HALIFAX HEALTH

BOARD OF COMMISSIONERS MEETING

May 1, 2017
4:00 p.m. - France Tower
Conference Room A

HALIFAX HEALTH BOARD OF COMMISSIONERS MEETING

303 No. Clyde Morris Boulevard, Daytona Beach, FL
France Tower Conference Room A
4:00 p.m. May 1, 2017

AGENDA (Page 1)

HALIFAX HEALTH BOARD OF COMMISSIONERS MEETING

303 No. Clyde Morris Boulevard, Daytona Beach, FL
France Tower Conference Room A
4:00 p.m. May 1, 2017

AGENDA (Page 2)

Old Business

New Business

Additional Information

Presentations

Public Participation

Next Meetings – July 10, 2017- France Tower Conf. Room A

- 4:00 p.m. - Regular HH Board Meeting
- Closed Strategic Planning and Litigation meetings to follow (Pursuant to FS 395.3035 & FS 286.001)

Adjourn

OUR MISSION is to be the community healthcare leader through exceptional talent and superior patient centered service delivered in a financially sustainable manner.

OUR VISION is to develop talented teams dedicated to providing competent, accountable patient centered healthcare in a financially sustainable manner.

OUR VALUES:

Halifax Health will cultivate a positive workplace in which each team member is valued, respected, and has an opportunity for personal and professional growth. We will develop patient centered systems of care.

OUR SERVICE PHILOSOPHY:

Halifax Health will ensure that those we serve are treated with courtesy and respect in a safe, compassionate, and professional environment.

Halifax Health will provide exemplary medical, emotional, and spiritual care for each of our patients and their families.

Adopted 7/14/10

HALIFAX HOSPITAL MEDICAL CENTER
BOARD OF COMMISSIONERS MEETING
Held at 303 North Clyde Morris Boulevard, France Tower, Daytona Beach, FL
March 6, 2017

Present:	Ed Connor, Assistant Secretary Dan Francati, Vice Chairman Harold Goodemote, Chairman Tom McCall, Secretary Glenn Ritchey, Member Susan Schandel, Treasurer
Also Present:	Mary Jo Allen, Executive Director, Halifax Hospice Kent Bailey, Director of Finance Mark Billings, Exec. VP/Chief Operating Officer Margaret Crossman, MD, Interim Chief Medical Officer Ben Eby, Director, Finance, Halifax Hospice Jeff Feasel, President & Chief Executive Officer Kim Fulcher, Vice President/Chief Human Resource Officer Vivian Gallo, Senior Vice President/General Counsel Bill Griffin, Director, System Research & Planning Joe Gordy, Vice President, Adams Management Services John Guthrie, Director, Communications Ginny Kwong, MD, Vice President/Chief Medical Information Officer Rev. John Long, Strategic Initiatives & Partnerships Suzanne Lovelady, Director, Quality Improvement Catherine Luchsinger, Vice President/Chief Nursing Officer Dan Miles, MD, President, Medical Staff Steve Miles, MD, Senior Vice President/Chief Quality Officer Jacob Nagib, Director, Engineering/Design/Construction Eric Peburn, Executive Vice President/Chief Financial Officer Andy Pollock, Chaplain Bill Rushton, Director, Internal Audit Shelly Shiflet, Vice President/Corporate Compliance Officer Dee Schaeffer, Executive Director, Healthy Communities Keith Sofiak, Manager, Quality Data Alberto Tineo, Vice President, Operations Lisa Tyler, Corporate Controller Bob Wade, Board Compliance Expert Bob Williams, Director, Population Health & Business Development Mike Finch, Daytona News Journal

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Chairman Goodemote called the meeting to order at 4:15 p.m. and the roll recorded.

APPROAL OF MINUTES

Discussion: Mr. Goodemote requested approval of the following minutes:

- Board of Commissioners Meeting – January 9, 2017

Action: Mr. Ritchey moved to approve minutes as presented. Mrs. Schandel seconded the motion. Carried unanimously.

APPROVAL OF AGENDA

Action: Mrs. Schandel moved to approve the agenda. Mr. Ritchey seconded the motion. Carried unanimously.

MEDICAL STAFF REPORT

Credentials Committee Actions – January 16 & February 20, 2017:

Discussion: Dr. Miles requested approval of the following physician applications as recommended by the Credentials Committee:

- **Falastin Abu-Samn, DDS, Pediatric Dentistry – Associate**

Action: Mrs. Schandel moved to approve Dr. Falastin Abu-Samn. Mr. Francati seconded the motion. Carried unanimously.

- **Gregor Alexander, MD, Neonatology – Associate**

Action: Mr. Ritchey moved to approve Dr. Gregor Alexander. Mrs. Schandel seconded the motion. Carried unanimously.

- **Rona Altaras, MD, General Surgery – Associate**

Action: Mr. Francati moved to approve Dr. Rona Altaras. Mr. McCall seconded the motion. Carried unanimously.

- **Jacqueline Bernard, MD, Diagnostic Radiology – Associate**

Action: Mr. Francati moved to approve Dr. Jacqueline Bernard. Mr. McCall seconded the motion. Carried unanimously.

- **Kirk Dockendorf, MD, Anesthesiology – Associate**

Action: Mr. Francati moved to approve Dr. Kirk Dockendorf. Mr. McCall seconded the motion. Carried unanimously.

- **Jose I. Gierbolini, MD, Neonatology – Associate**

Action: Mrs. Schandel moved to approve Dr. Jose Gierbolini. Mr. Francati seconded the motion. Carried unanimously.

- **Jesse S. Greenblum, MD, OB/GYN – Associate**

Action: Mr. Francati moved to approve Dr. Jesse Greenblum. Mrs. Schandel seconded the motion. Carried unanimously.

- **Elias Khoury, MD, Anesthesiology – Associate**

Action: Mrs. Schandel moved to approve Dr. Elias Khoury. Mr. Francati seconded the motion. Carried unanimously.

- **Ashley Lentz, MD, Plastic/Reconstructive Surgery – Associate**

Action: Mr. Ritchey moved to approve Dr. Ashley Lentz. Mrs. Schandel seconded the motion. Carried unanimously.

- **Angelina Pera, MD, Neonatology – Associate**

Action: Mr. Francati moved to approve Dr. Angelina Pera. Mr. McCall seconded the motion. Carried unanimously.

- **Eugene Rankin, Ph.D., Neuro Psychology – Associate**

Action: Mr. Francati moved to approve Dr. Eugene Rankin. Mrs. Schandel seconded the motion. Carried unanimously.

- **Jocelyn Rogers, MD, OB/GYN – Associate**

Action: Mrs. Schandel moved to approve Dr. Jocelyn Rogers. Mr. Francati seconded the motion. Carried unanimously.

Shannon Brown Work, MD, Neonatology will attend a future board meeting.

Discussion: Dr. Miles requested approval of following Resident Affiliate physicians, (personal appearance not required):

- **Joshau D. Grube, MD, Family Medicine – Residency Program**
- **Kathryn E. McHugh, MD, Family Medicine – Residency Program**
- **Marcia Newby-Goodman, MD, Family Medicine – Residency Program**

Action: Mr. Ritchey moved to approve Resident Affiliate physicians as presented. Mr. McCall seconded the motion. Carried unanimously.

Discussion: Dr. Miles requested approval of **Cynthia Tainish, MD, Interoperative Neuromonitoring (Telemedicine) – Courtesy** (personal appearance not required).

Action: Mr. Francati moved to approve Dr. Cynthia Tainish. Mr. McCall seconded the motion. Carried unanimously.

Discussion: Dr. Miles requested approval of the following Specified Professional Personnel:

- Ebony Benjamin, CRNA, Anesthesiology
- Rebecca Bird, ARNP, Hematology/Oncology
- Elizabeth Bonds, ARNP, Family Medicine
- Shannon D. Chrisholm, PA, Family Medicine/Internal Medicine
- Melissa Clegg, ARNP, Cardiology
- Chandell Fisher, Dental Assistant, Pediatric Dentistry
- Elvia Gabriel, ARNP, Vascular Surgery
- Anna Gutierrez, ARNP, Hospice/Palliative Care
- Bessie Kueffler, ARNP, Gastroenterology
- Neha Patel, PA, Family Medicine
- Kelly Perkins, ARNP, Neonatology
- Richard Miller, ARNP, Cardiology
- Candy Minske, Dental Assistant, Pediatric Dentistry
- Susan Stovall, ARNP, Internal Medicine
- Cathy Szymanski, ARNP, Neonatology
- Ryan Vickers, CRNA, Anesthesiology
- Donald Wend, PA, Family Medicine

Action: Mrs. Schandel moved to approve Specified Professional Personnel as presented. Mr. McCall seconded the motion. Carried unanimously.

Discussion: Dr. Miles requested reappointments and privileges changes as follows (Section C-G attached):

- Reappointment Physician Applications (Section C)
- Reappointment w/Changes (Section D)

- Reappointment of Specified Professional Personnel (Section E)
- Requests for Additional Privileges/Deletions/Other (Section F)
- Changes in Status (Section G)

Action: Mrs. Schandel moved to approve reappointments and privileges changes as recommended. Mr. Ritchey seconded the motion. Carried unanimously.

Discussion: Dr. Miles advised that Resignations, Leave of Absence and Automatic Relinquishments were provided for information only.

Discussion: Dr. Miles reported that revised Bylaws will be brought to the board for approval in the near future.

MANAGEMENT REPORT

Discussion: Mr. Feasel reported on the following items:

Deltona Emergency Department Construction Update

- Roof is complete
- Grading and paving is in progress
- Flooring inside has started
- Painting and cabinet work is in progress
- Systems completion, testing and verification is on-going
- IT room work is in progress
- Equipment started to arrive and will continue to arrive until mid-March

Deltona ED Grand Opening & Ribbon-Cutting

Halifax Health will sponsor two events to celebrate the grand opening of the Deltona Free Standing Emergency Department at 3300 Halifax Crossings Boulevard, Deltona

Sunday, April 23 – Family/Community Event with live DJ's music, refreshments, bounce houses, a photo booth, face painters and promotional giveaways. Attendees will be able to take guided tours for a sneak peak down the main corridor of the ED.

Monday, April 24 - Official VIP Grand Opening Ribbon-Cutting event takes place. Attendees will be able to take a self-guided tour. Refreshments will be served.

Leadership Academy

The 3rd annual Leadership Academy began February 28. Nineteen exceptional candidates were selected out of over 35 strong leaders who applied and were recommended throughout our organization. This rich learning program consists of graduate level education combined with experiential learning and knowledge sharing, exposing emerging leaders to a rich foundation from which to accelerate leadership experience and gain critical leadership competencies. Academy participants will learn cutting-edge leadership principles, skills, techniques and strategies to help move the organization forward. Individual leadership skills will be enhanced, complemented by an enriched curriculum. This year their capstone project will be Performance Improvement related.

NASCAR Foundation Texas Hold'em Tournament

On February 20th Halifax Health Foundation partnered with the NASCAR Foundation to host the Betty Jane France Memorial High Speed Hold 'Em Poker Tournament. This event raised over $312,000, a new fundraising record for this event. Out of the proceeds, a check in the amount of $250,000 was presented to Halifax Health Foundation benefiting the Betty Jane France Pediatric Center at Halifax Health, Speediatrics.

STRATEGIC & COMMUNITY HEALTH PLANNING COMMITTEE

Discussion: Dee Schaeffer provided the following report regarding the 2017 legislative session which will begin March 7th and is scheduled to end May 5th. There are many policy and regulatory issues affecting healthcare that will be considered this session. The budget will also be at the forefront due to indications that the Governor, Speaker and Senate President are all contemplating significant reductions in Medicaid hospital reimbursement.

A further complication to the budget process is the June 30 expiration of Florida's Medicaid Waiver which includes the Low Income Pool supplemental funding for hospitals. A request to renew the waiver was submitted to the federal government and is under review.

Healthcare taxing districts are again in the spotlight. A bill similar to one filed last year would require an initial voter referendum to keep healthcare taxing districts in place and require that process to be repeated every ten years. The bill also requires a voter referendum prior to a district establishing services beyond its geographic boundaries.

Bills that affect healthcare include:

- Repeal of CON for hospitals, hospices and nursing homes
- Allowing overnight stays in ambulatory surgery centers
- Creation of a new licensure category that would allow 72 hour stays in recovery care centers
- Revision of the overall guidelines for trauma centers, to include lifting the cap on the number of centers
- Expansion of scope of practice for ARNP's and PA's
- A requirement for AHCA to develop a "culture of safety" survey for administration to hospital employees
- Hospital staffing ratios
- A new proposal which would prohibit the requirement for maintenance of board certification and recertification as a condition of employment or hospital admitting privileges for physicians

Other matters under consideration include:

- Repeal of personal injury protection insurance
- Issues affecting mental health and substance abuse treatment
- Red light camera restrictions and/or repeal

AUDIT & FINANCE REPORT

Discussion: Mr. Peburn provided brief overview of statistical and financial summaries for Halifax Health Medical Center and Halifax Health Hospice (full report attached).

CONSENT AGENDA

Discussion: Mr. Goodemote requested approval of the Consent Agenda, which included following items:

- Appointment of Infection Control Officer
- Financial Statement Ended January 2017
- Financial Statement Ended December 2016
- Capital Expenditures - $50,000 and Over *(Working Capital)*
    - Emergency Replacement of Air Handling Units - $1,643,356
    - Neurosurgical & Small Bone Power Equipment - $652,141
    - Storage Area Network (SAN) Hardware - $477,180
    - Opthalmology Microscope - $130,000
    - Network Switches for Patient Monitoring - $140,503
    - Plasma Pheresis Equipment - $121,506
    - HVAC Units Hospice SE Volusia Care Center - $83,128
    - Minimally Invasive Valve Replacement System - $73,010
    - Mini C-Arm - $71,698
- Disposals - February & March 2017

Action: Mr. Ritchey moved to approve the consent agenda as presented. Mrs. Schandel seconded the motion. Carried unanimously.

OLD BUSINESS

Discussion: Shelly Shiflet, Vice President & Chief Compliance Officer reviewed the Compliance dashboard report advising that all metrics were met.

NEW BUSINESS

CIA Resolution

Discussion: Ms. Shiflet advised that we are in year three of five of the Corporate Integrity Agreement (CIA) and requested approval of the Board Resolution which states that the board has made a reasonable inquiry into the operations of the compliance department; that Halifax Health has an effective compliance program and complying with the CIA; and that the Resolution shall be applicable to all reporting periods for the three years.

Mr. Bob Wade, added that in his role as Compliance Expert to the Board, he actively participates in the Compliance Committee, Audit & Finance Committee and Physician Arrangement Committee, as well as attends the Board meetings, and he is not aware of any issue that would cause him to recommend the board not sign the resolution.

Action: Mr. Francati moved to approve the Resolution as presented. Mr. McCall seconded the motion. Carried unanimously.

Discussion: Mr. Feasel noted that the following annual plans have been reviewed and approved by the appropriate internal committees and are recommended to the board for approval:

2017 Infection Control Risk Assessment & Plan

Action: Mr. Ritchey moved to approve the 2017 Infection Control Risk Assessment & Plan as presented and previously approved by the Infection Control Committee, Quality Council and Medical Executive

Committee (attached). Mr. McCall seconded the motion. Carried unanimously.

2017 Performance Improvement Plan

Action Mr. Francati moved to approve the 2017 Performance Improvement Plan as presented and previously approved by the Patient Safety Committee, Quality Council and Medical Executive Committee (attached). Mrs. Schandel seconded the motion. Carried unanimously.

2017 Patient Safety Plan

Action: Mr. Ritchey moved to approve the 2017 Patient Safety Plan as presented and previously approved by the Patient Safety Committee, Quality Council and Medical Executive Committee (attached). Mr. Francati seconded the motion. Carried unanimously.

2016 Environment of Care Summary Report

Action: Mrs. Schandel moved to approve the 2016 Environment of Care Summary Report as presented and previously approved by the Environment of Care Committee and Patient Safety Committee. Mr. Ritchey seconded the motion. Carried unanimously.

Deltona Acute Care Hospital

Discussion: Mr. Feasel advised that the Deltona Acute Care Hospital Certificate of Need will be in the name of Halifax Health Medical Center and requested approval to move forward with Architectural & Engineering Services for the Deltona Acute Care Hospital. Funding will come from HH Holdings, Inc. Mr. Goodemote added that no tax dollars will be utilized to fund this project.

Action: Mr. Ritchey moved to approve the Architectural & Engineering services of $3,350,000 for the Deltona Acute Care Hospital funded by HH Holdings, Inc. Mr. Francati seconded the motion. Carried unanimously.

PUBLIC PARTICIPATION

Discussion: None.

NEXT MEETING

Discussion: Mr. Goodemote advised that the next Board of Commissioners meeting will be held on May 1, 2017, 4pm, France Tower Conf. Room A, followed by closed Litigation meeting.

ADJOURN

Action: There being no further action, the Halifax Health Board of Commissioners meeting adjourned at 5:10pm.

CLOSED STRATEGIC MEETING HELD

RECONVENE BOARD OF COMMISSIONERS MEETING

Discussion: Chairman Goodemote reopened the public portion of the Halifax Health Board of Commissioners meeting at 5:50pm.

Discussion: General Counsel, Vivian Gallo, advised that a Litigation meeting would be scheduled to follow the May 1, 2017 Board of Commissioners meeting.

Chairman Goodemote, open the floor for discussion concerning CEO compensation.

Action: Following board discussion, Mr. Ritchey made a motion to review the most recent Hay Group compensation report to determine if the scope should be expanded; and obtain costs associated with providing the board with an updated comprehensive report. Mr. Francati seconded the motion. Carried unanimously.

PUBLIC PARTICIPATION

Discussion: None.

ADJOURN

Action: There being no further business, the meeting adjourned at 5:10pm.

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Chairman

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Secretary

HALIFAX HOSPITAL MEDICAL CENTER
BOARD OF COMMISSIONERS SPECIAL MEETING
WITH STRATEGIC PLANNING SESSION
Held at 303 No. Clyde Morris Boulevard, Daytona Beach, Florida
March 6, 2017

Present:	Ed Connor, Assistant Secretary Dan Francati, Vice Chairman Harold Goodemote, Chairman Susan Schandel, Treasurer Tom McCall, Secretary Member Glenn Ritchey, Member
Also Present:	Kent Bailey, Director of Finance Margaret Crossman, MD, Interim Chief Medical Officer Jeff Feasel, President & Chief Executive Officer Vivian Gallo, Senior VP/General Counsel Bill Griffin, Director, System Research & Planning Arvin Lewis, Executive VP/Chief Revenue Officer Rev. John Long, Strategic Initiatives & Partnerships Ann Martorano, Chief Communications Officer Eric Peburn, Executive VP/Chief Financial Officer Dee Schaeffer, Exec. Director, Healthy Communities Shelly Shiflet, Vice President/Chief Compliance Officer Bill Rushton, Director, Internal Audit Lisa Tyler, Corporate Controller Bob Wade, Board Compliance Expert Sharon Dunlop, Court Reporter, Volusia Reporting Company

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The special meeting was called to order by Chairman, Harold Goodemote at 5:40 p.m. The roll was recorded.

STRATEGIC PLANNING SESSION

Discussion: The closed strategic planning session of the Halifax Health Board of Commissioners was called to order at 5:40 p.m. Upon conclusion of the closed session at 5:50 pm, the meeting was reconvened in open session.

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Chairman

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Secretary

HALIFAX HOSPITAL MEDICAL CENTER
BOARD OF COMMISSIONERS EDUCATION/ORIENTATION
Held at 303 North Clyde Morris Boulevard, France Tower, Daytona Beach, FL
April 3, 2017

Present:	Ed Connor, Assistant Secretary Harold Goodemote, Chairman Carl W. "Rick" Lentz, MD, Member Susan Schandel, treasurer
Also Present:	Jeff Feasel, President & Chief Executive Officer Eric Peburn, Exec. VP & Chief Financial Officer

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The meeting began at 4:00pm. Attendance was recorded.

Topics of review/discussion:

- Deltona
  - Financing
  - Medical Staff Call Coverage
  - Medical Office Building
  - Free Standing ED
- Legislative Update
- Partnership Opportunities & Updates
- Trauma
- Medical Staff Bylaws

Meeting concluded at 6:15pm

The next Education/Orientation session will be held on June 5, 2017, from 4pm to 6pm in France Tower Conf. Room A

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Chairman

_____
Secretary

HALIFAX HEALTH

TO: Members of the Board of Commissioners
FROM: Daniel Miles, MD, Medical Staff President
DATE: May 1, 2017
RE: Credentials Committee Actions, March 20, April 17, 2017

The Medical Staff report is attached for the Board's review and approval at the Board of Commissioner's meeting on May 1, 2017.

PHYSICIAN INTRODUCTION: None

BOARD APPROVAL REQUIRED

A. INITIAL APPLICATIONS FOR PHYSICIANS *Action Required (Applicants present should introduce themselves to the BOC prior to a Motion to Approve for each applicant)*
The following practitioners were required to appear before the **Credentials Committee on January 16, 2017** and are presented to the Board of Commissioners for approval:

Shannon Work Brown, MD	Neonatology	Associate

A-1. INITIAL APPLICATIONS FOR PHYSICIANS *Action Required (Applicants present should introduce themselves to the BOC prior to a Motion to Approve for each applicant)*
The following practitioners were required to appear before the Credentials Committee on March 20, April 17, 2017 and are presented to the Board of Commissioners for approval:

Daniel Miller, MD	Family Medicine	Associate
Gregory Samano, DO	Family Medicine	Community Affiliate
Guillermo Sanchez, MD	Internal Medicine	Associate
Susan Smith, MD	OB/GYN	Associate
Lydia Van, MD	Family Medicine	Associate

B. INITIAL APPLICATIONS FOR SPECIFIED PROFESSIONAL PERSONNEL – *Action Required (No appearance required; may propose Motion to Approve for entire group)*
The following practitioners were reviewed and approved by the Credentials Committee on March 20, April 17, 2017 and are presented to the Board of Commissioners for approval:

Sheilah Bailey, ARNP	Gastroenterology	Ammar Hemaidan, MD
Luke Brown, ARNP	Physical Med/Rehab	Carolyn Geiss, MD
Yaischa Dukes, ARNP	General Surgery	Joel Sebastian, MD

Taylor Langston, ARNP	Internal Medicine	Shemin Gupta, MD
Denise Livingston, ARNP	General Surgery	Lars Nelson, MD
Lawrence Pedley, PA	Family/Internal Medicine	Thendrex Estrella, MD
Lon S. Ratner, ARNP	Orthopaedic Surgery	J. Richard Rhodes, MD
Catherine Scanlon, CRNA	Anesthesiology	Derrick Payne, MD
Samantha Thorleifson, CRNA	Anesthesiology	Derrick Payne, MD
Bobby Tipton, ARNP	Neurosurgery	William Kuhn, MD
Jessica Wooten, ARNP	Family/Internal Medicine	Thendrex Estrella, MD

C. REAPPOINTMENTS AND PRIVILEGE CHANGES – *Action Required (No appearance required; may propose Motion to Approve for entire group)*

REAPPOINTMENT PHYSICIAN APPLICATIONS – ***SEE SECTION (C) OF THE REPORT***
REAPPOINTMENT WITH CHANGES – ***SEE SECTION (D) OF THE REPORT***
REAPPOINTEMENT SPP APPLICATIONS - ***SEE SECTION (E) OF THE REPORT***
REQUESTS FOR ADDITIONAL PRIVILEGES/DELETIONS/OTHER - ***SEE SECTION (F) OF THE REPORT***
CHANGES IN STATUS - ***SEE SECTION (G) OF THE REPORT***

BOARD ENDORSEMENT REQUIRED

D. RESIGNATIONS/LEAVE OF ABSENCE/AUTOMATIC RELINQUISHMENTS – The following practitioners have resigned from the Medical Staff, been granted a Leave of Absence, or have had their privileges automatically relinquished, for the reasons specified below:

Practitioner	Specialty	Status: Reason
Fasano, Margaret, ARNP	Psychiatry	No longer employed by HH
Grenier, Yannick, MD	Neurosurgery	Voluntary Relinquishment
Jochum, James, MD	Ophthalmology	No longer wished to maintain privileges
Kauffman, Christine, Dental	Oral/Maxillofacial	No longer wished to maintain privileges
Nasr, Isaam, MD	Gastroenterology	No longer wishes to maintain privileges
Purcell, Theresa, ARNP	Cardiology	No longer wished to maintain Privileges
Shunnarah, Kathryn, ARNP	Hematology/Oncology	No longer employed by HH
Thomas, Tamara, CRNA	Anesthesiology	No longer with Sheridan
White, Kim, CRNA	Anesthesiology	No longer with Sheridan
Zemball, Wendy, CRNA	Anesthesiology	No longer with Sheridan

E. OTHER

HALIFAX HEALTH
MEDICAL CENTER

BOARD OF COMMISSIONERS – May 1, 2017
CREDENTIALS COMMITTEE ACTIONS – March 20, 2017, April 17, 2017

FOR BOARD ACTION

A. INITIAL PHYSICIAN APPLICATIONS RECOMMENDED FOR APPROVAL

Shannon Work Brown, MD	Neonatology	Employed by MedNax
Daniel Miller, MD	Family Medicine	Employed by Halifax Health
Gregory Samano, DO	Family Medicine	Employed by Halifax Health
Guillermo Sanchez, MD	Internal Medicine	Employed by Halifax Health
Susan Smith, MD	OB/GYN	Employed by OB Hospitalist Group
Lydia Van, MD	Family Medicine	Employed by Halifax Health

B. INITIAL SPECIFIED PROFESSIONAL PERSONNEL RECOMMENDED FOR APPROVAL

Sheilah Bailey, ARNP	Gastroenterology	Employed by Advanced Gastroenterology
Luke Brown, ARNP	Physical Med/Rehab	Employed by Brooks Rehab
Yaischa Dukes, ARNP	General Surgery	Employed by Florida Health Care
Taylor Langston, ARNP	Internal Medicine	Employed by Florida Cancer Specialists
Denise Livingston, ARNP	General Surgery	Employed by Lars Nelson, MD
Lawrence Pedley, PA	Family/Internal Medicine	Employed by Halifax Health
Lon S. Ratner, ARNP	Orthopaedic Surgery	Employed by Richard Rhodes, MD
Catherine Scanlon, CRNA	Anesthesiology	Employed by Sheridan Healthcorp
Samantha Thorleifson, CRNA	Anesthesiology	Employed by Sheridan Healthcorp
Bobby Tipton, ARNP	Neurosurgery	Employed by Halifax Health
Jessica Wooten, ARNP	Family/Internal Medicine	Employed by Halifax Health

C. PHYSICIAN REAPPOINTMENTS RECOMMENDED FOR APPROVAL

<u>Department of Anesthesiology</u>

No reappointments this month		Active

<u>Department of Emergency Medicine</u>

Zabrina Evens, MD	Emergency Medicine	Active

<u>Department of Medicine</u>

Dodd, Paul, MD	Internal Medicine	Courtesy Affiliate
Dunn, Lucky, MD	Family Medicine	Courtesy Affiliate
Glidden-Wood, Angella, MD	Family Medicine	Community Affiliate
Guirgis, Wagid, MD	Family Medicine	Senior Active
Hemaidan, Ammar, MD	Gastroenterology	Active
Mai, Christopher, MD	Nephrology	Active
Minouei, Mohammadreza, MD	Internal Medicine	Active

Moses, Cheryl, MD	Critical Care	Active
Rosado, Jose, MD	Family Medicine	Courtesy Affiliate
Shamsin, Ahmad, MD	Cardiology	Active
Sorathia, Abdul, MD	Hematology/Oncology	Active
Suleiman, Saud, MD	Gastroenterology	Active
Verzal, Rhonda, MD	Family Medicine	Active
Walker, John, MD	Cardiology	Senior Active

Department of Obstetrics/Gynecology

Cortez, Stephen, MD	OB/GYN	Senior Active
Duke, Bill, MD	OB/GYN	Active
Modad, Patricia, MD	Gynecology	Active
Ramos Santos, Edgard, MD	Maternal Fetal Medicine	Courtesy
White, John, MD	OB/GYN	Senior Active

Department of Oncology

No reappointments this month

Department of Pathology

Grimes, Rene, MD	Anatomical & Clinical	Active

Department of Pediatrics

Jeanty, Jean-Claude, MD	Pediatrics	Active

Department of Psychiatry

Oh, Stephen, MD	Psychiatry	Senior Active

Department of Radiology

No reappointments this month

Department of Surgery

Craven, James, MD	Otolaryngology	Active
DiGaetano, Margaret, MD	Ophthalmology	Senior Active
Dunn, William, MD	Retina	Senior Active
Etienne, Annemarie, MD	Ophthalmology	Courtesy Affiliate
Holt, John, MD	Thoracic & Cardiovascular Surgery	Senior Active
Kennedy, Mark, MD	Ophthalmology	Courtesy Affiliate
Martin, Jeffrey, MD	Orthopaedic Surgery	Active

D. PHYSICIAN REAPPOINTMENTS (*WITH CHANGES)* RECOMMENDED FOR APPROVAL

Agana, Felicitas, MD *(Associate to Active)*	Pediatrics	Pediatrics
Chaiffetz, David, MD *(Associate to Active)*	Psychiatry	Psychiatry
Duncan, Jeffrey, MD *(Associate to Active)*	Medicine	Internal Medicine
Gupta, Shemin, MD *(Associate to Courtesy Affiliate)*	Medicine	Internal Medicine
Khanna, Sohit, MD *(Associate to Active)*	Surgery	Thoracic/Cardiovascular
Kim, Kirsten, MD *(Associate to Active)*	Medicine	Family Medicine
Leger, Rosanne, MD *(Associate to Active)*	Medicine	Family Medicine

Meyers, Cary, MD *(Associate to Active)*	Surgery	Thoracic/Cardiovascular
Obeid, Dany, MD *(Active to Courtesy Affiliate)*	Medicine	Pulmonology
Patel, Nishita, MD *(Associate to Active)*	Surgery	Ophthalmology
Rimple, Ricardy, MD *(Associate to Active)*	Medicine	Family Medicine
Singh, J. Peter, MD *(Associate to Active)*	Medicine	Nephrology
Van Ummersen, Lynn, MD *(Associate to Courtesy Affiliate)*	Medicine	Internal Medicine

E. SPECIFIED PROFESSIONAL PERSONNEL REAPPOINTMENTS RECOMMENDED FOR APPROVAL

Alexander, Michal, Dental Asst	Brian Hamilton, DDS	Oral/Maxillofacial
Brenner, Jeremy, PA	Zabrina Evens, MD	Emergency Medicine
Ebersole, Sarah, CRNA	Derrick Payne, MD	Anesthesiology
Gonzalez, Patricia, CRNA	Derrick Payne, MD	Anesthesiology
Martin, Kathryn, PA	Thendrex Estrella, MD	Family Medicine
McComb, Brian, CRNA	Derrick Payne, MD	Anesthesiology
Ramstad, Margaret, ARNP	Raul Zimmerman, MD	Hospice/Palliative Care
Taylor, Matthew, PA	Zabrina Evens, MD	Emergency Medicine

F. REQUEST(S) FOR ADDITIONAL PRIVILEGES / DELETIONS / OTHER RECOMMENDED FOR APPROVAL

Bogdanowicz, Brian, MD	*Withdrawing Emergency Medicine privileges. Will be working full time with the Family Medicine Residency program*
Bonds, Elizabeth, ARNP	*Additional supervising physician: Renuka Siddharthan, MD*
Mather, Nancy, ARNP	*Additional supervising physicians: Raul Zimmerman, MD, Arlen Stauffer, MD, Justin Chan, MD, John Bunnell, MD – No longer working with Dr. Woodard*

G. CHANGE(S) IN STATUS/SPECIALTY/PRIVILEGES RECOMMENDED FOR APPROVAL

Favis, Gregory, MD	Active	Honorary
Haynes, Delicia, MD *(status terminology change)*	Courtesy	Courtesy Affiliate

FOR INFORMATION ONLY

H. RESIGNATIONS:

Fasano, Margaret, ARNP *(no longer employed by HH)*	Psychiatry	08/18/16
Grenier, Yannick, MD *(Voluntary relinquishment)*	Neurosurgery	04/12/17
Jochum, James, MD *(no longer wish to maintain privileges)*	Ophthalmology	05/01/17
Kauffman, Christine, Dental Asst *(no longer with Dr. Schalit's offices)*	Oral/Maxillofacial	05/01/17
Nasr, Issam, MD *(no longer wish to maintain privileges)*	Gastroenterology	03/8/2017
Purcell, Theresa, ARNP *(no longer wish to maintain privileges)*	Cardiology	05/01/17
Shunnarah, Kathryn, ARNP *(no longer employed by HH)*	Hematology/Oncology	02/01/2017
Thomas, Tamara, CRNA *(no longer wish to maintain privileges)*	Anesthesiology	02/21/2017
White, Kim, CRNA *(no longer wish to maintain privileges)*	Anesthesiology	05/01/17

Zemball, Wendy, CRNFA *(no longer wish to maintain privileges)*	OB/GYN	03/27/17

I. LEAVE OF ABSENCE:
For Information Only:

J. LOCUM TENENS PHYSICIANS:
For Information Only - **Ongoing Privileges this month:**

Harrington, Michael, MD	Vascular Surgery
Fisher, Anton, DO	Psychiatry
Mehta, Jitendra, MD	Psychiatry
Upton, Monique, MD	Psychiatry

K. OTHER BUSINESS:

HALIFAX HEALTH MEDICAL CENTER

BOARD OF COMMISSIONERS
NEW PHYSICIAN PROFILES
May 1, 2017
(Credentials Committee March 20, April 17, 2017)

Shannon Brown Work, MD
Neonatology

Shannon Brown Work, MD, is requesting privileges in the Department of Pediatrics and is in practice with Halifax Health NICU.

Medical Education:
University of Tennessee College of Medicine - 06/26/1996

Residency
Children's Medical Center of Dallas 06/24/1996 to 06/30/1999
Pediatrics

Fellowship
University of Texas Southwestern 07/01/1999 to 06/30/2002
Neonatal-Perinatal Medicine

Board Certification:
American Board of Pediatrics -Neonatal-Perinatal Medicine

Daniel Miller, MD
Family Medicine

Daniel Miller, MD, is requesting privileges in the Department of Medicine and is in practice with Halifax Health Hospitalists.

Medical Education:
Loma Linda University - 05/01/2006

Residency
Halifax Health Family Medicine Residency 07/01/2006 to 06/30/2009
Family Medicine

Board Certification:
American Board of Family Medicine - Family Medicine

HALIFAX HEALTH MEDICAL CENTER

BOARD OF COMMISSIONERS
NEW PHYSICIAN PROFILES
May 1, 2017
(Credentials Committee March 20, April 17, 2017)

Gregory Samano, DO
Family Medicine

Gregory Samano, DO, is requesting privileges in the Department of Medicine and is in practice with New Smyrna Beach Family Practice.

Medical Education:
Philadelphia College of Osteopathic Medicine - 06/30/1972

Internship
Botsford Hospital 07/01/1972 to 06/30/1973
Rotating

Board Certification:
American Osteopathic Board of General Practice - Family Medicine

Guillermo Sanchez Delacruz, MD
Internal Medicine

Guillermo Sanchez Delacruz, MD, is requesting privileges in the Department of Medicine and is in practice with Halifax Health Hospitalists.

Medical Education:
Universidad Libre - 01/01/1989

Residency
Mayaguez Medical Cener 07/01/2004 to 06/30/2007
Internal Medicine

Board Certification:
American Board of Internal Medicine - Internal Medicine

HALIFAX HEALTH MEDICAL CENTER

BOARD OF COMMISSIONERS
NEW PHYSICIAN PROFILES
May 1, 2017
(Credentials Committee March 20, April 17, 2017)

Susan Smith, MD
OB/GYN

Susan Smith, MD, is requesting privileges in the Department of OB/GYN and is in practice with Ob Hospitalist Group.

Medical Education:
University of South Florida - 05/31/2003

Residency
University of South Florida Morsani College of Medicine 07/01/2003 to 06/30/2007
Obstetrics & Gynecology

Board Certification:
American Board of Obstetrics & Gynecology - Obstetrics & Gynecology

Lydia Van, MD
Family Medicine

Lydia Van, MD, is requesting privileges in the Department of Medicine and is in practice with Halifax Health Hospitalists.

Medical Education:
University of Miami - 05/30/2009

Internship
VCU - Fairfax Family Medicine 07/01/2009 to 06/30/2010
Family Medicine

Residency
Center for Family & Sports Medicine 07/01/2010 to 06/30/2012
Family Medicine

Board Certification:
American Board of Family Medicine - Family Medicine

HALIFAX HEALTH

Management Report
May 2017

Presentations

- Quality Update FY2017 (Oct. 2016-Dec. 2016)
- Uncompensated Care

Deltona Emergency Department Grand Opening & Ribbon-Cutting

We celebrated the grand opening of the Deltona Emergency Department with a community event from 1 to 4 pm on Sunday, April 23; and Grand opening ribbon cutting event on April 24, from 4 to 7pm. Both events were very well attended and tours were provided. At 7:00am on Tuesday, April 26th, our doors opened for patients.

Volusia/Flagler Business Report – Top 40 Under 40

The Daytona Beach News Journal's Volusia/Flagler Business Report held their Annual Top 40 Under 40 in March. This annual event recognizes our communities top young business professionals and Halifax Health was proud to have 3 of our own recognized at this event.

Mary Jo Allen, Executive Director, Halifax Health Hospice & Palliative Care Awarded the Young Professional of the Year

Mary Jo has been an advocate for Florida's elderly population for over 17 years. Mary Jo is currently the Executive Director for Halifax Health Hospice, Palliative Care and Care at Home. Previously Mary Jo worked for a large publicly traded home care agency as the Assistant Vice President of Nursing Specialties. In this role, she developed clinical programs that kept seniors aging at home. In her early nursing career she served as an intensive care nurse/charge nurse in Volusia County. Mary Jo earned a Bachelor of Science degree in Nursing from the University of Central Florida, a Master of Science degree in Nursing from the University of Phoenix, as well as a Master of Business Administration degree from the University of Phoenix. She is a Student Mentor for Take Stock in Children, Leadership Daytona Class 36 graduate, Port Orange Y.M.C.A board member, Rotarian and parent volunteer. Mary Jo is a Florida native and resides in Ormond Beach with her husband and two children.

Steve Mach, Manager, Financial Operations and Capital Planning Awarded the Young Private Sector Professional of the Year

Steve Mach serves Halifax Health as the Manager of Financial Operations and Capital Planning. He has 15 years' experience in finance, business development, and strategic planning. Mr. Mach holds a bachelor's degree in marketing from UCF, a MBA in Finance from Stetson University, and is on pace to attain fellowship status with the American College of Healthcare Executives by year end. Steve believes in community service and is a proven leader. He is a committee member of the following: Leadership Daytona Alumni Council, Leadership Daytona Steering Committee, Volusia Young Professionals Group, UCF Alumni Association, Basilica of St. Paul Finance and Endowment Committees, and Team Volusia EDC's strategy implementation

task force. In addition, he has founded or co-founded Innovate Daytona, Elevate Daytona Beach, YPG's lunch and learn series, and Museum of Arts and Sciences Young Philanthropists. An Ormond Beach native, Steve currently resides there with his wife and two children.

Ben Eby, Finance Director, Halifax Health Hospice & Palliative Care Recognized as one of the Top 40 Under 40

Ben is a CPA licensed in Ontario, Canada and holds a bachelor of science degree in business administration. Prior to relocating to Florida in 2013 to be closer to his wife's family, Ben had eight years of progressive management experience in healthcare finance roles with Revera, a senior living company headquartered in Toronto. He joined Halifax Health in 2015 as Finance Director for the Hospice division. Ben lives in Ormond Beach with his wife and four children.

Doctor's Day

On March 30th Halifax Health celebrated National Doctors' Day. Our Team Members put together a "thank you" campaign including print advertising, social media, a special luncheon and gift for all of our doctors. Team Members created videos thanking our doctors. Videos were posted on Facebook and received over 3,000 views and well over 100 likes. The focus of the campaign was thanking the talent who makes Halifax Health technology work for the care of the people in our community.

Family Medicine Residency Program

Halifax Health Family Medicine Residency Program had another successful recruiting year. March 17th was match day, where every medical student and residency program in the nation finds out where each applicant will complete his or her residency training.

Halifax Health Family Medicine Residency Program has a long tradition of successfully recruiting a high quality diverse group of residents, and this year was no different. A few of the incoming residents have ties to the area, and we are excited and hopeful that they will remain in the area to care for the community and patients that we serve.

We welcome Dr. Erin Hough from Morehouse School of Medicine, Dr. Ariana Abid from University of South Florida College of Medicine, Dr. Harry "Buddy" Blanke from Medical University South Carolina, Dr. Kirstin LaBell from University of Central Florida, Dr. Michael Faille from New York Medical College, Dr. Nally Calzado from Stonybrook University of Medicine, Dr. Jackson "Brooks" Turner from University of Mississippi School of Medicine, and Dr. Trang Van from University of Arkansas College of Medicine.

In addition to welcoming a new intern class, Halifax Health Sports Medicine Fellowship will be welcoming a new Sports Medicine Fellow. Dr. Ryan Cudahy will be joining Halifax, after his completion of his Family Medicine residency training at Mayo Family Medicine Residency Program in Jacksonville, Florida.

Marketing & Communications Update

May 3. Free Car Seat Safety Check. Halifax Health – Healthy Communities is offering free car seat safety checks the first Wednesday of every month from 1:00-3:00 pm at the Halifax Health Medical Center, France Tower. This program is also presented in conjunction with SafeKids Volusia/Flagler Counties.

May 4. Speakers and Sneakers Series. This educational program for residents offers free monthly presentations at Halifax Health featuring a wide variety of healthcare topics. Participants are encouraged to walk their choice of indoor and outdoor trails at Halifax Health

after the presentation event. Walking logs are available for participants. A light breakfast is also provided.

May 5. March for Babies Last Call Fundraiser Party. This is the last chance for Team Members to help Team Halifax Health raise funds for the next day's March for Babies Walk. There will be food available for purchase and fun activities taking place during this event being held at the main campus.

May 6. Greater Halifax March for Babies 2017. Halifax Health is a sponsor of this March of Dimes event. Team Halifax Health will be participating in the walk/run which takes place at Jackie Robinson Ballpark in Daytona Beach. Start time: 9:00 am.

May 6. **Halifax Health Neonatal ICU Reunion**. Join us as we celebrate our tiniest heroes, our NICU graduates! The celebration will take place during this year's March for Babies walk. There will be face painting, games, family photos and more!

May 7. DeLand Fitfest Triathlon. A part of the Live Your Life Well race series, this event will put your physical endurance and mental strength to the test. Great for beginners or for those readying for the triathlon season. www.lylwseries.com.

May 9. Stroke Awareness Event. Halifax Health will present this free education event in the France Tower, Meeting Room E, from 4:00 – 6:00 pm.

May 13. 7th Annual May Day Memorial Surf Classic. Held in loving memory of former Halifax Health intensive care unit nurse, Dollie Sue Watson, this Flagler Beach Pier surfing event has grown to 90 competitors and more than 300 attendees. Proceeds from the event benefit Halifax Health-Foundation.

May 20. Halifax Health Summer Fun Festival 2017. Join Halifax Health as we kick-off the summer season with this family-friendly event featuring fun free activities, refreshments and more. This event will take place at the Pavilion at Port Orange, Lakeside Park.

May 21 - 27. EMS Week. Halifax Health will thank Volusia County Emergency Medical Services practitioners with events in Daytona Beach, Port Orange and Deltona.

April 4. **National Donate Life Month Flag Raising Ceremony**. Halifax Health, and health organizations nationwide, participated in Flags Across America to help raise organ and tissue donation awareness. The ceremony featured presentations by transplant professionals, recipients and donor families. In addition, the hospital is being lit green each evening throughout the month in observance.

April 5. Free Car Seat Safety Check. Halifax Health – Healthy Communities is offering monthly free car seat safety checks from 1:00-3:00 pm at the Halifax Health Medical Center, France Tower. This program is presented in conjunction with SafeKids Volusia/Flagler Counties.

April 6. Speakers and Sneakers Series. This educational program for residents offers free monthly presentations at Halifax Health featuring a wide variety of healthcare topics. Participants are encouraged to walk their choice of indoor and outdoor trails at Halifax Health after the presentation event. Walking logs are available for participants. A light breakfast is also provided.

April 13. NASCAR Foundation & Daytona Tortugas Visit Speediatrics

April 17. Red Hot Mamas Menopause Education & Support Program – Hormone Therapy. Halifax Health's Red Hot Mamas Menopause Education and Support Program meets at Halifax Health Medical Center of Daytona Beach from 6:00-7:30 p.m. Topic: Celiac Disease and Menopause. Featured Speaker: Joy MidKiff, registered dietitian with the Halifax Health – Wellness Center. 386.425.5210.

April 21. National Donate Life Blue-Green Day. Throughout the day, Team Members in the Halifax Health – Center for Transplant Services will distribute information and blue and green carnations to staff and visitors to raise awareness of the importance of organ donation.

April 22. Southeast Volusia Family 5K Run/Walk, Edgewater. A part of the Halifax Health Live Your Life Well race series. lylwseries.com.

April 23. Halifax Health Emergency Department of Deltona Community Event. This free event will introduce West Volusia residents to this new medical facility. The event will feature music and refreshments for guests. 1:00 – 4:00 pm.

April 24. Halifax Health Emergency Department of Deltona Grand Opening & Ribbon-Cutting. State and local officials have been invited to this event. After the ribbon-cutting, tours will be given of the new facility. Refreshments will be served. 4:00 p.m.

April 29. Volusia/Flagler YMCA Healthy Kids Day. Halifax Health is a sponsor of this event at Jackie Robinson Ballpark. This event will feature healthy activities for kids of all ages. 11:00 am-1:00 pm. vfymca.org.

HALIFAX HEALTH

Legislative Update as of April 20, 2017
Prepared by: Dee Schaeffer

2017 Legislative Session Dates

The 2017 legislature convened March 7, 2017 and is scheduled to adjourn May 5, 2017.

General Appropriations Act

The Governor, House and Senate have developed their proposed budgets, all of which include Medicaid cuts to hospitals. The impact to Halifax Health is:

- Governor's Proposal ($4,313,309)
- House Proposal ($8,866,642)
- Senate Proposal ($2,345,798)

All three branches have indicated they do not intend to fund the slated 2% inflationary increase for hospitals. This results in an additional loss to Halifax of ($438,413).

The Medicaid Enhanced Ambulatory Patient Groups (EAPGs) outpatient prospective payment system for hospitals is scheduled to be implemented in July 2017. The House supports the implementation and has included language that would prevent a provider's reimbursement from being affected +/- 5%. The Senate is requesting a delay of one year to further refine the payment methodology. Budget proviso language is being drafted to require a retrospective reconciliation process to address unintended outcomes should the House position prevail.

An Appropriations request in the amount of $750,000 has been made by Senator Hukill and Representative Santiago to fund a Community Action Treatment team for Volusia and Flagler counties. The teams are designed to prevent out-of-home placements for youth with behavioral health needs. Funding is included in the proposed Senate budget.

Low Income Pool/Disproportionate Share/1115 Medicaid Waiver

The Federal Centers for Medicaid and Medicare Services approved a $1.5 billion Low Income Pool (LIP) supplemental funding program for Florida to cover a four year period beginning July 1, 2017.

While the news of increasing Florida's current $608 million allocation is encouraging, it is uncertain whether the federal government will provide Florida with the flexibility needed to ensure the entire amount can be earned by the state. Should the special terms and conditions stand as initially drafted,

without a significant infusion of state general revenue, experts estimate Florida would be limited to earning only half of the approved allocation. Therefore, the Agency for Health Care Administration is in negotiation with CMS to modify the parameters of the program. Critical issues include, but are not limited to:

- reinstating unreimbursed costs (Medicaid shortfall) as an allowable LIP expense – as was the case for the first ten years of Florida's LIP program;
- determination as to how the LIP funding "tiers" will be configured, to include creating a tier for public hospitals;
- developing a methodology to provide incentives to taxing districts and local governments to ensure adequate inter-governmental transfers are available to fund the state share;
- establishing a minimum Medicaid volume as a requirement for provider eligibility;
- reinstating a "sub cap" that was previously referred to as "below the line" that provided flexibility for funding various initiatives; and,
- matters pertaining to medical school faculty.

Disproportionate Share (DSH)

During the current fiscal year, DSH was utilized to offset losses to hospitals as a result of restructuring of LIP as well as a reduction in funding. This was intended to be a "one year solution" and the legislature is reverting to the formula in statute to determine the distribution of the $300+ million in DSH funds for SFY 2017-18. The first draft of the House proposal is available and the Senate version is reported to be similar. The attached House DSH spreadsheets reflect the following impact for Halifax Health:

Public DSH	$2,650,732
Family Practice DSH	$ 762,890
TOTAL DSH	$3,413,622
LESS DSH IGT	$1,985,610
NET DSH	$1,428,013

Upper Payment Limit (UPL)

The Senate Appropriations Bill includes language which allows AHCA to explore reinstating a UPL program with CMS. This may or may not be permissible, and is dependent on CMS regulations as well as how the LIP is structured. SNHAF staff estimate funds available through this mechanism would be approximately $352 million; however, only $60 million would be available to public hospitals.

Request for Information From House Appropriations Committee Chair Trujillo

All hospitals, regardless of ownership status, were asked, and most complied, to provide the following information for the 2016 calendar year by April 7, 2017:

- compensation received for all executive and administrative staff earning in excess of $200,000, identified by individual and job title;
- funds raised by foundations and direct fund raising;
- funds expended for private lobbying contracts by specific lobbyist or lobbying firm;
- funds expended on statewide association dues by specific association; and, if applicable,
- hospital or hospital system's current market capitalization.

LEGISLATION OF INTEREST

TAXING DISTRICTS

- Decennial reauthorization of taxing authority for healthcare taxing districts and requirement for voter referendum prior to establishing facilities beyond the district's geographic boundaries. There is still no House companion; however, there are bills pertaining to local government that this language could be offered as an amendment, to include HB 7065 which pertains to local governments, limits on ad valorem taxes and requirements for new local option taxes.
- Authorizing "open carry" of firearms at certain public meetings, to include taxing district meetings. Open carry gun bills are not likely to pass this session.
- Corporate Integrity Agreements. Bills have been introduced in both chambers which would require all hospitals with Medicaid earnings of $10 million or more to adhere to Corporate Integrity Agreements similar to those developed by the Department of Justice. The bills have not been heard in any of their committees of reference.

HEALTHCARE FACILITIES AND LICENSURE

- Repeal of Certificate of Need for hospitals, hospices and nursing homes. The bill passed the House but has not been heard in the Senate. Unless there is a change in Senate rules, this bill will not pass.
- Creation of a new licensure category for Recovery Care Centers for 72 hour stays and expansion of Ambulatory Surgery stays to 24 hours. The House bill has passed and has been sent to the Senate for action. The Senate bill was amended to remove Recovery Care Centers.
- Requirement for the Agency for Healthcare Administration (AHCA) to adopt criteria for an "acute ready stroke center" and a "comprehensive stroke center" similar to standards of a national accrediting organization. The bill also requires standardized electronic reporting by stroke centers and development of a statewide stroke center registry. The bill passed the House but has not been heard in the Senate.
- Revision of overall guidelines for trauma centers, to include the removal of the cap on the number of centers. The bill has passed all but its last House committee but has not been heard in the Senate.
- Modification to licensure requirements for Level I Cardiovascular care. The bill is advancing in both chambers.

PHYSICIAN AND WORKFORCE

- The bills that would have created new sections in law that would prohibit the Board of Medicine, the Department of Health, healthcare facilities licensed per FS 395 and insurers defined in FS 624 from requiring maintenance of certification or recertification as a condition of licensure, reimbursement, employment or admitting privileges for a physician who has achieved an initial certification have been amended to remove those restrictions.
- Expansion of scope of practice that would permit Advanced Registered Nurse Practitioners (ARNPs) to practice independently without physician supervision or protocols and changing the title to Advanced Practice Registered Nurse (APRN) passed its last House committee. There is no Senate companion.
- Expansion of scope of practice for certain ARNPs and Physician Assistants (PAs) allowing for initiation of Baker Act "certifications" are advancing in both chambers.

- Expansion of scope of practice for certain ARNPs that are certified nurse anesthetists. There is no House companion.
- Modifications to programs for impaired health care practitioners. The bills are advancing in both chambers.
- Requirement for AHCA to develop employee surveys to assess "patient safety culture". The bill has passed in the House but has not been heard in the Senate.
- Requirement for certain staffing ratios and prevention of mandatory overtime. The bill is not advancing in either chamber.

INSURANCE

- Repeal of Personal Injury Protection (PIP) insurance. Both chambers have passed bills that repeal PIP. The House replaces PIP with the requirement to carry bodily injury liability coverage of $25,000/person and $50,000 per accident. The Senate is proposing mandatory medical coverage of $5,000 and also initially requires $20,000 per person/$40,000 per accident in bodily injury liability coverage. Halifax's average PIP collections for FYs 2015 and 2016 average just under $5 million.
- Revisions to Workman's Compensation Insurance. The Senate bill proposes a cap on attorney's fees. The House bill ties hospital reimbursement to percentages of Medicare reimbursement. Estimated impact to Halifax, should the House position prevail, is $2.5 million.
- Revisions to Florida's Medicaid Managed Care Program which authorizes AHCA to request a waiver that requires monthly premium payments as well as work requirements unless an exemption is granted. The bill is scheduled to be heard by the House the week of April 24th. There is no Senate bill but this could be included in budget negotiations.
- Authorization to contract for Direct Primary Care outside of Department of Insurance regulations. The bill has passed in the House and is advancing in the Senate.
- Prohibition for health insurers to retroactively deny a claim once patient eligibility has been verified and an authorization number is given. The bill is advancing in both chambers.

MENTAL HEALTH AND SUBSTANCE ABUSE

- Modifications to Baker Act reporting requirements for state funded beds and requirements for certain hearings to occur within 5 days. Emergency Department requirements for patients with opioid overdoses. Bills pertaining to the Baker Act and opioids have been amended several times and are advancing in both chambers.

REIMBURSEMENT

- Limiting charges to Department of Corrections to 110% of Medicare unless a contract is in place that does not exceed 125% of Medicare. The bills have not been heard in either chamber.

RED LIGHT CAMERAS

- Repeal of local authority and/or overall authority for Red Light cameras. The bill has passed the House but has not been heard in the Senate.

ADMINISTRATIVE

- Limitation on charges for copying medical records. The bill is advancing in the House but has not been heard in the Senate.

CONSTITUTIONAL AMENDMENTS

- Proposed constitutional amendment that would change the percentage of electors required to approve a constitutional amendment or revision from 60% to 66 ¾%. If passed, the question will be on the next general election ballot November 6, 2018. The bill is advancing in the House but has not been heard in the Senate.
- Additional amendments may be proposed due to the convening of the Constitutional Revision Commission which occurs every twenty years.

MEMORIALS

- Introduction of a “Memorial” bill in the House which has no force in law but will serve as a mechanism for formally petitioning the federal government to act on a particular matter. The “Memorial” urges Congress to implement the Medicaid program through a per capita block grant that includes a rate of growth, adjustments for risk and enrollee income and allows for state authority over program design.

Halifax Hospital Medical Center
Audit and Finance Committee Meeting
303 N. Clyde Morris Blvd., France Tower, Conference Room A
Wednesday, March 1, 2017

Present:	Ted Serbousek, Chairman Daniel Francati, Member & Vice Chairman, Board of Commissioners Ammar Hemaidan, MD, Member & Member, Medical Staff Greg Motto, Member Susan Schandel, Member & Treasurer, Board of Commissioners
Not Present:	Decker Youngman, Member
Also Present:	Jeff Feasel, President & CEO Eric Peburn, Executive VP/Chief Financial Officer Kent Bailey, Director of Finance Lisa Tyler, Corporate Controller Bill Rushton, Director, Internal Audit Shelly Shiflet, Chief Compliance Officer Mark Billings, Executive VP/Chief Operating Officer Alberto Tineo, Vice President, Operations Tom Stafford, Vice President and Chief Information Officer Donald Stoner, Senior Vice President & Chief Medical Officer Mary Jo Allen, Executive Director, Halifax Health Hospice Tony Trovato, Director of Business Operations, Halifax Health Hospice Ben Eby, Director of Finance, Halifax Health Hospice Bob Wade, Compliance Expert Jill Wheelock, Associate General Counsel Arvin Lewis, Senior VP/Chief Revenue Officer Bob Williams, Director, Population Health, Business Development and VHN Jacob Nagib, Director, Construction, Engineering & Design Bill Griffin, Director, System Research and Planning Joe Gordy, ADAMS Management

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The meeting was called to order at 4:10 p.m. by Ted Serbousek. Attendance was recorded.

MINUTES

Discussion: Minutes from the February 1, 2017 Audit & Finance Committee Meeting were reviewed.

Action: Ms. Schandel moved to approve the minutes as presented and recommends approval by the Halifax Health Board of Commissioners. Mr. Francati seconded the motion and it carried unanimously.

Deltona Acute Care Hospital Architectural/Engineering Services

Discussion: Mr. Peburn stated the Certificate of Need issued for the acute care hospital in Deltona will reach its expiration in early December 2017 unless construction has begun on the acute care hospital. In order for construction to begin prior to this deadline, design related activities must commence in March 2017. He introduced Mr. Griffin and Mr. Gordy of ADAMS to present the projected timeline and budget, not to exceed $3,350,000 for architectural design and engineering services necessary to begin construction and preserve the CON. Mr. Gordy presented a time line of the work effort to meet the CON time requirement. Discussion ensued.

Action: Mr. Francati moved to approve that architectural fees and engineering services for the Deltona Acute Care Hospital not to exceed $3,350,000 and recommends approval by the Halifax Health Board of Commissioners. Ms. Schandel seconded the motion and it carried unanimously.

AUDIT COMMITTEE

Corporate Compliance

Discussion: Monthly Compliance Program Update Dashboard
Ms. Shiflet presented the Compliance Dashboard for the month ended January 2017, referencing no issues.

Action: None required.

Internal Audit

Discussion: Mr. Rushton requested approval to add the Meaningful Use Stage 2 – 2016 Modified project to the FY 2017 Audit Plan. The audit assesses required documentation to support the attestation requirements for the CMS Meaningful Use program.

Action: Mr. Francati moved to approve the Meaningful Use Stage 2 – 2016 Modified project for the FY 2017 Audit Plan as presented. Ms. Schandel seconded the motion which carried unanimously.

Independent Audit Engagement Letters

Discussion: Ms. Tyler presented the engagement letters for audit services for fiscal year ending 9/30/17 from RSM US LLP for approval.

Action: Mr. Francati moved to approve the engagement letters for audit services provided by RSM US LLP. Ms. Schandel seconded the motion and it carried unanimously.

FINANCE COMMITTEE

FINANCIAL REPORT

Discussion: Mr. Peburn reviewed the January 2017 Financial Report, reporting the performance compared to budget and long range targets, highlighting statistical and financial summaries. Mr. Serbousek inquired about the status of Length of Stay improvement efforts and requested a brief presentation at the next Audit & Finance Committee meeting.

Action: Mr. Francati moved to approve the January 2017 Financial Report and recommends approval by the Board of Commissioners. Ms. Schandel seconded the motion and it carried unanimously.

ACQUISITIONS, LEASES & DISPOSALS

Discussion: Capital Investment Strategy
Mr. Bailey presented the Capital Investment Strategy monthly update.

Action: None required.

Discussion: Capital Expenditures $50,000 and over

- *Replacement of Air Handling Units, #1, #3, #4, and #5 and Emergency Resolution* — $1,643,356
- *Ophthalmology Microscope with Lens & Digital Recorder* — $130,000
- *HVAC Units Southeast Volusia Care Center* — $83,128
- *Minimally Invasive Valve Replacement Instrumentation & Video System* — $73,010

Action: Ms. Schandel moved to approve the capital expenditures and recommends approval by the Board of Commissioners. Mr. Motto seconded the motion and it carried unanimously.

Discussion: Disposals

Action: Mr. Francati moved to approve the disposals and recommends approval by the Board of Commissioners. Ms. Schandel seconded the motion and it carried unanimously.

Discussion: Comparison of Projected and Actual Financial Results for Significant Projects
(none)

Action: None required.

OLD BUSINESS

Discussion: Meeting Request Tracker/Checklist

Action: The Summary Report, Timeline and List of Controls, Physician Contracts and Payments were brought to the committee as information only. No further action needed at this time.

Discussion: Revised Meeting Calendar, 2017

Action: An amended 2017 calendar was shared with the committee as information only, pursuant to action at the February committee meeting that the Investment Committee would hold its quarterly meetings through 2017 as scheduled and moving the monthly Audit & Finance Committee meetings so five more meetings would be held through calendar year 2017. No further action needed at this time.

NEW BUSINESS

Discussion: Proposed Revisions to Halifax Health Care at Home Governance
Mr. Peburn presented proposed revisions to the governance of Halifax Health Care at Home (HHCAH), providing the background of the affiliation and management agreements effective on June 16, 2012 and between East Volusia Health Services, Inc. and the Council on Aging. The affiliation agreement established a 50/50 membership in DASS (d/b/a Halifax Health Care at Home). Since the effective date of the agreement, HHCAH has operated at a loss and accumulated deficit equity. The Council on Aging is no longer financially positioned to fund its percentage of the membership. As such, a resolution and specified terms were recommended to reorganize HHCAH, resulting in an increase in the ownership interest by Halifax Health and forgiveness of the prior working capital deficit owed by Council on Aging. Brief discussion ensued.

Action: Ms. Schandel moved to approve the proposed revisions to the Halifax Health Care at Home Governance as presented and recommends approval by the Halifax Health Board of Commissioners. Mr. Francati seconded the motion and it carried unanimously.

INFORMATIONAL REPORTS

Discussion: The Discharged Based-Average Length of Stay and Case Mix Index, Investment Performance Report for January 2017, the Capital Expenditures, $25,000 - $50,000, and the Operating Lease, $50,000-$250,000 were presented under Information Only. The Capital Expenditures $25,000 - $50,000 were as follows:

- *Surgical Bed for Labor and Delivery* *$41,348*
- *Defibrillators for IMC and CIC* *$33,458*
- *Glass Partition for Registration* *$25,000*
- *Corepoint Web Services License* *$25,000*

The Operating Lease, $50,000-$250,000 was as follows:

- *Lease of Server Hardware* *$6,883.62 (monthly)*

Action: None required.

OPEN DISCUSSION

Discussion: None.

NEXT MEETING DATE: **MONDAY, March 27, 2017 4:00 p.m. – Investment Committee meeting**
WEDNESDAY, April 26, 2017 4:00 p.m. – Regular scheduled meeting

EXECUTIVE SESSION

Discussion: None.

ADJOURNMENT

Action: There being no further business, a motion was made and seconded to adjourn.

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Ted Serbousek, Chairman

Halifax Hospital Medical Center
Investment Committee Meeting
Sub Committee Audit & Finance Committee
France Tower, Conference Room A
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
Monday, November 14, 2016

Present:	Ted Serbousek, Chairman & Chairman, Audit & Finance Committee Dan Francati, Member & Secretary, Board of Commissioners Dave Graffagnino, Member Decker Youngman, Member Greg Motto, Member Mike Walsh, Advisor
Not Present:	Susan Schandel, Member & Treasurer, Board of Commissioners
Also Present:	Jeff Feasel, President & Chief Executive Officer Eric Peburn, Executive Vice President & Chief Financial Officer Kent Bailey, Director of Finance Ben Eby, Director of Finance, Halifax Health Hospice Leslie Wojcik, Ashford Investments Britt Cesarone, Ponder Investment

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The meeting was called to order at 4:05 p.m. by Ted Serbousek.

Manager Presentation

Discussion: Manager Presentation – Ponder Investment
Britt Cesarone from Ponder Investment was introduced and presented a portfolio update (board portal).

Action: None required.

Minutes

Discussion: Minutes from the August 8, 2016 Investment Committee meeting were reviewed.

Action: Mr. Francati moved to approve the August 8, 2016 Investment Committee minutes as presented. Mr. Youngman seconded the motion and it carried unanimously.

Quarterly Review

Discussion: Mr. Walsh, Ashford Investment Advisors, presented the investment review for the 3rd calendar quarter.

Action: None required.

Discussion: Manager Assessment – Ponder Investment
Mr. Walsh presented the results of his comparative evaluation for Ponder Investment (small value, emerging, international and large value comparisons), supporting his recommendation to remain with Ponder Investment. Brief discussion ensued.

Action: Mr. Graffagnino moved to remain with Ponder Investment Company. Mr. Francati seconded

the motion and it carried unanimously.

Old Business

Discussion: None.

New Business

Discussion: Discuss Investment Allocations
Mr. Walsh reviewed the annual investment allocation review as information only.

Action: None required.

Discussion: 2017 Quarterly Timeline
The 2017 Quarterly Timeline was presented as information only.

Action: None required.

Discussion: In other discussion, Mr. Graffagnino inquired about the limits and flexibility set on equities within the investment policies for the Halifax Health Pension Plan, Halifax Hospice and the Halifax Foundation. Discussion continued leading to the recommendation to modify the allocation strategy such that fixed income investments may represent up to 60% of the total portfolio. The current limitation on fixed income investments is 50% of the total portfolio. With this revision, the permitted ranges of fixed income and equity investments would be as follows:

- Equities – 40% to 70%
- Fixed income – 30% to 60%

Action: Mr. Graffagnino moved to approve the proposed investment policy changes as proposed and recommends this be presented to the Halifax Health Audit & Finance Committee and then approval by the Halifax Board of Commissioners. Mr. Youngman seconded the motion and it carried unanimously.

Informational Only

Discussion: Investment Performance Report, September 2016

Action: None required.

Next Meeting: Monday, February 13, 2017 4 p.m. – Regular scheduled meeting

Open Discussion

Discussion: None.

Adjournment

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Ted Serbousek

HALIFAX HEALTH MEDICAL CENTER
SCHEDULE OF USES OF PROPERTY TAXES
FOR THE SIX MONTHS ENDED MARCH 31, 2017

			in mills
Gross property tax levy	$	5,625,972	0.7561
Tax discounts and uncollectible taxes		(175,254)	(0.0236)
Net property taxes collected		5,450,718	0.7325
Amounts paid to Volusia County and Cities:			
Tax collector and appraiser commissions		(187,158)	(0.0252)
Volusia County Medicaid matching assessment		(1,453,879)	(0.1954)
Redevelopment taxes paid to Cities		(300,635)	(0.0404)
Subtotal		(1,941,672)	(0.2610)
Net taxes available for community health, wellness and readiness		3,509,046	0.4715
Amounts paid for community health and wellness services:			
Preventive health services (clinics, Healthy Kids, etc.)		(666,520)	(0.0896)
Physician services		(4,782,532)	(0.6427)
Trauma services		(2,783,360)	(0.3741)
Pediatric and neonatal intensive care services		(367,836)	(0.0494)
Child and adolescent behavioral services		(148,988)	(0.0200)
Subtotal		(8,749,237)	(1.1758)
Deficiency of net taxes available to fund hospital operating expenses		(5,240,191)	(0.7043)
Uncompensated care provided by Halifax Health, ***at cost***		(20,786,170)	(2.7935)
Total deficiency of net taxes available to fund hospital operating expenses and uncompensated care provided by Halifax Health, *at cost*	$	(26,026,361)	(3.4978)
Proforma tax levy to cover uncompensated care, at cost:			
Gross property tax levy			0.7561
Subsidized uncompensated care costs by operations			3.4978
Equivalent property tax levy expended *			4.2539

* This is an equivalent levy for demonstration purposes only and is not intended to represent a proposed millage rate.

Halifax Health
Investment Manager Performance Report - through March 31, 2017

		March Performance	Calendar YTD	Calendar 2016	Fiscal Year
Fixed Income					
VFSIX - Vangaurd Short-Term Investment Gr.	Perf	0.13%	0.84%	2.85%	0.01%
	BMK	0.07%	0.57%	1.56%	-0.49%
VSGDX - Vanguard Short-Term Federal	Perf	0.01%	0.39%	1.24%	-0.45%
	BMK	0.05%	0.39%	1.02%	-0.76%
Ponder Short-term Government/Corporate	Perf	0.09%	0.56%	1.95%	-0.79%
	BMK	0.07%	0.57%	1.56%	-0.49%
Ponder US Treasury Account	Perf	-0.07%	0.15%	0.30%	-0.03%
	BMK	0.05%	0.41%	-0.44%	-0.52%
Ponder Short-Term Government	Perf	0.04%	0.34%	0.88%	-0.49%
	BMK	0.05%	0.39%	1.02%	-0.76%
Ponder 2016 Project Fund	Perf	0.05%	0.11%	0.43%	0.55%
	BMK	0.05%	0.41%	0.29%	0.02%
Weighted Composite	**Perf**	**0.08%**	**0.62%**	**1.99%**	**-0.11%**
	BMK	**0.06%**	**0.52%**	**1.07%**	**-0.52%**
Equities					
DFSVX - DFA Small Cap Value	Perf	-1.14%	-1.35%	28.26%	13.50%
	BMK	-0.85%	-0.13%	31.74%	13.91%
DFLVX - DFA Large Cap Value	Perf	-0.93%	3.53%	18.89%	12.46%
	BMK	-1.02%	3.27%	17.34%	10.16%
DFIVX - DFA International Value	Perf	2.27%	5.93%	8.41%	11.32%
	BMK	2.54%	6.81%	2.75%	6.44%
DFEVX - DFA Emerging Markets	Perf	2.74%	14.20%	19.84%	13.09%
	BMK	2.52%	11.44%	11.19%	6.80%
VGELX - Vanguard Energy	Perf	-0.02%	-3.99%	33.18%	1.25%
	BMK	0.35%	-3.90%	27.66%	3.25%
VENAX - Vanguard Energy Index	Perf	-1.06%	-6.92%	28.94%	0.14%
	BMK	0.35%	-3.90%	27.66%	3.25%
VIGIX -Vanguard Large-Cap Growth	Perf	1.32%	9.61%	6.13%	9.15%
	BMK	1.16%	8.91%	7.08%	10.02%
VGHAX - Vanguard Health Care	Perf	0.38%	10.59%	-8.94%	4.01%
	BMK	0.29%	8.37%	-6.83%	2.44%
VSGIX - Vanguard Small-Cap Growth	Perf	0.42%	6.03%	10.74%	7.54%
	BMK	1.18%	5.35%	11.32%	9.11%
Weighted Composite	**Perf**	**0.48%**	**4.94%**	**15.17%**	**10.33%**
	BMK	**0.66%**	**4.86%**	**13.82%**	**8.79%**

Halifax Health

Investment Manager Performance Report - through March 31, 2017

		Invested Balance	March Performance		Calendar YTD	Fiscal YTD
HH Holdings						
VFSIX - Vanguard Short-Term Invest Grade	$	53,031,926	Perf	0.13%	0.84%	0.01%
			BMK	0.07%	0.57%	-0.49%
Ponder Short-Term Gov't/Corporate		31,837,878	Perf	0.09%	0.56%	-0.79%
			BMK	0.07%	0.57%	-0.49%
Ponder US Treasury Account		73,355,434	Perf	-0.07%	0.15%	-0.03%
			BMK	0.05%	0.41%	-0.52%
Total HH Holdings	$	158,225,238	Composite	**0.03%**	**0.46%**	**-0.17%**
			Budget			0.50%
HHMC						
Ponder Short-Term Government	$	42,099,744	Perf	0.04%	0.34%	-0.49%
			BMK	0.05%	0.39%	-0.76%
VSGDX - Vanguard Short-Term Federal		64,246	Perf	0.01%	0.39%	-0.45%
			BMK	0.05%	0.39%	-0.76%
Wells Fargo Halifax Hospital Trust		579,094	Perf	0.03%	0.11%	0.18%
			BMK	0.05%	0.39%	-0.76%
Ponder 2016 Project Fund		7,216,502	Perf	0.05%	0.11%	0.55%
			BMK	0.05%	0.41%	0.02%
Total HHMC	$	49,959,586	Composite	**0.04%**	**0.30%**	**-0.33%**
			Budget			0.50%

Halifax Health

Investment Manager Performance Report - through March 31, 2017

		Invested Balance		March Performance	Calendar YTD	Fiscal YTD
Foundation						
VFSIX - Vanguard Short-Term Invest Grade	$	22,264,215	Perf	0.13%	0.84%	0.01%
			BMK	0.07%	0.57%	-0.49%
DFSVX - DFA Small Cap Value		3,574,459	Perf	-1.14%	-1.35%	13.50%
			BMK	-0.85%	-0.13%	13.91%
DFIVX - DFA International Value		1,983,630	Perf	2.27%	5.93%	11.32%
			BMK	2.54%	6.81%	6.44%
DFEVX - DFA Emerging Markets		721,777	Perf	2.74%	14.20%	13.09%
			BMK	2.52%	11.44%	6.80%
DFLVX - DFA Large Cap Value		7,700,913	Perf	-0.93%	3.53%	12.46%
			BMK	-1.02%	3.27%	10.16%
VGELX - Vanguard Energy		471,076	Perf	-0.02%	-3.99%	1.25%
			BMK	0.35%	-3.90%	3.25%
VENAX - Vanguard Energy Index		217,716	Perf	-1.06%	-6.92%	0.14%
			BMK	0.35%	-3.90%	3.25%
VIGIX -Vanguard Large-Cap Growth		3,819,852	Perf	1.32%	9.61%	9.15%
			BMK	1.16%	8.91%	10.02%
VGHAX - Vanguard Health Care		692,772	Perf	0.38%	10.59%	4.01%
			BMK	0.29%	8.37%	2.44%
VSGIX - Vanguard Small-Cap Growth		3,869,369	Perf	0.42%	6.03%	7.54%
			BMK	1.18%	5.35%	9.11%
Total Foundation	$	45,315,779	Composite	**0.11%**	**2.80%**	**5.38%**
			Budget			2.00%

Halifax Health

Investment Manager Performance Report - through March 31, 2017

		Invested Balance	March Performance		Calendar YTD	Fiscal YTD
Hospice						
VFSIX - Vanguard Short-Term Invest Grade	$	34,232,224	Perf	0.13%	0.84%	0.01%
			BMK	0.07%	0.57%	-0.49%
DFSVX - DFA Small Cap Value		5,553,586	Perf	-1.14%	-1.35%	13.50%
			BMK	-0.85%	-0.13%	13.91%
DFIVX - DFA International Value		3,066,774	Perf	2.27%	5.93%	11.32%
			BMK	2.54%	6.81%	6.44%
DFEVX - DFA Emerging Markets		1,289,922	Perf	2.74%	14.20%	13.09%
			BMK	2.52%	11.44%	6.80%
DFLVX - DFA Large Cap Value		12,086,983	Perf	-0.93%	3.53%	12.46%
			BMK	-1.02%	3.27%	10.16%
VGELX - Vanguard Energy		104,094	Perf	-0.02%	-3.99%	1.25%
			BMK	0.35%	-3.90%	3.25%
VENAX - Vanguard Energy Index		580,285	Perf	-1.06%	-6.92%	0.14%
			BMK	0.35%	-3.90%	3.25%
VIGIX -Vanguard Large-Cap Growth		6,261,037	Perf	1.32%	9.61%	9.15%
			BMK	1.16%	8.91%	10.02%
VGHAX - Vanguard Health Care		602,390	Perf	0.38%	10.59%	4.01%
			BMK	0.29%	8.37%	2.44%
VSGIX - Vanguard Small-Cap Growth		5,624,964	Perf	0.42%	6.03%	7.54%
			BMK	1.18%	5.35%	9.11%
Total Hospice	$	69,402,259	Composite	**0.11%**	**2.83%**	**5.47%**
			Budget			2.00%

Halifax Health

Investment Manager Performance Report - through March 31, 2017

		Invested Balance	March Performance		Calendar YTD	Fiscal YTD
Pension						
VFSIX - Vanguard Short-Term Invest Grade	$	128,440,703	Perf	0.13%	0.84%	0.01%
			BMK	0.07%	0.57%	-0.49%
DFSVX - DFA Small Cap Value		20,401,423	Perf	-1.14%	-1.35%	13.50%
			BMK	-0.85%	-0.13%	13.91%
DFIVX - DFA International Value		33,672,203	Perf	2.27%	5.93%	11.32%
			BMK	2.54%	6.81%	6.44%
DFEVX - DFA Emerging Markets		12,027,546	Perf	2.74%	14.20%	13.09%
			BMK	2.52%	11.44%	6.80%
DFLVX - DFA Large Cap Value		22,244,533	Perf	-0.93%	3.53%	12.46%
			BMK	-1.02%	3.27%	10.16%
VGELX - Vanguard Energy		4,343,922	Perf	-0.02%	-3.99%	1.25%
			BMK	0.35%	-3.90%	3.25%
VENAX - Vanguard Energy Index		5,123,194	Perf	-1.06%	-6.92%	0.14%
			BMK	0.35%	-3.90%	3.25%
VIGIX -Vanguard Large-Cap Growth		13,237,536	Perf	1.32%	9.61%	9.15%
			BMK	1.16%	8.91%	10.02%
VGHAX - Vanguard Health Care		9,012,025	Perf	0.38%	10.59%	4.01%
			BMK	0.29%	8.37%	2.44%
VSGIX - Vanguard Small-Cap Growth		12,925,829	Perf	0.42%	6.03%	7.54%
			BMK	1.18%	5.35%	9.11%
Wells Fargo Cash		3,436,596				
Wells Fargo Money Market		1,719				
Total Pension	$	264,867,229	Composite	**0.39%**	**1.93%**	**5.11%**
			Budget			3.38%
Total Halifax Health, including Pension	**$**	**587,770,091**				
Total Halifax Health, excluding Pension	**$**	**322,902,862**				

Halifax Health

Investment Manager Performance Report - through February 28, 2017

		February Performance	Calendar YTD	Calendar 2016	Fiscal Year
Fixed Income					
VFSIX - Vangaurd Short-Term Investment Gr.	Perf	0.35%	0.70%	2.85%	-0.13%
	BMK	0.25%	0.50%	1.56%	-0.56%
VSGDX - Vanguard Short-Term Federal	Perf	0.18%	0.37%	1.24%	-0.47%
	BMK	0.15%	0.34%	1.02%	-0.81%
Ponder Short-term Government/Corporate	Perf	0.31%	0.47%	1.95%	-0.88%
	BMK	0.25%	0.50%	1.56%	-0.56%
Ponder US Treasury Account	Perf	0.05%	0.21%	0.30%	0.03%
	BMK	0.16%	0.35%	-0.44%	-0.58%
Ponder Short-Term Government	Perf	0.17%	0.29%	0.88%	-0.54%
	BMK	0.15%	0.34%	1.02%	-0.81%
Ponder 2016 Project Fund	Perf	0.04%	0.06%	0.43%	0.50%
	BMK	0.16%	0.35%	0.29%	-0.04%
Weighted Composite	**Perf**	**0.26%**	**0.53%**	**1.99%**	**-0.19%**
	BMK	**0.22%**	**0.45%**	**1.07%**	**-0.58%**
Equities					
DFSVX - DFA Small Cap Value	Perf	0.32%	-0.21%	28.26%	14.81%
	BMK	1.45%	0.72%	31.74%	14.88%
DFLVX - DFA Large Cap Value	Perf	3.01%	4.50%	18.89%	13.52%
	BMK	3.59%	4.33%	17.34%	11.29%
DFIVX - DFA International Value	Perf	-0.69%	3.58%	8.41%	8.85%
	BMK	1.15%	4.16%	2.75%	3.80%
DFEVX - DFA Emerging Markets	Perf	4.56%	11.15%	19.84%	10.07%
	BMK	3.06%	8.70%	11.19%	4.18%
VGELX - Vanguard Energy	Perf	-2.21%	-3.97%	33.18%	1.27%
	BMK	-1.98%	-4.23%	27.66%	2.90%
VENAX - Vanguard Energy Index	Perf	-2.67%	-5.92%	28.94%	1.21%
	BMK	-1.98%	-4.23%	27.66%	2.90%
VIGIX -Vanguard Large-Cap Growth	Perf	4.36%	8.18%	6.13%	7.73%
	BMK	4.15%	7.66%	7.08%	8.76%
VGHAX - Vanguard Health Care	Perf	7.20%	10.18%	-8.94%	3.62%
	BMK	5.73%	8.05%	-6.83%	2.14%
VSGIX - Vanguard Small-Cap Growth	Perf	2.75%	5.58%	10.74%	7.08%
	BMK	2.45%	4.12%	11.32%	7.84%
Weighted Composite	**Perf**	**2.01%**	**4.39%**	**15.17%**	**9.85%**
	BMK	**2.46%**	**4.13%**	**13.82%**	**8.17%**

Halifax Health

Investment Manager Performance Report - through February 28, 2017

		Invested Balance	February Performance		Calendar YTD	Fiscal YTD
HH Holdings						
VFSIX - Vanguard Short-Term Invest Grade	$	52,963,746	Perf	0.35%	0.70%	-0.13%
			BMK	0.25%	0.50%	-0.56%
Ponder Short-Term Gov't/Corporate		31,810,096	Perf	0.31%	0.47%	-0.88%
			BMK	0.25%	0.50%	-0.56%
Ponder US Treasury Account		80,403,364	Perf	0.05%	0.21%	0.03%
			BMK	0.16%	0.35%	-0.58%
Total HH Holdings	$	165,177,206	Composite	**0.20%**	**0.42%**	**-0.19%**
			Budget			0.42%
HHMC						
Ponder Short-Term Government	$	42,081,220	Perf	0.17%	0.29%	-0.54%
			BMK	0.15%	0.34%	-0.81%
VSGDX - Vanguard Short-Term Federal		64,239	Perf	0.18%	0.37%	-0.47%
			BMK	0.15%	0.34%	-0.81%
Wells Fargo Halifax Hospital Trust		583,892	Perf	0.03%	0.08%	0.15%
			BMK	0.15%	0.34%	-0.81%
Ponder 2016 Project Fund		7,213,019	Perf	0.04%	0.06%	0.50%
			BMK	0.16%	0.35%	-0.04%
Total HHMC	$	49,942,370	Composite	**0.15%**	**0.25%**	**-0.38%**
			Budget			0.42%

Halifax Health

Investment Manager Performance Report - through February 28, 2017

		Invested Balance	February Performance		Calendar YTD	Fiscal YTD
Foundation						
VFSIX - Vanguard Short-Term Invest Grade	$	22,235,591	Perf	0.35%	0.70%	-0.13%
			BMK	0.25%	0.50%	-0.56%
DFSVX - DFA Small Cap Value		3,615,570	Perf	0.32%	-0.21%	14.81%
			BMK	1.45%	0.72%	14.88%
DFIVX - DFA International Value		1,939,689	Perf	-0.69%	3.58%	8.85%
			BMK	1.15%	4.16%	3.80%
DFEVX - DFA Emerging Markets		702,512	Perf	4.56%	11.15%	10.07%
			BMK	3.06%	8.70%	4.18%
DFLVX - DFA Large Cap Value		7,773,453	Perf	3.01%	4.50%	13.52%
			BMK	3.59%	4.33%	11.29%
VGELX - Vanguard Energy		471,152	Perf	-2.21%	-3.97%	1.27%
			BMK	-1.98%	-4.23%	2.90%
VENAX - Vanguard Energy Index		220,051	Perf	-2.67%	-5.92%	1.21%
			BMK	-1.98%	-4.23%	2.90%
VIGIX -Vanguard Large-Cap Growth		3,770,050	Perf	4.36%	8.18%	7.73%
			BMK	4.15%	7.66%	8.76%
VGHAX - Vanguard Health Care		690,183	Perf	7.20%	10.18%	3.62%
			BMK	5.73%	8.05%	2.14%
VSGIX - Vanguard Small-Cap Growth		3,852,997	Perf	2.75%	5.58%	7.08%
			BMK	2.45%	4.12%	7.84%
Total Foundation	$	45,271,248	Composite	**1.43%**	**2.67%**	**5.30%**
			Budget			1.67%

Halifax Health

Investment Manager Performance Report - through February 28, 2017

		Invested Balance	February Performance		Calendar YTD	Fiscal YTD
Hospice						
VFSIX - Vanguard Short-Term Invest Grade	$	34,188,214	Perf	0.37%	0.70%	-0.13%
			BMK	0.25%	0.50%	-0.56%
DFSVX - DFA Small Cap Value		5,617,459	Perf	0.32%	-0.21%	14.81%
			BMK	1.45%	0.72%	14.88%
DFIVX - DFA International Value		2,998,840	Perf	-0.69%	3.58%	8.85%
			BMK	1.15%	4.16%	3.80%
DFEVX - DFA Emerging Markets		1,255,492	Perf	4.56%	11.15%	10.07%
			BMK	3.06%	8.70%	4.18%
DFLVX - DFA Large Cap Value		12,200,839	Perf	3.01%	4.50%	13.52%
			BMK	3.59%	4.33%	11.29%
VGELX - Vanguard Energy		104,110	Perf	-2.21%	-3.97%	1.27%
			BMK	-1.98%	-4.23%	2.90%
VENAX - Vanguard Energy Index		586,509	Perf	-2.67%	-5.92%	1.21%
			BMK	-1.98%	-4.23%	2.90%
VIGIX -Vanguard Large-Cap Growth		6,179,405	Perf	4.36%	8.18%	7.73%
			BMK	4.15%	7.66%	8.76%
VGHAX - Vanguard Health Care		600,138	Perf	7.20%	10.18%	3.62%
			BMK	5.73%	8.05%	2.14%
VSGIX - Vanguard Small-Cap Growth		5,601,163	Perf	2.75%	5.58%	7.08%
			BMK	2.45%	4.12%	7.84%
Total Hospice	$	69,332,169	Composite	**1.43%**	**2.69%**	**5.39%**
			Budget			1.67%

Halifax Health

Investment Manager Performance Report - through February 28, 2017

		Invested Balance	February Performance		Calendar YTD	Fiscal YTD
Pension						
VFSIX - Vanguard Short-Term Invest Grade	$	128,275,575	Perf	0.35%	0.70%	-0.13%
			BMK	0.25%	0.50%	-0.56%
DFSVX - DFA Small Cap Value		20,636,067	Perf	0.32%	-0.21%	14.81%
			BMK	1.45%	0.72%	14.88%
DFIVX - DFA International Value		32,926,317	Perf	-0.69%	3.58%	8.85%
			BMK	1.15%	4.16%	3.80%
DFEVX - DFA Emerging Markets		11,706,519	Perf	4.56%	11.15%	10.07%
			BMK	3.06%	8.70%	4.18%
DFLVX - DFA Large Cap Value		22,454,070	Perf	3.01%	4.50%	13.52%
			BMK	3.59%	4.33%	11.29%
VGELX - Vanguard Energy		4,344,612	Perf	-2.21%	-3.97%	1.27%
			BMK	-1.98%	-4.23%	2.90%
VENAX - Vanguard Energy Index		5,178,140	Perf	-2.67%	-5.92%	1.21%
			BMK	-1.98%	-4.23%	2.90%
VIGIX -Vanguard Large-Cap Growth		13,064,945	Perf	4.36%	8.18%	7.73%
			BMK	4.15%	7.66%	8.76%
VGHAX - Vanguard Health Care		8,978,341	Perf	7.20%	10.18%	3.62%
			BMK	5.73%	8.05%	2.14%
VSGIX - Vanguard Small-Cap Growth		12,871,135	Perf	2.75%	5.58%	7.08%
			BMK	2.45%	4.12%	7.84%
Wells Fargo Cash		683,485				
Wells Fargo Money Market		4,401,062				
Total Pension	$	265,520,268	Composite		**1.07%**	**2.48%**	**4.67%**
			Budget				2.81%
Total Halifax Health, including Pension	**$**	**595,243,261**				
Total Halifax Health, excluding Pension	**$**	**329,722,993**				

INFORMATIONAL REPORT
April 26, 2017

Capital Expenditures $25,000 -- $50,000

DESCRIPTION	DEPARTMENT	SOURCE OF FUNDS	TOTAL
Patient Monitors for Vital Signs	Nursing and Emergency Departments	Working Capital	$45,993
Venous Ablation System	Cardiology Department	Working Capital	$42,250
Telestroke Video Conferencing System	Business Development	Working Capital	$40,729

Operating Leases $50,000 -- $250,000

DESCRIPTION	DEPARTMENT	REPLACEMENT Y/N	LEASE TERMS	INTEREST RATE	MONTHLY PAYMENT

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Mark Billings, Executive Vice President and Chief Operating Officer
CC: Eric Peburn, Executive Vice President and Chief Financial Officer
Catherine Luchsinger, RN, Chief Nursing Officer
DATE: April 17, 2017
RE: Patient Monitors for Vital Signs

Halifax Health Nursing and Emergency Departments are requesting funds to purchase ten (10) patient monitors used to monitor patients' vital signs. The monitors will be used for patients who do not require continuous monitoring.

The vital signs monitors measure the patient's blood pressure, temperature and oxygen saturation levels. The new monitors connect with the electronic medical record which will facilitate integration of the patient's information to the medical record increasing efficiency and quality patient care.

The project was approved at the Capital Investment Committee meeting on March 15, 2017.

TOTAL CAPITAL COSTS **$45,993**

HALIFAX HEALTH

Halifax Health

Project Evaluation

Patient Monitors for Vital Signs

Chief Operating Officer:	Mark Billings
Chief Nursing Officer:	Catherine Luchsinger
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project is to purchase ten patient monitors used to monitor a patients blood pressure, temperature, and oxygen saturation levels.

Strategic Plan Core Competency Achievement:

Physician Integration	
Care Coordination	X
Cost Management	
Information Technology	
Service Distribution	
Financial Position	
Scale	
Managed Care Contracting	
Competitive Position	

Cornerstone:

Safety	X
Compassion	X
Image	
Efficiency	

Investment Request for Approval **$45,993**

Recommendation for approval of the project is not based upon incremental return on investment.

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Mark Billings, Executive Vice President and Chief Operating Officer
CC: Eric Peburn, Executive Vice President and Chief Financial Officer
Alberto Tineo, Vice President Operations
DATE: March 16, 2017
RE: Venous Ablation System

Halifax Health Cardiology Department is requesting funds to purchase a radiofrequency venous ablation system. This system is used to treat patients with leg disorders related to venous reflux disease, such as varicose veins.

With the expansion of our partnership with UF Health and the addition of two vascular surgeons, there is an increase in the need to provide venous ablation services. Purchasing this system will allow us to continue to have this service at Twin Lakes and add the service at the main campus.

The project was approved at the Capital Investment Committee meeting on October 19, 2016.

CAPITAL COSTS FOR APPROVAL **$42,250**

Halifax Health

Project Evaluation

Venous Ablation System

Chief Operating Officer:	Mark Billings
Vice President, Operations:	Alberto Tineo
Service Line Administrator:	Matt Petkus
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project is to purchase a radiofrequency venous ablation system which will be used to treat patients with leg disorders related to venous reflux disease.

Strategic Plan Core Competency Achievement:

Physician Integration	X
Care Coordination	X
Cost Management	
Information Technology	
Service Distribution	
Financial Position	
Scale	
Managed Care Contracting	
Competitive Position	X

Cornerstone:

Safety	X
Compassion	X
Image	
Efficiency	

Investment Request for Approval **$42,250**

Recommendation for approval of the project is not based upon incremental return on investment.

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Eric Peburn, Executive Vice President and Chief Financial Officer
DATE: March 16, 2017
RE: TeleStroke Video Conferencing System

Halifax Health Comprehensive Stroke Center is requesting funds to purchase a TeleStroke videoconferencing system. The system will be used as a pilot telemedicine project for the Halifax Health Port Orange Emergency Department.

To support the pilot program, each of the Halifax Health Port Orange emergency rooms will be equipped with video conferencing equipment including high definition cameras and video monitors. The system will utilize Halifax Health's existing computer network video conferencing infrastructure.

TeleStroke provides a physician consultation via video when a neurologist is not on location. The neurologist will be able to securely view and interact with the patient from a computer, tablet or mobile device from any remote location with an Internet connection. The neurologist will determine a course of action including the administration of Intravenous Tissue Plasminogen Activator (IV-tPA) which dissolves clots and restores blood flow to the injured area.

Further expansion of the system to other Halifax Health locations will be evaluated based upon the success of this pilot project.

The project was approved at the Capital Investment Committee meeting on December 21, 2016.

TOTAL CAPITAL COSTS **$40,729**

HALIFAX HEALTH

Halifax Health

Project Evaluation

TeleStroke Video Conferencing System

Chief Financial Officer:	Eric Peburn
Director, Population Health:	Bob Williams
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project is to purchase a TeleStroke videoconferencing system which will be used as a pilot telemedicine project for the Port Orange Emergency Department.

Strategic Plan Core Competency Achievement:	
Physician Integration	X
Care Coordination	X
Cost Management	
Information Technology	X
Service Distribution	X
Financial Position	
Scale	
Managed Care Contracting	
Competitive Position	

Cornerstone:	
Safety	X
Compassion	X
Image	
Efficiency	X

Investment Request for Approval $ 40,729

Recommendation for approval of the project is not based upon incremental return on investment.

HALIFAX HEALTH

TO: Jeff Feasel, President & CEO
FROM: Deanna Schaeffer, Executive Director, Healthy Communities
DATE: April 20, 2017
RE: Healthy Communities Board of Directors Appointment

Per the recommendation of the Healthy Communities Board of Directors at its meeting on April 19, 2017, I would like to respectfully request appointment consideration of Mr. Jeff Davidson to the Healthy Communities Board of Directors. Pending approval, Mr. Davidson will fulfill a term vacancy through October 31, 2018.

Jeff M. Davidson, Chief Financial Officer of Southeast Volusia Medical Services

Mr. Davidson is a native of Daytona Beach Florida, born at Halifax Medical Center. Mr. Davidson joined the Southeast Volusia Hospital District in 2011 as the Chief Financial Officer. Prior to joining the Southeast Volusia Hospital District, he was the Human Resource Manager at Kingspan, formerly known as Metecno Panel System in Deland, Florida and the Accounting Manager at Bert Fish Medical Center Inc. He holds a Bachelor and Master's degree in Accounting from the University of Central Florida. He is a Certified Public Accountant licensed in Florida and holds the designation of a Chartered Global Management Accountant. He is also a member of the American Institute of Certified Public Accountants and Florida Institute of Certified Public Accountants. In addition, he is a Director on the Bonner Chiles Foundation Board located in Daytona Beach, Florida.

Thank you for your consideration.

Halifax Health
Summary Financial Narrative
For the six months ended March 31, 2017

The performance of Halifax Health compared to budget and long-range targets (S&P "A" rated medians) for key financial indicators is as follows.

Financial Indicator	YTD Actual FY 17	YTD Budget FY 17	YTD Actual vs. Budget	S&P "A"	YTD Actual FY 17 vs. S&P "A"
Total Margin	3.0%	2.1%	Favorable	5.8%	Unfavorable
Operating Margin	1.6%	1.1%	Favorable	3.6%	Unfavorable
EBIDA Margin	10.4%	9.6%	Favorable	13.1%	Unfavorable
Operating EBIDA Margin	9.1%	8.7%	Favorable	10.8%	Unfavorable
Adjusted Operating EBIDA Margin *	8.4%	8.5%	Unfavorable	N/A	N/A
Days Cash on Hand	253	262	Unfavorable	249	Favorable
Cash to Debt	95.0%	98.9%	Unfavorable	189.9%	Unfavorable
Debt to Capitalization	56.2%	56.0%	Unfavorable	29.1%	Unfavorable
OG MADS Coverage	2.25	2.12	Favorable	4.50	Unfavorable
OG Debt to Capitalization	55.2%	55.0%	Unfavorable	29.1%	Unfavorable

* - Excludes investment income/loss of Foundation recorded as operating income.

Halifax Health Medical Center

Statistical Summary--

- Admissions for the month and fiscal year-to-date are less than budget and last year.
- Patient days for the month are greater than budget and less than last year; and for the fiscal year year-to-date are greater than budget and last year.
    - Observation patient days for the month are greater than budget and less than last year; and for the fiscal year-to-date are greater than budget and last year.
- Surgery volumes for the month are greater than budget and last year; and for the fiscal year-to-date are less than budget and last year.
- Emergency room visits for the month and fiscal year-to-date are less than budget and last year.

Financial Summary --

- Net patient service revenue for the fiscal year-to-date is 2.3% greater than budget.
- Total operating expenses for the fiscal year-to-date are 1.4% greater than budget.
- Income from operations fiscal year-to-date of $2.1 million compares favorably to budget by $947,000.
- Nonoperating gains/(losses) fiscal year-to-date of negative $160,000, primarily consisting of net investment losses, compare unfavorably to the budgeted amount by $1.3 million.
- The increase in net position fiscal year-to-date of $2.0 million compares unfavorably to budget by $398,000.

Halifax Health Hospice

Statistical Summary –

- Patient days for the month are less than budget and greater than last year; and for the fiscal year-to-date are less than budget and last year.

Financial Summary --

- Net patient service revenue for the fiscal year-to-date is 9.1% less than budget.
- Loss from operations fiscal year-to-date of $992,000 compares unfavorably to budget by $1.2 million.
- Nonoperating gains fiscal year-to-date of $4.0 million, including investment income of $3.6 million, is greater than the budgeted amount by $2.5 million.
- The increase in net position fiscal year-to-date of $3.0 million compares favorably to budget by $1.3 million.

Other Component Units - The fiscal year-to-date financial performance is consistent with budgeted expectations.

Halifax Health
Summary Financial Indicators – Excluding Estimated Hurricane Matthew Costs
For the six months ended March 31, 2017

The performance of Halifax Health compared to budget and long-range targets (S&P "A" rated medians) for key financial indicators, including computations excluding $1.8 million of estimated Hurricane Matthew related costs, is as follows.

Financial Indicator	YTD Actual FY 17	YTD Adjusted Actual FY 17 (2)	YTD Budget FY 17	YTD Adj. Actual vs. Budget	S&P "A"	YTD Adj. Actual FY 17 vs. S&P "A"
Total Margin	3.0%	3.6%	2.1%	Favorable	5.8%	Unfavorable
Operating Margin	1.6%	2.3%	1.1%	Favorable	3.6%	Unfavorable
EBIDA Margin	10.4%	11.0%	9.6%	Favorable	13.1%	Unfavorable
Operating EBIDA Margin	9.1%	9.8%	8.7%	Favorable	10.8%	Unfavorable
Adjusted Operating EBIDA Margin (1)	8.4%	9.1%	8.5%	Favorable	N/A	N/A
Days Cash on Hand	253	256	262	Unfavorable	249	Favorable
Cash to Debt	95.0%	95.5%	98.9%	Unfavorable	189.9%	Unfavorable
Debt to Capitalization	56.2%	56.0%	56.0%	Neutral	29.1%	Unfavorable
OG MADS Coverage	2.25	2.42	2.12	Favorable	4.50	Unfavorable
OG Debt to Capitalization	55.2%	55.0%	55.0%	Neutral	29.1%	Unfavorable

(1) - Excludes investment income/loss of Foundation recorded as operating income.

(2) - Financial indicator computed by excluding estimated Hurricane Matthew related expenses of $1.8 million.

Halifax Health
Statistical Summary

Month Ended March 31,					Six Months Ended March 31,			
2016	2017	Budget	Var.		2016	2017	Budget	Var.
				Inpatient Activity				
1,668	1,678	1,690	-0.7%	HHMC Adult/Ped Admissions	9,690	9,571	9,755	-1.9%
155	171	163	4.9%	HHMCPO Adult/Ped Admissions	870	880	948	-7.2%
144	132	152	-13.2%	Adult Psych Admissions	824	858	879	-2.4%
58	73	51	43.1%	Rehabilitative Admissions	328	392	308	27.3%
2,025	**2,054**	**2,056**	**-0.1%**	**Total Adult/Ped Admissions**	**11,712**	**11,701**	**11,890**	**-1.6%**
8,920	8,552	8,457	1.1%	HHMC Adult/Ped Patient Days	50,248	51,201	48,749	5.0%
681	978	784	24.7%	HHMCPO Adult/Ped Patient Days	3,168	4,928	4,560	8.1%
1,289	1,395	1,300	7.3%	Adult Psych Patient Days	8,634	8,374	8,710	-3.9%
1,004	935	866	8.0%	Rehabilitative Patient Days	5,341	5,448	5,085	7.1%
11,894	**11,860**	**11,407**	**4.0%**	**Total Adult/Ped Patient Days**	**67,391**	**69,951**	**67,104**	**4.2%**
5.3	5.1	5.0	1.8%	HHMC Average Length of Stay	5.2	5.3	5.0	7.0%
4.4	5.7	4.8	18.9%	HHMCPO Average Length of Stay	3.6	5.6	4.8	16.4%
5.3	**5.2**	**5.0**	**3.4%**	**HHMC/ HHMCPO Average Length of Stay**	**5.1**	**5.4**	**5.0**	**7.8%**
9.0	10.6	8.6	23.6%	Adult Psych Average Length of Stay	10.5	9.8	9.9	-1.5%
17.3	12.8	17.0	-24.6%	Rehabilitative Length of Stay	16.3	13.9	16.5	-15.8%
5.9	**5.8**	**5.5**	**4.1%**	**Total Average Length of Stay**	**5.8**	**6.0**	**5.6**	**5.9%**
384	**383**	**368**	**4.0%**	**Total Average Daily Census**	**368**	**384**	**369**	**4.2%**
722	719	625	15.0%	HHMC Observation Patient Day Equivalents	3,667	3,883	3,674	5.7%
134	134	103	30.10%	HHMCPO Observation Patient Day Equivalents	567	743	544	36.6%
856	**853**	**728**	**17.2%**	**Total Observation Patient Day Equivalents**	**4,234**	**4,626**	**4,218**	**9.7%**
28	**28**	**23**	**21.7%**	**Observation Average Daily Census**	**23**	**25**	**23**	**8.7%**
146	157	143	9.8%	HHMC Newborn Births	980	879	962	-8.6%
323	290	331	-12.4%	HHMC Nursery Patient Days	1,926	1,650	1,957	-15.7%
504	496	538	-7.8%	HHMC Inpatient Surgeries	2,764	2,697	2,952	-8.6%
1	9	1	800.0%	HHMCPO Inpatient Surgeries	5	26	3	766.7%
505	**505**	**539**	**-6.3%**	**Total Inpatient Surgeries**	**2,769**	**2,723**	**2,955**	**-7.9%**
				Inpatient Surgeries				
203	213			Orthopedics	1,063	1,077		
81	73			General Surgery	504	436		
52	49			Neurosurgery	310	263		
19	30			Vascular	129	157		
19	28			Thoracic Surgery	91	144		
131	112			All Other	672	646		
505	**505**	**539**	**-6.3%**	**Total Inpatient Surgeries**	**2,769**	**2,723**	**2,955**	**-7.9%**

Halifax Health
Statistical Summary

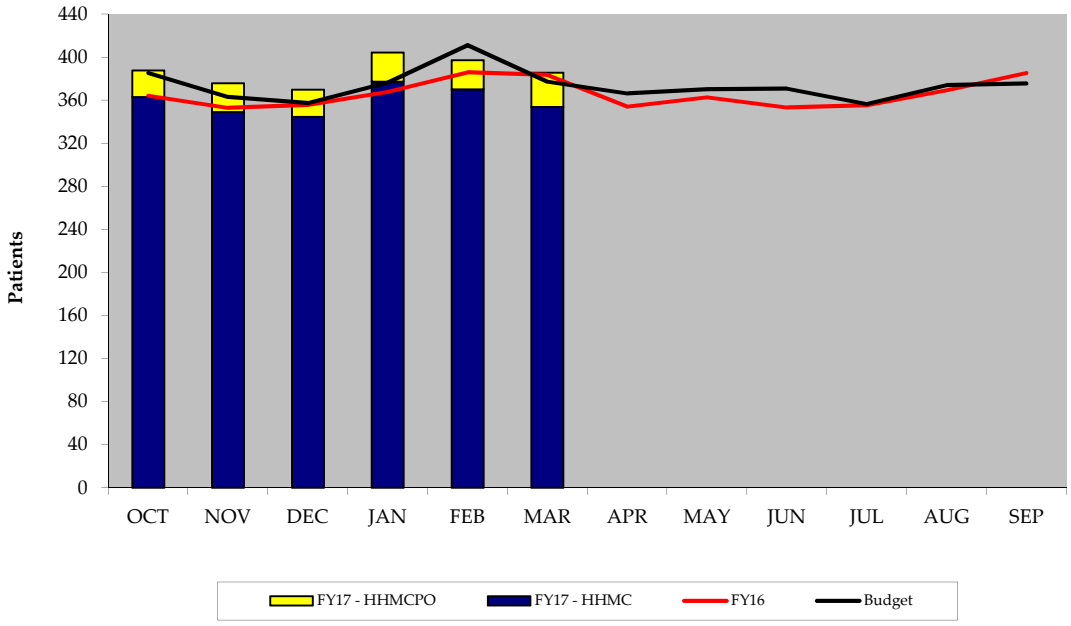
Month Ended March 31,					Six Months Ended March 31,			
2016	2017	Budget	Var.		2016	2017	Budget	Var.
				Outpatient Activity				
7,621	7,119	7,756	-8.2%	HHMC ED Registrations	42,221	40,489	42,971	-5.8%
3,228	2,808	3,363	-16.5%	HHMCPO ED Registrations	17,008	15,602	17,720	-12.0%
10,849	**9,927**	**11,119**	**-10.7%**	**Total ED**	**59,229**	**56,091**	**60,691**	**-7.6%**
427	452	409	10.5%	HHMC Outpatient Surgeries	2,334	2,522	2,239	12.6%
111	3	114	-97.4%	HPC Outpatient Surgeries	578	306	592	-48.3%
0	111	0	0.0%	HHMCPO Outpatient Surgeries	2	126	2	6200.0%
359	364	358	1.7%	Twin Lakes Surgeries	2,245	2,123	2,241	-5.3%
897	**930**	**881**	**5.6%**	**Total Outpatient Surgeries**	**5,159**	**5,077**	**5,074**	**0.1%**
				Outpatient Surgeries				
173	188			General Surgery	1,034	1,093		
176	176			Orthopedics	1,128	993		
99	71			Gastroenterology	646	449		
98	93			Obstetrics Gynecology	443	453		
66	76			Ophthalmology	360	359		
285	326			All Other	1,548	1,730		
897	**930**	**881**	**5.6%**	**Total Outpatient Surgeries**	**5,159**	**5,077**	**5,074**	**0.1%**
				Cardiology Procedures				
16	23			Open Heart Cases	92	111		
103	135			Cardiac Caths	694	766		
36	23			CRM Devices	211	189		
32	31			EP Studies	164	233		
187	**212**	**219**	**-3.2%**	**Total Cardiology Procedures**	**1,161**	**1,299**	**1,233**	**5.4%**
				Interventional Radiology Procedures				
7	5	6	-16.7%	Vascular	47	35	40	-12.5%
152	171	173	-1.2%	Nonvascular	1,222	942	1,113	-15.4%
159	**176**	**179**	**-1.7%**	**Total Interventional Radiology Procedures**	**1,269**	**977**	**1,153**	**-15.3%**
239	**207**	**231**	**-10.4%**	**GI Lab Procedures**	**1,197**	**1,193**	**1,156**	**3.2%**
				HH Hospice Activity				
				Patient Days				
17,046	16,273	17,050	-4.6%	Volusia/ Flagler	100,062	91,978	100,100	-8.1%
227.0	1,139	831	37.1%	Orange/ Osceola	1,057.0	5,472	4,256	28.6%
17,273	**17,412**	**17,881**	**-2.6%**	**HH Hospice Patient Days**	**101,119**	**97,450**	**104,356**	**-6.6%**
				Average Daily Census				
550	525	550	-4.6%	Volusia/ Flagler	547	505	550	-8.1%
7	37	27	37.1%	Orange/ Osceola	6	30	23	28.6%
557	**562**	**577**	**-2.6%**	**HH Hospice Average Daily Census**	**553**	**535**	**573**	**-6.6%**

Halifax Health
Statistical Summary

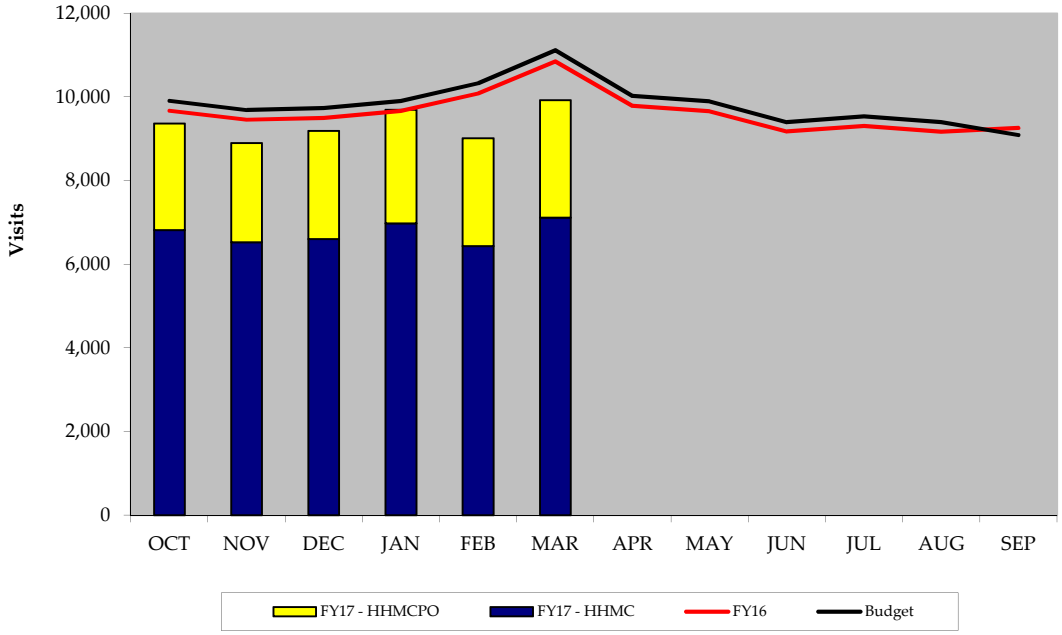
Month Ended March 31,					Six Months Ended March 31,			
2016	2017	Budget	Var.		2016	2017	Budget	Var.
				Physician Practice Activity				
				Primary Care Visits				
281	383	687	-44.3%	Ormond Beach	1,551	1,862	4,030	-53.8%
1,157	1,124	1,154	-2.6%	Daytona Beach	6,472	6,096	6,455	-5.6%
654	758	1,118	-32.2%	Port Orange	1,681	4,207	5,515	-23.7%
690	300	901	-66.7%	Deltona	3,044	1,812	3,976	-54.4%
647	591	1,448	-59.2%	Ormond Beach (Women's/OB)	2,589	2,923	5,794	-49.6%
3,429	**3,156**	**5,308**	**-40.5%**	**Primary Care Visits**	**15,337**	**16,900**	**25,770**	**-34.4%**
				Children's Medical Center Visits				
735	1,002	1,155	-13.2%	Ormond Beach	4,248	5,622	6,677	-15.8%
481	31	494	-93.7%	Palm Coast	2,497	324	2,562	-87.4%
517	522	547	-4.6%	Port Orange	2,810	3,026	2,975	1.7%
1,733	**1,555**	**2,196**	**-29.2%**	**Children's Medical Center Visits**	**9,555**	**8,972**	**12,214**	**-26.5%**
				Community Clinic Visits				
468	526	443	18.7%	Keech Street	2,390	2,496	2,264	10.2%
393	294	393	-25.2%	Adult Community Clinic	2,341	1,494	2,341	-36.2%
861	**820**	**836**	**-1.9%**	**Community Clinic Visits**	**4,731**	**3,990**	**4,605**	**-13.4%**

Halifax Health
Statistical Summary - Graphic

HHMC Average Daily Census
(Monthly)

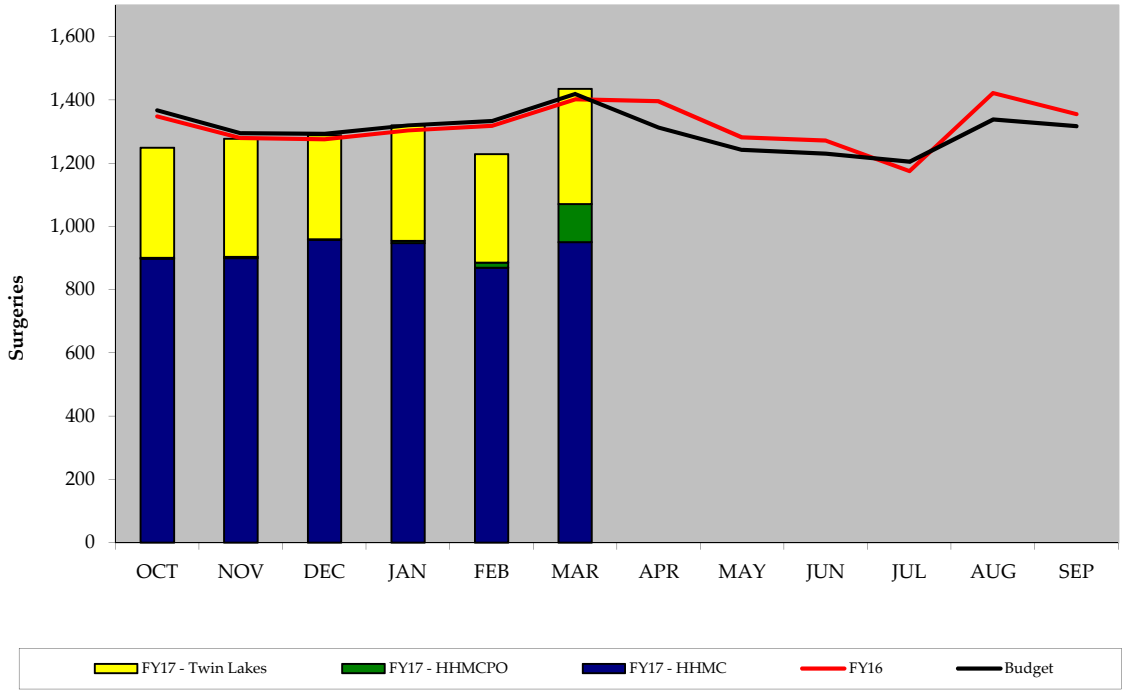


ED Visits
(Monthly)

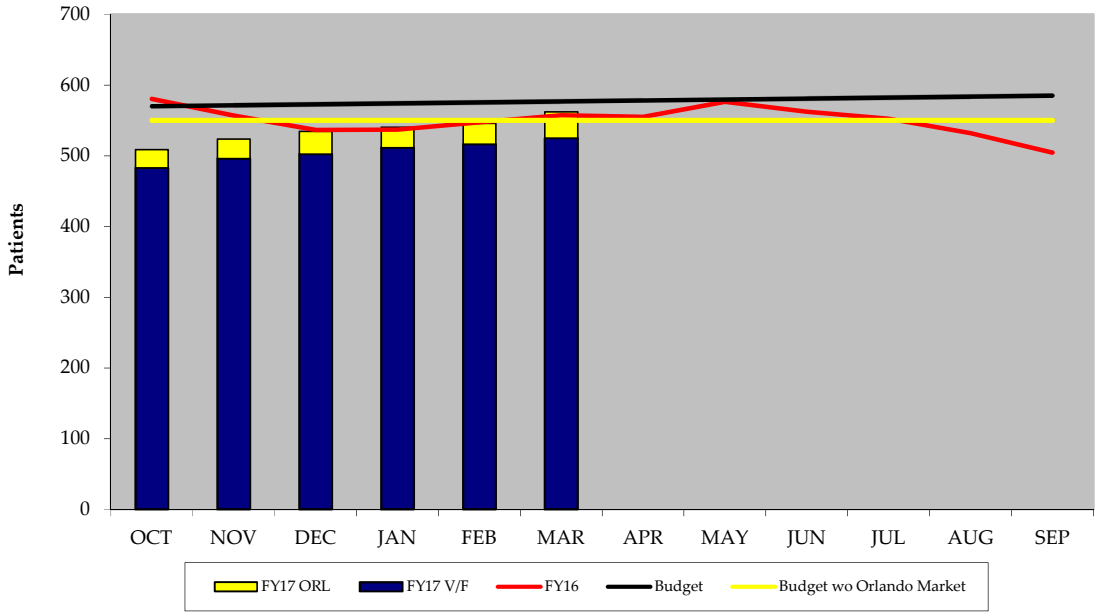


Halifax Health
Statistical Summary - Graphic

Surgeries
(Monthly)



Hospice Average Daily Census
(Monthly)



Halifax Health
Condensed Statement of Net Position
($ in thousands)

	March 31,		
	2017	2016	Change
Assets			
Cash and cash equivalents	$44,188	$52,802	($8,614)
Investments	265,332	256,264	9,068
Board designated assets	44,841	44,801	40
Accounts receivable	66,548	60,590	5,958
Restricted assets whose use is limited	13,670	21,623	(7,953)
Other assets	48,559	39,442	9,117
Deferred outflow - swap	29,980	38,517	(8,537)
Deferred outflow - loss on bond refunding	16,917	17,841	(924)
Deferred outflow - pension	27,833	32,296	(4,463)
Property, plant and equipment	353,603	362,574	(8,971)
Total Assets	$911,471	$926,750	($15,279)
Liabilities and Net position			
Accounts payable	$31,386	$29,436	$1,950
Other liabilities	83,278	86,317	(3,039)
Net pension liability	103,087	130,724	(27,637)
Long-term debt	353,221	355,547	(2,326)
Premium on LTD, net	19,597	20,267	(670)
Long-term value of swap	29,980	38,517	(8,537)
Net position	290,922	265,942	24,980
Total Liabilities and Net position	$911,471	$926,750	($15,279)

Halifax Health
Statement of Cash Flows
($ in thousands)

Month ended March 31, 2017	Month ended March 31, 2016	Variance		Six Months ended March 31, 2017	Six Months ended March 31, 2016	Variance
			Cash flows from operating activities:			
$43,951	$44,005	($54)	Receipts from third party payors and patients	$241,194	$248,391	($7,197)
(21,304)	(20,298)	(1,006)	Payments to employees	(158,532)	(147,299)	(11,233)
(14,779)	(18,844)	4,065	Payments to suppliers	(90,536)	(95,423)	4,887
286	342	(56)	Receipt of ad valorem taxes	10,086	11,877	(1,791)
(5,360)	-	(5,360)	Receipt (payment) of State UPL funds, net	(5,360)	612	(5,972)
2,558	5,077	(2,519)	Other receipts	16,748	18,259	(1,511)
(3,678)	(4,428)	750	Other payments	(21,207)	(22,514)	1,307
1,674	5,854	(4,180)	Net cash provided by (used in) operating activities	(7,607)	13,903	(21,510)
			Cash flows from noncapital financing activities:			
246	64	182	Proceeds from donations received	463	395	68
(8)	-	(8)	Nonoperating gain (loss)	(8)	(5)	(3)
238	64	174	Net cash provided by noncapital financing activities	455	390	65
			Cash flows from capital and related financing activities:			
(2,105)	(1,936)	(169)	Acquisition of capital assets	(9,100)	(12,073)	2,973
(195)	(190)	(5)	Payment of long-term debt	(1,170)	(1,140)	(30)
-	175,424	(175,424)	Proceeds from issuance of long-term debt	-	175,424	(175,424)
-	(15,118)	15,118	Transfers to trustee held funds	5,474	(15,118)	20,592
-	(168,728)	168,728	Payment for defeasance of bonds	-	(168,728)	168,728
(350)	(312)	(38)	Payment of interest on long-term debt	(8,443)	(8,789)	346
-	(1,774)	1,774	Payment of bond issue costs	-	(1,774)	1,774
(2,650)	(12,634)	9,984	Net cash used in capital financing activities	(13,239)	(32,198)	18,959
			Cash flows from investing activities:			
637	893	(256)	Realized investment income (loss)	3,470	4,793	(1,323)
(740)	(1,033)	293	Purchases of investments/limited use assets	(7,018)	(15,005)	7,987
7,005	20,441	(13,436)	Sales/Maturities of investments/limited use assets	9,554	25,166	(15,612)
6,902	20,301	(13,399)	Net cash provided by (used in) investing activities	6,006	14,954	(8,948)
6,164	13,585	(7,421)	**Net increase (decrease) in cash and cash equivalents**	(14,385)	(2,951)	(11,434)
38,024	39,217	(1,193)	**Cash and cash equivalents at beginning of period**	58,573	55,753	2,820
$44,188	$52,802	($8,614)	**Cash and cash equivalents at end of period**	$44,188	$52,802	($8,614)

Halifax Health
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended March 31, 2017	Actual Month Ended March 31, 2016	Favorable (Unfavorable) Variance		Actual Six Months Ended March 31, 2017	Actual Six Months Ended March 31, 2016	Favorable (Unfavorable) Variance
			Operating revenues:			
$55,840	$56,005	($165)	Net patient service revenue, before provision for bad debts	$299,145	$305,037	($5,892)
(9,935)	(10,565)	630	Provision for bad debts	(47,215)	(57,700)	10,485
45,905	45,440	465	Net patient service revenue	251,930	247,337	4,593
938	1,104	(166)	Ad valorem taxes	5,626	6,626	(1,000)
2,311	3,520	(1,209)	Other revenue	13,787	14,879	(1,092)
49,154	50,064	(910)	Total operating revenues	271,343	268,842	2,501
			Operating expenses:			
24,020	22,869	(1,151)	Salaries and benefits	138,995	129,182	(9,813)
6,629	7,099	470	Purchased services	37,091	40,639	3,548
9,046	8,303	(743)	Supplies	49,329	46,281	(3,048)
1,948	2,037	89	Depreciation and amortization	11,840	12,198	358
1,409	3,238	1,829	Interest	8,450	10,576	2,126
626	639	13	Ad valorem tax related expenses	3,732	3,790	58
743	766	23	Leases and rentals	4,405	4,586	181
2,099	2,737	638	Other	13,099	14,113	1,014
46,520	47,688	1,168	Total operating expenses	266,941	261,365	(5,576)
2,634	**2,376**	**258**	**Excess of operating revenues over expenses**	**4,402**	**7,477**	**(3,075)**
			Nonoperating revenues, expenses, and gains/(losses):			
637	893	(256)	Realized investment income/(losses)	3,471	4,794	(1,323)
(288)	4,225	(4,513)	Unrealized investment income/(losses)	(86)	1,107	(1,193)
246	63	183	Donation revenue	464	393	71
(8)	-	(8)	Nonoperating gains/(losses), net	(7)	(6)	(1)
587	5,181	(4,594)	Total nonoperating revenues, expenses, and gains/(losses)	3,842	6,288	(2,446)
$3,221	**$7,557**	**($4,336)**	**Increase in net position**	**$8,244**	**$13,765**	**($5,521)**

Halifax Health
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended March 31, 2017	Static Budget Month Ended March 31, 2017	Favorable (Unfavorable) Variance		Actual Six Months Ended March 31, 2017	Static Budget Six Months Ended March 31, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$55,840	$50,639	$5,201	Net patient service revenue, before provision for bad debts	$299,145	$285,596	$13,549
(9,935)	(6,370)	(3,565)	Provision for bad debts	(47,215)	(37,062)	(10,153)
45,905	44,269	1,636	Net patient service revenue	251,930	248,534	3,396
938	938	-	Ad valorem taxes	5,626	5,626	-
2,311	2,314	(3)	Other revenue	13,787	13,356	431
49,154	47,521	1,633	Total operating revenues	271,343	267,516	3,827
			Operating expenses:			
24,020	24,437	417	Salaries and benefits	138,995	140,693	1,698
6,629	5,803	(826)	Purchased services	37,091	34,804	(2,287)
9,046	8,478	(568)	Supplies	49,329	47,415	(1,914)
1,948	1,954	6	Depreciation and amortization	11,840	11,852	12
1,409	1,410	1	Interest	8,450	8,466	16
626	628	2	Ad valorem tax related expenses	3,732	3,748	16
743	704	(39)	Leases and rentals	4,405	4,210	(195)
2,099	2,245	146	Other	13,099	13,457	358
46,520	45,659	(861)	Total operating expenses	266,941	264,645	(2,296)
2,634	**1,862**	**772**	**Excess of operating revenues over expenses**	**4,402**	**2,871**	**1,531**
			Nonoperating revenues, expenses, and gains/(losses):			
637	385	252	Realized investment income/(losses)	3,471	2,313	1,158
(288)	-	(288)	Unrealized investment income/(losses)	(86)	-	(86)
246	60	186	Donation revenue	464	358	106
(8)	-	(8)	Nonoperating gains/(losses), net	(7)	-	(7)
587	445	142	Total nonoperating revenues, expenses, and gains/(losses)	3,842	2,671	1,171
$3,221	**$2,307**	**$914**	**Increase in net position**	**$8,244**	**$5,542**	**$2,702**

Halifax Health Medical Center
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended March 31, 2017	Static Budget Month Ended March 31, 2017	Favorable (Unfavorable) Variance		Actual Six Months Ended March 31, 2017	Static Budget Six Months Ended March 31, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$51,905	$46,879	$5,026	Net patient service revenue, before provision for bad debts	$279,106	$263,603	$15,503
(9,801)	(6,271)	(3,530)	Provision for bad debts	(46,636)	(36,467)	(10,169)
42,104	40,608	1,496	Net patient service revenue	232,470	227,136	5,334
938	938	-	Ad valorem taxes	5,626	5,626	-
1,518	1,598	(80)	Other revenue	8,108	9,059	(951)
44,560	43,144	1,416	Total operating revenues	246,204	241,821	4,383
			Operating expenses:			
21,871	22,270	399	Salaries and benefits	126,518	127,921	1,403
5,367	4,715	(652)	Purchased services	31,148	28,343	(2,805)
8,787	8,242	(545)	Supplies	47,975	46,032	(1,943)
1,811	1,817	6	Depreciation and amortization	11,017	11,029	12
1,399	1,400	1	Interest	8,384	8,400	16
626	628	2	Ad valorem tax related expenses	3,732	3,748	16
563	537	(26)	Leases and rentals	3,385	3,222	(163)
1,938	1,994	56	Other	11,933	11,961	28
42,362	41,603	(759)	Total operating expenses	244,092	240,656	(3,436)
2,198	**1,541**	**657**	**Excess of operating revenues over expenses**	**2,112**	**1,165**	**947**
			Nonoperating revenues, expenses, and gains/(losses):			
443	197	246	Realized investment income/(losses)	1,542	1,185	357
(164)	-	(164)	Unrealized investment income/(losses)	(1,728)	-	(1,728)
5	-	5	Donation revenue	33	-	33
276	197	79	Total nonoperating revenues, expenses, and gains/(losses)	(160)	1,185	(1,345)
$2,474	**$1,738**	**$736**	**Increase in net position**	**$1,952**	**$2,350**	**($398)**

Halifax Health Medical Center
Net Patient Service Revenue
($ in thousands)

Actual Month Ended March 31, 2016		Actual Month Ended March 31, 2017		Static Budget Month Ended March 31, 2017			Actual Six Months Ended March 31, 2016		Actual Six Months Ended March 31, 2017		Static Budget Six Months Ended March 31, 2017	
$152,972	100.00%	$163,514	100.00%	$158,179	100.00%	Gross charges	$840,205	100.00%	$906,228	100.00%	$882,706	100.00%
(5,478)	-3.58%	(4,082)	-2.50%	(9,227)	-5.83%	Charity	(36,819)	-4.38%	(43,502)	-4.80%	(51,463)	-5.83%
(95,228)	-62.25%	(107,527)	-65.76%	(102,073)	-64.53%	Contractual adjustments	(520,261)	-61.92%	(583,620)	-64.40%	(567,640)	-64.31%
52,266	34.17%	51,905	31.74%	46,879	29.64%	Gross charges, before provision for bad debts	283,125	33.70%	279,106	30.80%	263,603	29.86%
(10,517)	-6.88%	(9,801)	-5.99%	(6,271)	-3.96%	Provision for bad debts	(57,153)	-6.80%	(46,636)	-5.15%	(36,467)	-4.13%
$41,749	**27.29%**	**$42,104**	**25.75%**	**$40,608**	**25.67%**	**Net patient service revenue**	**$225,972**	**26.89%**	**$232,470**	**25.65%**	**$227,136**	**25.73%**

Halifax Health Hospice
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended March 31, 2017	Static Budget Month Ended March 31, 2017	Favorable (Unfavorable) Variance		Actual Six Months Ended March 31, 2017	Static Budget Six Months Ended March 31, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$3,935	$3,760	$175	Net patient service revenue, before provision for bad debts	$20,039	$21,993	($1,954)
(134)	(99)	(35)	Provision for bad debts	(579)	(595)	16
3,801	3,661	140	Net patient service revenue	19,460	21,398	(1,938)
169	199	(30)	Other revenue	1,026	1,195	(169)
3,970	3,860	110	Total operating revenues	20,486	22,593	(2,107)
			Operating expenses:			
2,075	2,092	17	Salaries and benefits	12,042	12,325	283
1,221	1,049	(172)	Purchased services	5,729	6,230	501
259	235	(24)	Supplies	1,352	1,378	26
70	70	-	Depreciation and amortization	423	423	-
175	162	(13)	Leases and rentals	989	957	(32)
128	181	53	Other	943	1,073	130
3,928	3,789	(139)	Total operating expenses	21,478	22,386	908
42	**71**	**(29)**	**Excess (deficiency) of operating revenues over expenses**	**(992)**	**207**	**(1,199)**
			Nonoperating revenues, expenses, and gains/(losses):			
194	188	6	Realized investment income/(losses)	1,929	1,128	801
(124)	-	(124)	Unrealized investment income/(losses)	1,642	-	1,642
241	60	181	Donation revenue	431	358	73
-	-	-	Nonoperating gains/(losses), net	-	-	-
311	248	63	Total nonoperating revenues, expenses, and gains/(losses)	4,002	1,486	2,516
$353	**$319**	**$34**	**Increase in net position**	**$3,010**	**$1,693**	**$1,317**

Volusia Health Network / Halifax Management Systems
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended March 31, 2017	Static Budget Month Ended March 31, 2017	Favorable (Unfavorable) Variance		Actual Six Months Ended March 31, 2017	Static Budget Six Months Ended March 31, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$0	$0	$0	Net patient service revenue, before provision for bad debts	$0	$0	$0
-	-	-	Provision for bad debts	-	-	-
-	-	-	Net patient service revenue	-	-	-
328	341	(13)	Other revenue	1,999	2,047	(48)
328	341	(13)	Total operating revenues	1,999	2,047	(48)
			Operating expenses:			
64	65	1	Salaries and benefits	371	384	13
39	35	(4)	Purchased services	205	209	4
-	1	1	Supplies	2	5	3
67	67	-	Depreciation and amortization	400	400	-
10	10	-	Interest	66	66	-
5	5	-	Leases and rentals	31	31	-
1	3	2	Other	7	20	13
186	186	-	Total operating expenses	1,082	1,115	33
142	**155**	**(13)**	**Excess of operating revenues over expenses**	**917**	**932**	**(15)**
			Nonoperating revenues, expenses, and gains/(losses):			
-	-	-	Realized investment income/(losses)	-	-	-
-	-	-	Unrealized investment income/(losses)	-	-	-
-	-	-	Donation revenue	-	-	-
-	-	-	Nonoperating gains/(losses), net	-	-	-
-	-	-	Total nonoperating revenues, expenses, and gains/(losses)	-	-	-
$142	**$155**	**($13)**	**Increase in net position**	**$917**	**$932**	**($15)**

Halifax Health Foundation
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

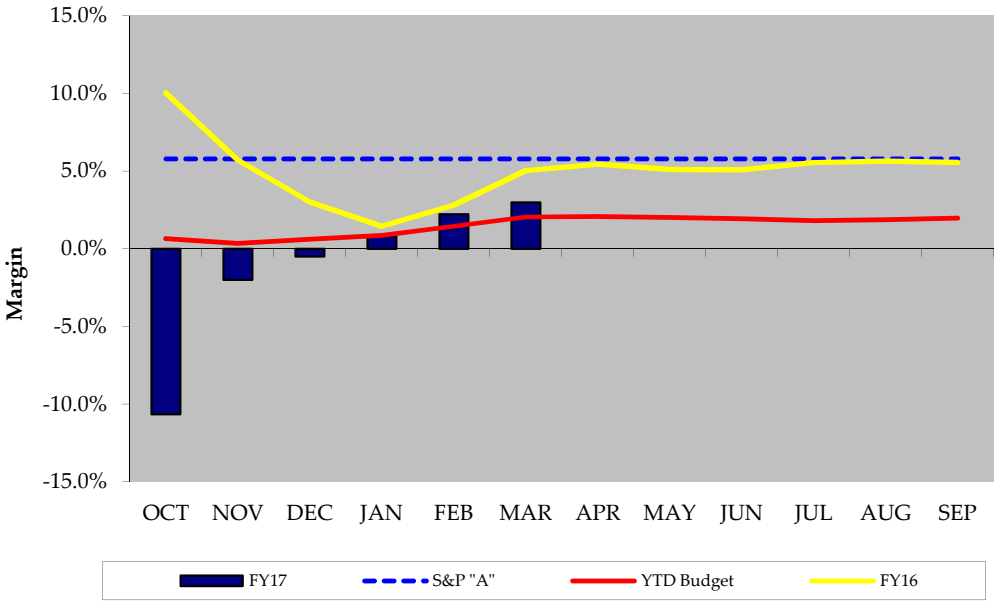
Actual Month Ended March 31, 2017	Static Budget Month Ended March 31, 2017	Favorable (Unfavorable) Variance		Actual Six Months Ended March 31, 2017	Static Budget Six Months Ended March 31, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$0	$0	$0	Net patient service revenue, before provision for bad debts	$0	$0	$0
-	-	-	Provision for bad debts	-	-	-
-	-	-	Net patient service revenue	-	-	-
100	105	(5)	Realized investment income/(losses)	966	630	336
(93)	-	(93)	Unrealized investment income/(losses)	1,043	-	1,043
289	71	218	Donation revenue	645	425	220
-	-	-	Other revenue	-	-	-
296	176	120	Total operating revenues	2,654	1,055	1,599
			Operating expenses:			
10	10	-	Salaries and benefits	64	63	(1)
2	4	2	Purchased services	9	22	13
-	-	-	Supplies	-	-	-
-	-	-	Depreciation and amortization	-	-	-
-	-	-	Interest	-	-	-
-	-	-	Leases and rentals	-	-	-
32	67	35	Other	216	403	187
44	81	37	Total operating expenses	289	488	199
$252	**$95**	**$157**	**Increase in net position**	**$2,365**	**$567**	**$1,798**

Halifax Health Medical Center (Obligated Group)
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

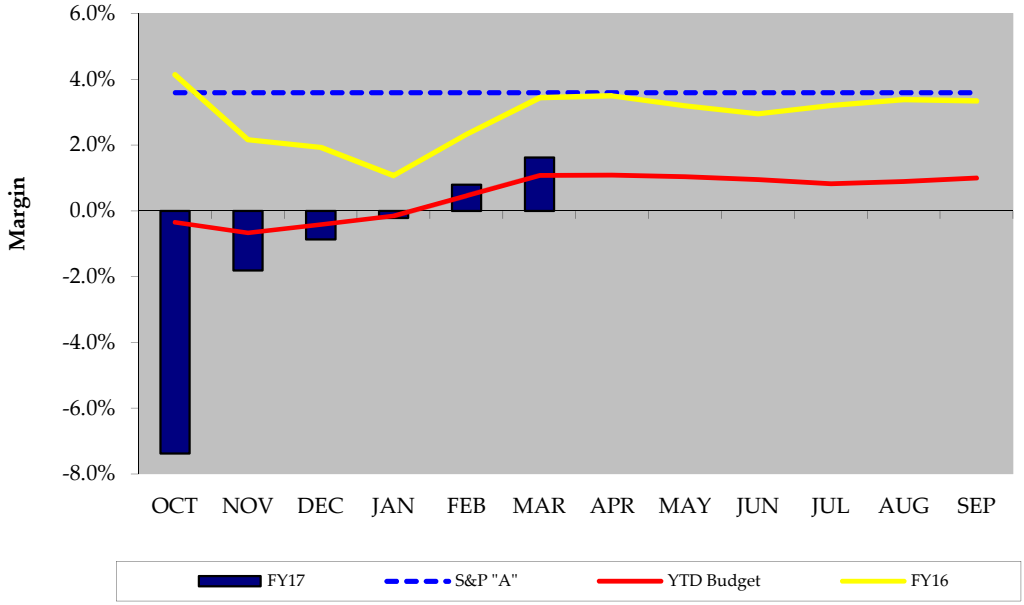
Actual Month Ended March 31, 2017	Static Budget Month Ended March 31, 2017	Favorable (Unfavorable) Variance		Actual Six Months Ended March 31, 2017	Static Budget Six Months Ended March 31, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$51,905	$46,879	$5,026	Net patient service revenue, before provision for bad debts	$279,106	$263,603	$15,503
(9,801)	(6,271)	(3,530)	Provision for bad debts	(46,636)	(36,467)	(10,169)
42,104	40,608	1,496	Net patient service revenue	232,470	227,136	5,334
938	938	-	Ad valorem taxes	5,626	5,626	-
1,518	1,598	(80)	Other revenue	8,108	9,059	(951)
44,560	43,144	1,416	Total operating revenues	246,204	241,821	4,383
			Operating expenses:			
21,871	22,270	399	Salaries and benefits	126,518	127,921	1,403
5,367	4,715	(652)	Purchased services	31,148	28,343	(2,805)
8,787	8,242	(545)	Supplies	47,975	46,032	(1,943)
1,811	1,817	6	Depreciation and amortization	11,017	11,029	12
1,399	1,400	1	Interest	8,384	8,400	16
626	628	2	Ad valorem tax related expenses	3,732	3,748	16
563	537	(26)	Leases and rentals	3,385	3,222	(163)
1,938	1,994	56	Other	11,933	11,961	28
42,362	41,603	(759)	Total operating expenses	244,092	240,656	(3,436)
2,198	**1,541**	**657**	**Excess of operating revenues over expenses**	**2,112**	**1,165**	**947**
			Nonoperating revenues, expenses, and gains/(losses):			
443	197	246	Realized investment income/(losses)	1,542	1,185	357
(164)	-	(164)	Unrealized investment income/(losses)	(1,728)	-	(1,728)
5	-	5	Donation revenue	33	-	33
(8)	-	(8)	Nonoperating gains/(losses), net	(7)	-	(7)
276	197	79	Total nonoperating revenues, expenses, and gains/(losses)	(160)	1,185	(1,345)
2,474	**1,738**	**736**	**Increase in net position before other changes in net position**	**1,952**	**2,350**	**(398)**
747	569	178	Income from affiliates	6,292	3,192	3,100
$3,221	**$2,307**	**$914**	**Increase in net position**	**$8,244**	**$5,542**	**$2,702**

Halifax Health
Financial Summary - Graphic

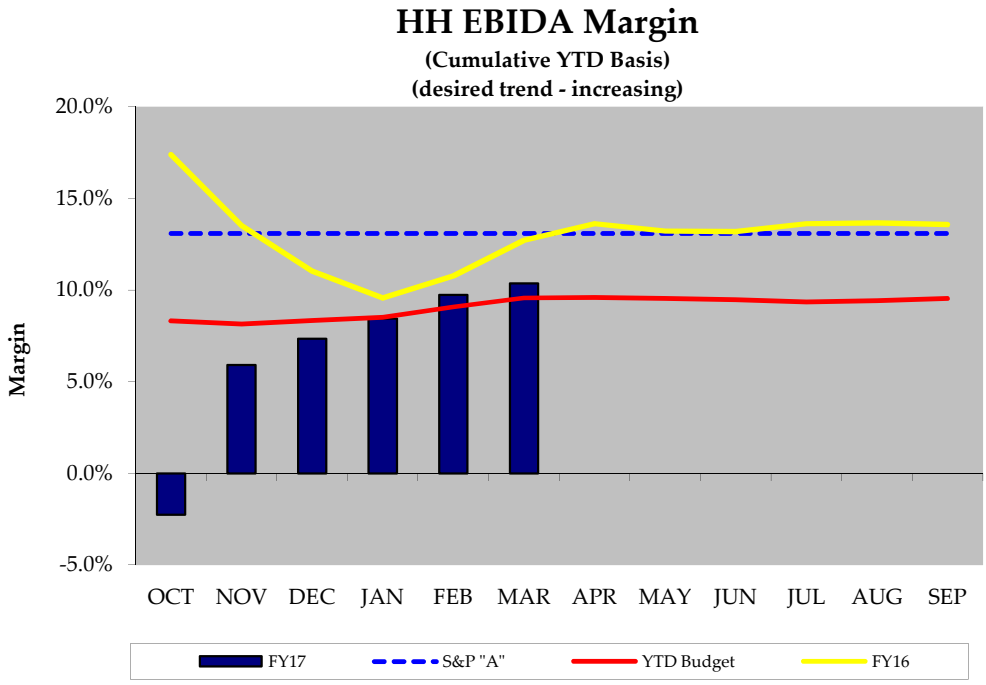
HH Total Margin
(Cumulative YTD Basis)
(desired trend - increasing)

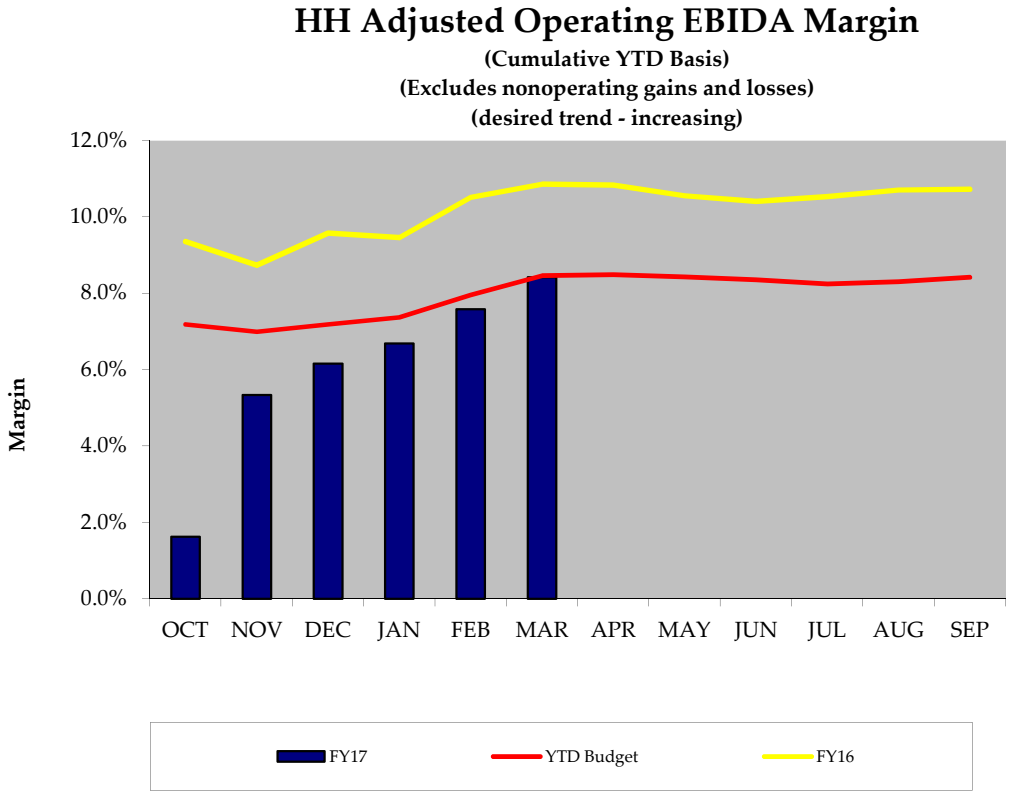


HH Operating Margin
(Cumulative YTD Basis)
(Excludes nonoperating gains and losses)
(desired trend - increasing)



Halifax Health
Financial Summary - Graphic

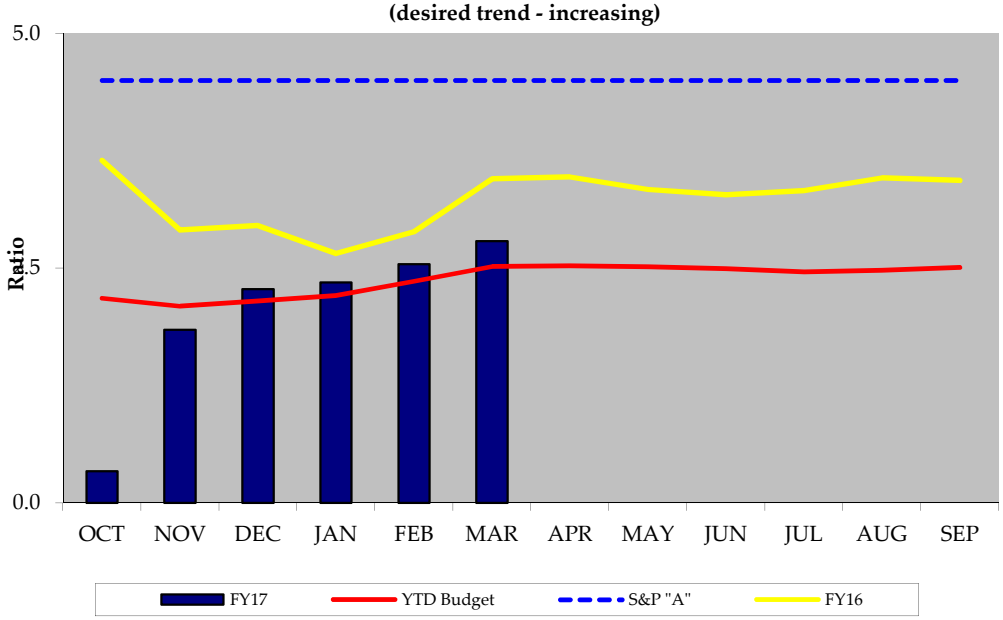




Halifax Health
Financial Summary - Graphic

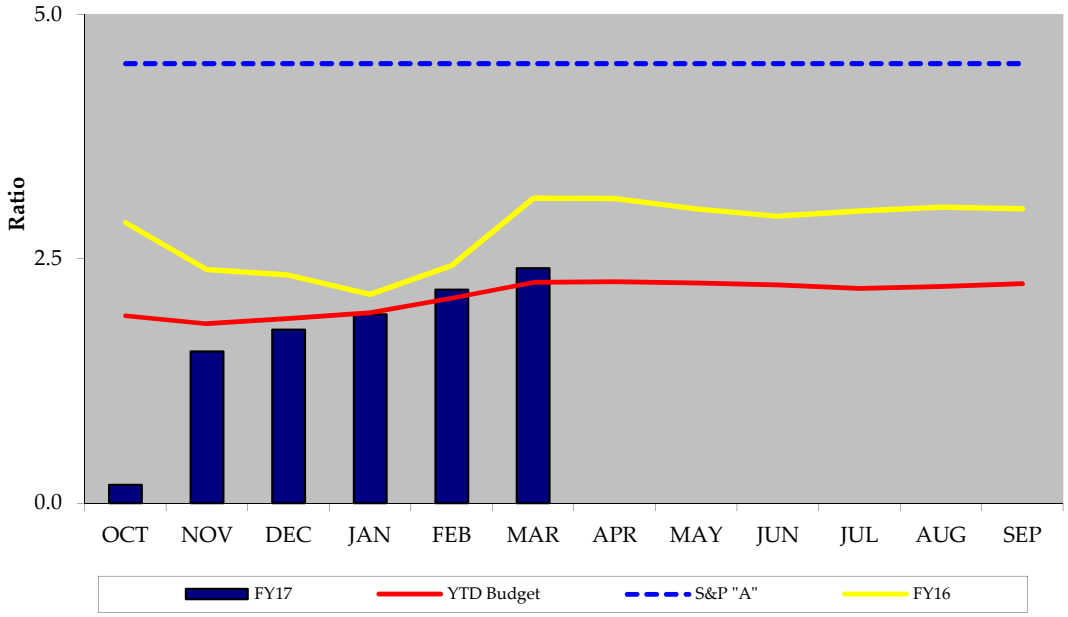
HH MADS Coverage Ratio

(Annualized Basis)
(Excludes unrealized investment gains/losses in accordance with covenant requirements)
(desired trend - increasing)



HH MADS Coverage Ratio - Operations Only

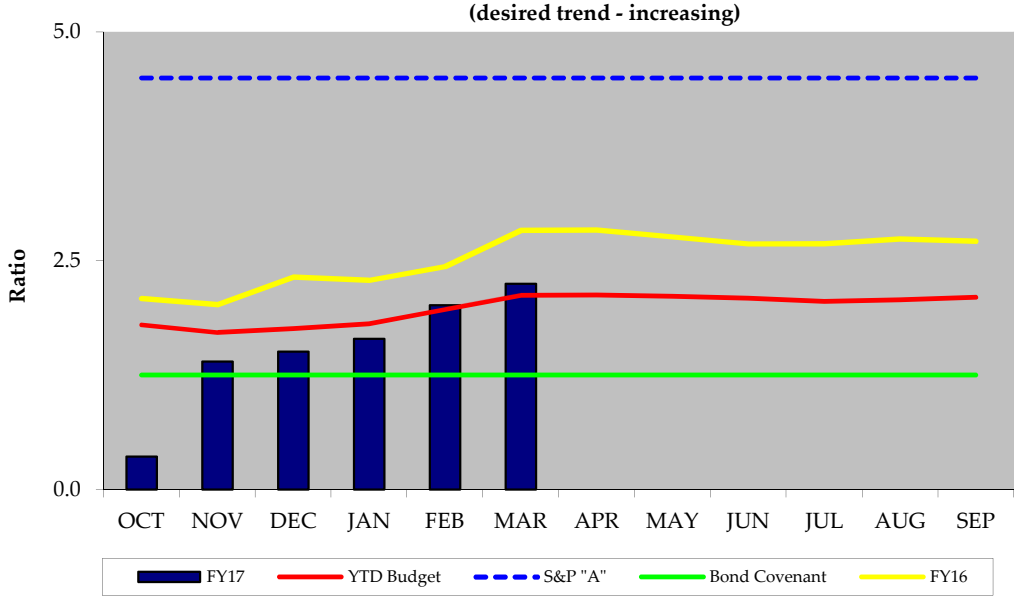
(Annualized Basis)
(Excludes nonoperating gains and losses)
(desired trend - increasing)



Halifax Health
Financial Summary - Graphic

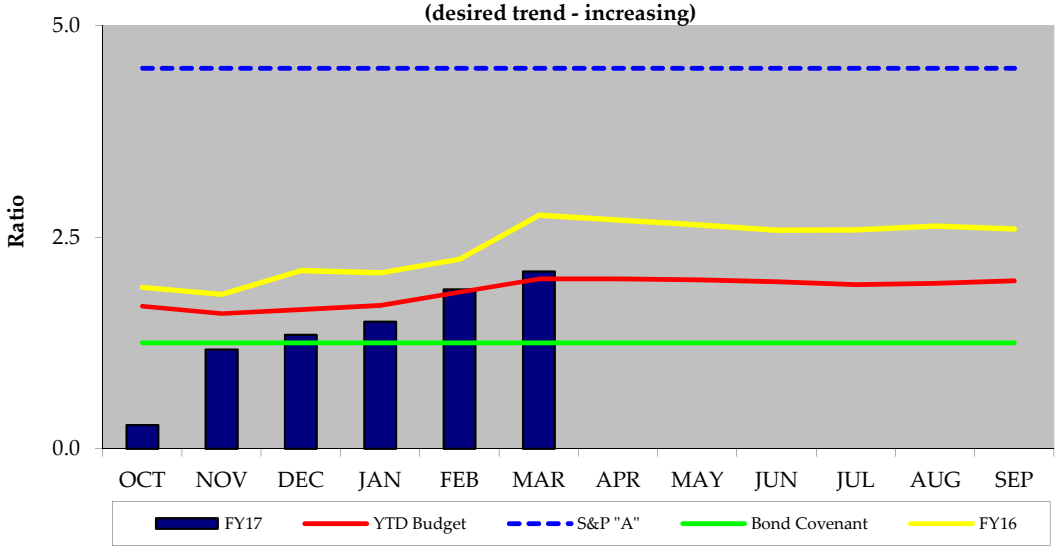
HHMC Obligated Group MADS Coverage Ratio

(Annualized Basis)
(Excludes unrealized investment gains/losses in accordance with covenant requirements)
(desired trend - increasing)



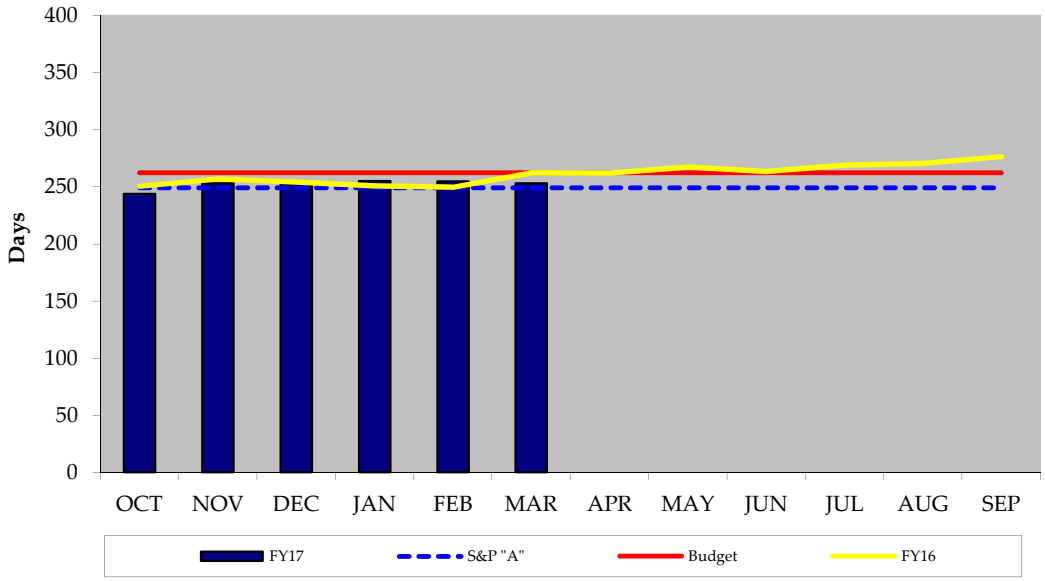
HHMC Obligated Group MADS Coverage Ratio - Operations Only

(Annualized Basis)
(Excludes nonoperating gains and losses)
(desired trend - increasing)

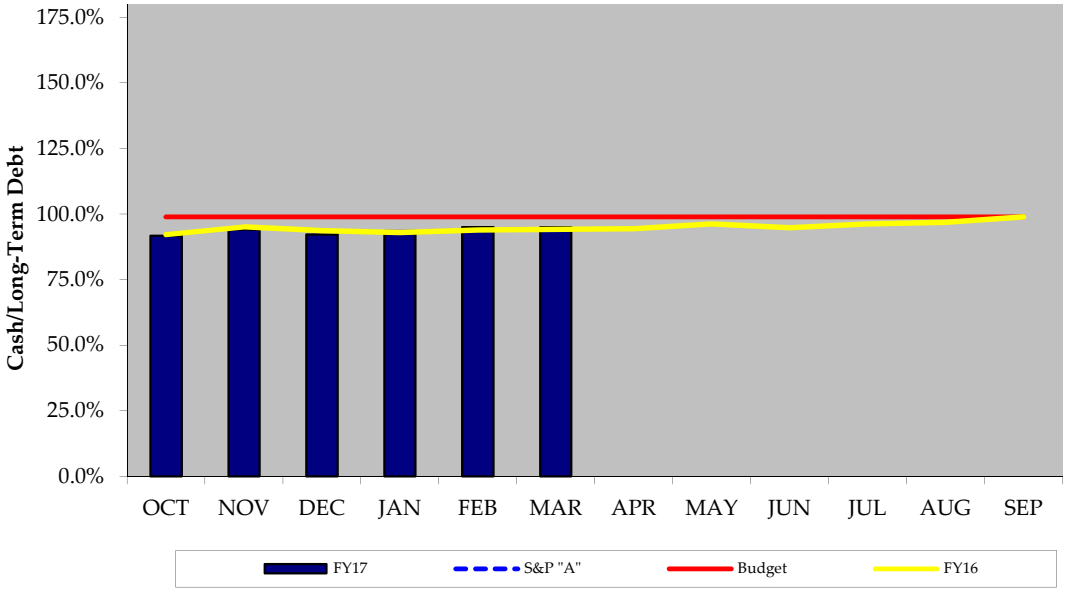


Halifax Health
Financial Summary - Graphic

HH Days Cash on Hand
(Annualized Basis)
(desired trend - increasing)

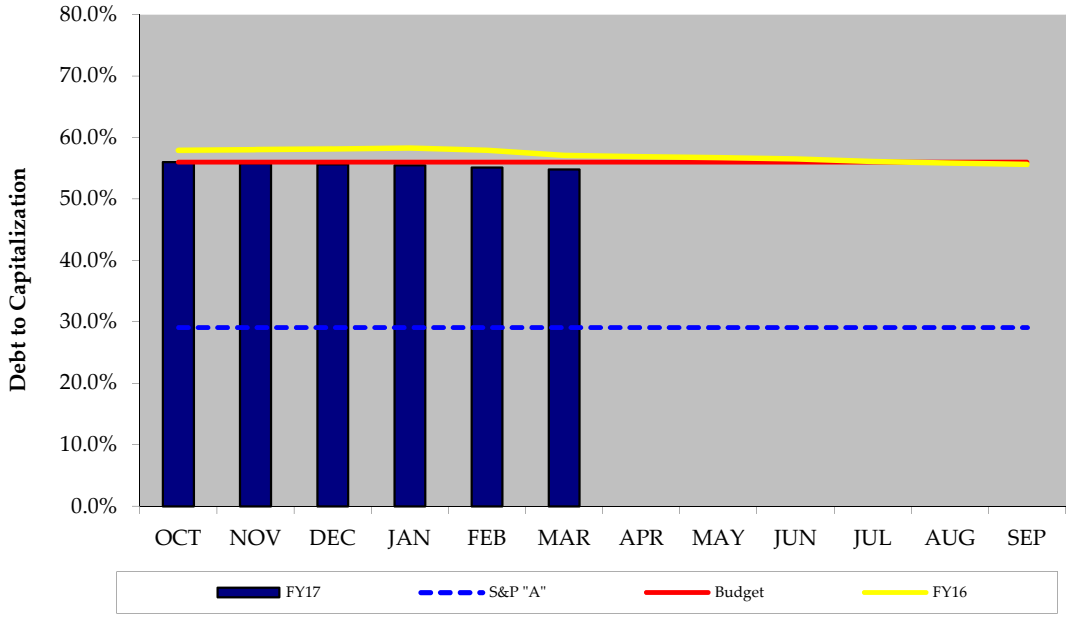


HH Cash/Debt
(Monthly)
(desired trend - increasing)

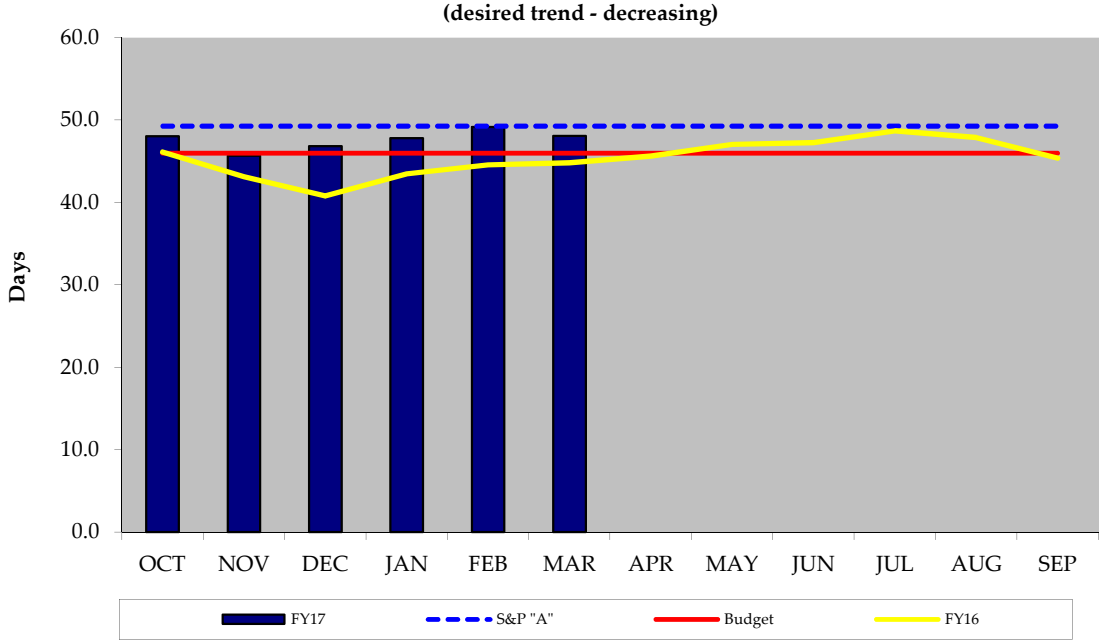


Halifax Health
Financial Summary - Graphic

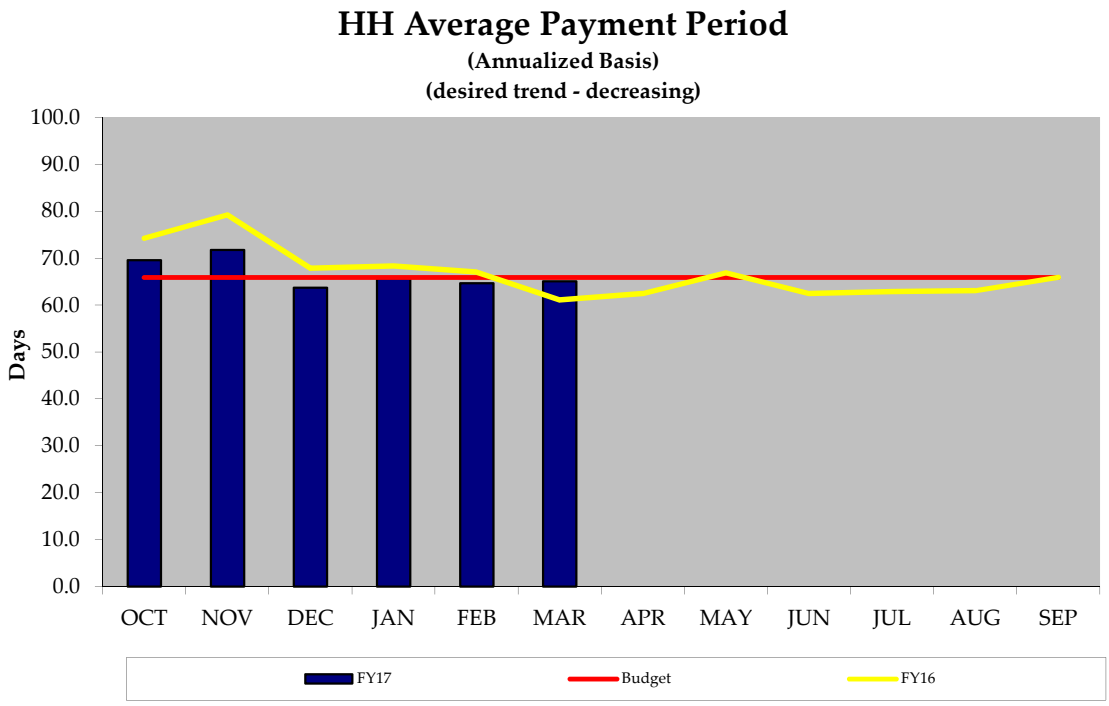
HH Debt to Capitalization
(Monthly)
(desired trend - decreasing)

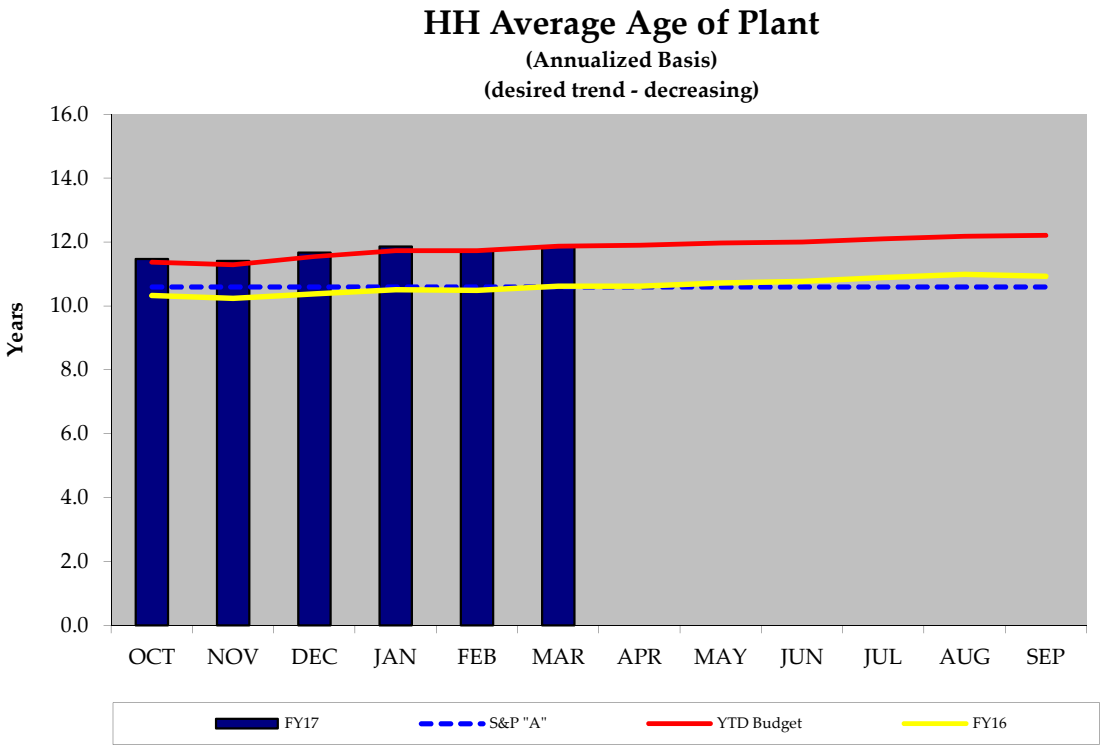


HH Days in A/R
(Annualized Basis)
(desired trend - decreasing)



Halifax Health
Financial Summary - Graphic





Halifax Health
Financial Ratios and Operating Indicators
Definitions and Calculations

Indicator	Definition	Calculation
Total Margin *	Gauges the relative efficiency with which the System produces its output.	Net Income / Total Revenues
EBIDA Margin *	Gauges the relative efficiency excluding capital costs with which the System produces its output.	Net income + Int + Depr + Amort / Total Revenues
MADS Coverage Ratio *	Measures profitability relative to the Maximum Principal and Interest Payment of Debt	Net Income + Depr + Amort + Int / Maximum Annual Debt Service
Days Cash on Hand	Measures the number of days of average cash expenses that the System maintains in cash and cash equivalents and unrestricted investments.	Unrestricted Cash and Investments / (Total Expenses - Depr) / Days in Period
Cash to Long-term Debt	Measures the percentage of unrestricted cash and investments to long-term debt.	Unrestricted Cash and Investments / Long-term Debt
Long-term Debt to Capitalization	Measures the reliance on long-term debt financing and ability to issue new debt.	Long-term Debt / Long-term Debt + Net Position
Days in Accounts Receivable	Measures the average time that receivables are outstanding, or the average collection period.	Accounts Receivable / Net Patient Service Revenue/ Days in Period
Average Payment Period	Provides a measure of the average time that elapses before current liabilities are paid.	Current Liabilities / (Total Expenses - Depr) / Days in Period
Average Age of Plant	Provides a measure of the average age in years of the System's fixed assets.	Accumulated Depreciation / Depreciation Expense
Operating Margin	Gauges the relative operating efficiency with which the System produces its output.	Excess of Operating Revenues / Total Operating Revenues + Bad Debt
* Operations Only Indicators	Excludes realized and unrealized investment income, donations, and nonoperating gains and losses	

Halifax Health
Summary Financial Narrative
For the five months ended February 28, 2017

The performance of Halifax Health compared to budget and long-range targets (S&P "A" rated medians) for key financial indicators is as follows.

Financial Indicator	YTD Actual FY 17	YTD Budget FY 17	YTD Actual vs. Budget	S&P "A"
Total Margin	2.2%	1.5%	Favorable	5.8%
Operating Margin	0.8%	0.5%	Favorable	3.6%
EBIDA Margin	9.7%	9.1%	Favorable	13.1%
Operating EBIDA Margin	8.4%	8.2%	Favorable	10.8%
Adjusted Operating EBIDA Margin *	7.6%	8.0%	Unfavorable	N/A
Days Cash on Hand	255	262	Unfavorable	249
Cash to Debt	95.1%	98.9%	Unfavorable	189.9%
Debt to Capitalization	56.5%	56.0%	Unfavorable	29.1%
OG MADS Coverage	2.01	1.97	Favorable	4.50
OG Debt to Capitalization	55.4%	55.0%	Unfavorable	29.1%

* - Excludes investment income/loss of Foundation recorded as operating income.

Halifax Health Medical Center

Statistical Summary--

- Admissions for the month and fiscal year-to-date are less than budget and last year.
- Patient days for the month are less than budget and last year; and for the fiscal year year-to-date are greater than budget and last year.
    - Observation patient days for the month are greater than budget and last year; and for the fiscal year-to-date are greater than budget and less than last year.
- Surgery volumes for the month and fiscal year-to-date are less than budget and last year.
- Emergency room visits for the month and fiscal year-to-date are less than budget and last year.

Financial Summary --

- Net patient service revenue for the fiscal year-to-date is 2.1% greater than budget.
- Total operating expenses for the fiscal year-to-date are 1.3% greater than budget.
- Loss from operations fiscal year-to-date of $82,000 compares favorably to budget by $296,000.
- Nonoperating gains/(losses) fiscal year-to-date of negative $437,000, primarily consisting of net investment losses, compare unfavorably to the budgeted amount by $1.4 million.
- The decrease in net position fiscal year-to-date of $519,000 compares unfavorably to budget by $1.1 million.

Halifax Health Hospice

Statistical Summary –

- Patient days for the month and fiscal year-to-date are less than budget and last year.

Financial Summary --

- Net patient service revenue for the fiscal year-to-date is 11.7% less than budget.
- Loss from operations fiscal year-to-date of $1.0 million compares unfavorably to budget by $1.2 million.
- Nonoperating gains fiscal year-to-date of $3.7 million, including investment income of $3.5 million, is greater than the budgeted amount by $2.5 million.
- The increase in net position fiscal year-to-date of $2.7 million compares favorably to budget by $1.3 million.

Other Component Units - The fiscal year-to-date financial performance is consistent with budgeted expectations.

Halifax Health
Summary Financial Indicators – Excluding Estimated Hurricane Matthew Costs
For the five months ended February 28, 2017

The performance of Halifax Health compared to budget and long-range targets (S&P "A" rated medians) for key financial indicators, including computations excluding $1.8 million of estimated Hurricane Matthew related costs, is as follows.

Financial Indicator	YTD Actual FY 17	YTD Adjusted Actual FY 17 (2)	YTD Budget FY 17	YTD Adj. Actual vs. Budget	S&P "A"	YTD Adj. Actual FY 17 vs. S&P "A"
Total Margin	2.2%	3.0%	1.5%	Favorable	5.8%	Unfavorable
Operating Margin	0.8%	1.6%	0.5%	Favorable	3.6%	Unfavorable
EBIDA Margin	9.7%	10.5%	9.1%	Favorable	13.1%	Unfavorable
Operating EBIDA Margin	8.4%	9.2%	8.2%	Favorable	10.8%	Unfavorable
Adjusted Operating EBIDA Margin (1)	7.6%	8.4%	8.0%	Favorable	N/A	N/A
Days Cash on Hand	255	258	262	Unfavorable	249	Favorable
Cash to Debt	95.1%	95.6%	98.9%	Unfavorable	189.9%	Unfavorable
Debt to Capitalization	56.5%	56.3%	56.0%	Unfavorable	29.1%	Unfavorable
OG MADS Coverage	2.01	2.23	1.97	Favorable	4.50	Unfavorable
OG Debt to Capitalization	55.4%	55.3%	55.0%	Unfavorable	29.1%	Unfavorable

(1) - Excludes investment income/loss of Foundation recorded as operating income.

(2) - Financial indicator computed by excluding estimated Hurricane Matthew related expenses of $1.8 million.

Halifax Health
Statistical Summary

Month Ended February 28,					Five Months Ended February 28,			
2016	2017	Budget	Var.		2016	2017	Budget	Var.
				Inpatient Activity				
1,688	1,565	1,684	-7.1%	HHMC Adult/Ped Admissions	8,022	7,905	8,065	-2.0%
176	144	165	-12.7%	HHMCPO Adult/Ped Admissions	715	708	784	-9.7%
126	129	155	-16.8%	Adult Psych Admissions	680	726	727	-0.1%
54	60	51	17.6%	Rehabilitative Admissions	270	320	256	25.0%
2,044	**1,898**	**2,055**	**-7.6%**	**Total Adult/Ped Admissions**	**9,687**	**9,659**	**9,832**	**-1.8%**
8,458	8,158	8,334	-2.1%	HHMC Adult/Ped Patient Days	41,328	42,649	40,292	5.8%
500	761	772	-1.4%	HHMCPO Adult/Ped Patient Days	2,487	3,950	3,776	4.6%
1,351	1,167	1,363	-14.4%	Adult Psych Patient Days	7,345	6,979	7,410	-5.8%
883	912	783	16.5%	Rehabilitative Patient Days	4,337	4,513	4,219	7.0%
11,192	**10,998**	**11,252**	**-2.3%**	**Total Adult/Ped Patient Days**	**55,497**	**58,091**	**55,697**	**4.3%**
5.0	5.2	4.9	5.3%	HHMC Average Length of Stay	5.2	5.4	5.0	8.0%
2.8	5.3	4.7	13.0%	HHMCPO Average Length of Stay	3.5	5.6	4.8	15.8%
4.8	**5.2**	**4.9**	**6.0%**	**HHMC/ HHMCPO Average Length of Stay**	**5.0**	**5.4**	**5.0**	**8.6%**
10.7	9.0	8.8	2.9%	Adult Psych Average Length of Stay	10.8	9.6	10.2	-5.7%
16.4	15.2	15.4	-1.0%	Rehabilitative Length of Stay	16.1	14.1	16.5	-14.4%
5.5	**5.8**	**5.5**	**5.8%**	**Total Average Length of Stay**	**5.7**	**6.0**	**5.7**	**6.2%**
386	**393**	**402**	**-2.3%**	**Total Average Daily Census**	**365**	**385**	**369**	**4.3%**
634	637	619	2.9%	HHMC Observation Patient Day Equivalents	2,945	3,164	3,049	3.8%
114	131	96	36.46%	HHMCPO Observation Patient Day Equivalents	433	609	441	38.1%
748	**768**	**715**	**7.4%**	**Total Observation Patient Day Equivalents**	**3,378**	**3,773**	**3,490**	**8.1%**
26	**27**	**26**	**3.8%**	**Observation Average Daily Census**	**22**	**25**	**23**	**8.7%**
163	126	161	-21.7%	HHMC Newborn Births	834	712	819	-13.1%
295	244	298	-18.1%	HHMC Nursery Patient Days	1,603	1,360	1,626	-16.4%
469	404	499	-19.0%	HHMC Inpatient Surgeries	2,260	2,202	2,414	-8.8%
0	4	0	0.0%	HHMCPO Inpatient Surgeries	4	17	2	750.0%
469	**408**	**499**	**-18.2%**	**Total Inpatient Surgeries**	**2,264**	**2,219**	**2,416**	**-8.2%**
				Inpatient Surgeries				
178	165			Orthopedics	860	864		
87	65			General Surgery	424	363		
51	41			Neurosurgery	258	214		
18	25			Vascular	72	127		
24	25			Thoracic Surgery	110	116		
111	87			All Other	540	535		
469	**408**	**499**	**-18.2%**	**Total Inpatient Surgeries**	**2,264**	**2,219**	**2,416**	**-8.2%**

Halifax Health
Statistical Summary

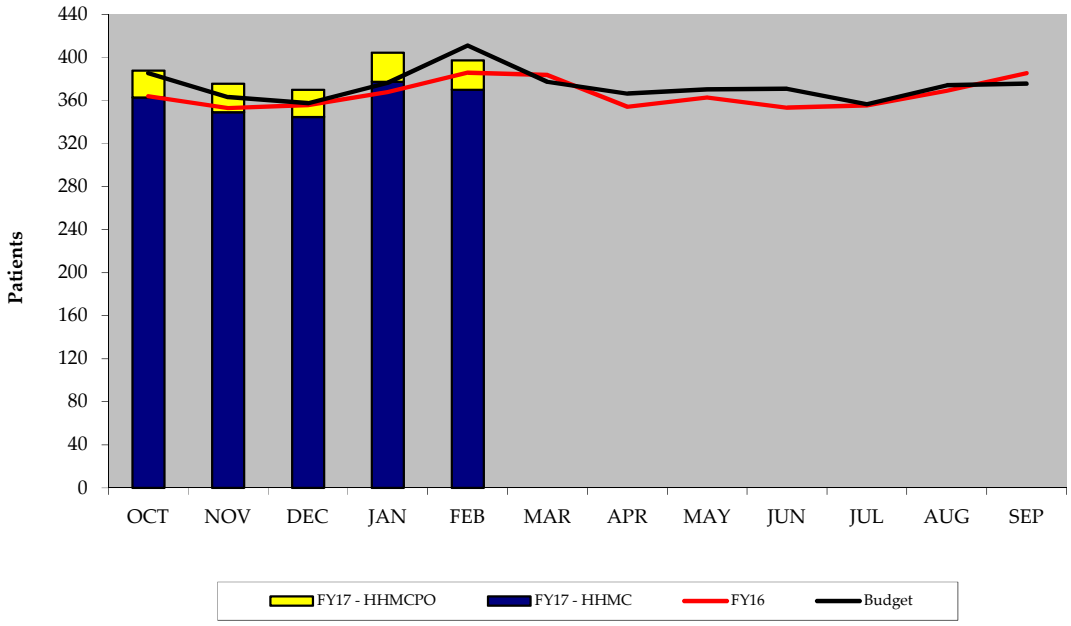
Month Ended February 28,					Five Months Ended February 28,			
2016	2017	Budget	Var.		2016	2017	Budget	Var.
				Outpatient Activity				
7,156	6,436	7,283	-11.6%	HHMC ED Registrations	34,600	33,370	35,214	-5.2%
2,929	2,575	3,050	-15.6%	HHMCPO ED Registrations	13,780	12,794	14,356	-10.9%
10,085	**9,011**	**10,333**	**-12.8%**	**Total ED**	**48,380**	**46,164**	**49,570**	**-6.9%**
366	411	351	17.1%	HHMC Outpatient Surgeries	1,907	2,070	1,830	13.1%
89	56	91	-38.5%	HPC Outpatient Surgeries	467	303	478	-36.6%
2	12	0	0.0%	HHMCPO Outpatient Surgeries	2	15	2	650.0%
392	342	391	-12.5%	Twin Lakes Surgeries	1,886	1,758	1,883	-6.6%
849	**821**	**833**	**-1.4%**	**Total Outpatient Surgeries**	**4,262**	**4,146**	**4,193**	**-1.1%**
				Outpatient Surgeries				
188	163			General Surgery	861	905		
187	162			Orthopedics	952	817		
99	82			Gastroenterology	547	378		
60	70			Obstetrics Gynecology	345	360		
58	56			Ophthalmology	294	283		
257	288			All Other	1,263	1,403		
849	**821**	**833**	**-1.4%**	**Total Outpatient Surgeries**	**4,262**	**4,146**	**4,193**	**-1.1%**
				Cardiology Procedures				
14	18			Open Heart Cases	76	88		
124	126			Cardiac Caths	591	631		
30	35			CRM Devices	175	166		
29	35			EP Studies	132	202		
197	**214**	**209**	**2.4%**	**Total Cardiology Procedures**	**974**	**1,087**	**1,014**	**7.2%**
				Interventional Radiology Procedures				
8	6	7	-14.3%	Vascular	40	30	34	-11.8%
152	137	176	-22.2%	Nonvascular	1,070	771	940	-18.0%
160	**143**	**183**	**-21.9%**	**Total Interventional Radiology Procedures**	**1,110**	**801**	**974**	**-17.8%**
198	**193**	**192**	**0.5%**	**GI Lab Procedures**	**940**	**986**	**926**	**6.5%**
				HH Hospice Activity				
				Patient Days				
15,758	14,449	15,400	-6.2%	Volusia/ Flagler	83,016	75,705	83,050	-8.8%
113.0	824	713	15.6%	Orange/ Osceola	830.0	4,333	3,425	26.5%
15,871	**15,273**	**16,113**	**-5.2%**	**HH Hospice Patient Days**	**83,846**	**80,038**	**86,475**	**-7.4%**
				Average Daily Census				
543	516	550	-6.2%	Volusia/ Flagler	546	501	550	-8.8%
4	29	25	15.6%	Orange/ Osceola	5	29	23	26.5%
547	**545**	**575**	**-5.2%**	**HH Hospice Average Daily Census**	**551**	**530**	**573**	**-7.4%**

Halifax Health
Statistical Summary

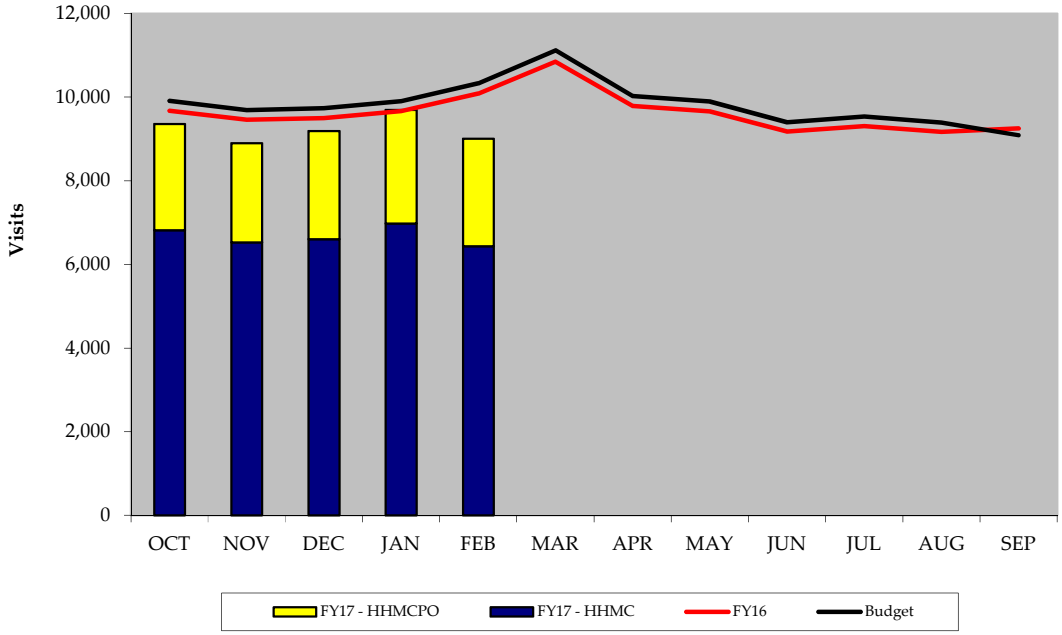
Month Ended February 28,					Five Months Ended February 28,			
2016	2017	Budget	Var.		2016	2017	Budget	Var.
				Physician Practice Activity				
				Primary Care Visits				
290	377	620	-39.2%	Ormond Beach	1,270	1,469	3,344	-56.1%
1,089	893	1,086	-17.8%	Daytona Beach	5,315	4,972	5,301	-6.2%
617	721	1,007	-28.4%	Port Orange	1,027	3,449	4,397	-21.6%
522	271	682	-60.3%	Deltona	2,354	1,512	3,075	-50.8%
460	474	1,029	-53.9%	Ormond Beach (Women's/OB)	1,942	2,332	4,346	-46.3%
2,978	**2,736**	**4,424**	**-38.2%**	**Primary Care Visits**	**11,908**	**13,734**	**20,463**	**-32.9%**
				Children's Medical Center Visits				
735	994	1,155	-13.9%	Ormond Beach	3,513	4,620	5,522	-16.3%
403	-	413	-100.0%	Palm Coast	2,016	293	2,068	-85.8%
455	533	482	10.6%	Port Orange	2,293	2,504	2,427	3.2%
1,593	**1,527**	**2,050**	**-25.5%**	**Children's Medical Center Visits**	**7,822**	**7,417**	**10,017**	**-26.0%**
				Community Clinic Visits				
403	462	382	20.9%	Keech Street	1,922	1,970	1,821	8.2%
339	240	339	-29.2%	Adult Community Clinic	1,948	1,200	1,948	-38.4%
742	**702**	**721**	**-2.6%**	**Community Clinic Visits**	**3,870**	**3,170**	**3,769**	**-15.9%**

Halifax Health
Statistical Summary - Graphic

HHMC Average Daily Census
(Monthly)

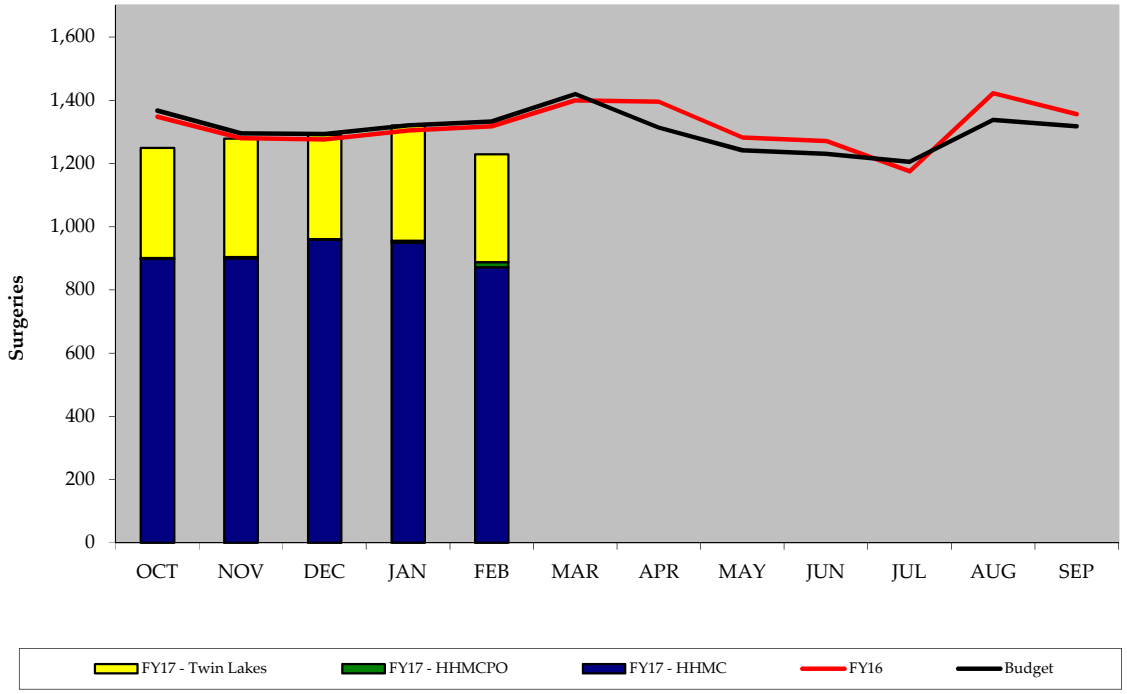


ED Visits
(Monthly)

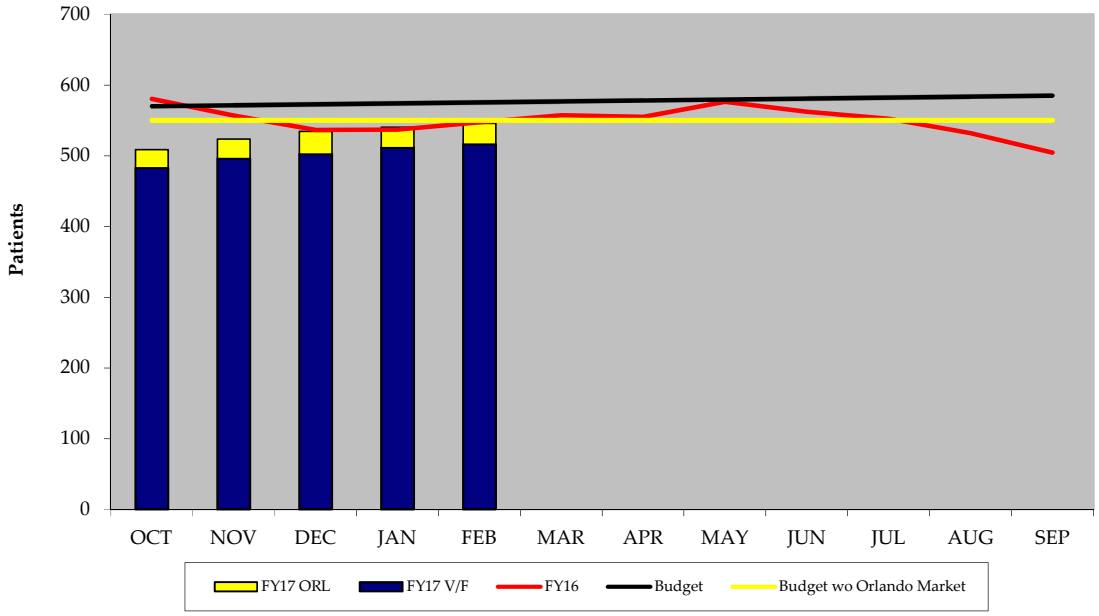


Halifax Health
Statistical Summary - Graphic

Surgeries
(Monthly)



Hospice Average Daily Census
(Monthly)



Halifax Health
Condensed Statement of Net Position
($ in thousands)

	February 28,		
	2017	2016	Change
Assets			
Cash and cash equivalents	$38,024	$39,217	($1,193)
Investments	272,016	249,870	22,146
Board designated assets	44,792	44,708	84
Accounts receivable	67,109	59,209	7,900
Restricted assets whose use is limited	13,681	26,629	(12,948)
Other assets	43,118	43,644	(526)
Deferred outflow - swap	30,473	39,512	(9,039)
Deferred outflow - loss on bond refunding	16,994	6,609	10,385
Deferred outflow - pension	27,906	31,608	(3,702)
Property, plant and equipment	353,446	362,676	(9,230)
Total Assets	$907,559	$903,682	$3,877
Liabilities and Net position			
Accounts payable	$31,652	$31,638	$14
Other liabilities	82,205	88,702	(6,497)
Net pension liability	102,459	130,160	(27,701)
Long-term debt	353,417	345,792	7,625
Premium on LTD, net	19,653	9,494	10,159
Long-term value of swap	30,473	39,512	(9,039)
Net position	287,700	258,384	29,316
Total Liabilities and Net position	$907,559	$903,682	$3,877

Halifax Health
Statement of Cash Flows
($ in thousands)

Month ended February 28, 2017	Month ended February 29, 2016	Variance		Five Months ended February 28, 2017	Five Months ended February 29, 2016	Variance
			Cash flows from operating activities:			
$36,430	$38,591	($2,161)	Receipts from third party payors and patients	$197,243	$204,386	($7,143)
(21,108)	(20,133)	(975)	Payments to employees	(137,228)	(127,001)	(10,227)
(13,903)	(14,875)	972	Payments to suppliers	(75,757)	(76,579)	822
368	342	26	Receipt of ad valorem taxes	9,800	11,535	(1,735)
-	2,765	(2,765)	Receipt (payment) of State UPL funds, net	-	612	(612)
2,370	2,166	204	Other receipts	14,190	13,182	1,008
(3,638)	(3,589)	(49)	Other payments	(17,529)	(18,086)	557
519	5,267	(4,748)	Net cash provided by (used in) operating activities	(9,281)	8,049	(17,330)
			Cash flows from noncapital financing activities:			
12	32	(20)	Proceeds from donations received	217	331	(114)
(2)	-	(2)	Nonoperating gain (loss)	-	(5)	5
10	32	(22)	Net cash provided by noncapital financing activities	217	326	(109)
			Cash flows from capital and related financing activities:			
(2,031)	(1,545)	(486)	Acquisition of capital assets	(6,995)	(10,137)	3,142
(195)	(190)	(5)	Payment of long-term debt	(975)	(950)	(25)
5,474	-	5,474	Transfers from trustee held funds	5,474	-	5,474
(316)	(298)	(18)	Payment of interest on long-term debt	(8,093)	(8,477)	384
2,932	(2,033)	4,965	Net cash provided by (used in) capital financing activities	(10,589)	(19,564)	8,975
			Cash flows from investing activities:			
194	330	(136)	Realized investment income (loss)	2,833	3,900	(1,067)
(240)	(398)	158	Purchases of investments/limited use assets	(6,278)	(13,972)	7,694
10	26	(16)	Sales/Maturities of investments/limited use assets	2,549	4,725	(2,176)
(36)	(42)	6	Net cash provided by (used in) investing activities	(896)	(5,347)	4,451
3,425	3,224	201	**Net increase (decrease) in cash and cash equivalents**	(20,549)	(16,536)	(4,013)
34,599	35,993	(1,394)	**Cash and cash equivalents at beginning of period**	58,573	55,753	2,820
$38,024	$39,217	($1,193)	**Cash and cash equivalents at end of period**	$38,024	$39,217	($1,193)

Halifax Health
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended February 28, 2017	Actual Month Ended February 29, 2016	Favorable (Unfavorable) Variance		Actual Five Months Ended February 28, 2017	Actual Five Months Ended February 29, 2016	Favorable (Unfavorable) Variance
			Operating revenues:			
$47,856	$51,858	($4,002)	Net patient service revenue, before provision for bad debts	$243,305	$249,031	($5,726)
(5,371)	(10,148)	4,777	Provision for bad debts	(37,279)	(47,135)	9,856
42,485	41,710	775	Net patient service revenue	206,026	201,896	4,130
938	1,104	(166)	Ad valorem taxes	4,688	5,522	(834)
2,422	3,750	(1,328)	Other revenue	11,476	11,359	117
45,845	46,564	(719)	Total operating revenues	222,190	218,777	3,413
			Operating expenses:			
22,238	21,159	(1,079)	Salaries and benefits	114,976	106,314	(8,662)
6,056	6,784	728	Purchased services	30,462	33,540	3,078
8,395	8,229	(166)	Supplies	40,282	37,978	(2,304)
1,949	2,025	76	Depreciation and amortization	9,892	10,161	269
1,374	1,449	75	Interest	7,040	7,338	298
631	641	10	Ad valorem tax related expenses	3,106	3,151	45
748	734	(14)	Leases and rentals	3,662	3,820	158
2,306	2,293	(13)	Other	11,002	11,376	374
43,697	43,314	(383)	Total operating expenses	220,422	213,678	(6,744)
2,148	**3,250**	**(1,102)**	**Excess of operating revenues over expenses**	**1,768**	**5,099**	**(3,331)**
			Nonoperating revenues, expenses, and gains/(losses):			
194	330	(136)	Realized investment income/(losses)	2,834	3,901	(1,067)
1,224	67	1,157	Unrealized investment income/(losses)	202	(3,117)	3,319
11	32	(21)	Donation revenue	217	330	(113)
(2)	-	(2)	Nonoperating gains/(losses), net	1	(6)	7
1,427	429	998	Total nonoperating revenues, expenses, and gains/(losses)	3,254	1,108	2,146
$3,575	**$3,679**	**($104)**	**Increase in net position**	**$5,022**	**$6,207**	**($1,185)**

Halifax Health
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended February 28, 2017	Static Budget Month Ended February 28, 2017	Favorable (Unfavorable) Variance		Actual Five Months Ended February 28, 2017	Static Budget Five Months Ended February 28, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$47,856	$47,154	$702	Net patient service revenue, before provision for bad debts	$243,305	$234,957	$8,348
(5,371)	(5,987)	616	Provision for bad debts	(37,279)	(30,692)	(6,587)
42,485	41,167	1,318	Net patient service revenue	206,026	204,265	1,761
938	938	-	Ad valorem taxes	4,688	4,688	-
2,422	2,092	330	Other revenue	11,476	11,042	434
45,845	44,197	1,648	Total operating revenues	222,190	219,995	2,195
			Operating expenses:			
22,238	22,492	254	Salaries and benefits	114,976	116,255	1,279
6,056	5,729	(327)	Purchased services	30,462	29,002	(1,460)
8,395	7,774	(621)	Supplies	40,282	38,936	(1,346)
1,949	1,950	1	Depreciation and amortization	9,892	9,899	7
1,374	1,410	36	Interest	7,040	7,056	16
631	628	(3)	Ad valorem tax related expenses	3,106	3,120	14
748	695	(53)	Leases and rentals	3,662	3,506	(156)
2,306	2,238	(68)	Other	11,002	11,212	210
43,697	42,916	(781)	Total operating expenses	220,422	218,986	(1,436)
2,148	**1,281**	**867**	**Excess of operating revenues over expenses**	**1,768**	**1,009**	**759**
			Nonoperating revenues, expenses, and gains/(losses):			
194	385	(191)	Realized investment income/(losses)	2,834	1,927	907
1,224	-	1,224	Unrealized investment income/(losses)	202	-	202
11	60	(49)	Donation revenue	217	298	(81)
(2)	-	(2)	Nonoperating gains/(losses), net	1	-	1
1,427	445	982	Total nonoperating revenues, expenses, and gains/(losses)	3,254	2,225	1,029
$3,575	**$1,726**	**$1,849**	**Increase in net position**	**$5,022**	**$3,234**	**$1,788**

Halifax Health Medical Center
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended February 28, 2017	Static Budget Month Ended February 28, 2017	Favorable (Unfavorable) Variance		Actual Five Months Ended February 28, 2017	Static Budget Five Months Ended February 28, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$45,765	$43,751	$2,014	Net patient service revenue, before provision for bad debts	$227,201	$216,724	$10,477
(5,381)	(5,888)	507	Provision for bad debts	(36,834)	(30,196)	(6,638)
40,384	37,863	2,521	Net patient service revenue	190,367	186,528	3,839
938	938	-	Ad valorem taxes	4,688	4,688	-
1,418	1,376	42	Other revenue	6,591	7,461	(870)
42,740	40,177	2,563	Total operating revenues	201,646	198,677	2,969
			Operating expenses:			
20,245	20,507	262	Salaries and benefits	104,647	105,651	1,004
5,203	4,715	(488)	Purchased services	25,781	23,628	(2,153)
8,178	7,559	(619)	Supplies	39,187	37,790	(1,397)
1,812	1,813	1	Depreciation and amortization	9,206	9,213	7
1,364	1,400	36	Interest	6,984	7,000	16
631	628	(3)	Ad valorem tax related expenses	3,106	3,120	14
570	537	(33)	Leases and rentals	2,822	2,685	(137)
2,081	1,994	(87)	Other	9,995	9,968	(27)
40,084	39,153	(931)	Total operating expenses	201,728	199,055	(2,673)
2,656	**1,024**	**1,632**	**Excess (deficiency) of operating revenues over expenses**	**(82)**	**(378)**	**296**
			Nonoperating revenues, expenses, and gains/(losses):			
138	197	(59)	Realized investment income/(losses)	1,099	987	112
322	-	322	Unrealized investment income/(losses)	(1,564)	-	(1,564)
-	-	-	Donation revenue	27	-	27
458	197	261	Total nonoperating revenues, expenses, and gains/(losses)	(437)	987	(1,424)
$3,114	**$1,221**	**$1,893**	**Increase (decrease) in net position**	**($519)**	**$609**	**($1,128)**

Halifax Health Medical Center
Net Patient Service Revenue
($ in thousands)

Actual Month Ended February 29, 2016		Actual Month Ended February 28, 2017		Static Budget Month Ended February 28, 2017			Actual Five Months Ended February 29, 2016		Actual Five Months Ended February 28, 2017		Static Budget Five Months Ended February 28, 2017	
$144,159	100.00%	$147,312	100.00%	$148,244	100.00%	Gross charges	$687,233	100.00%	$742,714	100.00%	$724,528	100.00%
(7,674)	-5.32%	(3,682)	-2.50%	(8,675)	-5.85%	Charity	(31,341)	-4.56%	(39,419)	-5.31%	(42,236)	-5.83%
(87,949)	-61.01%	(97,865)	-66.43%	(95,818)	-64.64%	Contractual adjustments	(425,033)	-61.85%	(476,094)	-64.10%	(465,568)	-64.26%
48,536	33.67%	45,765	31.07%	43,751	29.51%	Gross charges, before provision for bad debts	230,859	33.59%	227,201	30.59%	216,724	29.91%
(9,895)	-6.86%	(5,381)	-3.65%	(5,888)	-3.97%	Provision for bad debts	(46,636)	-6.79%	(36,834)	-4.96%	(30,196)	-4.17%
$38,641	**26.80%**	**$40,384**	**27.41%**	**$37,863**	**25.54%**	**Net patient service revenue**	**$184,223**	**26.81%**	**$190,367**	**25.63%**	**$186,528**	**25.74%**

Halifax Health Hospice
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended February 28, 2017	Static Budget Month Ended February 28, 2017	Favorable (Unfavorable) Variance		Actual Five Months Ended February 28, 2017	Static Budget Five Months Ended February 28, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$2,091	$3,403	($1,312)	Net patient service revenue, before provision for bad debts	$16,104	$18,233	($2,129)
10	(99)	109	Provision for bad debts	(445)	(496)	51
2,101	3,304	(1,203)	Net patient service revenue	15,659	17,737	(2,078)
162	199	(37)	Other revenue	857	996	(139)
2,263	3,503	(1,240)	Total operating revenues	16,516	18,733	(2,217)
			Operating expenses:			
1,925	1,915	(10)	Salaries and benefits	9,967	10,233	266
817	975	158	Purchased services	4,508	5,181	673
216	214	(2)	Supplies	1,093	1,142	49
70	70	-	Depreciation and amortization	353	353	-
173	153	(20)	Leases and rentals	814	795	(19)
174	174	-	Other	816	891	75
3,375	3,501	126	Total operating expenses	17,551	18,595	1,044
(1,112)	**2**	**(1,114)**	**Excess (deficiency) of operating revenues over expenses**	**(1,035)**	**138**	**(1,173)**
			Nonoperating revenues, expenses, and gains/(losses):			
56	188	(132)	Realized investment income/(losses)	1,735	940	795
902	-	902	Unrealized investment income/(losses)	1,766	-	1,766
11	60	(49)	Donation revenue	190	298	(108)
-	-	-	Nonoperating gains/(losses), net	-	-	-
969	248	721	Total nonoperating revenues, expenses, and gains/(losses)	3,691	1,238	2,453
($143)	**$250**	**($393)**	**Increase (decrease) in net position**	**$2,656**	**$1,376**	**$1,280**

Volusia Health Network / Halifax Management Systems
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

Actual Month Ended February 28, 2017	Static Budget Month Ended February 28, 2017	Favorable (Unfavorable) Variance		Actual Five Months Ended February 28, 2017	Static Budget Five Months Ended February 28, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$0	$0	$0	Net patient service revenue, before provision for bad debts	$0	$0	$0
-	-	-	Provision for bad debts	-	-	-
-	-	-	Net patient service revenue	-	-	-
328	341	(13)	Other revenue	1,671	1,706	(35)
328	341	(13)	Total operating revenues	1,671	1,706	(35)
			Operating expenses:			
59	60	1	Salaries and benefits	307	319	12
35	35	-	Purchased services	166	174	8
1	1	-	Supplies	2	4	2
67	67	-	Depreciation and amortization	333	333	-
10	10	-	Interest	56	56	-
5	5	-	Leases and rentals	26	26	-
2	3	1	Other	6	17	11
179	181	2	Total operating expenses	896	929	33
149	**160**	**(11)**	**Excess of operating revenues over expenses**	**775**	**777**	**(2)**
			Nonoperating revenues, expenses, and gains/(losses):			
-	-	-	Realized investment income/(losses)	-	-	-
-	-	-	Unrealized investment income/(losses)	-	-	-
-	-	-	Donation revenue	-	-	-
-	-	-	Nonoperating gains/(losses), net	-	-	-
-	-	-	Total nonoperating revenues, expenses, and gains/(losses)	-	-	-
$149	**$160**	**($11)**	**Increase in net position**	**$775**	**$777**	**($2)**

Halifax Health Foundation
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

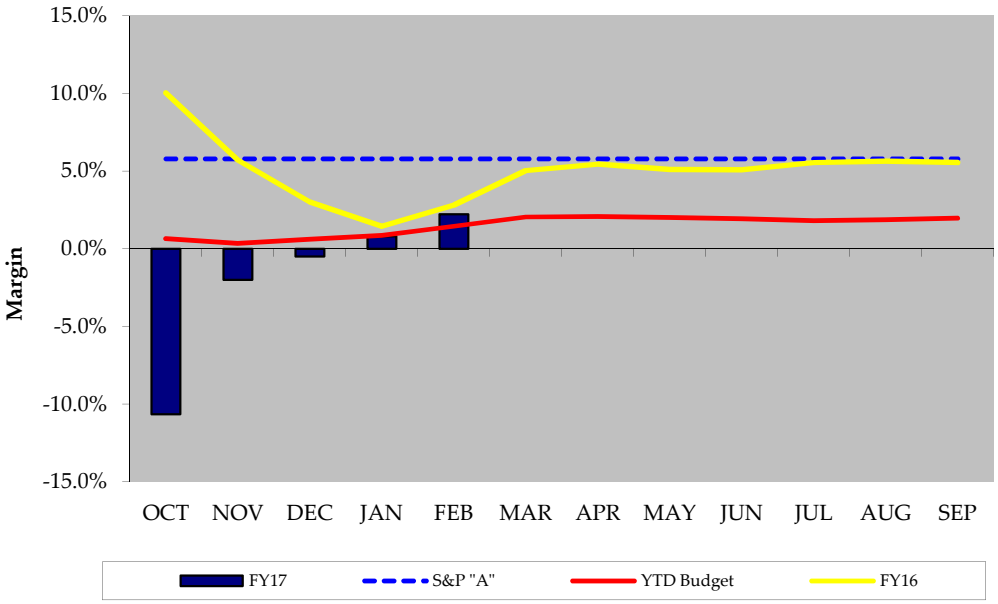
Actual Month Ended February 28, 2017	Static Budget Month Ended February 28, 2017	Favorable (Unfavorable) Variance		Actual Five Months Ended February 28, 2017	Static Budget Five Months Ended February 28, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$0	$0	$0	Net patient service revenue, before provision for bad debts	$0	$0	$0
-	-	-	Provision for bad debts	-	-	-
-	-	-	Net patient service revenue	-	-	-
34	105	(71)	Realized investment income/(losses)	866	525	341
422	-	422	Unrealized investment income/(losses)	1,136	-	1,136
58	71	(13)	Donation revenue	355	354	1
-	-	-	Other revenue	-	-	-
514	176	338	Total operating revenues	2,357	879	1,478
			Operating expenses:			
9	10	1	Salaries and benefits	55	52	(3)
1	4	3	Purchased services	7	19	12
-	-	-	Supplies	-	-	-
-	-	-	Depreciation and amortization	-	-	-
-	-	-	Interest	-	-	-
-	-	-	Leases and rentals	-	-	-
49	67	18	Other	185	336	151
59	81	22	Total operating expenses	247	407	160
$455	**$95**	**$360**	**Increase in net position**	**$2,110**	**$472**	**$1,638**

Halifax Health Medical Center (Obligated Group)
Statements of Revenues, Expenses and Changes in Net Position
($ in thousands)

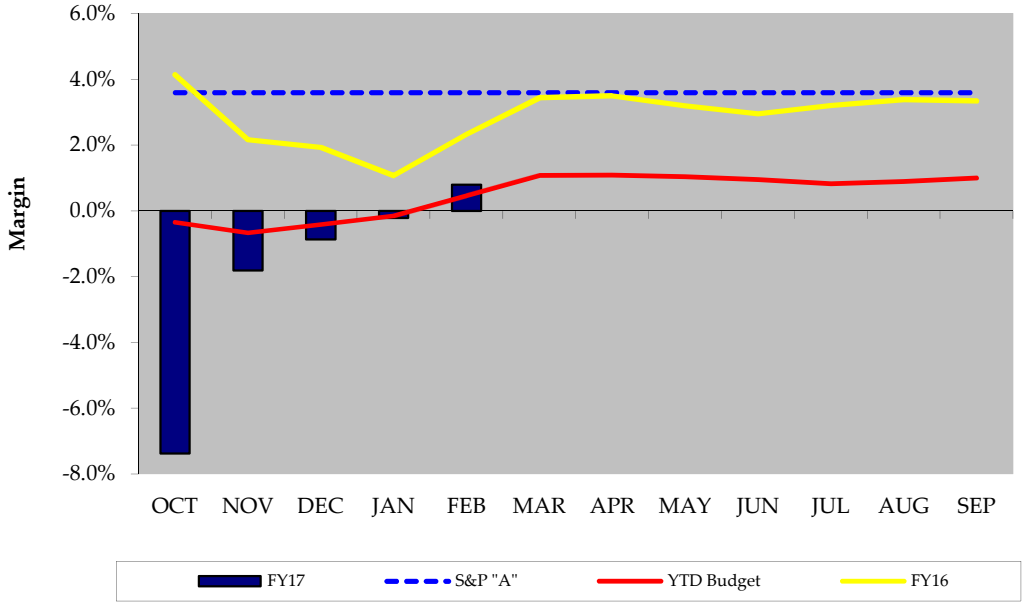
Actual Month Ended February 28, 2017	Static Budget Month Ended February 28, 2017	Favorable (Unfavorable) Variance		Actual Five Months Ended February 28, 2017	Static Budget Five Months Ended February 28, 2017	Favorable (Unfavorable) Variance
			Operating revenues:			
$45,765	$43,751	$2,014	Net patient service revenue, before provision for bad debts	$227,201	$216,724	$10,477
(5,381)	(5,888)	507	Provision for bad debts	(36,834)	(30,196)	(6,638)
40,384	37,863	2,521	Net patient service revenue	190,367	186,528	3,839
938	938	-	Ad valorem taxes	4,688	4,688	-
1,418	1,376	42	Other revenue	6,591	7,461	(870)
42,740	40,177	2,563	Total operating revenues	201,646	198,677	2,969
			Operating expenses:			
20,245	20,507	262	Salaries and benefits	104,647	105,651	1,004
5,203	4,715	(488)	Purchased services	25,781	23,628	(2,153)
8,178	7,559	(619)	Supplies	39,187	37,790	(1,397)
1,812	1,813	1	Depreciation and amortization	9,206	9,213	7
1,364	1,400	36	Interest	6,984	7,000	16
631	628	(3)	Ad valorem tax related expenses	3,106	3,120	14
570	537	(33)	Leases and rentals	2,822	2,685	(137)
2,081	1,994	(87)	Other	9,995	9,968	(27)
40,084	39,153	(931)	Total operating expenses	201,728	199,055	(2,673)
2,656	**1,024**	**1,632**	**Excess (deficiency) of operating revenues over expenses**	**(82)**	**(378)**	**296**
			Nonoperating revenues, expenses, and gains/(losses):			
138	197	(59)	Realized investment income/(losses)	1,099	987	112
322	-	322	Unrealized investment income/(losses)	(1,564)	-	(1,564)
-	-	-	Donation revenue	27	-	27
(2)	-	(2)	Nonoperating gains/(losses), net	1	-	1
458	197	261	Total nonoperating revenues, expenses, and gains/(losses)	(437)	987	(1,424)
3,114	**1,221**	**1,893**	**Increase (decrease) in net position before other changes in net**	**(519)**	**609**	**(1,128)**
461	505	(44)	Income from affiliates	5,541	2,625	2,916
$3,575	**$1,726**	**$1,849**	**Increase in net position**	**$5,022**	**$3,234**	**$1,788**

Halifax Health
Financial Summary - Graphic

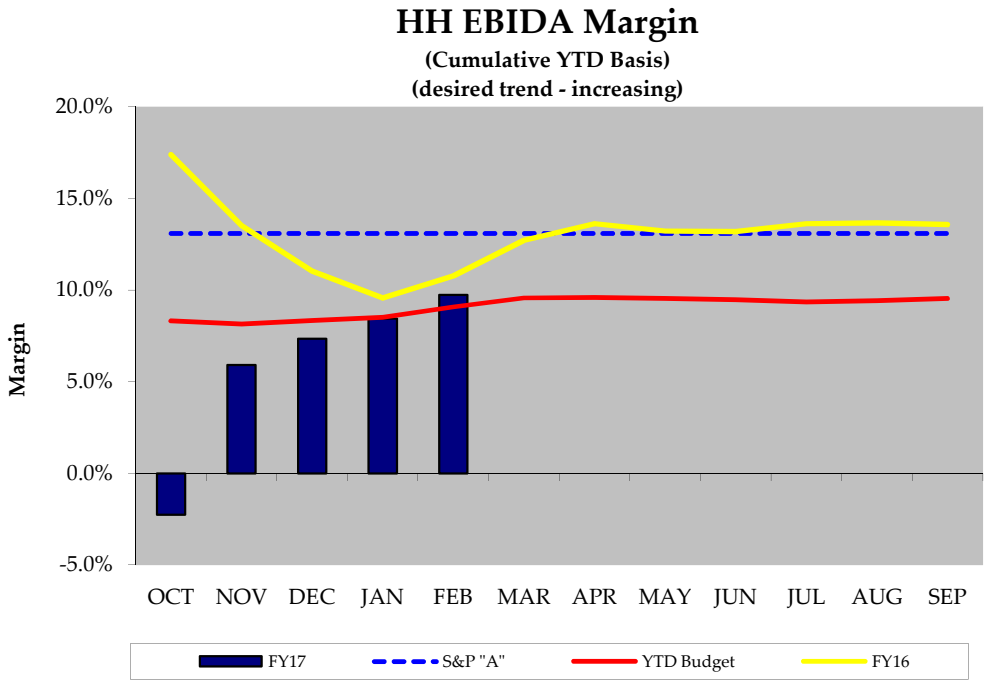
HH Total Margin
(Cumulative YTD Basis)
(desired trend - increasing)

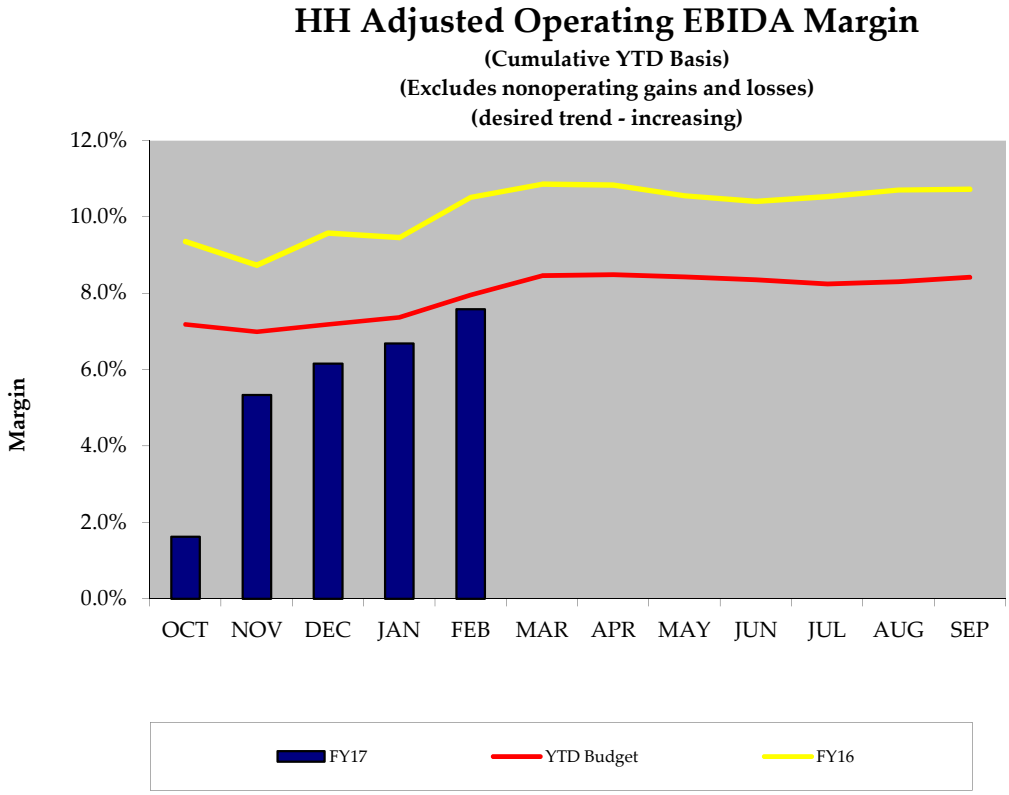


HH Operating Margin
(Cumulative YTD Basis)
(Excludes nonoperating gains and losses)
(desired trend - increasing)



Halifax Health
Financial Summary - Graphic

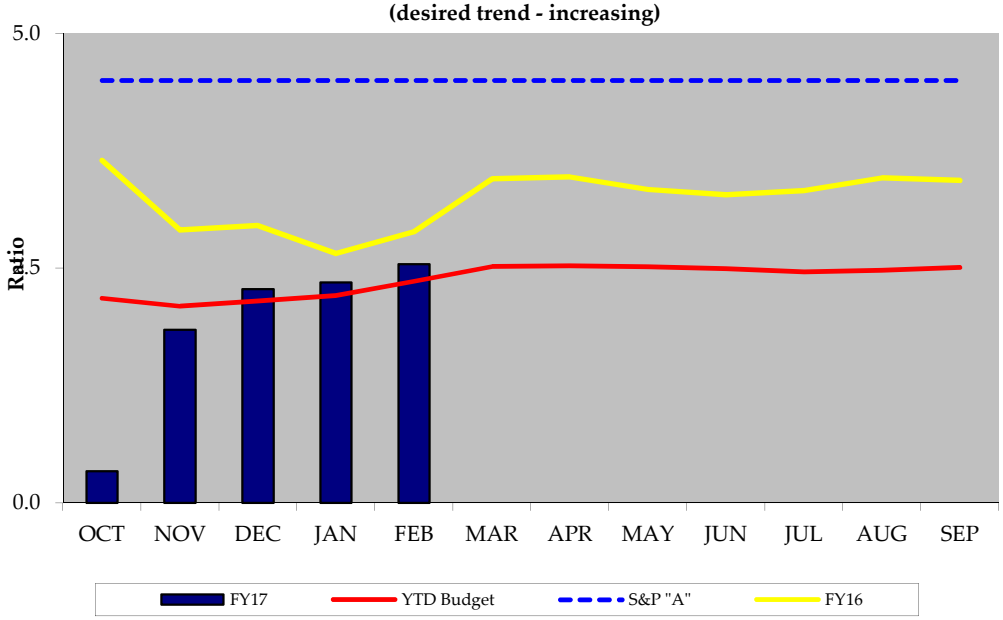




Halifax Health
Financial Summary - Graphic

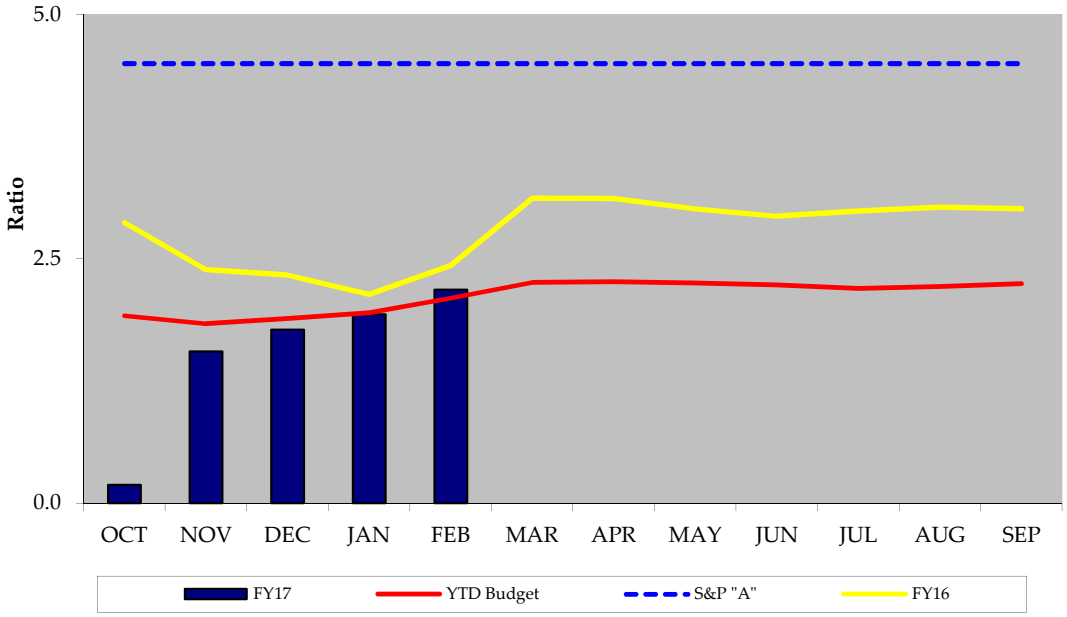
HH MADS Coverage Ratio

(Annualized Basis)
(Excludes unrealized investment gains/losses in accordance with covenant requirements)
(desired trend - increasing)



HH MADS Coverage Ratio - Operations Only

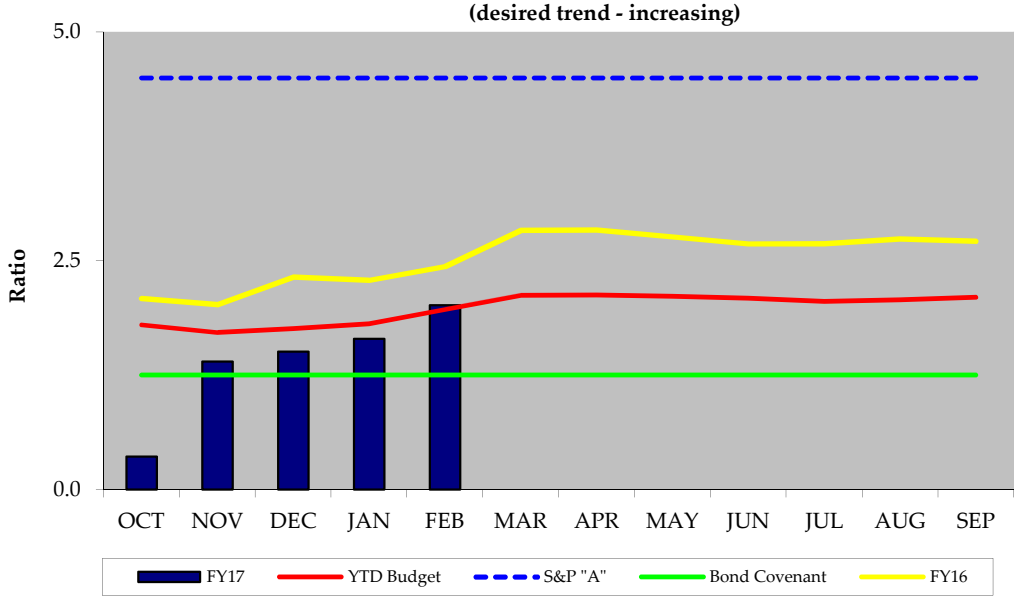
(Annualized Basis)
(Excludes nonoperating gains and losses)
(desired trend - increasing)



Halifax Health
Financial Summary - Graphic

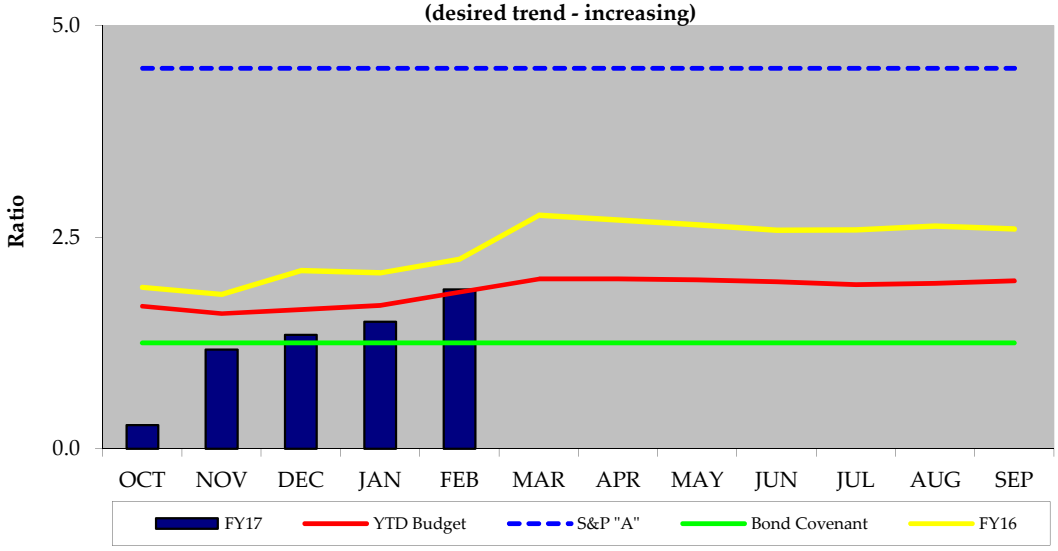
HHMC Obligated Group MADS Coverage Ratio

(Annualized Basis)
(Excludes unrealized investment gains/losses in accordance with covenant requirements)
(desired trend - increasing)



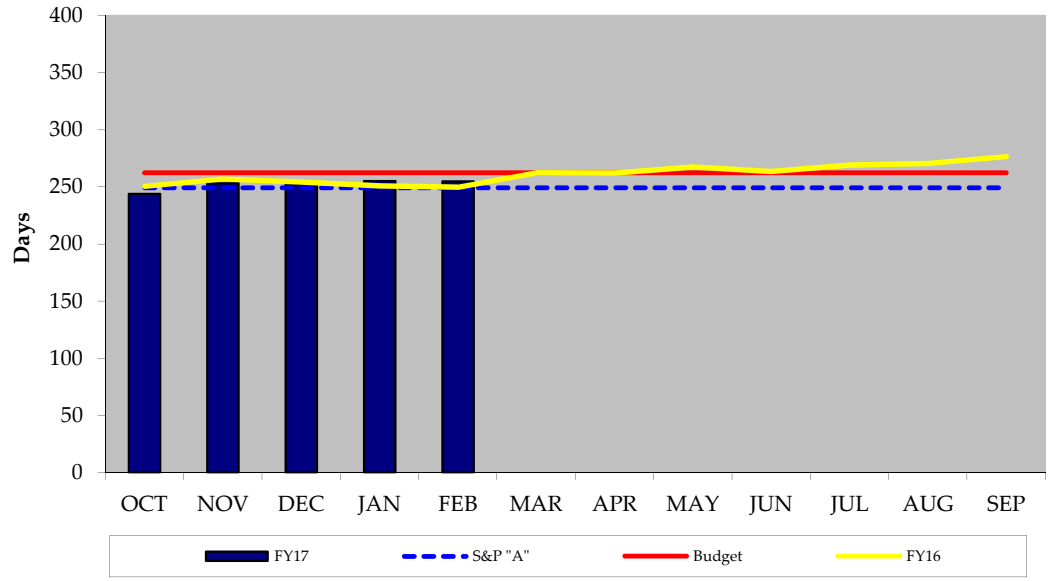
HHMC Obligated Group MADS Coverage Ratio - Operations Only

(Annualized Basis)
(Excludes nonoperating gains and losses)
(desired trend - increasing)

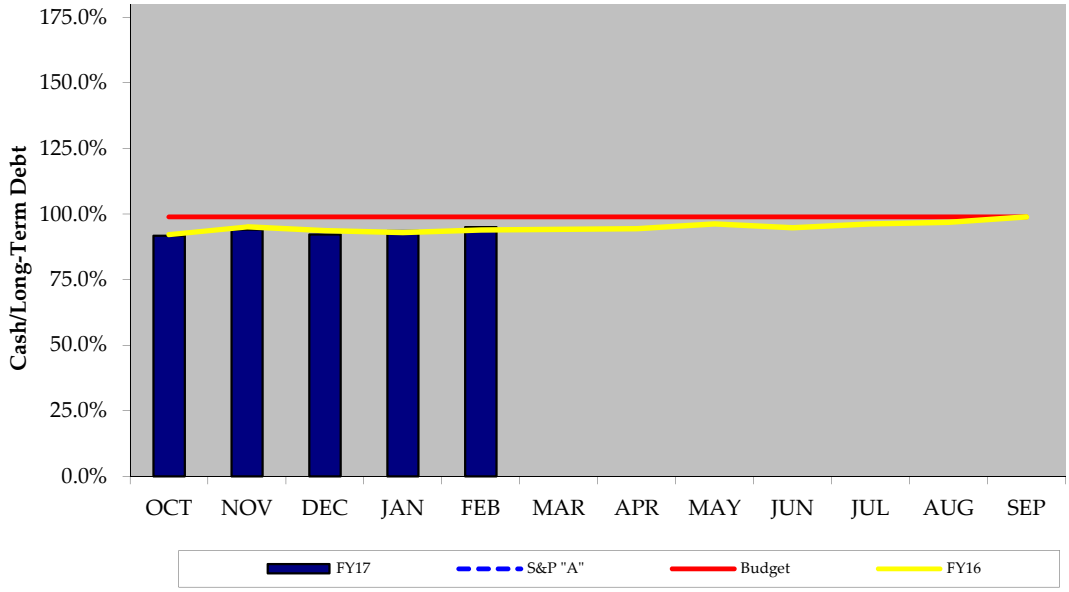


Halifax Health
Financial Summary - Graphic

HH Days Cash on Hand
(Annualized Basis)
(desired trend - increasing)

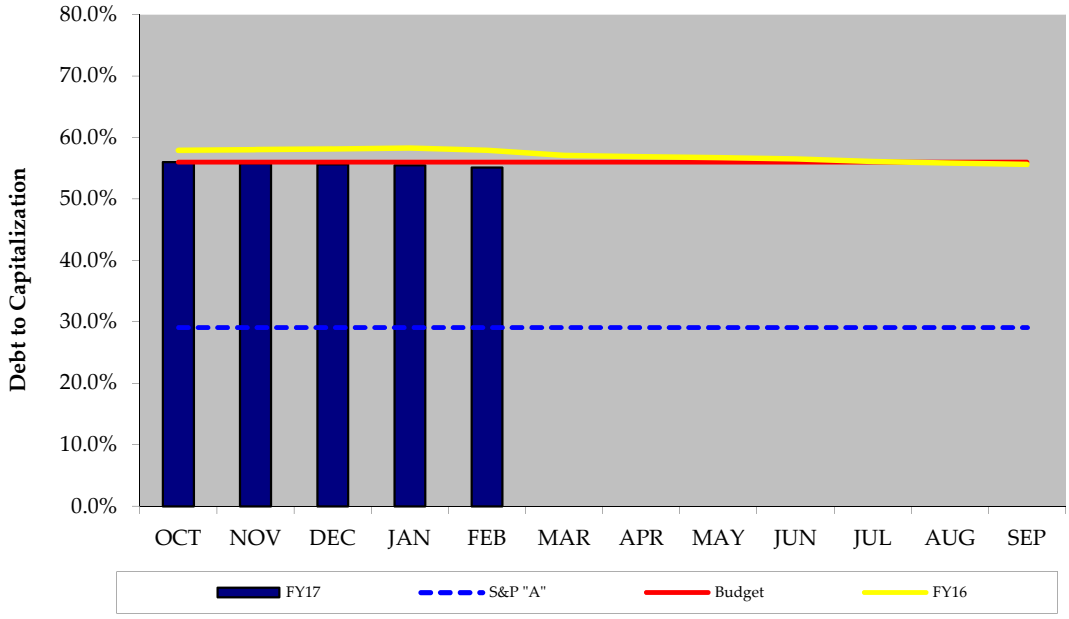


HH Cash/Debt
(Monthly)
(desired trend - increasing)

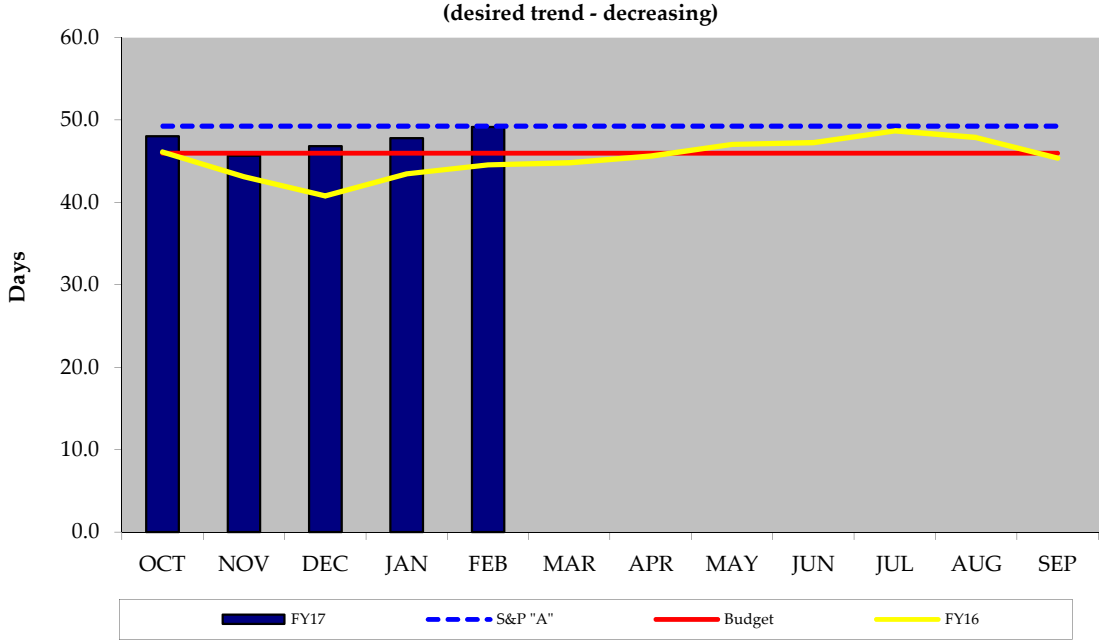


Halifax Health
Financial Summary - Graphic

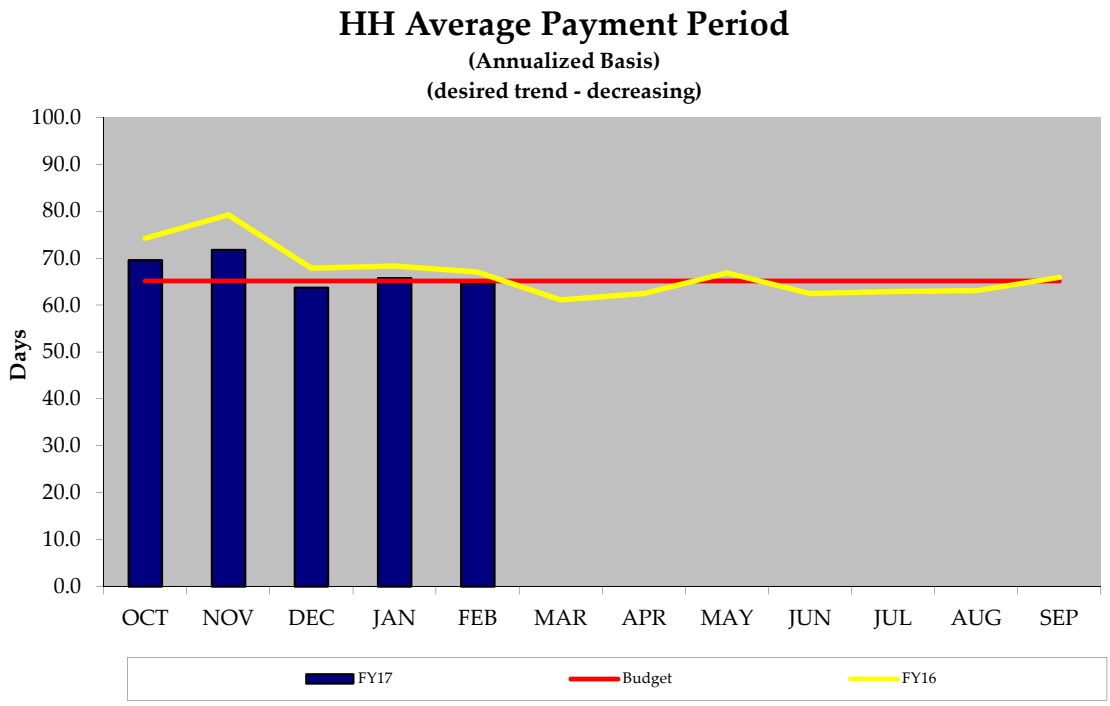
HH Debt to Capitalization
(Monthly)
(desired trend - decreasing)

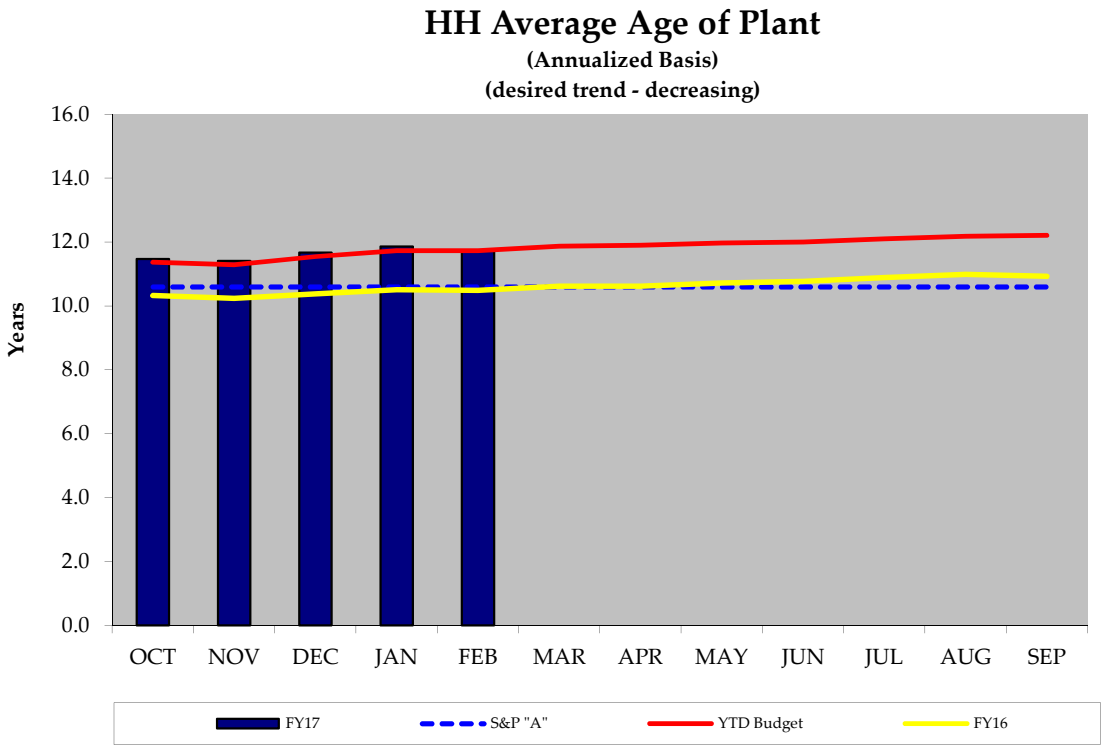


HH Days in A/R
(Annualized Basis)
(desired trend - decreasing)



Halifax Health
Financial Summary - Graphic





Halifax Health
Financial Ratios and Operating Indicators
Definitions and Calculations

Indicator	Definition	Calculation
Total Margin *	Gauges the relative efficiency with which the System produces its output.	Net Income / Total Revenues
EBIDA Margin *	Gauges the relative efficiency excluding capital costs with which the System produces its output.	Net income + Int + Depr + Amort / Total Revenues
MADS Coverage Ratio *	Measures profitability relative to the Maximum Principal and Interest Payment of Debt	Net Income + Depr + Amort + Int / Maximum Annual Debt Service
Days Cash on Hand	Measures the number of days of average cash expenses that the System maintains in cash and cash equivalents and unrestricted investments.	Unrestricted Cash and Investments / (Total Expenses - Depr) / Days in Period
Cash to Long-term Debt	Measures the percentage of unrestricted cash and investments to long-term debt.	Unrestricted Cash and Investments / Long-term Debt
Long-term Debt to Capitalization	Measures the reliance on long-term debt financing and ability to issue new debt.	Long-term Debt / Long-term Debt + Net Position
Days in Accounts Receivable	Measures the average time that receivables are outstanding, or the average collection period.	Accounts Receivable / Net Patient Service Revenue/ Days in Period
Average Payment Period	Provides a measure of the average time that elapses before current liabilities are paid.	Current Liabilities / (Total Expenses - Depr) / Days in Period
Average Age of Plant	Provides a measure of the average age in years of the System's fixed assets.	Accumulated Depreciation / Depreciation Expense
Operating Margin	Gauges the relative operating efficiency with which the System produces its output.	Excess of Operating Revenues / Total Operating Revenues + Bad Debt
* Operations Only Indicators	Excludes realized and unrealized investment income, donations, and nonoperating gains and losses	

CAPITAL EXPENDITURES & OPERATING LEASES

Audit & Finance Committee

April 26, 2017

Capital Expenditures $50,000 and over

DESCRIPTION	DEPARTMENT	SOURCE OF FUNDS	TOTAL
Pediatric Outpatient Rehabilitation Joint Venture with Brooks Rehabilitation	Business Development	Working Capital	$694,409
Bronchoscopy Suite Construction	Pulmonary Department	Working Capital	$579,926
Beds for IMC and CIC	Environmental Services	Working Capital	$475,506
Oncology Services Expansion for the Port Orange Treatment Center	Center for Oncology	Working Capital	$432,720
Fairwarning - Patient Privacy Intelligence System	Information Technology	Working Capital	$182,224
NICO Brain Path and Myriad System	Neurosurgery Services	Working Capital	$181,000
LogRhythm Security Information and Event Management	Information Technology	Working Capital	$150,038

Operating Leases $250,000 and over

DESCRIPTION	DEPARTMENT	REPLACEMENT Y/N	LEASE TERMS	INTEREST RATE	MONTHLY PAYMENT

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Mark Billings, Executive Vice President and Chief Operating Officer
CC: Eric Peburn, Executive Vice President & Chief Financial Officer
Alberto Tineo, Vice President Operations
DATE: April 17, 2017
RE: Bronchoscopy Suite Construction

Halifax Health Pulmonology Department is requesting funds for the construction of a new interventional bronchoscopy suite.

The construction of the suite will allow for the expansion of bronchoscopy services to accommodate both percutaneous and transbronchial lung interventions. Percutaneous procedures allow the physician to access the lung using a needle through the skin. Transbronchial procedures use a fiber optic bronchoscope to gain access into the main airways.

Lung interventions need to be performed in a negative air flow environment. The construction will include negative air flow designed to facilitate the safety and care of patients undergoing these procedures.

Currently, the procedures are performed at the Halifax Professional Center (HPC). The new bronchoscopy suite will be located in the Fountain Building near Interventional Radiology. This location will provide the department access to existing support services to reduce duplication of services.

The Interventional Pulmonary program supports the goal of reducing Volusia County's mortality rates from lung cancer by identifying malignancies as early as possible.

The project was approved at the Capital Investment Committee meeting on March 15, 2017.

TOTAL CAPITAL COST **$579,926**

HALIFAX HEALTH

Halifax Health

Project Evaluation

Bronchoscopy Suite Construction

Chief Operating Officer:	Mark Billings
Vice President, Operations:	Alberto Tineo
Service Line Administrator:	Matt Petkus
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project is to build a procedure room to perform bronchoscopy procedures. In 2016, the Board of Commissioners approved the purchase of three (3) bronchoscopes and a procedural navigation system at a total cost of $464,090. The bronchoscope procedures are expected to generate incremental volume and revenue that supports the return on investment of both the purchase of equipment and room renovation, which together represent a total capital cost of $1,044,016.

Strategic Plan Core Competency Achievement:

Physician Integration	X
Care Coordination	X
Cost Management	
Information Technology	
Service Distribution	X
Financial Position	
Scale	
Managed Care Contracting	
Competitive Position	

Cornerstone:

Safety	X
Compassion	
Image	X
Efficiency	X

Investment/Return:

	Investment Cash Flow	Operations Cash Flow	Cumulative Cash Flow
Year 0 [1]	($1,044,016)	$0	($1,044,016)
Year 1	$0	$127,995	($916,021)
Year 2	$0	$136,786	($779,235)
Year 3	$0	$147,690	($631,545)
Year 4	$0	$159,124	($472,421)
Year 5	$0	$171,112	($301,308)
Year 6	$0	$174,534	($126,774)
Year 7	$0	$178,025	$51,251
Year 8	$0	$181,586	$232,836
Year 9	$0	$185,217	$418,054
Year 10	$0	$188,922	$606,975
Terminal Value [2]	$0	$0	$606,975

Decision Metrics	
Required rate of Return	8.1%
Internal Rate of Return (IRR)	8.7%
10 Year Net Present Value (NPV)	$30,969
Payback Period (in Years)	6.3

Investment Request for Approval **$1,044,016**
(includes room renovation ($579,926) and previously approved equipment ($464,090)

[1] Includes capital acquisition and project startup costs
[2] Terminal value is estimated at $0.

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Eric M. Peburn, Executive Vice President and Chief Financial Officer
CC: Mark Billings, Executive Vice President and Chief Operating Officer
Bob Williams, Director of Business Development and Population Health
DATE: April 25, 2017
RE: Pediatric Outpatient Rehabilitation Joint Venture with Brooks Rehabilitation

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Halifax Health Business Development is requesting approval to renovate space and equipment related to the opening of a pediatric outpatient rehabilitation clinic to be located on the first floor of the Halifax Professional Center (HPC). The rehab clinic is planned to be operated as part of the Center for Inpatient Rehab joint venture between Halifax Health and Brooks Rehabilitation. Easter Seals currently offers pediatric rehabilitation for physical therapy, occupational therapy, and speech therapy. They have notified us that they are intending to close their rehab operations.

Halifax and Brooks are working closely with Easter Seals to assure patients will have an opportunity to continue care without a lapse in treatment. This outpatient pediatric clinic is projected to experience over 11,000 patient visits annually. Invested capital costs are projected to be recovered in 1.7 years.

TOTAL CAPITAL COSTS **$694,409**

HALIFAX HEALTH

Halifax Health

Project Evaluation

Pediatric Outpatient Therapy

Chief Financial Officer:	Eric Peburn
Director, Business Development:	Bob Williams
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project is to renovate space in the Halifax Professional Center and purchase equipment for a new outpatient pediatric therapy service line which includes physical therapy, occupational therapy, and speech therapy. This project is part of the Center for Inpatient Rehab Joint Venture with Brooks Rehabilitation.

Strategic Plan Core Competency Achievement:

Physician Integration	
Care Coordination	X
Cost Management	
Information Technology	
Service Distribution	X
Financial Position	X
Scale	X
Managed Care Contracting	
Competitive Position	X

Cornerstone:

Safety	X
Compassion	X
Image	X
Efficiency	X

Investment/Return:

	Investment Cash Flow	Operations Cash Flow [3]	Cumulative Cash Flow
Year 0 [1]	($694,409)	$347,205	($347,205)
Year 1	$0	$185,784	($161,420)
Year 2	$0	$245,501	$84,080
Year 3	$0	$237,999	$322,080
Year 4	$0	$239,731	$561,810
Year 5	$0	$241,405	$803,215
Terminal Value [2]	$0	$1,207,024	$2,010,239

Investment Request for Approval **$694,409**

Decision Metrics	
Required rate of Return	15.5%
Internal Rate of Return (IRR)	68.4%
5 Year Net Present Value (NPV)	$910,550
Payback Period (in Years)	1.7

[1] Includes capital acquisition and project startup costs

[2] Terminal value is estimated at 0, assumes technology is obsolete after 5 years

[3] Valuation based on Halifax estimated cash flow (50% of Joint Venture cash flow). Year 0 includes 50% of capital costs from Brooks Healthcare.

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Mark Billings, Executive Vice President and Chief Operating Officer
CC: Eric Peburn, Executive Vice President and Chief Financial Officer
Alberto Tineo, Vice President Operations
DATE: March 16, 2017
RE: Beds for IMC and CIC

Halifax Health Environmental Services is requesting funds for the purchase of 16 critical care beds with specialty mattresses and 25 medical beds with standard mattresses. The purchase is part of an ongoing capital plan to replace aging critical care and medical/surgical beds and mattresses.

The 16 critical care beds and mattresses will replace 20-year old beds and standard mattresses on the Intensive Medical Care (IMC) unit. This represents half of the IMC unit beds. The remaining IMC beds are scheduled to be replaced in Fiscal Year 2018. The new critical care beds will also reduce the need to rent beds with specialty mattresses for certain patients that require upgraded technology to avoid pressure ulcers and facilitate healing. The reduction in bed rentals will reduce future operating expenses.

The 25 medical beds with standard mattresses will replace 25 beds and mattresses on the Cardiac Intermediate Care (CIC) unit that are in poor condition.

The project was approved at the Capital Investment Committee meeting on December 21, 2016.

TOTAL CAPITAL COSTS $475,506

Halifax Health

Project Evaluation

Beds and Mattresses for IMC and CIC

Chief Operating Officer:	Mark Billings
Vice President, Operations:	Alberto Tineo
Manager, Environmental Services:	Mitch Norton
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project will replace 16 critical care beds and mattresses on the Intensive Medical Care (IMC) unit and 25 medical beds and mattresses on the Cardiac Intermediate Care (CIC) unit. The IMC beds and mattresses will reduce the need for bed rentals.

Strategic Plan Core Competency Achievement:

Physician Integration	
Care Coordination	
Cost Management	X
Information Technology	
Service Distribution	X
Financial Position	
Scale	
Managed Care Contracting	
Competitive Position	

Cornerstone:

Safety	X
Compassion	
Image	X
Efficiency	X

Investment/Return- IMC beds and mattresses:

	Investment Cash Flow	Operations Cash Flow [3]	Cumulative Cash Flow
Year 0 [1]	($337,836)	($17,763)	($355,599)
Year 1	$0	$53,000	($302,599)
Year 2	$0	$54,060	($248,539)
Year 3	$0	$55,141	($193,398)
Year 4	$0	$56,244	($137,154)
Year 5	$0	$57,369	($79,785)
Year 6	$0	$58,516	($21,269)
Year 7	$0	$59,687	$38,418
Year 8	$0	$60,880	$99,298
Year 9	$0	$62,098	$161,396
Year 10	$0	$63,340	$224,736
Terminal Value [2]	$0	$0	$224,736

Decision Metrics	
Required rate of Return	6.1%
Internal Rate of Return (IRR)	9.7%
10 Year Net Present Value (NPV)	$66,077
Payback Period (in Years)	6.6

IMC beds and Mattresses	$337,836
CIC beds and mattresses [4]	137,670
Investment Request for Approval	**$475,506**

[1] Includes capital acquisition and project startup costs

[2] Terminal value is estimated at $0.

[3] Cash flow represents reduction of equipment lease cost.

[4] Recommendation for approval for this component of the project is not based upon incremental return on investment.

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Mark Billings, Executive Vice President and Chief Operating Officer
CC: Eric Peburn, Executive Vice President and Chief Financial Officer
Alberto Tineo, Vice President Operations
DATE: March 16, 2017
RE: Oncology Services Expansion for the Port Orange Treatment Center

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Halifax Health Center for Oncology is requesting funds to expand the Port Orange Medical Oncology Treatment Center. The project includes construction costs and pharmacy equipment to accommodate increased patient volume.

The center has experienced a significant growth since 2012. A recent market analysis suggests continued market increase for oncology services in this demographic area. The expansion will increase capacity and reduce scheduling delays, which will lead to improved patient satisfaction and provide increased chemotherapy services to the community.

The expansion is projected to have an internal rate of return of 35.5% and a recovery of capital period of 3.9 years.

The project was approved at the Capital Investment Committee meeting on February 15, 2017.

TOTAL CAPITAL COSTS **$432,720**

HALIFAX HEALTH

Halifax Health

Project Evaluation

Oncology Services Expansion for the Port Orange Treatment Center

Chief Operating Officer:	Mark Billings
Vice President, Operations:	Alberto Tineo
Service Line Administrator, Oncology:	Debra Trovato
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project will add additional space and capacity (10 Chemotherapy chairs) to the Outpatient Port Orange Medical Oncology office.

Strategic Plan Core Competency Achievement:

Physician Integration	
Care Coordination	X
Cost Management	
Information Technology	
Service Distribution	X
Financial Position	X
Scale	X
Managed Care Contracting	
Competitive Position	X

Cornerstone:

Safety	X
Compassion	X
Image	X
Efficiency	X

Investment/Return:

	Investment Cash Flow	Operations Cash Flow	Cumulative Cash Flow
Year 0 [1]	($432,720)	($29,044)	($461,764)
Year 1	$0	$140,704	($321,061)
Year 2	$0	$151,960	($169,101)
Year 3	$0	$154,999	($14,102)
Year 4	$0	$158,099	$143,997
Year 5	$0	$161,261	$305,258
Terminal Value [2]	$0	$806,305	$1,111,564

Investment Request for Approval **$432,720**

Decision Metrics	
Required rate of Return	9.5%
Internal Rate of Return (IRR)	35.5%
5 Year Net Present Value (NPV)	$589,694
Payback Period (in Years)	3.1

[1] Includes capital acquisition and project startup costs

[2] Terminal value is estimated at 0, assumes technology is obsolete after 5 years

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Arvin Lewis, Senior Vice President and Chief Revenue Officer
CC: Eric Peburn, Executive Vice President and Chief Financial Officer
Tom Stafford, Vice President and Chief Information Officer
DATE: April 17, 2017
RE: Fairwarning - Patient Privacy Intelligence System

Halifax Health Information Technology is requesting funds to purchase Fairwarning, a Patient Privacy Intelligence System. The purchase includes hardware, software and licenses.

Fairwarning is a detection system that provides a single view of multiple electronic health records, employee data and system activity to log and report on irregularities in Electronic Personal Health Information (ePHI) to comply with HIPAA and other regulations. The system upon detecting unusual activity will automatically alert a team member to investigate the irregularities.

The project was approved at the Capital Investment Committee meeting on March 15, 2017.

TOTAL CAPITAL COST **$182,224**

Halifax Health

Project Evaluation

Fairwarning Appliance and Licenses

Chief Revenue Officer:	Arvin Lewis
Chief Information Officer:	Tom Stafford
Project Manager	Nancy Jeffreys
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project will implement a patient privacy system that will provide alerts when unusual activity is detected.

Strategic Plan Core Competency Achievement:

Physician Integration	
Care Coordination	
Cost Management	
Information Technology	X
Service Distribution	
Financial Position	
Scale	
Managed Care Contracting	
Competitive Position	

Cornerstone:

Safety	X
Compassion	
Image	
Efficiency	

Investment Request for Approval **$182,224**

Recommendation for approval of the project is not based upon incremental return on investment.

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Eric Peburn, Executive Vice President and Chief Financial Officer
CC: Jeanne Connelly, Executive Director of Physician Services
DATE: March 16, 2017
RE: NICO Brain Path and Myriad System

Halifax Health Neurosurgery Services is requesting funds to purchase a NICO Brain Path and Myriad System for use by neurosurgeons to provide access and visualization of the subcortical space of the brain. The system allows for minimally disruptive tissue damage to brain matter while the surgeons navigate and perform procedures deep within the confines of the brain.

The Brain Path's intended use is for patients who have intracranial hemorrhages, strokes, brain tumors or cysts, and vascular abnormalities/malformations.

The Myriad System is a device that cuts and extracts tissue without destroying the surrounding critical structure. This leads to much better patient outcomes with less risk of brain damage.

Community Benefits:

- Improved outcomes for intracranial hemorrhages and stroke patients
- New surgical technology that is not currently being offered in Volusia or surrounding counties
- Reduced outmigration for patients who require this type of surgery
- Reduced length of stay

The NICO Brain Path and Myriad System is projected to have an internal rate of return of 37.3% and a recovery of capital period of 2.3 years.

The project was approved at the Capital Investment Committee meeting on February 15, 2017.

TOTAL CAPITAL COSTS **$181,000**

HALIFAX HEALTH

Halifax Health

Project Evaluation

NICO BrainPath and Myriad System

Chief Financial Officer:	Eric Peburn
Executive Director, Physician Services:	Jeanne Connelly
Finance Analysis by:	Steve Mach

Summary

Purpose:

This purchase of the NICO BranPath and Myriad System will allow surgeons access and visualization of the subcortical space of the brain during Intracranial hemorrhage procedures.

Strategic Plan Core Competency Achievement:

Physician Integration	X
Care Coordination	X
Cost Management	
Information Technology	
Service Distribution	
Financial Position	X
Scale	
Managed Care Contracting	
Competitive Position	X

Cornerstone:

Safety	X
Compassion	X
Image	X
Efficiency	X

Investment/Return:

	Investment Cash Flow	Operations Cash Flow	Cumulative Cash Flow
Year 0 [1]	($181,000)	$0	($181,000)
Year 1	$0	$76,740	($104,260)
Year 2	$0	$80,472	($23,788)
Year 3	$0	$82,081	$58,293
Year 4	$0	$97,725	$156,018
Year 5	$0	$113,961	$269,978
Terminal Value [2]	$0	$0	$269,978

Investment Request for Approval **$181,000**

Decision Metrics	
Required rate of Return	11.5%
Internal Rate of Return (IRR)	37.3%
5 Year Net Present Value (NPV)	$140,704
Payback Period (in Years)	2.3

[1] Includes capital acquisition and project startup costs

[2] Terminal value is estimated at 0, assumes technology is obsolete after 5 years

HALIFAX HEALTH

TO: Jeff Feasel, President and Chief Executive Officer
FROM: Arvin Lewis, Senior Vice President and Chief Revenue Officer
CC: Eric Peburn, Executive Vice President and Chief Financial Officer
Tom Stafford, Vice President and Chief Information Officer
DATE: April 17, 2017
RE: LogRhythm Security Information and Event Management

Halifax Health Information Technology is requesting funds to purchase LogRhythm, a Security Information and Event Management (SIEM) solution. The purchase includes hardware, software and licenses.

LogRhythm is a detection system that provides a single view of multiple system logs to identify trends and patterns that are out of the ordinary. The system will improve the monitoring and alerting of unusual network activity.

The project was approved at the Capital Investment Committee meeting on March 15, 2017.

TOTAL CAPITAL COST **$150,038**

Halifax Health

Project Evaluation

Logrhythm Appliance License and Software

Chief Revenue Officer:	Arvin Lewis
Chief Information Officer:	Tom Stafford
Project Manager	Nancy Jeffreys
Finance Analysis by:	Steve Mach

Summary

Purpose:

This project will implement a security information and event management system to monitor and alert unusual network activity.

Strategic Plan Core Competency Achievement:	
Physician Integration	
Care Coordination	
Cost Management	
Information Technology	X
Service Distribution	
Financial Position	
Scale	
Managed Care Contracting	
Competitive Position	

Cornerstone:	
Safety	X
Compassion	
Image	
Efficiency	

Investment Request for Approval	**$150,038**

Recommendation for approval of the project is not based upon incremental return on investment.

Halifax Health Medical Center
Capital Disposals
April 2017

The Board hereby deems the following property to be surplus in that: the items are obsolete, their continued use would be uneconomical or inefficient, or they serve no useful function. Disposition of said property is therefore authorized pursuant to Florida Statutes, Chapter 274.

Asset #	Description	Department	Date Purchased	Original Cost	Book Value
42268	SOFTWARE-ORBIT/SCHEDULING	IS-MGMT	11/11/91	16,500.00	-
44048	FURNITURE - DESK	IS-MGMT	12/08/92	1,075.10	-
44049	FURNITURE - DESK	IS-MGMT	12/08/92	1,075.10	-
44050	FURNITURE - DESK	IS-MGMT	12/08/92	1,075.10	-
46878	FURNITURE - DESK	IS-MGMT	02/27/95	1,551.90	-
49725	DUAL T1 CARD W/CABLES	IS-MGMT	08/31/01	3,706.59	-
49781	DUAL T-1 CARD	IS-MGMT	10/23/01	3,706.59	-
50035	HARDWARE-SERVER-SAN	IS-MGMT	08/31/02	52,300.00	-
50157	HARDWARE-SERVER-EMULEX CARD	IS-MGMT	11/07/02	1,495.00	-
50158	HARDWARE-SERVER-EMULEX CARD	IS-MGMT	11/07/02	1,495.00	-
59653	HP ELITEBOOK TABLET	IT-TECH	10/04/12	1,424.21	169.01
59654	HP ELITEBOOK TABLET	IT-TECH	10/04/12	1,424.21	169.01
59655	HP ELITEBOOK TABLET	IT-TECH	10/04/12	1,424.21	169.01
63009-39	BARCODE SCANNERS (51)	IT-TECH	06/30/09	10,857.90	-
52493	WOW- CART & LAPTOP	IT-CLIENT SERVICES	03/01/11	4,563.00	-
52494	WOW- CART & LAPTOP	IT-CLIENT SERVICES	03/01/11	4,563.00	-
59123	WOW CARTS FOR INVENTORY	IT-CLIENT SERVICES	04/06/11	3,430.11	1,570.67
59125	HP6540B LAPTOP	IT-CLIENT SERVICES	05/01/11	865.00	-
59699	LAPTOP, ELITEBOOK 8460P	IT-CLIENT SERVICES	12/20/12	1,140.95	-
59700	LAPTOP, ELITEBOOK 8460P	IT-CLIENT SERVICES	12/20/12	1,140.95	-
59701	LAPTOP, ELITEBOOK 8460P	IT-CLIENT SERVICES	12/20/12	1,140.95	-
59702	LAPTOP, ELITEBOOK 8460P	IT-CLIENT SERVICES	12/20/12	1,140.95	-
59703	LAPTOP, ELITEBOOK 8460P	IT-CLIENT SERVICES	12/20/12	1,140.95	-
59704	LAPTOP, ELITEBOOK 8460P	IT-CLIENT SERVICES	12/20/12	1,140.95	-
59705	LAPTOP, ELITEBOOK 8460P	IT-CLIENT SERVICES	12/20/12	1,140.95	-
57354	RETCAM SHUTTLE CAMERA & LENS	NEONATAL-ICU	04/30/09	76,300.00	-
57355	RETCAM REVIEW SOFTWARE	NEONATAL-ICU	04/30/09	1,993.34	-
57356	RETCAM REVIEW SOFTWARE	NEONATAL-ICU	04/30/09	1,993.33	-
57357	RETCAM REVIEW SOFTWARE	NEONATAL-ICU	04/30/09	1,993.33	-
				$ 202,798.67	**$ 2,077.70**

HALIFAX HEALTH

To:	Audit and Finance Committee and Board of Commissioners
Cc:	Jeff Feasel, Chief Executive Officer
From:	Shelly Shiflet, Vice President and Chief Compliance Officer
Date:	April 17, 2017
Re:	Compliance Dashboard Report for March 2017

Enclosed is the Compliance Program Dashboard Report for March 2017.

Feel free to contact the Board's Compliance Expert, Robert Wade, Esq., or me regarding any questions on this report.

Mr. Wade can be reached at: rwade@kdlegal.com
Office: 574.485.2002

I can be reached at: shelly.shiflet@halifax.org
Office: 386.425.4970

Recommended Action: None. Information only.

Halifax Health
Corporate Compliance Program
Board Report – 3/31/2017

ON TARGET **ALERT**

I. EMPLOYEE AND BOARD EDUCATION – Halifax Health's compliance program and Corporate Integrity Agreement requires most employees to acknowledge the Code of Conduct within 30 days of hire. Employees who are considered "Covered Persons" are required to complete 1 hour of general compliance training within 30 days of hire and annually thereafter. Managers and others who are considered "Arrangements Covered Persons" must complete an additional hour of general education and 2 hours of arrangements training within 30 days of becoming an "Arrangements Covered Person," and annually thereafter. Members of the Board are required to complete 6 hours (2 hours general, 2 hours arrangements, and 2 hours governance) of training within 30 days of becoming a member. The following is the status of education for Halifax Health's employees:

	➢	**Code of Conduct Attestation[1]**
	1. 4,059	Number of Covered Persons and Board Members required to complete as of end of period
	2. 100%	% of Covered Persons who have completed (On Target at 100%)

	➢	**CIA Required Training[2]**
	1. 3,906	Number of Covered Persons and Board Members required to complete as of end of period
	2. 100%	% of Covered Persons who have completed (On Target at 100%)

II. SANCTION CHECKS - Halifax Health's Corporate Integrity Agreement requires all "Covered Persons" be screened for exclusions from participation in federal programs monthly. During the period:

	➢	**Sanction Check for Covered Persons[3]**
	1. 4,787	Number of Covered Persons as of the end of the period
	2. 100%	% of Covered Persons above who had no sanctions, based on monthly sanction check results (On Target at 100%)

III. COMPLIANCE COMMITTEE – Halifax Health has a Compliance Committee responsible for regulatory compliance matters, which meets monthly. Members of senior leadership across service lines as well as representatives from Hospice and the Medical Staff are represented. During the period:

	1. 13	Number of members on *Compliance Committee*
	2. 100%	% of members who attended the meeting on 3/1/2017 (On Target at 70% or Greater)
	3. 3	Number of meetings in the last quarter (On Target if 2 or more)

IV. HELP LINE *[844-251-1880]* *or* ***halifaxhealth.ethicspoint.com***

	1. 6 / 57	Number of Help Line calls received during month/past 12 months
	2. 4 / 41	Of calls in 1, how many related to Human Resource issues
	3. 0	Number of open Help Line calls rated as High Priority as of 2/28/2017
	4. 0	Number of open Help Line calls rated as High Priority as of 3/31/2017
	5. 3	Number of Help Line calls closed since last month

V. COMPLIANCE ISSUES

	1. 19	Number of issues open as of 2/28/2017
	2. 7	Of the issues in item 1, __ remain open as of 3/31/2017
	3. 12	Number of issues from item 1 closed as of 3/31/2017
	4. 63%	Percent of open issues from item 1 closed (On Target at 25% or Greater)

VI. COMPLIANCE POLICIES – Halifax Health's Compliance Program involves the development, implementation and monitoring of policies to ensure the organization conducts business compliant with applicable statutes, rules and regulations. During the period:

	1. 9	Number of Compliance Policies reviewed/ updated in the last month (On Target at 1)

VII. BILLING AND CODING REVIEWS - Halifax Health will conduct reviews as part of scheduled audits or to investigate concerns brought to the attention of the Compliance Committee or the Compliance Officer.

	1. 1	Number of concerns related to billing/coding received during the month
	2. 1	Number of concerns from #1 that required a billing/ coding review
	3. 0	Number of reviews from #1 still being investigated
	4. 1	Number of reviews from #1 closed or pending Committee review
	5. 1	Number of reviews from #1 expected to require repayment/processing of claims

[1] Code of Conduct Attestation – employees and vendors who meet the definition of a *Covered Person and* new Board Members.

[2] CIA Required Training – employees (except for housekeeping, maintenance and foodservice employees), Medical Staff who are party to a *Focus Arrangement* and vendors who meet the definition of a *Covered Person and* new Board Members.

[3] Sanction Check for Covered Persons - employees, Medical Staff and vendors who meet the definition of a *Covered Person*.

HALIFAX HEALTH

To:	Audit and Finance Committee and Board of Commissioners
Cc:	Jeff Feasel, Chief Executive Officer
From:	Shelly Shiflet, Vice President and Chief Compliance Officer
Date:	March 20, 2017
Re:	Compliance Dashboard Report for February 2017

Enclosed is the Compliance Program Dashboard Report for February 2017.

Feel free to contact the Board's Compliance Expert, Robert Wade, Esq., or me regarding any questions on this report.

Mr. Wade can be reached at: rwade@kdlegal.com
Office: 574.485.2002

I can be reached at: shelly.shiflet@halifax.org
Office: 386.425.4970

Recommended Action: None. Information only.

Halifax Health
Corporate Compliance Program
Board Report – 2/28/2017

ON TARGET **ALERT**

I. EMPLOYEE AND BOARD EDUCATION – Halifax Health's compliance program and Corporate Integrity Agreement requires most employees to acknowledge the Code of Conduct within 30 days of hire. Employees who are considered "Covered Persons" are required to complete 1 hour of general compliance training within 30 days of hire and annually thereafter. Managers and others who are considered "Arrangements Covered Persons" must complete an additional hour of general education and 2 hours of arrangements training within 30 days of becoming an "Arrangements Covered Person," and annually thereafter. Members of the Board are required to complete 6 hours (2 hours general, 2 hours arrangements, and 2 hours governance) of training within 30 days of becoming a member. The following is the status of education for Halifax Health's employees:		
	➢	**Code of Conduct Attestation[1]**
	1. 4,040	Number of Covered Persons and Board Members required to complete as of end of period
	2. 100%	% of Covered Persons who have completed (On Target at 100%)

	➢	**CIA Required Training[2]**
	1. 3,885	Number of Covered Persons and Board Members required to complete as of end of period
	2. 100%	% of Covered Persons who have completed (On Target at 100%)

II. SANCTION CHECKS - Halifax Health's Corporate Integrity Agreement requires all "Covered Persons" be screened for exclusions from participation in federal programs monthly. During the period:		
	➢	**Sanction Check for Covered Persons[3]**
	1. 4,775	Number of Covered Persons as of the end of the period
	2. 100%	% of Covered Persons above who had no sanctions, based on monthly sanction check results (On Target at 100%)
III. COMPLIANCE COMMITTEE – Halifax Health has a Compliance Committee responsible for regulatory compliance matters, which meets monthly. Members of senior leadership across service lines as well as representatives from Hospice and the Medical Staff are represented. During the period:		
	1. 13	Number of members on *Compliance Committee*
	2. 76%	% of members who attended the meeting on 2/1/2017 (On Target at 70% or Greater)
	3. 3	Number of meetings in the last quarter (On Target if 2 or more)
IV. HELP LINE *[844-251-1880]* *or* ***halifaxhealth.ethicspoint.com***		
	1. 3 / 55	Number of Help Line calls received during month/past 12 months
	2. 3 / 38	Of calls in 1, how many related to Human Resource issues
	3. 0	Number of open Help Line calls rated as High Priority as of 1/31/2017
	4. 0	Number of open Help Line calls rated as High Priority as of 2/28/2017
	5. 8	Number of Help Line calls closed since last month
V. COMPLIANCE ISSUES		
	1. 25	Number of issues open as of 1/31/2017
	2. 11	Of the issues in item 1, __ remain open as of 2/28/2017
	3. 14	Number of issues from item 1 closed as of 2/28/2017
	4. 56%	Percent of open issues from item 1 closed (On Target at 25% or Greater)
VI. COMPLIANCE POLICIES – Halifax Health's Compliance Program involves the development, implementation and monitoring of policies to ensure the organization conducts business compliant with applicable statutes, rules and regulations. During the period:		
	1. 1	Number of Compliance Policies reviewed/ updated in the last month (On Target at 1)
VII. BILLING AND CODING REVIEWS - Halifax Health will conduct reviews as part of scheduled audits or to investigate concerns brought to the attention of the Compliance Committee or the Compliance Officer.		
	1. 0	Number of concerns related to billing/coding received during the month
	2. 0	Number of concerns from #1 that required a billing/ coding review
	3. 0	Number of reviews from #1 still being investigated
	4. 0	Number of reviews from #1 closed or pending Committee review
	5. 0	Number of reviews from #1 expected to require repayment/processing of claims

[1] Code of Conduct Attestation – employees and vendors who meet the definition of a *Covered Person and* new Board Members.

[2] CIA Required Training – employees (except for housekeeping, maintenance and foodservice employees), Medical Staff who are party to a *Focus Arrangement* and vendors who meet the definition of a *Covered Person and* new Board Members.

[3] Sanction Check for Covered Persons - employees, Medical Staff and vendors who meet the definition of a *Covered Person*.

HALIFAX HEALTH

TO: Board of Commissioners, Halifax Hospital Medical Center
FROM: Daniel T Miles, MD, President of the Medical Staff
DATE: April 14, 2017
RE: New Medical Staff Bylaws

The Medical Executive Committee and the Active Medical Staff of Halifax Hospital Medical Center have voted to approve the attached complete rewrite of the Medical Staff Bylaws. Pursuant to Florida law, Joint Commission accreditation standards, and the "old" Halifax Medical Staff Bylaws, the Medical Staff present these new Medical Staff Bylaws for final approval by the Board of Commissioners, which is the governing body of Halifax Hospital Medical Center.

Background:

The Bylaws Committee of the Medical Staff worked through 2015 and 2016, with the assistance of outside counsel hired independently by the Medical Staff, to develop a complete rewrite of the Medical Staff Bylaws, with the goal of updating them to include current laws, regulations, and accreditation standards and references to those authorities. The MEC approved the rewritten Medical Staff Bylaws to be presented for an approval vote to the voting members of the General Medical Staff.

The first draft of the rewritten Medical Staff Bylaws were presented for a vote to the voting members of the Medical Staff at the General Medical Staff meeting in September, 2016, and did not pass. The Medical Executive Committee then worked with Administration and members of the Medical Staff to address the areas of concern raised by several Medical Staff members.

On January 31, 2017, an updated draft of the proposed new Medical Staff Bylaws was emailed to every voting member of the Medical Staff, in a "clean" format, as requested by the active members at the January 24, 2017 General Medical Staff meeting. In addition, the proposed Medical Staff Bylaws were also posted to the Halifax Physicians' Portal at that time. Thirty (30) days later, on March 2, 2017, voting was opened on the proposed new Medical Staff Bylaws.

In an effort to allow as many voting members of the Medical Staff the opportunity to consider and vote on the proposed new Medical Staff Bylaws, the decision was made to allow physicians to vote in person in three physicians' lounges at Halifax for an entire week, rather than limiting voting to one meeting. This expansion of the time for voting was communicated in several notices provided to the voting Members, and signs were also posted within the Physicians' lounges where voting was available. Voting was open between March 2, 2017 and March 8, 2017. The votes were counted electronically, and there were 71 votes to approve and 8 votes to disapprove, providing a greater than 2/3 vote in favor of approval.

<u>The Medical Staff respectfully requests that the Board of Commissioners vote to approve the new Medical Staff Bylaws as presented at the May 1, 2017 Board of Commissioners meeting.</u>

BYLAWS

OF THE

MEDICAL STAFF

OF

HALIFAX HEALTH MEDICAL CENTER

Adopted by the Medical Staff on March 21, 2017

Approved by the Board of Commissioners on (insert date)

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PREAMBLE

WHEREAS, Halifax Health Medical Center is a facility of a Special Taxing District organization and is organized under the laws of the State of Florida; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible to the Governing Board of the Special District for the quality and delivery of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer "CEO" and Governing Body are necessary to fulfill the Hospital's obligations to its patients;

NOW THEREFORE, the doctors of medicine, doctors of osteopathy, doctors of dentistry, doctors of psychology, and doctors of podiatry practicing in this Hospital hereby organize themselves into a Medical Staff for these purposes and in conformity with these Bylaws.

DEFINITIONS

1. ADMITTING PRIVILGES means the prerogatives granted to certain Members of the Staff to admit patients to the Hospital.

2. ADVERSE ACTION means an action that adversely affects an individual's Medical Staff membership or clinical privileges. An Adverse Action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.

3. APPLICANT means an individual who has completed the pre-application process and has been formally invited to apply for membership for appointment set forth in Article V, or a Member who has completed the process set forth in Article V for reappointment or an increase in or change to the Member's clinical privileges.

4. BOARD CERTIFICATION means having completed an approved educational training program and an evaluation process including an examination designed to assess knowledge, skills, and experience necessary to provide quality patient care in that specialty. For physicians, Board Certification shall be granted from an American Board of Medical Specialties (ABMS) member board, or from a member board of the American Osteopathic Association (AOA). For podiatrists, Board Certification shall be granted from the American Board of Podiatric Surgery (ABPS). For dentists and dental surgeons, Board Certification shall be granted from the American Board of Oral/Maxillofacial Surgeons (ABOMS). For Physician Assistants, Board Certification shall be granted from the National Commission on Certification of Physician Assistants (NCCPA). For Advanced Registered Nurse Practitioners, Board Certification shall be granted from either the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners (AANP). For Certified Nurse Midwives, Board Certification shall be granted from American Midwifery Certification Board (AMCB). For Certified Registered Nurse Anesthetists, Board Certification shall be granted from National Board of Certification & Recertification of Nurse Anesthetists (NBCRNA). When applicable, all Practitioners shall become Board Certified in their specialty within five (5) years of eligibility and maintain their status as Board Certified thereafter; provided, however, that Members who have been members for at least twenty (20) years as of the date these Bylaws are approved by the Board of Commissioners shall not be required to obtain and maintain Board Certified status.

5. BOARD RECERTIFICATION for physicians. Board Recertification shall be granted from an American Board of Medical Specialties (ABMS) member board, or from a member board of the American Osteopathic Association (AOA) or the National Board of Physicians and Surgeons (NBPAS). For podiatrists, Board Certification shall be granted from the American Board of Podiatric Surgery (ABPS). For dentists and dental surgeons, Board Certification shall be granted from the American Board of Oral/Maxillofacial Surgeons (ABOMS). For Physician Assistants, Board Certification shall be granted from the National Commission on Certification of Physician Assistants (NCCPA). For Advanced Registered Nurse Practitioners, Board Certification shall be granted from either the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse

Practitioners (AANP). For Certified Nurse Midwives, Board Certification shall be granted from American Midwifery Certification Board (AMCB). For Certified Registered Nurse Anesthetists, Board Certification shall be granted from National Board of Certification & Recertification of Nurse Anesthetists (NCBRNA). When applicable, all Practitioners shall become Board Certified in their specialty within five (5) years of eligibility and maintain their status as Board Certified thereafter; provided however, that Members who have been Members for at least twenty (20) years as of the date these Bylaws are approved by the Board of Commissioners shall not be required to obtain and maintain Board Certified status.

6. BOARD ELIGIBLE (PENDING BOARD CERTIFICATION) means having the education, training, and recommendations sufficient to entitle a Practitioner to sit for the certification examination administered by the appropriate Board Certifying entity.

7. CERTIFIED MAIL means registered or certified, return receipt requested.

8. DEPENDENT HEALTHCARE PROFESSIONAL means an individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license, and in accordance with individually granted clinical privileges if the dependent practitioner is an NPP.

9. DISRUPTIVE PROFESSIONAL CONDUCT means the conduct described as disruptive in the "Professional Conduct of Practitioners" policy adopted by the Medical Staff.

10. DISTRICT means the Halifax Hospital Medical Center special taxing district.

11. ESTABLISHED SUBSECTION or "Subsection" means a group of Practitioners with similar privileges that has been officially approved by the Executive Committee as constituting a valid subsection within a Department.

12. EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

13. FOCUSED PROFESSIONAL PRACTICE EVALUATION or FPPE means process whereby the Hospital evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital.

14. GOOD STANDING means a staff member who, during the current term of appointment, has continually maintained or met all qualifications for Medical Staff membership and assigned staff category, has met participation requirements, is not in arrears in the completion of medical records, and has not received a suspension or restriction of membership or privileges.

15. GOVERNING BODY means the Board of Commissioners of the Halifax Hospital Medical Center.

16. HOSPITAL means Halifax Health Medical Center of Daytona Beach, which includes the main campus in Daytona Beach and the campus in Port Orange and any future locations operating under the main hospital license. Hospital may also be referred to as "Halifax or Halifax Health" in these Bylaws.

17. INDEPENDENT HEALTHCARE PROFESSIONAL means an individual who is permitted by both the applicable Florida State law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges.

18. LICENSED INDEPENDENT PRACTITIONER (LIP) means an individual who is permitted by both the applicable Florida State law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with the individually granted clinical privileges. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Governing Body has determined that the categories of individuals eligible for clinical privileges such as a LIP are physicians (MD or DO), psychologists and neuropsychologists, oral/maxillofacial surgeons (DMD), dentists (DDS or DMD), and podiatrists (DPM).

19. MEDICAL STAFF means all physicians (MD or DO), dentists (DMD or DDS), podiatrists (DPM), clinical psychologists, and non-physician providers who are granted privileges to treat patients at the Hospital. The Medical Staff is an integral part of the Hospital and is not a separate legal entity.[1]

20. MEMBER means a Practitioner who has been granted and maintains Medical Staff membership in good standing pursuant to these Bylaws.

21. NON PHYSICIAN PROVIDER (NPP) means an individual, other than a Practitioner, who provides direct patient care services in the Hospital under a defined degree of supervision, and exercising judgment within the areas of documented professional competence consistent with applicable law. NPPs are designated by the Governing Body to be credentialed through the Medical Staff and are granted privileges; however, they are not eligible to be an officer of the Medical Staff.[2] NPPs include advanced registered nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse anesthetists, and certified registered nurse first assistants.

22. ONGOING PROFESSIONAL PRACTICE EVALUATION or OPPE means the ongoing assessment of an existing Member's performance.

23. PEER REVIEW means Peer Review for Patient Safety and Disciplinary Peer Review as described in Section 4.6 of these Bylaws.

24. PHYSICIAN means Doctor of Medicine licensed under Chapter 458, Florida Statutes, and Doctor of Osteopathy licensed under Chapter 459, Florida Statutes.

[1] 42 CFR §482.12(a)
[2] 42 CFR §482.12(a)(1)

25. PRACTITIONER means all physicians, dentists, podiatrists, psychologists and Non Physician Providers who are granted clinical privileges to treat patients at the Hospital, or where appropriate by the context of these Bylaws, is an applicant for membership on the Medical Staff.[3]

26. PRIVILEGES means authorization granted by the Governing Body to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment and individual character.[4] Privileges shall be setting-specific, meaning that the privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment, and services within a specified setting.

27. QUALIFIED PHYSICIAN means a Physician who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the Hospital to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.

28. SERVICE CALL shall refer to the obligation of Members to respond (as required by applicable law and regulation) to requests to come to a Hospital Emergency Department location to provide emergent care or emergent consultation of patients presenting to the Hospital seeking emergent care.

29. TELEMEDICINE involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link.

30. TELEMEDICINE PRACTITIONER means any licensed and appropriately credentialed member of the Medical Staff who prescribes, renders a diagnosis or otherwise provides clinical treatment to a patient through a telemedicine link.

31. UNASSIGNED PATIENT means any individual who comes to the Hospital for care and treatment who does not have an attending physician; or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

[3] 42 CFR §482.12(a)(1)
[4] 42 CFR §482.12(a)(6) and FS 395.0191(4)

ARTICLE I- NAME

The name of this organization shall be the Halifax Health Medical Staff.

ARTICLE II- PURPOSES

The purposes of this organization are:

- To work toward the end that all patients admitted to or treated in any of the facilities, departments or services of the Hospital shall receive appropriate care.
- To provide an appropriate educational setting that will maintain scientific and educational standards that will lead to the continued progress of the Members in professional knowledge and skill.
- To initiate and maintain Rules and Regulations for self-government of the Medical Staff.
- To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed and resolved by the Medical Staff with the Governing Body and the Chief Executive Officer.
- To assist the Governing Body by serving as a professional review body to complete professional reviews including quality assurance, performance improvement and Peer Review.[5]
- To serve as the formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the actions of its Members and other professionals with clinical privileges.
- To provide a mechanism for accountability of the Medical Staff to the Governing Body.[6]
- To maintain compliance of the Medical Staff with regard to applicable Federal, State, and local laws and regulations and applicable accreditation requirements.
- To provide a mechanism for recommending to the Governing Body the appointment and reappointment of Qualified Physicians and making recommendations regarding the clinical privileges for qualified and competent healthcare Practitioners.[7]

None of the foregoing purposes or goals shall be construed to impose a duty or standard of care greater than that otherwise imposed by law. These Bylaws reflect the current organization and functions of the Medical Staff.[8]

[5] 42 CFR §482.12(a)(5)
[6] 42 CFR §482.12(a)(5) and 42 CFR §482.22(b)(1)
[7] MS 01.01.01 EP 6
[8] 42 CFR §482.22(c)(3) and 42 CFR §482.12(a)(3)

ARTICLE III- CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into the following categories: Honorary, Active, Associate, Senior Active, Community Affiliate, Resident Affiliate, Courtesy Affiliate, Courtesy, and Outpatient Facility Staff. Non Physician Providers shall have the obligations and duties set forth below. The requirements and obligations of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state or federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.[9]

3.1 THE HONORARY MEDICAL STAFF

The Honorary Medical Staff shall consist of Practitioners who are not active in the Hospital or who are honored by emeritus positions. These members shall consist of Practitioners who have retired from active hospital practice and who made significant contributions to the Medical Staff and Hospital during the course of their active practice as determined by the Credentials Committee; or who are of outstanding reputation, but do not necessarily reside in the community. Honorary Staff members shall not be eligible to admit or treat patients, vote, hold office, or serve as voting members on standing Medical Staff Committees. Retirement from practice, without a determination of significant contributions by the Credentials Committee, is not in itself sufficient grounds for appointment to this category.[10]

3.2 THE ACTIVE MEDICAL STAFF

3.2-1 Requirements for Active Staff Membership

The Active Medical Staff shall consist of Practitioners who have a minimum of twenty-four (24) patient contacts at the Hospital annually (including inpatient and outpatient admissions and consultations), admit patients, or provide service to patients in the Hospital, who are located close enough to the Hospital to provide care to their patients, and who assume all functions and responsibilities of membership on the Active Medical Staff.

3.2-2 Obligations for Active Staff Membership

Each member of the Active Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Executive Committee. Active Staff Members should, where appropriate: participate in Service Call for at least one Hospital Emergency Department location (as specified by the Practitioner in their application for appointment or reappointment); provide emergency services, provided continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; and provide consultation assignments as delineated in the Rules and Regulations of the

[9] 42 CFR §482.12(a)(1)
[10] 42 CFR §482.22(c)(2) and MS 01.01.01 EP 15

Department to which each Active Staff Member is assigned. Active Staff Members in this category shall be reviewed in the OPPE/FPPE process. Members of the Active Medical Staff shall be appointed to a specific Department, shall be eligible to vote, to hold office, and to serve on Medical Staff Committees; and should attend Medical Staff meetings.[11] Service Call Obligations of Members may be limited to one or more of the Hospital campus locations (the main campus in Daytona Beach, the campus in Port Orange, or at any future Hospital Emergency Department location) where the Practitioner indicates he/she prefers to perform their Service Call Obligations on their initial application or reapplication for appointment, if such Service Call preference is approved by the Credentials Committee at their discretion and upon recommendation of the appropriate department. Participation in Service Call is a benefit, privilege, and obligation of Active Medical Staff membership. The call obligation shall be determined by the Credentials Committee. If there are an insufficient number of Active Medical staff members who are available or willing to participate in Service Call for one or more Hospital Emergency Department locations, Hospital Administration, in collaboration with the Credentials Committee may elect to outsource the Service Call obligation of a particular department or section for those Hospital Emergency Department locations in order to meet Hospital licensure, regulatory, or legal obligations, without further action by the Medical Staff, and will not be considered an adverse action under these Bylaws. No hearing or appeal rights under these Bylaws are available for any Credentials Committee, Hospital or Medical Staff action or recommendation affecting a Member's Service Call Obligations.

3.3 THE ASSOCIATE STAFF

3.3-1 Requirements for Associate Staff Membership and Consideration for Advancement to Active Staff

The Associate Staff shall consist of initial appointees to the Medical Staff, each of whom is eligible for advancement to Active Staff appointment, but whose status shall not be as full Members of the Active Staff until such advancement occurs. Members of the Associate Staff in all Departments shall be reviewed by the Chair of the Department and any Established Subsection in which clinical privileges are held, in consultation with Active Staff Members of the specific service, in accordance with FPPE policy. The Chair of the Department shall be responsible for determining if there are any deficiencies of performance or other factors, professional or otherwise, present in the performance of the Associate Staff member, which might influence or prevent that individual from obtaining full Active Staff membership at the end of the second year on associate Staff, and shall be responsible for reporting to the Credentials Committee any such findings or deficiencies. The Credentials Committee shall be responsible for considering any deficiencies of performance, or other factors so reported, and if such deficiencies exist, shall be responsible for meeting with the individual, discussing his/her performance with him/her, making him/her aware of such deficiencies and the fact that said deficiencies, if not corrected, could result in failure to obtain Active Staff membership. The Chair of the Department shall be responsible for further close monitoring of the performance of that individual, in accordance with policy.

At the end of one (1) year of Associate Staff membership and FPPE, the Associate Staff member will be eligible for elevation to Active Staff membership. The

[11] 42 CFR §482.22(c)(2), 42 CFR §482.5(b)(2) and MS 01.01.01 EP 15 and EP 17

Credentials Committee shall base its decision upon the recommendation of the Chair of the Department, in consultation with Members of any Established Subsection, if necessary, and in consultation with the Hospital. If after being on the Associate Staff for two (2) years the Associate Staff member is not felt to be qualified or suitable for Active Staff membership, such membership shall be recommended for a change to Courtesy Affiliate. In the event the Associate Staff member has not had a sufficient number of cases go through the OPPE/FPPE process before the expiration of two (2) years, reappointment to the Associate Staff may be recommended. In those instances, the Chair of the Department shall make a recommendation to the Credentials Committee as soon as a sufficient number of cases have been completely reviewed.

When non-reappointment is recommended, the reasons for such recommendation shall be stated. A Practitioner may not have his/her Associate Staff membership terminated except by the methods described in these Bylaws.

3.3-2 Obligations for Associate Staff Membership

Each member of the Associate Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Executive Committee. Each Associate Staff member shall be appointed and assigned to Service Call in the same manner as provided for the Active Staff, and each shall be supervised in accordance with the Rules and Regulations of the Department to which he/she is assigned. Associate Staff Members are not eligible to hold elective office or to vote, except in committees to which they have been assigned.[12]

3.4 SENIOR ACTIVE MEDICAL STAFF

3.4-1 Requirements for Senior Active Medical Staff Membership

The Senior Active Medical Staff shall consist of Members of the Active Medical Staff who have any of the foregoing:

- bona fide physical disability; or
- tenure on the Halifax Medical Center Medical Staff for twenty (20) consecutive years in good standing; or twenty (20) nonconsecutive years in Associate and Active Staff Category, in good standing, with explicit approval by the Credentials Committee and the Governing Body; or
- attained age 65 years with at least ten (10) consecutive years on Active Medical Staff in good standing.

Members of the Active Medical Staff who desire to be classified as members of the Senior Staff may acquire such status by application to the Credentials Committee in the appropriate manner as outlined in these Bylaws, at whatever time they meet the eligibility requirements for such classification. The Practitioner seeking Senior Active Medical Staff status shall provide a copy of said application to his/her Department Chair as well.

A member who has been granted Senior Staff category status because of physical disability shall submit a letter from his/her treating physician annually with his/her application for reappointment each year, such letter to certify that his/her disability continues to qualify

[12] 42 CFR §482.22(c)(2)

him/her for this type of Staff appointment.

3.4-2 Obligations for Senior Active Medical Staff Membership

Each member of the Senior Active Medical Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Credentials Committee. Members of the Senior Staff shall be required to meet the same requirements of Postgraduate Medical Education, payment of Staff dues, attendance at regular Departmental and Staff meetings, and shall be subject to the same rules, regulations and requirements of all other Staff members. Such members shall possess Active voting privileges, and shall be eligible for either elected or appointed office or committee appointments. Members of the Senior Active Medical Staff shall not have the obligation of Service Call unless the Member elects to do so.

3.5 RESIDENT AFFILIATE

The Resident Affiliate Staff shall consist of graduates of recognized medicals schools enrolled in accredited medical residency programs (including medical fellowship programs). The Resident Affiliate Staff shall not be eligible to admit patients, to vote or to hold office, but will be eligible for the privilege of the floor for discussion and may be appointed to serve on Medical Staff committees.[13] No Medical Staff dues will be required. Resident Affiliate Staff Members shall be appointed to a specific Department which pertains to the nature of their residency training or employment. The procedures for suspension, correction or discipline shall not follow the guidelines for the Medical Staff. After completion of, or suspension from a resident training program, Resident Affiliate Staff members will automatically be terminated from their Resident Affiliate Staff membership.

3.6 COURTESY AFFILIATE STAFF

The Courtesy Affiliate Staff consists of Practitioners who have successfully completed a full two year Associate Staff membership, and who by virtue of their specialty, or by the nature of their practice, have limited activity at the Hospital. Courtesy Affiliate Staff members must:

(i) meet the qualifications specified in these Bylaws for Active or Associate Staff membership;

(ii) meet all criteria established by the Credentials Committee to confirm that their Hospital practice will be limited; and

(iii) produce satisfactory quality assurance information concerning their practice.

A Courtesy Affiliate Staff member who exceeds the specified number of patient encounters, as determined by the Credentials Committee and reviewed and ratified by the Medical Executive Committee and the Governing Body shall automatically be returned to the Active Staff category for the remainder of the Practitioner's current appointment.

Courtesy Affiliate Staff members shall be subject to review by the Chair of the services in which clinical privileges are held. Courtesy Affiliate Staff members shall not be required to take Service Call; nor shall they be eligible to vote, to serve as voting members on Committees of the Medical Staff or a Department, or to hold office in the Medical Staff. Time spent as a member of the Courtesy Affiliate Staff shall not count towards tenure on any other

[13] 42 CFR §482.22(c)(2) and MS 01.01.01 EP 15

Medical Staff membership category.

3.7 COMMUNITY AFFILIATE

Community Affiliate Staff shall consist of Practitioners who maintain a clinical practice in the service area of the Hospital and, while not desiring to obtain clinical privileges or to provide hands-on care to their patients in the Hospital, do wish to review medical records of the patients referred by them for admission, follow the patients' progress, confer with the treating physician and observe diagnostic or surgical procedures with approval of the treating physician. Community Affiliate Staff members must:

- meet the qualifications specified in these Bylaws for Active or Associate Staff membership;
- comply with all Hospital and Medical Staff directives, policies and procedures; and
- produce satisfactory quality assurance information concerning their practice.

Community Affiliate Staff shall maintain a valid license to practice medicine in the State of Florida.

Community Affiliate Staff Members may: order non-invasive outpatient diagnostic tests and services for their patients who are not currently undergoing any Hospital care; visit their patients who are undergoing Hospital care and treatment; review the Hospital medical records of their patient; attend Medical Staff and Department meetings; and attend Hospital CME presentations. Community Affiliate Staff Members may not: manage or provide any patient care in the Hospital; make any entries into Hospital medical records; or hold or exercise any clinical privileges at the Hospital.[14]

Community Affiliate Staff members shall be subject to review by the Chair of the Department to which the member is assigned by the Credentials Committee. Community Affiliate Staff members shall not be required to take Service Call; nor shall they be eligible to vote on Medical Staff matters, to serve as voting members on Committees of the Medical Staff or Departments, or to serve as officers of the Medical Staff. Time spent as a member of the Community Affiliate Staff shall not count towards tenure on any other Medical Staff membership category.

3.8 COURTESY STAFF

3.8-1 Requirements for Courtesy Staff Membership

The Courtesy Staff consists of Practitioners who practice in a specialty or provide services not readily available on the Medical Staff and who meet the basic qualifications for staff membership, and who only occasionally admit, attend, or provide services for patients in the Hospital. Courtesy Staff members shall maintain a valid license to practice medicine in the State of Florida and maintain active or associate staff medical privileges at an accredited hospital which requires quality assurance activities similar to those at the Hospital.

3.8-2 Obligations of Courtesy Staff Membership

Each member of the Courtesy Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Credentials Committee. Courtesy Staff Members

[14] 42 CFR §482.22(c)(2) and MS 01.01.01 EP 5

shall not be required to take Service Call, nor shall they be eligible to vote, to serve as voting Members on Committees of the Staff or Department, or to hold office in the Medical Staff.[15] In the event a Courtesy Staff Member performs more than twenty-four (24) patient contacts in a 12 month period, such Member will be recommended at their next reappointment for Active Staff privileges.

3.9 OUTPATIENT FACILITY STAFF

The Outpatient Facility Staff consists of Practitioners who were members of the medical staff of an outpatient facility, such as an ambulatory surgery center, which was acquired by Halifax Health and who did not have privileges at the Hospital at the time of acquisition. Additionally, Outpatient Facility Staff may include Practitioners who are members of the medical staff of an outpatient facility, such as an ambulatory surgery center, which is operated by and/or owned in whole or in part by Halifax Health, or a Halifax Health affiliate or subsidiary. Outpatient Facility Staff must:

(i) meet the qualifications specified in these Bylaws for Active or Associate Staff membership;

(ii) be members in good standing of the staff of the outpatient;

(iii) produce satisfactory quality assurance information concerning their practice.

Outpatient Facility Staff members shall be subject to review by the Chair of the Department in which clinical privileges are held. Outpatient Facility Staff members shall not be required to take Service Call; nor shall they be eligible to vote, to serve as voting members on Committees of the Medical Staff or a Department, or to hold office in the Medical Staff. Outpatient Facility Staff privileges shall be determined by the Credentials Committee and shall be limited to the outpatient facility at which the Practitioner is a medical staff member. Outpatient Facility Staff members may provide inpatient care only to patients who are admitted in connection with services provided by the Practitioner at the outpatient facility. Time spent as a member of the Outpatient Facility Staff shall not count towards tenure towards any other Medical Staff membership category.

3.10 NON PHYSICIAN PROVIDERS

These provisions shall apply to those individuals who are describes and identified herein as Non Physician Providers (NPP), and whose expertise, skills, talents or activities may be of value to the patient, Medical Staff or Administration of the Hospital.[16] Each applicant's qualifications shall be considered and evaluated by the Credentials Committee as specified herein and shall be credentialed through the same process as a Medical Staff member and shall be granted privileges as either a Dependent or Independent Healthcare Professional.[17] NPP provide direct patient care services in the Hospital under a defined degree of supervision. NPP may attend regular Medical Staff Meetings, but shall not be eligible to vote, to serve as a Medical Staff officer, or serve as Chair of a Medical Staff Committee.

Only those NPP who are certified or licensed, if required by law, to perform their special services in the State of Florida; who maintain or are located in offices within a reasonable distance of the Hospital; who document their background, experience, training, and demonstrate competence in their field, their good reputation and sound moral character and ability to work with

[15] 42 CFR §482.22(c)(2) and MS 01.01.01 EP 5
[16] F.S. 395.0191, Florida Statues
[17] F.S. 395.0191 (2)(a) and (c)

others; and who assure the Medical Staff and the Governing Body that any patient served by them will be given a high quality of care in their field, shall be qualified to perform their specified service of function as appropriately credentialed.

3.10-1 Clinical Duties and Prerogatives

NPP may exercise privileges and perform services and duties in the Hospital that have been appropriately credentialed through the process as outlined in these Bylaws. Specifics regarding clinical duties, which are relatively standard for each category and subcategory of NPP shall be delineated in the Rules and Regulations of the Medical Staff, though exception to such may be dictated in the credentials process in specified cases.

3.10-2 Responsibilities

All credentialed NPP shall be responsible for maintaining their competence and, when applicable, their certification and/or licensure in their field of service; adhering to the ethics of their field, demonstrating their ability to work with others in a courteous and pleasant manner; and for the rendering of high quality care to any patient serviced by them in accordance with the Hospital and Medical Staff Bylaws, Rules and Regulations and their credentialed privileges.

All NPP shall be responsible for cooperating with any review of quality assurance function of the Hospital or Medical Staff pertaining to their field of service.

3.10-3 Functions and Limitations of NPP

(i) It is the Physician's responsibility to make it clear to the patient that the patient will be attended by an NPP when applicable.

(ii) The NPP must wear a name tag bearing his/her name and title while performing duties.

(iii) An NPP may perform examinations, treatments and procedures; may write orders and progress notes; and may dictate death summary, operative reports and clinical consultation reports pursuant to the privileges approved by the Credentials Committee and consistent with applicable laws and regulations.

(iv) With the exception of NPP that require the supervision to be formally reported to the Florida Board of Medicine, in the event of the absence of the physician employer, NPP may not function in the Hospital unless supervised by an alternate Physician designated by the Supervising Physician employer. The substitute Physician assumes the responsibility for the NPP during this time period.

(v) An NPP who is classified as an Independent Healthcare Professional is permitted to provide patient care services independently and may perform all or part of the medical history and physical examination, if granted such privileges.

(vi) AN NPP who is classified as a Dependent Healthcare Professional may, as permitted by Florida State law and by the Medical Staff as specified in policy, perform part of all of a patient’s medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The findings, conclusions, and assessment of risk shall be confirmed or endorsed by a qualified physician prior to surgery or other invasive procedure. The specific qualified physician shall retain accountability for the patient’s medical history and physical examination.

3.10-4 Protection from Liability

All NPP applicants, by the filing of the initial application for appointment or the filing of any application for reappointment agree and are deemed to agree that in matters relating to appointment, reappointment, termination or reduction of privileges or other "actions" pursuant to this Article III or any other pertinent section of the Medical Staff Bylaws, that all Members, the Governing Body and all Hospital employees and agents shall be deemed to be acting pursuant to the same rights, privileges, immunities and authorities, including but not limited to the exemption for liability to the NPP affected, as are provided in these Bylaws.

ARTICLE IV- MEMBERSHIP IN THE MEDICAL STAFF

4.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of Halifax Health Medical Center is a privilege, which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws.[18] Every patient shall be admitted by and remain under the care of a member of the Medical Staff. Medical Staff membership is a privilege extended by the Hospital and Governing Body, and not a right of any Physician, Practitioner or other person.

4.2 QUALIFICATIONS FOR MEMBERSHIP[19]

Individuals seeking membership on the Medical Staff shall be considered on an individual basis pursuant to criteria applied equally to all other disciplines. Such individuals will complete a pre-application screening process as set forth in these Bylaws. Only those Practitioners and individuals who meet all qualifications as determined by Credentials Services and Medical Staff Leadership will be invited to apply for membership on the Medical Staff.

4.2-1 General Qualifications

Only Practitioners licensed to practice in the State of Florida, who can document their background, experience, training and demonstrated competence,[20] health status, their adherence to the ethics of their profession, their good reputation and their ability to work with others, to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given high quality medical care, shall be qualified for membership on the Medical Staff.[21] No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice Medicine, Osteopathy, Dentistry, Podiatry, or Psychology in this or any other State, or that he/she is a member of some professional organization, or that he/she had in the past, or presently has, such privileges at another hospital.[22]

All members shall maintain competence in all core privileges, which were established by the relevant Department and were in effect at the time of the member's initial appointment, as a condition of ongoing membership and reappointment.

4.2-2 Specific Qualifications

(a) Physician or Licensed Independent Practitioner applicants for appointment must meet the following criteria:

(i) Medical School Graduate. A new physician applicant must be a graduate of an accredited medical school in the United States or Canada, which has been accredited by the Liaison Committee on Medical Education of the Association of the American Medical Colleges,

[18] 42 CFR §482.22(a)
[19] MS 07.01.01 EP1, EP 2, and EP 4
[20] 42 CFR §482.22(a)(2)
[21] 42 CFR §482.12(a)(6), 42 CFR §482.22(b)(4), and MS 01.01.01 EP13
[22] 42 CFR §482.12(a)(7)

or a graduate of a school of Osteopathic Medicine accredited by the American Osteopathic Association, and hold an unrestricted license to practice Medicine or Osteopathy under Florida Statutes Chapter 458 or 459, respectively; and be Board Certified or currently Board Eligible for certification, by a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.[23] A new applicant who is a graduate of a foreign medical or osteopathic school must have successfully completed the appropriate examinations required by Florida law, have met the other requirements of postgraduate education for licensure, hold an unrestricted license to practice Medicine or Osteopathy under Florida Statutes Chapters 458 or 459 respectively, and have completed a residency program sufficient to be Board Certified, or currently Board Eligible by a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association. Dentist applicants requesting surgical privileges must have graduated from an accredited School of Dentistry and be Board Certified or currently Board Eligible by the American Board of Oral Surgery. Podiatrist applicants must have graduated from an accredited School of Podiatry and be Board Certified or currently Board Eligible by the American Board of Podiatric Surgery.

(ii) Board Certification. Once any new applicant is Board Eligible, they must become Board Certified within five (5) years of their initial appointment to the Medical Staff and shall maintain such status throughout their membership, except as provided in these Bylaws. All Practitioners will be required to sign an Attestation Regarding Board Certification at initial appointment and reappointment in which they confirm they have continually maintained their Board Certification. If appropriate, the Governing Body may make an exception to the Board Certification requirement. In the event a Practitioner who is already Board Certified fails to maintain his/her Board Certification, but is otherwise a member in good standing of the Medical Staff in the opinion of the Credentials Committee, the Practitioner will be allowed probationary status (or a grace period) until the next opportunity to re-certify, which must be completed by the next scheduled date offered by the respective Board. If the Practitioner does not re-certify, the Practitioner will no longer continuously meet the qualifications for Medical Staff membership and will automatically relinquish their medical staff membership and privileges. In such event the Practitioner will be notified by the Credentials Committee of such status change, which shall not be considered an adverse action by the Hospital or Medical Staff. Notwithstanding the above, a Member of the Medical Staff in good standing as of (insert date of approval of new bylaws) who does not hold board certification as of that date is exempt from these board certification requirements.

(b) Non Physician Practitioner applicants for appointment must meet the following criteria:

(i) Active Licensure. NPP applicants must be certified or licensed as required by applicable law or regulation in Florida; comply with any physician or practitioner supervision requirements, including maintaining accurate and complete protocols filed with state agencies; and comply with continuing education requirements of their specialty, certifications, or profession.

4.3 CONDITIONS AND DURATION OF APPOINTMENT

Members are appointed to the Halifax Health Medical Staff, but may request that their Service Call Obligations be limited to one or more of the Halifax Health Medical Center or Emergency Department locations (the main hospital location in Daytona Beach, the hospital location in Port Orange, or at any future Halifax Health Medical Center hospital or Emergency Department, or at all Halifax Health Hospital or Emergency Department locations). Initial

[23] F.S. 395.0191(3)

Applicants and Practitioners must designate one or more Hospital campus locations where they prefer to perform their Service Call obligations at the time of initial application or application for reappointment, and such preference may be granted by the Credentials Committee, at their discretion and upon recommendation of the appropriate Department. No hearing or appeal rights under these Bylaws are available for any Credentials Committee, Hospital or Medical Staff action or recommendation affecting a Member's Service Call obligations. Acceptance of membership on the Medical Staff shall constitute the staff member's certification that he/she has in the past, and that he/she will in the future, strictly abide by the Principles of Medical Ethics of the American Medical Association, American Osteopathic Association, American Podiatry Association, American Dental Association, etc., whichever is applicable, and as may be amended from time to time.

Every applicant shall consent to furnish all information concerning his/her prior medical practice and training, and shall hold all persons and institutions furnishing such information in good faith, free and harmless from any and all legal liability or claims or allegations of liability resulting therefrom. By filing his/her application, the applicant further agrees that his/her training, performance, activities and statements at other health care facilities are relevant to the issue of whether he/she should be granted Medical Staff privileges in any category, whether he/she should be elevated from Associate to Active Staff privileges, whether he/she should be granted clinical privileges, whether any of his/her privileges should be revoked, whether any of his/her privileges should be suspended, or whether corrective action should be taken against the applicant. Furthermore, by filing his/her application, the applicant hereby releases and grants a continuing release to the Hospital, any of its Commissioners, officers or employees and all Members, or employees of the Medical Staff who make such inquiries, from any claim or cause of action applicant has or may have arising from such inquiries, and applicant hereby waives any such claim or causes of action related to same, and shall hold the Hospital, its commissioners, officers and employees and the Members and the Medical Staff harmless from any such claims or causes of action.

No appointment or reappointment shall be made for a period which exceeds two (2) years.[24] Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as are specified in the notice of appointment in accordance with these Bylaws.

Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his/her patients and to abide by the Medical Staff Bylaws, Rules and Regulations.

Notwithstanding any exemption from Service Call established by these Bylaws, all Members, regardless of staff category, may be subject to provide Service Call as deemed necessary by the Credentials Committee, at their discretion and upon recommendation of the appropriate Department. A Member may be relieved of Service Call obligations at one or more Halifax Health Medical Center or Emergency Department location(s) by not selecting that/those location(s) in the initial or reappointment application, by the Credentials Committee, at their discretion and upon recommendation of the appropriate Department, or by action of Hospital Administration pursuant to Section 3.2-2 or Section 4.5-2, herein.

All Members must maintain and unrestricted license to practice their profession in the State of Florida. All Members must maintain continual professional liability insurance, participate in a similar program of self-insurance, or otherwise meet the financial responsibility

[24] MS 07.01.01 EP 3

obligations for licensure where permitted by law or regulation (including the Florida Board of Medicine rules for financial responsibility), in the minimum amounts required by law or regulation during the duration of their appointment. In no event shall the limits of a Member's professional liability coverage available to settle a claim or judgment be reduced below said amount. In the event a Member elects to not carry standard professional liability insurance, he/she must provide proof of an appropriate bond, or letter, acceptable to the Credentials Committee and in compliance with Florida law or regulation, at the time the Member no longer has insurance coverage.

4.3-1 Resignation from the Medical Staff

A Member of the Medical Staff may resign his/her appointment and their clinical privileges by submitting a letter of resignation to the Credentials Committee. The letter should include the reasons for the resignation and the effective date. The Chief of Staff and the Credentials Committee shall review the request and forward a recommendation to the Governing Body for final action. If the Member is, at the time of requested resignation, at any stage of corrective action, suspension, hearing or appellate review, then his/her request for resignation shall be deemed a waiver of his/her right to any hearing or appellate review to which he/she might otherwise have been entitled on the matter. The recommendation of the last body to render a decision will then automatically be enforced. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding improper conduct or competence, a report shall be submitted to the Florida Department of Health for reporting to the National Practitioner Data Bank ("NPDB") as required by federal law.[25] Resignation may be made contingent upon completion of medical records.

4.3-2 Leave of Absence

Any member of the Medical Staff who is in good standing and who, for any reason, will be unable to carry out his/her responsibilities as a Medical Staff Member must apply for a leave of absence, which will be effective for any time period up to one year. The request must state the beginning date and ending date for the period of leave desired and include the reasons for the request. Application may be submitted to the Chief of Staff and the Credentials Committee, who will rule on the validity of the applicant's request. It will be the responsibility of the Member to provide whatever documentation is necessary to support his/her request for leave of absence, or to renew his/her request. To the extent permissible by applicable law and Hospital policy, a leave of absence shall be limited to one (1) year. Extension of leave of absence beyond this date must be requested by the Staff Member or the Department Chair and approved by the Credentials Committee. Such Members on leave of absence shall be eligible for reactivation of their former credentials status upon return from leave and upon the recommendation of the Department Chair and the Credentials Committee. Time spent on leave of absence shall not be considered in calculating the Member's tenure on the Medical Staff and will not be considered an adverse action or relinquishment of the Member's privileges. During the leave of absence, the Member agrees they may not exercise their privileges nor access Hospital medical records systems, and that their access to these systems will be deactivated during the leave of absence. Upon conclusion of the leave of absence, the Member must contact Credentials Services to request the reactivation of their medical staff status and access to Hospital records systems. If the leave of absence is related to rehabilitation or treatment under the Practitioner Health and Wellbeing Policy, the Member may be required to present documentation of completion of treatment or that any restrictions on their full practice of medicine have been removed, prior to the Member's reactivation of their medical staff

[25] 42 CFR §45, CFR 60.9(a)(ii)(A)

status. All qualifications of membership must be current at the time of reactivation of the Member's medical staff status following the leave of absence.

4.3-3 Automatic Relinquishment

A Member's appointment and clinical privileges will be automatically relinquished if the Practitioner fails to continually satisfy the Qualifications for Membership during the term of the individual's appointment, without right to a hearing or appeal, if any of the following occur:

- Licensure – revocation, expiration, suspension, or placement of conditions or restrictions on a Practitioner's license;
- Required by contract – if Member has agreed that his/her Medical Staff membership and privileges will be automatically relinquished or otherwise terminate under certain conditions in a contract they have signed with the Hospital or District, and such condition(s) occur;
- Controlled Substance Authorization – revocation, expiration, suspension, or the placement of conditions or restrictions on a Practitioner's DEA registration or state controlled substance authorization;
- Insurance Coverage/Financial Responsibility – expiration or lapse of a Practitioner's professional liability insurance coverage, or other lapse of their compliance with any applicable financial responsibility requirements of the state as a condition of licensure;
- Continuing Education Requirements – failure to complete or report the required number of continuing education hours that are required for active licensure by the state agency granting the Practitioner's license;
- Failure to Provide Requested Information – failure of a Member to provide information pertaining to their meeting the Qualifications for Membership, OPPE/FPPE, professional conduct or rehabilitation conditions or restrictions on the practice of their profession, or compliance with any other Condition under these Bylaws (for reappointment or at any time during their appointment) in response to a written request from the Credentials Committee;
- Medicare and Medicaid Participation – termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state healthcare programs;
- Criminal Activity – indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence.

If any Member shall have his/her medical staff appointment and clinical privileges automatically relinquished for the reasons stated above, the Member shall be informed directly of the nature of the problem and of the automatic relinquishment by personal phone call and by written certified mail, return receipt requested. Such automatic relinquishment shall not be considered an adverse action and will continue until such failure can be remedied or rectified, in compliance with these Bylaws and applicable Medical Staff policies.

4.4 NON-DISCRIMINATION POLICY

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care at the Hospital, to professional qualifications or to the Hospital's purposes, needs and capabilities.

4.5 HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Medical Staff or shall be granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Hospital Administration or the Governing Body may decline to accept, or have the Medical Staff review requests for Medical Staff membership and/or particular clinical privileges in connection with appointment, reappointment, the initial granting of clinical privileges, requests for revision of clinical privileges, the renewal of clinical privileges or otherwise on the basis of the following:

4.5-1 Availability of Facilities/Support Services

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, and capabilities of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.

4.5-2 Medical Staff Development Plan

The Hospital Administration and Medical Staff leadership may create a Medical Staff Development Plan to identify the medical staff service needs for current or future campus locations based on strategic initiatives, quality of patient care, financial sustainability, and the patient care needs of the community served by the Hospital. Based on such plan, the Credentials Services may decline to offer medical staff pre-applications to individuals, Practitioners or NPP seeking membership on the Medical Staff.

4.5-3 Effects of Declination

Refusal to accept or review requests for Medical Staff membership or clinical privileges, or to provide pre-applications to individuals, based upon then-existing Hospital or Medical Staff need and ability to accommodate, or a Medical Staff Development plan as described in this Section, shall not constitute a denial of Medical Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal under these Bylaws.

4.6 PEER REVIEW

4.6-1 Peer Review for Patient Safety

All Members are expected to participate in quality and patient safety reviews and assessments regarding clinical best practices as requested, including but not limited to OPPE and FPPE reviews and other peer review activities, as set forth in these Bylaws and applicable Hospital and Medical Staff policies. The Medical Staff through its Department Chairs and Credentials Committee will work collaboratively with the Hospital Quality Department, Chief Medical Officer, Chief Quality Officer, and Hospital Risk Management to perform the following actions to ensure that high quality standards of clinical competence and patient care are maintained:

- Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general clinical competencies defined by the Medical Staff, in accordance with applicable Hospital and Medical Staff policies (including the Medical Staff Professional Practice Evaluation policy).
- Set expectations and define both individual and aggregate measures to assess

current clinical competency, provide feedback to Members and develop plans for improving the quality of clinical care provided;

- Actively be involved in the measurement, assessment, and improvements of activities of Practitioner performance that include but are not limited to a review of the following: medical assessment and treatment of patient; use of blood and blood components; appropriate use of medications; operative and other procedures; education of patients and families; medical record documentation to include the quality of medical histories; physical examinations and the accuracy, timeliness and legibility of entries; appropriateness of clinical practice patterns; significant departures from established patterns of clinical performance; sentinel event and patient safety data;
- Coordination of care, treatment, and services with other Practitioners and Hospital personnel, as relevant to the care and treatment for an individual patient;
- Review cases and make recommendations for professional improvement, education, monitoring, proctoring, changes in practice, referral for possible rehabilitation or treatment for impairment, and for additional or external review when appropriate for Members;
- Create patient safety work product for submission to Patient Safety Organization;
- Make recommendations to the Credentials Committee for review and any necessary privilege actions.

4.6-2 Professional Conduct and Disciplinary Peer Review

All Members are expected to conduct themselves in a professional, courteous manner at all times, and shall demonstrate appropriate respect to patients, their families and visitors, other Members and Practitioners, and employees of the Hospital. Failure to do so my result in Disciplinary Peer Review or initiation of a Corrective Action or other action as set forth in these Bylaws and applicable Medical Staff or Hospital policies (including the Professional Conduct of Practitioners policy). The Medical Staff through its Department Chairs and the Credentials Committee, will work collaboratively with the Chief Medical Officer, Chief Quality Officer, and Hospital Risk Management to follow the procedures and perform the functions set forth below to ensure that high standards of professional behavior and courtesy are maintained and demonstrated by all Members:

- Conduct a study or investigation, consistent with these Bylaws and Hospital or Medical Staff policies, to determine if the conduct of a Member or Practitioner may constitute one or more grounds for discipline or corrective action;
- A disciplinary peer review study or investigation may be conducted for the following reasons: concerns regarding clinical competence or professional conduct; concerns regarding care or management of a patient or management of a case; known or suspected violation of the Bylaws or policies of the Hospital or the Bylaws or policies of the Medical Staff relating to professional conduct and activities; known or suspected failure to comply with the ethics of his/her profession or the Bylaws of the Hospital or Medical Staff; or behavior or conduct that is considered lower than the standards of the Hospital or Medical Staff, including a significant and recurring inability of a Member or Practitioner to work harmoniously with others;
- A request for a Disciplinary Peer Review may be made by the: Chief of Staff, Chair of any Department or Section; Chief Medical Officer, Chief Executive Officer, Chair of the Governing Body, Chief Quality Officer, or the majority vote of any Hospital or Medical Staff Committee;
- The disciplinary peer review study or investigation will be performed in accordance with applicable Hospital and Medical Staff policies and these Bylaws, and a written

report will be prepared to document the allegations, investigation, and any recommendations for necessary actions. Such report(s) shall be maintained by the Chief Medical Officer and the Credentials Committee (through Credentials Services or the Medical Staff office) as part of the Member's file for the duration of the Member's appointment to the Medical Staff;

- A Disciplinary Peer Review Committee may be formed for the purpose of conducting the above studies and investigations, provided the Committee includes members of the Medical Staff and Hospital Administration.

Where indicated, the Member may also be required to undergo rehabilitation or treatment as set forth in the Practitioner Health and Wellbeing Policy. Any Member undergoing rehabilitation or treatment as a result of actions taken from the Practitioner Health and Wellbeing Policy (or as a result of referral by a licensure/certification board, or on their own initiative) must provide regular documentation to the Credentials Committee of the status of such rehabilitation including any work or practice restrictions on the Member's practice of their profession recommended by the organization providing such rehabilitation or treatment. The Credentials Committee may require the Member to take a leave of absence during such rehabilitation or treatment until the restrictions on their full practice of their profession have been removed.

ARTICLE V- PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT[26]

5.1 APPOINTMENT AND REAPPOINTMENT[27]

5.1-1 Application for Clinical Privileges and Medical Staff Membership

(a) Halifax Health follows a pre-application screening process to verify an individuals' qualifications prior to inviting qualified individuals to formally apply for Medical Staff Membership. Invitations to apply for appointment to the Medical Staff shall only be sent to those individuals who have completed the pre-application process and for whom primary source verification has been successfully completed and who are determined to meet the Qualifications for Membership and other requirements of these Bylaws; desire to provide care and treatment to patients for conditions and diseases for which the Hospital has facilities and personnel; meet the clinical and strategic needs of the Hospital or any Hospital location; and indicate an intention to utilize the Hospital as required by the staff category to which they seek appointment.

(b) An individual requesting an initial application for appointment may request a pre-application from Credentials Services, who may send the individual the pre-application process information, including the following: (i) a letter that outlines the Qualifications for Membership and clinical privileges and explains the screening and original (primary) source verification process, (ii) an information release form which must be signed by the individual, and (iii) a pre-application form which requests proof that the threshold criteria for appointment and clinical privileges consideration can be met by the individual. The burden is on the individual to provide complete information for initial appointment. A completed pre-application form with copies of all required documents and any required fees must be returned to Credentials Services within thirty (30) days after receipt of same if the individual desires further consideration. Failure to provide all requested information or fees will result in suspension of further consideration of the individual until such time as the information is provided. Any pre-application form that continues to be incomplete ninety (90) days after the individual has been notified of the additional information required shall be deemed to be withdrawn. Once primary source verification has been completed, the Medical Staff leadership will also review the documentation.

(c) Those individuals who successfully complete the pre-application screening process and Medical Staff leadership review shall be formally invited to apply to become a Member of the Medical Staff. The combined pre-application documents and signed invitation to apply for membership, along with any required fees and recommendations from Medical Staff leadership, shall be considered a complete application for membership and the individual will then be considered an "Applicant" as referenced in Section VIII of these Bylaws herein, and all rights as set forth in Article VIII shall then attach to the Applicant. Individuals who do not successfully complete the pre-application screening process shall not be invited to apply and will be notified of such fact. Failure to be invited to apply to become a Member of the Medical Staff shall not be considered an adverse action and no hearing or appeal rights are available for the individual under these Bylaws, and no reporting to the NPDB or state licensure boards is required.

5.1-2 Required Information

(a) All pre-applications forms shall be approved by the Credentials Committee, and must be signed by the individual. The pre-application process shall be governed by these Bylaws and any applicable policies and procedures of the Medical Staff, Credentials Committee,

[26] MS 06.01.03 EP 1 and EP 4
[27] MS 01.01.01 EP 27

and/or Credentials Services.

(b) The pre-application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the individual's professional qualifications including, but not limited to the following:

(i) the names and complete addresses of at least three (3) physicians, dentists, podiatrists, psychologists or other individuals, as appropriate, who have had extensive experience in observing and working with the individual, and who can provide adequate information pertaining to the individual's professional competence and character. At least two references must practice in the same specialty area as the individual;

(ii) information as to whether the individual's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced or not renewed at any other hospital or healthcare facility;

(iii) information as to whether the individual's license to practice his/her profession in any state, or Drug Enforcement Administration (DEA) license is or has ever been limited, suspended, revoked, or voluntarily relinquished, or if any conditions or restrictions have been placed on the individual's DEA registration or state controlled substance authorization (including a list or copy and verification of all the individual's current licenses to practice, as well as copies of Drug Enforcement Administration license, medical, dental, podiatric or other appropriate graduate school diploma, and certificates from all post graduate training programs completed);

(iv) information as to whether the individual has currently in force professional liability insurance coverage, the name of the insurance company and the amount, classification and expiration of such coverage. Physicians who elect not to carry malpractice insurance must submit proof of continuing compliance with the financial responsibility requirements of the Florida Board of Medicine;

(v) information concerning the individual's professional litigation experience, specifically information concerning pending claims, final judgments or settlements; the substance of the allegations; the findings; the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, Executive Committee, or the Governing Body may deem appropriate;

(vi) information concerning any professional misconduct proceedings and any malpractice actions involving the individual in this state or any other state, whether such proceedings are closed or still pending;

(vii) current information regarding the individual's ability to exercise the privileges requested and to perform the duties and responsibilities of appointment;

(viii) information as to whether the individual has ever been terminated, excluded, or precluded by government action from participation in the Medicare/Medicaid or other federal or state healthcare programs, or has been a named defendant in an insurance or healthcare fraud investigation, litigation, settlement, or verdict;

(ix) information as to whether the individual has ever been indicted, or pled guilty or no contest to any felony, or to any misdemeanor involving controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence, with details about any such instance;

(x) a complete chronological listing of the individual's professional and educational appointments, employment, or positions;

(xi) an attestation of US citizenship, or documentation evidencing that the individual is in the US lawfully and permitted to work in the profession for which privileges are

requested;

(xii) the individual's signature; and

(xiii) an attestation of Board Certification or Board Eligibility and such other information as the Governing Body may require.

(c) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as criterion for appointment, reappointment, and the granting of clinical privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the individual's clinical competence, skill in the particular clinical privilege, or general behavior.

(d) A pre-application shall not be deemed to be complete until such time as the Practitioner produces all information as required in the pre-application form and this Section. Credentials Services shall collect and evaluate all reference information and other documents and materials from any and all sources deemed pertinent, and contact any of those institutions in which the individual received medical education or training to determine accuracy and completeness of facts disclosed along with any other relevant information. Individuals who provided references or recommendations, or other individuals with relevant information, shall also be contacted regarding the individual seeking appointment's professional competence and ethical character. Credentials Services will maintain clear documentation of these activities and inquiries, with such documentation being considered part of a completed pre-application for membership.

5.1-3 Basic Responsibilities, Releases and Consents

The following basic responsibilities, releases, and consents shall be applicable to every individual participating in the pre-application process, every Applicant and/or Practitioner seeking Medical Staff appointment or reappointment as a condition of consideration of such application and as a condition of continuing Medical Staff appointment if granted:

(a) An obligation to provide appropriate continuous and timely care and supervision to all patients in the Hospital for whom the individual, Applicant or Practitioner has responsibility;

(b) An agreement to abide by all bylaws and policies of the Hospital, including these Bylaws of the Medical Staff and Medical Staff policies and procedures as shall be in force during the time the individual, Applicant or Practitioner is appointed to the Medical Staff;

(c) An agreement to accept committee assignments and such other reasonable duties and responsibilities as may be appropriate;

(d) An agreement to provide to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form, including but not limited to loss of his/her right to participate in federal healthcare programs;

(e) A statement that the individual, Applicant or Practitioner has received and had an opportunity to read a copy of these Medical Staff Bylaws, and Rules and Regulations of the Medical Staff as are in force at the time of application, and that the individual has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

(f) A statement of the individual, Applicant, or Practitioner's willingness to appear for personal interviews in regard to the pre-application or credentialing process;

(g) An agreement that the hearing and appeal procedures set forth for Applicants and Members in these Bylaws shall be the sole and exclusive remedy with respect to any adverse action taken on clinical privileges at this Hospital;

(h) An obligation to authorize the release of all information necessary for an evaluation of the individual, Applicant or Practitioner's qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

(i) A willingness to appear for interview by the Credentials Committee in regard to his/her pre-application or formal application, and a grant of authorization to and consent for the Hospital and members of appropriate Hospital committees to consult with members of the medical staffs of other hospitals with which the individual has been associated and with others who may have information bearing on the clinical competence, character, ability to work with others or on the individual's moral and ethical standards. Further, the individual, Applicant or Practitioner consents to the Hospital and members of appropriate Hospital and Medical Staff committees inspecting all records and documents that may be material to an evaluation of the individual's professional qualifications and competence to carry out the clinical privileges requested, as well as material to evaluating the individual's ability to work well in the Hospital with others and the individual's moral and ethical qualifications for Medical Staff membership;

(j) The individual, Applicant or Practitioner seeking initial appointment or reappointment specifically releases from any liability all representatives of the Hospital and its Medical Staff, Credentials Committee, Governing Body, and all individuals acting by or on behalf of those entities or individuals for all acts or omissions performed in good faith in connection with evaluating the individual's credentials, and releases from any liability all persons and organizations who provide information to the Hospital concerning the individual, Applicant or Practitioner's competence, ethics, character and other qualifications for Staff appointment and clinical privileges. The individual, Applicant or Practitioner shall also sign forms evidencing his/her consent and release of liability as required by Credential Services or the Credentials Committee so that these forms may be provided to external individuals or entities as part of the original source verification and credentialing process; and

(k) An agreement to extend absolute immunity to the Hospital, its Medical Staff, Credentials Committee, Governing Body, and all individuals acting by or on behalf of those entities or individuals for all acts or omissions taken in good faith relating to evaluation and assessment of the individual, Applicant, Practitioner, or Member's ongoing compliance with the Qualifications of Membership and other Conditions of Membership and these Bylaws.

5.1-4 Medical Staff Leadership Review and Invitation to Apply

(a) After receipt of the properly completed pre-application and accompanying documentation, Credential Services will advise the CMO and shall forward the pre-application and attached documents and forms to the Chairs of all Departments in which the individual seeks clinical privileges for use in the evaluation and appraisal of the individual by such Chairs in order to make the required recommendations to the Credentials Committee regarding the individual's clinical privileges. As soon as practicable but within thirty (30) days of receipt of such application and documents, the Chair of each appropriate Department shall submit his/her recommendations regarding whether the individual meets the underlying qualifications for the requested, in writing, to the CMO, and such recommendations shall become a part of the completed pre-application. Chairs of the Departments should consider only the individual's information and pre-application in good faith and without regard to any personal or financial conflicts of interest, or the individual's potential business competition or contract(s) with the Hospital or a Hospital affiliate or subsidiary.

(b) After receipt of each clinical Department's recommendations, the CMO (or the

CMOs designee) shall confirm that the individual should be either invited to apply for membership on the Medical Staff and ensure the formal application is provided to the candidate, or will notify the individual that he/she will not be invited to formally apply for membership on the Medical Staff. If the individual formally applies for membership and pays any required fees, his/her application for membership to the Medical Staff shall be deemed complete and the candidate is then considered and "Applicant" as referenced in Article VIII herein, and all rights as set forth in Article VIII shall then attach to applicant. Credentials Services shall then deliver the completed application to the Chair of the Credentials Committee with the advice that such Application and inquiry is complete and ready for the consideration and recommendation of the Credentials Committee.

5.1-5 Miscellaneous Provisions

A Practitioner may not be appointed to the Medical Staff or be granted clinical privileges other than by the process described in Article V and Article VI of these Bylaws.

5.2 APPOINTMENT PROCESS

5.2-1 Appointment Recommendations

The Credentials Committee, on behalf of the Executive Committee, shall make a written report of its recommendations concerning an Applicant to the Governing Body through the Chief Executive Officer of the Hospital or his/her designee and the Chief of Staff. Prior to making this report, the Credentials Committee shall examine the appropriate character, professional competence, qualifications, ethical standing, and ability to work in the Hospital efficiently and harmoniously with others. The Credentials Committee shall evaluate the moral, emotional, physical and mental status of the Applicant. Should there be any inadequacies in these categories, appointment will not be recommended to the Governing Body. The Credentials Committee shall evaluate the information contained in references given by the Applicant and other matters contained in the completed application, including the recommendations of each Clinical Department in which privileges are sought, all to determine whether the Applicant meets all of the necessary qualifications for the category of Staff membership and the clinical privileges requested. The Credentials Committee should consider the Applicant's application and information in good faith and without regard to any personal or financial conflicts of interest, or the Applicant's potential business competition or contract(s) with the Hospital or a Hospital affiliate or subsidiary.

Within thirty (30) days of its consideration of the completed application, or as soon as possible given the meeting schedule of the Governing Body, the Credentials Committee or CEO shall transmit to the Governing Body its written recommendation that the Applicant(s) be either appointed to the Medical Staff or rejected for Medical Staff membership; and, as to the requested clinical privileges, whether to grant or deny those privileges recommended by the Credentials Committee only; or that the application for membership or certain clinical privileges or both be deferred for further consideration. When the recommendation of the Credentials Committee is adverse to the Applicant with respect to either Medical Staff membership or clinical privileges, the Governing Body may request further information prior to making a final decision on whether the Applicant should be appointed or reappointed to the Medical Staff. The CEO, through the Credentials Committee or its designee, shall promptly provide such information to the Governing Body. A the time of the Governing Body's final decision on whether to appoint, reappoint, or reject membership on the Medical Staff for an Applicant, the CEO, through the Credentials Committee or its designee, shall give written notice to the Applicant by Certified Mail, return receipt requested. In the instance where the certified mail receipt is not returned by the addressee the notification will

be forwarded by Overnight Mail. Such notice must be consistent with the "Notice" provisions in these Bylaws.

5.2-2 Decision by Governing Body

The Governing Body's decision with respect to granting or denying initial applications for Medical Staff membership and clinical privileges shall be according to the procedures and requirements of these Bylaws. Applicants may be asked to appear before the Governing Body to introduce themselves, but the Governing Body may act upon the recommendations of the Credentials Committee and may reject initial applications or approve initial applications and grant appointment to the Medical Staff and privileges without the necessity of a personal appearance by any Applicant at a meeting of the Governing Body. When the Governing Body's decision is final, it shall send notice of such decision through the CEO to the Secretary/Treasurer of the Medical Staff, the Chief of Staff, the Chair of the Credentials Committee and the Chair of the Department concerned, and to the Applicant.

5.3 REAPPOINTMENT PROCESS

5.3-1 Application for Reappointment

Each Medical Staff Member who is eligible to be reappointed to the Medical Staff shall be responsible for timely completion of the reappointment application form. The application shall be submitted to Credential Services according to the requirements of the Credential Services policy or process, which shall be communicated to all Members seeking reappointment. The Member may be required to provide documentation or attestations regarding the Required Information set forth in Section 5.1-2, as required by Credential Services, to demonstrate that the Member continues to meet all Qualifications for Membership and the Conditions set forth in these Bylaws. Reappointment, if granted, shall be for a period of not more than two (2) years. If no reappointment application is received, Credential Services may attempt to contact the Member to determine whether the Member intends to reapply. However, it remains the Member's responsibility to submit a timely application for reappointment. If no reappointment application is received after attempted contact this will be considered a voluntary relinquishment of privileges and the Practitioner will need to reapply.

5.3-2 Recommendation by Credentials Committee

(a) The Credentials Committee, on behalf of the Executive Committee, shall complete its review of all pertinent information available on each Member scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the Medical Staff, and for the delineation and granting of clinical privileges to Applicants for the ensuing period. The Credentials Committee will consider any Corrective Action or other informal process related to professional conduct of the Member, as well as any outstanding or unresolved OPPE/FPPE issues identified by the Halifax Quality Department for the Member. The CMO or Credential Services shall request any relevant information on such conduct or OPPE/FPPE issues for a Member seeking reappointment from the Halifax Quality Department or any other department or entity which may have such information in advance, so that any relevant information may be considered by the Credentials Committee prior to making a recommendation.

(b) Each recommendation concerning the reappointment of a Medical Staff Member and the clinical privileges to be granted upon reappointment shall be based upon such Member's professional competence and clinical judgment in the treatment of patients, ethics and conduct in

accordance and compliance with the Code of Medical Ethics as adopted by the American Medical Association, active participation in continuing postgraduate medical education, compliance with the Hospital policies, the Medical Staff Bylaws, Rules and Regulations and the Governing Body's Bylaws, rules regulations and resolutions and policies. The moral, emotional, physical and mental status of each Practitioner and their ability to work efficiently and harmoniously with others in a hospital setting shall be considered, and failure to meet the usual accepted standards in any or all categories shall be adequate grounds for denial of the reappointment of the Member.

(c) The Credentials Committee, on behalf of the Medical Executive Committee, shall make written recommendations to the Governing Body through the CEO or Chief of Staff concerning the reappointment or non-reappointment of each member of the Medical Staff, including the specific clinical privileges to be granted to each reappointed Member for the ensuing period. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented, but this shall not require that each incident of similar action or behavior be specifically stated and documented as long as the recommendation is sufficient to give notice of the type of action or behavior upon which the adverse recommendation is based. Recommendations for non-reappointment or for a lessening or limiting of clinical privileges shall not be sent to the Governing Body until the Practitioner has waived or exhausted fair hearing rights specified in these Bylaws.

- If the recommendation is favorable to the Member, the procedure provided above, relating to recommendations on applications for reappointment shall be followed. If the recommendation is adverse to the Member, the Member shall be entitled to the rights and procedures, as specified in Article VIII of these Bylaws.
- While considering a Member's reappointment the Credentials Committee, the Governing Body, the CEO and their representatives shall be entitled to the same rights and authority as are conferred upon them in connection with the consideration of an initial application for appointment to the Medical Staff, and shall be entitled to consider all the matters set forth in the preceding subsections with respect to the Member's activities at other hospitals and the Member's medical practice outside the Hospital. Specifically, the applicant for reappointment is bound by the same obligation to provide consents and releases of liability to those entities and individuals involved in the reappointment process as set forth in Section 5.1-3(i) above.

5.3-3 Reapplication Upon Denial

A Member of the Associate Staff who has served on the Associate Staff for two (2) years, and who has been deemed unqualified for elevation to Active Staff and denied reappointment may not apply for membership on the Medical Staff for a period of twelve (12) months from the date of final action on his/her application. At the end of a twelve (12) month period of time following denial of reappointment, such individual may request an application and reapply for membership to the Associate Staff of the Hospital as outlined in these Bylaws for any new individual.

5.4 EXPEDITED PROCESS

The Credentials Committee may develop, and the Governing Body may approve, an expedited approval process to be used when the full Governing Body may not meet during a particular month, or for other situations when hardship to the Practitioner or Hospital may occur if approval of credentials as recommended by the Credentials Committee is delayed until a meeting of

the full Governing Body. Such expedited process must be consistent with the applicable laws, regulations, accreditation standards, Enabling Act and the Bylaws of the Governing Body, and must be approved by the Governing Body.

ARTICLE VI - CLINICAL PRIVILEGES

6.1 GENERAL PROVISIONS[28]

Every Practitioner practicing at the Hospital, including the practice of telemedicine, by virtue of Medical Staff membership shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to the Practitioner by the Governing Body, except as otherwise provided in these Bylaws.[29]

The privileges must be specific, within the scope of the license authorizing the individual to practice in this state or any certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Department, and shall be granted for a period not to exceed two (2) years.[30] Clinical privileges may be granted, continued, modified, or terminated by the Governing Body upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outline in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

A completed application for Medical Staff appointment or reappointment must contain a request for all clinical privileges desired by the Applicant.[31] The evaluation of such requests shall be based upon the Applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Clinical Department in which such privileges are sought. The Applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges requested. Clinical privileges must be delineated for every Practitioner by each service, including Members in any category of Medical Staff status (**Note there are no clinical privileges associated with honorary or community affiliate members). These privileges must be stated in a precise manner, and be hospital-specific. The process to disseminate all granting, modification, or restriction decisions shall be approved by the Medical Staff.[32]

To have prescribing privileges for controlled substances, the Practitioner must possess a current Federal Drug Enforcement Administration (DEA) registration and any required state authorization or registration, or for NPP, must continually meet the conditions of all state laws and regulations which authorize prescribing privileges for NPP. NPP shall only have those prescribing privileges for controlled substances specifically authorized in state law and regulations. Prescribing privileges shall be limited to the classes of drugs granted to the Practitioner by the DEA and applicable law, and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the Practitioner.

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[28] MS 06.01.05 EP 4
[29] MS 06.01.07 EP 8
[30] MS 06.01.07 EP 9
[31] MS 01.01.01 EP 14
[32] MS 05.01.09 EP 4

In case of an emergency situation, any Practitioner, to the degree permitted by his/her license and regardless of service, or Staff status or lack thereof, shall be permitted to do and assist in doing everything possible to save the life of a patient, using every facility of the Hospital necessary, including calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Practitioner must request the privileges necessary to continue to provide those services to the patient. In the event such privileges are denied or the Practitioner does not desire to request such privileges, the patient shall be assigned to another appropriate Member of the Medical Staff. For the purposes of this Section, an "emergency situation" is defined as a situation in which serious permanent harm would result to a patient, or the life of a patient would be placed in immediate danger in the absence of immediate medical care.

6.1-1 Admitting Privileges

Only Members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.

6.1-2 Medical History and Physical Examination Requirements[33]

Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a qualified physician, oral/maxillofacial surgeon, or other qualified licensed Practitioner in accordance with State law and Hospital policy. A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physician examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a qualified physician, oral/maxillofacial surgeon, or other qualified licensed Practitioner in accordance with State law and Hospital policy.

6.2 ADDITIONS TO CLINICAL PRIVILEGES

A request by a Member with clinical privileges for additional clinical privileges or modifications in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. In processing such a request, the NPDB shall be queried,[34] the Practitioner's Florida license status and financial responsibility compliance shall be queried, and the response used by the Medical Staff and the Governing Body in considering the request. The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:

- Training, continuing education, and experience related to the new clinical privileges requested shall be verified.
- Evidence of current competence related to the new clinical privileges

[33] 42 CFR §482.22(c)(5)(i) and (ii) and MS 01.01.01 EP 16
[34] MS 06.01.05 EP 7

requested shall be verified with current supporting documentation.

- Information provided by peers of the Practitioner shall be included in deliberations when increasing privileges.

Practitioners are required to report malpractice insurance coverage information for the new privileges requested.

When revising clinical privileges, the Practitioner shall be required to respond to queries regarding whether there have been any:

- Previously successful or currently pending challenges, or voluntary relinquishment, of licensure or registration.
- Voluntary or involuntary reduction in privileges or termination of privileges or membership.
- Involvement in any liability actions, including any final judgments or settlements.

6.3 BASIS FOR PRIVILEGE DETERMINATION[35]

There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested.[36] Applications and requests for clinical privileges shall be evaluated on the basis of the Practitioner's education, training, current competence, the ability to perform the clinical privileges requested, professional references, information from the Practitioner's current or past facility affiliations, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chair of the Clinical Department in which the privileges have been sought. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the Practitioner and his/her patients. Clinical privileges that are granted, renewed, or revised shall be setting-specific, meaning that in approving privileges, considerations shall include not only the Practitioner's qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting. Clinical privileges may be restricted by the Governing Body to only certain settings within the Hospital, as appropriate to each setting.

Additionally, all Practitioners with delineated clinical privileges are required to participate in continuing education as related to their privileges, and the Practitioner's participation in continuing shall be considered when renewing or revising such privileges. Before clinical privileges are granted, renewed, or revised by the Governing Body, the Medical Staff and Credentials Committee shall evaluate each Practitioner with regard to the following information and make a recommendation based on the following information:

- For Practitioners in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of record, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;
- For Practitioners in non-surgical fields, the types and outcomes of medical conditions managed by the Practitioner as the responsible physician;

[35] MS 06.01.05 EP 2, EP 3, EP 9 and EP 10 and MS 06.01.07 EP 2 and EP 3
[36] 42 CFR §482.22(c)(6); MS 06.01.07 EP 6

- The Practitioner's clinical judgment and technical skills;
- Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the Practitioner;
- Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;
- Relevant Practitioner-specific data that are compared to aggregate data;
- Morbidity and mortality data, when available.

Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Governing Body may, in its discretion, obtain assistance with their evaluation.

6.4 DELINEATION[37]

Requests for clinical privileges shall be processed pursuant to the procedures outlined in these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating a Practitioner who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the Practitioner does not practice outside the scope of privileges granted, and information about the Practitioner's change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted. The delineation of a Practitioner's privileges shall include the limitations, if any, on the Practitioner's privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.

6.5 TELEMEDICINE PRIVILEGES[38]

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws.[39] The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through telemedicine medium, according to commonly accepted quality standards.[40] Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decision. Controlled substances may not be prescribed through the use of telemedicine.[41]

When telemedicine services are furnished to the Hospital's patients through an agreement with a distant-site hospital, after approval by the Credentials Committee, the Governing Body of the Hospital whose patients are receiving the telemedicine services may choose to have the Medical Staff rely upon the credentialing and privileging decisions may by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and

[37] MS 06.01.05 EP 12 and MS 06.01.07 EP 1
[38] MS 13.01.01 and MS 13.01.03
[39] 42 CFR §482.22(c)(6)
[40] MS 13.01.03 EP 1 and EP 2
[41] F.A.C. 64B-9.0141 and F.A.C. 64B15-14.0081

practitioners providing such services, if the Hospital's Governing Body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:[42]

(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

(ii) The individual distant-site physician or practitioner is board certified and privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State of Florida in which the hospital whose patients are receiving the telemedicine services is located.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the Hospital whose patients are receiving the telemedicine services, the Hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the Hospital's patient and all complaints the Hospital has received about the distant-site physician or practitioner.

(v) The distant-site telemedicine entity furnishes services that permit the Hospital to comply with all applicable conditions of participation for the contracted services.[43]

(vi) The distant-site telemedicine entity's Medical Staff credentialing and privileging process and standards at least meet the standards set by Hospital and as required by applicable law and accreditation standards.[44]

(vii) It is the responsibility of the governing body of the distant-site hospital to meet the requirements with regard to the distant-site hospital's physicians and practitioners providing telemedicine services.[45] The Governing Body of the Hospital whose patients are receiving services may grant privileges based on its Medical Staff recommendations that rely on information provided by the distant-site hospital.[46]

(viii) The distant-site telemedicine entity is a contractor of services to the Hospital and as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable Conditions of Participation for the contracted services with regard to the distant-site telemedicine entity's physicians and practitioners providing telemedicine services.[47] The Governing Body of the Hospital whose patient are receiving the telemedicine services may grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's Medical Staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.[48]

6.6 USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS, PODIATRISTS AND DENTISTS/ORAL SURGEONS

A physician, psychologist, podiatrist, chiropractor, dentist or oral surgeon, who is not

[42] 42 CFR §482.22(a)(3) and (4) and 42 CFR §482.12(a)(8) and (9)
[43] 42 CFR §482.12(e)
[44] 42 CFR §482.12(a)(1)-(a)(7) and 42 CFR §482.22(a)(1)-(a)(2)
[45] 42 CFR §482.12(a)(1)-(a)(7)
[46] 42 CFR §482.22(a)(3)
[47] 42 CFR §482.12(e) and 42 CFR §482.12(a)(1)-(a)(7)
[48] 42 CFR §482.22(a)(4)

a Member and who has not been granted clinical privileges may order outpatient ancillary services and the Hospital may occasionally accept and execute orders for outpatient ancillary services from Non-Privileged Practitioners who are not Members and who have not been granted any clinical privileges at the Hospital, at the Hospital's discretion, provided there is a Member of the Medical Staff with appropriate privileges willing to perform such service. Such orders from Non-Privileged Practitioners will be carried out at Hospital facilities only if all the following conditions are met in advance:

- The Non-Privileged Practitioner shall provide proof of current licensure within this State, which shall be verified by the Hospital prior to acceptance and execution of the order for services;
- If medications are being ordered that require the Non-Privileged Practitioner to hold a DEA registration, such Non-Privileged Practitioner shall provide proof of current, unrestricted DEA registration.
- The Hospital shall ensure that the Non-Privileged Practitioner is eligible to participate in federal and state health programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and at least every six months thereafter.
- The Non-Privileged Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order as established by Florida State law. The orders shall be confined to those for outpatient laboratory, non-invasive radiology, rehabilitation services (including physical therapy, occupational therapy, and speech therapy), diagnostic cardiopulmonary or electro diagnostic testing, or medications.
- The order of the Non-Privileged Practitioner can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering Non-Privileged Practitioner, and the Non-Privileged Practitioner may not bill any professional fees related to the performance of the order for services at the Hospital.
- The ordering Non-Privileged Practitioner does not hold himself/herself to be associated or affiliated with the Hospital or its Medical Staff.
- The Non-Privileged Practitioner's ordering practices shall be subject to the supervision of the Chair of the Hospital Department performing the test or services, the CMO, or the Chief of Staff. The Non-Privileged Practitioner's ordering practices shall be subject to a review for medical appropriateness and necessity by the Member of the Medical Staff who will provide the services ordered, or the CMO or Chair of the Hospital Department which would perform the services ordered, any of whom may decline to perform the order or service if they have any clinical or quality concerns. Orders from a Non-Privileged Practitioner that lack evidence of medical appropriateness or necessity shall not be performed and the Non-Privileged Practitioner shall be notified immediately to be given the opportunity to clarify/justify the order.
- All diagnostic tests that require an interpretation by a Medical Staff Member with a delineated clinical privilege to do so shall be subject to interpretation by a Member of the Medical Staff with such privileges, the Chair of the Department which would perform the services ordered, or the CMO, and the interpretation shall be provided to the Non-Privileged Practitioner.

6.7 LIMITED LICENSURE PRACTITIONERS

Requests for clinical privileges from a limited licensure Practitioner (e.g. Licensed Independent Practitioners (LIP)) shall be processed in the manner and based on the same conditions as for any Applicant for clinical privileges. Patients admitted by a limited licensure Practitioner

with admitting privileges shall be under the care of a physician Member of the Medical Staff with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting Practitioner. All patients admitted by a limited licensure Practitioner shall be responsible for securing the services of such physician Member of the Medical Staff prior to the admission of the patient and shall supply the name of the physician to the Hospital. The limited licensure Practitioner shall be responsible for performing the part of the history and physical examination related to the care he/she will provide:

- Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry.
- Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry and, if granted clinical privileges, may perform a full medical history and physical to provide medical clearance on uncomplicated patients. In order to request these privileges, podiatrists must provide documentation of training and competence in performing full medical history and physicals. If the patient is medically complex, the medical clearance examination and clearance for surgery must be performed by a Physician.
- An oral and maxillofacial surgeon who has successfully completed a post graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the US Department of Education, and who has been determined by the Medical Staff to be currently competent to perform a history and physical examination, may be granted the clinical privilege to perform the medical history and physical examination.
- Other LIP who are permitted to provide patient care services independently may perform all or part of the medical history and physical examination, if granted such privileges. The findings, conclusions, and assessment of risk shall be confirmed or endorsed by a qualified physician prior to major high-risk (as defined by the Medical Staff in the Rules and Regulations or policy) diagnostic or therapeutic interventions.
- In addition, as permitted by Florida State law and by the Medical Staff as specified in policy, Practitioners who are not LIP may perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified physician shall retain accountability for the patient's medical history and physical examination.

6.8 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall be denied. Because such a denial of clinical privileges is unrelated to the Practitioner's qualifications or competence, a Practitioner whose request is so denied shall not be entitled to the Fair Hearing and Appeal rights under these Bylaws and is not subject to reporting to the NPDB via the state professional licensure agency.

6.9 TEMPORARY PRIVILEGES[49]

6.9-1 Circumstances

Temporary privileges may be granted to meet an important patient care need for a limited time or while awaiting final approval of the Governing Body of the Applicant's Membership

[49] MS 06.01.13

on the Medical Staff. The CEO or designee, Chief Medical Officer, Chief of Staff, and the Chair of the applicable Department, or their respective designees, may, upon the basis of a completed application which can be relied upon as to the competence and ethical standing of the Practitioner, grant temporary Medical Staff Membership, which may include admitting and clinical privileges, to the Practitioner, for a maximum, non-renewable period of one hundred twenty (120) days. In exercising such privileges the Practitioner shall act under the supervision of the Chair of the Department to which the Practitioner is assigned.

Temporary clinical privileges for the care of a specific patient may be granted by the CEO to a Practitioner who is not an Applicant in the same manner and upon the same conditions set forth in the paragraph immediately above, provided the CEO or designee first is in receipt of such Practitioner's signed acknowledgment that the Practitioner has received and read copies of the Hospital's Bylaws and Medical Staff Bylaws, Rules and Regulations, and that the Practitioner agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of not more than ten patients in any one year by any Practitioner, after which such Practitioner shall be required to apply for temporary privileges under this Section, shall be Board Certified in their field of medicine, and shall maintain such Board Certified status for the duration of their temporary privileges.

6.9-2 Locum Tenens Practitioners

The Governing Body, upon the recommendation of the CEO or designee, may permit a Practitioner to serve in a locum tenens capacity and to attend patients without applying for formal membership on the Medical Staff, for a period not to exceed one hundred twenty (120) days of actual service, provided that such Practitioner has completed locum tenens application for privileges has been received and requested clinical privileges have been approved by the CMO, the Chief of Staff or designee, Chief Operating Officer (COO) or designee, and the appropriate Department Chair. Moreover, the Practitioner must certify that he/she has received and read copies of the Hospital's Bylaws and Medical Staff Bylaws, Rules and Regulations, and that the Practitioner agrees to be bound by the terms thereof in all matters relating to his/her locum tenens privileges. In all cases for locum tenens, the following will be verified: Florida licensure, Board Certification, DEA registration (if applicable), professional liability coverage, current hospital affiliations, NPDB information, and Office of Inspector General information. In the event that the Hospital has entered into a written agreement with an entity to provide locum tenens practitioners to the Hospital, such entity shall bear the responsibility of obtaining and maintaining temporary privileges for those locum tenens Practitioners that such locum tenens Practitioners provide to the Hospital. Other than locum tenens Practitioners provided through a written agreement between the Hospital and a physician staffing entity, no Practitioner may be credentialed under this provision as a locum tenens Practitioner for a period exceeding one (1) year. After that time, the Practitioner may apply for the appropriate active medical staff privileges.

6.9-3 Special Conditions of Supervision

Special conditions of supervision and reporting may be imposed by the appropriate Departmental Chair on any Practitioner holding temporary privileges. A Practitioner holding temporary privileges has no right to a hearing with respect to such conditions. Upon recommendation of the Credentials Committee and the Chair of the

Department concerned, temporary privileges shall be immediately terminated upon notice of any failure by the Practitioner to comply with any such special conditions.

6.9-4 Termination of Temporary Privileges

The CEO or designee may at any time, upon the recommendation of the Chair of the Credentials Committee or the Chair of the Department concerned, terminate a Practitioner's temporary privileges effective as of the discharge from the Hospital of the patient(s) of that Practitioner then under his/her care in the Hospital. However, where it is determined that failure to terminate such temporary privileges may result in an imminent danger to the health of such patient(s), the termination shall be immediately effective and the Departmental Chair, or in his/her absence, the Chair of the Credentials Committee shall assign a member of the Medical Staff to assume responsibility for the care of such patient(s) until discharge from the Hospital. The wishes of the patient(s) shall be considered, where feasible, in the selection of such a substitute physician.

6.10 DISASTER PRIVILEGES

During disasters, the CEO may grant Disaster Privileges to volunteer licensed Practitioners. For purposes of this Section, a disaster is an emergency that, due to its complexity, scope, or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

6.10-1 Elements of Performance

(i) The Hospital shall grant Disaster Privileges to Practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs;

(ii) The CEO, CMO, and Chief of Staff shall determine the specialties needed to meet the needs created by the disaster;

(iii) Volunteer Practitioners holding Disaster Privileges shall receive Hospital badges designating their status on the Medical Staff;

(iv) Volunteer Practitioners who are granted Disaster Privileges shall be monitored by direct observation and mentoring by the Chair of the appropriate Department, or their designees, as well as through medical record review.

(v) Before a Practitioner is considered eligible to function as a Volunteer Practitioner, the Hospital must obtain a copy of a valid government-issued photo identification for the Practitioner and at least one of the following:

- A current picture identification card from a healthcare organization that clearly identifies the Practitioner's professional designation;
- A current license to practice Practitioner's profession;
- Primary source verification of licensure;
- Identification indicating that the Practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or another recognized state or federal response organization or group;
- Identification indicating that the Practitioner has been granted

authority by a government entity to provide patient care, treatment, or services in disaster circumstances;

(vi) Confirmation in writing by a Practitioner currently privileged by the Hospital or by a Hospital employee with personal knowledge of the Practitioner's ability to act as a Volunteer Practitioner during the disaster.

(vii) During a disaster, the Medical Staff shall oversee the performance of each Volunteer Practitioner.

(viii) Based on the Medical Staff oversight of a Volunteer Practitioner, the Hospital shall determine within seventy-two (72) hours of the Practitioner's receipt of Disaster Privileges whether or not the Disaster Privileges should continue.

(ix) Primary source verification of a Volunteer Practitioner's licensure shall be sought as soon as the disaster is under control, or within seventy-two (72) hours from the time the Volunteer Practitioner received Disaster Privileges, whichever comes first. If primary source verification of a Volunteer Practitioner's licensure cannot be completed within this time frame due to extraordinary circumstances, the Hospital must commence such verification as soon as possible and document each of the following:

(x) Reasons why verification could not be timely performed in accordance with this Section;

(xi) Evidence of the Practitioner's demonstrated ability to provide adequate care, treatment, and services to patients;

(xii) Evidence of all attempts to perform primary source verification.

(xiii) Primary source verification of licensure is not required if the Volunteer Practitioner has not provided care, treatment, or services under the Disaster Privileges.

6. 11 PROTECTION FROM LIABILITY

In all matters relating to granting, denying or otherwise delineating clinical privileges, all persons who participate shall be acting pursuant to and with the benefit of the same rights, privileges, immunities and authority as are provided in these Bylaws.

ARTICLE VII- CORRECTIVE ACTION

7.1 PROCEDURE FOR CORRECTIVE ACTION

7.1-1 Initiation of Corrective Action

Any officer of the Medical Staff, the Chair of any Clinical Department, the CEO or the Governing Body of the Hospital may request corrective action against any Practitioner whenever such Practitioner's activities or professional conduct are reasonably believed to be (a) lower than the standards or aims of the Medical Staff, (b) contrary to the Governing Body or the Medical Staff's Bylaws, Rules and Regulations, or (c) to be such that they adversely affect patient care in the Hospital. Instances in which the health or physical abilities of the Practitioner are at issue shall be initially handled in accordance with applicable Hospital policies and procedures, including but not limited to the Peer Review Processes set forth in Section 4.6 of these Bylaws.

7.1-2 Form of Request for Corrective Action

All requests for corrective action shall be in writing and shall be directed to and filed with the Credentials Committee of the Medical Staff. This request shall include the reason for such requested action.

7.1-3 Records; Pre-Credentials Committee Meetings

A complete and detailed written record or minutes of each formal interview or appearance before a committee which might be reviewed by the Credentials Committee in conjunction with corrective action, shall be made and shall include the name of the Practitioner, reasons for the meeting, pertinent information regarding the matter and the decisions or recommendations, whether favorable or adverse. The Practitioner shall, within thirty (30) calendar days, receive a copy of this record and this shall serve as official notification of any decisions or recommendations unless otherwise provided for in the Bylaws. A copy of each of these written records will be placed in the permanent file of the affected Practitioner by the Department Chair, or the Committee Chair, whichever is applicable. There is no right to a hearing or appeal with respect to these decisions or recommendations as they are preliminary in nature. Should the matter go forward to the Credentials Committee, the Practitioner can challenge the decision or recommendation at the Credentials Committee level and the Practitioner, if he/she properly requests a hearing before a Hearing Officer or Hearing Panel, can further challenge such decision or recommendation at such hearing.

7.1-4 Credentials Committee Powers

The action of the Credentials Committee upon a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, letter of reprimand, to impose terms of probation, or a requirement for consultation; to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension be terminated, modified or sustained, or to recommend that the Practitioner's Staff membership be suspended or revoked. Such action may include a recommendation to the Governing Body that a Practitioner's Medical Staff membership or clinical privileges be suspended as disciplinary or corrective action, for reasons less urgent than those warranting summary suspension, including but not limited to any of the following: the alleged violation of the Bylaws, Rules and Regulations of the Medical Staff, or Principles of Ethics adopted by the Medical Staff; charges of professional incompetency;

conduct that is inimical to the Hospital, its staff, or the Medical Staff; conduct that either directly or indirectly adversely affects patient care in the Hospital.

7.1-5 Credentials Committee Procedures

Within thirty (30) days following the receipt of a request for corrective action, the Credentials Committee shall take action upon the request. Prior to taking such action the Credentials Committee shall afford the Practitioner an opportunity to appear before the Credentials Committee. Such appearance is preliminary in nature, does not constitute a hearing, and shall not be subject to procedural rules provided in these Bylaws for hearings. A record of such appearance or the failure of the Practitioner to accept the opportunity for such appearance shall be made.

7.1-6 Notice to the Chief Executive Officer

The Chair of the Credentials Committee shall promptly notify the CEO in writing of all requests for corrective action received by the Credentials Committee and shall continue to keep the CEO fully informed of all action taken in connection therewith.

7.1-7 Notice of Adverse Recommendation or Action

After the Credentials Committee has made its recommendation, the CEO shall promptly deliver to the Applicant or Practitioner (hereinafter the term "Practitioner" inclusively refers to both Applicant and Practitioner) special notice of any adverse recommendation or action in conjunction with an application for staff membership or clinical privileges or in conjunction with Peer Review activities or disciplinary actions or other professional review activities.

The recommendation by the Credentials Committee of corrective action as set forth in Section 8.1-2, whether or not a summary suspension is in effect, shall entitle the affected Practitioner to the procedural rights provided in Article VIII of these Bylaws.

All decisions and recommendations of the Credentials Committee shall be forwarded to the Governing Body for final action (except in the case of a recommendation of no action).

7.2 SUMMARY SUSPENSION

7.2-1 Initiation

The Chair of the Credentials Committee, Chief of Staff, Chair of a Clinical Department, or the CEO shall each have the right to summarily suspend a Practitioner's privileges for a period not to exceed fourteen (14) days during which an investigation is being conducted to determine the need for corrective action, if the person imposing the suspension reasonably believes that failure to take such action may result in an imminent danger to the health of any patient.[50] The suspension shall become effective immediately but shall not exceed fourteen (14) days unless following the Credentials Committee investigation during this period the Credentials Committee finds that termination of the summary suspension may result in imminent danger to the health of any patient.[51]

[50] MS 01.01.01 EP 30
[51] MS 01.01.01 EP 29 and MS 01.01.01 EP 30

7.2-2 Credentials Committee Procedure[52]

(a) Report. The person imposing a summary suspension shall immediately file a written report with the Credentials Committee, including a record of any interview with the Practitioner whose privileges have been suspended, if an interview has been conducted. A copy of the report shall also be sent to the Practitioner.

(b) Credentials Committee Investigation. As soon as reasonably possible, not to exceed ten (10) calendar days following imposition of the summary suspension, the Credentials Committee shall convene to consider whether the summary suspension shall be terminated, modified or sustained. The Practitioner shall be notified of the date, time and place of Credentials Committee meeting at least twenty-four (24) hours in advance.

(c) Appearance before the Committee. The Credentials Committee shall afford the Practitioner subject to summary suspension an opportunity to appear before the Committee, inform the Practitioner of the general nature of the charges upon which the summary suspension was based, and invite the Practitioner to discuss, explain or refute them. Such appearance shall be preliminary in nature and shall not constitute a hearing, and shall not be subject to the procedural rules provided in these Bylaws for hearings. A record shall be made of the meeting and appearance or failure of the Practitioner to accept the opportunity to appear.

(d) Credentials Committee Decision. Within three (3) calendar days after its convening, the Credentials Committee must terminate the summary suspension unless it finds that such termination may result in an imminent danger to the health of any patient. Even if the Credentials Committee terminates the summary suspension, this shall not prohibit the Credentials Committee or other appropriate persons or committees from initiating corrective action with respect to the Practitioner dealing with the same issues.

7.2-3 Hearing

If within the fourteen (14) day suspension period the Credentials Committee does not terminate the summary suspension, the Practitioner shall be entitled to the procedural rights provided in these Bylaws in Article VIII. In all such cases, however, the summary suspension as sustained, or as modified by the Credentials Committee, shall remain in effect pending the final decision thereon of the Governing Body.

7.2-4 Alternate Medical Coverage

Immediately upon the imposition of a summary suspension, the Chair of the Credentials Committee or responsible Departmental Chair shall have the authority to provide for alternative medical coverage for the suspended Practitioner's patients remaining in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Practitioner(s).

7.3 AUTOMATIC SUSPENSION

7.3-1 Action of the State Board of Medical Examiners

Action by the appropriate Professional State Board revoking or suspending a Practitioner's license shall result in automatic suspension of all Hospital privileges.[53]

Action by the appropriate State Board placing the Practitioner on probation

[52] MS 01.01.01 EP 32 and EP 33
[53] MS 01.01.01 EP 28 and EP 30

shall result in an automatic review of the Practitioner.[54] The CEO shall promptly advise the Practitioner in writing of such suspension or review.

Using the same time frame and procedures specified in Section 7.2-2 above, the Credentials Committee shall afford the Practitioner subject to automatic review because of probation by the Board of Medicine an opportunity to appear before the Committee, shall inform the Practitioner of the general nature of the charges upon which the automatic review was based, and shall invite the Practitioner to discuss, explain or refute them. Such appearance is preliminary in nature and does not constitute a hearing, and is not subject to the procedural rules provided in these Bylaws for hearings. A record shall be made of the meeting and appearance or failure of the Practitioner to accept the opportunity to appear. If the Credentials Committee recommends immediate suspension of Hospital Privileges, the Practitioner shall be entitled to the procedural rights provided in Article VIII of these Bylaws.[55]

7.3-2 Duty of the Chief of Staff

It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all automatic suspensions.

7.4 PROTECTION FROM LIABILITY

In all matters relating to corrective action, including summary suspension or automatic suspension, all persons who participate shall be acting pursuant to and with the benefit of the same rights, privileges, immunities and authority as are provided for in Article V of these Bylaws.

[54] MS 01.01.01 EP 30
[55] MS 01.01.01 EP 31 and EP 33

ARTICLE VIII - HEARINGS AND APPEALS

8.1 RIGHT TO HEARING AND APPELLATE REVIEW

8.1-1 General Provisions[56]

A Practitioner holding an existing Medical Staff appointment shall be entitled to request a de novo formal hearing before a Hearing Panel whenever a recommendation unfavorable to Practitioner has been made by the Credentials Committee regarding those matters enumerated in Section 8.1-2 below. A Practitioner holding an existing Medical Staff appointment shall be entitled, upon proper request, to a de novo formal hearing before a Hearing Panel prior to the time the Governing Body enters a final decision, should the Governing Body preliminarily reject a favorable recommendation by the Credentials Committee regarding any of said matters. Any Practitioner shall be entitled, upon timely application, to appellate review by the Governing Body of any decision of the Hearing Panel (or Hearing Officer in the case of an initial application for Medical Staff membership and clinical privileges) which is adverse to the Applicant/Practitioner prior to the time final action is taken upon the matter by the Governing Body. No rights under this Article VIII attach to an individual seeking initial appointment to the Medical Staff unless that individual has been formally invited to apply for membership and has completed the requirements set forth in Section V to be considered an "Applicant".

8.1-2 Grounds for Hearing

No matter or action other than those hereinafter enumerated shall constitute grounds for a hearing and/or appeal or other review under these Bylaws:

(i) Denial of an Applicant's initial Medical Staff appointment;
(ii) Denial of requested change in Medical Staff category;
(iii) Denial of Medical Staff reappointment;
(iv) Revocation of Medical Staff appointment;
(v) Denial of an Applicant's requested initial clinical privileges;
(vi) Denial of requested increased clinical privileges;
(vii) Revocation, decrease or restriction of clinical privileges;
(viii) Suspension of Medical Staff privileges or clinical privileges.

8.1-3 Actions Without Hearing

Notwithstanding Section 8.1-2 above, neither automatic suspension of clinical privileges as provided for elsewhere in these Bylaws, nor the imposition of any consultation requirement, nor the imposition of a probationary period, nor the imposition of a requirement for retraining, additional training or continuing education, no matter whether imposed by the Credentials Committee or the Governing Body, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

8.2 NOTICE OF ACTION; REQUEST FOR HEARING

8.2-1 Notice of Action Warranting Hearing

In all cases in which a recommendation unfavorable to Practitioner has been made by the Credentials Committee regarding those matters enumerated in Section 8.1-2 above, the CEO shall give the Practitioner prompt notice of the recommendation and notice of the right

[56] MS 10.01.01 EP 1

to request a hearing pursuant to the provisions of this Article, in writing via Overnight Mail with confirmation of delivery. The notice shall:

(i) advise the Practitioner of the recommendation or action, briefly state the grounds upon which the adverse recommendation or action is based, and advise the Practitioner of his/her right to request a hearing pursuant to the provisions of the Medical Staff Bylaws;

(ii) specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a written request for hearing and that within this thirty (30) day period the request must be served on the CEO by Certified Mail or Overnight Mail, with confirmation of delivery;

(iii) state that failure to request a hearing within the specified time period and in the proper manner as required under Section 8.2-2, or failure without good cause to appear in person as required by Section 8.3-3 shall be a waiver by the Practitioner which will automatically result in Practitioner losing all rights to any hearing or appellate review on the matter that is the subject of the notice;

(iv) enclose a copy of this Article VIII outlining the Practitioner's rights and the hearing procedures to be followed as provided for herein.

8.2-2 Request for Hearing

The Practitioner shall have thirty (30) calendar days following the date of the receipt of such notice under Section 8.2-1 above to file a written request for a hearing. The request must be delivered to the CEO by Certified Mail or Overnight Mail, with confirmation of delivery.

8.2-3 Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 8.2-2 above shall lose his/her right to any hearing or appellate review to which the Practitioner might otherwise have been entitled and the adverse recommendation or action shall be forwarded to the Governing Body and shall immediately become and remain effective against the Practitioner until such time as final action by the Governing Body.

8.3 NOTICE OF HEARING AND CHARGES; FAILURE TO ATTEND; RESCHEDULING HEARING

8.3-1 Notification of Hearing[57]

Upon receipt of a proper request for hearing in compliance with Section 8.2-2 from a Practitioner entitled to the same, the CEO shall schedule and arrange for such hearing. The CEO shall notify the Practitioner of the time, place and date of the scheduled hearing by Certified Mail or Overnight Mail, with confirmation of delivery. Notice shall be deemed to have been given on the date it was delivered to the addressee. This hearing shall be held not less than fifteen (15) calendar days nor more than thirty (30) calendar days after the date of receipt of a proper request for hearing signed by the Practitioner.[58]

8.3-2 Notice of Charges

The notice of hearing shall list all allegations and shall list all witnesses expected to give testimony or evidence on behalf of the Hospital. If the Practitioner is being charged with five (5) or fewer acts, omissions or incidents, then the notice of hearing shall state in concise language the acts, omissions or incidents with which the Practitioner is being charged. If the Practitioner is being charged with more than five (5) acts, omissions or incidents, then the notice of hearing need only state in concise language five (5) of the acts, omissions or incidents with which the Practitioner is being charged, but the notice must inform the Practitioner that these acts, omissions or incidents are representative of the types of acts, omissions or incidents for which the Practitioner is being questioned and that other acts, omissions or incidents of a similar or related nature may be dealt with at the hearing. In such a situation the Hearing Panel shall not be precluded from hearing evidence on any unlisted acts, omissions or incidents if they are of a nature similar or related to those specifically stated in the notice of hearing. If there are reasons for the Credentials Committee's adverse recommendation or decision other than specific acts, omissions or incidents involving the Practitioner, such reasons shall be stated in the notice of hearing in concise language.

8.3-3 Failure to Appear

No hearing shall be conducted without the personal presence of the Practitioner for whom the hearing has been scheduled unless the Practitioner waives such appearance or fails without good cause, as determined by the Hearing Panel, to appear for the hearing despite being given adequate notice. A Practitioner who fails to appear without good cause shall be deemed to have waived his/her rights to a hearing, to have voluntarily accepted the recommendation or decision, to have waived any right to appeal to the Governing Body and to have agreed that said recommendation or decision shall become and remain in effect until such time as acted on by the Governing Body.

8.3-4 Rescheduling of Hearings

Postponement or rescheduling of hearings beyond the time set forth in these Bylaws shall be made only with the approval of both the Hearing Panel and the Presiding Officer. Such postponements shall only be granted upon a showing of good cause by the Practitioner. If the Practitioner's request for a postponement has not been acted upon prior to

[57] MS 10.01.01 EP 2
[58] MS 01.01.01 EP 34

the time scheduled for hearing, the Practitioner must appear at the hearing, and if the Practitioner's request is at that time denied, then the hearing shall go forward. The fact that the Practitioner has requested a postponement shall not constitute justification or "good cause" for Practitioner's failure to appear at or to participate in the hearing.

8.4 HEARING PROCEDURE[59]

8.4-1 Hearing Panel

When a hearing is requested, the Chief of Staff shall appoint a Hearing Panel which shall consist of four (4) persons, three (3) voting Members and an alternate. One (1) of the three (3) voting Members shall be designated as the Hearing Officer by the Chief of Staff. The alternate will not vote on or participate in post-hearing deliberations of the Hearing Panel unless one (1) or more Members of the Hearing Panel is not allowed to participate due to being absent during the presentation of testimony. The Hearing Officer shall preside over the deliberations of the Hearing Panel after the conclusion of the evidentiary hearing. Each Member of the Hearing Panel, including the alternate, shall be an MD or DO physician licensed to practice medicine in the State of Florida. Two (2) of such physicians must be past Chiefs of Staff of the Hospital Staff selected from among all available past Chiefs of Staff on a rotating basis. The third Member of the Hearing Panel shall be Board Certified or Board Eligible in the specialty practiced by the Practitioner. None of the Members of the Hearing Panel may be a direct economic competitor of the Practitioner, nor shall they have actively participated in the consideration of the matter involved at any previous level.[60]

8.4-2 The Presiding Officer

The hearing shall be presided over by a Presiding Officer who is appointed by the Chief of Staff; who shall be a practicing attorney who is in good standing with The Florida Bar; who has civil trial experience; and who has not previously participated in formal deliberations, judicial or quasi-judicial proceedings involving the Practitioner. A panel of Presiding Officers, consisting of attorneys who meet the above specified criteria, and who have been approved by the Governing Body to act as Presiding Officers, shall be maintained by the CEO.

The Presiding Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Presiding Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. Any relevant matter upon which responsible persons might customarily rely in the conduct of serious affairs may be introduced, at the discretion of the Presiding Officer regardless of the admissibility of such evidence in a court of law. If the Presiding Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Presiding Officer may take such discretionary action as is warranted by the circumstances.

8.4-3 Witness Lists

If either side to the hearing makes a written request for a list of witnesses, then within ten (10) days after such request each party shall furnish to the other a written list of the

[59] MS 01.01.01 EP 34 and MS 10.01.01 EP 3 and EP 4
[60] MS 01.01.01 EP 35

names and addresses of the Practitioners, so far as is then reasonably known or anticipated, who may give testimony or evidence in support of the Practitioner at the hearing. Neither side in the hearing shall have any right to the discovery of documents or other evidence in advance of the hearing except for charts or other documents reviewed by the Credentials Committee in making its adverse recommendation. This shall not prohibit the parties from voluntarily exchanging copies of documents.

8.4-4 Procedural Disputes

It shall be the obligation of the Practitioner and the Credentials Committee, to notify the Presiding Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible so that decisions concerning such matters may be made in advance of the hearing. Objections to any such pre-hearing decisions may be briefly stated at the hearing.

8.4-5 Hearing Costs

As used herein, "hearing costs" shall consist of: (i) reasonable fees and costs paid to the Presiding Officer; (ii) reasonable fees and costs paid to the member of the Hearing Panel who is Board Certified or Board Eligible in the specialty practiced by the Practitioner if it is necessary to bring in a physician who is not a Member of the Medical Staff in order to assure that there is a physician of that specialty on the hearing panel who is not a direct economic competitor of the Practitioner. In every instance, such costs shall be initially advanced and incurred by the Governing Body but the Practitioner shall pay and reimburse the Governing Body an amount equal to one-half (1/2) of such costs within thirty (30) days of mailing by the Governing Body of interim and final invoices therefor to the Practitioner. The Practitioner and the Credentials Committee, in the event they are represented by counsel at the hearing, shall each be responsible for payment of their respective attorneys' fees and legal costs.

8.4-6 Rights of the Parties

Both the Practitioner and the Credentials Committee have the right to:

(i) be represented at any phase of the hearing or pre-hearing procedures by an attorney at law or by any other person of that party's choice. Both sides shall notify the other of the identity of any such counsel at least ten (10) days prior to the hearing date;

(ii) have a record of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;

(iii) call, examine, cross-examine, and impeach witnesses, and the Credentials Committee shall have the right to call the Practitioner as if under cross-examination;

(iv) to introduce documentary evidence determined by the Presiding Officer to be relevant and not redundant regardless of whether such evidence would be admissible in a court of law;

(v) to submit a written statement at the close of the hearing.

8.4-7 Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right

to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

8.4-8 Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Governing Body, but copies of the transcript shall be provided to the Practitioner upon request at his/her expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of Florida.

8.4-9 Burden of Proof

The Credentials Committee shall have the initial duty to present evidence in support of its action or recommendation. Thereafter the Practitioner has the burden of proving by a preponderance of the evidence that either (i) the adverse action or recommendation lacks substantial factual basis; or (ii) the adverse action or recommendation is unreasonable in light of the facts.

8.4-10 Adjournment and Conclusion

The Presiding Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and documentary evidence and the receipt of written statements submitted by the parties, the hearing shall be closed.

8.4-11 Deliberation, Recommendation and Report

At any time after the close of the evidentiary hearing and not later than five (5) days after the close of such hearing, the Hearing Panel under the direction of the Hearing Officer, shall reconvene in private to deliberate the issues and consider the evidence and, by majority vote to reach a recommendation to be forwarded to the Governing Body. The Presiding Officer shall not participate in the deliberations of the Hearing Panel. The recommendation of the Hearing Panel shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence, but shall not be based on evidence not introduced into evidence. Within thirty (30) calendar days after the final adjournment of the hearing, the Hearing Panel shall render a written recommendation which shall be accompanied by a report stating the reasons for the recommendation. The recommendation and report shall be delivered to the Credentials Committee, the Practitioner and the Governing Body through the CEO. Once the Hearing Panel has determined its recommendation, the Hearing Panel shall have the right to seek advice and assistance in the preparation of the written recommendation and report from the Presiding Officer or counsel of its choosing as long as such advice and assistance is not provided by an attorney representing the Credentials Committee or the Practitioner or any other attorneys in their firms respectively.

8.5 APPEAL TO THE GOVERNING BODY[61]

8.5-1 Time for Appeal

Within ten (10) days after notice of the Recommendation and Report of the Hearing Panel (or Hearing Officer if the Practitioner is a new Applicant) either party may request an appellate review by the Governing Body. The request shall be in writing, and shall be delivered to the CEO either in person or by Certified Mail, return receipt requested, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective.

8.5-2 Grounds for Appeal

The grounds for appeal to the Governing Body from an adverse recommendation and report shall be that:

(i) there was a substantial failure on the part of the Hearing Panel to comply with the Bylaws of the Medical Staff or the Hospital, which substantial failure resulted in the denial of due process or a fair hearing; or

(ii) the recommendation of the Hearing Panel was made arbitrarily or capriciously or with prejudice; or

(iii) the recommendation of the Hearing Panel is so unsupported by the record that no reasonable person could have made the same recommendation based solely on the record.

8.5-3 Time, Date Notice

Within five (5) business days after receipt of such notice of request for appellate review, the Chair of the Governing Body shall schedule a date for such review, and shall, through the CEO, by written notice sent by Certified Mail, return receipt requested, notify the affected Practitioner of the same. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail. Notice shall be deemed to have been given on the date the notice was delivered to the addressee.

The date of the appellate review shall not be less than thirty (30) days, nor more than forty-five (45) days, from the date of receipt of the notice of request for appellate review, except that when the Practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not less than fifteen (15) nor more than twenty-five (25) days from the date or receipt of such notice.

8.5-4 Appellate Body

The appellate review shall be conducted by the Governing Body or by a duly appointed Appellate Review Committee of the Governing Body consisting of not less than four (4) members of the Governing Body.

8.5-5 Appeal Procedure

The appellate review shall be in the nature of an appellate hearing based upon the record of the proceedings before the Hearing Panel. The Appellate Body may accept additional

[61] MS 10.01.01 EP 5

oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the Governing Body.

New or additional matters not raised during the hearing before the Hearing Panel (or Hearing Officer), nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances. The Governing Body or its Review Committee shall, in its sole discretion, determine whether such new matters shall be introduced. The Practitioner may, at any time prior to five (5) days before the meeting of the Governing Body at which the Practitioner's appellate review will be considered, submit to the Governing Body a brief written statement of the "unusual circumstances" which, in the Practitioner's opinion, would allow the raising of new or additional matters which the Practitioner wishes to raise. Nothing herein shall preclude the Governing Body from seeking legal advice from its attorney regarding the interpretation of "unusual circumstances" as contemplated in this section. Neither the Practitioner nor the Credentials Committee nor any of their representatives shall have the right to address the Governing Body with respect to the appellate review for a time period in excess of five (5) minutes to address the "unusual circumstances" only.

8.5-6 Submission of Written Statements

Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Governing Body may allow each party or its representative to appear personally and make oral argument. Each party shall submit its written statement no later than five (5) business days prior to the date scheduled for appellate review. Written statements shall be submitted to the Governing Body through the CEO by Certified Mail, return receipt requested, and shall simultaneously be served by Certified Mail, return receipt request, to the other party. No written statement shall exceed twenty (20) pages, including exhibits. At its discretion the Governing Body may choose not to consider any improperly filed or served written statement, and any portion of a written statement in excess of twenty (20) pages may be ignored by the Governing Body.

Within thirty (30) days after the conclusion of the appellate review proceeding, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the Practitioner and the Chair of the Credentials Committee, in person or by Certified Mail, return receipt requested. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail.

The Governing Body may affirm, modify or reverse the recommendation of the Hearing Panel or, in its discretion, refer the matter for further review and recommendation.

Except where the matter is referred for further action and recommendation, the final decision of the Governing Body following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Governing Body in accordance with the instructions given by the Governing Body. This further process and the report back to the Governing Body shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

8.5-7 Miscellaneous

Neither Practitioner nor the Credentials Committee nor their respective representatives shall lobby, coerce or otherwise communicate with members of the Governing Body

regarding an upcoming appellate review except as specifically authorized hereinabove. Any violations of this provision are to be reported at the appellate review and taken into consideration by the Governing Body. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in Section 8.5 have been completed or waived.

8.6 HEARING FOR NEW APPLICANT (Hearings authorized by Section 8.1-2(i))

8.6-1 Pre-Hearing Procedure

In all cases in which the Credentials Committee has made a recommendation which is unfavorable to a new Applicant regarding the matters enumerated in Section 8.1- 2, or to a Practitioner who applied for a change in Medical Staff category or additional/increased clinical privileges but was denied based upon the Practitioner's failure to meet existing threshold criteria, the Applicant shall have a period of thirty (30) calendar days after the mailing of the adverse decision or recommendation and notice of the right to hearing, in which to request a hearing. If the Applicant requests a hearing, the CEO shall appoint a Hearing Officer, who shall be a former Chief of Staff who has not been involved in any aspect of the recommendation being appealed, and schedule and arrange for such a hearing. The Hearing Officer shall, through the Hospital's CEO, notify the Credentials Committee and the Applicant by Certified Mail, return receipt requested, of the time, place and date of the hearing and of the basis for the adverse recommendation by the Credentials Committee, shall list the witnesses expected to testify at the hearing, shall advise the Applicant of the right to be represented by counsel and of the right to call as witnesses those persons whose names he/she provides to the CEO not less than ten (10) calendar days before the hearing. The hearing date shall be not be less than twenty (20) calendar days from the date of the receipt of the request for hearing. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail. Notice shall be deemed to have been given on the date the notice was delivered to the addressee.

8.6-2 Rescheduling of Hearing

The Applicant shall be entitled to request only one change in the scheduled hearing time. Granting such change in the hearing time shall be only for good cause shown and shall be at the sole discretion of the Hearing Officer. If the Applicant's request for a change in the hearing date has not been granted prior to the time scheduled for the hearing, the Applicant must appear at the hearing, and if the Applicant's request is denied, then the hearing shall go forward. The fact that the Applicant has requested that the hearing be rescheduled shall not constitute a justification or "good cause" for Applicant's failure to appear at the hearing, and if the Applicant fails to appear under such circumstances, the Applicant shall be deemed to have waived his/her rights to a hearing and the adverse recommendation shall become and remain in effect until final action by the Governing Body.

8.6-3 Hearing Procedure

The hearing shall be conducted before a Presiding Officer appointed by the CEO from a panel of Presiding Officers established pursuant to Section 8.4-2 above. Only the Presiding Officer and Hearing Officer, the Applicant, a representative of the Credentials Committee and counsel for the parties may be present at the hearing. The Applicant shall have a reasonable opportunity to present relevant oral and documentary evidence at the hearing. An accurate recording or transcription of the proceedings will be kept as set forth in Section 8.4-8.

8.6-4 Conclusion of Hearing

Within ten (10) calendar days after the conclusion of the hearing, the Hearing Officer will submit a written recommendation and a supporting written report to the Credentials Committee and the Governing Body through the CEO. The CEO shall promptly send a copy of the recommendation and report to the Applicant and if the recommendation is adverse, then it shall be sent by Certified Mail and must be accompanied by a Notice of Right to Appeal as provided in Section 8.5. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail.

8.6-5 General Provisions

The appeal to the Governing Body shall be conducted according to the procedures in Section 8.5 above.

8.7 FINAL APPELLATE REVIEW DECISION BY GOVERNING BODY

8.7-1 Decision

Within twenty (20) calendar days after the conclusion of the appellate review, the Governing Body shall make its decision in the matter and shall send written notice thereof through the CEO to the Credentials Committee by hand delivery, and to the Practitioner, by Certified Mail, return receipt requested. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail. Notice shall be deemed to have been given on the date the notice was delivered to the addressee. The decision by the Governing Body shall be immediately effective and final and shall not be subject to further hearing or appellate review unless the Governing Body refers the matter back to the Hearing Panel with instructions for further action, including, at the sole discretion of the Governing Body, a directive that an "additional hearing" not to exceed one (1) day be held to clarify facts still in doubt. The Hearing Panel shall comply with the Governing Body's instructions and within two (2) weeks, forward the additional record and updated recommendation and report to the Governing Body. The Governing Body shall then make its final decision with like effect and notice as first above provided in Section 8.5-6.

8.7-2 Right to One Hearing

Notwithstanding any other provision of these Bylaws, no Practitioner shall have more than one (1) hearing, one (1) "additional hearing" and one (1) appellate review on any matter which has been the subject of a recommendation and report by the Hearing Panel.

8.8 PROTECTION FROM LIABILITY

In matters relating to hearings and appellate reviews, all persons who participate shall be acting pursuant to and with the benefit of the same rights, privileges, immunities and authority as are provided for in these Bylaws.

ARTICLE IX - OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be Chief of Staff, Chief-Elect, and Secretary/Treasurer.[62]

9.2 QUALIFICATIONS OF OFFICERS

Officers must be members of the Active or Senior Active Medical Staff at the time of nomination and election and must remain Members in good standing during their term of office.[63] Failure to maintain such status shall immediately create a vacancy in the office involved.

9.3 ELECTION OF OFFICERS[64]

(a) The office of Secretary/Treasurer shall be elected at the Annual Meeting of the Medical Staff. At least eight (8) weeks prior to the date of the Annual Meeting, a notice shall be sent to all Active and Senior Active Members (the Voting Members), calling for those interested in serving in Medical Staff leadership to submit their names to the Medical Staff Office or the Chief of Staff no later than four (4) weeks prior to the Annual Meeting. The Nominating Committee may also submit names for the office of Secretary/Treasurer.

(b) All candidates interested in serving as Secretary/Treasurer shall meet with the Nominating Committee and/or the CMO or the CMO's designee prior to the preparation of the ballot in order to understand the duties and responsibilities of the Medical Staff Officers. Failure to have such a meeting will result in the Member's name not being placed on the ballot.

(c) The Nominating Committee shall prepare a ballot listing in alphabetical order the names and practice specialty of all candidates for the office of Secretary/Treasurer. The ballot must be sent to all Voting Members of the Medical Staff no later than ten (10) days prior to the Annual Meeting.

(d) Initial ballots shall be cast at the time the Voting Member signs in at the Annual Meeting. If a Voting Member does not have the original ballot at the time of sign-in, an official facsimile ballot shall be provided. The CMO may take all reasonable steps to ensure a valid election process. Each ballot cast must select only one (1) candidate for Secretary/Treasurer.

(e) Election shall be by a majority of Voting Members present. There shall be no proxy votes. In the event no candidate receives a majority of votes cast, the name of the candidate with the least number of votes shall be removed from consideration and a new vote taken. This procedure shall be repeated until one (1) candidate receives a majority vote. In the case of a tie, the outgoing Chief of Staff shall cast the deciding vote.

9.4 TERM OF OFFICE

All officers shall serve a two (2) year term with the option to continue on in the same capacity for one (1) additional one (1) year term. Officers shall take office on the first day of the Medical Staff year. On that date, each incumbent officer shall automatically assume the next senior office, with the Secretary/Treasurer position being filled in accordance with Section 9.3.

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[62] MS 01.01.01 EP 19
[63] 42 CFR §482.22(b)(3)
[64] MS 01.01.01 EP 18

9.5 VACANCIES IN OFFICE

9.5-1 Vacancy

Vacancies may occur upon the death, disability, resignation, or removal from office or upon failure to maintain active staff in good standing. Any officer of the Medical Staff may resign at any time by giving written notice to the Executive Committee. The acceptance of such resignation is not required to become effective. Vacancies in office during the Medical Staff year shall be filled by the immediately following officer moving into the vacant position, and all other officers moving up similarly to the next senior office. In case of a vacancy in the Secretary/Treasurer position, the Executive Committee of the Medical Staff shall appoint a member of the Active or Senior Medical Staff to fill the position for the remainder of the term.

9.5-2 Removal

Removal of an officer of the Medical Staff may be initiated by a two-thirds (2/3) vote of the Members of the Executive Committee.[65] No such removal shall be effective unless and until it is ratified by a two-thirds (2/3) vote of the Active Members, at a meeting that shall be held no longer than thirty (30) days following the action of the Executive Committee. Failure to perform duties listed in Section 9.6 constitutes condition for removal from office.

9.6 DUTIES OF OFFICERS

9.6-1 Chief of Staff

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff and:[66]

(i) act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;

(ii) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(iii) serve as Executive Committee Chair;

(iv) serve as advisory member of all other Medical Staff Committees without vote;

(v) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staffs compliance with the procedural safeguards in all instances where corrective action has been requested against a Practitioner;

(vi) appoint Committee Members to all standing, special and multi-disciplinary Medical Staff Committees with Executive Committee ratification, and consistent with the Bylaws (Article XI).

(vii) represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the CEO.

[65] MS 01.01.01 EP 18
[66] 42 CFR §482.22(b)(3)

(viii) receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

(ix) be the spokesman for the Medical Staff in its external professional and public relations; and

(x) keep the entire Medical Staff informed concerning the accreditation program, the current accreditation status of the Hospital, and the factors influencing that status.

9.6-2 Chief-Elect

In the absence of the Chief of Staff, the Chief-Elect shall assume all the duties and have the authority of the Chief of Staff. He/she shall be a member of the Executive Committee of the Medical Staff. He/she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason. In the event of the permanent assumption of the duties of the Chief of Staff by the Chief-Elect, in the event of the Chief of Staff being unable to serve the full term for any reason, a new election for Chief-Elect shall be held as soon as practical to fill the position of Chief-Elect for the remainder of the unexpired Medical Staff year. This nomination and election shall be held in the usual specified manner as stated in these Bylaws for other Staff officers.

9.6-3 Secretary/Treasurer

The Secretary/Treasurer shall be a member of the Executive Committee of the Medical Staff. The Secretary/Treasurer shall be responsible for accurate and complete minutes of all Medical Staff meetings, and shall call Medical Staff meetings on order of the Chief of Staff; attend to all correspondence; and perform such other duties as ordinarily pertain to his/her office.

ARTICLE X- CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SERVICES

Each Department and service shall be organized as a separate part of the Medical Staff and shall have a Chair who shall be responsible to the Executive Committee and Medical Staff.[67] Each Department shall determine in its Rules and Regulations the separation of subsections within the Department appropriate to organizing and performing the work of the Department. Each Hospital Professional Service must have Rules and Regulations approved by the Executive Committee delineating provisions for election of officers, membership, regular meeting and describing areas of responsibility.

10.1-1 Clinical Departments

(i) Department of Anesthesiology
(ii) Department of Emergency Services
(iii) Department of Medicine
(iv) Department of Obstetrics and Gynecology
(v) Department of Oncology
(vi) Department of Pathology
(vii) Department of Pediatrics
(viii) Department of Psychiatry
(ix) Department of Radiology
(x) Department of Surgery

10.1-2 Hospital Professional Services

(i) EEG
(ii) EKG
(iii) EMG
(iv) Rehabilitative Services
(v) Respiratory Therapy

10.2 QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIRS

10.2-1 Election/Qualification[68]

Each Chair shall be a Member of the Active Staff who possesses the qualifications set forth in Article IV herein. Such Practitioner must also be Board Certified by the appropriate specialty Board, or be Board Eligible unless waived by the Governing Body. The Chair of a Department is elected at intervals as shall be specified in the Rules and Regulations of that Department and by a majority vote of the Members present at the meeting for election. Failure to maintain membership in good standing on the Active Medical Staff shall immediately create a vacancy in the office involved.

[67] 42 CFR §482.22(c)(3) and MS 01.01.01 EP 12
[68] MS 01.01.01 EP 36

10.2-2 Removal

Removal of a Chair during his/her term of office may be initiated by a two-thirds (2/3) majority vote of all Active Staff members of the Department but no such removal shall be effective unless and until it has been ratified by the Executive Committee. The Executive Committee may initiate the removal of a Department Chair during his/her term of office by a two-thirds (2/3) vote, and instruct the Department to elect a new Chair.

10.2-3 Vacancy

In the event a Department Chair dies, resigns or is removed from office, then the Chief of Staff shall assign another Member of the Department who satisfies the qualifications set forth in Section 10.2-1 herein and who is approved by the Executive Committee to assume the duties of the Department Chair until such time as a special election is held to elect a new Department Chair.

10.3 RESPONSIBILITIES OF DEPARTMENT CHAIRS

Each Chair shall:[69]

(i) be accountable for all clinical and administrative activities within his/her service and OPPE/FPPE/Peer Review;

(ii) give guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own Department in order to assure quality patient care, and the integration of the Department into the primary functions of the Medical Staff;

(iii) maintain surveillance of the professional performance of all Practitioners with clinical privileges in his/her Department and report regularly thereon to Credentials Committee;

(iv) be responsible for compliance with the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within his/her Department;

(v) be responsible for implementation within his/her Department of actions taken by the Executive Committee of the Medical Staff;

(vi) recommend to the Credentials Committee the criteria for clinical privileges that are relevant to the care provided in the Department;

(vii) Maintain continuing review of the professional performance of all Practitioners with clinical privileges in the Department (including but not limited to participation in FPPE and OPPE in compliance with applicable Medical Staff policies, with information and/or support provided by the Hospital Quality Department and Credential Services; and to recommend clinical privileges for each Member of the Department to the Credentials Committee when the Chair of the Department is satisfied there are no outstanding FPPE or OPPE issues for any Practitioner for appointment or reappointment to the Medical Staff;

(viii) be responsible for the teaching, education and research program in his/her Department;

(ix) participate in every phase of administration of his/her Department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, space, supplies, special regulations, standing orders and techniques. This shall include recommendations for a sufficient number of qualified and competent persons to

[69] MS 01.01.01 EP 36

provide care of service;

(x) as part of the credentialing process participate in the assessment of the qualifications and competence of Department or service personnel who are not LIP and who provide patient care, treatment, and services;

(xi) review all discrepancies referred to him/her by Governing Body, Hospital, or Medical Staff committee and make dispositions on the recommendations of such committee;

(xii) continuously monitor and evaluate quality and appropriateness of care and monitor quality control programs, as appropriate;

(xiii) assess and recommend to Hospital Administration off-site sources for needed patient care services not provided by the Department or Hospital; and

(xiv) perform an annual assessment of the number of Department Members who are approaching eligibility for Senior Staff status, to determine the adequacy of Service Call coverage within the Department.

ARTICLE XI -COMMITTEES

11.1 MEDICAL EXECUTIVE COMMITTEE[70]

11.1-1 Composition[71]

The Medical Executive Committee shall consist of the Chief of Staff who acts as Chair, the Chief-Elect, Immediate Past Chief, , the Secretary/Treasurer, the Chair of Medicine, the Chair of Surgery, the Chair of Obstetrics/Gynecology, the Chair of Pediatrics, one (1) elected representative for the employed physicians to include Oncology, Emergency Medicine, Hospitalists, Psychiatry, Family Medicine, and Medical Intensivists and one (1) elected representative of the exclusively contracted physician groups to include Anesthesia, Pathology and Radiology. All Members are voting Members unless otherwise designated. No Member of the Active Medical Staff shall be ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline or specialty.[72] Members may attend meetings telephonically. Members of the Medical Executive Committee shall carry out their duties without regard to any personal or financial conflicts of interest, and shall recuse themselves in good faith from any discussion, consideration, vote, or action regarding an Applicant for Medical Staff Membership or a Member, or other medical staff action, where a conflict of interest may be perceived or exist.

11.1-2 Duties[73]

The duties of the Medical Executive Committee (also referred to as the "Executive Committee") shall be:

(i) to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws, and without regard to any personal or financial conflicts of interest;

(ii) to coordinate the activities and general policies of the various Departments;

(iii) to receive and act upon Committee reports, and to make comments or recommendations concerning them to the CEO, the CMO, and the Governing Body;

(iv) to implement policies of the Medical Staff not otherwise the responsibility of the Departments;

(v) to provide liaison between Medical Staff and the CEO and the Governing Body;

(vi) to recommend action to the CEO on matters of a medico-administrative nature;

(vii) to make Medical Staff membership recommendations to the Governing Body for its approval through the Chief of Staff. This duty may be performed by the Credentials Committee, acting on behalf of the Medical Executive Committee;

(viii) to fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered;

(ix) to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

(x) to provide for the preparation of all meeting programs, either directly or through delegation to a Program Committee or other suitable agent;

(xi) to take all reasonable steps to ensure professionally ethical conduct and

[70] MS 02.01.01
[71] MS 01.01.01 EP 20
[72] 42 CFR §482.22(b)(2) and MS 01.01.01 EP 21 and EP 22
[73] MS 01.01.01 EP 20 and EP 23

competent clinical performance on the part of all Members, including the initiation of Medical Staff corrective or review measures when warranted;

(xii) to report at each General Staff meeting;

(xiii) to recommend the yearly dues;

(xiv) to investigate any breach of ethics that is reported to it;

(xv) to act for the Medical Staff in the intervals between Medical Staff meetings;

(xvi) to make recommendations to the Governing Body concerning: Medical Staff structure; mechanisms used to review credentials and delineate privileges, including termination of Medical Staff membership and fair hearing procedures; participation and organization of Medical Staff performance improvement activities; and establishment of mechanisms to conduct, evaluate, and revise performance improvement activities.

(xvii) to ensure participation of the Medical Staff in performance improvement activities.

11.1-3 Actions

Actions of the Medical Executive Committee shall become effective at the time of their adoption, subject to amendment or appeal by the Governing Body.

11.1-4 Regular Meetings

The Medical Executive Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions. Fifty (50) percent of the voting Members shall constitute a quorum, and a majority vote of all voting Members present is required for action or to pass a motion.

11.1-5 Special Meetings

A special meeting of the Medical Executive Committee shall only be called by the Chief of Staff at his/her discretion, at the written request of the Governing Body, the CEO, or at the request of three (3) of the voting Members of the Medical Executive Committee. Notice of the special meeting shall be made within fourteen (14) days of receipt of the request, with the meeting being held not less than seven (7) days nor more than twenty-one (21) days thereafter. A written agenda will be prepared and distributed by the Chief of Staff at the same time as the notification of time and place of the meeting. No discussion or action may be taken on subjects not on the written agenda at such Special Meeting. In the event that an issue requires Medical Executive Committee action but there is insufficient time to wait for a special Medical Executive Committee meeting, the Medical Executive Committee may be presented with the question(s) by mail or email and their votes returned to the Chief of Staff by mail or email within the time period specified. Such a vote shall be valid so long as the question(s) are voted on by a majority of the Medical Executive Committee eligible to vote.

11.1-6 Removal of Members

Members of the Medical Executive Committee may be removed by a two-thirds (2/3) vote of the Medical Executive Committee. This action must be considered at the next meeting of the General Medical Staff.[74]

[74] MS 01.01.01 EP 21

11.1-7 Conflict Management[75]

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least fifty (50) percent of the voting Members) regarding a proposed or adopted rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five (5) Members of the voting General Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee and the petitioners' representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the General Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioners' representatives. Unresolved differences shall be submitted to the Governing Body for its consideration in making its final decision with respect to the proposed rule, policy, or issue.

11.2 CREDENTIALS COMMITTEE

11.2-1 Composition

The Credentials Committee shall consist of the current Chief of Staff, the Immediate Past Chief of Staff, Chief-Elect, CMO, and Chair of each of the following Departments: Medicine, Obstetrics and Gynecology, and Surgery. The Credentials Committee Chair shall be the Immediate Past Chief of Staff. If no Member has served longest, then the Member who served as Chief of Staff earliest shall be Chair.

The current CEO, COO, and General Counsel shall be an ex-officio, non-voting member of the Committee, and shall not count towards establishing a quorum. The Chairs of the following Departments may be invited to attend as non-voting Members when appropriate for input on Practitioner(s) who might be credentialed in their respective Departments: Anesthesiology, Emergency Medicine, Pathology, Radiology, and a representative for the Non-Physician Providers. Members may attend meetings telephonically. Members of the Credentials Committee shall carry out their duties without regard to any personal or practice-related conflicts of interest, and shall recuse themselves in good faith from any discussion, consideration, vote or action regarding an applicant for Medical Staff Membership or a Member, or any Medical Staff action, where a conflict of interest may be perceived or exist.

11.2-2 Duties

The duties of the Credentials Committee shall be:

(i) to review the credentials of all Applicants and make recommendations for Membership and delineation of clinical privileges on behalf of the Executive Committee and to otherwise perform all of the duties and obligations imposed by and in compliance with Articles V, VI, VII and VIII of these Bylaws, without regard to any personal or financial conflicts of interest;

(ii) to review periodically all information available regarding the competence of

[75] MS 01.01.01 EP 10

Staff Members or Applicants for Membership, including but not limited to the Staff Members' activities at other healthcare facilities, and as a result of such review, to make recommendations on behalf of the Executive Committee for the granting of privileges, reappointment, and the assignment of Practitioners and the various Departments or services as provided in Article V and Article VI of these Bylaws;

(iii) to review reports that are referred by the Medical Executive, Medical Record, Department Chair, Peer Review, and Utilization Review Committees and by the Chief of Staff. Additionally, to request and review reports of any corrective action or informal conduct/behavior issues, and any ongoing FPPE/OPPE issues regarding a Practitioner seeking reappointment to the Medical Staff from the Department Chair and Hospital Quality Department (or any other Department with relevant information) prior to making a recommendation for reappointment;

(iv) to review the credentials of all Applicants who request to practice at the Hospital as NPP, and to make a report of its findings and recommendations on behalf of the Credentials Committee, in accordance with Article III herein;

(v) in the event of special circumstances, the Credentials Committee may request the Governing Body to hold a special meeting to consider privileging issues in the event that prompt action by the Governing Body is required;

(vi) to review and resolve any possible conflicts of interest in the Peer Review process that are brought to the Credentials Committee by the affected Practitioner, and if unable to resolve the issue, to refer the matter to an ad hoc committee appointed in the same manner as the Hearing Panel set forth in Section 8.4-1.

11.2-3 Meetings

The Credentials Committee shall meet regularly throughout the year in order to accomplish its responsibilities as set forth by these Bylaws, at least ten (10) times per year, or more often as deemed necessary; shall maintain a permanent record of its proceedings and actions; and shall report its recommendations to the Medical Executive Committee through the Chief of Staff, to the CEO and to the Governing Body. Fifty (50) percent of the voting Members shall constitute a quorum, and a majority vote of all voting Members present is required for action or to pass a motion.

11.3 BYLAWS COMMITTEE

11.3-1 Composition

The Chairperson and Members shall be appointed by the Chief of Staff from Members of the Active Staff for a period of one (1) fiscal year.

11.3-2 Meetings

Meetings shall be held as deemed necessary by the Chief of Staff or the Chair of the Committee in accordance with such matters as require consideration.

11.3-3 Duties

The Committee shall be responsible for the consideration of any proposed changes or amendments to or revision of, the Bylaws of the Medical Staff, for formulating nomenclature or working of each Bylaw change, reconciling them with current Bylaws and submitting them to the Committee after review. The standard procedure for adoption or rejection

of such changes shall proceed in accordance with Article XV.

The Committee shall review the Bylaws at least every two (2) years.

11.4 OTHER STANDING AND SPECIAL COMMITTEES

Any other Standing Committee, Special Committee, and their Chairs shall be appointed by the Chief of Staff from the Members of the Active Staff or Senior Active Staff in accordance with the Medical Staff Rules and Regulations. The Chairs of these committees must be a Member of the Active Staff, with full privileges. When such committees are appointed, they must be charged specifically and in writing with their duties and responsibilities.

11.5 MEETINGS OF ALL COMMITTEES

Meetings of all committees shall be open to any Member of the Medical Staff; however, such guests may not enter into discussions of the committee except by permission of the Chair.

Upon initiation of a motion by one of the Members of a committee and a majority vote, any committee shall have the privilege of going into "Executive Session".

In the event a Member of any committee has a direct personal or financial interest in any action being considered by the committee, that Member shall recuse himself/herself from the vote and any discussion following a duly stated motion. However, nothing herein shall prohibit such Member from providing information to the committee of which he/she has personal knowledge.

ARTICLE XII- MEDICAL STAFF MEETINGS

12.1 ANNUAL MEETING

The annual meeting of the Medical Staff shall be held prior to the end of the fiscal year of the Hospital. At this meeting the retiring officers and committees of the Medical Staff shall make reports as may be requested by the Chief of Staff or required by these Bylaws. All officers and all elected committee Members of the ensuing year shall be elected. The Medical Staff may also take any action required of it, by presenting issues for discussion and vote in person at the annual meeting. Twenty-five (25) percent of the voting Medical Staff Members shall constitute a quorum, and a majority vote of all Members present is required for action or to pass a motion.

12.2 REGULAR MEETINGS

There may be three (3) regular meetings of the Medical Staff in addition to the Annual Meeting in September during each fiscal year of the Hospital, on a date and time designated by the Chief of Staff for the purpose of reviewing and evaluating Department and committee reports and recommendations, and acting on any other matters placed on the agenda by the Chief of Staff.

12.3 SPECIAL MEETINGS

A special meeting of the Medical Staff shall only be called by the Chief of Staff:

(i) at his/her discretion;
(ii) at the written request of the Governing Body;
(iii) by order of the Executive Committee; or
(iv) at the request of fifteen (15) percent of the voting Members of the Medical Staff.

Notice of the special meeting shall be made within fourteen (14) days of receipt of the request with the meeting called not less than seven (7) days, nor more than twenty-one (21) days, thereafter. (If mandatory attendance is required, notification of the meeting must be made at least thirty (30) days prior to the meeting date to all Members whose attendance is required.) A written agenda will be determined and distributed by the Chief of Staff at the same time as the notification of time and place of the meeting. No discussion or action may be taken on subjects not on the written agenda. In the event that an issue requires Medical Staff action, but there is insufficient time to wait for a special Medical Staff meeting, the Medical Staff may be presented with the question by mail and their votes returned to the Chief of Staff by mail. Such a vote shall be valid so long as the question is voted on by a majority of the Medical Staff eligible to vote.

12.4 QUORUM

Unless otherwise specified for specific Medical Staff Committees in these Bylaws, the presence of twenty-five (25) percent of the total membership of the voting Members of Medical Staff at any regular or special meeting or other Medical Staff meeting shall constitute a quorum, and Members or guests at such meetings may appear telephonically. Once a quorum is

established at any committee meeting or other medical staff meeting, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

12.5 STURGIS STANDARD CODE OF PARLIAMENTARY PROCEDURE

Unless otherwise specified, meetings shall be conducted according to Sturgis Standard Code of Parliamentary Procedure.

12.6 ATTENDANCE REQUIREMENTS

12.6-1 Medical Staff Meetings

Each Active, Associate and Senior Staff Member is encouraged to attend all regular Medical Staff meetings and applicable Department and committee meetings in each year. Attendance is required at least two (2) Medical Staff meeting per year. Attendance shall be enforced according to the policy "Attendance at Medical Staff Meetings"policy.

12.6-2 Department Meetings

All Active or Associate Staff Members are encouraged to attend a minimum of two (2) meetings per year of the Department to which he/she is assigned. A Clinical Department may require in its Rules and Regulations a category or categories of Members, or all Members, to attend a specific number or percentage of meetings.

12.7 AGENDA

The agenda at any regular Medical Staff meeting shall be prepared by the Chief of Staff.

The agenda at special meetings shall be:

(i) call the meeting to order;
(ii) transaction of business for which the meeting was called;
(iii) adjournment.

ARTICLE XIII- MEDICAL STAFF DUES AND FEES

13.1 DUES

Except as otherwise provided in these Bylaws, all persons appointed to the Medical Staff shall pay biennial staff dues to the Hospital's Medical Staff fund as may be required by the Executive Committee.

13.2 FEES

An application fee shall accompany all applications for Staff membership and reappointment, as recommended by the Credentials Committee as approved by the Medical Executive Committee. Additional fees may be imposed for non-attendance of the required Medical Staff meetings per Article 12.6 and as outlined in the policy "Attendance at Medical Staff Meetings" policy.

ARTICLE XIV- RULES AND REGULATIONS

14.1 GENERAL

Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, or to ensure compliance with applicable laws, regulations, accreditations or certifications, shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice which are to be required of each Practitioner exercising clinical privileges in the Hospital, and shall act as an aid in evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

14.2 ADOPTION AND AMENDMENT

Rules and Regulations may be adopted, amended, repealed, or added as recommended by the Bylaws Committee or the Credentials Committee in a meeting of the Executive Committee at any regular or special meeting, and become effective on the date(s) specified in such Rule or Regulation, or upon the date of approval by the Executive Committee.

14.3 URGENT ACTION[76]

How the Medical Staff shall act when urgent action is required to comply with law or regulation shall be set forth in the Medical Staff Rules and Regulations.

[76] MS 01.01.01 EP 11

ARTICLE XV- AMENDMENTS AND REVISIONS

15.1 REQUEST BY MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee shall request the Bylaws Committee to review and revise the Medical Staff Bylaws in part or in their entirety, upon receipt of a request for revision as provided herein, or upon its own action. The Governing Body, CEO, or any Member of the Active Staff my request consideration of an amendment or revision by filing such a request in writing with the Chair of the Bylaws Committee, Chief of Staff, or Chair of the Medical Executive Committee. Following study of the proposed change by the Bylaws Committee, the Chair shall submit its recommendation in writing to the Medical Executive Committee for their review. Upon approval of the Medical Executive Committee, the black-lined amendment or revision shall be sent in writing to each Active Member of the Medical Staff no less than thirty (30) days prior to the next regular meeting of the Medical Staff. To be adopted, the amendment or revision shall require a two-thirds (2/3) favorable vote of the Active Staff Members present or a two-thirds (2/3) favorable vote of the Active Staff Member responding to the request for approval, should such a request be sent out via mail or email. Amendment or revision so made shall be effective when approved by the Governing Body.[77] Notwithstanding the foregoing, the Medical Executive Committee may consider and vote to recommend to the Governing Body the approval of revisions or updates to these Bylaws when such revisions are necessary for the Bylaws to be in compliance with applicable laws, regulations, accreditation or certification standards; to meet requirements imposed by a state or deferral entity or agency with jurisdiction over the Hospital or if the proposed revisions do not diminish any Member's rights to exercise their privileges, to due process or a hearing as affirmatively granted in these Bylaws, or diminish any other rights affirmatively granted by these Bylaws to Members. In such situations, the Medical Executive Committee shall submit its recommended revisions to the Bylaws to the Governing Body for the Governing Body's final approval, and also submit its recommended revision to the full Medical Staff with any comments of the Medical Executive Committee at least thirty (30) days prior to any final vote by the Governing Body.

15.2 REQUEST BY MEDICAL STAFF

In addition to the foregoing, an amendment or revision(s) to the Medical Staff Bylaws may be proposed by a petition signed by at least forty (40) percent of the Active Members eligible to vote. Amendments or revisions submitted upon petition of the voting Members shall be provided to the Medical Executive Committee at least thirty (30) days before they are submitted to the Governing Body for review and comment as described in Section 15.1. The Medical Executive Committee has the right to have its comments regarding the proposed amendments or revisions circulated to the Governing Body when the proposed amendments or revisions are submitted to the Governing Body for comments; and to have its comments circulated to the Medical Staff with the proposed amendments or revisions at the time they are distributed to the Medical Staff for a vote.[78]

[77] MS 01.01.01 EP 1, EP 2, EP 3, and EP 24
[78] MS 01.01.01 EP 1, EP 2, EP 3, EP8 and EP 24

ARTICLE XVI- MEDICAL RECORDS

16.1 MEDICAL RECORDS

16.1-1 Compliance with Hospital and Medical Staff Policies

Medical Staff Members shall comply with all applicable Hospital and Medical Staff policies, applicable law, regulations, licensure and accreditation standards regarding the content and completion of patient medical records.

16.1-2 Admission History and Physical Examination

A patient admitted for inpatient care shall have a complete admission history and physical examination within twenty-four (24) hours of admission and prior to any procedure. Said history and physical examination shall be the responsibility of a licensed independent practitioner (i.e. physicians, oral and maxillofacial surgeons, dentists, podiatrists, PAs and some ARNPs). Dentists shall be responsible for the part of their patient's history and physical examination that relates to dentistry, and podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry. This report should include all pertinent findings resulting from an assessment of all systems of the body, to include a physical assessment which has been completed within the first twenty-four (24) hours of admission. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission or registration to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an update note indicating any changes or no changes to the history and/or physical findings must always be recorded prior to any procedures requiring anesthesia or conscious sedation and within twenty-four (24) hours of admission. An exception to these rules will be granted when the record is prepared by a resident physician or Dependent Healthcare Professional in which instance the attending physician countersigns the record.

16.1-3 History and Physical Required Prior to Procedure

When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending Practitioner states in writing that such delay would be detrimental to the patient.

ARTICLE XVII -ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Body of the Hospital.

Adopted by the Active Medical Staff of Halifax Health Medical Center.

_____
Chief of Staff, Medical Staff

Date: March, 21, 2017

_____
Secretary/Treasurer, Medical Staff

Approved by the Governing Body of Halifax Health Medical Center.

_____
Chairman, Board of Commissioners

Date:

_____
Secretary, Board of Commissioners

Halifax Health Board of Commissioners' Meeting

AUXILIARY REPORT

For

May 1st, 2017

Volunteer Hours: For the first six months of the fiscal year - October 1, 2016 to March 31, 2017, the Halifax Health Auxiliary has donated 34,807 volunteer hours.

Clothes Closets: Continued thanks to Don Stoner, Jr and Tim Leo, President of 1st Uniform for their support with donations of new shirts and scrub pants. The Auxiliary buys new sets of "essentials" (underwear), socks and inexpensive shoes. Discharging patients with dignity continues to be our pledge. Halifax Health Port Orange Clothes Closet has successfully transitioned from stocking donated-used clothes to all new.

Therapy Dogs: 24 Therapy Dog teams are busy and meeting the emotional needs of patients, staff, and visitors. 2017 Therapy Dog calendar sales assisted with the purchase of additional strollers (small dogs), embroidered dog vests, and new uniform polo shirts for handlers. Therapy Dog teams have participated in several community and hospital events.

Gift Shop: Gift Shop sales and financial margins are holding steady with donations to the Auxiliary of $30,000.

Auxiliary Software: The new Auxiliary Volunteer management software has been purchased, installed, and is now in use. **Vsys One** is a nationally recognized leader in volunteer management software and helps provide us with easy to use reports, concurrent hours information, as well as increased safety by knowing who is currently here volunteering at any one time. Organization wide communications are significantly improved with the ability to push messages to touchscreens, as well as easy mail merges for U.S. mail correspondence.

Courtesy Carts The Auxiliary Board of Directors have approved moving forward with the replacement of our existing 4x Moto Electric carts using finances generated from Auxiliary fundraising. The current MOTO Courtesy Carts which have not held up to service/reliability expectations, will be replaced with Polaris GEM models which we drove previously and experienced excellent usage and reliability, and value.

Volunteer of the Year 2016 Juanita Poffenbarger was named the 2016 V.O.Yr. during the annual Holiday Luncheon at LPGA on December 10th, 2016. Juanita has been with the Auxiliary for 30 years and donated over 6,800 hours – primarily in the Gift Shop.

Stitch N Knit The Stitch N Knit Auxiliary team continues to produce stuffed animal toys, prop pillows, nursing pillows, baby booties/mitts/hats, car seat pillows, burp pads, lap robes, ADL Busy Buddy activity pillows, oncology patient neck pillows and padded seatbelt covers for indwelling IV patients. Over 10,000 pieces were distributed over the past six months – each with a tag that says, "Made with Tender Loving Care –Halifax Auxiliary"

Halifax Humane Society The Halifax Health Auxiliary pledged to donate $50,000 over a period of four years to assist with Humane Society operations and building fund. Several of our Therapy Dog teams have come as a result of animal rescue efforts.

Sincerely,

W.G. Watts, President
Halifax Health Auxiliary, Inc.

HALIFAX HEALTH

TO: Jeff Feasel, President/CEO
FROM: Joe Petrock, Executive Director, Foundation
DATE: May 1, 2017
RE: Halifax Health Foundation/Associates Semi-Annual Report
October, 2016 – February, 2017

The Foundation and Associates Boards, consists of 112 community leaders who financially assist and support the Foundation and Halifax Health. Through special events and the generosity of our donors, the Foundation has raised over $600K in special events through February, 2017. Currently we have net assets of approximately $41M. Since 1998, the Foundation has funded over $13 million for the needs of the medical center including the purchase of state of the art technology/equipment and providing medical education for the staff.

The Foundation and Associates Boards welcomed the following speakers at bimonthly meetings:

- November, 2016: Susan Joss & Jennifer Pelidut – Breast Cancer Program
- February, 2017: Dr. Robert Feezor – Halifax Health/Univ. of Florida Vascular Surgery
- April, 2017: Dr. Nelson and Dr. Sebastien – Bariatric Program

FOUNDATION FUND RAISING PROJECTS

In an effort to increase its opportunity to raise funds and support Halifax Health, Halifax Health - Foundation, partners with numerous organization in the Volusia/Flagler County area. These partnerships are wonderful opportunities to help market Halifax Health, educate the community on the high quality of care Halifax provides, and promotes the quality of our medical staff.

Employee Giving Campaign

Through our yearly Employee Giving Campaign, employees support Halifax Health - Foundation.

October 7th - 9th: Daytona Blues Festival

This event, a partnership between Halifax Health - Foundation and the Daytona Blues Festival, was cancelled due to Hurricane Matthew. The Foundation received proceeds of $30K from the sale of sponsorships.

October 22nd: Vince Carters Pink Walk/Run

The 6th annual Vince Carter Pink Walk Run was presented by Vince Carter and Michelle Carter- Scott and held at Vince Carter's Restaurant. Kathryn Nagib, Halifax Health Foundation,

led the field of walkers and runners for this fun-filled event. A portion of the proceeds benefitted Halifax Health Oncology Services.

October 20th - 21st: Daytona International Speedway Pro-Am

The 43rd Annual Tournament was hosted by Halifax Health in partnership with Daytona International Speedway. The Pro-Am golf classic was held at LPGA and featured golf professionals from throughout Florida and Georgia. This fun-filled event, benefiting Halifax Health Foundation and Speediatrics, has raised more than $3.2M since it began in 2004.

December 8th-10th: Molto Bella Event

Sherry Graffagnino, owner of Molto Bella Boutique, once again partnered with Halifax Health - Foundation to sponsor a three day shopping event. Molto Bella presented Halifax Health - Foundation a check totaling 20% of their sales.

February 20, 2017: NASCAR Foundation/Halifax Health Texas Hold 'Em Tournament

The Celebrity Poker Tournament, held at ERAU, featured poker, racing, and sports celebrities. Proceeds from the event exceeded $300K.

February 24th: Hot Rods and Reels Fishing Tournament

Bass professionals and NASCAR drivers had a chance to fish with corporate teams to raise money for the Darrell Gwynn Foundation and Halifax Health - Foundation. A deserving young adult was presented with a high-tech wheel chair at the pre-race ceremony of the NASCAR truck race.

March 24th – 26th: 38th Mayor's Pro-Am Charity Golf Classic

Joe Petrock was chairman of this Pro-Am golf classic held at Daytona Beach Golf Club. The proceeds were divided between Halifax Health Keech Pediatric Neighborhood Care and Daytona Beach Pop Warner Football and Cheer Association.

March 25th: Halifax Health/Tomoka Marathon

The marathon, half marathon, and 5K Walk was organized to benefit Halifax Health Regional Oncology Program including breast cancer treatment technology. This event, organized by Don Stoner, Jr., started at the Casements and allowed participants to run/walk the Tomoka Loop in Ormond Beach.

Upcoming events/partnerships benefitting Halifax Health Foundation

May 6th – Hero's Challenge
May 13th – Peach Valley Appreciation Brunch
May 13th - Haley Watson Surf Classic
May 21st - Frank Scott Memorial Poker Tournament
June 2nd - Bahama Casual Event
August - Vince Carter Charity Gala
October 6-8 - Daytona Blues Festival
October - Vince Carter's Pink Walk Run
October 19th & 20th - DIS Pro-Am

HALIFAX HEALTH

Human Resources Executive Summary - March 2017

HALIFAX HEALTH

Recruitment

^Vacancy Rate	3.60%	New Hires	108	*Annualized Turnover Rate	7.88%
Number of Applications	2,837	FT	87	*Annualized RN Turnover Rate	6.59%
Average Days to Fill	41.8	PT	5	Terminated/Resigned	33
RNs	46.5	Casual Pool	16	Average Number of Employees	4,220
Allied Health	39.3	Core RNs	17	Average Number of FT /PT Employees	3,573

Turnover

Employee Relations

Employee of the Month:	
Service Awards	
5 Year	10
10 Year	12
15 Year	7
20 Year	3
25 Year	1
30 Year	1
35 Year	2
40 Year	-

Retention

Average Tenure of Active Employees	7.92
Active Employees	
Average Tenure 0 - 1 yr	30.00%
Average Tenure 2 - 5 yr	27.79%
Average Tenure 6 - 10 yr	10.23%
Average Tenure > 10 yr	32.03%
Seperations	
Average Tenure 0 - 1 yr	51.51%
Average Tenure 2 - 5 yr	24.24%
Average Tenure 6 - 10 yr	3.00%
Average Tenure > 10 yr	21.21%

*Organizational & Talent Development

****Inservice & Continuing Education**	
Number of Programs	431
Participants	3,550
Instructions Hours	8,948
*Computer Based Learning	2,717
***Continuing Physcician Education**	
Number of Programs	
Participants	
***Continuing Clinical Education**	16
Number of Programs	266
Participants	
***Medical Library**	32
Patrons	452
Article Sources	
	155
	363

Compensation

Total Evaluations Due	333	Includes 6 Month and Annual Performance Evals
Early/OnTime Evaluations	114	
Late Evaluations	76	
Outstanding Evaluations	143	
Avg Score	3.24	
Avg Hourly Rate	$ 25.15	
RN Referral Bonuses Paid	$ 2,000.00	
At Max/Bonus Paid		
Tuition Reimbursements	0	
Sign On/Relocation Bonuses	$ 5,000.00	
Nursing Loan Forgivness	$ -	

Work / Life Benefits & Leave Programs

Total Employees on Leave	89	Number of Benefits Eligible	4,645
Worker's Compensation Claims	3	Number of 457 Plan Participants	52
Leave of Absence Requests	33	Number of 403(b) PlanParticipants	3,573
Family Medical Leave Act Requests	52	1%-3% Contributions	2,682
Military Leave Requests	1	4% or Higher Contributions	891
Voluntary Summer Leave	0	* UNUM Wellness Claims Paid	$2,650.00
Number of Retirements	6	Disability Claims Paid	
Worker's Compensation Incidents	23	STD	11@$19,104.68
Administrative Leave	0	LTD	2@$5,533.94
		Management	$ -

Auxilary

Volunteer Hours	7,142
New Volunteer Orientees	11 Teen+14 Adult = 25

Visitor Access

Total Visitors	39,277
Halifax Main Campus	36,101
HHPO	1,840
HBS	1,336

**Based on statistics reported by Date

^Vacancy Rate = Open Positions / Entire House

*Turnover Rate = FT & PT Seperations / Average FT & PT Employees

HALIFAX HEALTH

Human Resources Executive Summary - February 2017

HALIFAX HEALTH

Recruitment

^Vacancy Rate	3.70%	New Hires	47	*Annualized Turnover Rate	11.08%
Number of Applications	2,373	FT	41	*Annualized RN Turnover Rate	13.60%
Average Days to Fill	42.9	PT	1	Terminated/Resigned	43
RNs	46.3	Casual Pool	5	Average Number of Employees	4,214
Allied Health	38.9	Core RNs	14	Average Number of FT /PT Employees	3,641

Turnover

Employee Relations

Employee of the Month:	
Service Awards	
5 Year	13
10 Year	15
15 Year	3
20 Year	3
25 Year	2
30 Year	1
35 Year	-
40 Year	2

Retention

Average Tenure of Active Employees	7.9
Active Employees	
Average Tenure 0 - 1 yr	30.87%
Average Tenure 2 - 5 yr	26.98%
Average Tenure 6 - 10 yr	10.34%
Average Tenure > 10 yr	31.77%
Seperations	
Average Tenure 0 - 1 yr	47.54%
Average Tenure 2 - 5 yr	29.51%
Average Tenure 6 - 10 yr	3.28%
Average Tenure > 10 yr	19.67%

*Organizational & Talent Development

****Inservice & Continuing Education**	
Number of Programs	270
Participants	1,782
Instructions Hours	11,643
*Computer Based Learning	2,576
***Continuing Physcician Education**	
Number of Programs	20
Participants	437
***Continuing Clinical Education**	
Number of Programs	32
Participants	436
***Medical Library**	
Patrons	160
Article Sources	347

Compensation

Total Evaluations Due	329	Includes 6 Month and Annual Performance Evals
Early/OnTime Evaluations	111	
Late Evaluations	90	
Outstanding Evaluations	128	
Avg Score	3.21	
Avg Hourly Rate	$ 25.35	
RN Referral Bonuses Paid	$ 2,000.00	
At Max/Bonus Paid	$ -	
Tuition Reimbursements	$ -	
Sign On/Relocation Bonuses	$ 12,000.00	
Nursing Loan Forgivness	$ -	

Work / Life Benefits & Leave Programs

Total Employees on Leave	89	Number of Benefits Eligible	3,723
Worker's Compensation Claims	4	Number of 457 Plan Participants	52
Leave of Absence Requests	20	Number of 403(b) PlanParticipants	3,517
Family Medical Leave Act Requests	64	1%-3% Contributions	2,626
Military Leave Requests	0	4% or Higher Contributions	891
Voluntary Summer Leave	1	* UNUM Wellness Claims Paid	$2,650.00
Number of Retirements	5	Disability Claims Paid	
Worker's Compensation Incidents	18	STD	8@$12,851.73
Administrative Leave	0	LTD	2@$4,885.45
		Management	-

Auxilary

Volunteer Hours	5,095

Visitor Access

Total Visitors	36,548
Halifax Main Campus	33,647
HHPO	1,437
HBS	1,464

**Based on statistics reported by Date

^Vacancy Rate = Open Positions / Entire House

*Turnover Rate = FT & PT Seperations / Average FT & PT Employees

HALIFAX HEALTH
TRAUMA CENTER

BIKE WEEK 2017 – STATISTICAL SNAPSHOT

These data are made possible by all the Team Members with the Halifax Trauma Registry Office

General Statistics throughout Ten (10) Day Event

	2013	2014	2015	2016	2017
Trauma Admissions	84	105	98	113	137
Bike Week-related Trauma Admissions	44	50	45	54	69
Trauma Team Activations	19	41	44	43	63
Bike Week-related Trauma Team Activations	10	21	24	31	38

Bike Week-Related Trauma Admission Statistics

	2013	2014	2015	2016	2017
Total Bike Week-related Trauma Admissions	44	50	45	54	69
Motorcycle Crash Admissions	39	44	42	46	65
Scooter (motorized)	0	0	0	1	2
Motorcycle/Scooter Driver (Passenger)	35 (4)	39 (5)	36 (5)	44 (3)	57(10)
Helmet Usage Driver (Passenger)	13 (2)	21 (4)	16 (2)	20 (1)	25 (2)
Non-motorcycle related Injuries	6	6	3	8	4
Patients with Head Injuries	20	21	13	16	25
Arrived by Ambulance	38	42	39	48	63
Arrived by Helicopter	2	6	3	6	6
Arrived by Private Vehicle	4	2	3	0	0
Average Age (median)	48 (49)	44 (48)	47 (42)	44 (47)	49 (53)
Gender	♂ 33 (75%) ♀ 11 (25%)	♂ 41 (82%) ♀ 9 (18%)	♂ 38 (84%) ♀ 7 (16%)	♂ 47 (87%) ♀ 7 (13%)	♂56 (81%) ♀ 13 (19%)
Transfers In (out)	5 (0)	3 (1)	1 (2)	1 (0)	5 (3)
To O.R. (Specials) from ED	12 (0)	7	6 (0)	10 (1)	7 (1)
To ICU (PICU) from ED	13 (0)	15 (1)	9 (2)	20 (0)	21 (1)
To Floor from ED	19	25	25	16	32
D/C Home from ED	0	1	1	7	5
Deaths	1	2	1	1	4
Hospital Length of Stay, Average (median)	7 (4)	5 (3)	9 (3)	9.5 (4)	5.2 (3)
ICU LOS, Average (median)	8 (2)	3 (1)	19 (3)	8 (4)	2.8 (2)
Ventilator Days, Average (median)	13 (7)	3 (1)	21 (23)	8.5 (4)	3.8 (3)
Received PRBCs in 4hrs (MTP cases)	-	5 (2)	1 (0)	5 (1)	5 (2)
Volusia Co Residence	8 (18.2%)	9 (18%)	7 (16%)	14 (25%)	17 (25%)
HMC Taxing District (Ø W or SE Volusia)	4 (9.1%)	6 (12%)	5 (11%)	11 (20%)	21 (41%)
Outside Volusia Co Residence	36 (82%)	41 (82%)	38 (84%)	41 (75%)	52 (75%)
Outside Florida Residence	28 (64%)	26 (52%)	22 (49%)	32 (59%)	30
Day of Week Peak	Saturday 03/09	Sat & Thurs 03/08&13	Sat & Sun 03/08-09	Saturday 03/05	Saturday 03/11
Hour of Day Peak	2100-2200	1200-1300	1300-1400	1900-2000	1800-1900
Surgeon Peak	Joseph Bianchi, MD	Harry Black, MD	Harry Black, MD	Harry Black, MD	Jazarevic and Altaras
ED Physician Peak	Tara Wilson, MD	D. Peterson / Z. Evens	R. Soontharothai, MD	Stephen Viel, MD	Shravanti Halpern, MD
Primary Payor	Auto Plans	Auto Plans	Private / Commercial	Self Pay	Self Pay
Phase of Moon Peak	New Moon	First Quarter	Waning Gibbous	New Moon	Full

Note: These data reflect patients meeting trauma registry inclusion criteria, which include Trauma Alerts, trauma transfers, and injured patients admitted >24 hours. Non-Trauma Alert patients admitted for observation <24 hours are not reflected in these data.

DRAFT

HALIFAXHEALTHY COMMUNITIES
Board of Directors Quarterly Meeting Minutes
France Tower – Conference Rm "G"
January 18, 2017

Members Present:	Don Quinn, Chair Harold Goodemote II Gwen Azama-Edwards Al Allred Patricia Boswell Jeff Feasel	Absent:	Dr. Pam Carbiener Robert (Bob) Snyder
Others Present:	Deanna Schaeffer, Healthy Communities Alicia Watson, Healthy Communities Steve Parris, Healthy Communities Cher Philio, Healthy Communities		

The meeting was called to order at 4:03 p.m. The minutes of October 19, 2016 were approved as written.

CHAIRMAN'S REPORT/COMMENT:

None.

PRESIDENT/CEO REPORT – Deanna Schaeffer:
Legislative Update
Ms. Schaeffer informed the Board that the pending change in the federal administration has prompted a lot of discussion in Washington, D.C. with possibly some good opportunities for Florida's healthcare and Medicaid. Ms. Schaeffer and her colleagues will remain engaged at both the state and federal level so that they are prepared to respond as things develop. Mr. Goodemote inquired whether there were any significant delegation changes in Tallahassee. Ms. Schaeffer responded yes. She stated that our district now has two representatives on the Health Care Committee in the Senate—Senator Hukill and Senator Hutson. In the House, Representative David Santiago is the Vice-Chair of the Health and Human Services Committee, and Representative Renner is on the Health Innovations Committee. There are also a number of changes in the appropriation committees that have potential to be positive. Discussion ensued.

Ms. Azama-Edwards inquired as to whether there is any new information regarding the President's promise to do away with the Affordable Care Act (ACA) and have insurance for all. Ms. Schaeffer stated that no one knows exactly what insurance for all would be, but there is some speculation that it could potentially be pursued via various methods to include, subsidies to purchase insurance, tax credits to purchase insurance, and or Medicare buy-in based on a sliding fee scale. Ms. Schaeffer added that the Affordable Care Act (ACA) is an extremely complex bill that could have various catastrophic results if repeal and replacement is not thoughtfully addressed. Ms. Schaeffer and her colleagues are attempting to engage as many members of the delegation as possible to

make sure they are aware of the ramifications a repeal of the bill without a comparable replacement could have. Discussion ensued.

Ms. Schaeffer informed the Board that the new Speaker of the Florida House of Representatives has the following priorities:

- Certificate Of Need Repeal
- Allowing for 24 hour stays in Ambulatory Surgery Centers; and, the creation of a new licensing category for Recovery Care Centers that could provide up to 72 hours of post-surgical care.

Ms. Schaeffer informed the Board that Beckers, a leading medical publication, has named Jeff Feasel one of the top 150 Chief Executive Officer's (CEOs) in the country. Mr. Goodemote added that Eric Peburn was also named one of the top 150 Chief Financial Officers (CFOs) by the Beckers Publication as well. The Board commended Mr. Feasel.

HEALTHY COMMUNITIES UPDATES:
Healthy Kids and KidCare Outreach/Enrollment – Steve Parris:

Mr. Parris reviewed the provided Florida KidCare Enrollment as follows:

- Medicaid (11/16) – Volusia 55,385; and, Flagler 9,741;
- MediKids (12/16) – Volusia 708; and, Flagler 123;
- Children's Medical Services (12/16) – Volusia 224; and, Flagler 47; and,
- Healthy Kids (12/16) – Volusia 4,138; and, Flagler 974.

Mr. Feasel inquired as to whether a lack of providers is an issue in Flagler. Mr. Parris responded that a lack of providers could have some impact in the enrollment. Discussion ensued.

Healthy Communities Annual Report FY 2015-16

Mr. Parris referenced the distributed report for review. He highlighted the following:

- Page 5. In October 2015, the full-pay buy-in option was no longer available under the Children's Health Insurance Program (CHIP) due to requirements of the Affordable Care Act (ACA). The full pay plan was made available via a separate program and two levels of payment were available. However, the monthly cost increased significantly rendering it unaffordable to most families, which continues to directly impact the enrollment numbers.
- Page 6. Written communications and promotional item distribution has decreased due to a lack of funding and or resources to obtain the materials for distribution over the years.

- Page 6 & 7. Per Mr. Feasel's request, the referenced population charts were added as a depiction of the economic status of our local community.

Mr. Feasel inquired as to whether there are any outreach programs to specifically assist homeless individuals attending college with their childcare needs. Ms. Schaeffer replied that there is not and this is an issue within the public school system as well. She added that Steve and his staff will look into a way to reach out to those families to make them aware of local resources that they may be able to access for services. However, the primary issue for the homeless college population is childcare as opposed to healthcare. Unfortunately, there is not immediate or efficient means to address that need at this time, but the Hope shelter is a future possibility.

- Page 9. 762 children received water safety lessons during the 2016 Water Safety Program; and, around 15,225 scholarships have been awarded since the program's inception in 1996.

Mr. Feasel inquired as to how Volusia County is doing in comparison to other counties in the area of drowning and or near drowning. Mr. Parris responded that in past years Volusia was always one of the top 10 counties for drowning and near drowning; however, the county is no longer one of the top ten and has not been for quite sometime. Although he can't say with 100% certainty, Mr. Parris stated that the program is making a great difference in our two-county area among residents. Local statistics are somewhat skewed as most cases of drowning or near drowning happen within our tourist population. Discussion ensued.

- Page 10. Safe Kid's Worldwide introduced The Ultimate Car Seat Guide, which is an online tool that offers how-to-videos to demonstrate proper car seat installation as well as tips to assist families to purchase the appropriate car seat for their child or children. It is a great resource that offers advice that covers all ages and stages of development.

Ms. Schaeffer informed the Board 2017 represents Healthy Communities' 25th Anniversary. The Board congratulated staff and commended them for their efforts over the years.

Safe Kids Outreach

Mr. Parris informed the Board that a Child Passenger Safety Technician Training is scheduled for February 27, 2017 through March 1, 2017. Several of the NICU as well as labor and delivery nurses will be attending the course to become certified.

Healthy Start

Ms. Philio reviewed the Healthy Start *Screening Results for Service Delivery Area (Volusia & Flagler County Residents) FY 16/17* for Quarter 2/YTD. All except one Healthy Start screening and consent goal were met or exceeded in the first quarter. The Quarter 1 rates were as follows:

- The infant screening rate of 90.29% exceeded the new goal of 84.00%;
- The prenatal screening rate of 88.60% exceeded the new goal of 78.00%;
- The women consenting to the prenatal screen rate of 93.33% exceeded the goal of 90.00%; and,
- The eligible prenatal referrals consenting to participation at the time of the screen rate of 95.32% was a bit under the goal of 96.00%.

Ms. Philio stated that although Halifax had a lower number of births than the Florida Hospital system in October; their screening rate remains to be significantly higher overall.

Ms. Philio reported that the number of prenatal care providers remains the same since the last quarter and they are all doing well. However, she did inform the Board that OB/GYNs are now seeing an increased number of mothers who are using drugs during pregnancy, which is resulting in the birth of more substance exposed newborns.

OTHER BUSINESS

Ms. Boswell informed the Board that the health department's tobacco cessation program welcomed its first tobacco free baby. Both parents remained smoke free throughout the pregnancy and as a result they will receive diapers as well as other baby essentials.

ADJOURNMENT

There being no further business, the meeting of January 18, 2017 adjourned. The next meeting is scheduled for Wednesday, April 19, 2017 at 4:00 p.m., unless otherwise notified.

Volusia Health Network
Board of Directors' Meeting Minutes
March 7, 2017 – 8:00 am

Call to order

Dr. Hemaidan called the Board of Directors' meeting to order at 8:00 a.m.

Members Present

Ammar Hemaidan, MD – David Turetsky, MD - Joseph Bianchi, MD - Walter Durkin, MD - Brent Fulton, MD – Eric Peburn

Others Present

Lane Jennings, MD – David Billmeier, MD - Bob Williams - Natasha Leverett - Carol Alvarado - Jean Carroll

Approval of Minutes

A motion was made and seconded to accept the minutes, as presented, from the November 8, 2016 meeting. The minutes were approved as presented.

Medical Director's Report

Dr. Jennings reported the following:

- Medical directors met with Dr. Sebastien regarding bariatric surgery. Dr. Sebastien would like the number of weeks in a supervised weight management program to be less than 24 weeks for members. Dr. Sebastien, along with Dr. Nelson, will be performing the duodenal switch surgery on patients with higher BMI.

- Continue to strive to keep members on formulary.

Administrative Report

Mr. Williams reported the following:

- **Out-patient Pharmacy** – The out-patient pharmacy project continues to move forward.

- **Bundle Payment Project** – Fee-for-service sepsis bundle payment project is going very well.

- **Post-Acute Care** – Working to improve the transition of care when patients are discharged from the hospital to a nursing facility.

- **Post-Acute Care Practice** – In the process of bringing in a new provider to oversee these patients. We have received great support from Dr. Zimmerman and Dr. Stauffer with this process.

- **Community Clinic –** With leadership from the Halifax Health Grants Development office, a partnership was formed with Azalea Health and other community organization to submit an application for a recurring grant under the Section 330 of the Public Health Service (PHS) Act for the establishment of a Federally Qualified Health Center. The grant was awarded in December 2016 and will result in $640,000 in federal funding each year to provide indigent care as part of a comprehensive primary care clinic to provide healthcare for the un-insured and under-insured in our community. The clinic will also provide for insured patients. The clinic is expected to open soon.

Operations Report

Natasha Leverett reported the following:

- **Precert Stats** – Utilization management have reviewed 599 cases since the start of the 2017 fiscal year.

- **Client Report** – The County of Volusia and Orthopaedic Clinic of Daytona Beach terminated their contracts with VHN, effective January 1, 2017.

- **Claims –** Claims turnaround time is 3 days.

- **Gym Membership –** Members are taking advantage of their gym membership.

Adjournment

There being no further business, Dr. Hemaidan adjourned the Board of Directors' meeting at 8:10 a.m.

Minutes submitted by: Jean E. Carroll

Minutes reviewed by: Natasha Leverett, Operations Coordinator

Volusia Health Network
Peer Review Minutes
March 7, 2017

Call to order

Dr. Hemaidan called the Peer Review meeting to order at 8:10 am.

Approval of Minutes

A motion was made to accept the minutes, as presented, from the November 8, 2016 meeting. The minutes were approved as presented.

Discussion

Forty-three providers were presented to the board for a two-year reappointment to Volusia Health Network.

Action

A motion was made to accept all the providers presented, as recommended by the credentials committee. Upon a vote, the motion carried.

Discussion

Nine providers were presented to the board for initial appointment to Volusia Health Network.

Action

A motion was made to accept all the providers presented, as recommended by the credentials committee. Upon a vote, the motion carried.

Adjournment

There being no further business, the Peer Review meeting was adjourned at 8:13 am.

Minutes submitted by: Jean E. Carroll

Minutes reviewed by: Natasha Leverett, Operations Coordinator

Halifax Health Foundation
Meeting Minutes
April 12, 2017

Meeting Called: 8:03 a.m. Meeting Adjourned: 9:02

Halifax Foundation Attendees:

Dr. Mary Bennett	Aubrey Long	Bud Ritchey	Rick Wells
Ronnie Bledsoe	Charlie Lydecker	Budd Severino	Dr. Alex White
Eleanor Callon	George Mirabal	Edith Shelley	Paul Joachimczyk
Doug Daniels	Frank Molnar	Greg Snell	Gary Yeoman
Joe Disanti	Steve Nameth	Bobby Thigpen	Patti Earl
Jeff Feasel	Glenn Padgett	Dr. John Tonkin	Kathryn Nagib
Dr. Brent Fulton	Carl Persis	Lisa Tyler	
John Guthrie	Joe Petrock	Larry Volenec	
Mike Kundid	Rafael Ramirez	W.G. Watts	

The meeting was called to order at 8:03 a.m. by Halifax Foundation President, Dr. Mary Bennett. Quorum present.

1. TOPIC:
   Minutes
   DISCUSSION:
   Aubrey Long, Secretary
   Approval of February 8, 2017 Halifax Foundation Board minutes.
   ACTION/FOLLOWUP:
   Motion and second for approval of minutes. Motion carried.

2. TOPIC:
   New Board Member Introduction
   DISCUSSION:
   Paul Joachimczyk- Vice President of Finance, TopBuild Corp.
   Gary Yeomans- Owner of Gary Yeomans Ford Lincoln

PRESENTATION:

TOPIC:
Bariatric
DISCUSSION:
Dr. Lars Nelson, MD Bariatric Surgeon presented to the Board on Bariatric services that are provided here at Halifax Health. "At East Coast Bariatrics Surgical Center of Excellence, we maintain a Prospective database on patients including outcomes, safety data, and process improvement. We are a high volume center and perform on average 200 bariatric cases/yr (at least 50 cases per year).
We communicate with patients at every stage of the process and are available 24hours/day. We feature support groups for patient participation and a strong commitment to the psychological aspects of the program."

REPORTS

1. TOPIC:
   Halifax Foundation Service Award
   DISCUSSION:
   Joe Petrock, Executive Director of Halifax Health Foundation presented Fi Roster an award in recognition of her exemplary service to our donors, patients, and their families.

2. TOPIC:
   Halifax Foundation Treasurers Report
   DISCUSSION:
   Joe Petrock, Executive Director of Halifax Health Foundation
   Foundation Board received the statement of net assets ending February 2017- $4 million.
   ACTION/FOLLOWUP:
   Motion and second to accept report as presented. Motion carried.

3. TOPIC:
   Auxiliary Report
   DISCUSSION:
   W.G. Watts President of Auxiliary gave an update to the Foundation Board on the 2,000+ volunteer hours that have donated in the month of March. Mr. Watts also announced there is a total of 32 therapy dogs that volunteer. The Auxiliary department will be purchasing 4 new carts for the parking lots.

4. TOPIC:
   Foundation Update
   DISCUSSION:
   Joe Petrock, Foundation Executive Director presented the Foundation Update which included information on all past and upcoming events for 2017. February 20th ~ NASCAR Foundation Texas Hold'em Tournament, February 24th ~ Hot Rods and Reels Fishing Tournament, March 24th ~ Mayor Derrick Henry ~ Daytona Beach Open, March 25th ~ Halifax Health/Tomoka Marathon, April 7th ~ Frank Scott Memorial Poker Tournament, May 21st 2017 ~ Sports Car Club of America, May 13th ~ Haley Watson Surf Classic, May 2017 ~ Spirit of the Automobile, June 2nd ~ Bahama Casual Event, Embassy of Hope Gala August 5th 2017 (Honorees this year will be Dr. Pam Carbiener and Radiology Associates) ~ Daytona Blues Festival, October 2017 ~ 44th Annual DIS Pro-Am October 19th-20th

5. TOPIC:
   President's Report
   DISCUSSION:
   Jeff Feasel, President/CEO, updated the members and answered questions regarding all services provided by Halifax Health. Mr. Feasel also updated Board members on the progress of the Deltona project. Grand opening will be April 25th.

   Next Foundation Board of Directors Meeting will be on June 14, 2017. The meeting will be held in France Tower Conference Rooms E & F.

_____

Aubrey Long, Halifax Foundation Secretary

HALIFAX HEALTH

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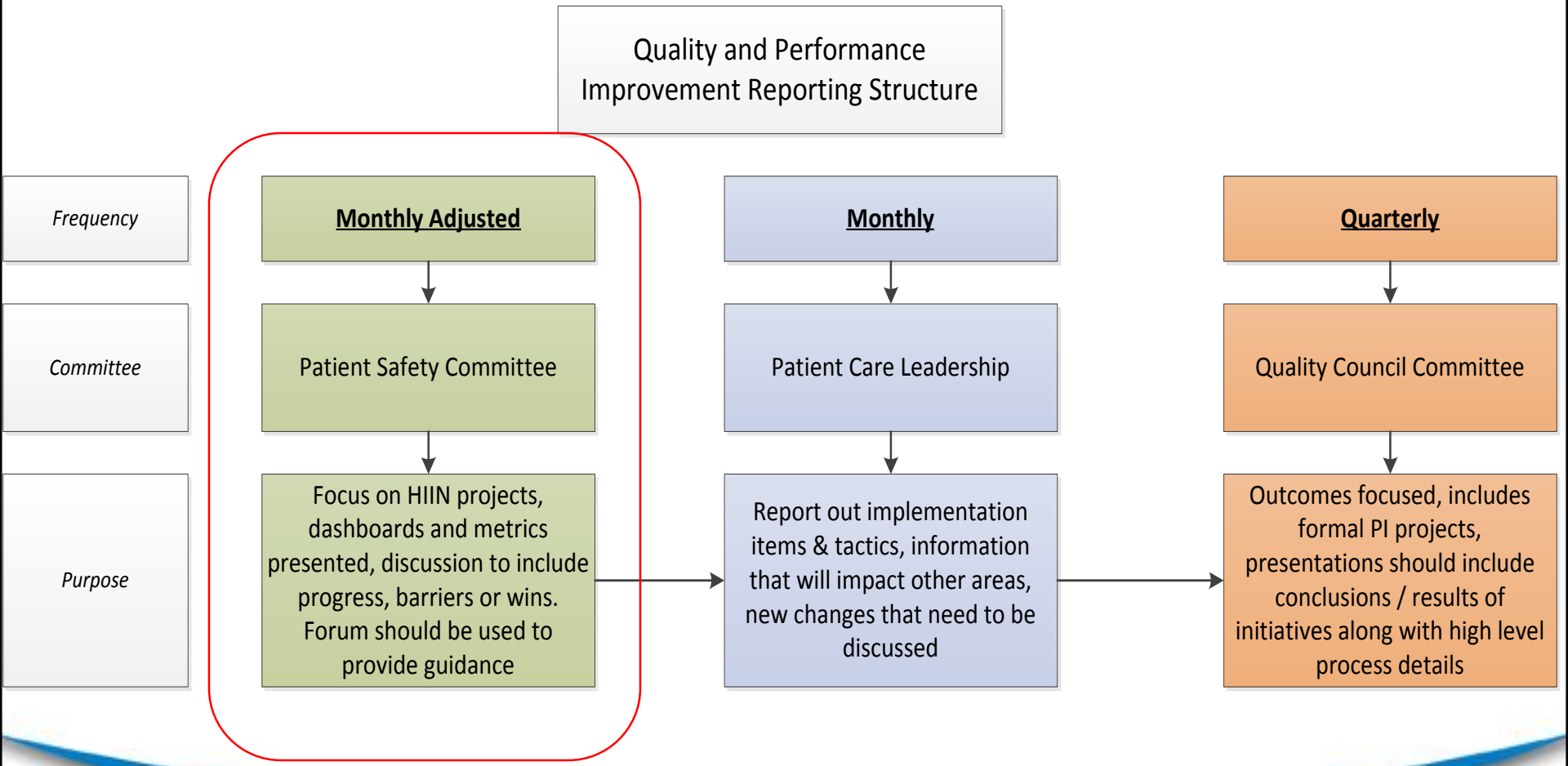
Halifax Health

Q1-FY2017 Quality Board Report

(October 2016 – December 2016)

Organizational



2017 Timeline

January	February	March	April
Patient Care Leadership	Patient Care Leadership	Patient Care Leadership	Patient Care Leadership
Patient Safety Council	Patient Safety Council	Quality Council	Patient Safety Council
May	**June**	**July**	**August**
Patient Care Leadership	Patient Care Leadership	Patient Care Leadership	Patient Care Leadership
Patient Safety Council	Quality Council	Patient Safety Council	Patient Safety Council
September	**October**	**November**	**December**
Patient Care Leadership	Patient Care Leadership	Patient Care Leadership	Patient Care Leadership
Quality Council	Patient Safety Council	Patient Safety Council	Quality Council

Hospital Improvement Innovation Network Projects (HIIN)

Performance Improvement Teams:

- Falls
- CAUTI
- CLABSI
- Venous thromboembolism (VTE)
- HCAHPS (non HIIN team)

Other HIIN Improvement Projects:

- C-diff
- Severe sepsis/septic shock
- Ventilator-associated events (VAE)
- Readmissions
- Adverse drug events (ADE)

Joint Commission Update

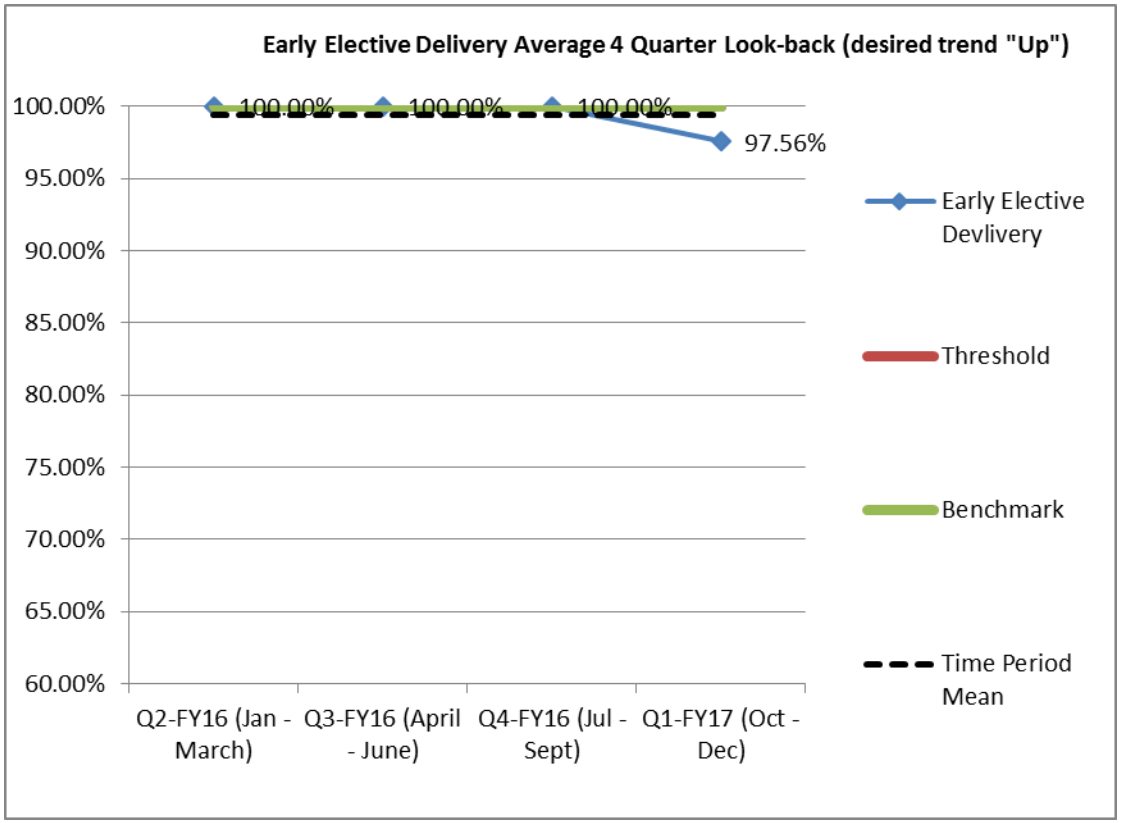
- Survey window currently open, anticipate the survey in late Fall
- Action Plans under development
  - As we move action items to **GREEN (completed)** focus on validating corrections
  - Team member awareness
  - Proper follow-up to pending corrections
  - Accountability, is your area / unit survey ready?

Core Measures

(Early Elective Delivery between 37 and 39 weeks)

Early Elective Delivery	
FY 2016 Final Score	**FY to date 2017 Score**
100%	*97.56%

*1 patient fallout



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Inpatient Mortality (AMI, PN, CHF only)

Mortality Measure Description	FY 2016	FY 2017 YTD (Oct - Dec)	FY16 Truven Mean (Nat'l)
Acute Myocardial Infarction	5.91%	3.45%	7.19%
Measure Failure Count	14	2	
Denominator Count	237	58	
Congestive Heart Failure	2.17%	3.61%	2.52%
Measure Failure Count	8	3	
Denominator Count	369	83	
Pneumonia **(New Population in FY17)**	0.71%	3.06%	5.32% (Based on new population)
Measure Failure Count	3	6	
Denominator Count	421	196	
New Pneumonia population (To include sepsis with secondary pneumonia)	3.07%	→	

Inpatient Mortality Rates (Sepsis DRGs 870 – 872)

Mortalities Description	FY 2016	FY 2017 (Oct - Dec)	FY16 Truven Mean
Septicemia or Severe Sepsis (870 DRG w/ Mechanical Vent 96+ hrs)	30.86%	41.67%	32.76%
Measure Failure Count	25	10	
Denominator Count	81	24	
Average Length of Stay	18.20	17.10	
Septicemia or Severe Sepsis (871 DRG w/out Mechanical Vent 96+ hrs w/ Major Comorbid Condition)	7.81%	4.95%	9.52%
Measure Failure Count	69	11	
Denominator Count	884	222	
Average Length of Stay	7.70	7.90	
Septicemia or Severe Sepsis (872 DRG w/out Mechanical Vent 96+ hrs w/out Major Comorbid Condition)	0.20%	0.00%	1.06%
Measure Failure Count	1	0	
Denominator Count	501	152	
Average Length of Stay	4.20	4.50	

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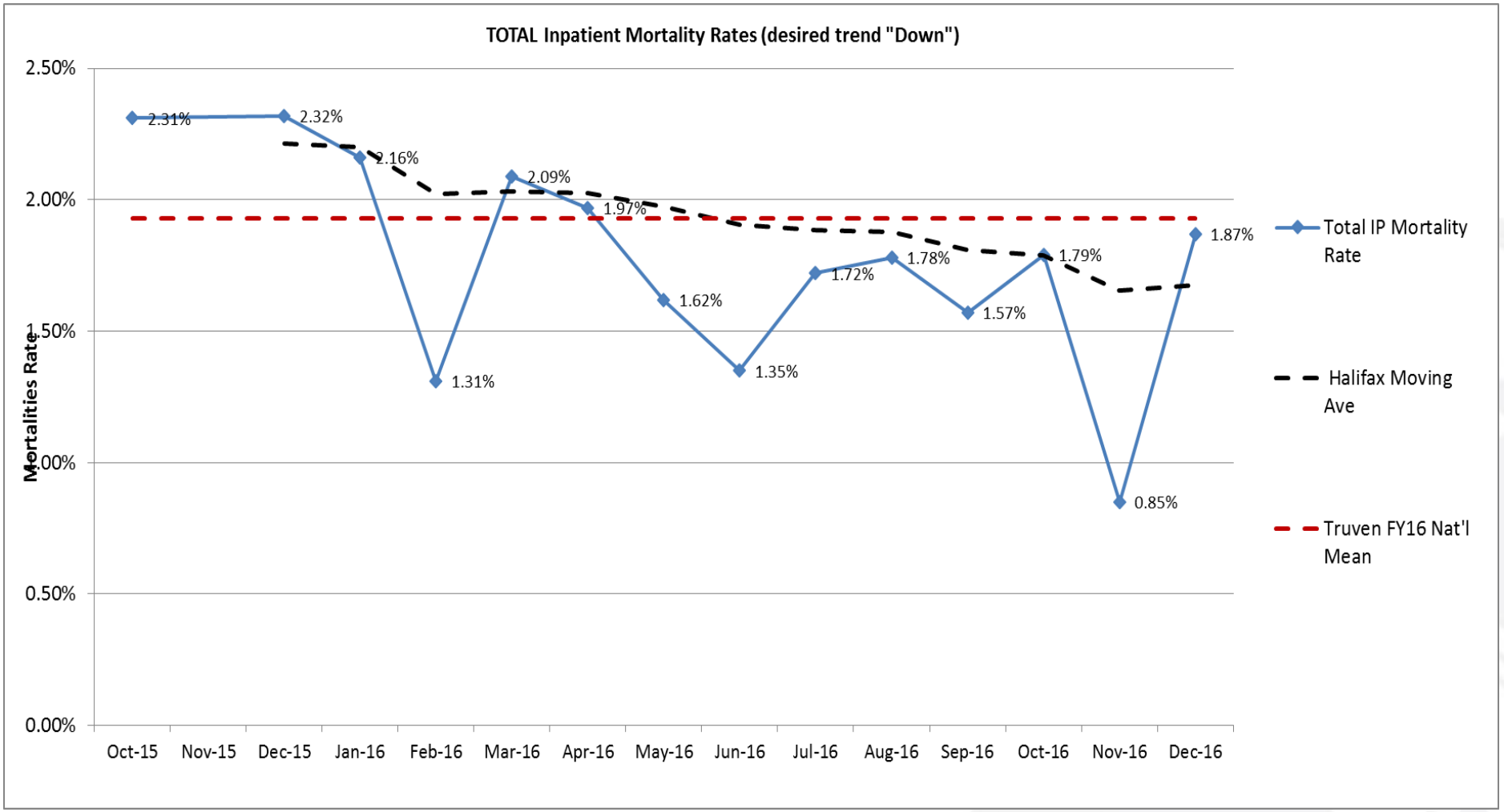
Quality Reports FY2017 – Q1

Inpatient Mortality Rates (All Mortalities)



Readmissions (AMI, PN, CHF, COPD, CABG, Stroke, Hip/Knee only)

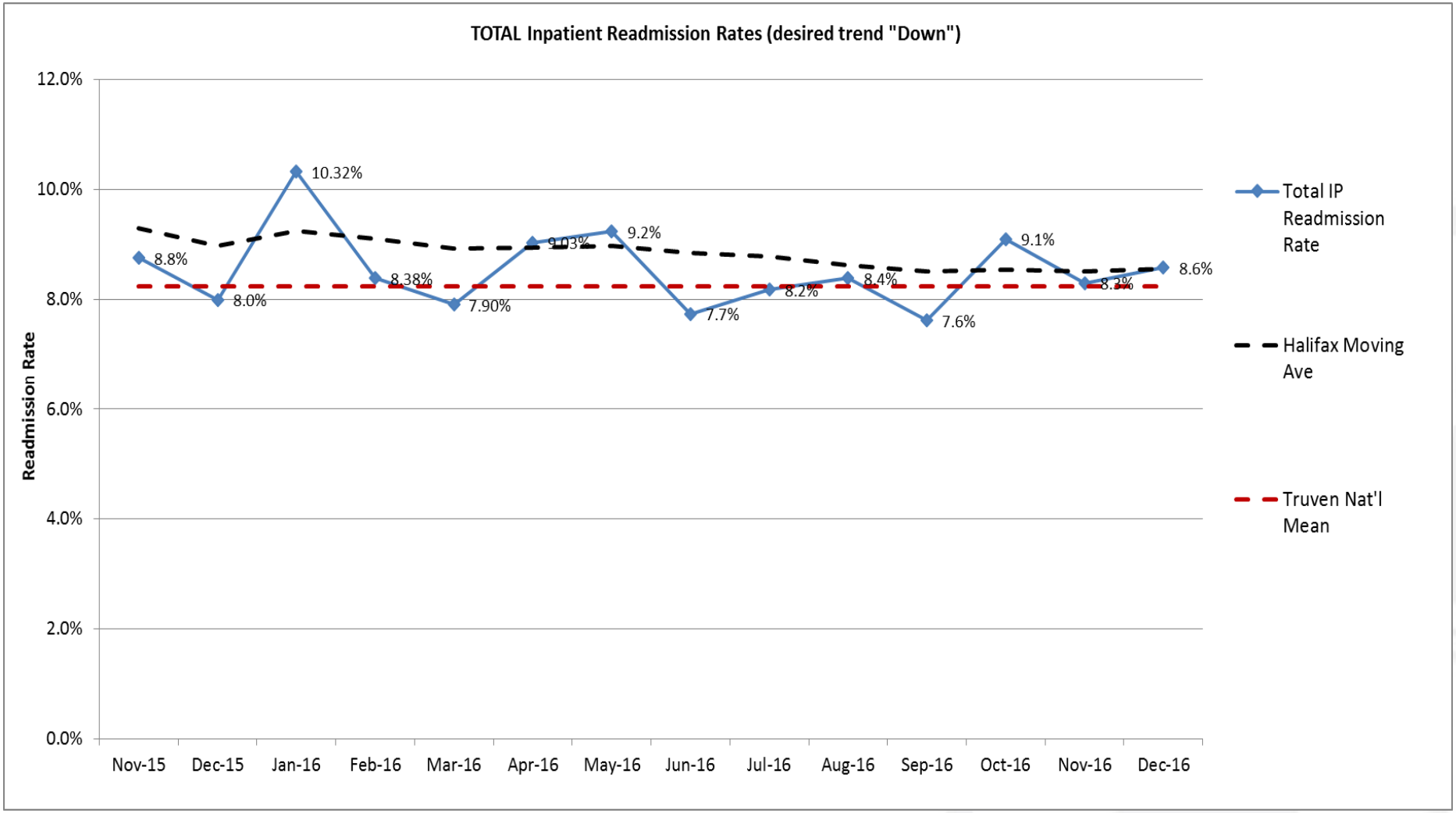
Readmission Measure Description	FY 2016	FY 2017 YTD (Oct - Dec)	FY2016 Truven Mean (Nat'l)
Acute Myocardial Infarction	9.55%	9.84%	10.86%
Measure Failure Count	21	6	
Denominator Count	220	61	
Congestive Heart Failure	15.07%	14.94%	16.19%
Measure Failure Count	55	13	
Denominator Count	365	87	
Pneumonia **(New Population in FY17)**	9.55%	12.62%	12.41%
Measure Failure Count	38	26	
Denominator Count	398	206	
Chronic Obstructive Pulmonary Disease	11.94%	9.41%	15.40%
Measure Failure Count	37	8	
Denominator Count	310	85	

FY16 = 12.40% (with new population)

Readmissions (AMI, PN, CHF, COPD, CABG, Stroke, Hip/Knee only)

Readmission Measure Description		FY 2016	FY 2017 YTD (Oct - Dec)	FY2016 Truven Mean (Nat'l)
Knee Arthroplasty		0.83%	0.93%	3.27%
	Measure Failure Count	4	1	
	Denominator Count	483	108	
Hip Arthroplasty		5.52%	6.77%	3.71%
	Measure Failure Count	26	9	
	Denominator Count	471	133	
CABG		9.30%	7.14%	8.71%
	Measure Failure Count	12	2	
	Denominator Count	129	28	
Stroke Readmissions		11.32%	9.35%	7.29%
	Measure Failure Count	43	10	
	Denominator Count	380	107	

Inpatient Readmission Rates (All Readmissions)



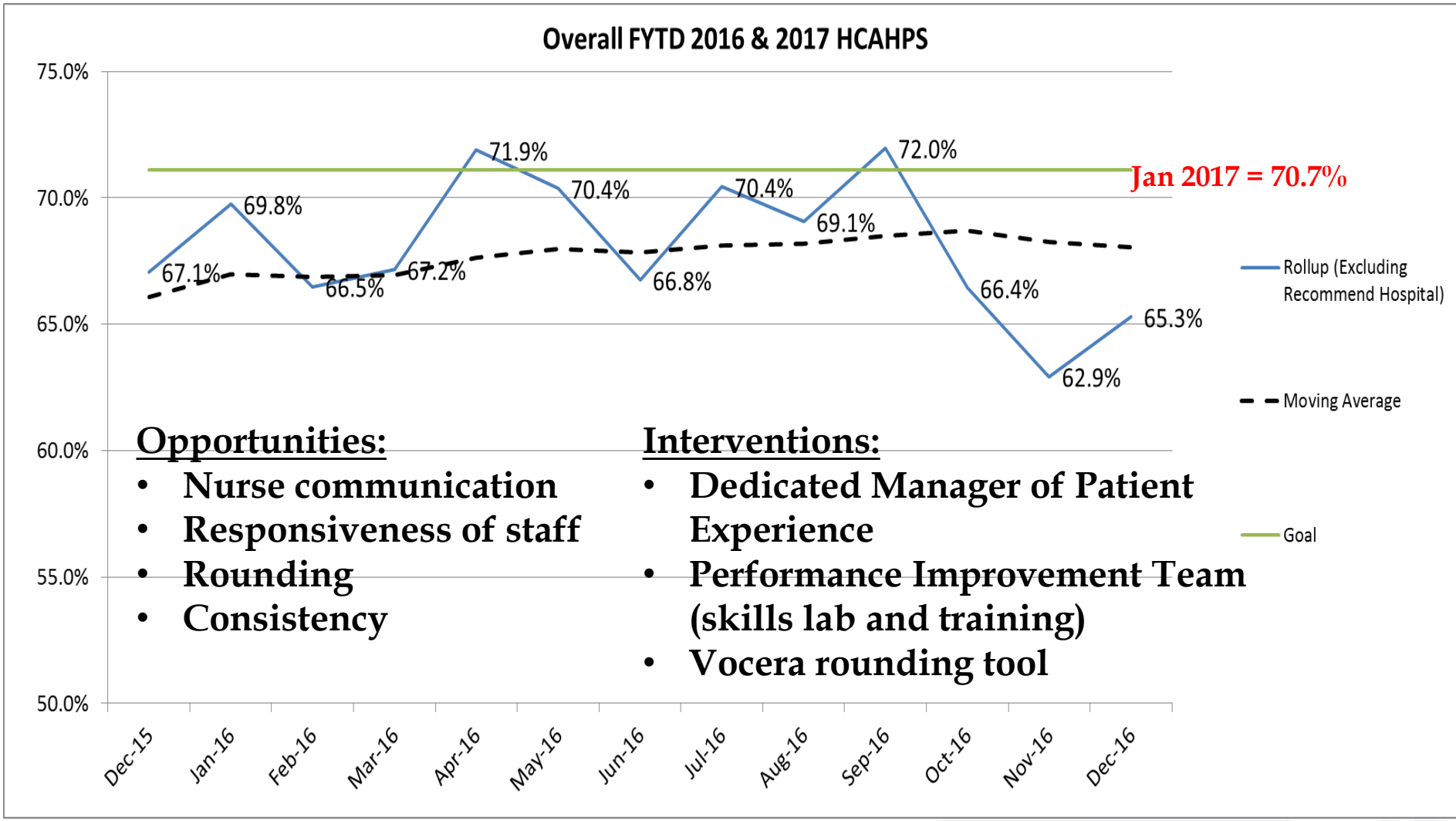
Catheter-Associated Urinary Tract Infections (CAUTI) (Standard Infection Ratio)

HAIs Measure Description *(SIR = observed infections / expected infections)*	FY 2016	FY 2017 YTD (Oct - Dec)	CMS VBP Benchmarks Threshold (Based on FY-2019 Indicators)	CMS VBP Benchmarks Benchmark (Based on FY-2019 Indicators)
CAUTI (ICUs Only) SIR	**0.95**	**0.34**	0.82	0.00
Observed number of CAUTIs	**36**	**3**		
Expected number of CAUTIs	**37.7**	**8.7**		
CAUTI (All Units) SIR	**0.82**	**0.52**	0.82	0.00
Observed number of CAUTIs	**49**	**8**		
Expected number of CAUTIs	**59.8**	**15.3**		

Central Line Associated Blood Stream Infections (CLABSI) (Standard Infection Ratio)

HAIs Measure Description *(SIR = observed infections / expected infections)*	FY 2016	FY 2017 YTD (Oct - Dec)	CMS VBP Benchmarks Threshold (Based on FY-2019 Indicators)	CMS VBP Benchmarks Benchmark (Based on FY-2019 Indicators)
CLABSI (ICUs Only) SIR	**0.60**	**0.91**	0.86	0.00
Observed number of CLABSIs	**14**	**4**		
Expected number of CLABSIs	**23.5**	**4.4**		
CLABSI (All Units) SIR	**0.72**	**1.64**	0.86	0.00
Observed number of CLABSIs	**24**	**11**		
Expected number of CLABSIs	**33.3**	**6.7**		

HCAHPS (Average Rollup Score)



Opportunities:

- **Nurse communication**
- **Responsiveness of staff**
- **Rounding**
- **Consistency**

Interventions:

- **Dedicated Manager of Patient Experience**
- **Performance Improvement Team (skills lab and training)**
- **Vocera rounding tool**

Questions?

HALIFAX HEALTH

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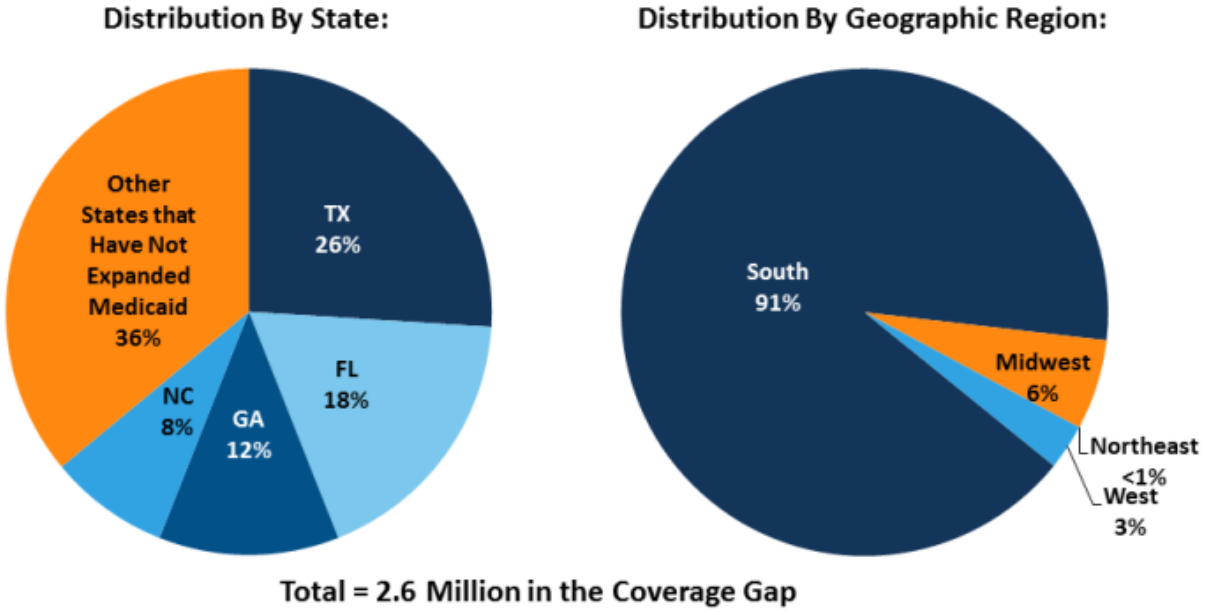
Uncompensated Care

Jeff Feasel
Chief Executive Officer

Adults- Ages 18-64 Uninsured

Figure 2

Distribution of Adults in the Coverage Gap, by State and Region



Note: Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.

Volusia County

- Population- 517,887
- 17.4% are below the Federal Poverty Level
- At or Below FPL- 90,112

https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

https://www.volusia.org/about-us/fast-facts.stml

Percent of Families Under FPL

- Halifax District- 40.0%
- Southeast Volusia- 15.4%
- West Volusia- 20.6%
- Volusia County- 17.4%

*Based on primary zip codes

http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#

Enrollment by Income

Exchange Enrollment							
Volusia County 2016							
Poverty Level	**Count**	**%**			**Plan Type**	**Count**	**%**
<100	957	2.4%			Platinum	1,032	2.6%
<138	15,782	39.2%			Gold	1,606	4.0%
<150	2,828	7.0%			Silver	30,069	74.7%
<200	8,734	21.7%			Bronze	7,101	17.6%
<250	4,770	11.8%			Catastrophic	454	1.1%
<300	2,554	6.3%					
<400	2,269	5.6%			**Total**	**40,262**	**100.0%**
>400	514	1.3%					
Unknown	1,854	4.6%					
Total	**40,262**	**100.0%**					
Note:							
94.1% of enrollees received a subsidy							
82.1% of enrollees received the cost sharing subsidy							

Healthcare Exchange Limitations

- Healthcare Exchange subsidies only apply to citizens with incomes between 100% to 400%
- Without Medicaid expansion, that leaves over 760,000 in Florida without coverage

Source: The Kaiser Commission on Medicaid and the Uninsured

Sliding Scale

% of FPL	The consumer contributes % of Income
Up to-133%	2%
133% to 150%	3%-4%
150% to 200%	4%-6.3%
200%-250%	6.3%-8.5%
250%-300%	8.05%-9.5%
300%-400%	9.5%

Cost Sharing Reduction (CSR)

- Incomes between 100% to 250% FPL reduces out of pocket expense, such as deductibles, co-pays, and co-insurance.
- If a low income customer buys a 70% AV plan, they get upgraded.

Cost Sharing Impact

	CSR 150% FPL	CSR 151% FPL to 200% FPL	CSR 201% FPL to 250% FPL	Standard Silver Plan
Portion of medical expenses typically paid by the health plan (i.e. actuarial value)	94%	87%	73%	70%
Portion of medical expenses paid for by typical enrollee	6%	13%	27%	30%
Limit on Annual Out-of-Pocket Costs	$2,250 individual / $4,500 family	$2,250 individual / $4,500 family	$5,200 individual / $10,400 family	$6,350 individual / $12,700 family

https://www.healthpocket.com/obamacare/cost-sharing-reduction-silver-plan

ACA Enrollment 2017

Exchange Product Membership Data by Plan					
1/31/2017					
State	**County**	**Plan Name**	**Contracted**	**Enrollment**	**Type**
FL	Volusia/Flagler	Florida Blue - Blue Care (Health Options) & (Network Blue)	YES	2,200	3
FL	Volusia	Humana, Inc. HUMX	YES	3,458	2
FL	Volusia	Florida Health Care Plans	YES	30,000	3
FL	Volusia	Sunshine Health Plan, Inc AMBETTER (Estimate)	YES	5,000	1
Key			**Total**	**40,658**	
Network	1- HMC only, 2- HMC & BFMC, 3- Halifax Health and Adventist Health				
NOTE:	Some plans final numbers are not in yet. Enrollment ended January 31, 2017.				
94% with Subsidy:	38,219				
82% with Cost Sharing:	33,340				

Uncompensated Care as a % of Gross Revenue

	National Average	Southern States	Halifax Health (FY16)
• Bad Debt	3%	4.4%	4.9%
• Charity Care	3.1%	3%	6.3%
• Total	6.1%	7.4%	11.2%

Average for profit- <3%

Uncompensated Care as a % of Total Expense

- NAPH Data National Average- 5.5%
- Urban Governmental- 15.7%
- NAPH Members- 21.0%
- Halifax Health- 36.04%

(NAPH- National Association of Public Hospitals and Health Systems)

Uncompensated Care

- Uncompensated Care in FY 2016 was $172.9 million in charges.

	FY 2016	%
• Inpatient	$83,571,836	48.3%
• Emergency Room	$65,188,787	37.7%
• Observation Patients	$14,100,784	8.2%
• Same Day Surgery	$4,620,466	2.7%
• Other Outpatient	$5,484,422	3.2%

By Patient Residence

Halifax District	FY 2016	%
Daytona Beach	62,398,535	36.1%
Holly Hill	19,068,065	11.0%
Ormond Beach	13,991,042	8.1%
Port Orange / SD	41,247,213	23.8%
Halifax Total	**136,704,855**	**79.0%**

	FY 2016	%
SE Volusia Tax District	7,058,196	4.1%

West Volusia Tax District	FY 2016	%
DeLand	3,361,419	1.9%
SW Volusia	1,631,132	0.9%
NW Volusia	2,075,826	1.2%
West Volusia Total	**7,068,377**	**4.1%**

By Patient Residence

	FY 2016	%
Flagler County	5,174,071	3.0%
Non Volusia / Flagler	16,960,795	9.8%
Grand Total	**172,966,294**	
Non-Halifax District Total	*36,261,438*	21.0%

Halifax

	Halifax	%
Inpatient	64,154,122	46.9%
Emergency Room	52,838,448	38.7%
Observation	11,452,300	8.4%
Same Day Surgery	3,490,109	2.6%
Other Outpatients	4,769,876	3.5%
Total	**136,704,855**	

SE Volusia

	SE Volusia	%
Inpatient	3,172,460	44.9%
Emergency Room	2,890,400	41.0%
Observation	563,967	8.0%
Same Day Surgery	202,237	2.9%
Other Outpatients	229,131	3.2%
Total	**7,058,196**	

West Volusia

	West Volusia	%
Inpatient	3,616,630	51.2%
Emergency Room	2,268,835	32.1%
Observation	472,521	6.7%
Same Day Surgery	430,476	6.1%
Other Outpatients	279,916	4.0%
Total	**7,068,378**	

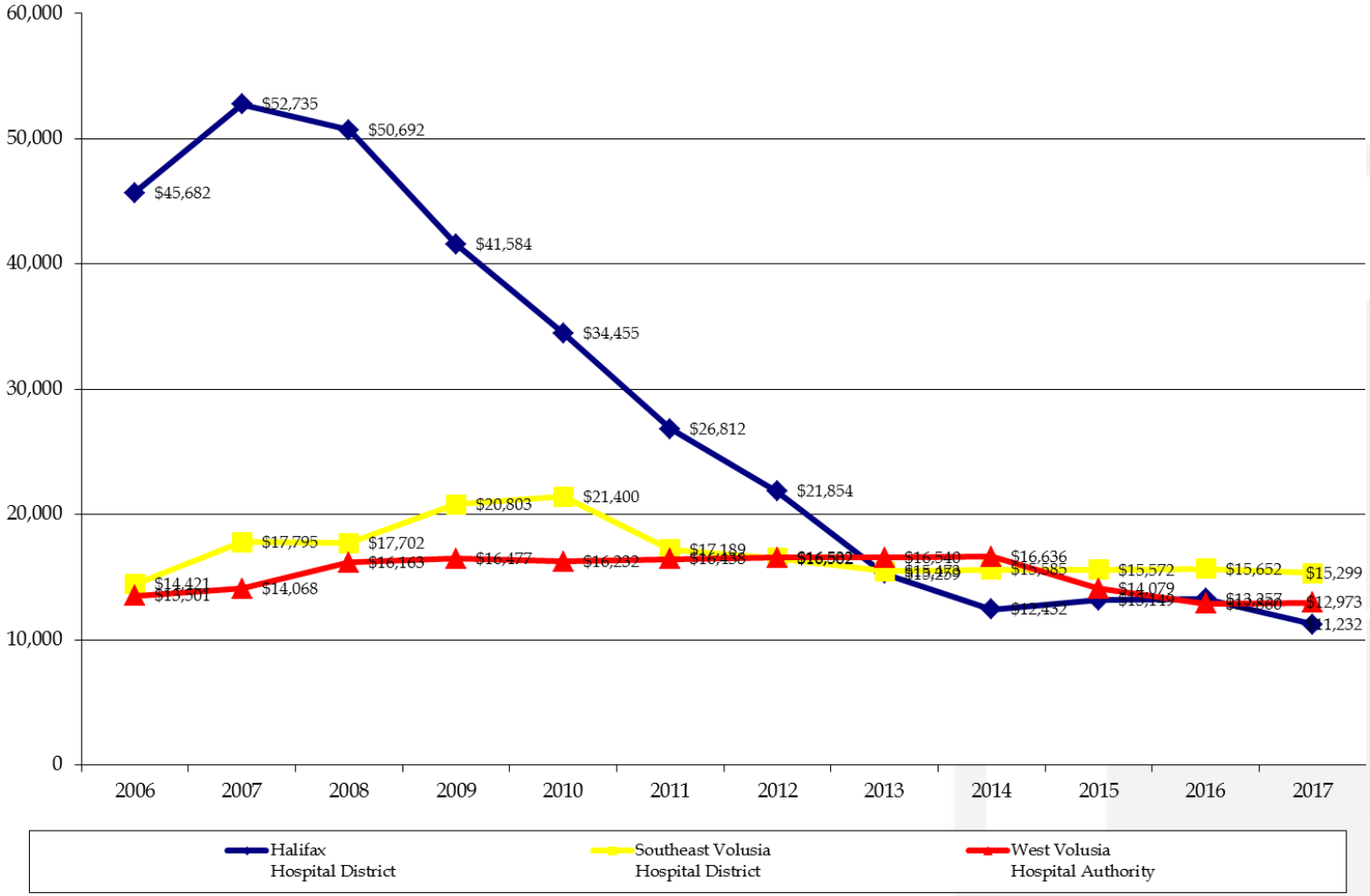
Flagler

	Flagler	%
Inpatient	3,049,686	58.9%
Emergency Room	1,431,109	27.7%
Observation	349,287	6.8%
Same Day Surgery	268,222	5.2%
Other Outpatients	75,767	1.5%
Total	**5,174,071**	

Outside Volusia/Flagler

	O/S Vol/Flag	%
Inpatient	9,578,938	56.5%
Emergency Room	5,759,995	34.0%
Observation	1,262,708	7.4%
Same Day Surgery	229,421	1.4%
Other Outpatients	129,732	0.8%
Total	**16,960,795**	

Volusia County Hospital Taxing Districts- Tax Revenue



Volusia County Hospital Taxing Districts- Tax Millage