 75th percentile for fair market value.

3. Background: El Camino Mountain View Hospital is a Thrombectomy-Capable Center and receives about 800 stroke alerts each year, while Los Gatos as a Primary Stroke Center receives about 200. The Mountain View Hospital admits over 500 stroke patients annually, while Los Gatos admits about 60.

4. Fair Market Value Assessment:

ECH currently pays neurologists $1,040 per diem for the Mountain View campus and $624 for the Los Gatos campus to provide 24-hour Emergency Department and Inpatient Emergency Coverage. The current Mountain View campus rate is above the 90th percentile.

This coverage arrangement is being replaced by two agreements.

1) **Neurology Telemedicine Services Agreement**

A third party consultant has reviewed the proposed compensation, and has determined that the proposed Enterprise Tele-neurology Services Agreement arrangement at $650 per diem, not to exceed $237,250 per year (plus one-time $9,900 implementation fee) is commercially reasonable and between the 75th percentile at $503 per diem and the 90th percentile at $776 per diem for fair market value.

2) **Neurology Inpatient Consultation Non-Emergency Coverage Agreement**

ECH considered hiring 3 neuro-hospitalists but the risks and net cost of approx. $750,000 - $1,000,000 per year or $2,054 - $2,739 per day are prohibitive at this time.

For the proposed enterprise neurology inpatient non-emergency consults, ECH obtained a third-party consultant fair market value (FMV) analysis for two models/options to achieve coverage, and the results were:

- 12 hour on-site Neurohospitalist – FMV range of $1074 (75th) to $1,871 (90th)
- On-call coverage with 12 hour onsite response – FMV range of $421 (75th) to $810 (90th)

Our initial ECH offer was $450 per day based on third party consultant evaluation which was at 75th percentile ($421 per day). However, in negotiations with our current panel members the initial demand was $3,500 per day. They stated that they are aware of a similar arrangement at a regional hospital paying at least $2,300 per day. Initial discussions with another neurology group indicated interest in compensation in the range of $1,400 to $1,500 per day. A few of the current call coverage neurologists are willing to consider $1,640 per day.

Management therefore recommends the proposed Enterprise Tele-Neurology Services Agreement at $650 per diem, and an enterprise on-call rate for inpatient non-emergency consults not to exceed $1,640 per diem, and will attempt to negotiate below this maximum if possible.

5. Other Reviews: Legal and compliance will review the final agreements and compensation terms prior to execution.

6. Outcomes: Measurable goals have been established for the Telestroke neurology group that include improvements in timeliness of response and TPA delivery and for the inpatient non-emergency consult panel to achieve reduced length of stay, and appropriate risk-adjusted mortality rate.

List of Attachments: None.

Suggested Board Discussion Questions: None.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, CMO
Date: April 15, 2020
Subject: Resolution 2020-02

Recommendation:

To approve Resolution 2020-02 finding that Director Fung's Neurology Inpatient Non-Emergency Consultation Panel Agreement is fair and in ECH's best interest.

Summary:

1. Situation: Management wishes to enter into a Neurology Inpatient Non-Emergency Consultation Panel Agreement with Board Director Peter C. Fung, MD. Dr. Fung's Stroke and Neurology ED On-Call Agreement currently expires on April 30, 2020. A new call panel is being developed to provide non-emergency inpatient consults to supplement the new Tele-Neurology program. Management believes that the proposed contract is in the best interest of El Camino Health and is fair to its patients. Moreover, the amount to be paid will be no greater than the amounts paid under the same or similar agreements.

2. Authority: The agreement must be approved by the Board in order to comply with the California Nonprofit Corporations Act. In addition, although Director Fung's agreement is with El Camino Hospital, not with the District, I recommend that the Board approve Resolution 2020-02 in a manner that would comply with Health and Safety Code Section 32111; if it applied.

3. Background: California Government Code Section 1090 generally bars contracts between governmental entities and directors, among others, who are financially interested in certain agreements. California Health and Safety Code Section 32111 provides an exception to contracts involving a member of a medical staff who is subject to Section 1090, where the contract is between the district and the officer for professional services to the district's patients, employees, or medical staff members and their respective dependents, provided that similar contracts exist with other staff members and the amounts payable under the contract are no greater than the amounts payable under similar contracts covering the same or similar services if the following conditions have been satisfied:

(i) the officer abstains from any board action regarding the contract;
(ii) the officer's relationship to the contract is disclosed to the board and noted in its official records; and
(iii) the board finds the contract is fair and in its best interest and authorizes the contract in good faith without the participation by the officer.

4. Assessment:

Dr. Fung will be compensated at the same per diem rate as the other physicians on the call panel. The maximum per diem rate will be $1,640 per day with 5 physicians expected to be on the enterprise call panel. The proposed per diem rate is over the 90% ($810) according to a third party consultant. Our initial ECH offer was $450 per day based on third party consultant evaluation which was 75th percentile ($421 per day). However, in negotiations with our current panel members the initial demand was $3,500 per day. They stated that they are aware of a similar arrangement in a

regional hospital paying at least $2,300 per day. Initial discussions with another neurology group indicated interest in compensation in the range of $1,400 to $1,500 per day. A few of the current call coverage neurologists are willing to consider $1,640 per day.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. Resolution 2020-03

Suggested Board Discussion Questions: None.

RESOLUTION 2020-03
BOARD OF DIRECTORS
EL CAMINO HOSPITAL

WHEREAS, Peter C. Fung, MD ("Dr. Fung") has provided services as an Emergency Room on-call physician to El Camino Hospital, a California nonprofit corporation, since October 1, 2005;

WHEREAS, Dr. Fung became a member of the Board of Directors of El Camino Hospital on December 9, 2014;

WHEREAS, El Camino Hospital is entering into a teleneurology services agreement to replace the Emergency Room on-call panel and is developing a new neurology inpatient non-emergency consultation panel with members of its Medical Staff;

WHEREAS, El Camino Hospital management has proposed entering into a new Neurology Inpatient Non-Emergency Consultation Panel physician agreement with Dr. Fung with terms, including payments terms, that are similar to those entered into with other physicians;

WHEREAS, El Camino Hospital management has determined that entering into a new Neurology Inpatient Non-Emergency Consultation Panel Agreement with Dr. Fung is fair and in the interests of El Camino Hospital and El Camino Hospital could not have obtained a more advantageous arrangement; and

WHEREAS, Dr. Fung has recused himself from voting or otherwise participating in this matter;

NOW, THEREFORE, BE IT:

RESOLVED, that the Board of Directors finds that the proposed contract with Dr. Fung is fair and in the interests of El Camino Hospital and El Camino Hospital could not have obtained a more advantageous arrangement; be it further

RESOLVED, that the proposed agreement with Dr. Fung is hereby approved and the President and CEO is authorized to execute and deliver such agreement on behalf of El Camino Hospital.

AYES:

NOES:

ABSTAIN:

RECUSED:

____

Julia E. Miller, Secretary/Treasurer

DRAFT

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: John Conover, Chair, El Camino Health Foundation Board of Directors
Andrew Cope, President, El Camino Health Foundation
Date: April 15, 2020
Subject: Report on El Camino Health Foundation Activities FY20 Period 7

Purpose: For information.

Summary:

1. Situation: During period 7 of fiscal year 2020, El Camino Health Foundation secured $368,492, bringing the total raised by end of January to $5,889,072, which is 77% of the annual goal.

2. Authority: N/A

3. Background:

Major & Planned Gifts

In January, the Foundation received $47,383 in major and planned gifts. This includes sponsorships and ticket sales for the Allied Professionals Seminar, which was held on February 12, and a $40,000 gift designated for mental health & addiction services from the daughter of suicide prevention pioneer Charlotte Ross. That major gift will be recognized in the staff lounge of the Taube Pavilion and the family is reaching out for additional donations.

Fundraising Events

- *Golf Tournament*
  In January, the foundation collected $12,000 in outstanding sponsorships to the October 2019 golf tournament. This brings total golf proceeds received by the end of January to $328,277, which exceeds goal.

- *Norma's Literary Luncheon*
  In January, the foundation received $23,880 in sponsorships and ticket sales for Norma's Literary Luncheon. The event took place on February 6. Additional ticket sales, sponsorships, and donations will be reflected in the period 8 fundraising report.

Annual Giving

In January, the foundation raised $183,735 in annual gifts from the October direct mail and end-of-year follow-up appeals, online donations, Employee Giving Campaign, Circle of Caring grateful patient program, matching gifts, and personal solicitations.

Upcoming Events

- *Spring Gala – Taking Wing,* Saturday, May 16, 2020, 5:30 p.m. – 11 p.m. at Los Altos Golf & Country Club, benefiting the Women's Hospital-Orchard Pavilion renovation

- *Chinese Health Initiative 10th Anniversary Celebration* (replacing the South Asian Heart Center gala), Saturday, September 26, 2020 at Chef Chu's in Los Altos

FOUNDATION PERFORMANCE

FY20 Fundraising Report through 1/31/20 - Period 7

ACTIVITY		FY20 YTD (7/1/19 - 1/31/20)	FY20 Goals	FY20 % of Goal	Difference Period 6 & 7	FY19 YTD (7/1/18 - 1/31/19)
Major & Planned Gifts		$3,926,183	$5,500,000	71%	$47,383	$11,382,845
Special Events	**Spring Event**	$22,500	$350,000	6%	$0	$500
	Golf	$328,277	$325,000	101%	$12,000	$328,580
	*** SAHC / CHI Events**	$13,786	$200,000	7%	$1,741	$41,761
	Norma's Literary Luncheon	$168,580	$200,000	84%	$23,880	$86,450
Annual Gifts		$474,305	$600,000	79%	$183,735	$506,121
Investment Income		$955,441	$500,000	191%	$99,753	$1,126,438
TOTALS		***$5,889,072***	***$7,675,000***	***77%***	***$368,492***	***$13,472,695***

** Support transitioning from South Asian Heart Center to Chinese Health Initiative in FY20*

Highlighted Assets through 1/31/20 - Period 7

Board Designated Allocations	$844,461
Donor Endowments	$6,907,994
Operational Endowments	$14,446,371
Pledge Receivables	$4,607,579
Restricted Donations	$16,804,976
Unrestricted Donations	$1,727,972

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: John Conover, Chair, El Camino Health Foundation Board of Directors
Andrew Cope, President, El Camino Health Foundation
Date: April 15, 2020
Subject: Report on El Camino Health Foundation Activities FY20 Period 8

Purpose: For information.

Summary:

1. Situation: During period 8 of fiscal year 2020, El Camino Health Foundation secured $394,617, bringing the total raised by end of February to $6,283,689, which is 82% of the annual goal.

2. Authority: N/A

3. Background:

Major & Planned Gifts
In February, the Foundation received $60,075 in major and planned gifts. This includes a $50,000 planned gift from the estate of former Auxilian Erika Richards, which will be recognized in the Health Library & Resource Center, and a $10,000 gift to mental health and addiction services.

Fundraising Events

- *Golf Tournament*
In February, the foundation collected $25,000 in outstanding donation commitments to the October 2019 golf tournament. This brings total golf proceeds received by the end of February to $353,277, which exceeds goal.

- *Norma's Literary Luncheon*
In February, the foundation received $24,135 in sponsorships, donations, and ticket sales for Norma's Literary Luncheon. The event took place on February 6. Additional revenue will be reflected in the period 9 fundraising report.

- *Spring Event*
In light of COVID-19 the foundation has cancelled this year's gala. We are actively working to secure a date and location for May 2021. The beneficiary will remain the Women's Hospital renovation.

Annual Giving
In February, the foundation raised $62,143 in annual gifts from the October direct mail and end-of-year follow-up appeals, Circle of Caring grateful patient program, Hope to Health membership, matching gifts, and a $50,000 donation from Santa Clara Sporting Club for the Free Mammogram Program.

El Camino Health

El Camino Health COVID-19 Emergency Response Fund

On March 18, El Camino Health Foundation sent out an e-appeal for donations to our newly established COVID-19 Emergency Response Fund. To date, we have received approximately $2.3 million from more than 200 donors, many of whom are contributing to the foundation for the first time. These gifts will be reflected in next month's fundraising report. We have also received more than 60 in-kind donations, including N-95 masks.

Upcoming Events

- *Chinese Health Initiative 10th Anniversary Celebration* (replacing the South Asian Heart Center gala), Saturday, September 26, 2020 at Chef Chu's in Los Altos

FOUNDATION PERFORMANCE

FY20 Fundraising Report through 2/29/20 - Period 8

ACTIVITY		FY20 YTD (7/1/19 - 2/29/20)	FY20 Goals	FY20 % of Goal	Difference Period 7 & 8	FY19 YTD (7/1/18 - 2/28/19)
Major & Planned Gifts		$3,986,258	$5,500,000	72%	$60,075	$15,505,954
Special Events	**Spring Event**	$22,500	$350,000	6%	$0	$500
	Golf	$353,277	$325,000	109%	$25,000	$334,580
	*** SAHC / CHI Events**	$14,826	$200,000	7%	$1,040	$52,061
	Norma's Literary Luncheon	$192,715	$200,000	96%	$24,135	$122,755
Annual Gifts		$536,448	$600,000	89%	$62,143	$528,603
Investment Income		$1,177,665	$500,000	236%	$222,224	$1,281,762
TOTALS		***$6,283,689***	***$7,675,000***	***82%***	***$394,617***	***$17,826,215***

** Support transitioning from South Asian Heart Center to Chinese Health Initiative in FY20*

Highlighted Assets through 2/29/20 - Period 8

Board Designated Allocations	$798,140
Donor Endowments	$6,776,529
Operational Endowments	$14,560,850
Pledge Receivables	$4,638,951
Restricted Donations	$17,100,057
Unrestricted Donations	$1,903,726

El Camino Hospital Auxiliary

Membership Report to the Hospital Board
Meeting of April 15, 2020

Combined Data as of February 29, 2020 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	286	-3 Net change compared to previous month
Dues Paid Inactive	79	(Includes Associates & Patrons)
Leave of Absence	21	
Subtotal	**386**	

Resigned in Month	3
Deceased in Month	1

Junior Members

Active Members	235	-10 Net Change compared to previous month
Dues Paid Inactive	0	
Leave of Absence	9	
Subtotal	**244**	

Total Active Members	**521**
Total Membership	**630**

Combined Auxiliary Hours from Inception (to February 29, 2020): 6,033,670
Combined Auxiliary Hours for FY2019 (to February 29, 2020): 48,475
Combined Auxiliary Hours for February 29, 2020: 5,187

El Camino Hospital Auxiliary

Membership Report to the Hospital Board
Meeting of April 15, 2020

Combined Data as of March 31, 2020 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	285	-1 Net change compared to previous month
Dues Paid Inactive	80	(Includes Associates & Patrons)
Leave of Absence	21	
Subtotal	**386**	

Resigned in Month	1
Deceased in Month	0

Junior Members

Active Members	234	-1 Net Change compared to previous month
Dues Paid Inactive	0	
Leave of Absence	10	
Subtotal	**244**	

Total Active Members	**519**
Total Membership	**630**

Combined Auxiliary Hours from Inception (to March 31, 2020): 6,034,897
Combined Auxiliary Hours for FY2019 (to March 31, 2020): 49,702
Combined Auxiliary Hours for March 31, 2020: 1,084