

AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, April 7, 2021 – 5:30pm

El Camino Hospital 2500 Grant Road Mountain View, CA 94040

PERKINS ACT OF CALIFORNIA EXECUTIVE ORDER 02920 DATED ARCH 1, 2020, EL CAMINO HEALTH WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING. LEAD, THE PUBLIC COMMENT PERIOD OF THE OPEN MEETING AREA RECONFERENCE A:

1-669-900-9128, MEETING CODE: 603-158-1129#. No participant code. Just press #.

To watch the meeting livestream, please visit: www.elcaminohealth.org/about-us/leadership/board-meeting-stream
 Please note that the livestream is for **meeting viewing only** and there is a slight delay to provide public comment, please use the phone number listed above.

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

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1. CALL TO ORDER/ROLL CALL	Janhee Chen, Board Chair		5:30 – 5:31pm
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Janhee Chen, Board Chair		information 5:31 – 5:32
3. PUBLIC COMMUNICATION a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.</i> Written Correspondence	Janhee Chen, Board Chair		information 5:32 -5:35
4. RESOLUTION 2021-03: BOARD RECOGNITION ATTACHMENT 4	Jim Griffith, COO		motion 5:35 – 5:40
5. QUALITY COMMITTEE REPORT ATTACHMENT 5	Julie Liger, Quality Committee Chair Barbara Adams, MD, CEO		discussion 5:40 – 5:55
6. FY21 PERIOD 8 FINANCIALS ATTACHMENT 6	Carlos Bohorquez, CFO		motion 5:55 – 6:10
7. GOVERNANCE COMMITTEE REPORT a. Proposed Resolution 2021-04: Proposed Temporary Suspension of El Camino Hospital Bylaws Article Section 3 b. Proposed Revised Board Officer Nomination and Election Procedures	Peter Fung, Board Member		possible motion 6:10 – 6:40
8. ADJOURN TO CLOSED SESSION	Janhee Chen, Board Chair	<i>public comment</i>	motion required 6:40 – 6:41
9. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Janhee Chen, Board Chair		information 6:41 – 6:42
10. CONSENT CALENDAR <i>Any Board Member may remove an item for discussion before a motion is made.</i> Approval <i>Gov't Code Section 54957.2:</i>	Janhee Chen, Board Chair		motion required 6:42 – 6:44

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
<p>a. Minutes of the Closed Session of the Hospital Board Meeting 3/10/2021</p> <p>Executive Compensation Committee Closed Session Minutes 11/5/2020</p> <p>Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee</p> <p>Health & Safety Code Section 32155 for a report of the Medical Staff Deliberations concerning reports on Medical Staff Quality Assurance matters:</p> <p>c. Quality Committee Report</p> <p>i. Medical Staff Credentials and Privileges Report</p> <p>ii. Quality Council Minutes</p> <p>Information</p> <p>Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation</p> <p>d. Annual Summary of Physician Financial Arrangements</p>			
<p>11. Health and Safety Code Section 32106(b) for a report and discussion involving health care facility trade secrets:</p> <p>- Medical Staff Report</p>	<p>Apurva Arfatia, MD Michael Chan, MD</p>		<p>discussion 6:44 – 6:54</p>
<p>12. Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation Gov't Code Section 54957 and 54957.6 for discussion and report on personnel matters:</p> <p>- CEO Report on Legal Update and Personnel Matters</p>	<p>Dan Woods, CEO</p>		<p>discussion 6:54 – 7:04</p>
<p>13. Report involving Gov't Code Section 54957 for discussion and report on personnel performance matters – Senior Management:</p> <p>- Executive Session</p>	<p>Manhee Chen, Board Chair</p>		<p>discussion 7:04 – 7:14</p>
<p>14. ADJOURN TO OPEN SESSION</p>	<p>Manhee Chen, Board Chair</p>		<p>motion required 7:14 – 7:15</p>
<p>15. RECONVENE OPEN SESSION/ REPORT OUT</p> <p>To report any required disclosures regarding permissible actions taken during Closed Session.</p>	<p>Manhee Chen, Board Chair</p>		<p>information 7:15 – 7:16</p>
<p>16. CONSENT CALENDAR ITEMS: Any Board Member or member of the public may remove an item for discussion before a motion is made.</p>	<p>Manhee Chen, Board Chair</p>	<p>public comment</p>	<p>motion required 7:16 – 7:19</p>
<p>Approval</p> <p>a. Minutes of the Open Session of the Hospital Board Meeting 3/10/2021</p> <p>Revised FY21 Advisory Committee Assignments</p> <p>Reviewed and Recommended for Approval by the Executive Compensation Committee</p>			

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
<p>c. Letters of Reasonableness</p> <p>d. Executive Compensation Open Session Meeting Minutes 1/5/2020</p> <p><i>Reviewed and Recommended for Approval by the Finance Committee</i></p> <p>e. F21 Period 7 Financials</p> <p>f. Prology Call Panel</p> <p><i>Reviewed and Recommended for Approval by the Medical Executive Committee</i></p> <p>g. Medical Staff Report</p>			
<p><i>Information</i></p> <p>h. Finance Committee Approvals Acute Reha Professional Services Agreement and Community Benefit Grant</p>			
<p>17. CEO REPORT ATTACHMENT 17</p>	Dan Woods, CEO		information 7:19 – 7:29
<p>18. BOARD COMMENTS</p>	Manhee Chen, Board Chair		information 7:29 – 7:34
<p>19. ADJOURNMENT</p>	Manhee Chen, Board Chair	<i>public comment</i>	motion required 7:34 – 7:35 pm

Upcoming Regular Meetings: May 12, 2021 May 24, 2021 Joint with Finance Committee June 9, 2021

El Camino Hospital Board

RESOLUTION 2021 - 03

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE AND SUPPORT

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

WHEREAS, the Board wishes to honor and recognize the COVID-19 vaccination program team for their dedication, ingenuity and herculean efforts to immunize our community, which will bring an eventual end to the pandemic.

The pandemic has been a part of our daily lives for more than one year. In December 2020, the first vaccines received emergency authorization and health care providers were tasked with vaccinating the communities they serve. As a result, El Camino Health employees worked quickly to design and implement a vaccination site that provides vaccines six days per week. Vaccinators, which include nurses, physicians and other caregivers, many of whom have come out of retirement, administer nearly 100 first and second dose vaccines daily to members of our community at El Camino Health's First Street Clinic. In March, El Camino Health secured a larger community vaccination site capable of administering up to 3000 vaccines daily, a tenfold increase from the original clinic. Once fully operational, the site will help speed our population toward herd immunity. In addition to configuring and operationalizing the vaccine sites, our IT systems had to be integrated with California's vaccine website along with creating online appointments and a unique automated standby appointment system. Staff continues to work diligently to advocate through multiple county, state and federal channels for enough vaccine supply to enable the continued expansion of these vital vaccine efforts. El Camino Health's COVID-19 vaccination program is truly a team effort and has been made possible thanks to the tireless efforts of countless staff from several departments including: Corporate Compliance, Environmental Services, Facilities, Governance Services, Government Relations, Human Resources, IT, Legal Services, Marketing and Communications, Nursing, Operations, Pharmacy, Quality, Registration, Revenue Cycle, Risk Management, Security, Supply Chain and the staff of El Camino Health Medical Network. Vaccines are the pathway out of the pandemic and El Camino Health's COVID-19 vaccination program team is paving this path for our communities.

WHEREAS, the Board would like to acknowledge El Camino Health's COVID-19 vaccination program team for their commitment to creating community access to convenient vaccination centers, so that El Camino Health's patients, families and community members can soon resume a way of life that existed prior to the pandemic.

NOT THEREFORE BE IT RESOLVED that the Board does formally and unanimously pay tribute to:

The COVID-19 Vaccination Program Team

FOR THEIR UNWAVERING COMMITMENT AND DEDICATION TO OUR COMMUNITY IN PROVIDING SAFE
AND CONVENIENT LOCATIONS FOR COVID-19 VACCINATIONS.

IN WITNESS THEREOF, I have here unto set my hand this 15TH DAY OF APRIL 2021.

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee J. Chen, JD, PhD

Julia E. Miller

Carol A. Somersille, MD, FACOG

John L. Zoglin

Peter C. Fung, MD, MS, FACP, FAAN, FAHA

Jack Po, MD

George O. Ting, MD

Julie Eliger, MPA, BSN, RN

Bob Rebitzer

Don Watters

Julia E. Miller

Secretary/Treasurer,

El Camino Hospital Board of Directors



This document will not be available until April 6th or 7th and will not be included in the Board packet. Instead, it will be e-mailed to the Board members as soon as available.



El Camino Health

Summary of Financial Operations

*Fiscal Year 2021 – Period 8
7/1/2020 to 02/28/2021*

Operational Financial Results: Period – February as of

PERIOD - RESULTS

(\$ thousands)		PERIOD - RESULTS				Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians		Performance to 'A' Medians
		Current Year	Budget	Variance to Budget	Performance to Budget				'A'	'Aa'	
Activity Volume	ADC	22	23	(1)	-3.3	2	(31)	-11.0	---	---	---
	Total Discharges	1,00	1,40	(13)	-13	1,04	(1)	-10.0	---	---	---
	Adjusted Discharges	2,13	2,00	(44)	-1.0	3,00	(34)	-11.3	---	---	---
	Emergency Room	3,03	3,00	(24)	-4	0,30	(1,4)	-31.0	---	---	---
	OP Procedural Cases	13,213	0,00	14	3.0	0,03	3,4	3.0	---	---	---
	Gross Charges	314,20	24,12	20,4	0	32,032	(11,312)	-3.0	---	---	---
Operations	Total FTEs	2,00	2,00	2	2.0	2,04	(2)	-0.0	---	---	---
	Productive Hrs. / APD	33.0	31.2	2.4	0.0	2.0	3.0	13.2	---	---	---
	Cost Per Adjusted Discharge	1,02	1,14	31	2.2	1,000	1,41	10.3	---	---	---
	Net Days in A/R	1.3	4.0	2.3	4.0	2.0	(0.0)	-1.3	4.0	4.1	
Financial Performance	Net Patient Revenue	0,23	4,02	10,01	14.2	0,443	(1,10)	-1.4	10,023	2,000	
	Total Operating Revenue	0,20	0,00	0,00	12.1	1,12	(2,4)	-2.0	11,04	314,40	
	Operating Income	3,200	243	3,042	122.4	0,003	(4,400)	-0.0	3,40	10,130	
	Operating EBITDA	0,000	0,000	0,000	0.4	0,000	0,000	-24.0	0,000	0,000	
	Net Income	1,033	1,000	1,000	0.4	(20,41)	3,24	-10.4	0,210	1,020	
	Operating Margin	3.0	0.3	3.4	110.3	0.0	-4.0	-0.0	2.0	3.0	
	Operating EBITDA	0,000	0,000	0,000	3.0	0,000	-0,000	-22.4	0,000	0,000	
	DCOH (days)	0.2	43	11	2.0	4.2	100	22.1	2.4	2.4	

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

Operational Financial Results: YTD FY as of

YTD FY - RESULTS

(\$ thousands)

	Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year
Activity Volume	ADC	242	203	40	100	100	100
	Total Discharges	14,000	13,040	1,130	102	102	102
	Adjusted Discharges	22,003	20,000	2,200	111	111	111
	Emergency Room	32,044	20,100	4,400	100	100	100
	OP Procedural Cases	103,000	02,000	41,001	03	03	03
	Gross Charges (\$)	2,000,101	2,100,003	000,210	204	204	204
Operations	Total FTEs	2,011	2,030	(20)	00	00	00
	Productive Hrs. / APD	31.4	34.4	(3.0)	00	00	00
	Cost Per Adjusted Discharge	10,200	10,034	(1,230)	00	00	00
	Net Days in A/R	1.3	4.0	2.3	40	40	40
Financial Performance	Net Patient Revenue (\$)	00,000	00,003	13,200	240	240	240
	Total Operating Revenue (\$)	03,100	00,000	131,100	210	210	210
	Operating Income (\$)	30,100	(32,120)	01,234	2210	2210	2210
	Operating EBITDA (\$)	00,000	00,000	00,000	3430	3430	3430
	Net Income (\$)	100,122	(0,000)	20,000	2000	2000	2000
	Operating Margin (%)	0.3	-0.3	10.00	200.10	200.10	200.10
	Operating EBITDA (%)	0.0	0.0	0.0	200.0	200.0	200.0
	DCOH (days)	02	43	11	200	200	200

Moody's Medians		Performance to 'A' Medians
'A'	'Aa'	
---	---	---
---	---	---
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---	---	---
---	---	---
400	401	---
03,000	2,000,000	---
034,012	2,010,100	---
31,000	01,000	---
00,000	000,000	---
00,040	14,000	---
2.00	3.00	---
0.00	0.00	---
204	204	---

Moody's Medians: Not-for-profit and public healthcare annual report September 0, 2020. Dollar amounts have been adjusted to reflect 0 month totals.

Financial Overview: Period □ - February □□□□

Period ending □□□□□□□□

Financial Performance

- February operating income was □3.2M compared to a budgeted □243□, resulting in a favorable variance of □1M. The primary drivers are favorable outpatient activity and payer mix.
- February volumes were challenged, but revenues continue to be stronger than budget as demonstrated by:
 - IP discharges were unfavorable to budget by □0 cases / 4□ and 1□□ cases / 11.1□ lower than the same period last year while Adjusted Discharges (OP impact included) were unfavorable to budget by 44 cases / 1.□□ and 34□ cases / 11.3□ lower than same period last year
 - Favorable variance gross charges of □21.3M due primarily to inpatient services:
 - Inpatient gross charges: Favorable to budget by □14M / 11□ variance primarily driven by c
 - Cath lab, Operating Room, and Laboratory Services
 - Operating Expenses were unfavorable to budget by □□.□M / □.3□, primarily due to patient activity, increased use / cost of PPE associated with Covid-1□ and other Covid-1□ associated expenses
 - SWB were unfavorable by □□.2M / 12□
 - Supplies were unfavorable by □1.□M / 22□
 - All other discretionary non-volume driven expenses were favorable to budget by □400□
 - Additional expenses attributed to Covid-1□ have been □1.2M per month for the first eight months of FY2021
- Non Operating Income includes:
 - Favorable variance of □12.□M primarily due to unrealized gains on investments

Financial Overview: Period □ – February □□□□ cont. □

Period ending □□□□□□□□

Financial Performance

Hospital Operations:

- Adjusted Discharges (AD): Unfavorable to budget by 44 ADs / 1.□□ and below prior year by 34□ ADs / 11□ :
 - Mountain View: Unfavorable to budget by □□ ADs / 4.□□ and below prior year by 3□□ ADs/ 14.□□
 - Los Gatos: Favorable to budget by □□ ADs / 10□ and above than prior year by □ ADs / 1□
- Operating Expense Per CMI Adjusted Discharge: □1 □, □2□ which is 2.2□ unfavorable to budget

Note: Excludes depreciation and interest

El Camino Health Medical Network □ECHMN□Operations:

- February's total visits of 26,454 was 16% above prior month and 25.2% favorable to budget and included □,□□2 COVID vaccination visits
- Net Income was unfavorable to budget by □□□0□ in February, but was □□□1□ favorable to February of 2020
- YTD February ECHMN Net Income is slightly unfavorable to budget by □□00□ / 3.4□ , but remains favorable to prior year by □2.1M / □.1□

Financial Overview: YTD FY2021 as of 12/31/2021

Consolidated Financial Performance

- YTD FY2021 net operating margin of \$32.1M compared to the budget of -\$32.1M
- Year-over-year operating margin is \$22.3M lower than the same period last year, which is primarily due to an increase in depreciation and interest of \$12.1M expenses associated with recently completed capital projects at the Mountain View campus
- Strong volume recovery from the first wave of Covid-19, continues to be the primary driver of favorable performance to budget
 - Adjusted discharges are 2,200/110 favorable to budget and 2,000/ 10.10 lower than the same period last year
- Operating expenses are \$104.4M / 0.40 unfavorable to budget
 - Unfavorability driven higher than budgeted volumes and expenses associated with Covid-19 pandemic
 - Operating expense per CMI adjusted discharge of \$1,200 is 00 favorable to budget which demonstrates consistent management of variable expenses

Note: Excludes depreciation and interest expense

Consolidated Statement of Operations (\$000s)

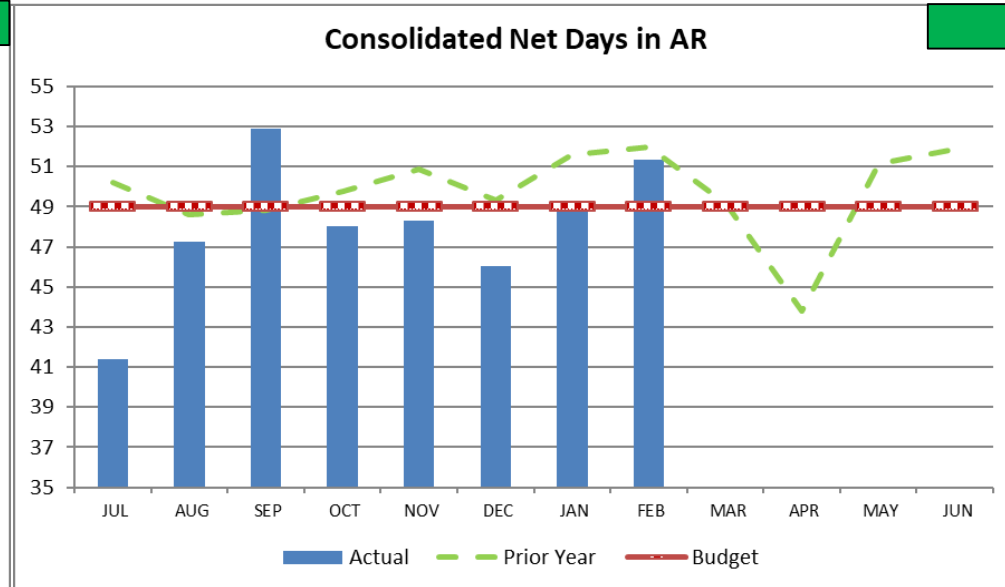
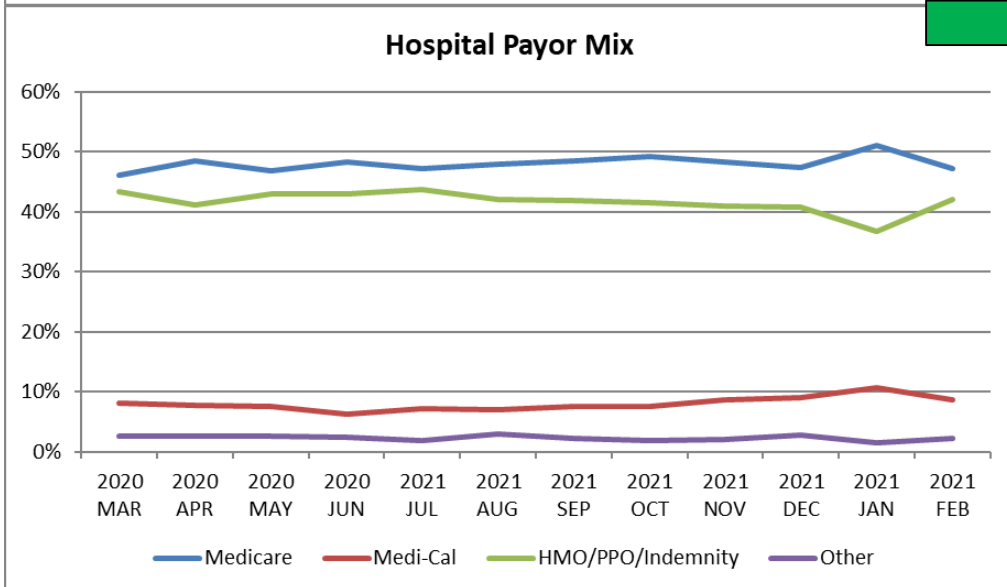
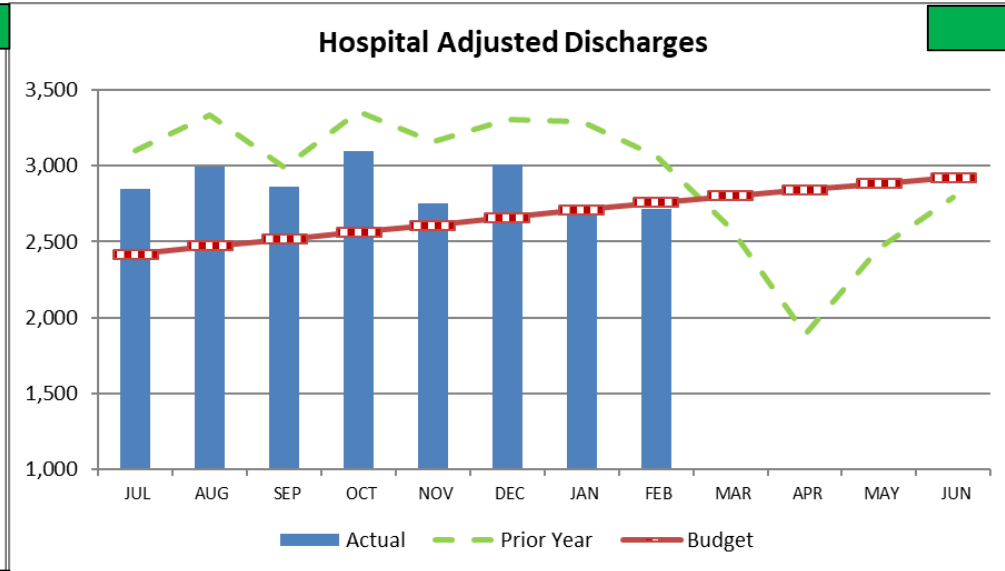
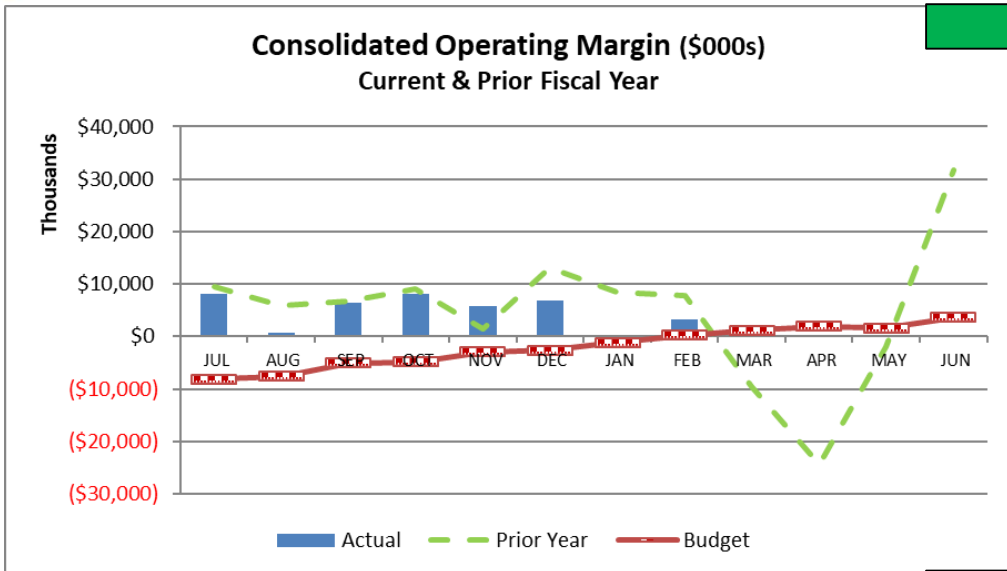
Period ending □□□□□□□□

Period 8 FY 2020	Period 8 FY 2021	Period 8 Budget 2021	Variance Fav (Unfav)	Var%	\$000s	YTD FY 2020	YTD FY 2021	YTD Budget 2021	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
325,932	314,620	294,152	20,468	7.0%	Gross Revenue	2,603,852	2,756,191	2,197,973	558,217	25.4%
(239,489)	(229,347)	(219,450)	(9,897)	(4.5%)	Deductions	(1,919,864)	(2,048,133)	(1,627,171)	(420,963)	(25.9%)
86,443	85,273	74,702	10,571	14.2%	Net Patient Revenue	683,988	708,057	570,803	137,255	24.0%
4,729	3,352	4,348	(996)	(22.9%)	Other Operating Revenue	36,843	31,110	37,196	(6,086)	(16.4%)
91,172	88,625	79,050	9,575	12.1%	Total Operating Revenue	720,831	739,167	607,998	131,169	21.6%
					OPERATING EXPENSE					
46,497	48,592	43,397	(5,195)	(12.0%)	Salaries & Wages	369,822	389,591	353,670	(35,921)	(10.2%)
12,903	13,587	11,392	(2,195)	(19.3%)	Supplies	106,240	111,641	88,249	(23,392)	(26.5%)
14,080	14,770	13,927	(843)	(6.1%)	Fees & Purchased Services	113,084	114,109	115,015	907	0.8%
3,669	1,097	3,571	2,474	69.3%	Other Operating Expense	30,090	27,926	29,451	1,526	5.2%
1,458	1,392	916	(477)	(52.1%)	Interest	4,227	11,392	7,396	(3,997)	(54.0%)
4,781	5,903	5,605	(298)	(5.3%)	Depreciation	35,928	45,402	46,345	943	2.0%
83,388	85,341	78,807	(6,534)	(8.3%)	Total Operating Expense	659,391	700,060	640,126	(59,934)	(9.4%)
7,783	3,285	243	3,042	1252.4%	Net Operating Margin	61,440	39,107	(32,128)	71,234	(221.7%)
(28,424)	14,349	1,512	12,836	848.7%	Non Operating Income	24,461	156,016	22,170	133,845	603.7%
(20,641)	17,633	1,755	15,878	904.6%	Net Margin	85,901	195,122	(9,957)	205,080	(2059.6%)
14,023	10,580	6,763	3,817	56.4%	Operating EBIDA	101,595	95,900	21,613	74,288	343.7%
					Operating EBIDA Margin	14.1%	13.0%	3.6%	9.4%	
					Operating Margin	8.5%	5.3%	-5.3%	10.6%	
					Net Margin	11.9%	26.4%	-1.6%	28.0%	



APPENDI □

YTD FY Financial PIs – Monthly Trends



Investment Scorecard as of □□□□□□□□□□

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY21 Budget	Expectation Per Asset Allocation
Investment Performance		CY 4Q 2020 / FY 2Q 2021		Fiscal Year-to-Date 2021		8y 2m Since Inception (annualized)		FY 2021	2019
Surplus cash balance*		\$1,302.1	--	--	--	--	--	--	--
Surplus cash return		8.5%	8.0%	13.0%	12.2%	6.6%	6.4%	4.0%	5.6%
Cash balance plan balance (millions)		\$336.2	--	--	--	--	--	--	--
Cash balance plan return		11.2%	9.2%	17.1%	14.3%	8.9%	7.9%	6.0%	6.0%
403(b) plan balance (millions)**		\$581.5	--	--	--	--	--	--	--
Risk vs. Return		3-year			8y 2m Since Inception (annualized)			2019	
Surplus cash Sharpe ratio		0.69	0.67	--	--	0.93	0.93	--	0.34
Net of fee return		7.8%	7.3%	--	--	6.6%	6.4%	--	5.6%
Standard deviation		9.0%	8.6%	--	--	6.3%	6.1%	--	8.7%
Cash balance Sharpe ratio		0.73	0.64	--	--	1.00	0.96	--	0.32
Net of fee return		9.8%	8.0%	--	--	8.9%	7.9%	--	6.0%
Standard deviation		11.4%	10.3%	--	--	8.1%	7.4%	--	10.3%
Asset Allocation		CY 4Q 2020 / FY 2Q 2021							
Surplus cash absolute variances to target		9.4%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Cash balance absolute variances to target		7.9%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Manager Compliance		CY 4Q 2020 / FY 2Q 2021							
Surplus cash manager flags		16	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		19	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~\$12 mm), District assets (~\$34 mm), and balance sheet cash not in investable portfolio (\$214 mm). Includes Foundation (~\$39 mm) and Concern (~\$15 mm) assets.

**As of September 30, 2020 as more recent data not yet available.

YTD FY□□□□ and □anuary Operating Margin, Non-Operating Income and Net Margin by Affiliate □as of □□□□□□□□□□

(\$ in thousands)

	Period 8- Month			Period 8- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	443	678	(235)	41,383	(18,135)	59,518
Los Gatos	5,777	2,006	3,771	23,341	11,571	11,770
Sub Total - El Camino Hospital, excl. Affilates	6,220	2,685	3,536	64,724	(6,565)	71,289
Operating Margin %	7.5%	3.7%		9.2%	-1.2%	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	13,099	1,207	11,892	150,506	19,744	130,762
El Camino Hospital Net Margin	19,319	3,892	15,427	215,230	13,180	202,051
ECH Net Margin %	23.2%	5.3%		30.7%	2.3%	
Concern	21	54	(32)	288	248	40
ECSC	0	0	0	(3)	0	(3)
Foundation	1,276	33	1,243	3,795	3	3,792
El Camino Health Medical Network	(2,983)	(2,223)	(760)	(24,188)	(23,388)	(800)
Net Margin Hospital Affiliates	(1,686)	(2,137)	451	(20,108)	(23,137)	3,029
Total Net Margin Hospital & Affiliates	17,633	1,755	15,878	195,122	(9,957)	205,080

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO**

To: El Camino Hospital Board of Directors
From: Peter Fung, M.D., Governance Committee Chair
Date: April 7, 2021
Subject: Resolution 2021-04: Suspending Section 13 of the Hospital Bylaws

Recommendation:

The Governance Committee recommends the Hospital Board approve Resolution 2021-04 suspending Section 13 of the Hospital Bylaws thereby allowing the current Hospital Board Chair to serve as Chairperson for an additional one year past the two-term limit, which expires June 30, 2021. This action will facilitate continuity of Board leadership during the COVID-19 pandemic, implementation of Hospital's updated strategic plan and Board Chair succession planning. The Committee further recommended that the Vice Chair shall be the presumptive Chairperson at the end of the current Chairperson's extended term on June 30, 2022.

Summary:

1. **Situation:** The current Hospital Board Chair has served as Chairperson for two terms and his second two-year term is expiring on June 30, 2021. To preserve continuity in Board leadership for the Hospital, it is in the best interests of the organization to have the current Board Chair serve an additional one year term to ensure continuity during COVID-19 pandemic, oversee implementation of the updated strategic plan and development of a Board Chair succession plan.
2. **Authority:** Section 13 of the Hospital Bylaws states that a Director may not serve more than two consecutive terms as Chairperson. Section 1-11 of the Bylaws provides that the Bylaws may be adopted, repealed, amended or restated upon a majority vote of Directors and approval of the District.
3. **Background:** Hospital Bylaws Sections 13 and 1-11 are set forth below for your reference:
 - 13 Term of Board Officers.** Each officer shall hold office for a two (2)-year term or until his or her successor is elected and qualified, subject to any employment agreement provided that a Director may not serve more than two (2)-consecutive terms as Chairperson.
 - 1-11 Amendments.** The Articles or these Bylaws may be adopted, repealed, amended or restated or new Articles or Bylaws may be adopted upon a majority vote of the authorized number of Directors including vacancies and Directors with a conflict of interest. No such adoption, repeal, amendment, restatement or new Articles or Bylaws shall be effective until approved by the member. Moreover, the Articles and Bylaws may be adopted, repealed, amended or restated or new Bylaws adopted upon the vote of the member.
4. **Assessment:** Rather than a permanent amendment to the Bylaws, the Board can pass a resolution to temporarily suspend Section 13 of the Bylaws and extend the term of the current Board Chair for an additional one year. This action requires a majority vote of Hospital Directors and approval by the District Board.

5. Outside Counsel Legal Review. Colin Coffey at West, West & Priege, LLP reviewed the Hospital Bylaws and advised that a motion or resolution for a temporary suspension of Section 3 of the Bylaws allowing a one-time extension for a one year term for the current Board Chair is legally permissible. Even though this is not a formal amendment to the Bylaws, outside counsel recommends obtaining District Board approval because it is a significant departure from the current Bylaws.

Suggested Discussion Questions:

1. Does the Board have any concerns with a temporary suspension of the two-term limit in the Bylaws to allow the current Board Chair to serve an additional one year through June 30, 2022?
2. Does the Board have any concerns with the Governance Committee's recommendation that the Vice Chair become Chairperson at the end of the current Chairperson's extended term to ensure succession planning?

Attachment

1. Resolution 2021-04

DRAFT RESOLUTION 2021-04

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING TEMPORARY SUSPENSION OF EL CAMINO HOSPITAL BYLAWS ARTICLE VIII., SECTION 8.3

WHEREAS, Article VIII, Section 8.3 of the Amended and Restated Bylaws of El Camino Hospital (the “Bylaws”) provides that each officer shall hold office for a two (2) year term or until his or her successor is elected and qualified, subject to any employment agreement; provided that a director may not serve more than two (2) consecutive terms as Chairperson;

WHEREAS, the Board of Directors of El Camino Hospital (the “Board”) wishes to have the flexibility to extend the term of the current Chairperson for an additional one (1) year period to facilitate continuity of Board leadership during the COVID-19 pandemic, implementation of Hospital’s updated strategic plan and Board chair succession planning;

WHEREAS, the Board wishes to temporarily suspend the provisions set forth in Article VIII., Section 8.3 of the Bylaws that require that each officer shall hold office for a two (2) year term and that a director may not serve more than two (2) consecutive terms as Chairperson;

WHEREAS, the Board wishes that the temporary suspension of the provisions set forth in Article VIII, Section 8.3 of the Bylaws shall continue for a period of twelve (12) months;

WHEREAS, the Board wishes to amend the Hospital Board Officer Nomination and Selection Procedures policy to provide that the Vice Chair shall be the presumptive Chairperson at the end of the current Chairperson’s term;

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors of El Camino Hospital hereby approves of the temporary suspension of the provisions set forth in Article VIII, Section 8.3 of the Bylaws that require that each officer shall hold office for a two (2) year term and that a director may not serve more than two (2) consecutive terms as Chairperson, in order to give the Board the flexibility to extend the term of the current Chairperson for an additional one (1) year period;

BE IT FURTHER RESOLVED, that the temporary suspension of the provisions set forth in Article VIII, Section 8.3 of the Bylaws shall continue for a period of twelve (12) months; and

BE IT FURTHER RESOLVED, that the Board hereby approves of the amendment to the Hospital Board Officer Nomination and Selection Procedures policy that provides that the Vice Chair shall be the presumptive Chairperson at the end of the current Chairperson’s term.

[Continued on the following page]

DULY PASSED AND ADOPTED at a Regular Meeting held on the 7th day of April, 2021 by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

By: _____

Julia E. Miller Secretary, El Camino Hospital Board of Directors

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO**

To: El Camino Hospital Board of Directors
From: Peter C. Fung, MD, Chair, Governance Committee
Date: April 7, 2021
Subject: Draft Revised Hospital Board Officers Nomination and Election Procedures

Recommendation(s):

to approve the Draft Revised Hospital Board Officers Nomination and Election Procedures.

Summary:

- Situation:** The current Board Officer terms expire on June 30, 2021 and the next Board Officer Election is scheduled for the May 12, 2021 Board meeting.
- Authority:** Per its Charter, this Governance Committee is responsible for recommending to the full Board policies, processes, and procedures related to Board development, Board effectiveness, Board composition, and other governance matters. The Board has the authority to approve these recommendations.
- Background:** In May 2013, 2015, 2017 and 2019, the Board Officer Election was conducted using the attached procedures and Board Chair competencies that were approved by the Board following recommendation of the Governance Committee.
- Assessment:** The Governance Committee recommends three revisions 1 updating the dates for submitting declarations of interest and positions statements, 2 changing the reference to the “Director of Governance Services” and “Board Liaison” to “the CEO or designee” during this staff transition, and 3 providing for a succession plan for the Board Chair role (see, vice Chair, new item 4)
- Other Reviews:** At its March 23, 2021 meeting, the Governance Committee voted unanimously to recommend Board approval of the proposed revisions.
- Outcomes:** The Board should approve a revision no later than the April 7th Board meeting so that it is in place in preparation for the May 12th Board meeting when Board Officers are scheduled to be elected.

List of Attachments:

- Draft Revised Hospital Board Officers Nomination and Election Procedures
- Board Chair Competencies

Suggested Committee Discussion Questions:

- Are the Procedures and Competencies still relevant and working well for the Board or could the Board like to propose other revisions?



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**HOSPITAL BOARD OFFICERS
NOMINATION AND SELECTION PROCEDURES
FOR FY218**

Draft Revised/Approved 04-3/07213/20219

Any current director of the El Camino Hospital Board is eligible to serve as a Hospital Board Officer. The Hospital Board Officer terms begin July 1, 20219. El Camino Hospital Board Officer elections shall be held in any of odd numbered years. Following the election, it shall be the role of the Board Chair to meet with the Hospital CEO in any and time to develop a slate of Board Advisory Committee Chairs and members for the following fiscal year and to present the slate to the Board for approval in time.

Hospital Board Chair:

1. Interested Directors will declare their interest to the ~~CEO or designee~~ ~~Director of Governance Services~~ ~~Cindy Murphy~~ by close of business April 22, 20219. The ~~CEO or designee~~ ~~Director of Governance Services~~ will notify the Board of all declarations of interest by close of business April 23, 20219. Any other interested Directors will then declare their interest to the ~~CEO or designee~~ ~~Board Liaison~~ by close of business on April 26, 20219. The ~~CEO or designee~~ ~~Board Liaison~~ will notify the Board of any additional declarations of interest by close of business April 27, 20219. Interested Directors will prepare a one page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the attached Hospital Board Chair competencies, no later than close of business April 29, 20219.
2. Position statements will be distributed to Board members along with other routine Hospital Board materials one week in advance of the May 12, 20219 meeting.
3. Position statements will be made available to the public and posted on the El Camino Hospital website when the Hospital Board materials are issued to the Board.
4. Standard questions for Hospital Board Chair:
 - a. What do you see as the ECH strategic priorities over the coming two years?
 - b. Name three defining roles of an effective Board Chair.
 - c. How would you judge the success of your leadership and the Board at the end of your term?
5. At the May 12, 20219 meeting, interested Directors will present the information below, in public session, in the sequence outlined. Approximately 25 minutes will be allocated to each interested Director: five (5) minutes for the Position Statement, ten (10) minutes for responses to standard questions, and ten (10) minutes to respond to general questions from the Board and public:
 - a. Each interested director will read his or her Position Statement
 - b. Each interested director will provide responses to the standard questions. Directors will present one question at a time in random order.
 - c. The Public will be invited to ask Interested Directors any questions related to the candidate's interest in the position, and relevant experience as it relates to the Hospital Board Chair competencies

- d. The Board will be invited to ask interested Directors any additional questions related to an Interested Director's candidacy.
- 6. Upon review and discussion of the candidates, the Board will vote in public session. The current Chair will facilitate the discussion and voting process.
- 7. The Hospital Board Chair will be elected by the Board in accordance with the following procedure at a meeting where a quorum is present.
 - a. Preliminary Balloting
 - i. Each Board member shall vote for a candidate via roll call.
 - ii. In the event a majority is not achieved, the vote will be announced for each candidate and the candidate receiving the lowest number of votes will be dropped from the next ballot.
 - iii. This procedure will continue until one candidate receives a majority of the votes cast.
 - iv. In the event a tie vote occurs (e.g., 3/3 or 4/4), interested Directors may be asked additional questions by Hospital Board members and the balloting procedure will continue until a majority is achieved by one candidate.

Electing a Board Chair

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

Hospital Vice-Chair:

1. At the day ~~12~~, 2021~~9~~ Hospital Board meeting, interested Directors will announce their candidacy following the successful election of the Hospital Board Chair.
2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.
3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.
- 3-4. The Vice Chair is the presumptive Chair at the end of the current Chair's term.

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Hospital Secretary/Treasurer:

1. At the day ~~12~~, 2021~~9~~ Hospital Board meeting, interested Directors will announce their candidacy following the successful election of the Hospital Board Chair and the Hospital Vice Chair.
2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.
3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

**COMPETENCY CRITERIA Approved by the ECH Board April 10, 2013; April 8, 2015;
April 2017; March 13, 2019**

HOSPITAL BOARD CHAIR COMPETENCIES

Authors: Neal Cohen, MD (Former Board Chair) and Marjorie Les (Former Governance Committee member)

Original: April 10, 2013

Leadership Effectiveness

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

Innovative and Generative Thinking

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

Organizational Awareness

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

Collaborative Spirit

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

Professionalism

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

Strategy

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

Fiduciary Responsibilities

Ability to ensure:

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

Risk & Risk Management

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

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

Quality and Compliance

Ability to ensure:

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

Governance

Ability to ensure:

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



**Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, March 10, 2021**

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

Board Members Present

- Lanhee Chen, Chair ☐☐
- Peter C. Fung, MD ☐☐
- Julie Kliger ☐☐
- Julia E. Miller, Secretary/Treasurer ☐☐
- Jack Po, MD, PhD ☐☐
- Bob Rebitzer ☐☐
- George O. Ting, MD ☐☐
- Carol A. Somersille, MD ☐☐
- John Zoglin, Vice Chair ☐☐

Board Members Absent

- ☐one
- **via teleconference

Members Excused

- ☐one

Agenda Item	Comments/Discussion	Approvals/ Action
<p>1. CALL TO ORDER/ ROLL CALL</p>	<p>☐he open session meeting of the ☐oard of Directors of El Camino Hospital (the “Board”) ☐as called to order at 5:30pm ☐y Chair Chen. A verbal roll call ☐as taken. All ☐oard members ☐ere present at roll call. All members participated via videoconference pursuant to Santa Clara County’s shelter in place order. Chair Chen reviewed the logistics for the meeting. A ☐orum ☐as present pursuant to ☐tate of California Executive Orders ☐25☐20 dated ☐arch 12, 2020 and ☐29☐20 dated ☐arch 1☐, 2020.</p>	
<p>2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES</p>	<p>Chair Chen asked if any ☐oard members may have a conflict of interest ☐ith any of the items on the agenda. ☐o conflicts ☐ere noted.</p>	
<p>3. PUBLIC COMMUNICATION</p>	<p>☐one.</p>	
<p>4. QUALITY COMMITTEE REPORT</p>	<p>Director ☐liger, ☐uality Committee Chair, provided an overview of the discussion at the ☐arch 1, 2021 ☐uality Committee meeting, noting that the mortality index is up, sepsis is trending up and the ☐uality Committee asked for time to dig deeper at a future meeting on these issues. ☐he also noted that the Correction rate is not favorable. ☐he also reported that surgical site infections, other hospital acquired infections (HA☐), serious safety events, and blood utilization trends are favorable. Director ☐liger further noted that, for C☐2020, ECH ☐ould not ☐e subject to a C☐☐ penalty for HA☐☐.</p> <p>☐he also reported that the ☐uality Committee is maturing – utilizing the consent calendar more and thus carving out time for discussion. Finally, she commented that the Committee ☐ould like to spend time discussing Profession Practice Evaluation and how it can enhance ☐oard level dialogue regarding ☐uality activities</p> <p>☐ar☐Adams, ☐D, C☐O, reported that management is investigating COVID☐9 patients and have learned that this is one of the main drivers of a spike in readmissions as their rate of readmission is higher than the rest of the patient population. However, he also reported that the mortality rate for COVID☐9 patients is lower than the rest of the patient population, so they are not driving the increase in ECH’s mortality index ☐here does appear to</p>	

	<p>There is a trend of patients seeking care later in some disease states, particularly sepsis, which may be driving the mortality index.</p> <p>In response to Director Miller's questions, Dr. Adams commented that ECH has a sepsis manager with a team and that COVID-19 and that rate of sepsis are related in that COVID-19 patients' mortality is attributed to sepsis or pulmonary failure or both.</p> <p>In response to Director Rebitzer's question, Dr. Adams noted that management is exploring the unintended consequences of patients deferring care.</p>	
<p>5. ADJOURN TO CLOSED SESSION</p>	<p>Before taking a motion to adjourn to closed session, Board Chair Chen commended Bruce Harrison, departing President, Wilton Kelley Medical Development, Bob and Cindy Murphy, departing Director, Governance Service, and thanked them for their service to ECH. Dan Woods, CEO, introduced Vince VanOogian, incoming interim President, Wilton Kelley Medical Development, Bob.</p> <p>Motion: To adjourn to closed session at 5:50pm pursuant to <i>Gov't Code Section 54957.2</i> for approval of the minutes of the Closed Session of the Hospital Board Meeting 02/10/2021 pursuant to <i>Health and Safety Code Section 32155</i> for a report of the Medical Staff deliberations concerning reports on Medical Staff quality assurance matters: Quality Committee Report Medical Staff Credentials and Privileges Report, Quality Council minutes pursuant to <i>Health and Safety Code Section 32155</i> for a report of the Medical Staff deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report pursuant to <i>Health and Safety Code Section 32106(b)</i> for a report and discussion involving health care facility trade secrets: Strategic Planning Update pursuant to <i>Gov't Code Section 54956.9(d)(2)</i> – conference with legal counsel – pending or threatened litigation and <i>Gov't Code Section 54957</i> and <i>54957.6</i> for a discussion and report on personnel matters: CEO Report on Legal Services and Personnel matters and pursuant to <i>Gov't Code Section 54957</i> for discussion and report on personnel performance matters – Senior Management: Executive Session.</p> <p>Movant: Miller Second: Liger Ayes: Chen, Fung, Liger, Miller, Po, Reiter, Somerville, King, Oglin Noes: None Abstentions: None Absent: None Recused: None</p>	<p><i>Adjourned to closed session at 5:50pm</i></p>
<p>6. AGENDA ITEM 12: RECONVENE OPEN SESSION/ REPORT OUT</p>	<p>Open session was reconvened at 6:05pm by Chair Chen. Agenda items 6-11 were addressed in closed session.</p> <p>During the closed session, the Board approved the minutes of the Closed Session of the Hospital Board Meeting 02/10/2020, Quality Committee Report, including the Medical Staff Credentials and Privileges Report and the Quality Council minutes, and the Medical Staff Report by a unanimous vote in favor of all members present and participating in the meeting (Directors Chen, Fung, Liger, Miller, Po, Reiter, Somerville, King, and Oglin).</p>	

<p>7. AGENDA ITEM 13: CONSENT CALENDAR</p>	<p>Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. No items were removed.</p> <p>Motion: To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting 02/10/2021 PCC Operator Scope of Service Enterprise Mental Health and Addiction Aspire Program Physician Psychiatric Contract with ECH A Medical Staff Report and for information: Education: Medical Staff Office Function F21 Period 7 Financials.</p> <p>Movant: King Second: Miller Ayes: Chen, Fung, Liger, Miller, Po, Reiter, Somersille, King, Oglin Noes: None Abstentions: None Absent: None Recused: None</p>	<p><i>Consent calendar approved</i></p>
<p>8. AGENDA ITEM 14: CEO REPORT</p>	<p>Dan Woods, CEO, reported ECH has administered over 25,000 COVID-19 tests, administered over 1000 COVID-19 complete vaccinations to physicians, vaccinated all ECH employees who wish to be vaccinated 40% and administered 1,000 doses to members of the public through ECH's community clinics. He also commented that ECH has a "standby" list for extra vaccine doses at days end.</p> <p>Mr. Woods also announced the hiring of Dr. Nathan a new Medical Director for Behavioral Health Services. He also described new programs for employees in leadership training and equity, diversity and inclusion. Mr. Woods also announced Norma's Literary Luncheon, a virtual philanthropic event and the return of the volunteers to service.</p> <p>Director Oglin requested additional information on the level of CONCERN's virtual visits pre-pandemic.</p> <p>In response to Director Rebitzer's question, Dr. Adams and Kathryn Fisk, CHRO, reported that the organization is continuing to make efforts to vaccinate all employees and confirm whether some may have received vaccine elsewhere.</p> <p>Mr. Woods also addressed Director Miller's questions about vaccine supply, noting that ECH has agreed to terms with Blue Shield.</p>	
<p>9. AGENDA ITEM 15: BOARD COMMENTS</p>	<p>None.</p>	
<p>10. AGENDA ITEM 16: ADJOURNMENT</p>	<p>Motion: To adjourn at 11pm. Movant: King Second: Miller Ayes: Chen, Fung, Liger, Miller, Po, Reiter, Somersille, King, Oglin Noes: None Abstentions: None</p>	<p><i>Meeting adjourned at 8:18pm</i></p>

	Absent: <input type="checkbox"/> one Recused: <input type="checkbox"/> one	
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Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Hospital:

Janhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services

DRAFT

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO**

To: El Camino Hospital Board of Directors
From: Cindy Murphy, Director, Governance Services
Date: April 7, 2021
Subject: Appointment of Director Don Watters to Board Advisory Committees

Recommendation:

To approve the appointment of Director Don Watters to the Governance Committee and the Finance Committee.

Summary:

1. Situation: On March 16, 2021, the El Camino Healthcare District Board of Directors elected Don Watters to the El Camino Hospital Board of Directors.
2. Authority: The Board's Advisory Committee Charters provide that the El Camino Hospital Board Chair shall appoint the members of the Advisory Committee subject to Board approval.
3. Background: The attached propose Revised Advisory Committee and Liaison Appointments reflects Board Chair Chen's recommendation to appoint Director Watters to the Governance Committee and the Finance Committee. The other changes are (1) removal of former Director Kalbach from the Finance Committee and the Governance Committee, and (2) removal of Patricia Wadors from the Executive Compensation Committee, both due to voluntary resignations.
4. Assessment: N/A
5. Other Reviews: None.
6. Outcomes: N/A

List of Attachments:

1. Proposed Revised Advisory Committee and Liaison Appointments

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

FY21 El Camino Hospital Board of Directors Advisory Committee & Liaison Appointments

Committee Appointments						
COMMITTEE	COMPLIANCE AND AUDIT	EXECUTIVE COMPENSATION	FINANCE	GOVERNANCE	INVESTMENT	QUALITY
CHAIR	Sharon Anolik Shakked	Bob Miller	John Zoglin	Peter C. Fung, MD	Brooks Nelson	Julie Kliger
BOARD MEMBERS	Jack Po, MD	Julie Kliger	Carol A. Somersille, MD	Bob Rebitzer	Peter C. Fung, MD	Jack Po, MD
	Julia E. Miller	George O. Ting, MD	Don Watters	Don Watters	Carol A. Somersille, MD	George O. Ting, MD
COMMUNITY MEMBERS	Lica Hartman	Teri Eyre	Joseph Chow	Christina Lai	Nicola Boone	Terrigal Burn, MD
	Christine Sublett	Jaison Layney	Wayne Doiguchi	Peter Moran	John Conover	Alyson Falwell
			Boyd Faust	Mike Kasperzak	Richard Juelis	Krutica Sharma
				Ken Alvares		Melora Simon
EX OFFICIO MEDICAL STAFF OFFICERS						Apurva Marfatia, MD
						Michael Kan, MD
						Prithvi Legha, MD <i>Alternate</i>
						Philip Ho, MD <i>Alternate</i>

Liaison Appointments

ECH FOUNDATION BOARD OF DIRECTORS (Liaison)

Julia E. Miller

COMMUNITY BENEFIT ADVISORY COUNCIL (CBAC) (Liaison)

John Zoglin

LEGEND

*Board Members

*Community Members



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April 7, 2021

Lanhee J. Chen, J.D., Ph.D.
Chair
El Camino Hospital
P.O. Box 7025
2500 Grant Road
Mountain View, CA 94040

Re: Reasonableness of Executive Compensation

Dear Lanhee:

El Camino Hospital engaged Mercer (US) Inc. (“Mercer”), an independent healthcare consulting firm, to evaluate executive compensation levels as part of its overall executive compensation process with respect to certain executives. El Camino Hospital intends to obtain the benefit of the rebuttable presumption of reasonableness pursuant to regulations implementing Section 4958 of the Internal Revenue Code. In order to invoke the presumption, the amount of compensation must be approved in advance by an authorized body; the decision must be based on appropriate data as to comparability; and the decision must be adequately documented.

El Camino Hospital’s decisions to compensate executives are approved in advance by its Board of Directors (“Board”) or the Executive Compensation Committee (acting as a “body authorized by state law following procedures specified by the governing body”) (the “Committee”). The Board approves the Chief Executive Officer’s compensation and may approve other executives’ compensation. The compensation of the remaining executives is approved by the Committee. The Board and the Committee are each to act without the participation of any individual who has a conflict of interest with respect to the matter under consideration. In addition, the Board has also delegated to the Committee the authority to take other actions or to provide advice to the Board with respect to executive compensation as provided in the Committee’s charter. The Board and the Committee (so long as it is following the specified procedures described above) are each an authorized body as defined by Section 4958. Further, we understand that the Board and the Committee has each relied upon comparability data when acting as an authorized body, specifically, for example, data provided by Mercer analyzing the amount of compensation organizations in El Camino Hospital’s peer

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Lanhee J. Chen, J.D., Ph.D.

April 7, 2021

Page 2

group pay executives in similar positions.

We note that certain information regarding comparability that had been presented in prior letters from Mercer has not been presented in the letter on the grounds that the data sources consider the information to be confidential and proprietary. The Chief Human Resources Officer and the Director, Total Rewards, have each individually represented to us that such detailed information has been presented to the Board and the Committee, and that such documentation has been preserved and will be maintained as described below.

In the letter attached (the "Letter"), Mercer concludes that the total remuneration El Camino Hospital will pay its Executives (who are specified in the Letter) during fiscal year 2021 "falls within a reasonable range of competitive market practices applicable to like positions among like organizations under like circumstances." The Letter constitutes Mercer's report of its conclusions, and includes a summary of its interactions with the Committee and the Board and a summary of the information considered by the Board or the Committee prior to the actions of the Board or the Committee with respect to executive compensation.

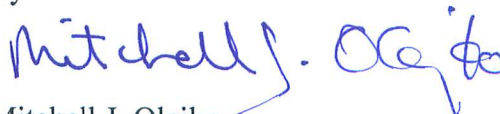
Finally, in order to invoke the rebuttable presumption, El Camino Hospital must adequately document the basis for its decision. El Camino Hospital maintains documentation in the form of meeting minutes, which set forth the terms of the arrangements, the date(s) of approval, and the members who were present to vote on and discuss the arrangement. El Camino Hospital also maintains documentation – including the Letter – in the form of comparability data that it obtained and relied upon to reach the compensation levels.

El Camino Hospital should keep this letter and the attached Letter as further documentation of the basis of its decision and its intent to obtain (and the steps taken to obtain) the benefits of the rebuttable presumption of reasonableness.

Very truly yours,

BUCHALTER
A Professional Corporation

By



Mitchell J. Olejko



Andrea Musker

Buchalter

Lanhee J. Chen, J.D., Ph.D.

April 7, 2021

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Attachments

Private & Confidential

Mr. Robert Miller
Chair, Executive Compensation Committee
El Camino Hospital
Mountain View, CA 94040

February 23, 2021

Subject: Reasonableness Opinion for El Camino Hospital Disqualified Persons

Dear Bob,

As requested by the Executive Compensation Committee (“Committee”) of the Board of Directors (“Board”) of El Camino Hospital (“El Camino” or “ECH”), Mercer conducted an evaluation of the maximum total remuneration to be provided to El Camino’s executives for the fiscal year ending June 30, 2021 (FY 2021). The covered executives include the Chief Executive Officer and the eleven executives named in Table 1. Mercer provided market benchmarking results at the May 2020 Executive Compensation Committee meeting; these results were used to inform the Committee’s approval of FY 2021 compensation for non-CEO executives during its September meeting. CEO compensation market data was presented to the Board at the November 11, 2020 meeting; these data informed the Board’s decision on CEO base salary. The Board approved final decisions on the CEO’s FY 2021 compensation in its November and December meetings. Market data for the Chief Financial Officer role were provided along with data for other executive roles in May 2020, however the Chief Financial Officer’s base salary was approved by the Committee in July 2020 when the current incumbent was hired. This letter outlines the study’s objectives, Mercer’s evaluation process, findings, and our opinion that the approved FY 2021 total remuneration program for the covered executives falls within a reasonable range of the competitive practice.

I. Purpose

The purpose of this letter is to document the market comparability data and provide Mercer’s opinion on the reasonableness of the executive total remuneration program in support of the organization’s pursuit of the rebuttable presumption of reasonableness under IRC §4958. To do so, we have:

- Presented relevant market comparability data to the Committee and the Board to ensure that the Committee and the Board are well-informed of current executive compensation and benefits practices when making decisions on El Camino’s executive remuneration;

- Advised the Committee regarding interpretation of the market data;
- Assisted the Committee in its governance responsibility with respect to the compensation program by providing Mercer's opinion that approved fiscal year 2021 total remuneration for all executives falls within a reasonable range of competitive market practices applicable to like positions among like organizations under like circumstances in accordance with the Intermediate Sanctions legislation and applicable regulations; and
- Documented the recent changes to compensation approved by the Committee and the Board of Directors in September and November, respectively.

II. Background

Mercer serves as an independent advisor to the Committee. In this capacity, we provide advice and competitive compensation and benefits market data to the Committee to inform its decision-making process relative to the compensation program for El Camino's executives.

The executive compensation program is governed by the Board of Directors and the Executive Compensation Committee, which advises the Board to meet all applicable legal and regulatory requirements as they relate to executive compensation and effectiveness in attracting, retaining, and motivating executives.

Organizational Context

El Camino Hospital's mission is to heal, relieve suffering, and advance wellness as a publicly accountable partner. El Camino opened its doors to its first patients on September 1, 1961 with 21 medical staff. An expanding population in Silicon Valley drove El Camino to develop further, and today El Camino Hospital consists of two fully accredited hospital campuses in Los Gatos and Mountain View. Net operating revenue was \$997 million¹ for FY 2019 and \$1.03 billion¹ for FY 2020.

Silicon Valley Medical Development LLC (SVMD), an affiliate of El Camino Hospital, aspires to elevate the healthcare experience for the communities served. Through physician partnerships, SVMD provides patients with healthcare options including urgent care, primary care, and specialty care services at 11 locations across Santa Clara County.

In addition to delivering healthcare services across Santa Clara County, El Camino's employee assistance and mental health program, Concern, offers employers across the country an

¹ Source: El Camino FY 2019 and FY 2020 Financial Audits.

optimized blend of human connection, compassion, and technology to help employees build resilience and achieve emotional well-being. Services include resources for employees and their families to stay creative, calm, and effective even when dealing with setbacks, change, and/or pressure.

El Camino Covered Executives

Table 1 details the incumbents included in Mercer’s review of FY 2021 total remuneration.

Table 1: Covered Executives Reviewed

Incumbent	Title
Adams, Mark	Chief Medical Officer
Griffith, James	Chief Operating Officer
Bohorquez, Carlos	Chief Financial Officer
Harrison, Bruce	President, SVMD
Rotunno, Mary	General Counsel
Muro, Deborah A	Chief Information Officer
Reinking, Cheryl	Chief Nursing Officer
Fisk, Kathryn	Chief Human Resource Officer
King, Ken	Chief Administrative Services Officer
Cope, Andrew	President of ECH Foundation
Currier, Cecile	VP Corp & Comm Hlth Svcs & President Concern

Note: Chief Executive Officer compensation information found in Section V.

Executive Compensation Philosophy²

El Camino’s Executive Compensation Philosophy utilizes the following guiding principles and objectives to drive executive compensation decisions:

1. Support the Hospital’s ability to attract, retain, and motivate a highly talented executive team with the ability and dedication to manage the Hospital accordingly.
2. Support the Hospital’s mission, vision, and achievement of strategic goals.
3. Encompass a total compensation perspective in developing and administering cash compensation and benefit programs.

² This is extracted from El Camino’s official stated philosophy, as approved at the February 12, 2020 Board meeting.

4. Considers the Hospital’s financial performance and ability to pay which shall be balanced with the Hospital’s ability to attract, retain, and motivate executives.
5. Govern the executive compensation programs to comply with state and federal laws.

The executive compensation program encompasses both cash compensation (base salary, incentive compensation, and other cash compensation) and non-cash compensation (benefit plans and perquisites) which, in whole, represent total remuneration.

The three key components of the program are base salary, incentives, and benefits. In evaluating executive compensation, the Executive Compensation Committee uses the following market definition and desired positioning guidelines:

Table 2: El Camino Market Definition and Desired Positioning

Component	Market Definition and Desired Positioning
Market Definition	<ul style="list-style-type: none"> • National, not-for-profit, independent hospitals/health systems of comparable revenue size and complexity to ECH. • Data increased by a 25% geographic salary differential to account for the salary differences in the Bay Area (reviewed annually to verify appropriateness).
Base Salary	<ul style="list-style-type: none"> • Salary range midpoints are based on the market 50th percentile, with ranges set at +/- 20% of 50th percentile. • Market base salary data are also compared to ECH fixed cash compensation (base salary plus 7% taxable allowance) as a reference point. • Actual salary is determined based on a combination of the following factors: paying competitively, rewarding performance, and recognizing competence, credentials, and experience. • The Board may approve salaries above the salary range for hard-to-recruit positions or positions deemed critical to the organization’s success.
Incentives	<ul style="list-style-type: none"> • Actual total cash compensation targets the 50th percentile on average and up to the 75th percentile, dependent on individual and organizational performance.
Benefits	<ul style="list-style-type: none"> • Executive benefits and severance are targeted at competitive levels (i.e., median). Perquisites should only be provided when supported by

	specific business reasons. ECH’s practice is to minimize the use of perquisites.
Total Remuneration	<ul style="list-style-type: none"> Actual total remuneration (total cash plus benefits) targets between the 50th and 75th percentile and reflects individual and organizational performance.

El Camino’s Total Remuneration Program

Mercer assessed the value of the total remuneration provided to the executives, which consists of the elements in Table 3 below. See Table 8 for total remuneration elements specific to the CEO.

Table 3: Compensation Elements

Element	Overview
Base Salary	<ul style="list-style-type: none"> Annual cash salary based on position, market data, and incumbent skills and experience. For FY 2021, approved base salary increases were provided and ranged from 2.5% – 4.0%. Increases were determined based on market, merit, and executive experience.
Incentives	<ul style="list-style-type: none"> Annual cash incentive awards are provided based on 1) annual performance against system-wide metrics and 2) performance against individual metrics. Due to the impact of the COVID-19 pandemic, the organization was forced to shift focus beginning in March of 2020. The Committee recommended, and the Board approved, (1) recalibration of the FY 2020 Organizational Performance Goals to an 8-month period ending February 2020 and (2) elimination of one of the goals (due to the decision to delay the employee engagement survey) with redistribution of its weight to the other goals. Individual goals for FY 2020 were measured over the full 12-month fiscal year period; however, total FY 2020 target incentive opportunity was 8/12 of the full target opportunity. For FY 2021, the target incentive opportunity has not changed, and remains at 20% of base salary for all non-CEO executives. Maximum incentive opportunity is 30% of base salary for all non-CEO executives.
Retirement	<ul style="list-style-type: none"> Executives receive employer contributions to the following plans:

	<ul style="list-style-type: none"> — 403(b) Retirement Plan: 4-7% depending on years of service³ — Cash Balance Plan: 5% of salary³ — Nonqualified SERP: Non-CEO executives receive 5% of salary — Executive Taxable Benefit Plan: 7% of salary contribution; can be used to purchase voluntary long-term disability, long-term care, and life insurance; unused allowance can be deferred to the 457(b) or paid in cash⁴ <ul style="list-style-type: none"> • Executives may also defer their own pay into the 403(b) and 457(b) plans. • See Appendix C for a detailed market analysis of benefits.
Health & Welfare	<ul style="list-style-type: none"> • Executives are eligible to receive the same health benefits as all other El Camino employees. • Executives receive group life insurance coverage of up to 3x base salary (capped at \$2 million); no medical underwriting required. • Executives are eligible to receive salary continuation if disabled: 100% of base salary for six months (offset for state disability insurance, worker's compensation, paid time off, extended sick leave). • Executives are eligible for long-term disability equal to 60% of base salary up to a monthly maximum of \$15,000. • See Appendix C for a detailed market analysis of benefits.
Severance	<ul style="list-style-type: none"> • Executive severance policy provides up to six months of base salary and health continuation benefit for all executives other than the CEO.
Perquisites	<ul style="list-style-type: none"> • Executives other than the CEO do not receive any perquisites. • See Appendix C for a detailed market analysis of perquisites.

Table 4 summarizes the approved target and maximum FY 2021 total remuneration program for El Camino's covered executives. Target values below reflect the structure of El Camino's program; actual payouts will vary based on performance. Maximum values assume annual incentive is paid at the maximum value (30% of base salary for Executives) based on attainment of stretch performance under the annual incentive plan.

³ Contributions on pay up to IRS limit (\$285K in 2020)

⁴ In prior letters, the 7% Taxable Benefit was described under Perquisites; the nomenclature has been updated to reflect the benefit under Retirement to better align with the nature of the benefit.

Table 4: El Camino’s FY 2021 Target and Maximum Total Remuneration (Data in \$000s)

Incumbent	Title	FY21 Base Salary	Total Cash Compensation				Total Remuneration		
			Target Bonus	Target TCC ⁽¹⁾	Max Bonus	Max TCC ⁽¹⁾	Benefits	Target TR ⁽²⁾	Max TR ⁽²⁾
Adams, Mark	Chief Medical Officer	\$610	20%	\$732	30%	\$793	\$125	\$857	\$918
Griffith, James	Chief Operating Officer	\$584	20%	\$700	30%	\$759	\$128	\$828	\$887
Bohorquez, Carlos	Chief Financial Officer	\$565	20%	\$678	30%	\$735	\$106	\$784	\$841
Harrison, Bruce	President, SVM D	\$543	20%	\$652	30%	\$706	\$123	\$775	\$829
Rotunno, Mary	General Counsel	\$440	20%	\$528	30%	\$572	\$110	\$639	\$683
Muro, Deborah A	Chief Information Officer	\$407	20%	\$489	30%	\$529	\$101	\$589	\$630
Reinking, Cheryl	Chief Nursing Officer	\$394	20%	\$473	30%	\$512	\$113	\$586	\$625
Fisk, Kathryn	Chief Human Resource Officer	\$382	20%	\$458	30%	\$496	\$97	\$555	\$593
King, Ken	Chief Administrative Services Officer	\$322	20%	\$386	30%	\$418	\$100	\$485	\$517
Cope, Andrew	President of ECH Foundation	\$291	20%	\$349	30%	\$379	\$92	\$442	\$471
Currier, Cecile	VP Corp & Comm Hlth Svcs & President Concern	\$283	20%	\$340	30%	\$368	\$94	\$434	\$462

⁽¹⁾ Total Cash Compensation (TCC) calculated as Base Salary + Target Bonus.

⁽²⁾ Total Remuneration (TR) calculated as Total Cash Compensation + Benefits.

III. Methodology

Mercer’s evaluation was conducted in accordance with our firm’s standards for reviewing compensation arrangements in tax-exempt organizations.

Cash Compensation Assessment Methodology

- Market Composite - Healthcare Surveys:
 - Mercer: *Integrated Health Networks (IHN) Compensation Survey (2019)* (Scope: Net Revenue \$500 million to \$2 billion);
 - Integrated Healthcare Strategies: *National Healthcare Leadership Compensation Survey (2019)* (Scope: Net Revenue \$500 million to \$1.5 billion); and
 - Sullivan, Cotter and Associates, Inc.: *Manager and Executive Compensation in Hospitals and Health Systems Survey (2019)* (Scope: Net Revenue \$700 million to \$2 billion).
- Survey Data Methodology:
 - From each survey, we collected market data for base salary and total cash compensation at the 25th 50th and 75th percentiles.
 - Survey data were scoped to approximate ECH’s FY 2019 net revenue of \$996M.
 - Data sources were trended to January 1, 2021 using a 3.0% update factor, the expected annual increase budgeted for executives at healthcare organizations
 - All data sources were increased by 25% to account for the geographic salary differences in the Bay Area. See Appendix E for detail.

- Mercer developed a position matching strategy for each role through a detailed review of job descriptions and discussions with El Camino.

Benefits Assessment

- El Camino's benefits and perquisites were compared to practices among not-for-profit organizations using the following surveys:
 - Mercer: *Healthcare Executive Benefits and Perquisites Survey (2019)* (Scope: Healthcare organizations; Revenue \$500 million to \$2 billion);
 - Mercer: *Executive and Broad-Based Employee Retirement Tool* (Scope: Revenue \$500 million to \$2 billion); and
 - Mercer: *US Executive Rewards Year End Survey (2018-2019)* (Scope: Revenue \$500 million to \$2 billion).
- Methodology:
 - To develop the survey total remuneration market perspective, Mercer added the market annualized value of retirement, health and welfare benefits, and perquisites to market total cash compensation levels.

IV. Findings and Observations

Target and Maximum Total Remuneration

Tables 5-7 display the comparison of El Camino's approved FY 2021 target and maximum total remuneration program to market composite levels. See Appendix A for FY 2020 actual total remuneration compared to market.

The market ratio shown in these tables reflects each El Camino executive's compensation element as a percentage of the market 50th or 75th percentile. For example, a market ratio P50 of 100% means that executive's compensation element is at the 50th percentile.

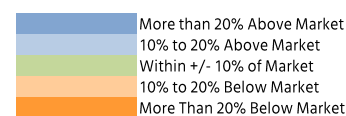
Base Salary

As shown in Table 5, in aggregate, FY 2021 base salary levels fall at or below the 50th percentile of the not-for-profit healthcare market for all executives, with the exception of the Chief Administrative Services Officer and President, SVMD, who are positioned between the 50th and 75th percentiles.

Table 5: FY 2021 Approved Base Salary compared to Market (Data in \$000s)

Incumbent	Title	ECH FY2021	Market Base Salary			Market Ratio P50
			P25	P50	P75	
Adams	Chief Medical Officer	\$610	\$570	\$632	\$725	97%
Griffith	Chief Operating Officer	\$584	\$583	\$718	\$867	81%
Bohorquez	Chief Financial Officer	\$565	\$582	\$663	\$749	85%
Harrison	President, SVM D	\$543	\$409	\$494	\$585	110%
Rotunno	General Counsel	\$440	\$446	\$530	\$589	83%
Muro	Chief Information Officer	\$407	\$434	\$489	\$541	83%
Reinking	Chief Nursing Officer	\$394	\$348	\$406	\$453	97%
Fisk	Chief Human Resource Officer	\$382	\$368	\$431	\$485	89%
King	Chief Administrative Services Officer	\$322	\$241	\$294	\$372	109%
Cope	President of ECH Foundation	\$291	\$249	\$294	\$353	99%
Currier	VP Corp & Comm Hlth Svcs & President Concern	\$283	\$291	\$320	\$393	89%
Aggregate						91%

Note: All market data include 25% geographic differential.



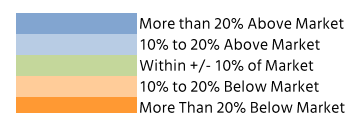
Annual Incentives and Total Cash Compensation

Table 6 provides a comparison of El Camino’s total cash compensation (base salary + bonus) to market composite total cash compensation. In aggregate, El Camino’s FY 2021 target total cash compensation is in line with the market 50th percentile. Most covered executives are positioned within 15% of the 50th percentile for target total cash compensation, with the exception of the Chief Administrative Services Officer and President, SVM D, who are both between the 50th and 75th percentiles.

Table 6: FY 2021 Approved Target and Maximum Total Cash Compensation compared to Market (Data in \$000s)

Incumbent	Title	ECH TCC FY2021		Market Actual Total Cash Compensation			Market Ratio	
		Target	Max	P25	P50	P75	Target / P50	Max / P75
Adams	Chief Medical Officer	\$732	\$793	\$617	\$731	\$862	100%	92%
Griffith	Chief Operating Officer	\$700	\$759	\$690	\$825	\$1,073	85%	71%
Bohorquez	Chief Financial Officer	\$678	\$735	\$624	\$753	\$881	90%	83%
Harrison	President, SVM D	\$652	\$706	\$439	\$559	\$693	117%	102%
Rotunno	General Counsel	\$528	\$572	\$494	\$570	\$707	93%	81%
Muro	Chief Information Officer	\$489	\$529	\$474	\$538	\$620	91%	85%
Reinking	Chief Nursing Officer	\$473	\$512	\$382	\$445	\$532	106%	96%
Fisk	Chief Human Resource Officer	\$458	\$496	\$387	\$472	\$550	97%	90%
King	Chief Administrative Services Officer	\$386	\$418	\$247	\$318	\$407	121%	103%
Cope	President of ECH Foundation	\$349	\$379	\$260	\$322	\$388	109%	98%
Currier	VP Corp & Comm Hlth Svcs & President Concern	\$340	\$368	\$308	\$365	\$439	93%	84%
Aggregate							98%	88%

Note: All base salary and total cash market data include a 25% geographic differential.



Benefits

El Camino’s executive benefit offerings are generally consistent with market practice. The total value of El Camino’s benefits is generally aligned with the market 50th percentile of the not-for-profit healthcare industry. See Appendix C for more detailed information.

Target Total Remuneration

In aggregate, El Camino’s target total remuneration is between the market 50th and 75th percentiles (Table 7). Only one covered executive, the Chief Administrative Services Officer, is above the 75th percentile, but only to a slight degree (2% above the 75th percentile).

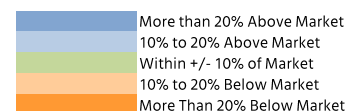
Maximum Total Remuneration Opportunity

Maximum total remuneration assumes the annual incentive plan pays out at maximum (i.e., 150% of target opportunity), assuming attainment of stretch goals under the annual incentive plan. In aggregate, covered executive maximum total remuneration (Table 7) is positioned between the 50th and 75th percentile, in alignment with philosophy, but individual positioning varies from below 50th to above 75th percentiles. No covered executive has maximum total remuneration that is more than 9% above the 75th percentile.

Table 7: FY 2021 Approved Target and Maximum Total Remuneration compared to Market (Data in \$000s)

Incumbent	Title	ECH TR FY2021		Market Total Remuneration			Market Ratio Target / P50	Market Ratio Max / P75
		Target	Max	P25	P50	P75		
Adams	Chief Medical Officer	\$857	\$918	\$711	\$833	\$976	103%	94%
Griffith	Chief Operating Officer	\$828	\$887	\$786	\$938	\$1,206	88%	74%
Bohorquez	Chief Financial Officer	\$784	\$841	\$708	\$848	\$988	92%	85%
Harrison	President, SVMMD	\$775	\$829	\$512	\$643	\$790	120%	105%
Rotunno	General Counsel	\$639	\$683	\$572	\$659	\$804	97%	85%
Muro	Chief Information Officer	\$589	\$630	\$551	\$621	\$711	95%	89%
Reinking	Chief Nursing Officer	\$586	\$625	\$447	\$518	\$611	113%	102%
Fisk	Chief Human Resource Officer	\$555	\$593	\$455	\$549	\$633	101%	94%
King	Chief Administrative Services Officer	\$485	\$517	\$298	\$376	\$475	129%	109%
Cope	President of ECH Foundation	\$442	\$471	\$312	\$380	\$453	116%	104%
Currier	VP Corp & Comm Hlth Svcs & President Concern	\$434	\$462	\$366	\$426	\$510	102%	91%
Aggregate							103%	91%

Note: All base salary and total cash market data include a 25% geographic differential.



V. CEO Compensation

The tables below detail the compensation elements for El Camino’s Chief Executive Officer, Daniel Woods. Final CEO pay decisions regarding FY 2020 incentive payout and FY 2021 base salary and incentive targets were approved in November 2020. See Appendix B for details.

Table 8: Compensation Elements for the CEO, Where Different from Other Executives

Element	Overview
Base Salary	<ul style="list-style-type: none"> For FY 2021, the Chief executive Officer’s base salary increased 4%.
Incentives	<ul style="list-style-type: none"> For FY 2021, target opportunity has not changed, and remains at 30% of base salary for the Chief Executive Officer. Maximum incentive opportunity is 45% of base salary.
Retirement	<ul style="list-style-type: none"> The Chief Executive Officer receives 13% of salary in total between qualified retirement plans and SERP.
Severance	<ul style="list-style-type: none"> Chief Executive Officer severance policy provides up to 12 months of base salary and health continuation benefit.
Perquisites	<ul style="list-style-type: none"> The Chief Executive Officer was provided a \$400,000 interest-free loan to support housing costs.

See Appendix D for a detailed market analysis of CEO benefits.

Table 9: CEO FY 2021 Target and Maximum Total Remuneration Opportunity (Data in \$000s)

Incumbent	Title	FY21 Base Salary	Total Cash Compensation				Total Remuneration		
			Target Bonus	Target TCC ⁽¹⁾	Max Bonus	Max TCC ⁽¹⁾	Benefits	Target TR ⁽²⁾	Max TR ⁽²⁾
Woods, Daniel	Chief Executive Officer	\$1,035	30%	\$1,346	45%	\$1,501	\$242	\$1,587	\$1,742

⁽¹⁾ Total Cash Compensation (TCC) calculated as Base Salary + Target Bonus.

⁽²⁾ Total Remuneration (TR) calculated as Total Cash Compensation + Benefits (employer cost of all benefits).

The CEO received a 4% base salary increase for FY 2021, positioning base salary at 85% of the market 50th percentile (see Table 10 below). Target FY 2021 total remuneration is 97% of the 50th percentile, and maximum total remuneration is 83% of the 75th percentile (see Table 12).

Table 10: CEO FY 2021 Approved Base Salary compared to Market (Data in \$000s)

Incumbent	Title	ECH FY2021	Market Base Salary			Market Ratio P50
			P25	P50	P75	
Woods	Chief Executive Officer	\$1,035	\$1,034	\$1,211	\$1,454	85%

Note: All market data include 25% geographic differential

Table 11: CEO FY 2021 Approved Target and Maximum Total Cash Compensation compared to Market (Data in \$000s)

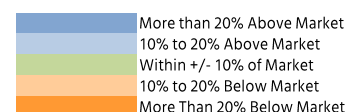
Incumbent	Title	ECH TCC FY2021		Market Actual Total Cash Compensation			Market Ratio Target / P50	Market Ratio Max / P75
		Target	Max	P25	P50	P75		
Woods	Chief Executive Officer	\$1,346	\$1,501	\$1,103	\$1,440	\$1,865	93%	80%

Note: All market data include 25% geographic differential

Table 12: CEO FY 2021 Approved Target and Maximum Total Remuneration compared to Market (Data in \$000s)

Incumbent	Title	ECH TR FY2021		Market Total Remuneration			Market Ratio Target / P50	Market Ratio Max / P75
		Target	Max	P25	P50	P75		
Woods	Chief Executive Officer	\$1,587	\$1,742	\$1,278	\$1,644	\$2,108	97%	83%

Note: All base salary and total cash market data include a 25% geographic differential.



VI. Basis for Opinion

Many factors are considered in an evaluation of the reasonableness of pay, including the organization's performance, its total rewards philosophy, and the qualifications and roles of the incumbents. Market data and external factors play a role in determining a reasonable range of compensation practices. Differences in pay levels between an organization and the market data (i.e., variation from the 50th percentile) do not mean that an organization is necessarily over- or under-competitive. El Camino can compensate an executive above the 50th percentile of the market and still be within a range of reasonable compensation, depending on the facts and circumstances of the particular situation.

- Industry Pressure: With the significant changes in the healthcare industry, El Camino faces a strategic crossroads as an independent community hospital system. The ability to attract and retain key talent remains critical to the future success of the organization during this turbulent time and providing compensation at market (50th percentile) or above levels is part of El Camino's strategy to ensure its ability to attract and retain executive talent.
- Executive Compensation Philosophy: El Camino's desired market positioning as described in the executive compensation philosophy is the market 50th percentile, with upside to the 75th percentile based on performance. In aggregate, El Camino covered executives are positioned within 10% of the 50th percentile for target compensation across compensation elements and in alignment with the compensation philosophy. Some individuals exceed the targeted 50th percentile positioning. Only one executive has target compensation in excess of the market 75th percentile; target total remuneration for the Chief Administrative Services Officer is 2% above the 75th percentile.

VII. Opinion of Reasonableness

Mercer (US) Inc. certifies that it (1) is a compensation consulting firm, (2) performs compensation valuation studies of this type on a regular basis, and (3) is qualified to perform the valuations of the type of property or services involved. In our opinion, the total remuneration we have reviewed falls within a reasonable range of competitive market practices applicable to like positions among like organizations under like circumstances.

Disclaimers

Mercer has relied on the information and data provided to us without any independent review or verification and we assume all data provided to us is accurate, factual and complete. This does not constitute an opinion regarding the underlying business decisions.

This opinion has been prepared exclusively for El Camino to assist in understanding market total remuneration positioning for its senior executives. This letter provides the Committee with market comparability data as required by Intermediate Sanctions regulations and we urge the Committee to ensure that the additional requirements for establishing the rebuttable presumption/determining reasonable compensation have been met and to seek the advice of counsel as needed in this regard. This letter may not be used or relied upon by any other party or for any other purpose; Mercer is not responsible for the consequences of any such unauthorized use.

We have not been made aware of any family members of the CEO or the covered executives listed in Table 1 that also work for El Camino who might also be considered disqualified persons.

As always, it is our pleasure to be of service. If you have any questions about this letter, please do not hesitate to contact me at 213-346-2531.

Sincerely,



Heidi O'Brien, Partner

Appendix A: Actual FY 2020 Total Remuneration for Executives (Data in \$000s)

For FY 2020, due to the impact of the COVID-19 pandemic, the Board approved (1) recalibration of the FY 2020 Organizational Performance Goals to an 8-month period ending February 2020 and (2) elimination of the one goal (due to the decision to delay the employee engagement survey) with redistribution of its weight to the other goals. This resulted in below full-year target payouts for all executives.

Table 13: FY 2020 Actual Incentive Payout

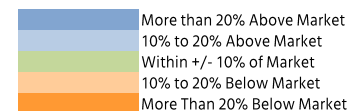
Incumbent	Title	FY2020 Base Salary	FY2020 Incentive Plan Payout			
			Full-Year Target	Full-Year Maximum	Actual (\$)	Actual (% Tgt)
Adams, Mark	Chief Medical Officer	\$592	\$118	\$178	\$84	71%
Griffith, James	Chief Operating Officer	\$567	\$113	\$170	\$72	64%
Harrison, Bruce	President, SVM D	\$527	\$105	\$158	\$78	74%
Rotunno, Mary	General Counsel	\$427	\$85	\$128	\$74	87%
Muro, Deborah A	Chief Information Officer	\$393	\$79	\$118	\$62	79%
Reinking, Cheryl	Chief Nursing Officer	\$379	\$76	\$114	\$65	86%
Fisk, Kathryn	Chief Human Resource Officer	\$369	\$74	\$111	\$53	71%
King, Ken	Chief Administrative Services Officer	\$312	\$62	\$94	\$49	79%
Cope, Andrew	President of ECH Foundation	\$280	\$56	\$84	\$38	67%
Currier, Cecile	VP Corp & Comm Hlth Svcs & President Concern	\$275	\$55	\$83	\$39	71%

Note: This table shows incumbents who participated in the FY 2020 annual incentive plan; the CFO is not included as he was hired into the position in October 2020. Payouts are prorated as of 8/12 of the 2020 fiscal year.

Table 14: FY 2020 Actual Total Remuneration compared to Market (Data in \$000s)

Incumbent	Title	ECH TR FY2020	Market Total Remuneration			Market Ratio
		Actual	P25	P50	P75	Actual / P50
Adams	Chief Medical Officer	\$802	\$711	\$833	\$976	96%
Griffith	Chief Operating Officer	\$767	\$786	\$938	\$1,206	82%
Harrison	President, SVMD	\$729	\$512	\$643	\$790	113%
Rotunno	General Counsel	\$612	\$572	\$659	\$804	93%
Muro	Chief Information Officer	\$556	\$551	\$621	\$711	90%
Reinking	Chief Nursing Officer	\$557	\$447	\$518	\$611	108%
Fisk	Chief Human Resource Officer	\$519	\$455	\$549	\$633	95%
King	Chief Administrative Services Officer	\$461	\$298	\$376	\$475	123%
Cope	President of ECH Foundation	\$410	\$312	\$380	\$453	108%
Currier	VP Corp & Comm Hlth Svcs & President Cor	\$408	\$366	\$426	\$510	96%
Aggregate						98%

Note: This table shows incumbents who participated in the FY 2020 annual incentive plan; the CFO is not included as he was hired into the position in October 2020. All base salary and total cash market data include a 25% geographic differential.



Appendix B: Additional CEO Compensation Information

Table 15: CEO FY 2020 Actual Incentive Payout (Data in \$000s)

Incumbent	Title	FY2020 Base Salary	FY2020 Incentive Plan Payout			
			Full-Year Target	Full-Year Maximum	Actual (\$)	Actual (% Tgt)
Woods, Daniel	Chief Executive Officer	\$995	\$299	\$448	\$249	83%

Note: Payouts are prorated as of 8/12 of the 2020 fiscal year.

Table 16: CEO FY 2020 Actual Total Remuneration compared to Market (Data in \$000s)

Incumbent	Title	ECH TR FY2020	Market Total Remuneration			Market Ratio
		Actual	P25	P50	P75	Actual / P50
Woods	Chief Executive Officer	\$1,485	\$1,278	\$1,644	\$2,108	90%

Note: All base salary and total cash market data include a 25% geographic differential.

Appendix C: Executive (non-CEO) Benefits and Perquisites Review

Retirement Plans Summary

	El Camino	Market Practice	Comments
Employer Paid	<p>Qualified Plans</p> <p><u>Defined Contribution (DC) – 403(b) Plan</u></p> <ul style="list-style-type: none"> Employer match of salary, based on pension years: <ul style="list-style-type: none"> – 1 – 14 years: 4% – 15 – 19 years: 5% – 20+ years: 7% <p><u>Defined Benefit (DB) – Cash Balance Plan</u></p> <ul style="list-style-type: none"> 5% of salary <p>Contributions on pay up to IRS limit (\$285K in 2020)</p> <p>Nonqualified Plan</p> <p><u>Defined Contribution SERP - 457(f) Plan</u></p> <ul style="list-style-type: none"> Executives receive employer contribution of 5% of salary <p>Total employer contribution ranges from 9%-17% of salary, based on current executive demographics (e.g., pay and years of service)</p>	<ul style="list-style-type: none"> Nearly all provide employer contributions to a qualified defined contribution plan <ul style="list-style-type: none"> – Less than 10% provide a qualified DB plan <p>Not-for-Profit</p> <ul style="list-style-type: none"> 60% provide a nonqualified plan to top executives <ul style="list-style-type: none"> – The vast majority are DC SERPs Median total employer contribution from all sources is 13% of salary <p>For-Profit¹</p> <ul style="list-style-type: none"> 50% provide a nonqualified plan to top executives Median total employer contribution from all sources is 6% of salary 	<ul style="list-style-type: none"> Overall structure is consistent with market practice although prevalence of DB plans continues to decline Total contribution is generally aligned with market median of not-for-profits Because El Camino does not have an offset SERP, the retirement contribution as a percentage of compensation is higher for lower-paid executives than for higher-paid executives

Sources: Mercer's 2019 Healthcare Executive Benefits and Perquisites Survey. Tier 1 Executives: CEO direct reports; Tier 2 Executives: Tier 1 direct reports.

Retirement Plans Summary, continued

	El Camino	Market Practice	Comments
Employee Deferrals	<p><u>403(b) Plan</u></p> <ul style="list-style-type: none"> Allows for deferral of pay (up to \$19,500 in 2020; \$26,000 if age 50+) <p><u>457(b) Plan</u></p> <ul style="list-style-type: none"> Allows for additional deferral up to \$19,500 in 2020 All but one executive have elected to defer a portion of their Taxable Benefit Allowance into the 457(b) plan 	<ul style="list-style-type: none"> Nearly all allow for deferrals to a 403(b)/401(k) plan <p>Not-for-Profit</p> <ul style="list-style-type: none"> ~90% allow additional deferrals into a 457(b) plan <p>For-Profit</p> <ul style="list-style-type: none"> 50% allow additional deferrals into a nonqualified plan 	<ul style="list-style-type: none"> Consistent with market practice to provide a 457(b) plan
Taxable Benefit Allowance	<ul style="list-style-type: none"> 7% of salary Can be used to purchase LTC, additional LTD, and life insurance, defer into 457(b) plan, or distributed in cash 	<ul style="list-style-type: none"> Prevalence of flexible plans has declined over time (less than 20% provide), due to complexity and compliance risk 	<ul style="list-style-type: none"> Consider reallocating to SERP (and shorten vesting from 5 yrs to 3 yrs) or cash compensation

Sources: Mercer's 2019 Healthcare Executive Benefits and Perquisites Survey. Tier 1 Executives: CEO direct reports; Tier 2 Executives: Tier 1 direct reports.

Health & Welfare Plans Summary

	El Camino	Market Practice	Comments
Medical	<ul style="list-style-type: none"> Executives receive the same health benefits as all employees 	<ul style="list-style-type: none"> It is common to provide the same health benefits and employer/employee cost sharing to all employees 	<ul style="list-style-type: none"> Consistent with market practice
Life Insurance	<ul style="list-style-type: none"> 3X annual salary, up to a maximum of \$2 million; no medical underwriting required (effective 1/1/2019) Has the option to buy additional coverage with Taxable Benefit Allowance 	<ul style="list-style-type: none"> Almost all provide employer-paid group coverage ~50% provide supplemental coverage to top executives Median coverage is 2X salary (3X at the 75th percentile), up to a maximum of \$1M 	<ul style="list-style-type: none"> Aligned with the market 75th percentile
Long-term Care (LTC)	<ul style="list-style-type: none"> Executives can buy coverage with Taxable Benefit Allowance 2 executives have 2008 policies that were provided as a non-elective employer-paid benefit 	<ul style="list-style-type: none"> Approximately 15% provide executive coverage to executives 	<ul style="list-style-type: none"> Providing LTC is not prevalent in the market

Sources: Mercer's 2019 Healthcare Executive Benefits and Perquisites Survey. Tier 1 Executives: CEO direct report; Tier 2 Executives: Tier 1 direct report

Health & Welfare Plans Summary, continued

	El Camino	Market Practice	Comments
Salary Continuation	<ul style="list-style-type: none"> Employer-paid executive coverage equal to 100% of salary for up to 6 months, offset by long-term disability benefits, accrued PTO, etc. 	<ul style="list-style-type: none"> 80% provide group coverage <ul style="list-style-type: none"> 60% of salary is the most common benefit 50% provide supplemental coverage to top executives through a formal plan <ul style="list-style-type: none"> In practice (and outside of a formal plan), it is common to continue 100% of base salary for executives 	<ul style="list-style-type: none"> Consistent with market practice
Long-term Disability (LTD)	<ul style="list-style-type: none"> Employer-paid group coverage equal to 60% of salary up to a monthly maximum of \$15,000 Has the option to buy additional coverage with Taxable Benefit Allowance 	<ul style="list-style-type: none"> Nearly all provide group coverage 50% provide supplemental coverage to executives Median coverage is 60% of salary up to \$18,000 per month 	<ul style="list-style-type: none"> Coverage level is consistent with market practice but the monthly maximum is slightly below market Hartford (LTD carrier) is willing to increase the cap to \$20K for ~\$5K in total, which does not impact TR market positioning

Sources: Mercer's 2019 Healthcare Executive Benefits and Perquisites Survey. Tier 1 Executives: CEO direct report; Tier 2 Executives: Tier 1 direct report

Severance and Perquisites Summary

	El Camino	Market Practice	Comments
Severance	<ul style="list-style-type: none"> Salary and health benefits continue for up to 6 months 	<ul style="list-style-type: none"> 85% provide additional severance for executives Median severance period is 12 months for executives Nearly all continue health benefits during the severance period 	<ul style="list-style-type: none"> Length of severance period is below market median
Perquisites	<ul style="list-style-type: none"> El Camino does not provide any executive-only perquisites 	<ul style="list-style-type: none"> Car/car allowance is the most prevalent remaining perquisite (20% provide) Financial counseling is the second most prevalent perquisite (11% provide) Perquisites are slightly more prevalent among for-profit companies, with ~70% providing at least one perquisite 	<ul style="list-style-type: none"> Perquisites without a clear business-related purpose continue to become less prevalent ECH could consider a financial planning benefit for executives (e.g., reimbursement up to \$3K/year) to assist with retirement planning

Sources: Mercer's 2019 Healthcare Executive Benefits and Perquisites Survey. Tier 1 Executives: CEO direct report; Tier 2 Executives: Tier 1 direct report

Appendix D: CEO Benefits and Perquisites Review

The CEO receives the same benefits as other executives with the exception of:

	El Camino	Market Practice	Comments
Employer-paid Retirement	<ul style="list-style-type: none"> Total contribution of 13% of salary <ul style="list-style-type: none"> Between qualified plans (403(b) and cash balance plans) and SERP 	<ul style="list-style-type: none"> 60% provide a nonqualified plan to the CEO <ul style="list-style-type: none"> The vast majority are DC SERPs Median total employer contribution from all sources is 16% of salary 	<ul style="list-style-type: none"> Contribution level is slightly below market median
Perquisites	<ul style="list-style-type: none"> Interest-free loan of \$400,000 (compensatory value of interest included in total remuneration) 	<ul style="list-style-type: none"> Car/car allowance is the most prevalent remaining perquisite <ul style="list-style-type: none"> 35% for the CEO Perquisites are slightly more prevalent among for-profit companies, with ~75% providing at least one perquisite to the CEO Financial counseling is the second most prevalent perquisite (17% provide) Executive relocation benefits are common; however, prevalence of mortgage/loan assistance is low 	<ul style="list-style-type: none"> ECH could consider a financial planning benefit for executives (e.g., reimbursement up to \$3K/year) to assist with retirement planning Consider a relocation policy that allows flexibility rather than a formal policy
Severance	<ul style="list-style-type: none"> Salary and health benefits continue for up to 12 months 	<ul style="list-style-type: none"> 85% provide additional severance for the CEO Median severance period is 18 months for the CEO <ul style="list-style-type: none"> Nearly all continue health benefits during the severance period 	<ul style="list-style-type: none"> Length of severance period is below market median

Appendix E: Geographic Salary Differential

- A geographic salary differential is a numerical value that expresses how a position’s pay in a particular location compares to the national average pay for the same position.
 - For example, a differential of 29% for Mountain View means that the average executive salary in Mountain View is 29% higher than the average salary of executives in like positions across the US.
- The purpose of applying a geographic salary differential to market data is to account for the market differences in that employee’s location.
- Geographic salary differentials used in this study are calculated using data from the Economic Research Institute (ERI), which determines differentials using salary survey data from across the country. The differential in the Bay Area has been increasing over the past decade, with that increase accelerating over the past three to five years.

	Bay Area ¹	Silicon Valley ²	Mountain View	Top 5 Cities ³
Average Differential	24%	28%	29%	29%

⁽¹⁾ Bay Area includes Silicon Valley (see below), San Francisco, Oakland, Berkeley, Piedmont, Lafayette, Walnut Creek, Alameda, and Marin County (Belvedere, Corte Madera, Fairfax, Larkspur, Mill Valley, Novato, Ross, San Anselmo, San Rafael, Sausalito, and Tiburon).

⁽²⁾ Silicon Valley includes Mountain View, Palo Alto, Cupertino, Sunnyvale, Los Altos, and Los Gatos.

⁽³⁾ Top 5 Cities with the most ECH employees includes Milpitas, Mountain View, San Jose, Santa Clara, and Sunnyvale.

A geographic salary differential of 25% has been applied to survey data for base salary and total cash compensation in this study.



**Minutes of the Open Session of the
Executive Compensation Committee
of the El Camino Hospital Board of Directors
Thursday, November 5, 2020**

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

Members Present

Teri Eyre ☐
 Jaison Layney ☐
 Bob Miller, Chair ☐
 George Ting, MD ☐
 Pat Wadors ☐

Members Absent

Julie Kliger, Vice Chair
 ☐ via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	<p>The open session meeting of the Executive Compensation Committee of El Camino Hospital (the “Committee”) was called to order at 4:01pm by Chair Bob Miller. A verbal roll call was taken. Ms. Kliger was absent. All other Committee members were present and participated via videoconference pursuant to Santa Clara County’s shelter in place order. A quorum was present pursuant to State of California Executive Orders 02520 dated March 12, 2020 and 02920 dated March 13, 2020.</p>	
2. ADJOURN TO CLOSED SESSION	<p>Motion: To adjourn to closed session at 4:02pm. Movant: Layney Second: Ting Ayes: Eyre, Layney, Miller, Ting, Wadors Noes: none Abstentions: none Absent: Kliger Recused: none</p>	<p><i>Adjourned to closed session at 4:02pm</i></p>
3. AGENDA ITEM 8: RECONVENE OPEN SESSION/ REPORT OUT	<p>Open session was reconvened at 5:59pm. Agenda items 3-7 were addressed in closed session.</p> <p>During the closed session, the Committee approved the minutes of the Closed Session of the Executive Compensation Committee meeting 7/27/2020, the minutes of the Closed Session of the Executive Compensation Committee meeting 9/22/2020, and the F21 CFO Individual Performance Goals by unanimous vote in favor of all members present by teleconference (Eyre, Kliger, Layney, Miller, Ting, Wadors)</p>	
4. AGENDA ITEM 10: SELECTION OF EXECUTIVE COMPENSATION CONSULTANT	<p>This item was taken out of order.</p> <p>Motion: To approve the selection of Mercer for a three year contract to be the Committee’s executive compensation consultant, subject to the terms of the Agreement that will be drafted by Human Resources. Movant: Layney Second: Wadors Ayes: Eyre, Layney, Miller, Ting, Wadors Noes: none Abstentions: none Absent: Kliger Recused: none</p> <p>Chair Miller thanked the Ad Hoc Committee and staff for their work</p>	<p><i>Mercer selected as consultant</i></p>

<p>5. AGENDA ITEM 9: POTENTIAL CONFLICT OF INTEREST DISCLOSURES</p>	<p>Chair Miller asked if any Committee members had a conflict of interest with any of the items on the open session agenda. No conflicts were noted.</p>	
<p>6. AGENDA ITEM 11: PUBLIC COMMUNICATION</p>	<p>None.</p>	
<p>7. AGENDA ITEM 12: CONSENT CALENDAR</p>	<p>Chair Miller asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed.</p> <p>Motion: No approve the consent calendar: Minutes of the Open Session of the Executive Compensation Committee Meeting 9/22/2020 and for information: Progress Against FY21 Committee Goals.</p> <p>Movant: King Second: Payne Ayes: Eyre, Payne, Miller, King, Adams Noes: None Abstentions: None Absent: Liger Recused: None</p> <p>Ms. Eyre and Ms. Adams left the meeting at 6:01pm.</p>	<p><i>Consent calendar approved</i></p>
<p>8. REPORT ON BOARD ACTIONS</p>	<p>Chair Miller reported that the Board approved the FY20 organizational goal score and commended the Committee's work in this area.</p>	
<p>9. ASSESS EFFECTIVENESS OF DELEGATION OF AUTHORITY</p>	<p>Committee members noted that the Committee generally receives enough information to perform its responsibilities.</p> <p>Chair Miller suggested asking the Board leadership and support staff about whether the Committee's delegated authority is successful and if it is saving the Board time.</p>	
<p>10. AGENDA ITEM 15: FY21 PACING PLAN</p>	<p>Chair Miller noted that the discussion on the geographic differential was deferred to the Committee's March 2021 meeting.</p>	
<p>11. AGENDA ITEM 16: CLOSING COMMENTS</p>	<p>There were no additional comments from the Committee.</p>	
<p>12. AGENDA ITEM 22: ADJOURNMENT</p>	<p>Motion: No adjourn at 6:04pm. Movant: Payne Second: King Ayes: Payne, Miller, King Noes: None Abstentions: None Absent: Eyre, Liger, Adams Recused: None</p>	<p><i>Meeting adjourned at 6:04pm</i></p>

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

 Chair, Executive Compensation Committee

 Julia E. Miller
 Secretary, ECH Board of Directors

Prepared by: Sarah Rosenbarg, Contracts Administrator/ Governance Services EA



El Camino Health

Summary of Financial Operations

*Fiscal Year 2021 – Period 7
7/1/2020 to 01/31/2021*

Operational Financial Results: Period – January as of

PERIOD - RESULTS

(\$ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's Medians		Performance to 'A' Medians
									'A'	'Aa'	
Activity Volume	ADC	200	200	0	200	204	0	1.00	---	---	---
	Total Discharges	1,040	1,000	142	100	2,120	(100)	-0.00	---	---	---
	Adjusted Discharges	2,043	2,010	33	1.20	3,204	(001)	-1.00	---	---	---
	Emergency Room	2,000	2,001	00	1.00	4,400	(1,440)	-32.00	---	---	---
	OP Procedural Cases	10,404	10,000	0,000	1.20	14,000	1,010	10.10	---	---	---
	Gross Charges (\$)	33,000	20,000	4,100	1040	34,412	(10,024)	-3.10	---	---	---
Operations	Total FTEs	2,000	2,000	20	0.00	2,040	00	2.00	---	---	---
	Productive Hrs. / APD	32.0	34.0	(1.0)	-4.40	20.0	3.0	12.00	---	---	---
	Cost Per Adjusted Discharge	10,200	10,412	(2,100)	-11.00	10,200	001	0.30	---	---	---
	Net Days in A/R	401	400	0.1	0.20	01.0	(3)	-4.00	400	401	
Financial Performance	Net Patient Revenue (\$)	0,000	0,002	14,033	100	0,002	(100)	-0.20	10,023	20,000	
	Total Operating Revenue (\$)	4,222	0,001	13,421	100	4,200	(00)	-0.10	11,004	314,040	
	Operating Income (\$)	0,000	0,000	0,000	0.00	0,000	0,000	-100.00	0,000	0,000	
	Operating EBITDA (\$)	0,000	0,000	0,000	20.20	0,000	0,000	-0.20	0,000	0,000	
	Net Income (\$)	(23)	2,213	(2,230)	-101.00	12,002	(12,000)	-100.20	0,210	10,020	
	Operating Margin (%)	-0.00	-0.00	0.00	0.30	0.00	-0.00	-100.00	0.00	0.00	
	Operating EBITDA (%)	0.00	0.00	0.00	10.00	0.00	-0.00	-0.20	0.00	0.00	
	DCOH (days)	044	430	100	2010	400	00	10.00	204	204	

Moody's Medians: Not-for-profit and public healthcare annual report September 0, 2020. Dollar amounts have been adjusted to reflect month averages.

Operational Financial Results: YTD FY as of

YTD FY - RESULTS

(\$ thousands)

		YTD FY - RESULTS				YTD FY - RESULTS			Moody's Medians		Performance to 'A' Medians
		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	'A'	'Aa'	
Activity Volume	ADC	244	100	44	23.2%	23%	1%	3.0%	---	---	---
	Total Discharges	13,200	12,000	1,201	10.0%	14,443	(1,100)	-0.0%	---	---	---
	Adjusted Discharges	20,200	10,040	2,302	13.1%	22,040	(2,241)	-0.0%	---	---	---
	Emergency Room	21,400	10,102	3,204	10.0%	20,023	(0,400)	-2.0%	---	---	---
	OP Procedural Cases	112,100	0,213	3,000	0.3%	0,000	1,002	1.1%	---	---	---
	Gross Charges (\$)	2,441,001	1,003,022	0,304,000	20.2%	2,200,020	103,001	0.2%	---	---	---
Operations	Total FTEs	2,003	2,040	(41)	-1.0%	2,000	1	0.0%	---	---	---
	Productive Hrs. / APD	31.1	34.0	(3.0)	-10.0%	30.0	0.2	0.0%	---	---	---
	Cost Per Adjusted Discharge	10,000	10,044	(1,000)	-10.0%	10,024	1,101	0.3%	---	---	---
	Net Days in A/R	40.1	40.0	0.1	0.2%	0.0	(2.0)	-4.0%	40.0	40.1	---
Financial Performance	Net Patient Revenue (\$)	0,004	400,101	120,003	20.0%	0,004	20,230	4.2%	0,000	1,000,000	---
	Total Operating Revenue (\$)	0,042	0,040	121,004	23.0%	0,000	20,003	3.3%	0,000	2,202,030	---
	Operating Income (\$)	0,000	0,000	0,000	210.0%	0,000	0,000	-33.2%	0,000	0,000	---
	Operating EBITDA (\$)	0,000	0,000	0,000	404.0%	0,000	0,000	-2.0%	0,000	0,000	---
	Net Income (\$)	100,400	(11,013)	100,202	100.3%	100,042	0,040	0.0%	0,000	131,000	---
	Operating Margin (%)	0.0%	-0.0%	0.0%	100.0%	0.0%	-0.0%	-3.4%	0.0%	0.0%	---
	Operating EBITDA (%)	0.0%	0.0%	0.0%	300.2%	0.0%	-0.0%	-0.0%	0.0%	0.0%	---
	DCOH (days)	0.44	43	10	20.1%	40	0	1.0%	20	20	---

Moody's Medians: Not-for-profit and public healthcare annual report September 0, 2020. Dollar amounts have been adjusted to reflect 0 month totals.

Overall Commentary for Period □ - □ January □□□□

Period ending □□□□□□□□

- January operations and financial performance was significantly impacted by a □□ increase in Covid-1□ patients over the prior three month averages. As a result of this increase, the organization incurred an additional □4.0M in SWB and had to reduce OR block times at the MV campus for 3 weeks of the month which resulted in a loss of revenue of approximately □□.0M.
- Due to an increase in the case mix index (CMI) total average length of stay (ALOS) has increased by 0.□ days which has resulted in ADC is 3.4□ higher year-over-year
- Total gross charges, a surrogate for volume, were favorable to budget by □40.2M / 1□.4□ and □10.□M / 3.0□ lower than the same period last year
- Net patient revenue was favorable to budget by □14.0M / 14.□□ and □1□□□ / 0.0□ better than the same period last year
- Operating expenses were □12.4M / 1□.1□ unfavorable to budget, which is primarily attributed to higher than expected volume versus budget and the significant increase in Covid-1□ patients in January
- Operating margin was favorable to budget by □1.1M / □4.□□ and □□.4M / 101□ lower than the same period last year
- Operating EBIDA was favorable to budget by □1.□M / 2□.2□ and □□.□M / □2.□□ lower than the same period last year

Financial Overview: Period □ - □ January □□□□

Period ending □□□□□□□□

Financial Performance

- January operating loss was □□2□ compared to a budgeted loss of □1.1M, resulting in a favorable variance of □1M. The primary drivers are due primarily to volumes which have significantly exceeded budget.
- Volumes and Revenues continue to be stronger than budget as demonstrated by:
 - Adjusted discharges were favorable to budget by 32 cases / 1□ and □□1 / 1□.□□ lower than the same period last year
 - Favorable variance gross charges of □4□.2M due primarily to inpatient services:
 - Inpatient gross charges: Favorable to budget by □4□M / 31□ variance primarily driven by lab, pharmacy, and critical care
 - Outpatient gross charges: Favorable to budget by □1M / 1□ variance primarily impacted by lower than budgeted Operating Room and Interventional services activity at Mt View
 - Operating Expenses were unfavorable to budget by □12.4M / 1□.1□, primarily due to increased patient activity, increased use / cost of PPE associated with Covid-1□ and other Covid-1□ associated expenses
 - SWB were unfavorable by □□.□M / 1□.□□
 - Supplies were unfavorable by □1.4M / 1□□
 - All other discretionary non-volume driven expenses were unfavorable to budget by □3.4M
 - Additional expenses attributed to Covid-1□ were □2.4M in January and an average of approx. □1.□M per month for the first seven months of FY2021
- Non Operating Income includes:
 - Unfavorable variance of □3.1M primarily due to unrealized losses on investments

Financial Overview: Period – January cont.

Period ending

Financial Performance

Hospital Operations:

- Adjusted Discharges (AD): Favorable to budget by ADs / and below prior year by ADs / :
 - Mountain View: Unfavorable to budget by ADs / and below prior year by /
 - Los Gatos: Favorable to budget by ADs / and above than prior year by /
- Operating Expense Per Adjusted Discharge: , which is unfavorable to budget

Note: Excludes depreciation and interest

El Camino Health Medical Network ECHMNOperations:

- January total visits of , was above prior month and favorable to budget and included , COVID vaccination visits
- Operating income was unfavorable to budget by / () in January. YTD ECHMN is slightly unfavorable to budget by / () but remains favorable to prior year by M / ()

Financial Overview: YTD FY2021 as of 12/31/2021

Consolidated Financial Performance

- YTD FY2021 net operating margin of \$31.1M is favorable to budgeted by \$32.4M
- Year-over-year operating margin is \$11.1M lower than the same period last year, which directly due to an increase in depreciation and interest of \$11.1M expenses associated with recently completed capital projects at the Mountain View campus
- Strong volume recovery from the first wave of Covid-19, continues to be the primary driver of favorable performance to budget
 - Adjusted discharges are 2,342 /13% favorable to budget and 2,230 / 11.5% lower than the same period last year
- Operating expenses are \$33.4M / 11.5% unfavorable to budget
 - Unfavorability driven higher than budgeted volumes and expenses associated with Covid-19 pandemic
 - Operating expense per adjusted discharge of \$2,114 is 1% favorable to budget which demonstrates consistent management of variable expenses

Note: Excludes depreciation and interest expense

Consolidated Statement of Operations (\$000s)

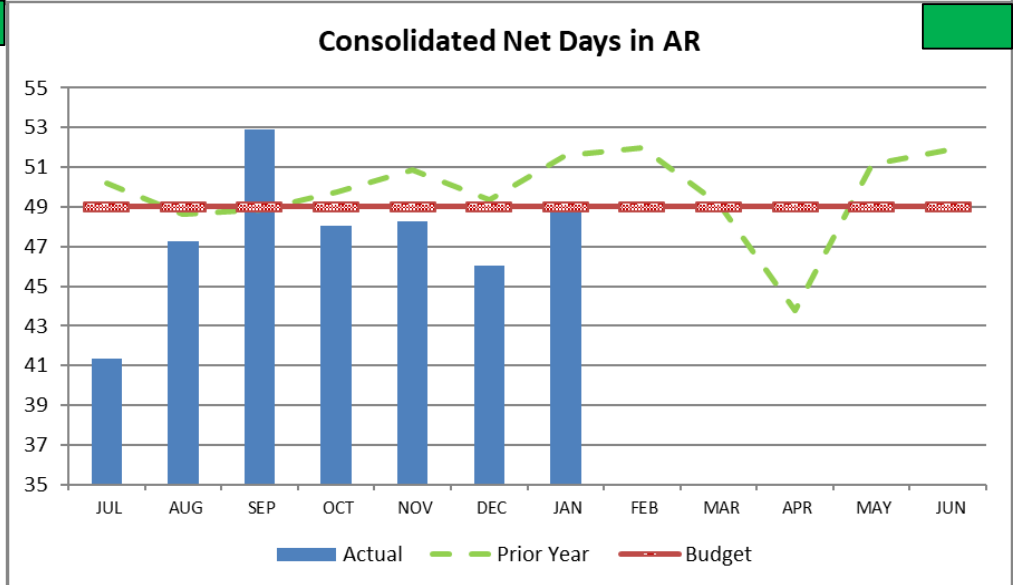
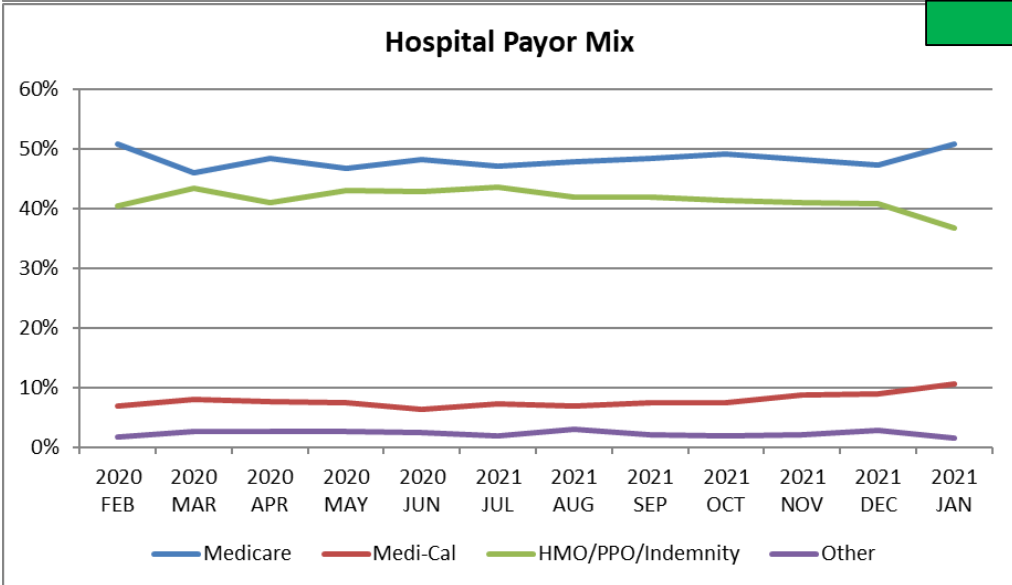
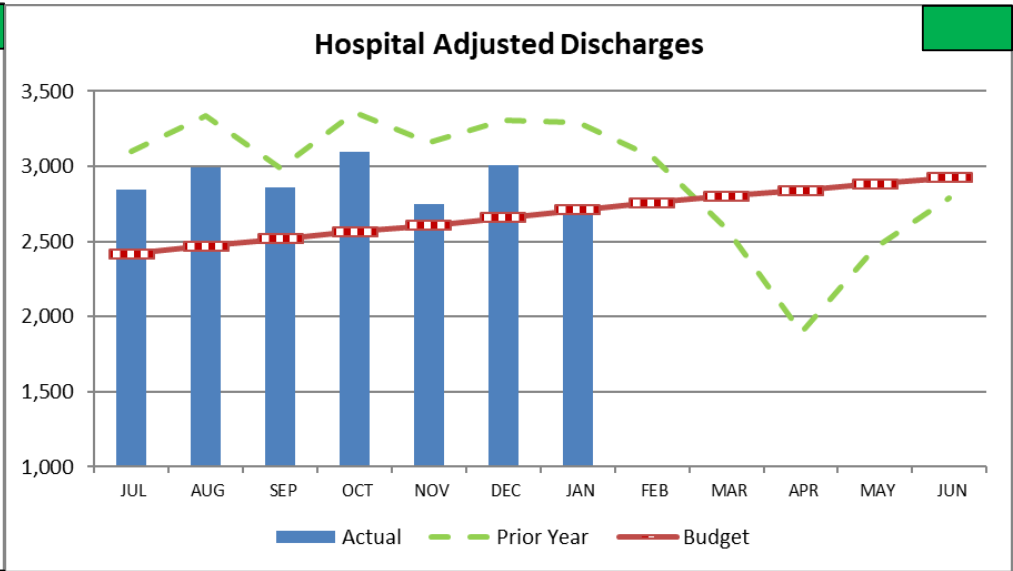
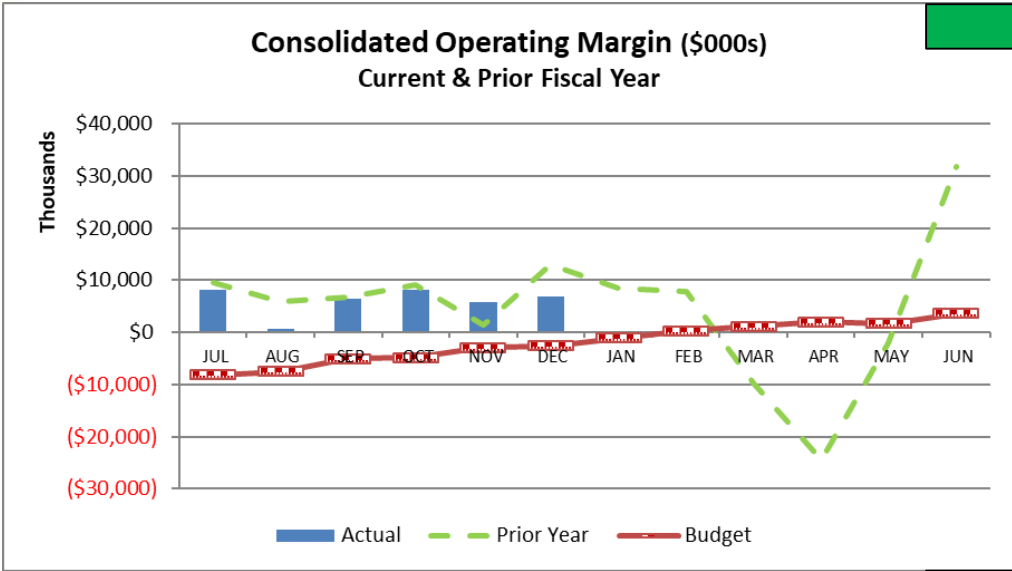
Period ending

Period 7 FY 2020	Period 7 FY 2021	Period 7 Budget 2021	Variance Fav (Unfav)	Var%	\$000s	YTD FY 2020	YTD FY 2021	YTD Budget 2021	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
346,412	335,788	288,598	47,190	16.4%	Gross Revenue	2,277,920	2,441,571	1,903,822	537,749	28.2%
(256,441)	(245,993)	(212,836)	(33,157)	(15.6%)	Deductions	(1,680,375)	(1,818,787)	(1,407,721)	(411,066)	(29.2%)
89,972	89,795	75,762	14,033	18.5%	Net Patient Revenue	597,545	622,784	496,101	126,683	25.5%
4,309	4,427	5,039	(612)	(12.2%)	Other Operating Revenue	32,114	27,758	32,848	(5,090)	(15.5%)
94,280	94,222	80,801	13,421	16.6%	Total Operating Revenue	629,659	650,542	528,948	121,593	23.0%
					OPERATING EXPENSE					
48,046	53,636	46,005	(7,631)	(16.6%)	Salaries & Wages	323,325	340,999	310,273	(30,726)	(9.9%)
12,923	13,888	11,390	(2,498)	(21.9%)	Supplies	93,337	98,055	76,858	(21,197)	(27.6%)
14,682	15,825	14,434	(1,391)	(9.6%)	Fees & Purchased Services	99,004	99,339	101,088	1,749	1.7%
3,655	3,819	3,513	(306)	(8.7%)	Other Operating Expense	26,421	26,829	25,880	(949)	(3.7%)
1,552	1,428	926	(502)	(54.2%)	Interest	2,769	10,000	6,480	(3,520)	(54.3%)
5,059	5,689	5,653	(35)	(0.6%)	Depreciation	31,146	39,499	40,740	1,241	3.0%
85,918	94,284	81,922	(12,362)	(15.1%)	Total Operating Expense	576,003	614,720	561,319	(53,401)	(9.5%)
8,362	(62)	(1,121)	1,059	(94.5%)	Net Operating Margin	53,657	35,822	(32,371)	68,193	(210.7%)
4,510	39	3,334	(3,295)	(98.8%)	Non Operating Income	52,885	141,667	20,658	121,009	585.8%
12,872	(23)	2,213	(2,236)	(101.1%)	Net Margin	106,542	177,489	(11,713)	189,202	(1615.3%)
14,974	7,055	5,459	1,596	29.2%	Operating EBIDA	87,572	85,321	14,850	70,471	474.6%
15.9%	7.5%	6.8%	0.7%		Operating EBIDA Margin	13.9%	13.1%	2.8%	10.3%	
8.9%	-0.1%	-1.4%	1.3%		Operating Margin	8.5%	5.5%	-6.1%	11.6%	
13.7%	0.0%	2.7%	(2.8%)		Net Margin	16.9%	27.3%	-2.2%	29.5%	



APPENDI □

YTD FY Financial PIs – Monthly Trends



Investment Scorecard as of □□□□□□□□□□

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY21 Budget	Expectation Per Asset Allocation
Investment Performance		CY 4Q 2020 / FY 2Q 2021		Fiscal Year-to-Date 2021		8y 2m Since Inception (annualized)		FY 2021	2019
Surplus cash balance*		\$1,302.1	--	--	--	--	--	--	--
Surplus cash return		8.5%	8.0%	13.0%	12.2%	6.6%	6.4%	4.0%	5.6%
Cash balance plan balance (millions)		\$336.2	--	--	--	--	--	--	--
Cash balance plan return		11.2%	9.2%	17.1%	14.3%	8.9%	7.9%	6.0%	6.0%
403(b) plan balance (millions)**		\$581.5	--	--	--	--	--	--	--
Risk vs. Return		3-year				8y 2m Since Inception (annualized)			2019
Surplus cash Sharpe ratio		0.69	0.67	--	--	0.93	0.93	--	0.34
Net of fee return		7.8%	7.3%	--	--	6.6%	6.4%	--	5.6%
Standard deviation		9.0%	8.6%	--	--	6.3%	6.1%	--	8.7%
Cash balance Sharpe ratio		0.73	0.64	--	--	1.00	0.96	--	0.32
Net of fee return		9.8%	8.0%	--	--	8.9%	7.9%	--	6.0%
Standard deviation		11.4%	10.3%	--	--	8.1%	7.4%	--	10.3%
Asset Allocation		CY 4Q 2020 / FY 2Q 2021							
Surplus cash absolute variances to target		9.4%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Cash balance absolute variances to target		7.9%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Manager Compliance		CY 4Q 2020 / FY 2Q 2021							
Surplus cash manager flags		16	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		19	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~\$12 mm), District assets (~\$34 mm), and balance sheet cash not in investable portfolio (\$214 mm). Includes Foundation (~\$39 mm) and Concern (~\$15 mm) assets.

**As of September 30, 2020 as more recent data not yet available.

YTD FY□□□□ and □anuary Operating Margin, Non-Operating Income and Net Margin by Affiliate □as of □□□□□□□□□□

(\$ in thousands)

	Period 7- Month			Period 7- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	(862)	405	(1,267)	40,940	(18,814)	59,754
Los Gatos	3,924	1,511	2,412	17,564	9,564	7,999
Sub Total - El Camino Hospital, excl. Affililates	3,062	1,916	1,146	58,504	(9,249)	67,753
Operating Margin %	3.4%	2.5%		9.5%	-1.9%	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	316	3,028	(2,712)	137,408	18,537	118,870
El Camino Hospital Net Margin	3,378	4,945	(1,566)	195,911	9,288	186,623
ECH Net Margin %	3.8%	6.6%		31.8%	1.9%	
Concern	(104)	25	(129)	267	194	72
ECSC	0	0	0	(3)	0	(3)
Foundation	(328)	(21)	(306)	2,518	(30)	2,548
El Camino Health Medical Network	(2,970)	(2,735)	(235)	(21,205)	(21,165)	(40)
Net Margin Hospital Affiliates	(3,402)	(2,732)	(670)	(18,423)	(21,001)	2,578
Total Net Margin Hospital & Affiliates	(23)	2,213	(2,236)	177,489	(11,713)	189,202

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO**

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, FACS, Chief Medical Officer
Date: April 7, 2021
Subject: Urology ED & Inpatient On-Call Panel (Los Gatos)

Recommendation: To approve delegating to the Chief Executive Officer the authority to execute a one-year renewal of the LG Urology On-Call Panel agreement at the existing rate of \$1,100/day; \$401,500/year.

Summary:

1. **Situation:** Currently, Urological Surgeons of Northern CA (“USNC”) is the sole provider of urologists that provide LG campus urology call coverage. This agreement expires April 30, 2021. ECH proposed a renewal term of two years, but USNC would only agree to a renewal term of one year.
2. **Authority:** According to Administrative Policies and Procedures 51.00, Finance Committee recommendation and Board approval is required prior to the Chief Executive Officer signature of physician agreements that exceed \$250,000 in annual compensation, and exceed the 75th percentile for fair market value.
3. **Background:** USNC physicians have provided sole urology call coverage services at the LG campus since 2010. Urologists with Palo Alto Medical Foundation (“PAMF”) and USNC are both contracted to provide urology call coverage at the MV Campus. On April 15, 2020, the Board of Directors approved a one-year renewal at an increased rate from \$930/day to the existing rate of \$1,100/day. USNC participation is essential to provide sufficient urology call coverage at both campuses.
4. **Fair Market Value Assessment:** Compensation will be constrained to the existing rate of \$1,100/day, \$401,500 per year, which is between the 75th percentile (\$1,000) and 90th percentile (\$1,250) according to the 2020 MD Ranger – Urology ED Call Coverage Per Diem San Francisco Bay Area Report.
5. **Other Reviews:** At its march 29, 2021 meeting the Finance Committee voted to recommend Board approval. Legal and Compliance will review the renewal amendment and compensation terms prior to CEO execution.
6. **Outcomes:** Physicians will participate in the peer review process for consultations related to urology call coverage at the Los Gatos campus.

List of Attachments: N/A

Suggested Committee Discussion Questions: N/A

Interventional Radiology ED & Inpatient On-Call Panel Renewal (Los Gatos)
January 25, 2021

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO**

To: El Camino Hospital Board of Directors
From: Apurva Sarfatia, MD, Enterprise Chief of Staff
Michael Chan, MD Chief of Staff Cosmetics
Date: April 7, 2021
Subject: Medical Staff Report – Open Session

Recommendation:

To approve the Medical Staff Report, including Policies, Plans and scopes of service identified in the attached list as well as the OIG/DOJ Delineation of Privileges.

Summary:

1. **Situation:** The Medical Executive Committee met on March 25, 2021
2. **Background:** MEC received the following informational reports.
 - a. **Quality Council** – The Quality Council met on March 6, 2021. Reports and performance dashboards were reviewed and approved from the following ECH Departments/Service Lines:
 1. Epsis Semi Annual Performance Improvement Report
 2. Epsis Quality Performance Tracking Dashboard
 3. Acute Reha Annual Performance Improvement Report
 4. Acute Reha Quality Dashboard
 5. Annual P Report Sterile Processing F21
 6. Sterile Processing Dashboard F21
 7. Hospital Value Based Purchasing ECH F2122
 - b. **Leadership Council** – The Leadership Council met on March 9, 2021 and discussed the following:
 1. Physician Portal Update
 2. Financial Update
 3. MyLA/credentials Update
 4. ER and ICU Interaction
 - c. **The CEO Report** was provided and included the following updates:
 1. Introduction Interim President ECH, since Anoojian
 2. Visitor Policy
 3. COVID19 Testing Update
 4. COVID19 Vaccination Update
 5. ECH – ICU Family Centered Care Committee David Wirtschafter Award
 - d. **The CFO Report** was provided and included the following updates:
 1. Visitor Guidelines
 2. COVID19 Update

List of Attachments:

1. Policy spreadsheet

2. Policies, Plans, Scopes of Service
3. O/R/D Delineation of Privileges

Suggested Board Discussion Questions: One. This is a consent item.

BOARD
Policies, Plans and Scopes of Service for Approval
April 7th, 2021

Department	Policy/Procedure Name	Type of Change	Type of Document	Notes	Committee Approvals
Infection Prevention	1. FY2021 Infection Control Plan	Revised	Plan	Updated for 2021	Infection Control Committee
Patient Care Services	1. Scope of Service Telemetry/Cardiac Unit Mountain View	None	Scope of Svc.	3 year review, no changes	Dept. of Medicine
Finance	1. Hospital Pricing and Chargemaster Policy	Revised	Policy	Revised title of policy to include "Hospital", revised El Camino Hospital to El Camino Health and clarified statement in the Medication Charge section	CFO
Finance	1. Financial Assistance Policy/Charity Care	Revised	Policy	1. Toyon (outside consulting firm that we use to support Medicare cost reporting and government audit settlements) made some recommendations for strengthening the language in our Financial Assistance Policy. They explained the primary purpose of the recommended revisions are to better reflect our policy's compliance with changes made by the CARES Act and FY2021 IPPS Final rule (ultimately related to uncompensated care reporting on the Medicare cost report/worksheet S-10). They believe these changes (incorporated to this revised policy) provide us additional protection in the event of an audit. I have also added the clarification that the uninsured/self-pay discount is applicable to charges for any services deemed "non-covered" by government payers, such as Medicare.	CFO



Origination: 01/1996
Effective: Upon Approval
Last Approved: N/A
Last Revised: 02/2021
Next Review: 1 year after approval
Owner: Catherine Nalesnik: Director
 Infection Prevention
Area: Infection Prevention
Document Types: Plan

FY 2021 Infection Control Plan

COVERAGE:

All El Camino Hospital staff

PURPOSE:

The El Camino Hospital Infection Prevention & Control Program's primary function is to prevent transmission of infectious agents among patients, staff and visitors. It is the goal of the Infection Prevention and Control Department:

- To reduce infection risk by implementing strategic policies and procedures for surveillance and control of healthcare-associated infection and other contagious infection
- To monitor and identify drug-resistant pathogens and emerging pathogens.
- To provide education to staff upon hire and as needed in developing practices which reflect current infection control guidelines and standards of care.
- To conduct an annual evaluation of the Infection Control Risk Assessment for acquiring and transmitting infections within the hospital environment and set goals to reduce infections.

STATEMENT:

The El Camino Hospital Infection Control and Prevention Plan include policies and procedures that are created on evidence based guidelines or expert consensus. At least annually, and whenever risks significantly change, an evaluation of the effectiveness of the infection prevention and control plan will be completed. Assessment of the prevention strategies will be based on their effectiveness at preventing and controlling infection. The Infection Prevention Nurses report all communicable diseases to the Public Health Departments to help prevent spread of certain infections within the public at large.

The Infection Prevention and Control Plan evaluate the risk of communicable disease transmission based on the following:

- El Camino Hospital Mountain View and Los Gatos: location and services provided
- Santa Clara County geographic location and demographics
- Mountain View and Los Gatos demographics
- Santa Clara County Community health status assessment
- Tuberculosis (TB) Risk Assessment: California and Community profiles
- Seasonal Influenza Activity
- Threats facing Santa Clara County
- National trends and novel infections and International outbreaks
- [COVID-19 Pandemic](#)
- [California Department of Public Health Alerts](#)

El Camino Hospitals: Mountain View and Los Gatos

Geographic location, patient volume and services provided: (FY2019 data):

- Hospital geographic location – 2 hospital campuses in a large urban areas
- MV beds: 274 General Acute Care
- LG beds: 143 General Acute Care
- Patient volume: greater than 18,000 discharges per year
- Enterprise admissions: 20,712 (FY 2019: 21,592 (FY 2018: 22,059))
- Enterprise admissions Patient Days: 24,592,608 (FY 2018: 22,019,102,059-026)
- Patient population served: multicultural
- Hospital clinical focus – emergency services, maternal child services, cancer services, Adult & neonatal critical care services, diagnostic services, medical/surgical services, cardiac services, cyber knife & radiosurgery center, acute rehab center, behavioral health services and out-patient services

Santa Clara County Geographic Location and Demographics:

<https://www.census.gov/quickfacts/fact/table/santaclaracountycalifornia/PST045216>

With 1.9 million residents, Santa Clara County is the sixth most populated of California's 58 counties and the most populated in the Bay Area. More than one-third (37%) of county residents are foreign-born. The largest percentage of foreign-born residents were born in Mexico (21%), followed by Vietnam (15%), India (13%), the Philippines (9%), and China (8%), excluding Hong Kong and Taiwan.

Santa Clara County encompasses 1,312 square miles and runs the entire length of the Valley from north to south, ringed by the rolling hills of the Diablo Range on the east, and the Santa Cruz Mountains on the west. Nearly 92% of the population lives in suburban areas

The local industry of the County of Santa Clara is dominated by the technology sector. The County has three main interstate highways; 280, 680, and 880, one U.S. Route (101), and the following CA State Routes; 9, 17, 82, 85, 87, 130, and 237. Airports include: Norman Y. Mineta International Airport, Moffett Federal Airfield, and three County airports: Reid Hillview, Palo Alto, and South County.

Mountain View Demographics:

<https://www.census.gov/quickfacts/fact/table/mountainviewcitycalifornia.santaclaracountycalifornia/>

The resident population of Mountain View is approximately ~~7680,260~~447. More than half the population is between 20 and 54, while nearly 25% is in the 25 to 34 year age bracket. The median age is 34.6 years old.

Los Gatos Demographics:

<https://www.homefacts.com/demographics/California/Santa-Clara-County/Los-Gatos.html>

The resident population of Los Gatos is approximately 30,705. The median age resident is 45.4 years young. The largest racial/ethnic groups are White (73.8%) followed by Asian (14.5%) and Hispanic (6.3%)

Santa Clara County Community Health Status Assessment:

<https://www.sccgov.org/sites/phd/collab/chip/Documents/cha-chip/cha-chip.pdf>

(Data: 2015-2020 Partners for Health Santa Clara County)

Access to Care	87% of adults have health insurance
Chronic Disease	8% of adults have diabetes. Heart disease: 22% of the death among county residents.
Overweight and Obesity	Over 50% of adults and over 33 25% of adolescents in the county are overweight or obese
HIV/ AIDS	Over 33424,500 adults in Santa Clara County are living with HIV
Tobacco use	1 in 10 adults and 1 in 12 adolescents in the county smoke cigarettes

T Risk Assessment: (retrieved from Santa Clara County TB Control Report; based on CY ~~2018~~2019)

California Overview

- California reported ~~20942~~118 new TB cases in ~~2019 compared to 2097 cases in 2018 compared to 2059 cases in 2017~~
- California's annual TB incidence was 5.3 cases per 100,000 persons, which is nearly double the national incidence rate of ~~2.8~~7.
- More than 2 million Californians (6% of the population) have Latent TB Infection (LTBI) which can progress to active TB without diagnosis and treatment.
- Among California's TB cases, an estimated 6% were imported from outside of the United States, 13% resulted from recent transmission and 81% were due to reactivation of latent tuberculosis infection (LTBI) to active TB..

COMMUNITY T PROFILE

www.SCCPHD.ORG

- Santa Clara County (SCC) has the fourth highest number of cases among all jurisdictions in California, after Los Angeles, San Diego and Orange counties.
- SCC had ~~469~~164 cases of tuberculosis (TB) disease in ~~2019, which decreased compared with 2018, which decreased compared with 2017~~ (486)169 TB cases).
- This represents a case rate of ~~8.6~~4 per 100,000 residents
- The case rate is 1.6 times as high as the overall California rate (5.3/100,000 people) (Figure 2) and 3.1 times as high as the national rate (2.8 per 100,000 persons)

El Camino T Profile CY : Medium Risk Facility

- ~~3026~~ total cases ~~911~~ In-patients and ~~2415~~ Out-patients which is an ~~increase~~decrease from ~~2330~~ cases in ~~2017~~2018.
- Designated as a "Medium Risk Facility" for TB based on the community rate of infection.
- El Camino Hospital and their Infectious Disease Specialists are considered the 2nd largest provider of TB care in Santa Clara County (~~next to the SCC Valley Medical Center) and the SCC~~ TB Clinic.

Seasonal Influenza Activity

Infection Prevention and Control: Seasonal Influenza Procedure

The Infection Prevention Department has a procedure in place to protect all staff, patients and visitors from potential exposure to seasonal influenza virus and to prevent an outbreak of health-care-associate influenza.

Annual Seasonal Influenza Procedure (located in the Toolbox)

Threats facing Santa Clara County:

- ~~COVID-19~~ SARS Co-V-2 virus ~~is a~~ worldwide Pandemic Santa Clara County (SCC) experienced a significant impact of the SARS Co-V-2 virus circulation in

[the county. On March 16, 2020 The Health Officer of the County of Santa Clara issued a "Shelter in Place" mandate. Goal of the mandate was to ensure that the maximum number of people isolated in their place of residence to slow the spread of COVID-19.](#)

2. **Major Earthquake**

The Operational Area is in the vicinity of several known active and potentially active earthquake faults including the San Andreas, Hayward, and Calaveras faults.

3. **Wild Land Urban Interface Fire**

The months of August, September and October have the greatest potential for wild land fires as vegetation dries out, humidity levels fall, and off shore winds blow.

4. **Hazardous Material Incident**

There are four major highways in the county that carry large quantities of hazardous materials: U.S. 101, I-880, and I-680, and I-280. Truck, rail, and pipeline transfer facilities are concentrated in this region, and are involved in considerable handling of hazardous materials.

5. **Flood**

There are approximately 700 miles of creeks and rivers in the County, all of which are susceptible to flooding. An Emergency Action Plan exists for the Anderson Dam and a general Dam Plan exists which includes other dams within Santa Clara County. These plans are maintained by the Santa Clara Valley Water District.

6. **Landslide**

For Santa Clara, the hillside areas in the Los Gatos areas have the greatest potential for economic loss due to landslides. The winters of 1982, 1983, 1986, and 1996/1997 provided a reminder of the degree of hazard from landslides in Santa Clara County

PROCEDURE:

A. **Goals**

1. Maintain Enterprise hospital acquired Central Line Associated Bloodstream Infections (CLABSI) at or below National [Healthcare Safety Network \(NHSN\) Standardized Infection Ratio \(SIR\) SIR < 0.50](#).
~~Healthcare Safety Network (NHSN) Standardized Infection Ratio (SIR) SIR < 0.50.~~
2. Maintain Enterprise hospital acquired Catheter Associated Urinary Tract Infection (CAUTI) at or below NHSN SIR ≤ 0.75.
3. Maintain Enterprise hospital acquired Clostridium difficile (C.diff) infections at or below NHSN SIR ≤ 0.70
4. Maintain hospital acquired Pacemaker Surgical Site Infections (SSI) at or below NHSN SIR <1.00
5. Maintain hospital acquired Total Knee SSI at or below NHSN SIR <1.00.
6. Maintain hospital acquired Total Hip SSI at or below NHSN SIR <1.0.
7. Maintain hospital acquired Laminectomy SSI at or below NHSN SIR <1.00.
8. Maintain hospital acquired Spinal fusion /Re-fusion SSI at or below NHSN SIR < 1.00.
9. Maintain Enterprise hospital acquired Methicillin Resistant Staphylococcus aureus (MRSA) infection rate to ≤ 0.90 /10,000 patient days.
10. Maintain Enterprise MRSA screening compliance rate to ~~94~~92% or more.
Maintain Enterprise hospital onset Multi- Drug Resistant Organisms (MDRO) infection rate to ≤ 0.50 / 10,000 patient days.
11. Maintain hand hygiene compliance at ≥ 80%.
12. Maintain reporting compliance with regulatory and accrediting agencies
13. Maintain compliance with Infection Control Risk Assessment (ICRA) for [all new construction projects](#)
14. Maintain compliance with Seasonal Influenza Procedure

B. **Objectives**

1. Perform daily targeted Surveillance for the following:
 - a. Surgical Site Infections
~~CAUTI~~
~~CLABSI~~
 - b. [CAUTI: Catheter Associated Urinary Tract Infections -hospital-wide](#)
 - c. [CLABSI: Central Line Associate Blood Stream Infections - hospital-wide](#)
 - d. ~~Clostridium difficile~~[Hospital-acquired Clostridium difficile \(C.diff\) infections](#)
 - e. [Hospital-acquired](#) Methicillin resistant Staph aureus (MRSA)
 - f. [Hospital-acquired](#) Multi-Drug Resistant Organisms (MDRO)
 - g. [MRSA Nares screening compliance per CDPH regulatory guidelines](#)
2. Perform daily active disease surveillance for the following:
 - a. [Daily surveillance of the following: MRSA, C.difficile, Multi-Drug Resistant Organisms \(MDRO\)](#)
 - b. Tuberculosis and other communicable diseases
 - c. [Daily COVID-19 surveillance for patients admitted from Skilled Nursing Facilities \(SNF\) with COVID-19 outbreaks.](#)
 - d. Carbapenem-resistant Enterobacteriaceae (CRE) surveillance: for patients hospitalized outside the U.S. within 12 months

- e. CRE surveillance: for Skilled Nursing Facilities (SNFs) with increased risk of CRE in their patient population
 - Candida auris**
 - Pseudomonas aeruginosa from areas identified in Mexico**
 - f. [Perform specialized response to exposure and outbreaks including COVID-19 contact tracing](#)
 - g. [Perform review and tracking for mold-related organisms in construction areas](#)
3. Report mandated conditions to the following accrediting agencies:
 - a. Report all required data monthly to [Center for Disease Control \(CDC\) NHSN data base](#)
 - b. [Report all COVID-19 positive cases and deaths to SCC PHD within 24 hours of identification](#)
 - c. Report mandated conditions (86 total) to SCC PHD
 - d. Report all Tuberculosis cases to the Santa Clara County TB Control
 - e. Report unusual infectious disease occurrences to CDPH and CDC
 4. Educate staff on hand hygiene standards and measure compliance outcomes
 - a. Upon hire, educate all staff on how to correctly perform hand hygiene (HH)
 - b. During daily isolation rounding by IP staff, observe compliance with hand hygiene and provide immediate feedback to staff with non-compliance.
 - c. Track monthly HH compliance with the HAI committee and strategize on performance improvement activities.
 - d. [Review monthly hand hygiene compliance data from the clinical nursing units dashboard.](#)
 5. Perform [Infection Control Risk Assessments \(ICRA\)](#) for all hospital construction activities
 - a. Conduct a risk assessment for all new construction projects and sign permit
 - b. Perform daily rounding on all construction sites for compliance [to ICRA permit standards](#)
 - c. Conduct ICRA permit for unexpected water intrusion and mold issues
 6. Attend the following hospital committee meetings to represent IC
 - a. HAI Committee
 - b. Critical Care Committee
 - c. Antimicrobial Stewardship
 - d. Emergency Management
 - e. Value Analysis
 - f. Clinical Microbiology Lab, Pharmacy and Infection Prevention (MIPP)
 - g. Central Safety
 - h. E-policy
 7. Provide Infection Prevention and Control Education to the following:
 - a. General Hospital Orientation
 - b. Physician Orientation
 - c. Ancillary Staff and any hospital department in-service as requested
 - d. Environmental Services Department (EVS) yearly update
 - e. Health Stream: annual Infection Prevention and Control Standards
 8. Initiate the Seasonal Influenza Procedure in August (prior to flu season)
 - a. Meet with required departments to verify readiness for flu season
 - b. Track daily numbers of influenza hospital admissions and deaths
 - c. Monitor trends of influenza on the local, state and national level
 - d. Institute visitor restrictions if widespread flu is present in the community
 9. Perform Monthly Infection Control/ Quality tracers
 - a. Attend monthly safety rounds at Mountain View and Los Gatos
 - b. Educate staff on areas on infection control non-compliance
 - c. Report outcomes to the Infection Control Committee Meeting

C. Infection Prevention and Control Committee (ICC)

1. The responsibility for monitoring the Infection Prevention and Control Program is invested in the Infection Control Committee (ICC). The Infection Control (IC) Medical Director has the authority to institute any appropriate control measures or studies when a situation is reasonably felt to be a danger to any patient, Healthcare Worker (HCW) or visitor, or in the event of an infection control crisis situation (The committee functions as the central decision and policymaking body for infection control). The Infection Control Committee shall meet not less than quarterly.
2. The ICC shall be a multi-disciplinary committee consisting of representatives from at least the Clinical Laboratory, Quality Department administration, Sterile Processing Department, Perioperative services, Nutrition Services, Environmental Services, Employee Wellness, Pharmacy and Health and the

Infection Prevention Nurses. The Chairman is the Infection Control Medical Director, a physician with knowledge of and special interest in infectious disease. Representatives from key hospital departments shall be available on a consultative basis when necessary..

3. The Infection Prevention and Control Department in collaboration with the ICC shall develop a system for reporting, identifying and analyzing the incidence and cause of all hospital onset infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.
4. The Infection Prevention and Control Department in collaboration with the ICC shall develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating isolation precautions and cleaning and disinfection techniques. Such techniques shall be defined in written policies and procedures.
5. The Infection Prevention and Control Department shall develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.
6. The committee minutes shall be reviewed by the Medical Executive Committee.

D. Scope of Services

1. The infection control program is divided into functional groups of routine activities that address the integrated facets of surveillance and prevention of infections, monitoring and evaluation, epidemiological investigation, risk reduction, consultation and education.
2. Hospital Onset Infection Surveillance and Prevention
 - a. For the purpose of surveillance, hospital onset infections shall be clinically active infections occurring in hospitalized patients in whom the infection was not present or incubating at the time of admission.
 - b. Infections with endogenous organisms of the patient and those organisms transmitted either by healthcare workers or indirectly by a contaminated environment shall be included.
 - c. Strict criteria shall be used for assessment in regard to targeted hospital onset infections. Not all hospital onset infections in the hospital shall be counted and presented for statistical analysis. The type of data collection to be used and analyzed shall be determined by the Infection Control Committee (ICC) based upon the annual Risk Assessment.
 - d. The criteria written by the Center for Disease Control and Prevention (CDC) shall be used when calculating infection rates for statistical analysis.

E. General Surveillance Activities

1. Active infection surveillance within the hospital shall be an ongoing observation of the occurrence and distribution of disease or disease potential and of the conditions that increase or decrease the risk of disease transmission.
 - a. The surveillance of patients, staff and environment shall ensure appropriate patient placement, initiation of appropriate isolation or special precautions, identification of patient care problems associated with hospital infection control, prevention of targeted hospital onset infections in high risk, high volume procedures, facilitation of data collection for selected quality indicators and the collection of required information for reporting to the Public Health Department.
 - b. Daily laboratory reports, utilization review reports and verbal communications with staff shall be reviewed routinely by the Infection Prevention Nurses. Surveillance shall be a blend of routine physical presence in all areas of the facility and the use of clinical and laboratory computer information systems.

F. Data Collection Methods

1. All identified cases related to targeted infections and communicable diseases will be maintained in a database. Specific methods used by infection control to obtain surveillance data include daily lab reports, patient census reports, daily serological reports, patient charts, referred cases from case managers and verbal communication with staff and physicians.
2. Surveillance shall be a blend of routine physical presence in all area of the facility and use of clinical and laboratory computer information systems.

G. Investigation of Disease Clusters Outbreak Control

1. The Infection Control Infection Control Medical Director in coordination with the Director of Infection Control shall have ultimate authority and responsibility for investigating epidemic/outbreak situations and implementing appropriate interventions in order to prevent and to control further disease and to identify factors that contributed to the outbreak. (See Infection Control Procedure Outbreak Investigation).

H. Reporting to Outside Agencies

1. Specified communicable diseases (in accordance with Title 17, California Code of Regulation) identified at El Camino Hospital shall be reported to the Santa Clara Department of Public Health (SCDPH) in the required timelines to prevent the spread of certain communicable diseases to the public at large. (See Infection Control Procedure on Communicable Disease Reporting).
2. El Camino Hospital shall provide follow-up management for pre-hospital caregivers who may have been exposed to a communicable disease during the performance of their duties and reporting of these exposures to the proper authorities. (See Infection Control Procedure Pre-hospital Communicable Disease Exposure).
3. El Camino Hospital shall report the mandated requirements to the National Healthcare Safety Network (NHSN) as required by CDPH and CMS.

I. Education

1. Orientation for all hospital employees shall include general information on potential infection risks, transmission routes, and infection prevention measures, proper hand hygiene, isolation precautions, and environmental cleaning and disinfection.
2. Annual review of infection control principles shall be done through a computer-based learning system (Health Stream) and tracked by the Education Department.
3. Department specific education shall be done as deemed necessary by the Infection Control Medical Director and/or the Infection Prevention Nurses, working in conjunction with department managers.
4. Quarterly In-service presentations are provided to the Infection Control Resource Groups (ICRG). The ICRG is comprised of staff members from all

nursing departments and ancillary departments (Lab, RT, etc.).

5. Infection control isolation "Quick Reference Guide" (hard copy) is readily available in every department of the hospital. This document summarized the isolation guidelines for all infectious and communicable diseases.

J. Liaison

1. Provide ongoing expert advice and consultation as appropriate to other departments including but not limited to Microbiology Laboratory, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
2. Coordinate Infection Control activities with other departments or units including but not limited to Dialysis Services, Patient Care Services, Microbiology Laboratory, Pathology, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
3. Function as a liaison to the Santa Clara Public Health Department and other agencies.
4. Function as a liaison to Infection Control Programs at other hospitals and long-term care facilities.

K. Policy Formation

1. Policies and procedures shall be reviewed on a regular basis with changes made as new guidelines and information become available.
2. Infection control departmental policies are found on the toolbox.

L. Quality Improvement

1. Provide ongoing evaluation and assessment of the goals and accomplishments of the Infection Control Program to ensure that it meets the needs of the hospital, employees, physicians, patient population, and visitors.
2. Evaluation of the Infection Control Plan shall be done at least annually or when a change in the scope of the Infection Control Program or in the Infection Control risk analysis occurs. Assessment of Infection Control strategies shall also be evaluated for their effectiveness at preventing infections.

M. Environmental Conditions

1. To ensure a safe environment during times of construction and or remodeling, protective measures shall be approved by the Infection Control Staff and implemented before the project commences. All construction projects will have an Infection Control Risk Assessment (ICRA) performed by the Infection Control staff prior to start of construction.
2. Sterile Processing (SP): Cleaning, disinfection, high-level disinfection and sterilization standards will be maintained by the SP department. Manager of SP will present a quarterly report to the ICC.
3. Endoscopes, bronchoscopes, probes & TEE scopes: Instrument cleaning, disinfection and high level disinfection (HLD) shall be monitored by the SP and endoscopy departments. A quarterly Quality Report will be presented to the Infection Control and Committee meeting.
4. Dialysis water testing: Water used to prepare dialysis fluid shall be tested according to current AAMI standards and monitored monthly by the dialysis manager. A quarterly Quality Report will be presented to the Infection Control and Committee meeting.

N. Reporting Mechanisms

1. A report regarding all infection control activities shall be made each quarter to the Infection Control Committee. The report shall include appropriate results related to routine surveillance, sentinel organisms, emerging pathogens, public health issues, employee health issues and special studies or reports. Copies of the committee meeting minutes shall be forwarded to the Medical Executive Committee. C. diff, CAUTIs, CLABSIs and MRSA Hospital Onset cases will be reported to the departmental manager on a monthly basis. Hand hygiene compliance will be reported to the departmental managers monthly.

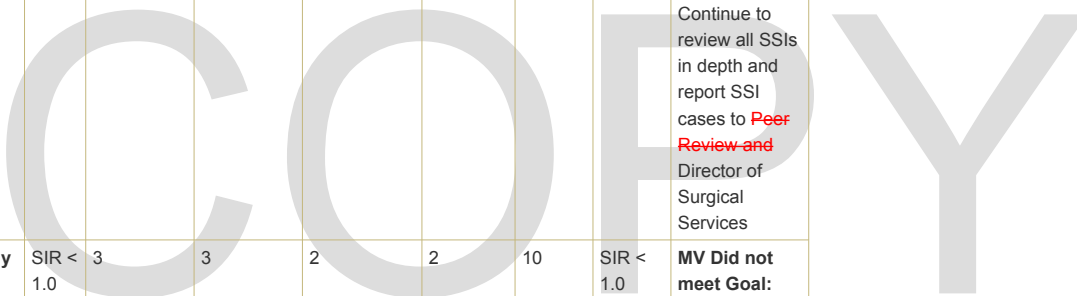
REFERENCES:

1. Deborah Yokoe et al. Compendium of Strategies to Prevent Hospital Acquired Infections in Acute Care Hospitals ICHE 2008:29; S12-S21.
2. Jonas Maschall et al. Strategies to Prevent Central Line Associated Blood Stream Infections in Acute Care Hospitals ICHE 2008:29; S22-S30.
3. Susan Coffin et al. Strategies to Prevent Ventilator Acquired Pneumonia in Acute Care Hospitals ICHE 2008:29; S31-S60.
4. Deverick J. et al. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals ICHE 2008:29; S51-S61.
5. David Calfee et al. Strategies to Prevent Transmission of Methicillin Resistant *Staphylococcus aureus* in Acute Care Hospitals ICHE 2008:29; S62-S80.
6. Erik Dubberke et al. Strategies to Prevent *Clostridium difficile* Infection in Acute Care Hospitals ICHE 2008:29; S81-S92.

Infection Control Risk Assessment


Enterprise Risk Event FY Outcome Measurement: FY Rate NHSN SIR	FY Goal	Probability Risk will occur	Probability Severity if Risk occurs	Stability of Process Stability	FY Outcome	Priority Rank	FY Goal	Comments
Pacemaker SSI: FY2019-2020 MV: 21 SSI/ LG: 0 SSI MV SIR: 1-1 LG SIR: 1-1	SIR < 1.0	3	3	2	2	10	SIR < 1.0	MV: did not meet Goal. SIR: 1-1 MV decreased SSI FY: 1-1 SSI vs FY: 1-1 SSI Plan: Continue to

								review SSI cases in depth and to report all cases for Peer-Review and to Director of Cardiac Cath Lab.			
Hip SSI: FY20192020 MV: 2 SSI/ LG: 31 SSI MV SIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG SIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	SIR < 1.0	3	3	2	2	40	1	1	8	SIR < 1.0	MV and LG: Met Goal SIR <input type="checkbox"/> <input type="checkbox"/> LG Did not meet Goal: SIR <input type="checkbox"/> <input type="checkbox"/> IP Team continues to review SSIs in depth; report cases for Peer-Review and to the Director of Surgical Services
nee SSI: FY20192020 MV: 3 SSI/ LG: 1 SSI MVSIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG SIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	SIR < 1.0	3	3	2	2	10	SIR < 1.0	MV did not meet goal of SIR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MV : 3 SSI cases increased from "0" to 3 - SIR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> in FY19 and FY20. LG met goal. Continue to review all SSIs in depth and report SSI cases to Peer-Review and Director of Surgical Services			
Laminectomy SSI: FY20192020 MV: 32 SSI/ LG: 0 SSI MV SIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG SIR: <input type="checkbox"/>	SIR < 1.0	3	3	2	2	10	SIR < 1.0	MV Did not meet Goal: SIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG met goal SIR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG met goal. Review all SSIs in depth. Report SSI cases for Peer-Review and to Director of Surgical Services			
Spinal Fusion Re-fusion SSI: FY <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MV: 21 SSI/ LG: 40 SSI MVSIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG SIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	SIR < 1.0	3	3	2	2	40	1	1	8	SIR < 1.0	MV did not meet and LG met goal of SIR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . Increase Continue to review all SSIs in depth and report SSI from FY18 "0" cases to FY19 2 cases, with SIR > 1.0. Continue to review all SSIs in depth and report SSI cases to Peer-Review and Director of Surgical Services



Enterprise Risk Event FY <input type="checkbox"/> <input type="checkbox"/> Outcome Measurement: FY <input type="checkbox"/> <input type="checkbox"/> NHSN SIR	FY <input type="checkbox"/> <input type="checkbox"/> Goal	Probability risk will occur 1=low/ 2=mod/ 3=high	Probability Severity if Risk occurs 1=low/ 2=mod/ 3=high	Stability of Process 1=High. 2=needs improvement	FY 19 Outcome 1=met goal/ 2=Goal not met	Priority Rank	FY <input type="checkbox"/> <input type="checkbox"/> Goal	Comments	
HO CAUTI (Catheter Associated Urinary Tract Infection): FY 19 Enterprise Rate: 1.09 (MV: 1.64 CAUTI/ LG: 1 CAUTI) SIR: MV: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG SIR: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG Rehab SIR: <input type="checkbox"/> <input type="checkbox"/> SIR: <input type="checkbox"/> <input type="checkbox"/> Rehab SIR: <input type="checkbox"/> <input type="checkbox"/>	SIR ≤0.75	3	2	2	2	9	SIR ≤0.75	Enterprise rate increased from <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> in FY <input type="checkbox"/> <input type="checkbox"/> to <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> in FY <input type="checkbox"/> <input type="checkbox"/> 1)FY20 HAI Task Force in place. 2)Standardized procedure for Foley removal in place.3) HOUUDINI protocol approved. 4)MV and LG Met Goal. LG Rehab did not meet goal. Event reviews on all CAUTI cases with Clinical Manager, front line staff, HAI team	
HO CLASI (Catheter Associated Bloodstream Infection): FY 19 Enterprise Rate: 0.27 (MV: 0.42 CLABS/ LG: 0 CLABS) SIR: MV: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LG SIR: <input type="checkbox"/> <input type="checkbox"/>	SIR ≤ 0.50	3	3	2	1	9	1	8	SIR ≤ 0.50 Met Goal of SIR <input type="checkbox"/> <input type="checkbox"/> Enterprise Rate decreased from FY18 (0 Event reviews on all CLABS cases with Clinical Manager, front line staff, HAI team. 30-) to FY19 (0.27). Plan: 1)FY19 HAI Task Force in place. 2)Event reviews Ongoing Education update on all CLABS cases reduction measures with Clinical Manager, front line staff, HAI team. 3)Education update on blood draws for staff
HO C.diff (Clostridium difficile): FY 19 Enterprise Rate: 0.30 (MV: 17 C.diff/ LG: 3 C.diff) SIR: MV: 0.64356/ LG Main SIR: 0.53818 LG Rehab SIR: 0.45465	SIR ≤ 0.70	3	3	2	1	9	1	8	SIR ≤ 0.70 Enterprise: Met Goal of SIR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> in MV and LG. Plan: Event reviews with HAI team and staff. IC staff member a member of the Antibiotic stewardship committee. Continue surveillance procedures in place for high risk

										admissions; IC staff member a member of the Antibiotic stewardship committee and HAI committee.
HO MRSA: (Methicillin resistant <i>Staph aureus</i>) Enterprise rate: <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> (MV: 3 cases/ LG: 30 cases)	Rate: ≤ 0.90	2	2	1	1	6	Rate: ≤ 0.90	Met Goal. Decreased enterprise HO rate from FY 1819 (.62) to FY 1920 (0.59 31)		
Enterprise Risk Event FY <input checked="" type="checkbox"/> <input type="checkbox"/> Outcome Measurement: FY <input checked="" type="checkbox"/> <input type="checkbox"/> Rate <input type="checkbox"/> NHSN SIR	FY Goal	Probability risk will occur	Probability Severity if Risk occurs	Probability Severity if Risk occurs	FY 1920 Outcome	Priority Rank	FY Goal	Comments		
		1=low/ 2=mod/ 3=high	1=low/ 2=mod/ 3=high	1=low/ 2=mod/ 3=high	1=met goal/ 2=Goal not met					
HO MDRO: (Multi drug-resistant Organisms) Enterprise rate: 0.00 10 <input type="checkbox"/> MV: <input type="checkbox"/> cases <input type="checkbox"/> LG: <input type="checkbox"/> cases	Rate: ≤ 0.50	2	2	1	1	6	Rate: ≤ 0.50	Met Goal. <input checked="" type="checkbox"/> HO cases in both MV and LG. Plan: continue current surveillance and isolation practices to sustain current successfully low rates of hospital transmission;.		
Enterprise Endoscopy Units <input type="checkbox"/> Quality: All endoscopes/ bronchoscopes will pass ATP quality check after manual clean, prior to HLD.	Pass rate: 100%	21	3	2	2	9	1	1	6	Pass rate: 100% FY20 Improvement Plan in place. FY 19 -Instituted a new quality process for ATP testing and monitoring. Continue to monitor cleaning and HLD procedures and ATP results monthly. Endo Manager to provide quarterly reports to ICC meeting.
COVID-<input type="checkbox"/> Case Reporting Compliance: all cases and deaths reported within 24 hours	new goal	1	3	1	1	6	Rate: ≥ 95%	New Risk event: Process for COVID-19 regulatory reporting initiated in FY20 compliance rate > 95%		
Hand Hygiene <input type="checkbox"/> Enterprise Observed Compliance:	Rate: ≥80%	1	2	1	2	6	Rate: ≥80%	Did not meet goal. FY 2021: Continue strategies in place from		

HH on entry: average 68% HH on exit: average 79%								FY19: 1)monthly hand hygiene observations to be performed by clinical units.2) Advocate for electronic hand monitoring system. 3)HAI committee reviews monthly data	
MRSA Nares Screening: per CDPH guidelines FY  Enterprise Rate: <input type="checkbox"/> <input type="checkbox"/>	Rate: $\geq 91\%$	1	2	1	1	5	Rate: $\geq 92\%$	Enterprise: Met Goal. Continue current surveillance practice to sustain outcomes.	

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Attachments

[IC Plan Evaluation- Annual Report FY 2020.pdf](#)

Approval Signatures

Step Description	Approver	Date
MEC	Catherine Carson: Senior Director Quality	pending
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	03/2021
Infection Prevention Committee	Catherine Nalesnik: Director Infection Prevention [JH]	02/2021
	Catherine Nalesnik: Director Infection Prevention [JH]	02/2021



Origination: 03/2012
Effective: Upon Approval
Last Approved: N/A
Last Revised: 02/2021
Next Review: 3 years after approval
Owner: Alicia Potolsky: Dir
 Cardiovascular Services
Area: Scopes of Service
Document Types: Scope of Service/ADT

Scope of Service Telemetry Cardiac Unit Mountain View

Types and Ages of Clients Served

The Telemetry Unit is a 2-bed medical/surgical unit providing care for patients from adolescence to geriatric who require cardiac monitoring and as defined in the department's admission, discharge and transfer criteria. The Telemetry Unit also accepts overflow medical/surgical patients not requiring cardiac monitoring when bed availability permits.

Assessment Methods

Nursing care is provided by a registered nurse utilizing the nursing process. Registered nurses provide direct supervision to clinical support staff in the provision of patient care. The staff participates in continuous quality improvement processes relating to patient care delivery.

Scope and Complexity of Services Offered

Common diagnoses served on the Telemetry Unit include post CABG or valve surgery, post PCI, MI, chest pain, CHF, syncope, and patients with cardiac arrhythmias. Care is given as directed and prescribed by the physician. All non-nursing orders are communicated to the appropriate ancillary departments through the electronic medical record. Staff communicates specific patient needs and coordinates treatment and the plan of care with all ancillary departments. The discharge planning process is initiated on admission, in collaboration with the physician, social services, care coordinator, other health disciplines, patient, family and homecare providers, if appropriate.

Appropriateness, Necessity and Timeliness of Services

The Clinical Manager, in collaboration with shift charge nurses, assess the appropriateness, necessity, and timeliness of service. The appropriateness of service is addressed in hospital and department policies and procedures.

A continuous quality improvement process is in place to identify opportunities for improvement in patient care processes and to measure staff performance for compliance with standards. The patient's progress is evaluated by medical staff, nursing and other health disciplines, as well as the perception of patient and family.

Staffing Skill Mix

The Telemetry Unit staffing includes a skill mix of registered nurses (RNs), clinical support staff, monitor technicians and administrative support staff to provide patient care based on patient census and nursing intensity measures. Staffing follows the DHS ratio of 1:4 (RN to patient) taking into account patient care needs, and shall be determined each shift by the RN in charge. The charge nurse serves to coordinate patient care activities for his/her designated shift.

RN staff must have a California license. On the Telemetry Unit, 100% of RNs on a given shift must be ACLS certified. All other staff must be BCLS certified. Clinical Support staff must be currently certified by the State of California. The competency of the staff is evaluated through observation of performance and skill competency validation. Staff education and training is provided to assist in the achievement of performance standards.

Level of Service Provided

The level of service is consistent with the needs of the patient as determined by the medical staff. The department is designed to meet the level of care needs of the patient.

Performance assessment and improvement processes are evaluated through continuous quality improvement activities in conjunction with the multidisciplinary health care professionals who provide services to the units.

Standards of Practice

The Telemetry Unit is governed by state regulations as outlined in Title 22 and standards established by the Joint Commission on Accreditation of Healthcare Organizations. Additional practices are described in the Patient Care Policies and Procedures, and Clinical Practice Standards.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Catherine Carson: Senior Director Quality	pending
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	03/2021
Department of Medicine	Jeanne Hanley: Policy and Procedure Coordinator	02/2021
Department Medical Director	Alicia Potolsky: Dir Cardiovascular Services	02/2021
	Alicia Potolsky: Dir Cardiovascular Services	02/2021



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PolicyStat ID: 9349440



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Last Revised: 03/2021
Next Review: 3 years after approval
Owner: Sandi Fujitani: Manager
 Revenue Integrity
Area: Finance
Document Types: Policy

Hospital Pricing and Chargemaster Policy

COVERAGE:

All El Camino [Health \(El Camino Hospital\)](#) staff

PURPOSE:

The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls, that El Camino [Hospital Health](#) has an established charge rate structure which, within appropriate business parameters, is reasonably and consistently related to the overall cost of providing medical care and to ensure compliance with the billing regulations of Government and Accrediting entities. The steps in this policy must be followed before new clinical procedures/services are performed or new supplies or new medications are added. In addition, the steps in this policy must all be followed if modifications are made to existing procedures, supplies, or medications.

STATEMENT:

This policy is established to maintain the integrity of the chargemaster, to ensure competitive and consistent pricing, to ensure compliance with all pertinent billing and coding regulations, and to maintain integrity in system generated reports. The organization's objective is to establish consistent prices reasonably related to the cost of providing the service through effective chargemaster maintenance and pricing in all revenue producing departments. Annual changes to the rate structure will be determined in the budget process and approved by the Board of Directors through their approval of the operating budget. Other changes may be made from time to time by management if costs or other relevant factors for a particular service change during the year.

Any changes to the rate structure – whether through the addition of new charges, deletion of existing charges or the modification of existing charges – will be reasonably and consistently related to the services. Charges will be rational and consider the complexity of the service rendered relative to other similar procedures.

Guidelines related to charging for supplies, medications, room and board, and ancillary services are [attached hereto in Appendices 1—4 listed under "Procedure" below](#).

PROCEDURE:

Updates to the chargemaster and annual pricing adjustments will follow the guidelines prescribed in the [Hospital Pricing and Chargemaster Change Management Procedures](#) document, maintained by the Finance Division.

I. ENFORCEMENT:

VIOLATIONS OF THIS POLICY WILL BE ADDRESSED ACCORDING TO THE GUIDELINES OF THE ORGANIZATION'S DISCIPLINE AND DISCHARGE POLICY.

~~Appendix - Supply Charges~~

Supply Charges

Hospital supplies used for patient care can be separated into two categories: 1) supplies that are built into the room or procedure charge, 2) supplies charged separately from the room charge. In determining how to set up the supply charge in the Chargemaster, the department utilizing the supply must validate the cost of the supply and how it will be used.

Supplies charged per the first category (i.e. used on all patients and built into the room or procedures) are those supplies that are generally used for all patients for specific care. Such supplies include, but are not limited to, cotton swabs, gauze, etc. Equipment (non-disposable) is also included in this category and is not to be charged separately.

Supplies in the second category (i.e. charged to the patient separately) are necessary to patient care, necessary to the service/procedure being performed, separately identifiable to an individual patient, not reusable (with the exception of reusable supplies), and are not floorstock.

~~Appendix - Medication Charges~~

Medication Charges

Hospital medications used for patient care can be separated into two categories: 1) medications charged individually (separate from a procedure charge), 2) medications built into a procedure charge. In determining how to set up the medication charge in the Chargemaster, validation of the clinical/ancillary department or Pharmacy department must validate the cost of the medication and any factors that affect billing.

Medications in the first category (charged to the patient individually) are necessary to patient care and are necessary to the procedure being performed and not included in the procedure charge (in compliance with appropriate requirements and billing regulations of Government and Accrediting entities ~~must~~).

Medications charged per the second category (built into the procedure charge) are those medications required by the billing regulations of Government and Accrediting entities to be performed.

~~Medications in the first category (charged to the patient individually) are necessary to patient care and are necessary to the procedure being performed and not included in the procedure charge (in compliance with appropriate requirements and billing regulations of Government and Accrediting entities).~~

~~Medications charged per the second category (built into the procedure charge) are those medications required by the billing regulations of Government and Accrediting entities to be included in the procedure charge.~~

~~Appendix - Inpatient Room Charges~~

Inpatient Room Charges

The hospital's inpatient room charge (also known as the "Daily Hospital Service" charge) shall be considered inclusive of the following: reusable items, supplies, equipment that are routinely used or provided to all patients during their stay on the inpatient unit. The inpatient room charge is not inclusive of procedures performed at the bedside by medical personnel when such procedures are not routine / provided to all patients in the unit. Such procedures may be charged separately, in addition to the inpatient room charge.

~~Appendix Ancillary Charges~~

Ancillary Charges

Ancillary charges (in addition to the aforementioned supplies and pharmaceuticals) are charges that may include, but are not limited to, diagnostic testing, surgical or interventional procedures, therapy, and other medical services rendered to patients. Ancillary charges shall be charged separately from inpatient room charges as applicable.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	03/2021
CFO	Carlos Bohorquez: CFO	02/2021
Senior Director, Revenue Cycle	Brian Fong: Sr Dir Revenue Cycle	02/2021
	Sandi Fujitani: Manager Revenue Integrity	02/2021



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Owner: Brian Fong: Sr Dir Revenue Cycle
Area: Finance
Document Types: Policy

Financial Assistance, Charity Care and Discounts

COVERAGE:

Individuals eligible to receive financial assistance, charity care or discounts.

PURPOSE:

Consistent with its Mission, El Camino Hospital (ECH) strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. [This can be initiated by the patient or Patient Accounting staff.](#)

POLICY STATEMENT:

ECH is committed to providing financial assistance and charity care to persons who have healthcare needs and are uninsured and ineligible for a government program, as well as to those patients with High Medical Costs, who are unable to pay for medically necessary care based on their individual financial situation. ECH will also provide discounts and extended payment plans to patients taking into consideration Essential Living Expenses. ECH is also committed to providing and assisting our patients with information necessary on how to apply for Covered California Plans, and will assist patients in determining eligibility for enrollment with Medi-Cal, and other government programs. Patients that are eligible for financial assistance are not charged more than the amounts generally billed (AGB) for emergency or other medically-necessary care.

El Camino Hospital adopts the look-back method for amounts generally billed; however, patients who are eligible for Financial Assistance are not financially responsible for more than the amounts generally billed because eligible patients do not pay any amount.

ECH's financial assistance programs are not substitutes for personal responsibility. Patients are expected to cooperate with ECH's procedures for obtaining financial assistance and to contribute to the cost of their care based on their ability to pay. In order to manage its resources responsibly and to allow ECH to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes these guidelines for the provision of charity care.

REFERENCES:

[Patient Protection and Affordable Care Act of 2010 and California AB 774 and SB 1276](#)

DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

Monetary Assets: The fair market value of the Patient's Family's savings and investments, excluding amounts held in retirement plans or deferred compensation plans.

Eligible Services: The following services are ineligible for the application of Financial Assistance under this policy, except as required by law:

- Purchases from ECH retail operations, such as gift shops & cafeteria;
- Cosmetic surgery; and
- Any products or services that are:
 - Inconsistent with the symptom(s) or diagnosis and treatment of the condition, disease or injury;
 - Primarily for the convenience of the patient, the patient's family, the physician or other provider;
 - Not the most appropriate level of services that can safely be provided to the patient.
- Services which are programmatically bundled and discounted. Some examples of these bundled services include packages for Self-Pay Endometriosis and Maternity Services. -
- Physician Services that are not billed by Hospital ~~(See Attachment A for Hospital Departments where Physician Services are not covered by this policy.~~
- Physician Services are not covered by this policy.

Excluding any services specifically listed as ineligible, the following healthcare services are eligible for ECH's financial assistance program:

- Emergency medical services provided in an emergency room setting;
- Services for a condition which, in the opinion of the treating physician or other health care professional, would lead to an adverse change in the health status of an individual if not treated promptly; ~~and~~
- Non-elective services provided in response to life-threatening or health-threatening circumstances.

In addition, in its sole discretion, ECH management may elect to make other services eligible for Financial Assistance.

Patient's Family:

1. For Persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.
2. For Persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Family Income: Family Income is determined using the following income of a Patient's Family when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- ~~Noncash~~ Non-cash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- Includes the income of Patient's Family members as defined above.

High Medical Costs: A patient who's Family Income does not exceed 400 percent of the federal poverty level and has annual out-of-pocket medical costs incurred by the individual at ECH or other healthcare providers that exceed 10 percent of the patient's Family Income in the prior 12 months.

For expenses incurred at other providers, the patient must provide documentation of medical expenses paid by the patient or the patient's family in the prior 12 months. .

The definition of High Medical Costs will include patients who have a balance due after insurance payment of a discounted rate as a result of 3rd party coverage. [A patient balance may relate to the co-insurance, copayment or deductible amounts, as well as non-covered charges from the patient's insurance carrier.](#)

Out-of-network: Certain insurance carriers and governmental health care programs may reduce or eliminate benefits unless care is provided at designated facilities. In cases where ECH is not one of the designated facilities, any non-emergency care provided is considered to be out-of-network. Out-of-network care will not be eligible for charity discounts except that ECH may, on a case-by-case basis, grant assistance in the case of medical indigence. An Uninsured Discount will be given on amounts denied for out of network amounts. [ECH is compliant with out of network billing requirements per State and Federal regulations, including the CARES Act Terms & Conditions.](#)

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations. A patient who has insurance or third party assistance to provide medical services but whose insurance or assistance does not include services provided at ECH will be considered as out-of-network, not as uninsured. An Uninsured Discount will be given on amounts denied as non-covered.

Essential Living Expenses: Include rent, house payment and maintenance, food, household supplies, utilities telephone, clothing, medical and dental payment, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning and other extraordinary expenses.

PROCEDURE:

A. Charity Care Program

Information in this section applies to the provision of charity care when a patient has no health insurance or has High Medical Costs and is not eligible for any government programs.

1. **Eligibility Criteria for Charity Care.** Eligibility for charity care will be considered for those individuals who are unable to pay for their care and are uninsured and ineligible for any government health care benefit program or for those patients that have High Medical Costs. The granting of charity care shall be based on an individualized determination of Family Income, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Full Charity Care will be offered if Family Income is AT OR BELOW 400% of the Federal Poverty Guidelines.

[a. Non-covered and denied services provided to Medicaid eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability and all charges related to services not covered, including all denials, are charity care. Examples may include, but are not limited to:](#)

- [Services provided to Medicaid beneficiaries with restricted Medicaid \(i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care\)](#)

- [Medicaid-pending accounts](#)
- [Medicaid or other indigent care program denials](#)
- [Charges related to days exceeding a length-of-stay limit](#)
- [Out-of-state Medicaid claims with "no payment"](#)

2. **Determination of Eligibility for Charity Care.** The cooperation of the patient and/or the Patient's Family is necessary in order for ECH to determine eligibility.

a. Eligibility will be determined in accordance with the following procedures to ensure an individual assessment of Family Income. The application process will require the following information from the patient:

- Completed signed application
- Proof of Income Tax return and monetary assets or subsequent month bank statements or most recent payroll stub or FICA earning summary from SSA.
- Include reasonable efforts by ECH to explore appropriate alternative sources of payment and coverage from public and private payment programs and to assist patients to apply for such programs. However if the patient applies, or has a pending application for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program. ~~and~~
- Include a review of the patient's outstanding accounts for any open accounts that may also be eligible for charity care for the approval timeframe.
- For patients who are unable to complete the application or provide financial information, ECH may determine eligibility [either \(1\) using presumptive determination based on information obtained from Experian or \(2\) as documented and approved by business office management at ECH.](#)

b. Eligibility determination may be done at any point in the collection cycle. The eligibility for Charity Care shall be based on the patient's insured status at the time services are rendered, and shall give consideration to any retroactive denial or granting of insurance. That is, if the patient is believed to be insured at the time services are rendered but is subsequently found to have been uninsured at that time, then the patient is eligible for an Uninsured discount. Similarly, if the patient is believed to be uninsured at the time services are rendered but is subsequently found to have been insured at that time, then the patient is not eligible for an Uninsured discount. Charity Care will be reversed in these situations.

c. If at any time information relevant to the eligibility of the patient changes, it is the patient's responsibility to notify ECH of the updated information.

The determination of financial need shall be done consistently with the requirements of California AB 774, including the requirement that the first ten thousand dollars (\$10,000 of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars (\$10,000) be counted in determining eligibility.

d. Eligibility for financial assistance shall be reevaluated every 12 months or at any time additional information relevant to the eligibility of the patient becomes known. If such information does change, it is the patient's responsibility to notify ECH of the updated information.

- e. ECH's values of respect and integrity shall be reflected in the application process, eligibility determination and granting of an uninsured discount. Requests for Charity Care shall be processed promptly and ECH shall notify the patient or applicant in writing of its decision on a completed application.-

B. Uninsured Discounts and Extended Payment Plans

1. Uninsured Discounts

ECH Patients who do not have third-party insurance and are not eligible for a government program will receive a published discount off ECH charges.- A patient may choose not to use available third-party insurance and may receive an ~~Uninsured~~uninsured discount. Furthermore, the uninsured discount may be applied to billed charges that are deemed non-covered (not a covered benefit) by a government program. The uninsured discount percentage for Hospital/Facility billing is 75%.

Uninsured discounts are determined by ECH management.

2. Extended Payment Plans

ECH will negotiate an extended payment plan to allow payment over time that is agreed upon between ECH and the patient based on the patient's Family Income and Essential Living Expenses. All payment plans shall be interest free. The extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments during a 90-day period. Before declaring the extended payment plan no longer operative, ECH or its collection agency shall make a reasonable attempt to contact the patient by phone and to give notice in writing, that the extended payment plan may become inoperative and of the opportunity to renegotiate the extended payment plan. ECH does not report to consumer credit agencies.

C. Other Provisions

1. **Communication of this Policy to Patients and the Public.** Notification about charity care and discounts available from ECH, which shall include a contact number, shall be disseminated by ECH by various means, which may include, but are not limited to, the publication of notices on facility websites or on patient bills, and by posting notices in the emergency room, admitting and registration departments, hospital business offices, ~~Clinics and patient financial services~~clinics, and Patient Financial Services offices that are located on facility campuses, and at other public places as ECH may elect. Such information shall be provided in the primary languages spoken by the population serviced by ECH. Referral of patients for financial assistance may be made by anyone, subject to applicable privacy laws.

Such communications include:

- Published Uninsured Discount Percentage
 - Extended Payment Plans option with phone number to call
 - Charity Care eligibility and current Federal Poverty Guidelines along with a customer service phone number to call for assistance
 - High Medical Costs definition
 - Links to other programs, including Covered California
 - Phone number for Consumer Support/Legal Assistance
 - Discounts from Emergency Room Physicians and a phone number to call for assistance.
2. **Relationship to Collection Policies.** ECH management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient

qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from ECH, a patient's good faith effort to comply with his or her payment agreements with ECH, and all applicable laws and regulations. The Patient Accounts-Collection Practices and Collection Agency Management Policy outlines the presumptive charity care eligibility screening process used to evaluate charity care eligibility prior to an account being sent to collections. The patient's account will not be sent to collections if eligible for Charity Care. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, ECH may offer extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences, and will not send unpaid bills to outside collection agencies. Any agency performing routine monitoring and follow-up for such accounts on ECH's behalf shall be instructed not to report such accounts to any credit monitoring agency, and shall not be considered to be an "outside collection agency" under this policy. In the event ECH should ~~error~~ in following these policies, ECH will take appropriate steps to correct its error in a timely fashion. If it is discovered an account is eligible for financial assistance, ECH will reverse the account of collections and document the respective discount in charges as charity care.

3. **Errors and Misrepresentations.** ECH may deny an application for Financial Assistance and/or may reverse previously applied discounts if it learns of information which it believes supports a conclusion that information previously provided was inaccurate. In addition, ECH may elect to pursue legal actions, against persons who it believes knowingly misrepresented their financial condition, and including those who accept financial assistance after an improvement in their financial circumstances which was not made known to ECH.
4. **Regulatory Requirements.** In implementing this Policy, ECH shall comply with all federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy such as AB 774 and SB 1276.

D. **Exceptions and Limitations**

The Chief Executive Officer and Chief Financial Officer of ECH are each granted the authority to provide exceptions to these policies and procedures as appropriate to the individual patient's circumstances and as appropriate to the financial ability and needs of ECH. These individuals are also each granted the authority to adjust the parameters of the financial assistance program in order to ensure the total amount of financial assistance provided is consistent with the organization's financial ability and to ensure ECH is able to meet its financial obligations.

This policy is intended to be a statement of general intent, setting forth the basic principles to be followed by the organization in administration of its programs to provide financial assistance and charity care to its patients. However, because the complexities of human existence can present myriad possible individual circumstances, and because of the challenges present in managing a health care organization, it is recognized that some degree of flexibility is appropriate in administering these programs. As such, nothing in this policy shall be construed to create an affirmative obligation for ECH to grant financial assistance to any particular patient, other than as required under the law.

REFERENCES:

~~Patient Protection and Affordable Care Act of 2010 and California AB 774 and SB 1276~~

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Jeanne Hanley: Policy and Procedure Coordinator	pending
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	03/2021
CFO	Carlos Bohorquez: CFO [JH]	03/2021
Senior Director, Revenue Cycle	Brian Fong: Sr Dir Revenue Cycle	02/2021
	Brian Fong: Sr Dir Revenue Cycle	02/2021

COPY

Practitioner Name:

INSTRUCTIONS:

Indicate Request Type: Initial Appointment Renewal of Privileges Additional Privileges

Applicant: Check off the “Requested” box for each privilege requested. Please note: Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications, and for resolving any doubts related to qualifications for requested privileges.

Department Chief: Check the appropriate box for recommendation on the last page of this form and include your recommendation for focused professional practice evaluation (FPPE). If recommended with conditions or not recommended, provide conditions or explanation on the last page of this form.

Other conditions:

If any privileges are covered by an exclusive contract or an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience.

REQUIRED QUALIFICATIONS

To be eligible to apply for privileges in Obstetrics & Gynecology, the applicant must meet the following criteria:

Education/Training	Basic Education: MD or DO Minimal Formal Training: Successful completion of residency program in Obstetrics & Gynecology, accredited by AC-GME, AOA or Royal College of Physicians and Surgeons of Canada
Certification	Currently certified or eligible in Obstetrics & Gynecology by the American Board of Obstetrics & Gynecology or the Osteopathic Board of Obstetrics & Gynecology, or completion of certification must occur within five (5) years of completion of residency/fellowship. Once certified members must maintain board certification as required by the same board or association.
Current Experience	Applicants for initial appointment must be able to demonstrate At least fifty (50) deliveries [including at least five (5) C-sections] in the past 12 months and the performance of least twenty-five (25) gynecological surgical procedures [including at least five major abdominal cases] reflective of the scope of privileges requested, in the past 12 months, or successful completion of an AOA- or ACGME accredited residency or clinical fellowship within the past 12 months (case logs required)
Licensure	Current active, unrestricted physician license by the Medical Board of California or the Board of Osteopathic Examiners of the State of California.
DEA	Have an active, individual federal, registered DEA number for prescribing of controlled substances.
Additional Requirements	Board certification must be maintained in the physician’s primary specialty in order for the physician to be qualified for continued medical staff membership. A two year grace period will be granted if needed, for practitioners to obtain recertification.
FPPE	Method and quantity to be determined by the Department Chief at time of application review for Core and Non-Core privileges and evidenced on the specialty FPPE Plan
Renewal of Privileges	Current demonstrated competence and an adequate volume of experience one-hundred (100) deliveries, [including at least ten (10) C-sections], and twenty-five (25) gynecological surgical procedures, [including at least five (5) major abdominal cases]) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes Participation in the annual assessment of Electronic Fetal Monitoring providers with privileges in Obstetrics will be assessed at the time of reappointment Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.
Special Non-Core Privileges (See Specific Criteria below)	Non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria as applicable to the applicant or reapplicant.

Requested	Privilege	Additional Special Criteria
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<input type="checkbox"/>	<p><u>CORE PRIVILEGES SPECIALTY - OBSTETRICS</u></p> <p>Admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult female patients and/or provide medical and surgical care of the female reproductive system and associated disorders, including major medical diseases that are complicating factors in pregnancy. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services</p> <p><u>Core Procedures List</u></p> <p>The core procedures in Obstetrics include the following procedures and such other procedures that are extensions of the same techniques and skills. It defines the types of activities/procedures/privileges that the majority of practitioners meeting the core educational, certification and experience requirements are competently able to perform.</p> <ul style="list-style-type: none"> • Perform history and physical exam • Amnioinfusion • Amniocentesis • Amniotomy • Anesthesia privileges: pudendal anesthetic infiltration, local anesthetic infiltration • Application of internal fetal and uterine monitors • Augmentation and induction of labor • Cesarean hysterectomy, cesarean section • Cerclage • Cervical biopsy or conization of cervix in pregnancy • External version of breech • Forceps Delivery: rotation, mid forceps, low forceps, outlet forceps • Immediate care of the newborn (including resuscitation and intubation) • Interpretation of fetal monitoring • Management of high risk pregnancy inclusive of such conditions as pre-eclampsia, post-datism, third trimester bleeding, intrauterine growth restriction, premature rupture of membranes, premature labor, and placental abnormalities • Management of patients with/without medical, surgical or obstetrical complications for normal labor including toxemia, threatened abortion, normal puerperal patient, normal antepartum and postpartum care, postpartum complications, fetal demise • Manual removal of placenta, uterine curettage • Medication to induce fetal lung maturity • Methotrexate administration for treatment of ectopic pregnancy • Normal spontaneous vaginal delivery • Obstetrical diagnostic procedures, including ultrasonography and other relevant imaging techniques • Operative vaginal delivery (including the use of obstetric forceps and/or the vacuum extractor) • Perform breech and multifetal deliveries • Pudendal and paracervical blocks • Repair of 4th degree perineal lacerations or of cervical or vaginal lacerations • Treatment of medical and surgical complications of pregnancy • Ultrasound as part of a pelvic exam • Vaginal birth after previous Cesarean section (VBAC) 	
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Requested	Privilege	Additional Special Criteria
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<input type="checkbox"/>	<p><u>CORE PRIVILEGES SPECIALTY – GYNECOLOGY</u></p> <p>Admit, evaluate, diagnose, treat, and provide consultation and the pre-, intra-, and postoperative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system, and nonsurgically treat disorders and injuries of the mammary glands. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.</p> <p><u>Core Procedures List</u></p> <p>The core procedures in Gynecology include the following procedures and such other procedures that are extensions of the same techniques and skills. It defines the types of activities/procedures/privileges that the majority of practitioners meeting the core educational, certification and experience requirements are competently able to perform.</p> <ul style="list-style-type: none"> • Perform history and physical exam • Adnexal surgery, including ovarian cystectomy, oophorectomy, salpingectomy, and conservative procedures for treatment of ectopic pregnancy • Anterior repair; Posterior/enterocele repair • Aspiration of breast masses • Bladder Suspension: Marshall Marchetti, Burch, Pereyra, Stamey, Sling • Cervical biopsy including conization • Colpocleisis • Colpoplasty • Colposcopy • Cystoscopy as part of gynecological procedure • Diagnosis and management of pelvic floor dysfunction, including operations for its correction e.g. (repair of rectocele, enterocele, cystocele, or pelvic prolapse) • Diagnostic and therapeutic D & C • Diagnostic and operative laparoscopy (other than tubal sterilization) • Endometrial ablation • Laparotomy (other than tubal sterilization) • Gynecologic diagnostic procedures including ultrasonography and other relevant imaging techniques • Gynecologic endoscopy procedures: pelviscopy/laparoscopy including removal of ec-topic pregnancy; tubal ligation, Oophorectomy, Ovarian cystectomy, salpingectomy, myomectomy, laparoscopic assisted hysterectomy, hysteroscopy, ablation, resection, destruction and/or removal of endometriosis • Hypogastric artery ligation • Hysterectomy, abdominal, vaginal, including laparoscopically assisted • Hysterosalpingography • Hysteroscopy, diagnostic or ablative excluding use of resection technique • I & D of pelvic abscess • Incidental appendectomy • IUD insertion and removal • Metroplasty • Operation for treatment of early stage carcinoma of the vulva, vagina, endometrium, ovary or cervix • Operation for treatment of urinary stress incontinence; vaginal approach, retropubic urethral suspension, sling procedure • Operation for uterine bleeding (abnormal and dysfunctional) 	
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Requested	Privilege	Additional Special Criteria
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	<p><u>Gynecology Core Procedures List (Cont.)</u></p> <ul style="list-style-type: none"> • Tubal ligation (non-laparoscopic): post-partum and non-post-partum • Ultrasound as part of a pelvic exam • Uterosacral vaginal vault fixation, paravaginal repair • Uterovaginal, vesicovaginal, rectovaginal, and other fistula repair • Vulvar biopsy • Vulvectomy, simple • Operative management of pelvic pain • LEEP • Coldknife Conization • Hymenotomy • Suprapubic Catheter Insertion • D&C • Salpingostomy and repair (non-endoscopic) • Abdominal hysterectomy • Vaginal hysterectomy • Simple vulvectomy • Colpocleisis 	
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Requested	Privilege	Additional Special Criteria
	<u>NON – CORE (SPECIAL) PRIVILEGES - GYNECOLOGY</u>	
<input type="checkbox"/>	Tuboplasty: <ul style="list-style-type: none"> • Endoscopic • Tubal re-anastomosis 	<p>New applicant applying for non-core privileges:</p> <ul style="list-style-type: none"> • Documentation of at least five (5) tubaoplasty procedures within the past 12 months <p style="text-align: center;">OR</p> <p>Documentation of tubaoplasty training. The first two (2) cases are to be procotored by a practitioner with tubaoplasty privileges, and until competency is achieved.</p> <p>Current medical staff applying for reappointment:</p> <ul style="list-style-type: none"> • Documentation of five (5) tubaoplasty procedures within the past 24 months

Requested	Privilege	Additional Special Criteria
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<input type="checkbox"/>	<p><u>CORE PRIVILEGES SPECIALTY - GYNECOLOGICAL ONCOLOGY</u></p> <p>Core privileges in gynecologic oncology include the ability to admit, evaluate, diagnose, treat, and provide consultation and surgical and therapeutic treatment to female patients with gynecologic cancer and resulting complications, including carcinomas of the cervix, ovary and fallopian tubes, uterus, vulva, and vagina, and the performance of procedures on the bowel, urethra, and bladder. Physicians also may provide care to patients in the intensive care setting in conformance with unit policies. They should also be able to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services</p> <p><u>Core Procedures List</u></p> <ul style="list-style-type: none"> • Perform history and physical exam • Radical hysterectomy • Hypogastric artery ligation • Inguinal lymphadenectomy • Pelvic lymphadenectomy • Radical vulvectomy • Chemotherapy administration/supervision • Omentectomy • Treatment of malignant disease with chemotherapy • Lymphadenectomy (inguinal, femoral, pelvic, para-aortic) • Microsurgery • Myocutaneous flaps, skin grafting • Para-aortic and pelvic lymph node dissection • Pelvic exenteration (anterior, posterior, total) • Hysterectomy (vaginal, abdominal, laparoscopic assisted) • Vaginectomy (simple, radical) • Vulvectomy (skinning, simple, partial) • Insertion of intracavity radiation application • Salpingo-oophorectomy • Surgery of the gastrointestinal tract and upper abdomen, including placement of feeding tube for jejunostomy/gastrostomy, resection and reanastomosis of small bowel, bypass procedures of small bowel, mucous fistula formations of small bowel, ileostomy, repair of fistula, resection and reanastomosis of large bowel (including low-anterior resection and reanastomosis), bypass procedures of the large bowel, mucous fistula formations of large bowel, colostomy, splenectomy, and liver biopsy • Surgery of the urinary tract: cystectomy (partial, total), repair of vesicovaginal fistulas (primary, secondary), cystotomy, ureteroneocystostomy with/without bladder flaps or psoas fixation, end-to-end ureteral reanastomosis, transureteroureterostomy, small-bowel interposition, cutaneous ureterostomy, repair of injuries to the ureter, and conduits developed from the ileum and colon • Incision and drainage of abdominal or perineal abscesses • Reconstruction procedures, including development of neovagina and development of a new pelvic floor • Evaluation procedures, including cystoscopy, laparoscopy, colposcopy and loop excision, sigmoidoscopy, breast mass fine-needle aspirations, and needle biopsy • Management of operative and postoperative complications 	<p>New applicant applying for core privileges:</p> <ol style="list-style-type: none"> 1. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)- or AOA-accredited residency in OB/ GYN, plus an ABOG- or AOA-approved fellowship in gynecologic oncology AND/OR 2. Current subspecialty certification or active participation in the examination process (with achievement of certification within five (5) years) leading to subspecialty certification in gynecologic oncology by the ABOG or completion of a certificate of special qualifications by the ABOG. 3. Required current experience: At least twelve (12) gynecologic oncology procedures, reflective of the scope of privileges requested, in the past twelve (12) months, or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past twelve (12) months. 4. Case logs required <p>Current medical staff applying for reappointment:</p> <ol style="list-style-type: none"> 1. To be eligible to renew privileges in gynecologic oncology, the applicant must demonstrate current competence and an adequate volume of experience, of at least twenty-four (24) gynecologic oncology procedures with acceptable results, reflective of the scope of privileges requested, within the past 24 months based on results of ongoing professional practice evaluation and outcomes 2. Case logs required
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Requested	Privilege	Additional Special Criteria
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<input type="checkbox"/>	<p><u>CORE PRIVILEGES SPECIALTY – MATERNAL AND FETAL MEDICINE</u></p> <p>Core privileges for MFM include the ability to admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult female patients with medical and surgical complications of pregnancy, such as maternal cardiac, pulmonary, and metabolic complications; connective tissue disorders; and fetal malformations, conditions, or disease. MFM physicians may provide care to patients in the intensive care setting in conformance with unit policies. Privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.</p> <p><u>Core Procedures List</u></p> <ul style="list-style-type: none"> • Perform history and physical exam • MFM and high risk pregnancy consultation • Amnioreduction • Breech delivery (spontaneous, assisted, application of forceps) • Cephalocentesis • Cesarean hysterectomy • Chorionic villus sampling, Trans-cervical or Trans-abdominal • Complicated cesarean delivery • Delivery of multiple gestations • Diagnostic laparoscopy • Episiotomy and vaginal laceration repair • External cephalic version of abnormal lie • Fetal assessment: non-stress test, contraction stress test, biophysical profile, vibroacoustic stimulation test, and Doppler velocimetry (antepartum) and fetal heart rate monitoring and scalp stimulation (intrapartum) • Genetic amniocentesis • In utero fetal transfusion • Induction of labor • Intrauterine fetal therapy (thoracentesis, paracentesis, administration of medications, placement of thoracic shunt, and placement of urinary catheter) • Interoperative support to obstetrician as requested, including operative first assist • Laparoscopic enterolysis • Manual removal of placenta • Medical and surgical control of hemorrhage • Neonatal resuscitation • Operative vaginal deliveries • Percutaneous umbilical blood sampling • Performance of history and physical exam • Sterilization procedures • Transvaginal cervical cerclage • Ultrasound examination, including first-, second-, and third-trimester targeted anatomic fetal evaluation and cardiac evaluation, such as color Doppler, Doppler velocimetry (fetal umbilical artery, fetal middle cerebral artery, and maternal uterine artery), cervical and placental evaluation, and 3D and 4D ultrasound • Version of second twin 	<p>New applicant applying for core privileges:</p> <ol style="list-style-type: none"> 1. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)- or AOA-accredited residency in OB/ GYN, plus an ABOG- or AOA-approved fellowship in maternal and fetal medicine AND/OR 2. Current subspecialty certification or active participation in the examination process (with achievement of certification within five (5) years) leading to subspecialty certification in gynecologic oncology maternal fetal medicine by the ABOG or completion of a certificate of special qualifications by the ABOG. 3. Required current experience: Provision of care to at least twenty-five (25) patients, reflective of the scope of privileges requested, in the past twelve (12) months, or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past twelve (12) months. 4. Case logs required <p>Current medical staff applying for reappointment:</p> <ol style="list-style-type: none"> 1. To be eligible to renew privileges in gynecologic oncology maternal fetal medicine, the applicant must demonstrate current competence and an adequate volume of experience, the provision of care to at least fifty (50) patients with acceptable results, reflective of the scope of privileges requested, within the past 24 months based on results of ongoing professional practice evaluation and outcomes <p>Case logs required</p>
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Requested	Privilege	Additional Special Criteria
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<input type="checkbox"/>	<p>CORE PRIVILEGES SPECIALTY – MATERNAL AND FETAL MEDICINE – CONSULTATION ONLY</p> <p>Core privileges for MFM include the ability to admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult female patients with medical and surgical complications of pregnancy, such as maternal cardiac, pulmonary, and metabolic complications; connective tissue disorders; and fetal malformations, conditions, or disease. MFM physicians may provide care to patients in the intensive care setting in conformance with unit policies. Privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.</p> <p>Core Procedures List</p> <ul style="list-style-type: none"> ● Perform history and physical exam ● MFM and high risk pregnancy consultation ● Amnioreduction ● Breech delivery (spontaneous, assisted, application of forceps) ● Cephalocentesis ● Cesarean hysterectomy ● Chorionic villus sampling, Trans-cervical or Trans-abdominal ● Complicated cesarean delivery ● Delivery of multiple gestations ● Diagnostic laparoscopy ● Episiotomy and vaginal laceration repair ● External cephalic version of abnormal lie ● Fetal assessment: non-stress test, contraction stress test, biophysical profile, vibroacoustic stimulation test, and Doppler velocimetry (antepartum) and fetal heart rate monitoring and scalp stimulation (intrapartum) ● Genetic amniocentesis ● In utero fetal transfusion ● Induction of labor ● Intrauterine fetal therapy (thoracentesis, paracentesis, administration of medications, placement of thoracic shunt, and placement of urinary catheter) ● Interoperative support to obstetrician as requested, including operative first assist ● Laparoscopic enterolysis ● Manual removal of placenta ● Medical and surgical control of hemorrhage ● Neonatal resuscitation ● Operative vaginal deliveries ● Percutaneous umbilical blood sampling ● Performance of history and physical exam ● Sterilization procedures ● Transvaginal cervical cerclage ● Ultrasound examination, including first-, second-, and third-trimester targeted anatomic fetal evaluation and cardiac evaluation, such as color Doppler, Doppler velocimetry (fetal umbilical artery, fetal middle cerebral artery, and maternal uterine artery), cervical and placental evaluation, and 3D and 4D ultrasound ● Version of second twin 	<p>New applicant applying for core privileges:</p> <ol style="list-style-type: none"> 1. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)- or AOA-accredited residency in OB/ GYN, plus an ABOG- or AOA-approved fellowship in maternal and fetal medicine AND/OR 2. Current subspecialty certification or active participation in the examination process (with achievement of certification within five (5) years) leading to subspecialty certification in gynecologic oncology maternal fetal medicine by the ABOG or completion of a certificate of special qualifications by the ABOG. 3. Required current experience: Provision of care to at least twenty-five (25) patients, reflective of the scope of privileges requested, in the past twelve (12) months, or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past twelve (12) months. 4. Case logs required <p>Current medical staff applying for reappointment:</p> <ol style="list-style-type: none"> 1. To be eligible to renew privileges in gynecologic oncology maternal fetal medicine, the applicant must demonstrate current competence and an adequate volume of experience, the provision of care to at least fifty (50) patients with acceptable results, reflective of the scope of privileges requested, within the past 24 months based on results of ongoing professional practice evaluation and outcomes 2. Case logs required
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Requested	Privilege	Additional Special Criteria
<input type="checkbox"/>	<p>Laser Privileges:</p> <ul style="list-style-type: none"> • Laser Pelviscopy • Laser Laparotomy • Laser Lower Genital Tract • KTP Laser 	<p>New applicant applying for non-core privileges:</p> <ul style="list-style-type: none"> • Documentation of training: <ul style="list-style-type: none"> ○ Residency/Fellowship (within 12 months of application) or <ul style="list-style-type: none"> ▪ Verifiable through program director ○ Medical/Surgical Laser Training Course (within 12 months of application) or <ul style="list-style-type: none"> ▪ Documentation required ○ Currently credentialed at another facility <ul style="list-style-type: none"> ▪ Experience to be verified through chief of service where privileges are held at the time of application for appointment <p>Current medical staff applying for reappointment:</p> <ul style="list-style-type: none"> • Current demonstrated competence and an adequate volume of experience of at least five (5) procedures using lasers with acceptable results over a 24 month period • Documentation of CME covering use of lasers, complications and equipment use • Case logs required
<input type="checkbox"/>	<p>Placement of Central IV Line</p>	<p>New applicant applying for non-core privileges:</p> <ul style="list-style-type: none"> • Documentation of at least six (6) central line placements within the past 12 months <p style="text-align: center;">OR</p> <p>Documentation of central line placement training. The first two (2) central line placements are to be proctored by a practitioner with central line placement privileges, and until competency is achieved.</p> <p>Current medical staff applying for reappointment:</p> <ul style="list-style-type: none"> • Documentation of twelve (12) central line placements within the past 24 months

Requested	Privilege	Additional Special Criteria
<input type="checkbox"/>	<p>daVinci Robot</p> <p><u>* da Vinci Proctor Requirements:</u></p> <ol style="list-style-type: none"> 1. Surgeon currently in good standing on the El Camino Medical Staff and has the same specialty da Vinci Robotic privileges. (Surgeon must have themselves successfully completed their FPPE/proctoring for robotic privileges) 2. Surgeon who is currently approved by Intuitive as a da Vinci Robotic Proctor. Note: If surgeon is not on the El Camino Medical Staff, they will not have clinical privileges at El Camino, and therefore must not touch the patient. <p># Any Proctor not on the El Camino Medical Staff must be processed through the Medical Staff Office prior to scheduling any cases.</p>	<p>New applicant applying for non-core privileges:</p> <p>Basic Qualifications:</p> <ul style="list-style-type: none"> • Basic education: MD or DO • Board certified or Board admissible within the appropriate surgical specialty or subspecialty • Recent and ongoing experience in advanced laparoscopic or thoracoscopic surgery <ol style="list-style-type: none"> 1. Experience to be verified through chief of service where privileges are held • Must be privileged to perform advanced laparoscopic surgical procedures at El Camino Hospital • Please refer to specific surgical specialty delineation of privileges for any additional requirements • Case logs required <p>Training and Experience Requirements: Applicants must follow one of the three pathways listed below:</p> <ol style="list-style-type: none"> 1. Surgeons who have successfully completed a post-graduate residency or fellowship program which included robotic-assisted operative laparoscopic or thoracoscopic surgery training: <ul style="list-style-type: none"> • Applicant to submit documentation of at least fifteen (15) robotic-assisted operative laparoscopic or thoracoscopic procedures as primary surgeon during training • Training to be verified through residency or fellowship program director and primary robotic surgical attending (if different) • Provisional privileges may be granted once reviewed by Credentials Committee, the MEC and the Board • Must be proctored for three (3) procedures with an evaluation submitted for each procedure (* See Proctor Requirements) • Full privileges would be granted once the proctor has signed off with acceptable outcomes

Requested	Privilege	Additional Special Criteria
	da Vinci Robot (cont.)	<p>2. Surgeons who currently are credentialed at another facility to perform robotic-assisted operative laparoscopic or thoracoscopic procedures:</p> <ul style="list-style-type: none"> • Applicant to submit documentation of at least ten (10) robotic-assisted operative laparoscopic or thoracoscopic procedures as primary surgeon within the last 24 months • Experience and competence to be verified from the appropriate chief of service from the facility where current privileges are held • Case logs required • Additional reference to be obtained from the Director of Robotic Surgery, should the position exist • Provisional privileges may be granted once reviewed by Credentials Committee, the MEC and the Board • Must be proctored for one (1) procedure with an evaluation submitted for the procedure • Full privileges would be granted once the proctor has signed off with acceptable outcomes <p>3. Surgeons who were not trained in robotic laparoscopic or thoracoscopic surgery during residence/fellowship and who are not currently credentialed to perform this procedure at another institution must:</p> <ul style="list-style-type: none"> • Provide evidence of comprehensive training with the daVinci Robot. The training must include certification by Intuitive Surgical (or comparable course approved in advance by the Department Chief) that covers theory, instrumentation, complications and safety factors. Training should include hands on laboratory experience, utilizing cadaver tissue and/or animal models. It should also include observation of live robotic assisted surgery

Requested	Privilege	Additional Special Criteria
	da Vinci Robot (cont.)	<ul style="list-style-type: none"> Provisional privileges may be granted once reviewed by Credentials Committee, the MEC and the Board Be proctored for at least three (3) robotic procedures with an evaluation submitted for each procedure Full privileges would be granted once the proctor has signed off with acceptable outcomes <p>Required ongoing experience:</p> <ul style="list-style-type: none"> A minimum twenty (20) robotic surgery cases as the attending of record during a two (2) year appointment period is required to maintain privileges If threshold is not met during a two (2) year appointment period continuation privileges will be reviewed on a case by case basis pending review and recommendation by the Section Chief and Department of Surgery Chief Case logs required
<input type="checkbox"/>	Moderate (Conscious) Sedation	<p>New applicant applying for non-core privileges:</p> <ul style="list-style-type: none"> Non-anesthesiologist practitioners are required that they have received training in administering moderate sedation as part of their residency or specialty training program or that they have received the El Camino Moderate Sedation Study Module Current ACLS and/or PALS if applicable Requires passing the Moderate Sedation Examination with score of 85% or higher Exam must be taken as provided by ECH Medical Staff Office <p>Current medical staff applying for reappointment:</p> <ul style="list-style-type: none"> Applicants must be able to demonstrate current competence and evidence of the administration of moderate sedation to at least fifteen (15) patients in the previous 24 months Case logs required Current ACLS and/or PALS if applicable Requires passing the Moderate Sedation Examination with score of 85% or higher Exam must be taken as provided by ECH Medical Staff Office

Requested	Privilege	Additional Special Criteria
<input type="checkbox"/>	Surgical Assist: <ul style="list-style-type: none"> • Provide hemostasis to reduce potential for postoperative infection and potential for fluid volume deficit by clamping and/or ligating vessels, using electro-surgical or laser units, applying direct pressure, applying chemical agents that promote coagulation and other means as directed by the surgeon • Provide exposure of the operative site through the appropriate use of retractors and other instruments and through suctioning and sponging • Use surgical instruments skillfully in ways consistent with their design and purpose as directed by the surgeon • Handle all variety of tissue appropriately to reduce potential for injury or compromised blood supply • Suture skillfully all varieties of tissue with the appropriate suture 	New applicant applying for privileges: Requires MD or DO degree and completion of any surgical residency program accredited by the AC-GME, AOA or Royal College of Physicians and Surgeons of Canada. <ul style="list-style-type: none"> • Physician must have current surgical privileges at another facility • Case logs required Current medical staff applying for reappointment: <ul style="list-style-type: none"> • Current demonstrated competence and an adequate volume of experience as Surgical Assist, for at least twenty-four (24) cases within the past 24 months, with acceptable results • Case logs required
<input type="checkbox"/>	Fluoroscopy Use (Non-Core) <ul style="list-style-type: none"> ▪ Includes supervision of other staff using the equipment 	New applicant applying for non-core privileges: <ul style="list-style-type: none"> • California CDPH Valid Radiology Supervisor and Operator Certificate or Fluoroscopy Supervisor and Operator Permit Required • Certificate/permit must be maintained • Copy of valid certificate/permit must be on file in the Medical Staff Office at all times Current medical staff applying for reappointment: <ul style="list-style-type: none"> • California CDPH Valid Radiology Supervisor and Operator Certificate or Fluoroscopy Supervisor and Operator Permit Required • Certificate/permit must be maintained • Copy of valid certificate/permit must be on file in the Medical Staff Office at all times

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at **El Camino Hospital**, and I understand that:

- (a) In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
- (b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Applicant Signature: _____ **Date:** _____

Requested	Privilege	Additional Special Criteria
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DEPARTMENT CHIEF RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

- Recommend all requested privileges**
- Recommend privileges with the following conditions/modifications:**
- Do not recommend the following requested privileges:**

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
Notes:	

 Division Chief Signature (if applicable)

 Print Name

 Date

 Department Chief Signature

 Print Name

 Date

Finance Committee Approvals Report to the Board – April 7, 2021

In accordance with the El Camino Hospital Community Benefit Grants Policy and the Finance Committee Charter, the Finance Committee approved the following Grant at its March 29, 2021 meeting:

Grantee	Location	Grant Amount	Description of Grant and Statement of Need
City of Mountain View	Cuesta Park, Mountain View	\$150,000	Development of a Community Fitness Court in Cuesta Park. This free outdoor fitness area is designed to support the health of local community members. According to Santa Clara County Public Health, only 61% of Mountain View residents meet CDC guidelines for physical activity. Furthermore, 17% of residents are obese. These factors can lead to the development or worsening of chronic medical conditions. To address these pressing health issues, more outdoor physical activity areas are needed. The fitness court would provide an important tool to improve physical and mental well-being, during the pandemic and for years to come. This is a partnership with the City of Mountain View; the city will fund more than 50% of the project (\$351,500 total).

In accordance with the Corporate Compliance: Physician Financial Arrangements Policy, the Finance Committee approved the following agreements at its March 29, 2021 meeting:

Clinical Area	Campus	Agreement Type	Hourly or Per Diem Rate	Hours	Not-to-Exceed	FMV Assessment	Statement of Need
Acute In Patient Rehab	Los Gatos	Professional Services Agreement	\$6,289 per discharge; Monthly Medical Director and Clinical Liaison Fees; Quality Performance Bonus	365 Days	\$4,653,967 Over Three Years Based on Estimated Volume	Does not Exceed the 75 th percentile	Provides Therapy Services to the In-Patients in Acute Rehabilitation Facility

Memorandum

To: El Camino Health Hospital Board of Directors
From: Dan Woods, CEO
Date: April 1, 2021
Subject: March Board Report

Operations

As a result of improving pandemic conditions, on March 11, El Camino Health relaxed its no visitor policy for emergency department patients. On March 22, the visitation policy expanded to include additional patient populations. El Camino Health's visitor guidelines are based on the most recent guidance from the California Department of Public Health. The policy allows for one visitor in most hospital areas with up to two visitors per day based on a patient's location and condition. El Camino Health believes it is important to provide this gradual lifting of the visitor restrictions while remaining vigilant with our safety precautions. Visitors play a significant role in the mental well-being and healing process of our patients. Visitor screenings for fever and other COVID-19 symptoms will remain at each entrance. Visitors will be asked to wear a mask at all times, adhere to social distancing, use hand sanitizer upon entry, and will only be permitted to remain in the patient's room they are visiting while at the hospital.

El Camino Health -- Los Gatos earned a spot on Newsweek's national Best Maternity Care Hospitals list for 2021. To achieve this distinction, the hospital exceeded quality measures as defined by the Leapfrog Group. Los Gatos was one of just 22 hospitals nationwide recognized in this way. El Camino Health's NICU at our Mountain View campus was singled out by CPACC (California Perinatal Quality Care Collaborative), a statewide network of California's neonatal intensive care units. The award recognizes just one NICU quality improvement team in the state that has made significant contributions, not only within their own unit but also across the neonatal community.

Ambulatory Care | Silicon Valley Medical Development – SVMDD

SVMD and SEIU-UHW reached a new, first agreement for 3 years, effective February 1, 2021 to January 31, 2024. The agreement was ratified by SEIU-UHW last week. New pay rates and future benefits are competitive with ambulatory clinics in the local market. SVMDD has 143 represented employees at the 12 clinics acquired from Verity where the San Jose Medical Group providers practice.

SVMD has opened two vaccine clinics since January where we have administered more than 10,000 doses of Pfizer and Moderna vaccines the community members.

To improve access to care in the communities we serve, we have undertaken a sweeping improvement initiative to expand and ease access through our call centers and in all 12 of our locations. The initiative includes call center optimization, referral process optimization, and an initiative to reduce no shows and cancellations. The result will be increased access to high quality care at our clinic locations.

COVID-19 testing continues throughout our clinic locations. We administer approximately 100 tests per day.

Quality and Safety

Non-ventilator associated hospital acquired pneumonia is a significant risk to hospitalized patients and can lead to serious complications. To reduce the threat of this hospital-acquired condition, we have instituted a comprehensive program called ICOUGH (incentive spirometry, cough, oral hygiene understanding/education, get out of bed, and head of bed up 30 degrees). As a result of this initiative, we have seen a 40% reduction this fiscal year in hospital acquired pneumonia.

Finance

El Camino Health met with the credit rating agencies, Moody's and Standard & Poor's late last year to cover the financial impact of the COVID-19 pandemic and what our organization put in place to ensure recovery. Both agencies have recently affirmed our credit rating and outlook to the following: Moody's -- Revenue Bonds: Rating: 'A1'; Outlook: 'Stable'; General Obligation Bonds: Rating: 'Aa1'; Outlook: 'Stable'; Standard & Poor's: Revenue and General Obligation Bonds: Rating: 'AA'; Outlook: 'Stable'. El Camino Health's strong balance sheet, liquid assets, and the organization's financial profile all were factors for the positive ratings.

Human Resources

Clinical Education will begin a new cohort of El Camino Health's Nurse Residency Program. Ten of the best nurses were chosen from a pool of more than 100 applicants for the current cohort. This program paves the way to advance the careers of our med-surg nurses to attain training in other difficult-to-recruit specialty areas. The Inclusion, Diversity, Equity and Belonging (IDEB) Steering Committee chose a training and education program that will launch in April. The first mandatory training module is focused on "Unconscious Bias." Two other modules are focused on "Diversity and Inclusion" and "Microaggressions in the Workplace." The committee has also developed IDEB-related survey questions, which will be added to upcoming the Employee and Medical Staff engagement surveys.

Information Services

The most recent Epic upgrade enables compliance with the 21st Century CURES Act by providing real-time patient access to clinical notes and other required elements of electronic health information in MyChart. The CURES Act, effective April 1, 2021, promotes interoperability and restricts information blocking by healthcare providers. In response to the CURES mandate, El Camino Health activated a website tool for patient electronic information requests and geocoding to help patient families find nursing homes in the area.

To improve the patient experience and care, new features were added to MyChart including: Zoom and virtual visit features on bedside iPads to allow patients to interact with family and friends while hospitalized during restricted visitor timeframes, enhanced analytics to identify, bill and track COVID-19 vaccination patients, and self-service analytical tools for ICU and Maternal Child Health clinical areas.

Our total MyChart enrollments continue to increase as well as the percentage of patients who self-pay electronically in MyChart before service. This amount has doubled since Sept 2020 and is in the top 2% of Epic customers. Moreover, the percent of appointments scheduled online for MyChart patients is entering the top 10% range of Epic organizations.

Marketing and Communications

While consumer perceptions of safety in healthcare settings have improved, some concerns remain. We extended the media for the “Return to Health” brand advertising campaign media to run through April to continue to message on patient safety at El Camino Health. In addition, the digital part of the primary care campaign, to support brand-building efforts for primary care, relaunched.

Information on vaccines and our online scheduler (on the COVID-19 Resource Center on the website) updated as changes by the county and state on vaccine guidelines occurred.

El Camino Health launched a successful 11th Annual Heart Forum (virtual event on March 1) with 1300 registrants and 101 attendees. Six Norma Melchor Heart and Vascular Institute physicians presented and participated in the live Q&A.

Philanthropy

For FY21 to date, the El Camino Health Foundation has secured a total of \$2,004,200 in fundraising, which is 32 percent of goal. This includes \$4,200 in major and planned gifts, \$53,224 in annual gifts and \$107,840 in support for special events (Norma’s Literary Luncheon). Two upcoming virtual events include Healthy Connections “Building for the Future” on March 31 and the spring gala, a benefit for the Women’s Hospital renovation, at the end of May.