El Camino Health

AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, August 18, 2021 – 5:30 pm
El Camino Hospital 2500 rant Road ountain ie CA 94040

P RS A O S A E O CA I OR IA E EC I E OR ER 29 20 A E ARCH 18 2020 El CA I O HEA H **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. I S EA HE P IC IS I I E O OI HE OPE SESSIO EE I IA E ECO ERE CE A:

1-669-900-9128, MEETING CODE: 985-3920-3975# No participant code. Just press #.

o atch the meeting ivestream please visit: www.elcaminohealth.org/about-us/leadership/board-meeting-stream
Please note that the ivestream is for **meeting viewing only,** and there is a slight delay to provide pu lic comment please use the phone num er listed a ove.

MISSION: o heal relieve suffering and advance ellness as your pu licly accounta le health partner.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	anhee Chen oard Chair		**5:30 – 5:31pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	anhee Chen oard 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.* ritten Correspondence	anhee Chen oard Chair		**information 5:32 -5:34**
4.	**QUALITY COMMITTEE REPORT** a. Quality Improvement Patient Safety Plan (QAPI)	ulie liger Chair of Quality Committee	*public comment*	**motion required 5:34 – 5:44**
5.	**FY21 PERIOD 12 FINANCIALS**	Carlos ohor ue Chief inancial Officer		**information 5:44 – 5:54**
6.	**GOVERNANCE BEST PRACTICES**	an oods Chief E ecutive Officer eorge . Anderson Consultant		**information 5:54 – 6:09**
7.	**ADJOURN TO CLOSED SESSION**	anhee Chen oard Chair	*public comment*	**motion required 6:09– 6:10**
8.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	anhee Chen oard Chair		**information 6:10 – 6:11**
9.	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.*	anhee Chen oard Chair		**motion required 6:11 – 6:14**
	Approval *Gov't Code Section 54957.2:* a. inutes of the Closed Session of the Hospital oard eeting (06/23/2021) ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee***			

A copy of the agenda for the Regular oard eeting ill e posted and distri uted at least seventy t o (72) hours prior to the meeting.
In o servance of the Americans ith isa ilities Act please notify us at (650) 988 8254 prior to the meeting so that e may provide the agenda in alternative formats or ma e disa ility related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	Health & Safety Code Section 32155 for a report of the □ edical Staff□deli□erations concerning reports on □ edical Staff □uality assurance matters*:* □ Quality Committee Report (i) □ edical Staff Credentials and Privileges Report			
10.	*Health & Safety Code Section 32155* for a report of the □ edical Staff□deli□erations concerning reports on □ edical Staff □uality assurance matters: a. □ edical Staff Report □ Pediatric □PPE Plan – Revised c. □ edical Staff □yla□s Amendments	Apurva □ arfatia□□ □□ □ ountain □ie□ Chief of Staff□ □ ichael □an□□ □□ □os □atos Chief of Staff		**information** **6:14 – 6:24**
11.	*Gov't Code Section 54956.9(d)(2)* – conference □ith legal counsel – pending or threatened litigation: - Enterprise Ris□□ anagement	□im □riffith□ Chief Operating Officer□ □ ary Rotunno□□eneral Counsel □iane □ iggles□orth□ Sr. □irector of Compliance		**discussion** **6:24– 6:39**
12.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: - Strategic Plan □pdate	□an □ oods□ Chief E□ecutive Officer		**discussion** **6:39 – 6:59**
13.	*Gov't Code Section 54956.9(d)(2)* – conference □ith legal counsel – pending or threatened litigation: - CEO Report a. Pacing Plan	□an □ oods□ Chief E□ecutive Officer		**discussion** **6:59 – 7:09**
14.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior □ anagement: - E□ecutive Session	□anhee Chen□□oard Chair		**discussion** **7:09 – 7:14**
15.	**ADJOURN TO OPEN SESSION**	□anhee Chen□□oard Chair		**motion required** **7:14 – 7:15**
16.	**RECONVENE OPEN SESSION/ REPORT OUT**	□anhee Chen□□oard Chair		**information** **7:15 – 7:16**
	□o report any re□uired disclosures regarding permissi□le actions ta□en during Closed Session.			
17.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.*	□anhee Chen□□oard Chair	*public comment*	**motion required** **7:16 – 7:18**

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
Approval a. Hospital □oard □ inutes (06/23/21) Open Session □ inutes ***Reviewed and Recommended for Approval by the Finance Committee*** □ □□21 Period 11 □inancials c. □ ountain □ie□ □aytime Intensivist Professional Services Rene□al Agreement d. Investment in □e□ □oint □enture □ith Satellite Healthcare ***Reviewed and Recommended for Approval by the Medical Executive Committee*** e. □ edical Staff Report f. Pediatric □PPE Plan – Revised g. □ edical Staff □yla□s Amendments			
17. AMENDMENT TO CEO EMPLOYMENT AGREEMENT	□anhee Chen□□oard Chair	*public comment*	**motion required 7:18 – 7:21**
18. CEO REPORT	□an □ oods□ Chief E□ecutive Officer		**information 7:21 – 7:26**
19. BOARD COMMENTS	□anhee Chen□□oard Chair		**information 7:26 – 7:29**
20. ADJOURNMENT	□anhee Chen□□oard Chair	*public comment*	**motion required 7:29 – 7:30pm**

Upcoming Regular Meetings: Septem□er 15□2021□Octo□er 13□2021□□ovem□er 10□2021□□ecem□er 8□2021□□e□ruary 9□2022□□ arch 9□2022□April 13□2022□□ ay 11□2022□□ ay 23□2022 (□oint □ith □inance Committee)□□une 8□2022

Upcoming Special Meetings - Education/Retreat: Octo□er 27□2021(□oint □oard and Committee Education)□□e□ruary 23□2021 (Retreat)□April 27□2022 (□oard Education)

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital □oard of □irectors
From: □eorge □ing MD, □uality Committee □ice□Chair
□ ar□Adams, MD, □□ O
Date: August 18, 2021
Subject: Quality, Patient Care and Patient E□perience Committee Report

Purpose: □o inform the □oard of the □or□of the Quality Committee and recommend the Quality Improvement Patient Safety Plan (QAPI) for approval.

Summary:

1. □he acting committee chair, □r. □ing, facilitated a discussion regarding the committee pacing plan. □raditionally, the pacing plan has e□panded to include an increasing num□er of rote reports □hich tends to consume committee time at the e□pense of discussion time. Since many of the standard quality metrics don't appreciably change from month to month, it might ma□e sense to decrease the fre□uency of such reports or move some of these items to the consent calendar. □arious committee mem□ers suggested discussion topics for future meetings. □his included health e□uity, drilling do□n on the factors contri□uting to li□elihood to recommend (LT R), population health, our participation in the QIP program (formerly the PRI□ E program for □ edi□Cal patients), and selection of metrics/measures.

2. □ ar□Adams MD, □□ O, revie□ed the most recent patient story □hich came from the ne□ly instituted post discharge phone call program. □he patient praised the nursing care and the food □ut complained a□out the difficulty navigating the ne□ □et □ ell □et□or□ TV system. □his provided an illustration that patient e□perience is more than □ust medical care □ut many other factors that must □e considered.

3. □ince □ anoogian and □te □urness presented the □uarterly □uality update for the El Camino Health □ edical □et□or□. ECH□ □ has esta□lished true north pillars, one of □hich is □uality and service. □or □uality, the goals are: achieve top decile HE□IS composite score □y 2023 and achieve □ IPS composite e□ceptional rating annually. □ hile there are many more HE□IS measures, 8 □ey metrics have □een selected □ased on importance to patient care, impact on financial reim□ursement, and concordance □ith □ IPS measures. □he latest □uarter results in the composite score is 3.4, □hich is up from the previous □uarter of 3.2. □he overall FY 21 score □as 3.375 compared to a target of 3.0. □he FY 22 target is 3.6 □ased on the same □ey metrics. A detailed drill do□n □as provided on the efforts □eing made to improve each of the eight select metrics. □his □as received favora□ly □y the committee.

4. □ ar□Adams revie□ed the Q4 □oard □uarterly □uality dash□oard:
   a. Safe Care:
      i. □ ortality inde□has decreased to .79 for the □uarter and .86 FYTD . □his is lo□er than target □hich □as set as .76 □hich is the most recent top performers score. Ho□ever, it is significantly less than 1.0 □hich is desira□le.
      ii. Sepsis mortality inde□has decreased this □uarter □ut □ill end at 1.08 FYTD . □here has □een an up□ard shift nationally as the current top tier performers are no□ at 1.05. □here is some contri□ution from CO□I□- 9 cases but that's not the only explanation. Some

e□perts are indicating the hesitance to see□care may □e contri□uting to more advanced sepsis cases □here salvage is more difficult.

iii. C□A□SI: 0 this □uarter and FYTD is 0.5 □ased on a fe□ instances in Q2 and Q3. Efforts have □een made to reinforce the application of the central line □undle for placement and the ongoing care of the lines.

iv. C. diff. □ill end slightly a□ove target (1.46) at 1.78.

b □imely:

i. All three E□ measures continue a□ove target. Identification of CO□I□- 9 patients including testing continue to slo□ throughput as □ell as a resurgence of more E□ visits no□ approaching pre□pandemic levels.

c. Effective Care:

i. Readmission Inde□has returned to a level □ust □elo□ target □hich is a very positive trend.

ii. C□S SEP- Compliance rate: decreased in Q4 to 58.0% □elo□ internal goal of 86%; (C□S median rate is 60% across all hospitals) FYTD rate: 72.0%

iii. PC□02 C/S rate: this has remained steady □ut a□ove target of 23.5%. □here is a □ide variation among practitioners □ith some □ell □elo□ target and some approaching 50%. Efforts are □eing made to counsel those a□ove the target.

d. Efficient Care: □o issues

e. E□uita□le Care: □o issues

f. Patient□Centered Care:

i. IP enterprise LT R and E□ LT R remain □elo□ target at FYTD 80.3% and 75.3%, respectively. □CH LT R is also □elo□ target □ith FYTD 80.8%. (As a reminder, the IBM □atson Health □op 100 hospitals median IP LT R □as 77%.)

Recommendation:

□o approve the Quality Improvement Patient Safety Plan (QAPI).

Attachments:

1. □oard Quality □ash□oard Q4
2. Quality Improvement Patient Safety Plan (QAPI) – **FOR APPROVAL**

El Camino Health

Month to Quality Committee of the Board: August 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 21, Q4 (unless otherwise specified by *)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 20	FY 21	FY21, Q1	FY21, Q2	FY21, Q3	FY21, Q4	FYTD21 Total
Safe Care	Risk Adjusted Mortality Index	0.74	0.76	0.75	0.79	1.06	0.79	**0.86**
	Sepsis Mortality Index	0.96	0.90	0.76	1.14	1.31	1.08	**1.08**
	Serious Safety Events Rate (SSER) (baseline Dec'19 to Jun'20)	4.28	4.00	3.98	3.35	3.54	**3.24	**3.24**
	Surgical Site Infections (SSI)	0.36	1.0 (SIR)	0.62	0.11	0.23	0.26	**0.30**
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.47	<= 0.48	0.51	0.71	0.00	0.26	**0.37**
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.15	<= 0.20	0.0	0.71	0.82	0.00	**0.5**
	Clostridium Difficile Infection (CDI) - HAI	1.46	<= 1.46	1.6	1.43	2.59	1.54	**1.78**
	Modified PSI-90 CMS HAC Reduction Program	0.919	0.90	0.898	0.815	1.034	0.809	**0.751**
Timely	Patient Throughput - ED Door to Admit Order	190 min	181 min	188 min	195 min	196 min	194 min	**193.5 min**
	Patient Throughput - Median Time Arrival to ED Departure	284 min	245 min	255 min	274 min	271 min	258 min	**264 min**
	ED Arrival to Direct Discharge for ED Patients	151 min	145 min	154 min	154 min	162 min	166 min	**159 min**
Effective	Risk Adjusted Readmissions Index	0.96	0.93	0.88	0.96	0.95	*0.86	**0.92**
	CMS SEP-1 Compliance Rate	70.9%	86%	67.6%	81.8%	80.5%	58.0%	**72.0%**
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 1.3%	1.3%	0%	1.2% (1/85)	0.00%	*2.0%	**0.67%**
	PC-02 NTSV C-Section	ENT: 24.0%	23.5%	27.6% (142/514)	25.8% (120/466)	25.44% (115/452)	*25.26%	**26.2%**
	ECMN: CMS 165 Controlling High Blood Pressure	51.20%	<= 63%	58.0%	56.0%	59.0%	60.0%	**59.0%**
	ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.30%	<= 45	27.0%	29.0%	32.0%	33.0%	**30.0%**
	HEDIS: Composite	NA	3.0	3.3	3.3	3.2	3.4	**3.3**
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.32	1.30	1.32	1.32	1.31	0.97	**1.23**
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 18)	0.99	0.99	None, updated annually in January	1.00	None, updated annually in January	**0.99**
Equitable	Hospital Charity Care Support	$20.5 mil	NA	$6.6 mil	$5.7 mil	$7.4 mil	$7.3 mil	**$19.7 mil**
	Clinic Charity Care Support	$44.3k	NA	$8.4k	$1.1k	$3.3k	$2.1k	**$14.9k**
	Language Line Unmet Requests (data collection started Q2)	0.34%	<1%	0.39%	0.64%	1.07%	0.77%	**0.72%**
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.05	NA	3.98	4.56	4.11	4.08	**4.00**
		White: 3.79		3.81	3.97	3.92	3.77	**3.89**
		Asian: 3.64		3.54	3.38	3.72	3.53	**3.57**
Patient-centered	IP Enterprise - HCAHPS Likelihood to Recommend	83.1	83.6	80.7	78.6	81.4	80.6	**80.3**
	ED - Likelihood to Recommend (PG)	75.7	78.2	73.9	78.7	76.5	72.6	**75.3**
	ECHMD - Likelihood to Recommend Care Provider (NPS)	73.2	75.7	76.2	76.0	76.4	75.7	**76.1**
	MCH - HCAHPS Likelihood to Recommend	84.1	84.6	82.9	78.2	83.4	79.5	**80.8**
	OAS - HCAHPS Likelihood to Recommend	84.7	86.4	83.5	86.1	86.1	86.47	**85.61**

Report updated 7/26/21

* data available up to FYTD 21 May only

** data available FYTD 21 April only, displaying rolling 12 month data (December 2019 to April 2021)

STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

El Camino Health

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 Improvement & Patient Safety Plan (QAPI)

PURPOSE

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

ORGANIZATION OVERVIEW

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

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

EI CAMINO HEALTH MISSION

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

EI CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

EI CAMINO HOSPITAL VALUES

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

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

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

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

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

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

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

HIGH RELIABILITY

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

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

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

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

DEFINITIONS:

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

- **Safe:** Avoiding harm to patients from the care that is intended to help them

- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

SERVICES/PROGRAMS

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

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 Units
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) Level II and Level III		Infusion Services (MV & LG)
Mental Health and Addiction Services (Inpatient Psychiatry)		Nuclear Medicine
Acute Rehabilitation		Wound Care Clinic
Cardiac Catheterization Services		Occupational Therapy/Physical Therapy
Cardiovascular Surgery		Speech Therapy

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 or accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

A. Governing Board

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

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

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

Other specific responsibilities with regard to quality 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 11.5, the Medical Executive Committee is responsible for the quality and effectiveness of patient care and competent clinical performance rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

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

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

C. Medical Staff Departments and Divisions

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

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

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

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

D. Leadership and Support

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

1. Adopt an approach to quality improvement, set expectations, plan, and manage processes to measure,

assess, and improve the hospital's governance, management, clinical, and support activities

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

E. Medical Staff, Employees, and Contracted Services

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

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

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

The Enterprise **Patient and Employee Safety Committee** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Injuries, Hospital-acquired Infection Teams (CAUTI, CLABSI, C. Diff), National Patient Safety Goals, Safety/Security, Antibiotic Stewardship, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Medication Errors, Employee Injures, and the Grievance Committee. (See Attachment C: Patient and Employee Safety Dashboard). The Committee also reviews reports from Culture of Safety Surveys and works with the medical staff and hospital

administration to develop action plans in response to the results. The Director of Risk Management also conducts risk assessments regarding the safety of patient care including Failure Mode Effects Analysis (FMEA) for new or changed hospital services. The Director of Risk Management/Patient Safety Officer provides data on incident reports (iSafe – ECH's Online System for– adverse event reporting) the adequacy of the reporting process, including updates on the number and type of iSafe reports, serious safety events and RCAs (root cause analyses). Updates are also provided on the performance improvement teams that are chartered through this committee and as a result of RCAs or Intensive Analyses. This Committee uses the Management of Adverse Events/Sentinel Events Procedure to outline the process for categorizing patient safety events, including serious safety events, performance of a root cause analysis for sentinel events, compliance with regulatory requirements for mandated reporting of adverse events and process of notification of ECH leadership of sentinel and adverse events.

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

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

G. Quality Services Department

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

The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
2. Produces and maintains two quality dashboards for the organization and the board of directors: Enterprise Quality, Safety, and Experience Dashboard, and Quarterly Board Quality Dashboard (STEEEP). See Attachments D and E
3. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements

4. Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment F for Data Registries in use)
5. Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities
6. Collaborates with the Director of Risk Management on efforts to manage and reduce risk through Root Cause Analyses and Intense Analyses as responses to adverse events and near misses
7. Collaborates to facilitate failure mode and effectiveness analysis (FMEA) at least every 18 months through the leadership of both the Director of Risk Management & Patient Safety and the Director of Accreditation & Public Reporting
8. Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"
9. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital – acquired infections and conditions
10. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
11. Providing data as requested to external organizations, see data provided in Appendix B
12. Providing oversight for the hospital's participation in Clinical Registries, see Appendix C for current list
13. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, the MBSAQIP, and all Transfusion review and data
14. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health to improve the quality of care and safety of care provided to our patients

H. Improving Organizational Performance

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

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

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of quality improvement, patient safety and risk reduction activities
3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)

4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.

I. Performance Processes

Design

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

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

safety firstmission zero

   a. iSafe reports, surgical site infections, MRSA infections, evidenced-based bundle failures and other events that result in patient harm are reported and evaluated weekly by the Safety Event Classification Team. This team determines if there were defects in care or deviations from generally

accepted performance standards (GACPS) and the level and type of patient harm. This information is translated and reported as the Serious Safety Event Rate.

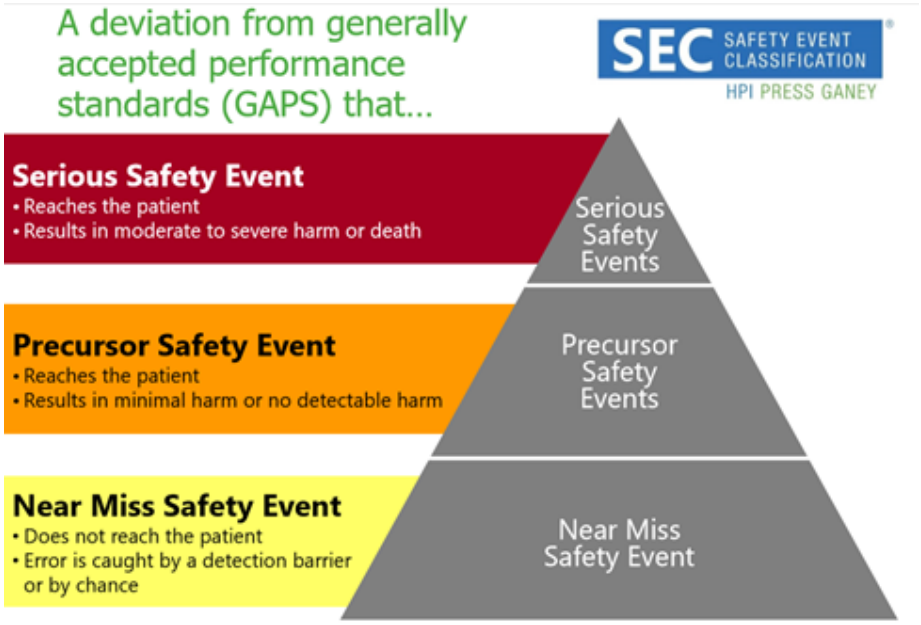
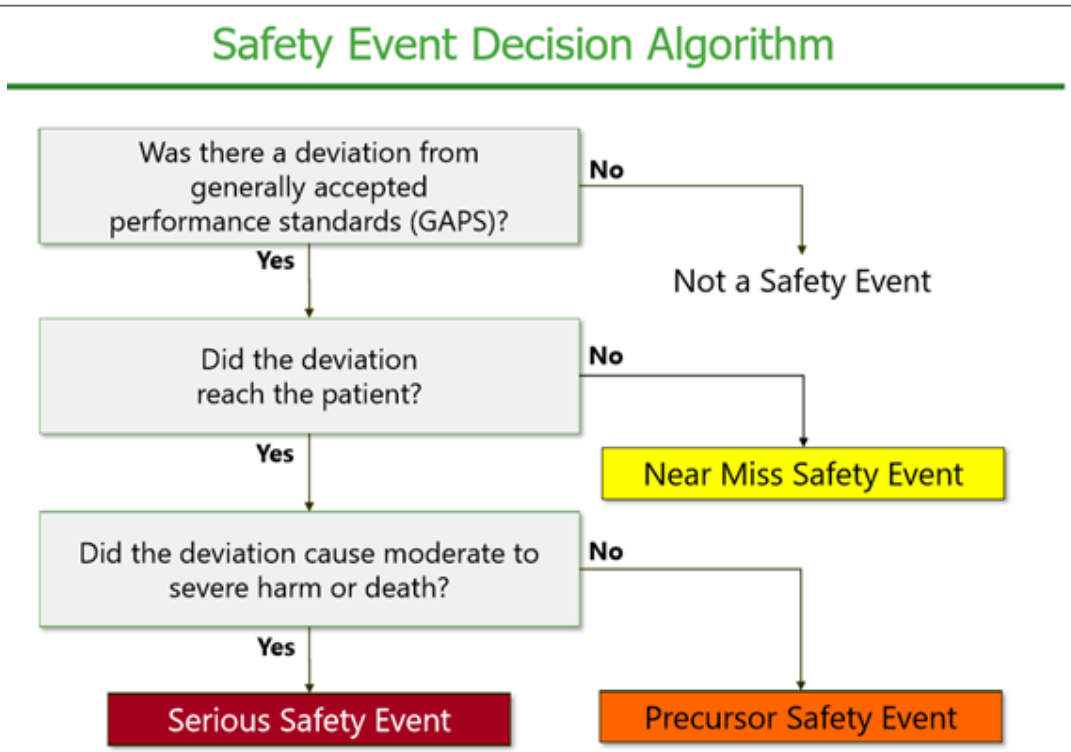


Table 1. HPI SEC Levels of Harm

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



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

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

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

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

collection is systematic and is used to:

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

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

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

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

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

J. Improvement Model And Methodology

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

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

The model has two parts:

1. ***Three fundamental questions, which can be addressed in any order.***
    - What are we trying to accomplish?

- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

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

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

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

Step 1: Plan

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

Step 2: Do

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

Step 3: Study

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

Summarize and reflect on what was learned.

Step 4: Act

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

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

3. ***Goal Setting and Auditing Methodology***

   a. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part

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

S – Specific

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

M – Measurable

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

A – Achievable

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

R – Relevant

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

T – Time-Bound

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

b. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample

size to ensure the auditing has encompassed the correct % of needed audit to be statically valid. Measure of Success (MOS) auditing process has specified the following minimums:

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

K. Performance Improvement and the El Camino Health Operating System

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

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

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

ECHOS: El Camino Health Operating System

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

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

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

local and large cross-functional processes to be improved and even transformed

L. Quality improvement Link With Organizational Goals

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

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

True North Pillar	OBJECTIVES/OUTCOMES	Measurement Defined		
		Minimum	Target	Stretch
Threshold	Return to, and maintain positive EBIDA	≥ 3% EBIDA		
Quality and Safety	Serious Safety Event (SSEs) Rate	5.0	4.0	3.6
	Readmission Index	0.96	0.93	0.915
	Medical Network: HEDIS Composite Score	2.75	3.0	3.2
Service	Likelihood to Recommend (LTR) – Inpatient	83.1	83.6	85.2
	LTR – Emergency Department	76.4	78.2	80.7
	LTR – El Camino Health Medical Network	72.9	75.9	78.9
Finance	Operating EBIDA margin	90% of Budget	100% of Budget	110% of Budget

M. Commitment to Patient Experience

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

N. Allocation of Resources

The CEO and the Senior Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee,

Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities will be provided through monies allocated in expense budgets. Budgetary planning shall include resources for effective information systems, when appropriate.

O. Confidentiality

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

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

P. Annual Evaluation

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

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

Cross References:

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

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

Attachments

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

Attachment E: Quarterly Board Quality Dashboard STEEEP 2.2021
Attachment D: Org Goals and Quality FY21
Attachment A: Information Flow QA-PI-PS Plan 2021
Attachment B: Combined Quality Council Reporting Calendar FY21
Attachment C: Patient and Employee Safety Dashboard FY21

El Camino Health

Summary of Financial Operations

Fiscal Year 2021 – Period 12

7/1/2020 to 06/30/2021

Executive Summary - Overall Commentary for Period 12

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

Operational / Financial Results: Period 12 – June 2021 (as of 6/30/2021)

PERIOD 12 - RESULTS

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians 'A1'	Moody's Medians 'Aa3'	Performance to 'A1' Medians
Activity / Volume	ADC	269	234	35	15.0%	212	57	26.9%	---	---	---
	Total Discharges	1,789	1,586	203	12.8%	1,425	364	25.5%	---	---	---
	Adjusted Discharges	3,415	2,924	491	16.8%	2,791	624	22.4%	---	---	---
	Emergency Room Visits	5,620	4,440	1,180	26.6%	4,006	1,614	40.3%	---	---	---
	OP Procedural Cases	12,733	8,353	4,380	52.4%	10,289	2,444	23.8%	---	---	---
	Gross Charges ($)	408,078	314,599	93,479	29.7%	308,375	99,703	32.3%	---	---	---
Operations	Total FTEs	2,924	2,744	180	6.6%	2,668	256	9.6%	---	---	---
	Productive Hrs. / APD	28.4	31.9	(3.5)	(11.0%)	32.2	(3.8)	(11.8%)	---	---	---
	Cost Per CMI Adjusted Discharge	16,225	17,111	(886)	(5.2%)	15,743	482	3.1%	---	---	---
	Net Days in A/R	50.0	49.0	1.0	2.0%	51.9	(1.9)	(3.6%)	47.7	47.1	
Financial Performance	Net Patient Revenue ($)	112,238	82,074	30,165	36.8%	100,746	11,493	11.4%	106,723	257,000	
	Total Operating Revenue ($)	116,945	86,512	30,432	35.2%	108,768	8,177	7.5%	116,864	314,648	
	Operating Income ($)	**20,664**	**3,635**	**17,029**	468.5%	**31,695**	**(11,032)**	(34.8%)	**3,948**	**10,135**	
	Operating EBIDA ($)	**27,771**	**10,052**	**17,719**	176.3%	**37,522**	**(9,751)**	(26.0%)	**11,301**	**27,969**	
	Net Income ($)	40,705	6,968	33,737	484.2%	50,672	(9,967)	(19.7%)	8,219	18,726	
	Operating Margin (%)	**17.7%**	**4.2%**	**13.5%**	320.6%	**29.1%**	**(11.5%)**	(39.4%)	**2.9%**	**3.6%**	
	Operating EBIDA (%)	**23.7%**	**11.6%**	**12.1%**	104.4%	**34.5%**	**(10.8%)**	(31.2%)	**9.7%**	**8.9%**	
	DCOH (days)	388	264	124	47.0%	313	75	24.0%	254	264	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect monthly averages.
DCOH total includes cash, short-term and long-term investments.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Operational / Financial Results: Pre-Audit YTD FY2021 (as of 6/30/2021)

YTD FY2021 - RESULTS

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians 'A1'	Moody's Medians 'Aa3'	Performance to 'A1' Medians
Activity / Volume	ADC	245	211	34	16.2%	227	18	7.9%	---	---	---
	Total Discharges	19,157	17,351	1,806	10.4%	18,966	191	1.0%	---	---	---
	Adjusted Discharges	36,226	32,156	4,070	12.7%	35,326	900	2.5%	---	---	---
	Emergency Room Visits	52,059	45,202	6,857	15.2%	56,334	(4,275)	(7.6%)	---	---	---
	OP Procedural Cases	160,728	95,074	65,654	69.1%	106,245	54,483	51.3%	---	---	---
	Gross Charges ($)	4,309,257	3,427,558	881,699	25.7%	3,648,324	660,933	18.1%	---	---	---
Operations	Total FTEs	2,841	2,620	221	8.4%	2,763	79	2.8%	---	---	---
	Productive Hrs. / APD	31.0	33.7	(2.8)	(8.2%)	32.6	(1.6)	(4.9%)	---	---	
	Cost Per CMI Adjusted Discharge	16,815	18,201	(1,385)	(7.6%)	17,243	(428)	(2.5%)	---	---	
	Net Days in A/R	50.0	49.0	1.0	2.0%	51.9	(1.9)	(3.6%)	47.7	47.1	
Financial Performance	Net Patient Revenue ($)	1,107,911	893,139	214,772	24.0%	982,696	125,215	12.7%	1,280,670	3,083,998	
	Total Operating Revenue ($)	1,156,342	947,971	208,371	22.0%	1,038,489	117,854	11.3%	1,402,368	3,775,777	
	Operating Income ($)	**87,244**	**(23,735)**	**110,979**	467.6%	**57,017**	**30,227**	53.0%	**47,381**	**121,614**	
	Operating EBIDA ($)	**170,690**	**55,823**	**114,867**	205.8%	**120,447**	**50,243**	41.7%	**135,606**	**335,624**	
	Net Income ($)	328,083	11,770	316,313	2687.4%	109,274	218,809	200.2%	98,622	224,710	
	Operating Margin (%)	**7.5%**	**(2.5%)**	**10.0%**	401.3%	**5.5%**	**2.1%**	37.4%	**2.9%**	**3.6%**	
	Operating EBIDA (%)	**14.8%**	**5.9%**	**8.9%**	150.7%	**11.6%**	**3.2%**	27.3%	**9.7%**	**8.9%**	
	DCOH (days)	388	264	124	47.0%	313	75	24.0%	254	264	

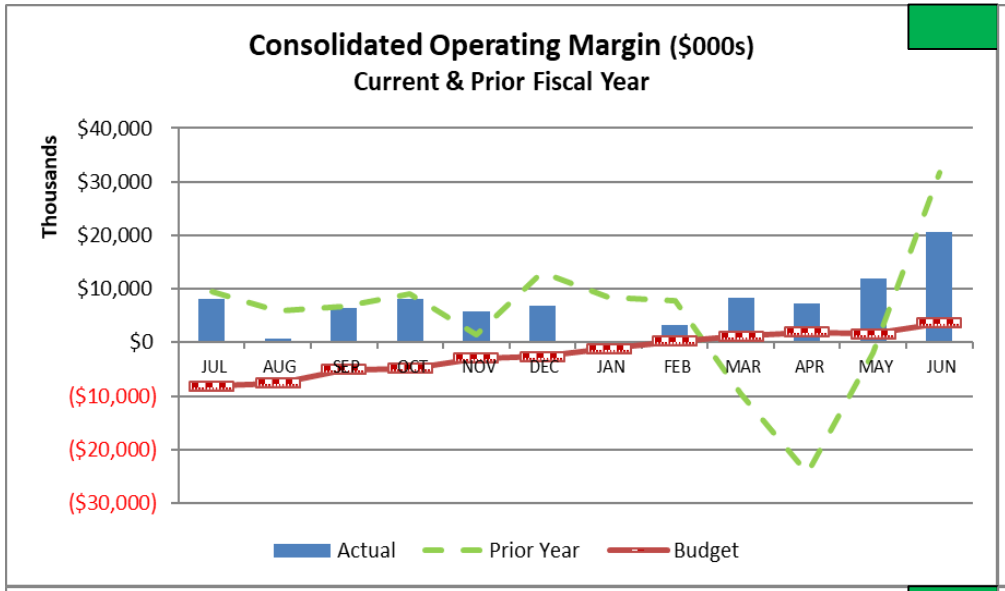
Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020.
DCOH total includes cash, short-term and long-term investments.

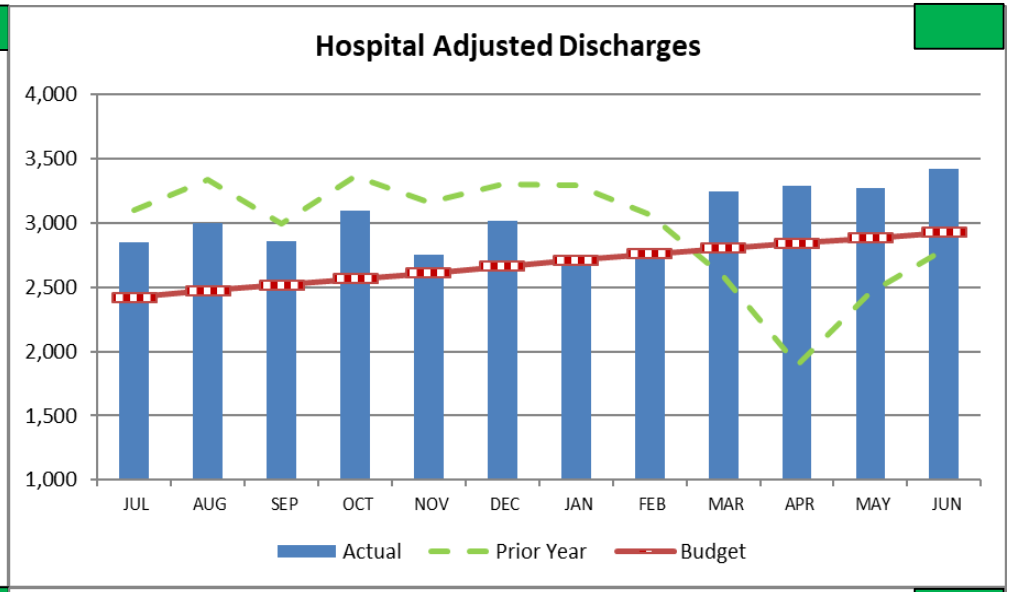
El Camino Health

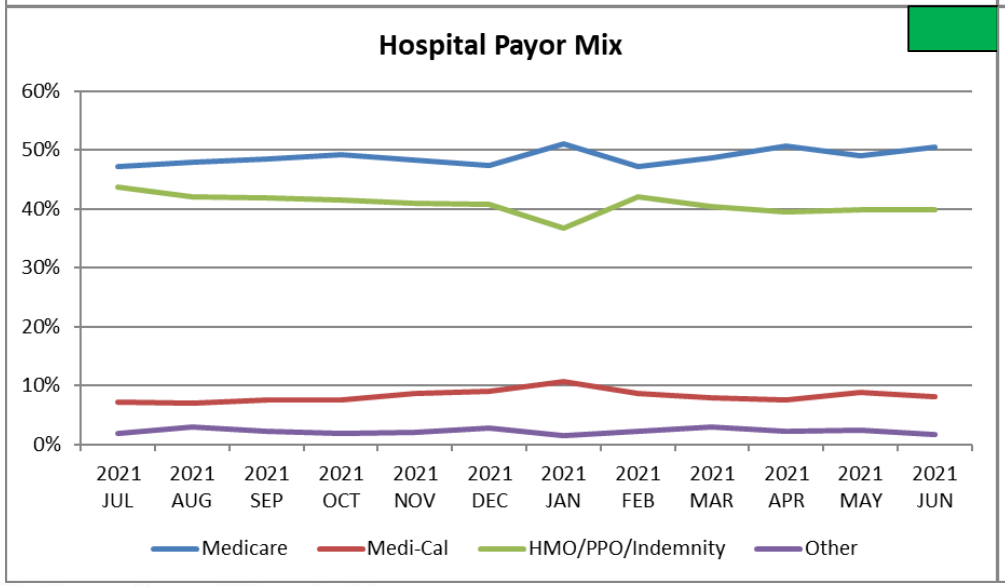
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

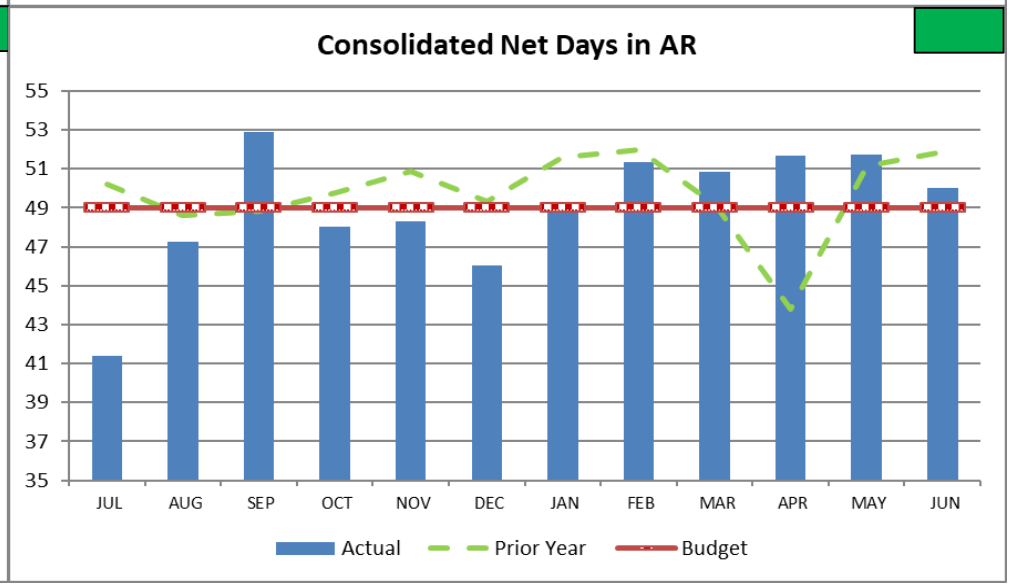
APPENDIX

YTD FY2021 Financial KPIs – Monthly Trends









El Camino Health

Period 12 and Pre-Audit YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 6/30/2021)

($000s)

	Period 12- Month			Period 12- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	19,736	4,538	15,198	91,033	(5,232)	96,266
Los Gatos	3,963	1,675	2,287	33,913	17,852	16,060
Sub Total - El Camino Hospital, excl. Afflilates	**23,698**	**6,213**	**17,485**	**124,946**	**12,620**	**112,326**
Operating Margin %	**21.4%**	**7.7%**		**11.4%**	**1.4%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**18,886**	**3,028**	**15,858**	**231,276**	**31,858**	**199,418**
El Camino Hospital Net Margin	**42,584**	**9,242**	**33,343**	**356,222**	**44,478**	**311,744**
ECH Net Margin %	**38.4%**	**11.5%**		**32.5%**	**5.1%**	
Concern	90	36	54	485	369	116
ECSC	0	0	0	(3)	0	(3)
Foundation	829	30	799	6,986	(159)	7,145
El Camino Health Medical Network	(2,798)	(2,339)	(459)	(35,607)	(32,917)	(2,689)
Net Margin Hospital Affiliates	**(1,879)**	**(2,273)**	**394**	**(28,138)**	**(32,707)**	**4,569**
Total Net Margin Hospital & Affiliates	**40,705**	**6,968**	**33,737**	**328,083**	**11,770**	**316,313**

Pre-Audit Consolidated Balance Sheet (as of 06/30/2021)

($000s)

ASSETS

CURRENT ASSETS	June 30, 2021	Audited June 30, 2020
Cash	151,641	228,464
Short Term Investments	284,262	221,604
Patient Accounts Receivable, net	166,283	128,564
Other Accounts and Notes Receivable	9,540	13,811
Intercompany Receivables	15,116	72,592
Inventories and Prepaids	23,079	101,267
Total Current Assets	**649,921**	**766,303**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	20,932	15,364
Plant & Equipment Fund	258,191	166,859
Women's Hospital Expansion	30,401	22,563
Operational Reserve Fund	123,838	148,917
Community Benefit Fund	18,412	17,916
Workers Compensation Reserve Fund	16,482	16,482
Postretirement Health/Life Reserve Fund	30,658	30,731
PTO Liability Fund	32,498	27,515
Malpractice Reserve Fund	1,977	1,919
Catastrophic Reserves Fund	24,874	17,667
Total Board Designated Assets	**558,264**	**465,933**
FUNDS HELD BY TRUSTEE	**5,694**	**23,478**
LONG TERM INVESTMENTS	**603,211**	**372,175**
CHARITABLE GIFT ANNUITY INVESTMENTS	**728**	**680**
INVESTMENTS IN AFFILIATES	**34,170**	**29,065**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,799,463	1,342,012
Less: Accumulated Depreciation	(742,921)	(676,535)
Construction in Progress	94,236	489,848
Property, Plant & Equipment - Net	**1,150,778**	**1,155,326**
DEFERRED OUTFLOWS	21,444	21,416
RESTRICTED ASSETS	29,332	28,547
OTHER ASSETS	86,764	3,231
TOTAL ASSETS	**3,140,306**	**2,866,153**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	June 30, 2021	Audited June 30, 2020
Accounts Payable	39,762	35,323
Salaries and Related Liabilities	50,039	35,209
Accrued PTO	33,197	28,124
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	12,990	10,956
Intercompany Payables	14,704	70,292
Malpractice Reserves	1,670	1,560
Bonds Payable - Current	9,430	9,020
Bond Interest Payable	8,293	8,463
Other Liabilities	16,953	3,222
Total Current Liabilities	**189,338**	**204,469**
LONG TERM LIABILITIES		
Post Retirement Benefits	30,658	30,731
Worker's Comp Reserve	17,002	16,482
Other L/T Obligation (Asbestos)	6,227	4,094
Bond Payable	479,621	513,602
Total Long Term Liabilities	**533,509**	**564,908**
DEFERRED REVENUE-UNRESTRICTED	**67,576**	**77,133**
DEFERRED INFLOW OF RESOURCES	**28,009**	**30,700**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,097,010	1,771,854
Board Designated	193,782	188,457
Restricted	31,082	28,631
Total Fund Bal & Capital Accts	**2,321,874**	**1,988,942**
TOTAL LIABILITIES AND FUND BALANCE	**3,140,306**	**2,866,153**

El Camino Health

El Camino Health

CONFIDENTIAL

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital □oard of □irectors
From: □an □ oods□CEO
Date: August 18□2021
Subject: □overnance □est Practices

Purpose:

Introduce Spencer Stuart□an outside consulting firm□to clarify o□□ectives□e□pected outcomes/approach and outline the process/timeline of the □overnance assessment to □e conducted for □iscal □ear 2021□2022.

Summary:

1. Situation: □he Hospital □oard of □irectors □ill utili□e the services of an independent consulting firm to conduct a □overnance assessment to promote optimal processes and practices.

2. Authority: Per its Charter□the Hospital □oard of □irectors □ill conduct a revie□ of all □oard and Committee processes to gauge effective governance.

3. □ac□ground: □he □overnance assessment □ill revie□ the actions ta□en □y the El Camino Hospital □oard of □irectors to address Strategic Planning□Operational □opics□Corporate □overnance □ atters□Administrative □ atters and □ ritten Reports. □he assessment □ill include□□ut not □e limited to□□irector and □ anagement intervie□s.

4. Assessment: □or discussion □y the Committee.

5. Other Revie□s: □/A

6. Outcomes: □/A

List of Attachments:

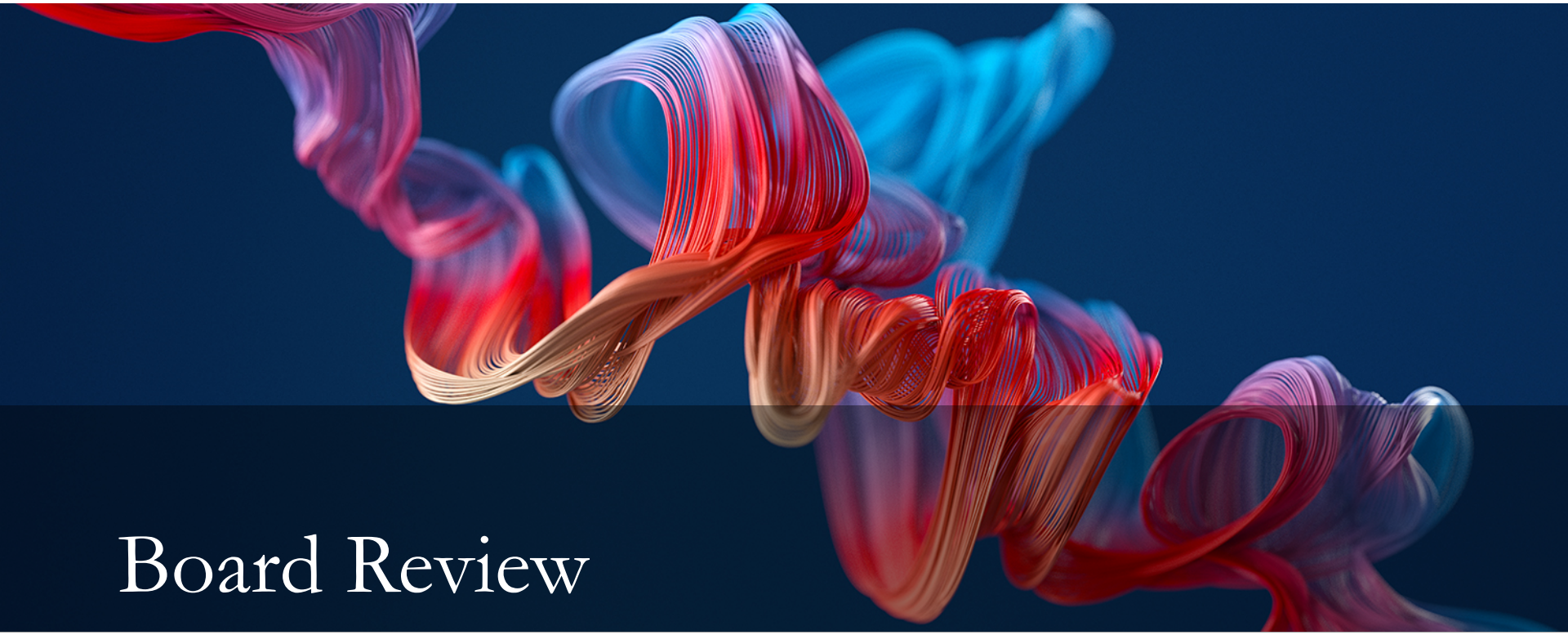
1. El Camino Hospital □oard Revie□ – 1st □ear □ ilestones

Suggested Committee Discussion Questions:

1. □one

SpencerStuart

El Camino Health

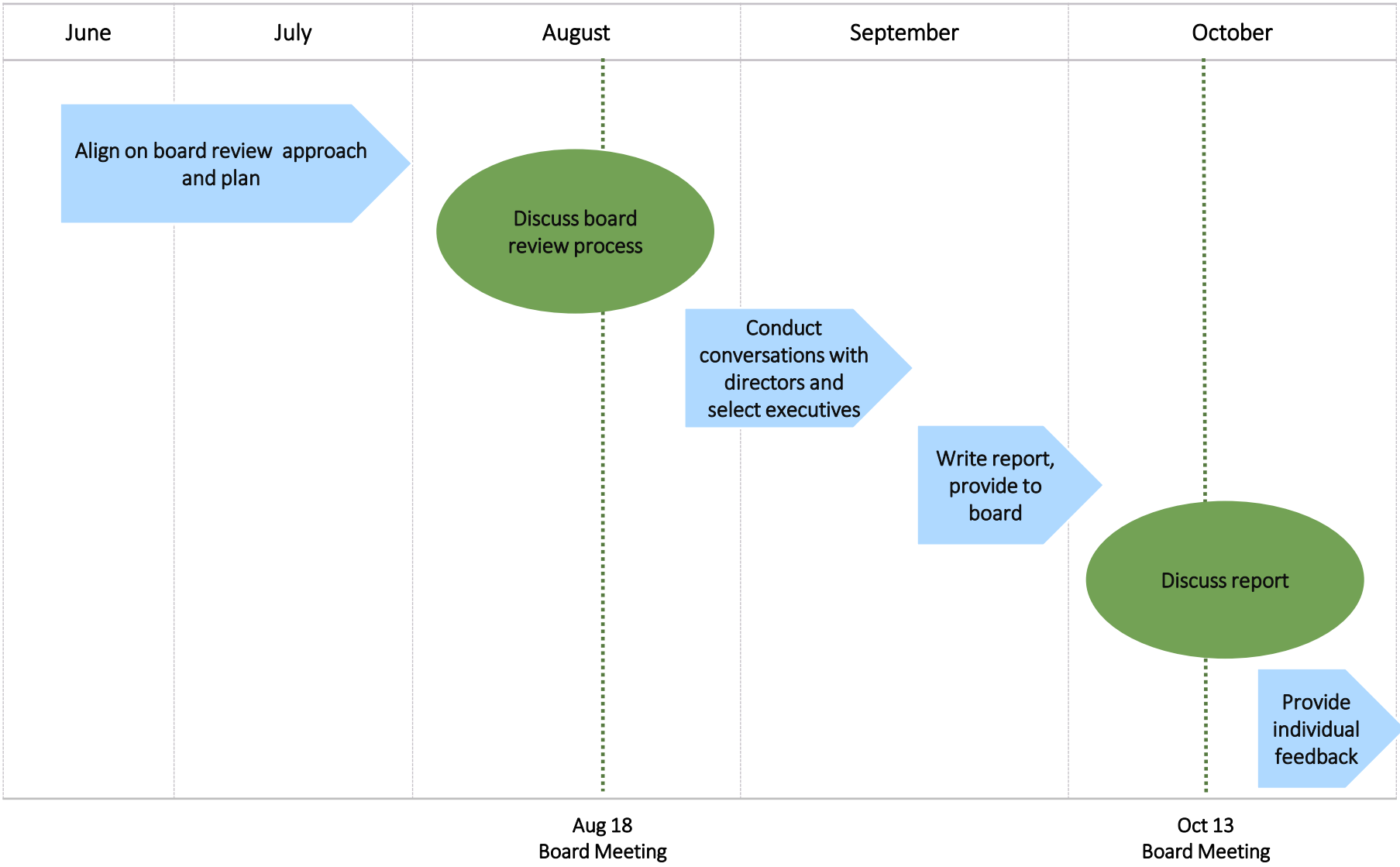


Board Review

George Anderson
Phil Dawes
Jennifer Heenan
Megan Kurtz

August 18, 2021

El Camino Hospital Board Review – 1st Year Milestones



El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, June 23, 2021

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

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair **Peter C. Fung, MD** **Julie Kliger, MPA, BS** **Julia E. Miller,** Secretary/reasurer **Jack Po, MD, Ph.D.** **Bob Rebitzer** **George O. Ting, MD** **Carol A. Somersille, MD** **Don Watters**** **John Zoglin**ice Chair	one ****via teleconference	one

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	he open session meeting of the oard of irectors of El Camino Hospital (the "Board") as called to order at 5:30 pm y Chair Chen. A ver al roll call as ta en. irector atters oined the meeting at 5:39 pm during Pu lic Communication and irector Po oined the meeting at 5:44 pm during the Quality Committee Report. All other oard mem ers ere present at roll call. Chair Chen revie ed the logistics for the meeting. A uorum as present pursuant to State of California E ecutive Orders 25 20 dated arch 12 2020 and 29 20 dated arch 18 2020.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen as ed if any oard mem ers have a conflict of interest ith any of the items on the agenda. o conflicts ere noted.	
3. PUBLIC COMMUNICATION	one.	
4. QUALITY COMMITTEE REPORT	r. eorge O. ing opens y sharing a patient story from the Quality Committee eeting in hich the patient shared some pro lems they had e perienced hile a aiting surgery on the ountain ie campus hich included aiting more than tolera le and difficulty convincing the nurse a out her dosing amounts (given she as a type one dia etic). Ho ever she also shared that aside from those t o areas of friction she had an overall positive e perience and that she ould not hesitate to recommend the hospital. He also discusses the readmission data collected over the past five years hich has een categori ed into seven different areas that C S uses to score the HRRP (hospital readmission reduction penalty program). He noted three items that ere o served more than e pected ut also noted there is no pattern et een them and had nothing to do ith the care eing received. irector ing discusses the highlights the patient safety indicators for the third uarter as presented y r. ar Adams C O during the uality committee meeting: • He dra s attention to the si cases involving pressure ulcers in the	

	□uarter. Each one □as revie□ed for root cause and several of them involved CO□I□ patients□the □ay the o□ygen mas□is inserted□and the pressure from it that is placed on to them □hich is causing the ulcers. □ He spea□s a□out the five cases of hemorrhage and hematoma and mentions that no pattern could □e o□served at the moment and that more occurrences □ould □e follo□ed closely. □ □irector □ing also touched on the t□o cases of acrogenic pneumothora□ □hich derived from the same patient. □he patient ended up doing o□. □ He discussed the vaginal in□ury due to trauma during child□irth□so there is an ongoing discussion □ith maternal child health medical leadership. □he instances put the hospital over the normal threshold□and there are various hypotheses as to □hy this occurred □ut none definitive. He also touches on the □uality assurance and performance improvement plan □hich descri□es the structure□functions□and peer revie□ processes that go into the □uality concerns. He states that there is a □oint commission that revie□s this every three years and that they are due this year□so a lot of time has □een spent loo□ing at this. □r. Shreyas □ allur□□ .□. □opens the discussion for □uestions that he could address given that □r. Adams □as not present at the meeting. □irector □ iller as□ed for further comment on the increase in the mortality and readmission rates. In response to Director Miller's question, □r. □ allur states that the readmission has □een trending do□n□ards overall throughout the year□and the increase is attri□uted to the CO□I□ patients that came □ac□ □et□een □anuary and □ arch. He also discusses the mortality inde□and that some of it □as attri□uted to CO□I□ patients□□ut that there □as also an increase in the sepsis inde□ □hich is a □ig driver of the inde□. □irector Somersille in□uired if there has □een a specific population that has □een e□periencing this and □hether any thought or initiative to doing a pro□ect or study of some sort in regards to the vaginal trauma during child□irth. □r. □ allur addresses that in addition to the Asian population e□periencing vaginal trauma□the South Asian population also has huge increases and that the □epartment of □ aternal Child Health is loo□ing at this very closely. He also mentions that there is no specific case study or pro□ect □eing conducted□and instead trends □ere □eing identified among different hospitals□□ut that they could □ring this idea □ac□to the □epartment of □ aternal Child Health. □irector □oglin in□uired if there is a ECH□ □ e□uivalent of the research. □irector □ing states that there is no one right no□ □□ut that it is in the □or□s□and the information surrounding it is e□tremely minimal. □irector □liger also adds that there is minimal information surrounding this as well and hasn't seen this item being driven but that it could be added to the agenda to at least create a plan. □an □ oods□CEO□agrees that □ith □irector □liger and that the same	

	structure as the enterprise □uality plan could □e used to develop this. □irector □ung as□s a□out □hether inpatient data could □ecome availa□le in the □uality committee reports□and □hy are □e only revie□ing outpatient data. □ r. □ oods□comments that □irector □ung □rings up a really valid concern□ and that the □est place to start □ith this □ould □e to emphasi□e focus on the service lines and start □uilding data from there. □irector Somersille made a correction to the □uality improvement of patient safety plan in the medical staff and department's division surgery. She addresses that it should read gynecologic surgery instead gynecologic oncology.	
5. FY21 PERIOD 10 FINANCIALS	Carlos □ohor□ue□□C□O□starts a □rief discussion □y sharing results from the month of April in □hich he notes that it □as an overall strong month from a volume and activity standpoint □hich is attri□uted to the rate of vaccination and the increase in volume of procedural cases as restrictions ease up. He also noted a strong operating margin □hich indicates a very strong recovery and sta□ility for the months to come. He additionally touches on the □uality mortality rate indicating that the C□ I has increased□ meaning that less patients are coming in to the organi□ation□□ut that they are receiving care a little □it later. He mentions that the one item that is not fully recovered yet is the E□ □ith strong activity in the month of □ ay and □une□ho□ever patients are still s□eptical a□out receiving care in general. He notes that despite the challenges and costs associated □ith CO□I□□the organi□ation is on a sta□le and strong path to recovery. **Movant**: □ atters **Second**: □oglin **Ayes**: Chen□□ung□□liger□□ iller□Po□Re□it□er□Somersille□□ing□□ atters□ □oglin **Noes**: □one **Abstentions**: □one **Absent**: □one **Recused**: □one	***FY21 Period 10 Financials approved***
6. ADJOURN TO CLOSED SESSION	**Motion:** □o ad□ourn to closed session at 5:57 pm pursuant to *Gov't Code Section 54957.2* for approval of the □ inutes of the Closed Session of the Hospital □oard □ eeting (05/12/2021)□□ inutes of the Closed Session of the Hospital □oard □ eeting (05/22/2021)□and □□22 Individual E□ecutive Performance Incentive □oals□pursuant to *Health and Safety Code Section 32155* for a report of the □ edical Staff□deli□erations concerning reports on □ edical Staff □uality assurance matters: Quality Committee Report (□ edical Staff Credentials and Privileges Report□Quality Council □ inutes)□pursuant to *Health and Safety Code Section 32155* for a report of the □ edical Staff□deli□erations concerning reports on □ edical Staff □uality assurance matters: □ edical Staff Report□pursuant to *Gov't Code Section 54957.6* for a report and discussion on personnel matters: Potential Amendment to CEO Employment Agreement□pursuant to *Gov't Code Section 54956.9* for a report and discussion on personnel matters: E□ecutive Performance Incentive □enefit Plan □esign□pursuant to *Gov't Code Section 54957.6* for a report and discussion on personnel matters: Proposed CQO Salary Range□pursuant to *Health and Safety Code Section 32106(b)* for a	***Adjourned to closed session at 5:57 pm***

	report and discussion involving healthcare facility trade secrets: Anesthesia Professional Services Agreement□pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: □□22 Strategic □ etrics and □oals□pursuant to *Gov't Code Section 54956.9(d)(2)* – conference □ith legal counsel – pending or threatened litigation and *Gov't Code Section 54957* and *54957.6* for a discussion and report on personnel matters: CEO Report on □egal Services and Personnel □ atters□and pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior □ anagement: E□ecutive Session. **Movant:** □ iller **Second:** □ing **Ayes:** Chen□□ung□□liger□□ iller□Po□Re□it□er□Somersille□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	
7. AGENDA ITEM 15/16: RECONVENE OPEN SESSION/ REPORT OUT	Open session □as reconvened at 8:35 pm □y Chair Chen. Agenda Items 7□ 14 □ere addressed in closed session. □uring the closed session□the □oard approved the □ inutes of the Closed Session of the Hospital □oard □ eeting (05/12/2021 & 5/22/21)□□□ 22 Individual E□ecutive Performance Incentive □oals□Quality Committee Report□including the □ edical Staff Credentials and Privileges Report□and the Annual Summary of Physician □inancials □y a unanimous vote in favor of all mem□ers present and participating in the meeting (□irectors Chen□ □ung□□liger□□ iller□Po□Re□it□er□Somersille□□ing□and □ atters).	
8. AGENDA ITEM 17: CONSENT CALENDAR	Chair Chen as□ed if any mem□er of the □oard or the pu□lic □ished to remove an item from the consent calendar. □o items □ere removed. **Motion:** □o approve the consent calendar: □ inutes of the Open Session of the Hospital □oard □ inutes (05/22/21)□□□22 □ aster Calendar□□□22 Committee □oals□□□22 Committee and □iaisons Appointments□□□22 Community □enefit Plan□Anesthesia Professional Services Agreement□ Revie□ed and Recommended for Approval □y the □inance Committee□ □□21 Period 9 □inancials□Infection Control □ edical □irector Agreement□ Revie□ed and Recommended for Approval □y the □ edical E□ecutive Committee□□ edical Staff Report Information□□ □ □ a□or Pro□ects □pdate **Movant:** Chen **Second:** □ atters **Ayes:** Chen□□ung□□liger□□ iller□Po□Re□it□er□Somersille□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Consent calendar approved***
9. AGENDA ITEM 18: CONSIDERATION OF BENEFITS COVERAGE FOR	Agenda Item □ill □e deferred to a later date.	

BOARD MEMBERS RECLASSIFIED AS W-2 EMPLOYEES FOR IRS PURPOSES		
10. AGENDA ITEM 19: CEO REPORT	□an □ oods□CEO□reported on participation in □ agnet4Europe research pro□ect□achieving Healthgrades 2021 Outstanding Patient E□perience A□ard□CO□I□□19 vaccination partnership □ith □oogle□launch of Employee □oice Survey□and the holding of □a□ing □ ing cele□ration.	
11. AGENDA ITEM 20: BOARD COMMENTS	□one.	
12. AGENDA ITEM 21: ADJOURNMENT	**Motion**: □o ad□ourn at 8:43pm. **Movant: Chen** **Second:** □ atters **Ayes:** Chen□□ung□□liger□□ iller□Po□Re□it□er□Somersille□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Meeting adjourned at 8:43pm***

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

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□

□anhee Chen
Chair□ECH □oard of □irectors

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□

□ulia E. □ iller
Secretary□ECH □oard of □irectors

Prepared □y: Shira□Ali□□irector

El Camino Health

Summary of Financial Operations

Fiscal Year 2021 – Period 11

7/1/2020 to 05/31/2021

Executive Summary - Overall Commentary for Period 11

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

Operational / Financial Results: Period 11 – May 2□21 (as of □/31/2□21)

($ thousands)

		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians		Performance to "A1" Medians
									"A1"	"Aa3"	
Activity / Volume	ADC	254	223	31	13.7%	197	57	29.2%	---	---	---
	Total Discharges	1,724	1,562	162	10.4%	1,359	365	26.9%	---	---	---
	Adjusted Discharges	3,270	2,883	387	13.4%	2,455	814	33.2%	---	---	---
	Emergency Room Visits	4,601	4,319	282	6.5%	3,036	1,565	51.5%	---	---	---
	OP Procedural Cases	13,397	8,282	5,115	61.8%	7,199	6,198	86.1%	---	---	---
	Gross Charges ($)	381,888	309,389	72,498	23.4%	253,514	128,374	50.6%	---	---	---
Operations	Total FTEs	2,919	2,692	227	8.4%	2,625	294	11.2%	---	---	---
	Productive Hrs. / APD	30.9	32.8	(1.9)	(5.7%)	36.3	(5.4)	(14.8%)	---	---	---
	Cost Per CMI Adjusted Discharge	15,165	17,507	(2,343)	(13.4%)	19,528	(4,363)	(22.3%)	---	---	---
	Net Days in A/R	51.7	49.0	2.7	5.6%	51.1	0.6	1.2%	47.7	47.1	
Financial Performance	Net Patient Revenue ($)	95,542	80,704	14,838	18.4%	70,930	24,612	34.7%	106,723	257,000	
	Total Operating Revenue ($)	100,927	85,201	15,726	18.5%	74,480	26,447	35.5%	116,864	314,648	
	Operating Income (□)	**11,□21**	**1,□4□**	**1□,2□3**	623.5%	**(1,□□□)**	**13,□□□**	700.6%	**3,□4□**	**1□,13□**	
	Operating EBIDA (□)	**1□,13□**	**□,□□2**	**1□,□4□**	124.3%	**2,□□□**	**1□,□□4**	609.4%	**11,3□1**	**2□,□□□**	
	Net Income ($)	28,588	4,981	23,606	473.9%	22,981	5,607	24.4%	8,219	18,726	
	Operating Margin (□)	**11.□□**	**1.□□**	**□.□□**	510.7%	**(2.□□)**	**14.□□**	543.2%	**2.□□**	**3.□□**	
	Operating EBIDA (□)	**1□.□□**	**□.□□**	**□.□□**	89.4%	**3.4□**	**14.□□**	423.5%	**□.□□**	**□.□□**	
	DCOH (days)	580	435	144	33.1%	498	82	16.4%	254	264	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect monthly averages.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Operational / Financial Results: YTD FY2□21 (as of □/31/2□21)

($ thousands)

		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody□s Medians		Performance to □A1□ Medians
									□A1□	□Aa3□	
Activity / Volume	ADC	242	209	34	16.3%	228	14	6.4%	---	---	---
	Total Discharges	17,368	15,765	1,603	10.2%	17,541	(173)	(1.0%)	---	---	---
	Adjusted Discharges	32,789	29,232	3,557	12.2%	32,535	254	0.8%	---	---	---
	Emergency Room Visits	46,439	40,762	5,677	13.9%	52,328	(5,889)	(11.3%)	---	---	---
	OP Procedural Cases	147,978	95,074	52,904	55.6%	106,245	41,733	39.3%	---	---	---
	Gross Charges ($)	3,901,178	3,112,958	788,220	25.3%	3,339,949	561,230	16.8%	---	---	---
Operations	Total FTEs	2,834	2,609	225	8.6%	2,771	63	2.3%	---	---	---
	Productive Hrs. / APD	31.2	33.9	(2.7)	(8.0%)	32.6	(1.4)	(4.2%)	---	---	---
	Cost Per CMI Adjusted Discharge	16,876	18,300	(1,424)	(7.8%)	17,379	(503)	(2.9%)	---	---	---
	Net Days in A/R	51.7	49.0	2.7	5.6%	51.1	0.6	1.2%	47.7	47.1	
Financial Performance	Net Patient Revenue ($)	995,673	811,065	184,608	22.8%	881,951	113,722	12.9%	1,173,948	2,826,998	
	Total Operating Revenue ($)	1,039,398	861,459	177,939	20.7%	929,721	109,677	11.8%	1,285,504	3,461,129	
	Operating Income (□)	□□,□□□	**(2□,3□□)**	**□3,□□□**	343.3%	**2□,321**	**41,2□□**	162.9%	**43,433**	**111,4□□**	
	Operating EBIDA (□)	**142,□1□**	**4□,□□1**	**□□,14□**	212.2%	**□2,□2□**	**□□,□□3**	72.3%	**124,3□□**	**3□□,□□□**	
	Net Income ($)	287,378	4,802	282,577	5884.6%	58,603	228,776	390.4%	90,404	205,984	
	Operating Margin (□)	**□.4□**	**(3.2□)**	**□.□□**	301.6%	**2.□□**	**3.□□**	135.2%	**2.□□**	**3.□□**	
	Operating EBIDA (□)	**13.□□**	**□.3□**	**□.4□**	158.8%	**□.□□**	**4.□□**	54.2%	**□.□□**	**□.□□**	
	DCOH (days)	580	435	144	33.1%	498	82	16.4%	254	264	

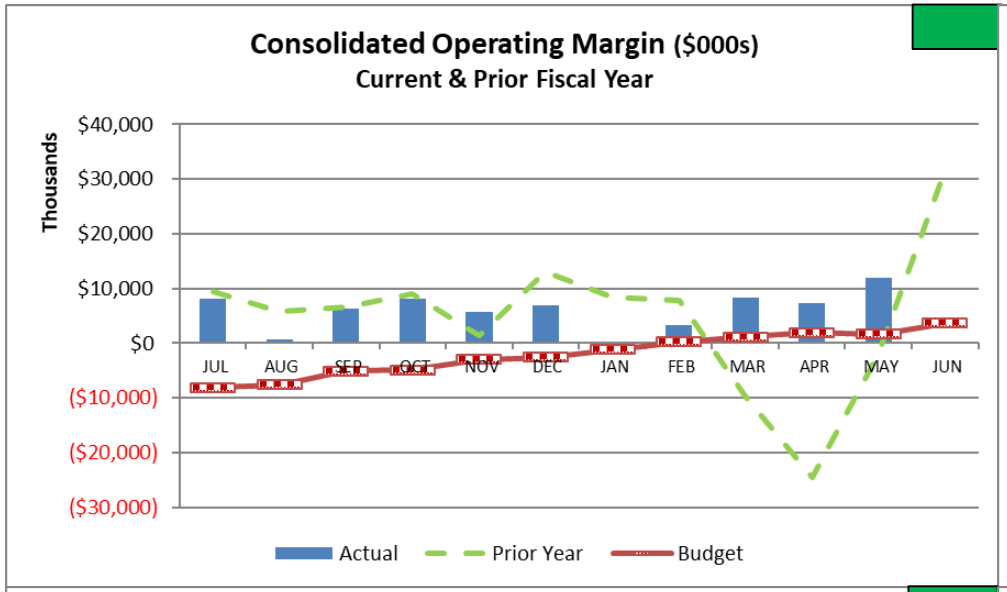
Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2020. Dollar amounts have been adjusted to reflect 11 month totals.

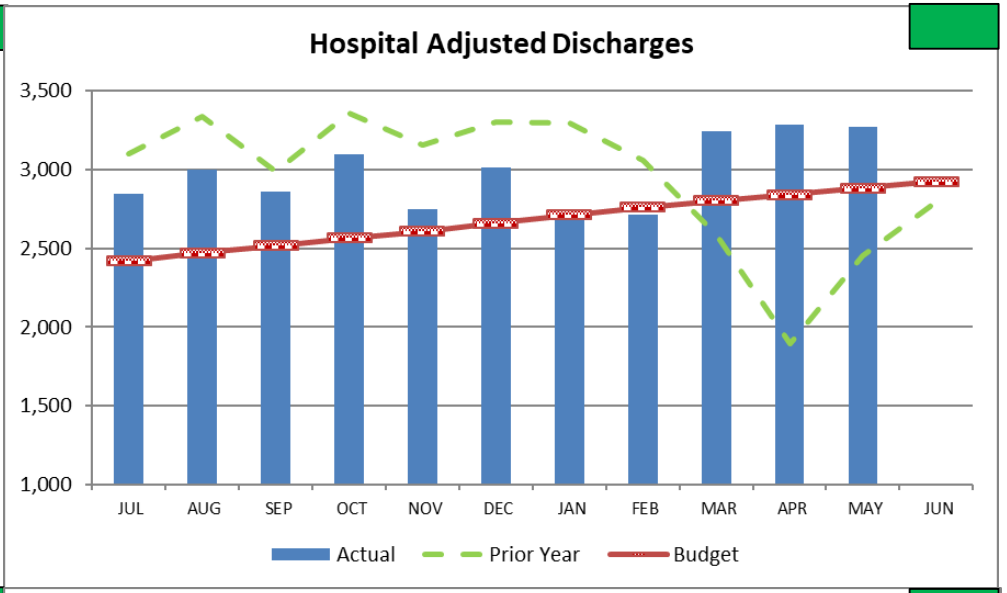
El Camino Health

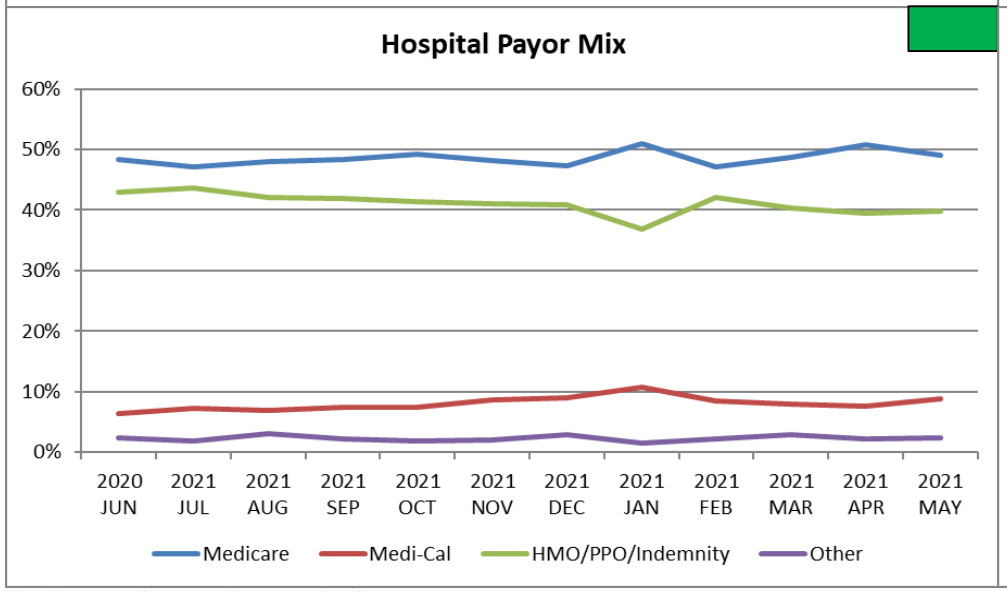
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

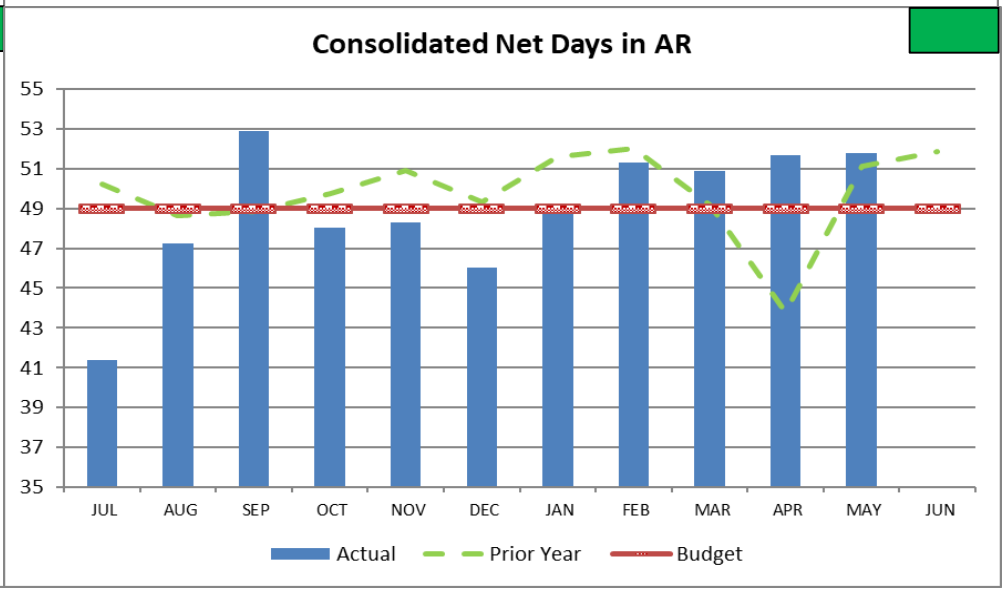
APPENDI□

YTD FY2□21 Financial KPIs – Monthly Trends









El Camino Health

Period 11 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of □/31/2□21)

($000s)

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

Consolidated Balance Sheet (as of □□/31/2□21)

($000s)

ASSETS

CURRENT ASSETS	May 31, 2021	Audited June 30, 2020
Cash	124,049	228,464
Short Term Investments	296,066	221,604
Patient Accounts Receivable, net	161,773	128,564
Other Accounts and Notes Receivable	3,744	13,811
Intercompany Receivables	20,565	72,592
Inventories and Prepaids	23,528	101,267
Total Current Assets	**629,725**	**766,303**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	19,868	15,364
Plant & Equipment Fund	245,596	166,859
Women's Hospital Expansion	30,401	22,563
Operational Reserve Fund	123,838	148,917
Community Benefit Fund	19,683	17,916
Workers Compensation Reserve Fund	16,482	16,482
Postretirement Health/Life Reserve Fund	31,728	30,731
PTO Liability Fund	32,007	27,515
Malpractice Reserve Fund	1,964	1,919
Catastrophic Reserves Fund	25,249	17,667
Total Board Designated Assets	**546,815**	**465,933**
FUNDS HELD BY TRUSTEE	**7,083**	**23,478**
LONG TERM INVESTMENTS	**585,321**	**372,175**
CHARITABLE GIFT ANNUITY INVESTMENTS	**734**	**680**
INVESTMENTS IN AFFILIATES	**33,928**	**29,065**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,785,242	1,342,012
Less: Accumulated Depreciation	(737,181)	(676,535)
Construction in Progress	101,904	489,848
Property, Plant & Equipment - Net	**1,149,965**	**1,155,326**
DEFERRED OUTFLOWS	21,175	21,416
RESTRICTED ASSETS	29,241	28,547
OTHER ASSETS	87,530	3,231
TOTAL ASSETS	**3,091,517**	**2,866,153**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	May 31, 2021	Audited June 30, 2020
Accounts Payable	24,350	35,323
Salaries and Related Liabilities	47,147	35,209
Accrued PTO	32,725	28,124
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	12,077	10,956
Intercompany Payables	20,582	70,292
Malpractice Reserves	1,565	1,560
Bonds Payable - Current	9,430	9,020
Bond Interest Payable	6,634	8,463
Other Liabilities	11,279	3,222
Total Current Liabilities	**168,091**	**204,469**
LONG TERM LIABILITIES		
Post Retirement Benefits	31,728	30,731
Worker's Comp Reserve	16,482	16,482
Other L/T Obligation (Asbestos)	6,294	4,094
Bond Payable	484,373	513,602
Total Long Term Liabilities	**538,876**	**564,908**
DEFERRED REVENUE-UNRESTRICTED	**72,199**	**77,133**
DEFERRED INFLOW OF RESOURCES	**28,009**	**30,700**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,059,433	1,771,854
Board Designated	193,881	188,457
Restricted	31,027	28,631
Total Fund Bal & Capital Accts	**2,284,342**	**1,988,942**
TOTAL LIABILITIES AND FUND BALANCE	**3,091,517**	**2,866,153**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors

From: Mary Adams, MD, FACS, Chief Medical Officer

Date: August 18, 2021

Subject: Mountain View Daytime Intensivist On-Call Professional Services Renewal Agreement

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

Summary:

1. Situation:

   - Palo Alto Medical Foundation ("PAMF") provides 12-hour on-site daytime (7:00 am to 7:00 pm) intensivist on-call professional services, plus on-call surge physician coverage 365 days per year at the rate of $1,980 per 12-hour shift, not to exceed $722,700 per year. In addition, ECH pays for the costs of each physician providing services to obtain ECMO training and certification in neurocritical care, not to exceed $1,200 per physician. The physicians under this arrangement have consistently provided excellent intensivist services, with fifteen physicians participating on the panel. The current agreement expires August 31, 2021.

   - Nighttime intensivist services (7:00 pm to 7:00 am) will continue to be provided by the same physicians who recently formed a group called El Camino Anesthesia. ECH is contracted with El Camino Anesthesia for nighttime intensivist services effective August 1, 2021, as approved by the ECH Board of Directors on June 23, 2021.

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

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

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

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

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

List of Attachments: None

Suggested Committee Discussion Questions: None

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD OF DIRECTORS MEETING MEMO

To: El Camino Hospital □oard of □irectors
From: Carlos □ohor□ue□□Chief □inancial Officer□□im □riffith□Chief Operating Officer
Date: August 18□2021
Subject: Satellite Healthcare □□oint □enture □unding Re□uest

Purpose:

At the August 9th □inance Committee meeting□management presented an overvie□ of the performance of the □oint □enture ('JV') □ith Satellite Healthcare and revie□ed the □usiness case for an investment in a ne□ □ialysis center located in □orth Sunnyvale.

1. Recommendation:

□he □inance Committee is recommending that the □oard of □irectors approve funding not to e□ceed □1.98 million for 30□ o□nership in the ne□ center and authori□e □an □ oods□CEO to e□ecute the operating and other agreements re□uired to enter into this ne□ □□ □ith Satellite Healthcare.

2. Summary:

a. Situation:

- □he follo□ing is an overvie□ of the □□ □ith Satellite Healthcare
  i. ECH entered into a □□ □ith Satellite Healthcare to operate outpatient □ialysis facilities in the community. □he □□ transaction □as completed in □e□ruary 2015.
  ii. □oth organi□ations meet □uarterly to revie□ operating□□uality□and financial metrics.
  iii. Satellite Healthcare's quality and patient satisfaction star ratings□as reported □y C□ S compare favora□ly to national averages.
  iv. □he □uality and financial performance of the □□ have □een at or close to performance targets. □ anagement continues to □or□ □ith Satellite Healthcare to ensure any measure(s) □hich are □elo□ target are an area of focus.

□. Authority: Policy re□uires that capital e□penditures e□ceeding □1 million need □inance Committee and □oard of □irectors approval.

c. □ac□ground: □ anagement has □een in discussion □ith Satellite Healthcare on an investment of □1.98□ for a 30□ o□nership of a ne□ center located in □orth Sunnyvale.

3. List of Attachments:

a. □one

4. Suggested Board Discussion Questions:

a. □oes the re□uest to invest in a ne□ center align □ith our strategy□

□. □ hen is the ne□ center e□pected to □egin operations□

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital □oard of □irectors
From: Apurva □ arfatia□□ □□Enterprise Chief of Staff
□ ichael □an□□ □ Chief of Staff □os □atos
Date: August 18□2021
Subject: □ edical Staff Report – Open Session

Recommendation:

□o approve the □ edical Staff Report□including Policies and Procedures identified in the attached list and the □elineation of Privileges.

Summary:

1. Situation: □he □ edical E□ecutive Committee met on □une 24□2021

2. □ac□ground: □ EC received the follo□ing informational reports.

A. Quality Council – □he Quality Council met on □une 2□2021. Reports and performance dash□oards □ere revie□ed and approved from the follo□ing ECH □epartments/Service □ines:
   i. Annual PI Report
   ii. □ □ and □□ Peri□operative dash□oard
   iii. Annual PI Report Stro□e Program 2021
   iv. Stro□e Program □ash□oard □□21
   v. □□21 Annual Performance Improvement Report
   vi. Palliative Care □ash□oard □□21

□. □eadership Council – □he □eadership Council met on □une 8□2021 and discussed the follo□ing:
   i. □yla□s/Rules and Regulations□Committees (e□cluding □eadership Council)
   ii. ER to IC□ Handoff Policy
   iii. □ aternal Child Health □pdate
   iv. □inances
   v. □elicitation of Retirees 2020□2021
   vi. □yla□s Committees□□eadership Council
   vii. □ edical Staff Committee Chairs
   viii. Ethics & □ ellness Committee

C. □he COO Report □as provided and included the follo□ing updates:
   i. Employees of ECH are 92□ vaccinated
   ii. □isitor Policy □pdate
   iii. □pdate on vaccination site
   iv. Santa Clara County is the most vaccinated county □ith larger than 1 million population
   v. Chief Human Resources Office is on □OA. □reg Sou□a has □een □rought on □oard
   vi. □he □os Olivos group transition is going □ell

□. □he C□ O Report □as provided and included the follo□ing updates:
   i. I□□E□ presentation given □y Carol Somersille□□ □□□iego Rodrigue□□□eth Shafran□ □ u□ai

List of Attachments: □one

Suggested Board Discussion Questions: □one

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

MEDICAL STAFF - PEDIATRICS
FOCUSED PROFESSIONAL PRACTITIONER EVALUATION (FPPE)

Date:

Practitioner Name: **ID #:**

- ☒ **New Applicant**
- ☐ **Request Additional Privilege(s)**
- ☐ **For Ongoing Professional Practice Evaluation**

Proctoring Required:

Name of Privilege/Procedure	Type of Observation/Review	Number of Cases Proctored
Pediatric Admissions/Consults	Concurrent and/or Retrospective Revie	3
Pediatric Circumcision ~~(initial applicant)~~	irect O servation – proctor must e present at start of case	5
~~Pediatric Circumcision (reappointment 10 cases not performed)~~	~~irect O servation – proctor must e present at start of case~~	~~2~~
renotomy	irect O servation – proctor must e present at start of case	2

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

Formatted: Font color: Red, Strikethrough

Commented [T1]: his elongs on OP not PPE plan

Formatted: Font color: Red, Strikethrough

Formatted: Font color: Red, Strikethrough

Evaluation period: p to 12 months ***proctoring that is not completed within 12 months will result in relinquishment of the privileges where proctoring is incomplete.*** After the practitioner has completed the proctoring re uirements and a minimum of 6 months (ma imum 12 months) have elapsed practitioner ill e promoted to the appropriate category ased on patient contacts. A patient contact is defined as an admission discharge surgical assist E short stay E discharge consultation or procedure.

Terms of evaluation (one or more of the following):

- ☒ Chart Revie Concurrent
- ☒ Chart Revie Retrospective
- ☒ Clinical Practice Patterns
- ☒ irect O servation
- ☐ E ternal Peer Revie
- ☒ iscussion ith other individuals involved in the care of each patient (e.g. consulting physicians assistants at surgery nursing or administrative personnel).

Advancement to Active Staff: The Provisional Staff member may be promoted to the appropriate staff category after the following:

1. Proctoring requirements have been completed.
2. The Provisional Staff member has been a member of the medical staff for at least 6 months.

ED/On Call: Practitioners who are initially appointed to the medical staff may not serve alone – that is without his/her proctor – in the emergency department or on call until all required proctoring (either concurrent or retrospective as determined by the departments) has been completed and the practitioner has been removed from proctoring by the department chief.

Department Chief: Proctor forms submitted to the Department Chief when the required number of forms have been submitted by the proctor.

☐ A sufficient number of cases done at El Camino Hospital have been presented for review to properly evaluate the clinical privileges requested.

☐ Proctoring not completed in the timeframe prescribed by PPE Policy 13.5.1. Privileges shall be relinquished as noted below:

Recommendation:

New Applicant (select one)

☐ Recommend removal of proctoring and continued clinical privileges as requested. Transfer to status after 6 months on Provisional Staff (based on patient contacts during the provisional period).

☐ Recommend limited removal of proctoring as noted:

☐ Do not recommend permanent membership and continued clinical privileges as requested – follow bylaws with regard to adverse action (Article 7).

New or Additional Privileges (select one)

☐ Recommend that the practitioner be granted privileges to independently perform the requested privileges.

☐ Recommend an additional proctoring period.

☐ Do not recommend granting of the new privilege as requested – follow bylaws with regard to adverse action (Article 7).

_____ _____

Department Chief Signature **Date**

Office Use Only:

Computer Updated: _____ (date)

Practitioner Informed: _____ (date)

Credentials Report, transfer to _____ Staff on _____
(date of Board Approval)

Documents scanned and uploaded to MSOW: _____ (date)

Menu - Images – Scan Image – FPPE Complete

ARTICLE 3
MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

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

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

the MEC and Governing Board.

(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 **may not**:

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

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

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

ARTICLE 4
CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

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

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

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

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

(a) 11+ patient contacts per year (defined below *)

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

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

4.2-2 PREROGATIVES

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

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

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

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

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

4.2-3 RESPONSIBILITIES

Each Active Medical Staff member shall:

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

(b) Actively participate in and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of his/her professional competence, including, but not limited to, emergency service and 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

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

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

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

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

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

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

5.3 PROCESSING THE APPLICATION

5.3-1 APPLICANT'S BURDEN

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

5.3-2 VERIFICATION OF INFORMATION

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

When collection and verification is accomplished, the Medical Staff Services Office shall transmit

information as to continuing education activities during the past two (2) years and whether the applicant requests any change in his/her staff status and/or in his/her clinical privileges, including any reduction, deletion, or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same. The results of peer review at this Hospital and others will be considered as a part of the reappointment review. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital must also be reported at this time in addition to information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, or voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or prerogatives, or clinical or admitting privileges at any other Hospital or Institution; membership or fellowship in any local, state regional, national or international professional organization for cause; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

5.4-2 VERIFICATION OF INFORMATION

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

5.4-3 DEPARTMENT ACTION

(a) The department **Vice-Chairs, or designee** ~~chief~~ shall review the application ~~and the staff member's file~~ and **shall convey** ~~transmit~~ **his/her recommendations** to the **Credentials Committee** ~~Medical Staff Executive Committee his/her written report and recommendations,~~ which are prepared in accordance with Section 5.4-5. Concerns if any can be discussed and reviewed with the appropriate Medical Directors or with the Department Executive Committees. ~~This may include a recommendation for change in staff category, change or no change in clinical privileges, or reappointment for one year, based on departmental guidelines.~~

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

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

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

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

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

5.4-4 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review recommendations of the department Vice-Chair or designee and any relevant supporting information in the reapplication. Any outstanding issues shall be resolved. The Credentials Committee shall make their recommendations to the Medical Executive Committee

5.4-5 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

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

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

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

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

5.4-5 REAPPOINTMENT REPORTS

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

5.4-6 BASIS FOR REAPPOINTMENT

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.5, and met all of the standards and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession, with

6.3 PROFESSIONAL PRACTICE

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

(a) FOR INITIAL APPOINTMENTS

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

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

(b) MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

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

(c) TERM OF PROCTORING PERIOD

Each department will establish terms for proctoring with a minimum number of cases, and/or a specific number of cases applicable to particular clinical privileges, whenever such requirements are appropriate in view of the clinical privileges which are involved. The period of proctoring may be extended in increments of not more than six (6) months each, for a total proctoring period of not more than (12) twelve months. If an initial appointee fails within that period to complete the applicable minimum number of cases and/or to furnish the certifications required in Section 6.3-1, his/her Medical Staff particular clinical privileges, as applicable, shall be relinquished. If a Medical Staff member requesting modification fails within that period to complete the minimum number of cases and/or furnish the certifications required in 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.

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

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

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

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

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

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

6.5 TEMPORARY PRIVILEGES

6.5-1 CIRCUMSTANCES

The Chief Executive Officer, or his/her designee, upon the recommendation of the Department Chief, when available, or the Chief of Staff in all other circumstances, may grant temporary privileges with or without medical staff membership to a practitioner, subject to the conditions set forth in Section 6.5-2 below, in the following circumstances:

(a) Pendency of Application: Temporary privileges may be granted upon the recommendation of the department chief for a period not to exceed 120 days when a new applicant with a complete application that raises no significant concerns is awaiting review and approval of the Medical Staff Executive Committee and Board of Directors. The minimum processing time is expected to be 72 business hours after submission of all the documents. The following items must be verified:

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

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

ARTICLE 11
COMMITTEES

11.1 GENERAL

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

11.1-1 DESIGNATION AND SUBSTITUTION
The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the members of such committees and the chairman of such committees shall be appointed by the MV or LG Chief of Staff if the committee is a campus-specific committee; by the Enterprise Chief of Staff if an enterprise committee and is subject to Medical Staff Executive Committee approval. Unless specified, non-Medical Staff committee members shall be appointed by the Chief Executive Officer or his/her designee, subject to approval by the Medical Staff Executive Committee. Medical staff committees shall be responsible to the Medical Staff Executive Committee. In addition, special committees may be created by the Medical Staff Executive Committee on an ad hoc basis to perform specified tasks. The members of special committees shall also be appointed by the Enterprise, MV, or LG Chief of Staff as appropriate, and is subject to the Medical Staff Executive Committee's approval.

11.1-2 TERMS of APPOINTMENT AND REMOVAL OF CHAIRS AND COMMITTEE MEMBERS Unless otherwise specified, a chair or any committee member shall be appointed for a term of one (1) year and shall serve until the end of this period and until his/her successor is appointed, unless he/she shall sooner resign or be removed from the committee. A Chair must be an active member of the medical staff in good standing and will be appointed by the Enterprise Chief of Staff with unlimited extensions as long as the chair remains eligible and is approved by the MEC. Committee members will be appointed by the Enterprise Chief of Staff in consultation with the Chair with unlimited extensions as long as the member remains eligible and approved by the MEC. Any chair or committee member who is appointed by the Enterprise, MV, or LG Chief of Staff as appropriate may be removed by a majority vote of the Medical Staff Executive Committee. Any committee member who is appointed by the Department Chief may be removed by a majority vote of the Department Executive Committee or the Medical Staff Executive Committee. The removal of any committee member who is automatically assigned to a committee because he/she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official pursuant to Article 10, Section 10.1-7. There will be up to four (4) at-large members elected by the Medical Staff for the MEC to ensure balanced representation of both campuses. Two (2) at-large members will be elected from the Mountain View campus and two (2) from the Los Gatos campus. All the at-large members shall be elected for three (3) year terms.

11.1-3 VACANCIES
Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made. Vacancies resulting from resignations or retirements between election periods will be filled by the Enterprise Chief of Staff in consultation with leadership Council members and to be approved by the MEC.

11.1-4 CONDUCT AND RECORDS OF MEETINGS
Committee meetings shall be conducted and documented in the manner specified for such meetings in Article 12.

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

11.2 PRACTITIONER'S EXCELLENCE COMMITTEE

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

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

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

11.3 CREDENTIALS COMMITTEE

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

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

11.3-3 MEETINGS
The meetings and requirements are described in the Credentials Policy and Procedure document.

11.4 LEADERSHIP COUNCIL – *Enterprise Committee*

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

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

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

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

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

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

11.5-1 COMPOSITION
The Medical Staff Executive Committee members shall consist of:
(a) The general officers of the Medical Staff as listed in Section 10.l-1; The Chair of Medical Staff Executive Committee will be the MV Chief of Staff. The Chair of Medical Staff Executive Committee will act as the Enterprise Chief of Staff.
(b) The department chairs of the three Medical Staff Departments. If the department chair is unable to attend a Medical Staff Executive Committee, a Department Vice Chair may attend and vote in both General and Executive sessions.
(c) There will be up to four (4) at-large members elected by the Medical Staff to ensure balanced representation of both campuses. Two (2) at-large members will be elected from the

Mountain View campus and two (2) from the Los Gatos campus. Two of the at-large members shall be elected for a two (2) year term for the first term. This term shall last from July 1, 2020 till June 30, 2022. The other two-at- large shall be elected for a three (3) year term. Subsequently, after the completion of the first terms all the at-large members shall be elected for three (3) year terms

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

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

11.5-2 DUTIES
The duties of the Medical Staff Executive Committee (MEC) shall be to:

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

(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.

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

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

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

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

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

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

11.7 QUALITY COUNCIL – *Enterprise Committee*

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

11.7-2 DUTIES
The details regarding duties of the Quality Council may be found in the Medical Staff Committees Policy and Procedure.

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

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

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

11.9 DEPARTMENT EXECUTIVE COMMITTEES – *Enterprise Committee*

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

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

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

11.10 CAMPUS SPECIFIC OPERATIONS COMMITTEES – *(MVOC & LGOC)*

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

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

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

El Camino Health

OPEN SESSION CEO Report
August 18, 2021
Dan Woods, Chief Executive Officer

Operations

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

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

Finance

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

Human Resources

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

Marketing and Communications

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

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

Information Services

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

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

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

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

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

Philanthropy

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

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

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

Corporate & Community Health Services

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

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

Government Relations & Community Benefit

Government Relations

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

Community Benefit

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

Auxiliary

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