El Camino Health

AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, December 9, 2020 – 5:30pm
El Camino Hospital 2500 rant Road o ntain ie C 94040

P R O C OR E O C OR E EC E OR ER 29 20 E RCH 18 2020 El C O HE H **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. E E HE P C E O O HE OPE E O EE E ECO ERE CE :

1-669-900-9128, MEETING CODE: 369-007-4917#. No participant code. Just press #.

o atch 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 p lic comment please se the phone n m er listed a ove.

MISSION: o heal relieve s ffering and advance ellness as yo r p licly acco nta le health partner.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	anhee Chen oard Chair		**5:30 – 5:31pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	anhee Chen oard Chair		**information 5:31 – 5:32**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.* ritten Correspondence	anhee Chen oard Chair		**information 5:32 -5:35**
4.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 4**	lie liger ality Committee Chair ar dams C O		**discussion 5:35 – 5:50**
5.	**FY21 PERIOD 4 FINANCIALS** **ATTACHMENT 5**	Carlos ohor e C O	*public comment*	**possible motion 5:50 – 6:15**
6.	**ADJOURN TO CLOSED SESSION**	anhee Chen oard Chair	*public comment*	**motion required 6:15 – 6:25**
7.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	anhee Chen oard Chair		**information 6:25 – 6:26**
8.	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.*	anhee Chen oard Chair		**motion required 6:26 – 6:28**
	Approval *Gov't Code Section 54957.2:* a. in tes of the Closed ession of the Hospital oard eeting 11/11/2020 ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** *Health & Safety Code Section 32155* for a report of the edical taff deli erations concerning reports on edical taff ality ass rance matters: ality Committee Report i edical taff Credentials and Privileges			

copy of the agenda for the Reg lar oard eeting ill e posted and distri ted at least seventy t o 72 ho rs prior to the meeting.
n o servance of the mericans ith isa ilities ct please notify s at 650 988 7504 prior to the meeting so that e may provide the agenda in alternative formats or ma e disa ility related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	Report □ii□ □□ality Co□ncil □in□tes			
9.	*Health & Safety Code Section 32155* for a report of the □edical □taff□deli□erations concerning reports on □edical □taff □□ality ass□rance matters: - □edical □taff Report	□p□rva □arfatia□□ □□ Enterprise Chief of □taff□ □ichael □an□□ □□ □os □atos Chief of □taff		**motion required** **6:28 – 6:38**
10.	*Health and Safety Code Section 32106(b)* for a report and disc□ssion involving health care facility trade secrets: - □trategic Planning □pdate	□an □oods□CEO		**discussion** **6:38 – 7:28**
11.	*Gov't Code Section 54956.9(d)(2)* – conference □ith legal co□nsel – pending or threatened litigation□*Health and Safety Code Section 32106(b)* for a report and disc□ssion involving health care facility trade secrets: - CEO Report on □egal □ervices and □e□ Programs and □ervices	□an □oods□CEO		**discussion** **7:28 – 7:43**
12.	Report involving *Gov't Code Section 54957* for disc□ssion and report on personnel performance matters – □enior □anagement: - E□ec□tive □ession	□anhee Chen□□oard Chair		**discussion** **7:43 – 7:48**
13.	**ADJOURN TO OPEN SESSION**	□anhee Chen□□oard Chair		**motion required** **7:48 – 7:49**
14.	**RECONVENE OPEN SESSION/ REPORT OUT** □o report any re□□ired disclos□res regarding permissi□le actions ta□en d□ring Closed □ession.	□anhee Chen□□oard Chair		**information** **7:49 – 7:50**
15.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** a. □in□tes of the Open □ession of the Hospital □oard □eeting □11/11/2020□ □. □□20 CEO □ncentive Compensation Payo□t ***Reviewed and Recommended for Approval by the Finance Committee*** c. □□21 Period 3 □inancials ***Reviewed and Recommended for Approval by the Medical Executive Committee*** d. □edical □taff Report ***Information*** e. □o□ntain □ie□ □ite Plan □tat□s	□anhee Chen□□oard Chair	*public comment*	**motion required** **7:50 – 7:52**
16.	**RESOLUTION 2020-12: Establishing and Appointing Members of a Strategic Planning Ad Hoc Committee** **ATTACHMENT 16**	□anhee Chen□□oard Chair	*public comment*	**possible motion** **7:52 – 7:55pm**
17.	**CEO REPORT** **ATTACHMENT 17**	□an □oods□CEO		**information** **7:55 – 7:58**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
18.	**BOARD COMMENTS**	□anhee Chen□□oard Chair		**information 7:58 – 7:59**
19.	**ADJOURNMENT**	□anhee Chen□□oard Chair	*public comment*	**motion required 7:59 – 8:00pm**

Upcoming Regular Meetings: □e□r□ary 10□2021□□ arch 10□2021□□pril 7□2021□□ ay 12□2021□□□ne 9□2021

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Julie Kliger, MPA, BSN, Quality Committee Chair
Mark Adams, MD, CMO
Date: December 9, 2020
Subject: Quality, Patient Care and Patient Experience Committee Report

Purpose: To inform the Board of the work of the Quality Committee.

Summary:

1. Two items were extracted from the consent agenda: the enterprise quality and safety dashboard and the hospital update. The Serious Safety Event Rate (SSER) portion of the dashboard was further elucidated. SSER is defined as the number of Serious Safety Events (SSE) per 10,000 patient days. To be meaningful, at least 12 months of data is required to make this calculation. We will have our first valid 12 month period starting in January, 2021. We will show the actual SSE's for each month as a raw number for reference but the FYTD column will show the rolling 12 month SSER. The latter is the most meaningful metric as the monthly volatility for SSE's does not accurately reflect trends. Over the next several years we will be striving to reduce the SSER to near zero. There was a question regarding the October spike in sepsis mortality index. Every mortality is reviewed and every sepsis case is reviewed by the sepsis team. So far no specific issues have been identified to account for this spike. The FYTD sepsis mortality index is still less than 1.0 and the spike is within control limits. This will be monitored closely for any indication of a trend that needs to be addressed. There was another question from the hospital report regarding the role of the newly constituted Diversity, Equity, and Inclusion (DEI) Committee in influencing the equity metrics contained in the Board Quality STEEEP dashboard. While the DEI committee is still under construction, we anticipate that they will be influential in this area.

2. Cheryl Reinking, RN, CNO, presented a recent patient story that involved a complaint regarding the bedside manner of a physician and an imaging service employee. This led to a discussion about how the patient experience team conducts service recovery and how the medical staff is held accountable for professional behavior.

3. Mark Adams, MD, CMO, reviewed the readmission dashboard. Overall readmission index FYTD is down to 0.87. The dashboard highlights the seven key diagnostic areas that contribute to the CMS readmissions penalty program. Good progress has been made except for a recent bump in CABG readmissions. This is being addressed. 80% of hospitals experienced a penalty for FY21 but we have kept our impact fairly low at a 0.3% penalty for the FY21, which started October 1.

4. Dr. Adams reviewed the most recent Patient Safety Index (PSI) report. The good news is that many of the measures are in the green—better than benchmark—including PSI-4, death in surgical patients with treatable complications, which had been a concern by the Committee in the past. PSI-18 and PSI-19, OB trauma, continue to be areas of intense focus for improvement.

5. The Committee raised a question regarding how we might establish quantitative triggers on important metrics which would ensure that the Committee would be alerted when there is a quality

or safety area that are exceeding control limits. A good discussion ensued and this will be further considered going forward.

Attachments:

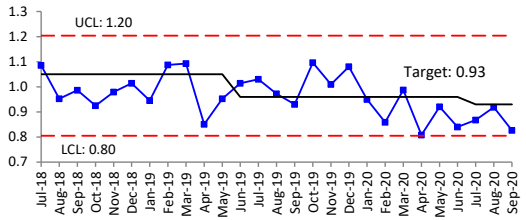
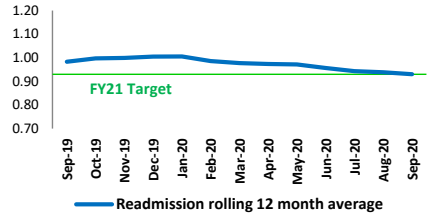
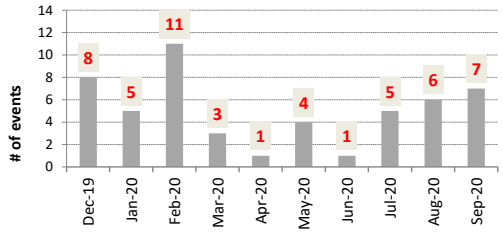
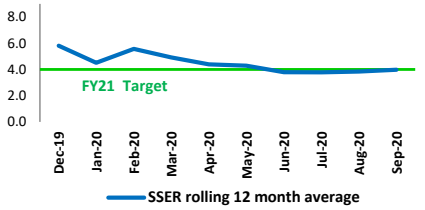
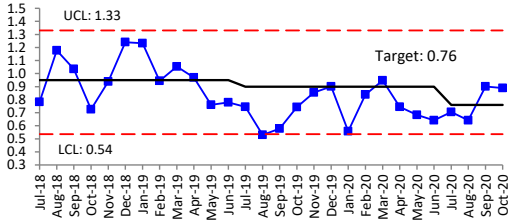
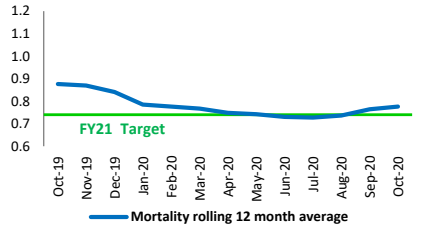
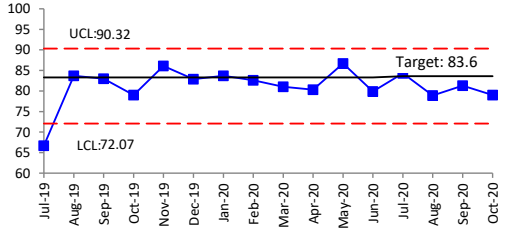
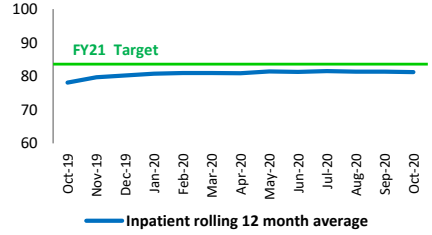
1. FY21 Enterprise Quality Dashboard

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

October 2020 (unless otherwise specified)

Month to Board Quality Committee:
December, 2020

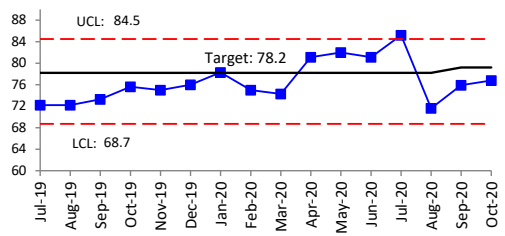
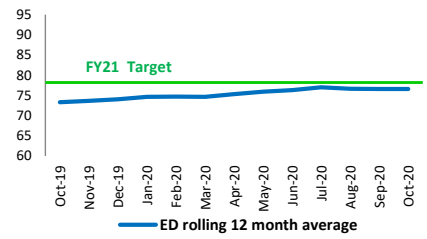
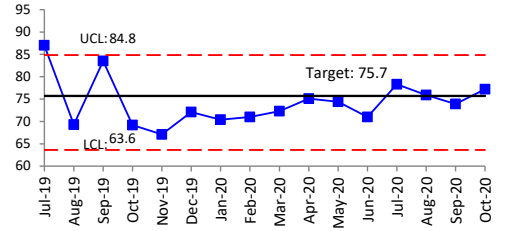
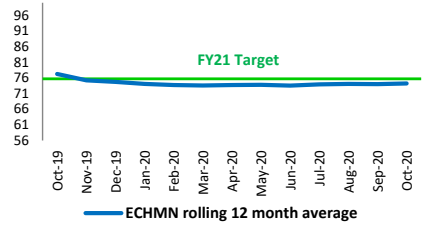
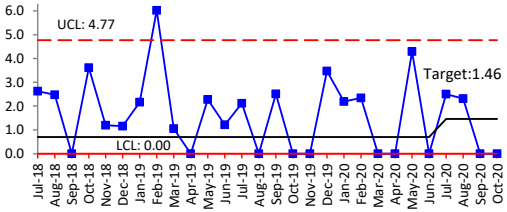
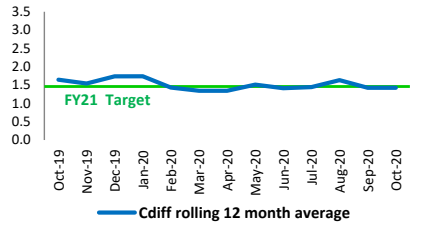
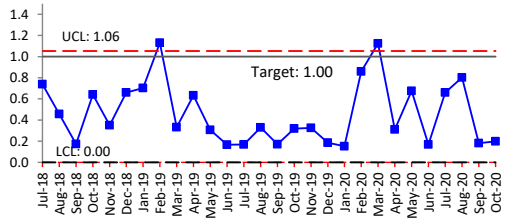
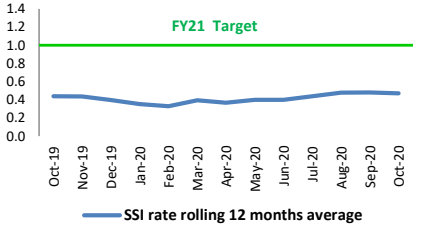
		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: September 2020**	0.83 (6.62%/8.01%)	0.87 (6.97%/8.00%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** # of events ***Latest data month: September 2020**	7	3.98 (51/127985)	4.28	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: October 2020*	0.89 (1.55%/1.74%)	0.78 (1.44%/1.85%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: October 2020*	79	80.2	83.1	83.6		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

October 2020 (unless otherwise specified)

Month to Board Quality Committee:
December, 2020

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
5	* Organizational Goal **ED Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: October 2020*	76.8	74.6	75.7	78.2		
6	* Organizational Goal **ECHMN** (El Camino Health Medical Network)**: Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: October 2020*	77.2	76.4	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: October 2020*	0.00 (0/9989)	1.14 (4/34945)	1.46	<= 1.46 (MV: 10/ LG: 3)		
8	Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: October 2020*	0.20 (1/506)	0.48 (11/2285)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

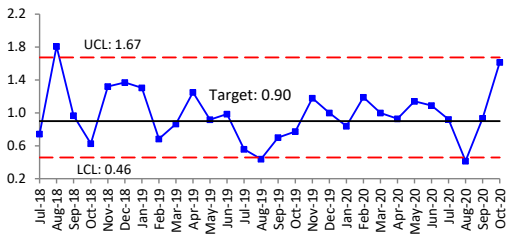
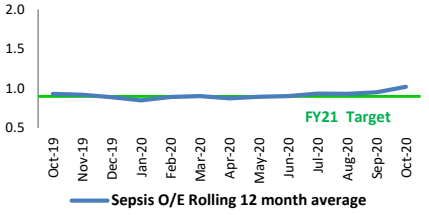
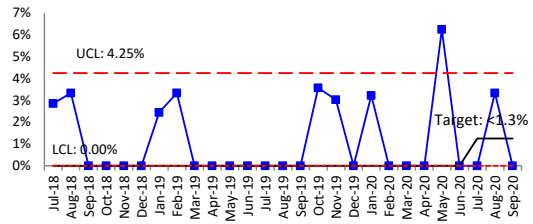
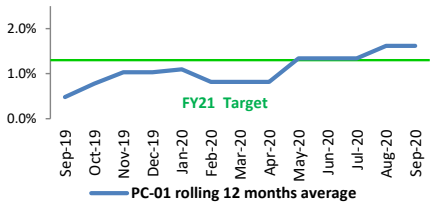
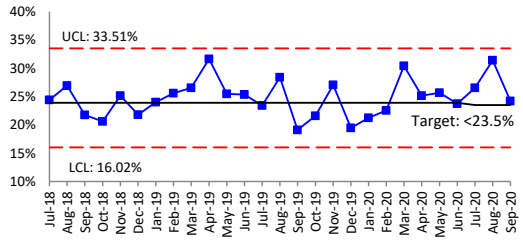
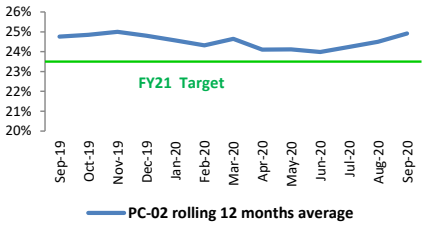
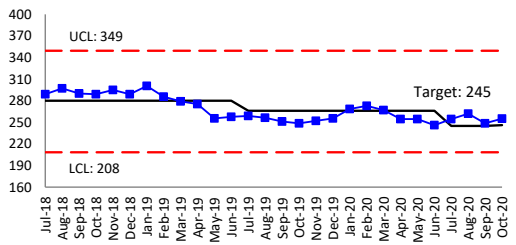
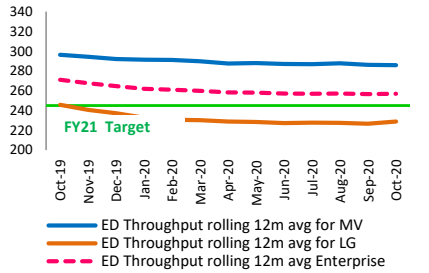
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

October 2020 (unless otherwise specified)

Month to Board Quality Committee:

December, 2020

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: October 2020*	1.62 (14.53%/8.99%)	0.95 (9.98%/10.52%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) *******Latest data month: September 2020*	MV: 0.00% (0/10) LG: 0.0% (0/4) **ENT: 0.00%** (0/14)	MV: 0.00% (0/49) LG: 4.55% (1/22) **ENT: 1.41%** (1/71)	MV: 1.47% (5/341) LG: 0.00% (0/48) **ENT: 1.29%** (5/389)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) *******Latest data month: September 2020*	MV: 25.2% (35/139) LG: 18.2% (4/22) **ENT: 24.2%** (39/161)	MV: 29.13% (125/429) LG: 20.00% (17/85) **ENT: 27.63%** (142/514)	MV: 24.74% (412/1665) LG: 18.97% (48/253) **ENT: 23.98%** (460/1918)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Latest data month: October 2020*	MV: 270 min LG: 240 min **Ent: 255 min**	MV: 276 min LG: 235 min **Ent: 256 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

□□data available up to September

Report updated: 11/20/20

El Camino Health

Summary of Financial Operations

Fiscal Year 2021 – Period 4

7/1/2020 to 10/31/2020

Overall Commentary for Period □ □Octo□er 2□2□

- ECH and ECHMN volumes continue to exceed budget and pre-Covid levels with the exception of MV's emergency room
- Overall gross charges, a surrogate for volume, were favorable to budget by □□□.2M / □4□ and □2□.□M / □□ better than the same period last year
- Net patient revenue was favorable to budget by □1□.□M / 27□ and □□12□ / 1□ better than the same period last year
- Operating expenses were □5.□M / 7□ unfavorable to budget, which is primarily attributed to higher than expected inpatient and outpatient volumes
- Operating margin was favorable to budget by □1□M / 2□5□ and □□47□ / 10□ lower than the same period last year
- Operating EBIDA was favorable to budget by □1□.4M / □□□□ and □1.□M / □□ better than the same period last year

Consolidated Statement of Operations ($000s)

Period ending 10/31/2020

Period 4 FY 2020	Period 4 FY 2021	Period 4 Budget 2021	Variance Fav (Unfav)	Var%	$000s	YTD FY 2020	YTD FY 2021	YTD Budget 2021	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
337,610	366,453	273,274	93,179	34.1%	**Gross Revenue**	1,280,865	1,396,640	1,055,311	341,329	32.3%
(247,968)	(275,898)	(202,008)	(73,891)	(36.6%)	**Deductions**	(942,375)	(1,044,537)	(780,855)	(263,682)	(33.8%)
89,642	**90,554**	**71,266**	**19,288**	**27.1%**	**Net Patient Revenue**	**338,490**	**352,103**	**274,456**	**77,648**	**28.3%**
3,591	4,024	4,478	(455)	(10.2%)	**Other Operating Revenue**	17,154	17,018	17,712	(695)	(3.9%)
93,233	**94,578**	**75,745**	**18,833**	**24.9%**	**Total Operating Revenue**	**355,643**	**369,121**	**292,168**	**76,953**	**26.3%**
					OPERATING EXPENSE					
47,294	49,061	44,483	(4,578)	(10.3%)	**Salaries & Wages**	183,373	191,367	174,516	(16,852)	(9.7%)
14,479	13,496	11,091	(2,405)	(21.7%)	**Supplies**	53,238	56,007	43,099	(12,909)	(30.0%)
13,423	12,982	14,607	1,625	11.1%	**Fees & Purchased Services**	53,701	55,215	58,126	2,911	5.0%
4,006	3,721	3,615	(106)	(2.9%)	**Other Operating Expense**	14,431	15,398	14,937	(461)	(3.1%)
661	1,429	926	(503)	(54.3%)	**Interest**	2,251	5,716	3,701	(2,015)	(54.4%)
4,332	5,798	5,926	128	2.2%	**Depreciation**	17,691	22,151	23,503	1,352	5.8%
84,194	**86,487**	**80,649**	**(5,838)**	**(7.2%)**	**Total Operating Expense**	**324,685**	**345,854**	**317,881**	**(27,973)**	**(8.8%)**
9,038	**8,091**	**(4,905)**	**12,996**	**(265.0%)**	**Net Operating Margin**	**30,959**	**23,267**	**(25,713)**	**48,980**	**(190.5%)**
10,058	(27,499)	3,053	(30,552)	(1000.8%)	**Non Operating Income**	16,273	19,304	10,782	8,522	79.0%
19,097	**(19,408)**	**(1,852)**	**(17,556)**	**948.1%**	**Net Margin**	**47,231**	**42,571**	**(14,931)**	**57,502**	**(385.1%)**
15.1%	16.2%	2.6%	13.6%		**EBIDA**	14.3%	13.9%	0.5%	13.3%	
9.7%	8.6%	-6.5%	15.0%		**Operating Margin**	8.7%	6.3%	-8.8%	15.1%	
20.5%	-20.5%	-2.4%	(18.1%)		**Net Margin**	13.3%	11.5%	-5.1%	16.6%	

El Camino Health

Dashboard - as of October 31, 2020

	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Consolidated Financial Perf.								
Total Operating Revenue	93,233	94,578	75,745	18,833	355,643	369,121	292,168	76,953
Operating Expenses	84,194	86,487	80,649	(5,838)	324,685	345,854	317,881	(27,973)
Operating Margin $	9,038	8,091	(4,905)	12,996	30,959	23,267	(25,713)	48,980
Operating Margin %	9.7%	8.6%	(6.5%)	15.0%	8.7%	6.3%	(8.8%)	15.1%
EBIDA $	14,032	15,318	1,948	13,370	50,901	51,134	1,491	49,643
EBIDA %	15.1%	16.2%	2.6%	13.6%	14.3%	13.9%	0.5%	13.3%
Hospital Volume								
Licensed Beds	443	454	454	-	443	454	454	-
ADC	232	242	196	46	228	238	192	46
Utilization MV	63%	64%	51%	12.8%	62%	62%	50%	12.2%
Utilization LG	31%	31%	26%	4.6%	30%	32%	26%	5.4%
Utilization Combined	52%	53%	43%	10.2%	51%	52%	42%	10.1%
Adjusted Discharges	3,358	3,093	2,564	529	12,786	11,795	9,971	1,824
Total Discharges (Excl NNB)	1,709	1,617	1,377	240	6,662	6,254	5,363	891
Total Discharges	2,079	1,969	1,712	257	8,092	7,669	6,684	985
Inpatient Cases								
MS Discharges	1,160	1,096	857	239	4,600	4,152	3,316	836
Deliveries	395	379	354	25	1,507	1,519	1,396	123
BHS	103	98	121	(23)	378	394	477	(83)
Rehab	51	44	44	0	177	189	174	15
Outpatient Cases	14,728	16,572	10,326	6,246	53,503	61,851	40,065	21,786
ED	4,076	3,138	2,599	539	16,369	12,379	9,792	2,587
Procedural Cases								
OP Surg	514	572	333	239	1,961	2,080	1,314	766
Endo	271	263	142	121	919	962	544	418
Interventional	203	206	104	102	730	735	378	357
All Other	9,664	12,393	7,148	5,245	33,524	45,695	28,037	17,658
Hospital Payor Mix								
Medicare	50.1%	49.2%	48.3%	0.9%	50.0%	48.2%	48.3%	(0.1%)
Medi-Cal	6.7%	7.5%	7.6%	(0.2%)	7.6%	7.3%	7.5%	(0.2%)
Commercial IP	18.0%	19.6%	20.5%	(0.9%)	18.4%	20.6%	20.6%	(0.0%)
Commercial OP	22.6%	21.8%	21.0%	0.7%	21.8%	21.7%	21.1%	0.6%
Total Commercial	40.6%	41.4%	41.6%	(0.1%)	40.3%	42.3%	41.7%	0.6%
Other	2.6%	1.9%	2.6%	(0.6%)	2.2%	2.3%	2.5%	(0.2%)
Hospital Cost								
Total FTE [1]	2,811.4	2,808.2	2,864.8	56.6	2,764.7	2,752.9	2,831.1	78.2
Productive Hrs/APD	31.3	31.4	35.1	3.7	31.5	31.1	35.5	4.4
Consolidated Balance Sheet								
Net Days in AR	49.7	48.0	49.0	1.0	49.7	48.0	49.0	1.0
Days Cash	473	522	435	87	473	522	435	87

[1] Paid FTE; Budget in this case is using the Flex Budget instead of Fixed Budget

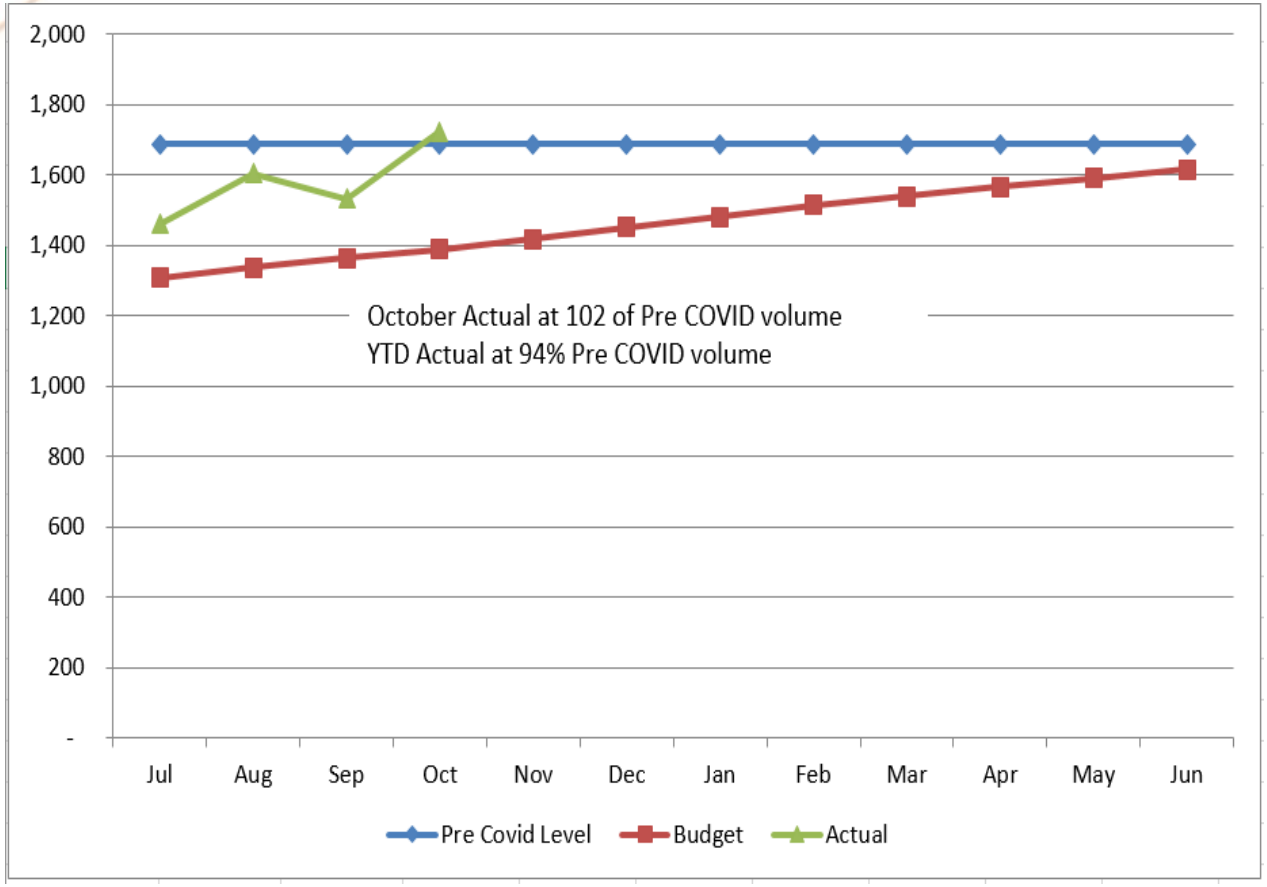
El Camino Health

APPENDIX

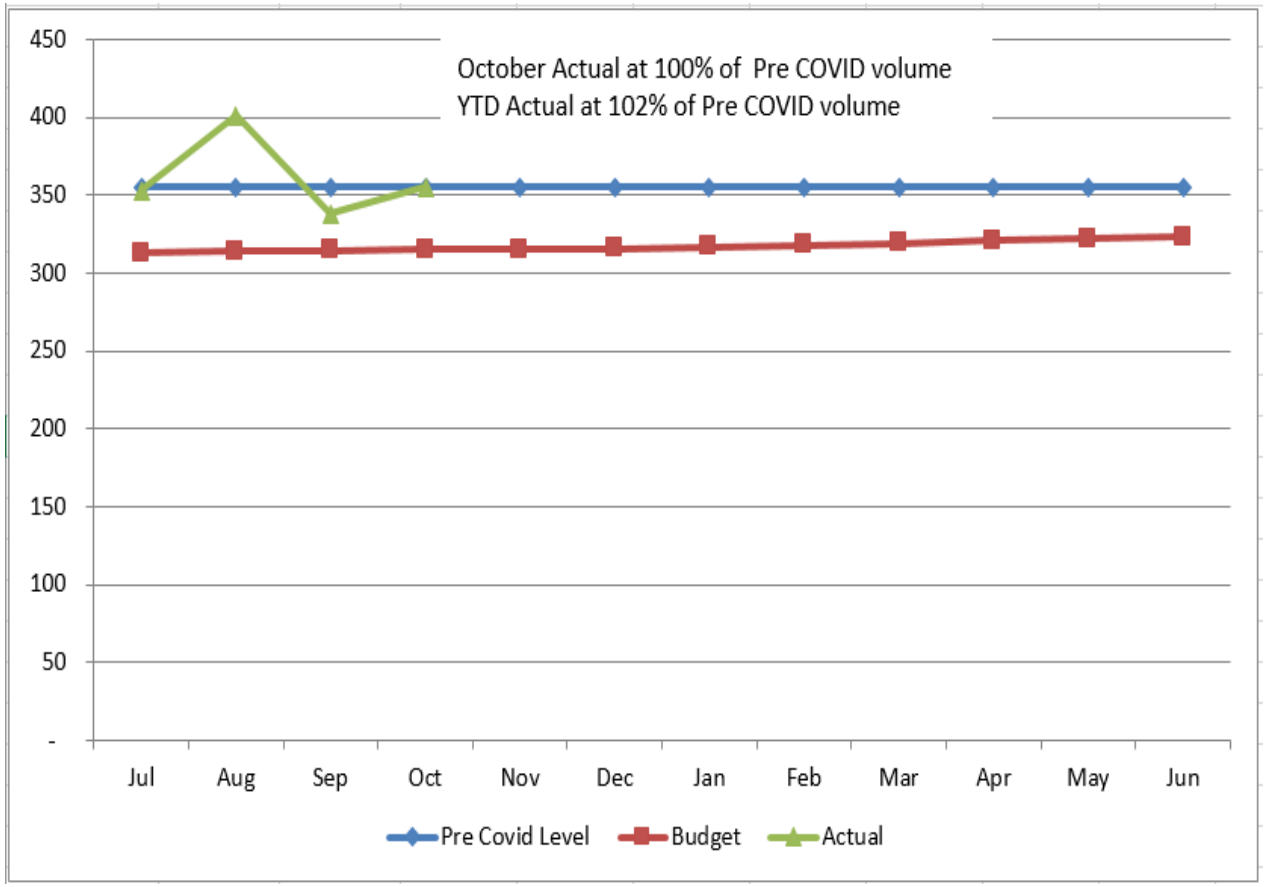
Monthly Inpatient Volume Trends

FY2□21 Budget vs Actual – Including Pre COVID Level

MV



LG

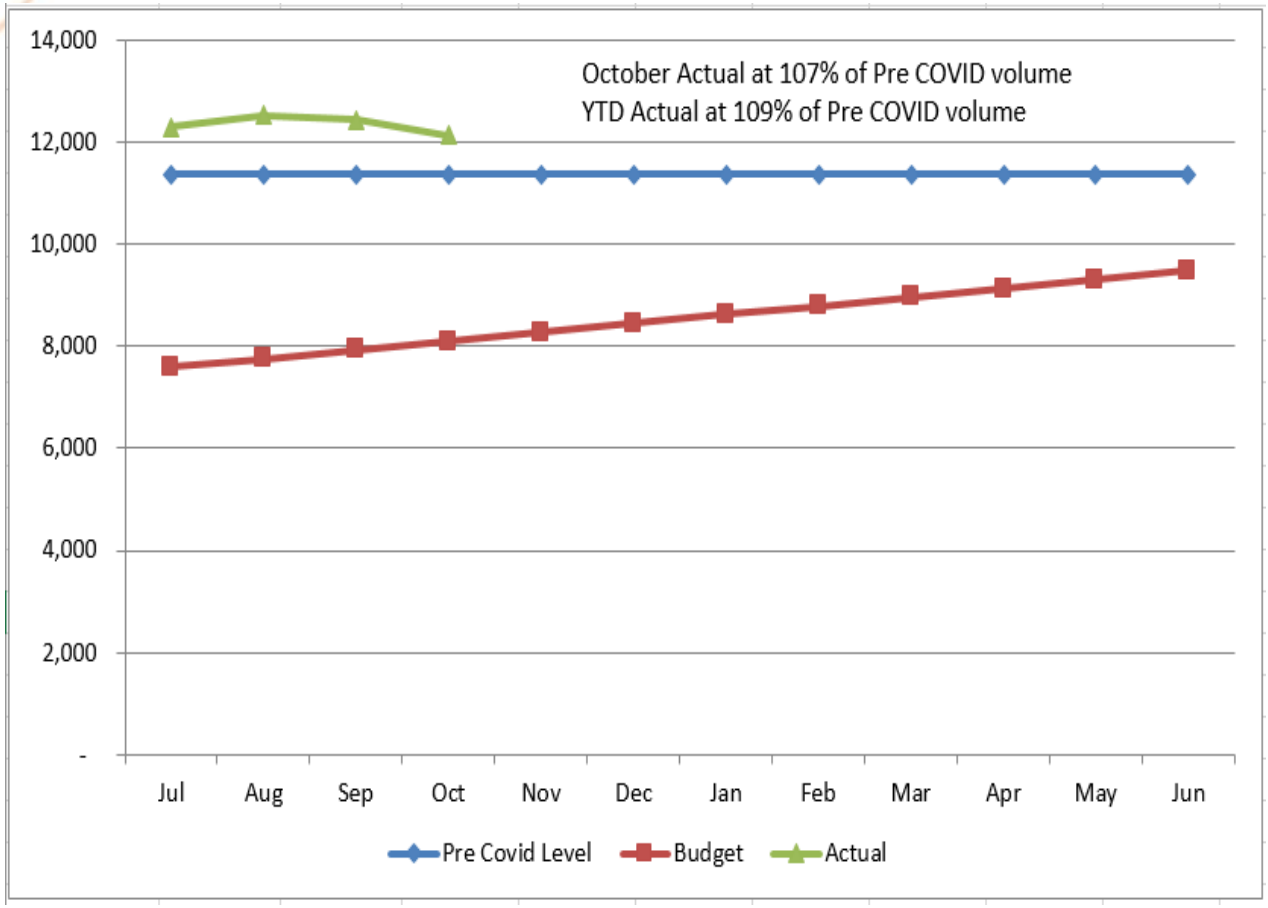


El Camino Health

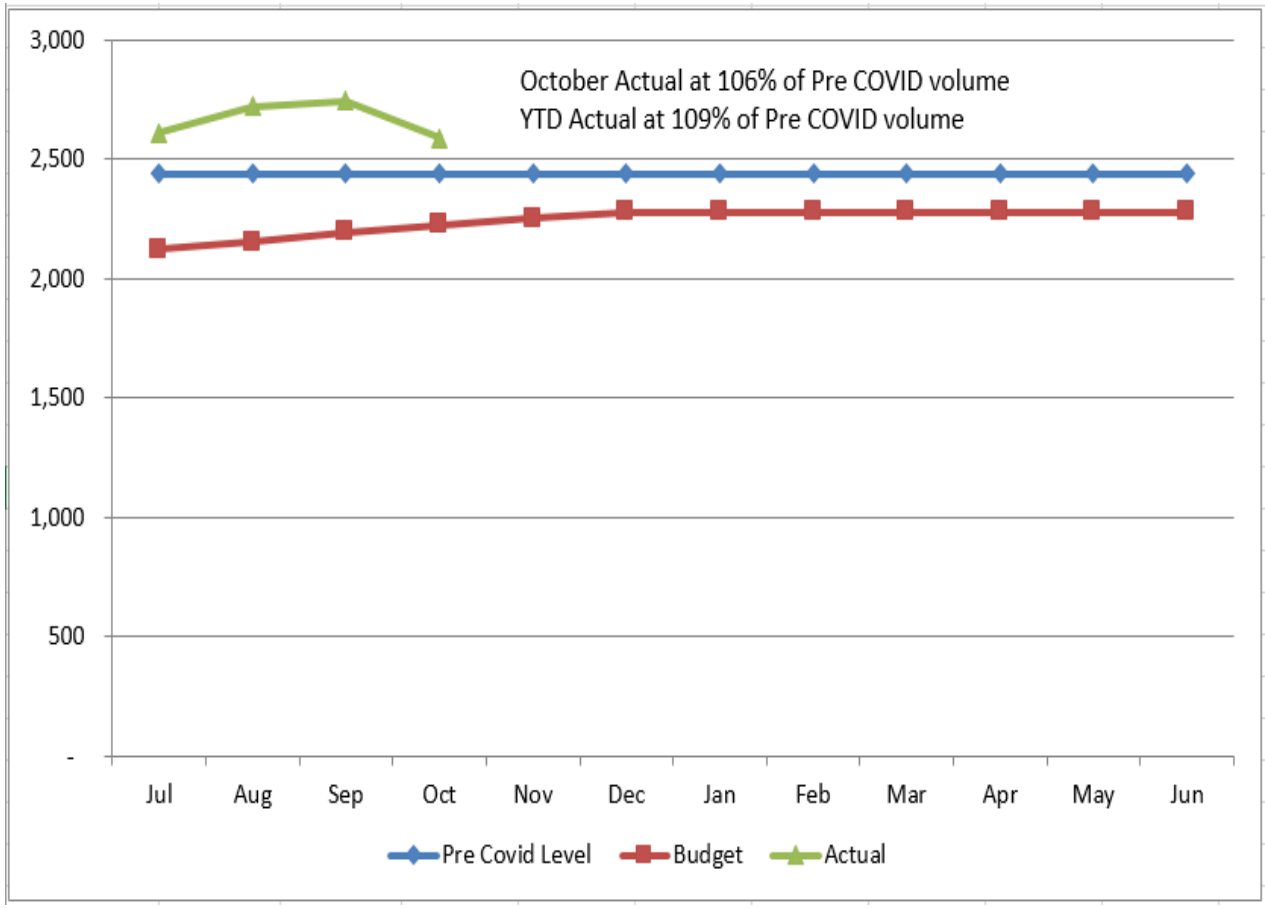
Monthly Outpatient Volume Trends

FY2□21 Budget vs Actual – Including Pre COVID Level

MV



LG



El Camino Health

Investment Scorecard as of September 30, 2020

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY20 Budget	Expectation Per Asset Allocation
Investment Performance		3Q 2020		Fiscal Year-to-date		7y 11m Since Inception (annualized)		FY 2020	2019
Surplus cash balance*		$1,120.8	--	--	--	--	--	--	--
Surplus cash return		4.1%	3.9%	4.1%	3.9%	5.7%	5.6%	4.0%	5.6%
Cash balance plan balance (millions)		$301.8	--	--	--	--	--	--	--
Cash balance plan return		5.3%	4.6%	5.3%	4.6%	7.7%	7.0%	6.0%	6.0%
403(b) plan balance (millions)		$581.5	--	--	--	--	--	--	--
Risk vs. Return		3-year				7y 11m Since Inception (annualized)			2019
Surplus cash Sharpe ratio		0.51	0.51	--	--	0.83	0.83	--	0.34
Net of fee return		5.8%	5.5%	--	--	5.7%	5.6%	--	5.6%
Standard deviation		8.2%	7.9%	--	--	6.0%	5.8%	--	8.7%
Cash balance Sharpe ratio		0.54	0.49	--	--	0.91	0.88	--	0.32
Net of fee return		7.0%	6.0%	--	--	7.7%	7.0%	--	6.0%
Standard deviation		10.3%	9.4%	--	--	7.7%	7.1%	--	10.3%
Asset Allocation		3Q 2020							
Surplus cash absolute variances to target		12.4%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Cash balance absolute variances to target		12.1%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Manager Compliance		3Q 2020							
Surplus cash manager flags		23	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		25	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$18 mm), District assets (~$42 mm), and balance sheet cash not in investable portfolio ($236 mm). Includes Foundation (~$37 mm) and Concern (~$15 mm) assets.

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El Camino Health

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, November 11, 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.

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair□□ **Peter C. Fung, MD**□□ **Gary Kalbach**□□ **Julie Kliger**□□ **Julia E. Miller,** □ecretary/□reas□rer□□ **Jack Po, MD, PhD**□□ **Bob Rebitzer**□□ **George O. Ting, MD**□□ **Don Watters**□□ **John Zoglin**□□ice Chair□□	□one ****via teleconference	□one

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	□he open session meeting of the □oard of □irectors of El Camino Hospital (the "Board") was called to order at 5:30pm □y Chair Chen. □ ver□al roll call □as ta□en. □irector Re□it□er □oined the meeting at 5:32pm d□ring the call to order. □ll other □oard mem□ers □ere present at roll call. □ll mem□ers participated via videoconference pursuant to Santa Clara County's shelter in place order. Chair Chen revie□ed the logistics for the meeting. He also recognized Veterans' Day and thanked veterans for their service. □ □□or□m □as present p□rs□ant to □tate of California E□ec□tive Orders □□ 25□20 dated □ arch 12□2020 and □□29□20 dated □ arch 18□2020.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen as□ed if any □oard mem□ers may have a conflict of interest □ith any of the items on the agenda. □o conflicts □ere noted.	
3. PUBLIC COMMUNICATION	□one.	
4. BOARD RECOGNITION *Resolution 2020-10*	□en □ing□C□□O□recogni□ed □rian Richards for his steadfast a□dio vis□al s□pport of the □oard and El Camino Health□incl□ding the □ni□□e needs d□ring the CO□□□□19 pandemic. **Motion:** □o approve *Resolution 2020-10* recogni□ing the □rian Richards. **Movant:** □al□ach **Second:** □ iller **Ayes:** Chen□□□ng□□al□ach□□liger□□ iller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one □he □oard commended □r. Richards for his □or□□and □r. Richards than□ed the □oard.	***Resolution 2020-09***
5. QUALITY COMMITTEE REPORT	□irector □liger□□ □ality Committee Chair□provided an overvie□ of the disc□ssion at that □ovem□er 2□2020 □□ality Committee meeting: □ □ edical □taff leadership recently initiated ne□ processes for	

	Clinical □oc□mentation □ntegrity, □ontri□□ting to high response and agreement rates. - □f any metrics are mar□ed red on the □□EEEP dash□oard for m□ltiple reporting periods, □he Committee □ill revie□ and disc□ss those in depth. - □he Committee disc□ssed health e□□ity meas□rements and approaches (□hat the organi□ation can do) for staff, physicians and patients they serve, 2) to improve the health of the comm□nity, incl□ding those □ho may not □e patients, and 3) to □or□□ith other organi□ations in the regions to raise health □roadly) - □here □as a ro□□st disc□ssion a□o□t the □□arterly SVMD □□ality □pdate, incl□ding concerns a□o□t electronic medical record (E□R) optimi□ation to capt□re patient care data. □irector □liger noted that this is an important area of foc□s. □ar□□dams, MD, □□O, highlighted the reference article, "The High-Performing □edical □ro□p, □rom □ggregation of Employed Practices to an Integrated Enterprise." He and the □oard f□rther disc□ssed the article and □irector □al□ach re□□ested copies for the □oard mem□ers. □r. □dams noted that there has □een a significant change in □an □ose Medical Group's compensation over the last year (40% are recent additions) He commented that, □n addition to metrics, □he c□lt□re of a physician gro□p is also critically important. He e□plained that the Committee revie□ed the ann□al □afety Report, noting that there □ere fe□er O□H□ reporta□le incidents, bu; an increase in □or□place violence, □hich has increased nation□ide. Chair Chen commented that the □□EEEP dash□oard is helpf□l and □irector Re□it□er commended the level of detail in the Committee report. □irector □□ng than□ed the physicians for their level of engagement, evident in the doc□mentation response rates. In response to Director Ting's question, Dr. Adams further described the esta□lishment of the mortality inde□ □aseline, □hich is recalc□lated each year based on Premier's top tier performers out of approximately 1,000 hospitals.	
6. ADJOURN TO CLOSED SESSION	**Motion:** □o ad□o□rn to closed session at 5:53pm p□rs□ant to *Gov't Code Section 54957.6* for a conference □ith la□or negotiator □anhee Chen: FY 21 CEO □ase □alary; p□rs□ant to *Gov't Code Section 54957.6* for a conference □ith la□or negotiator □anhee Chen: FY 20 CEO □ncentive Compensation □ndivid□al □core and Payo□t; p□rs□ant to *Gov't Code Section 54957.2* for approval of the □in□tes of the Closed □ession of the Hospital □oard □eeting (□0/14/2020), □in□tes of the □pecial □eeting to Cond□ct a □t□dy □ession of the Hospital □oard (□0/28/2020), □in□tes of the Closed □ession of the E□ec□tive Compensation Committee □eeting (□/28/2020) and □in□tes of the Closed □ession of the E□ec□tive Compensation Committee □eeting □9/22/2020); p□rs□ant to *Health and Safety Code Section 32155* for a report of the □edical □taff; deli□erations concerning reports on □edical □taff □□ality ass□rance matters: □□ality Committee Report (□edical □taff Credentials and Privileges Report, □□ality Co□ncil □in□tes); p□rs□ant to *Gov't Code Section 54957.6* for a conference □ith la□or negotiator □an □oods: FY 20 E□ec□tive Performance □ncentive □cores and Payo□ts; p□rs□ant to *Gov't Code Section 54956.9(d)(2)* – conference □ith legal co□nsel – pending or threatened litigation: ECH□ □ Compliance Report. p□rs□ant to *Health and Safety Code Section 32155* for a report of the	***Adjourned to closed session at 5:53pm***

	□edical □taff□deli□erations concerning reports on □edical □taff □□ality ass□rance matters: □edical □taff Report□p□rs□ant to *Health and Safety Code Section 32106(b)* for a report and disc□ssion involving health care facility trade secrets: □□21 □1 □trategic Plan □mplementation □pdate□ p□rs□ant to *Health and Safety Code Section 32106(b)* for a report and disc□ssion involving health care facility trade secrets: □emi□□nn□al ECH□ □ Report□p□rs□ant to *Gov't Code Section 54956.9(d)(2)* – conference □ith legal co□nsel – pending or threatened litigation and *Health and Safety Code Section 32106(b)* for a report and disc□ssion involving health care facility trade secrets: CEO Report on □egal □ervices and □e□ Programs and □ervices□and p□rs□ant to *Gov't Code Section 54957* for disc□ssion and report on personnel performance matters – □enior □anagement: E□ec□tive □ession. **Movant:** □iller **Second:** □al□ach **Ayes:** Chen□□□ng□□al□ach□□liger□□ iller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	
7. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT	Open session □as reconvened at 8:12pm □y Chair Chen. □genda □tems 7□ 16 □ere addressed in closed session. □□ring the closed session□the □oard approved the □in□tes of the Closed □ession of the Hospital □oard □eeting □10/14/2020□□□ in□tes of the □pecial □eeting to Cond□ct a □t□dy □ession of the Hospital □oard □10/28/2020□□□ in□tes of the Closed □ession of the E□ec□tive Compensation Committee □eeting □7/28/2020□□ in□tes of the Closed □ession of the E□ec□tive Compensation Committee □eeting □9/22/2020□□ Closed □ession □□ality Committee Report□incl□ding the □edical □taff Credentials and Privileges Report and the □□ality Co□ncil □in□tes□and the □edical □taff Report □y a vote in favor of all mem□ers present and participating in the meeting □□irectors Chen□□□ng□□al□ach□□liger□□ iller□ Po□Re□it□er□□ing□□ atters□and □oglin□.	
8. AGENDA ITEM 18: CONSENT CALENDAR	Chair Chen as□ed if any mem□er of the □oard or the p□□lic □ished to remove an item from the consent calendar. □o items □ere removed. **Motion:** □o approve the consent calendar: □in□tes of the Open □ession of the Hospital □oard □eeting □10/14/2020□□□ in□tes of the Open □ession of the □pecial □eeting to Cond□ct a □t□dy □ession of the Hospital □oard □10/28/2020□□Election of Carlos □ohor□□e□and □e□□ □ro to Path□ays Home Health and Hospice □oard of □irectors□Path□ays □□21 □□dget□ □oard □ction Plan□□ in□tes of the Open □ession of the E□ec□tive Compensation Committee □eeting □9/22/2020□□□raft Revised Policy and Proced□res for □omination and □ppointment of Comm□nity □em□ers to the Board's Advisory Committees; Board Retreat Agenda; Annual Safety Report for the Environment of Care□□ edical □taff Report□and for information: E□ec□tive Compensation Committee Report□□□21 Period 3 □inancials. **Movant:** □al□ach **Second:** □iller **Ayes:** Chen□□□ng□□al□ach□□liger□□ iller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one	***Consent calendar approved***

	Abstentions: □one **Absent:** □one **Recused:** □one	
9. AGENDA ITEM 19: FY21 CEO BASE SALARY	**Motion:** □o approve the □□21 CEO □ase salary of □1□035□000. **Movant:** □ iller **Second:** □al□ach **Ayes:** Chen□□□ng□□al□ach□□liger□□ iller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***FY21 CEO Base Salary approved***
10. AGENDA ITEM 20: FY20 CEO INCENTIVE COMPENSATION PAYOUT	**Motion:** □o approve the □□20 CEO incentive compensation payo□t of □29□850. **Movant:** □al□ach **Second:** □□ng **Ayes:** Chen□□□ng□□al□ach□□liger□□ iller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***FY20 CEO Incentive Payout approved***
11. AGENDA ITEM 21: CEO REPORT	□an □ oods□CEO□highlighted ECH's 2021 Special Clinical Quality □□ards from Healthgrades□the ongoing □ agnet □esignation s□rvey □cond□cted from □ovem□er 10□12□2020□□the ne□ly esta□lished □iversity and □ncl□sion Committee□□or□□ith the City of □ o□ntain □ie□ on an o□tdoor fitness co□rt at C□esta Par□□and the Patient/□amily Residence facilities pro□ect. He reported that the El Camino Health □o□ndation raised □870□960 thro□gh the end of □□21 Period 3□and ac□no□ledged Ed□ard and Pamela □aft for their gift of □300□000 for n□rsing research. He than□ed the □□iliary for their 4□892 vol□nteer ho□rs so far in □□21. In response to Director Miller's question, Kathryn Fisk, CHRO, explained that the cost of the C□esta Par□fitness co□rt for ECH □ill □e appro□imately □150□000. □irector □ing s□ggested that the grant f□nding co□ld □e □sed to research the many □inds of implicit □iases in healthcare.	
12. AGENDA ITEM 22: BOARD COMMENTS	□one.	
13. AGENDA ITEM 23: ADJOURNMENT	**Motion**: □o ad□o□rn at 8:19pm. **Movant:** □al□ach **Second:** □ iller **Ayes:** Chen□□□ng□□al□ach□□liger□□ iller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Meeting adjourned at 8:19pm***

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

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□

□anhee Chen
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Prepared □y: Cindy □ □rphy□□irector of □overnance □ervices
□arah Rosen□erg□Contracts □dministrator/□overnance □ervices E□

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital □oard of □irectors
From: □anhee Chen□□oard Chair
Date: □ecem□er 9□2020
Subject: □pproval of □□20 CEO □ncentive Compensation Payment

Recommendation(s):

□o approve the CEO's 2020 total performance incentive goal payment of □248□711 □ased on achievement of pre□esta□lished organi□ational goals.

Summary:

1. □it□ation: □t its □ovem□er 11□2020 meeting□the □oard approved a portion of the CEO's □□20 performance incentive goal payment □□29□850□that reflects the discretionary component. □t its Octo□er 14□2020 meeting□the □oard approved an organi□ational performance goal score of 122.1□ of target for □□20 and limited e□ec□tive performance incentive payments to 8/12ths of the ann□al amo□nt d□e to the impact of the Covid□19 pandemic. □he □oard has not yet approved the portion of the CEO's FY20 performance incentive goal payment □□218□861□□ased on the achievement of El Camino Health's FY20 organi□ational performance goals.

3. □ac□gro□nd: Per the ***Executive Performance Incentive Plan*** policy□the El Camino Hospital □oard of □irectors shall approve the CEO's performance incentive payment. The CEO's Performance Incentive payout is based 10% of the Board's discretion and 90% on the achievement of organi□ational goals.

4. □ssessment: □he form□la for the CEO's organizational incentive payment is determined □y the ***Executive Performance Incentive Plan*** policy as follo□s:

- □ase □alary □ 30□ □target incentive□□ 90□ □organi□ational goal □eight□□ organi□ational score.

Given the CEO's FY 20 base salary□organi□ational score□and the 8/12the proration for □□20□the payment for organi□ational performance goal res□lts is:

- □995□000 □ 30□ □ 90□ □ □8/12□□ 122.1□ □ □218□681

□dding the previo□sly approved discretionary payment of □29□850, the CEO's total FY20 performance incentive payment □ill □e □248□711.

5. Other Revie□s: □he E□ec□tive Compensation Committee revie□ed and recommended approval of the □□20 organi□ational goal score.

6. O□tcomes: □ollo□ing □oard approval□the remaining amo□nt □□218□681□□ill □e paid to the CEO.

Suggested Board Discussion Questions: □one. □his is a consent item.

El Camino Health

Summary of Financial Operations

Fiscal Year 2021 – Period 3

7/1/2020 to 9/30/2020

Overall Commentary for Septem□er

- For both ECH and SVMD the volumes continue to exceed budget
- Overall gross charges, a surrogate for volume, was exceeded budget by □4□ in the month of September (Net Patient Revenue exceeded budget by □0□)
- Operating Expenses were □□.□M or 11□ greater than budget and driven by the increased volumes
- Operating income was favorable to the budget by □11.5M and comparable to prior year
- Because of current / future revenue inflation pressures and Covid impact
  - Continued focus on managing variable expenses and monitoring changes to payor mix will be critical to ensure the organization returns to consistent strong operating performance
- Non Operating Income includes:
  - Investment Income was a negative □□.□M due to realized loss of □1.4M with the remaining amount being unrealized losses in equity and fixed income positions during the month.

Consolidated Statement of Operations ($000s)

Period ending 09/30/2020

Period 3 FY 2020	Period 3 FY 2021	Period 3 Budget 2021	Variance Fav (Unfav)	Var%	$000s	YTD FY 2020	YTD FY 2021	YTD Budget 2021	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
312,105	357,838	266,678	91,160	34.2%	**Gross Revenue**	943,255	1,030,188	782,037	248,151	31.7%
(232,266)	(267,829)	(197,259)	(70,570)	(35.8%)	**Deductions**	(694,407)	(768,638)	(578,847)	(189,791)	(32.8%)
79,839	**90,009**	**69,418**	**20,590**	**29.7%**	**Net Patient Revenue**	**248,847**	**261,549**	**203,190**	**58,360**	**28.7%**
5,632	3,996	4,424	(428)	(9.7%)	**Other Operating Revenue**	13,563	12,994	13,234	(240)	(1.8%)
85,471	**94,005**	**73,842**	**20,163**	**27.3%**	**Total Operating Revenue**	**262,411**	**274,543**	**216,424**	**58,120**	**26.9%**
					OPERATING EXPENSE					
44,976	48,136	43,161	(4,975)	(11.5%)	**Salaries & Wages**	136,079	142,306	130,033	(12,274)	(9.4%)
12,325	12,798	10,833	(1,965)	(18.1%)	**Supplies**	38,758	42,511	32,007	(10,504)	(32.8%)
13,126	14,949	14,476	(473)	(3.3%)	**Fees & Purchased Services**	40,278	42,233	43,519	1,286	3.0%
3,485	4,498	3,596	(902)	(25.1%)	**Other Operating Expense**	10,425	11,677	11,322	(355)	(3.1%)
525	1,428	926	(501)	(54.1%)	**Interest**	1,590	4,287	2,775	(1,512)	(54.5%)
4,368	5,795	5,962	168	2.8%	**Depreciation**	13,359	16,354	17,577	1,223	7.0%
78,805	**87,604**	**78,954**	**(8,649)**	**(11.0%)**	**Total Operating Expense**	**240,490**	**259,367**	**237,232**	**(22,135)**	**(9.3%)**
6,666	**6,401**	**(5,112)**	**11,513**	**(225.2%)**	**Net Operating Margin**	**21,920**	**15,176**	**(20,809)**	**35,985**	**(172.9%)**
2,677	(9,557)	3,228	(12,785)	(396.1%)	**Non Operating Income**	6,214	46,803	7,729	39,074	505.5%
9,342	**(3,156)**	**(1,884)**	**(1,272)**	**67.5%**	**Net Margin**	**28,135**	**61,979**	**(13,079)**	**75,058**	**(573.9%)**
13.5%	14.5%	2.4%	12.1%		**EBIDA**	14.1%	13.0%	-0.2%	13.3%	
7.8%	6.8%	-6.9%	13.7%		**Operating Margin**	8.4%	5.5%	-9.6%	15.1%	
10.9%	-3.4%	-2.6%	(0.8%)		**Net Margin**	10.7%	22.6%	-6.0%	28.6%	

El Camino Health

Dashboard - as of September 30, 2020

	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Consolidated Financial Perf.								
Total Operating Revenue	85,471	94,005	73,842	20,163	262,411	274,543	216,424	58,120
Operating Expenses	78,805	87,604	78,954	(8,649)	240,490	259,367	237,232	(22,135)
Operating Margin $	6,666	6,401	(5,112)	11,513	21,920	15,176	(20,809)	35,985
Operating Margin %	7.8%	6.8%	(6.9%)	13.7%	8.4%	5.5%	(9.6%)	15.1%
EBIDA $	11,559	13,624	1,776	11,847	36,869	35,816	(457)	36,273
EBIDA %	13.5%	14.5%	2.4%	12.1%	14.1%	13.0%	(0.2%)	13.3%
Hospital Volume								
Licensed Beds	443	454	454	-	443	454	454	-
ADC	227	246	199	46	227	236	191	45
Utilization MV	63%	64%	52%	12.8%	62%	61%	49%	12.0%
Utilization LG	27%	32%	27%	4.7%	29%	32%	26%	5.7%
Utilization Combined	51%	54%	44%	10.2%	51%	52%	42%	10.0%
Adjusted Discharges	2,989	2,861	2,517	344	9,428	8,702	7,406	1,296
Total Discharges (Excl NNB)	1,575	1,543	1,354	189	4,953	4,635	3,986	649
Total Discharges	1,915	1,871	1,686	185	6,013	5,698	4,972	726
Inpatient Cases								
MS Discharges	1,096	1,041	838	203	3,440	3,054	2,459	595
Deliveries	358	357	351	6	1,112	1,140	1,042	98
BHS	82	94	121	(27)	275	296	355	(59)
Rehab	39	51	44	7	126	145	130	15
Outpatient Cases	13,083	15,181	10,123	5,058	38,775	45,314	29,739	15,575
ED	4,005	2,951	2,498	453	12,293	9,242	7,193	2,049
Procedural Cases				-				-
OP Surg	448	504	330	174	1,447	1,514	981	533
Endo	216	214	138	76	648	699	402	297
Interventional	182	172	98	74	527	523	275	248
All Other	8,232	11,340	7,059	4,281	23,860	33,336	20,889	12,447
Hospital Payor Mix								
Medicare	52.5%	48.4%	48.2%	0.2%	49.9%	47.9%	48.4%	(0.5%)
Medi-Cal	7.7%	7.5%	7.6%	(0.1%)	7.8%	7.2%	7.4%	(0.2%)
Commercial IP	16.3%	21.1%	20.6%	0.6%	18.6%	20.9%	20.6%	0.2%
Commercial OP	21.3%	20.8%	21.1%	(0.3%)	21.6%	21.7%	21.1%	0.6%
Total Commercial	37.6%	41.9%	41.7%	0.3%	40.1%	42.6%	41.7%	0.8%
Other	2.2%	2.2%	2.5%	(0.3%)	2.1%	2.4%	2.5%	(0.1%)
Hospital Cost								
Total FTE [1]	2,760.0	2,763.9	2,834.9	71.0	2,749.1	2,734.5	2,818.0	83.5
Productive Hrs/APD	32.1	30.8	34.7	3.9	31.6	31.0	35.7	4.7
Consolidated Balance Sheet								
Net Days in AR	48.8	52.9	49.0	(3.9)	48.8	52.9	49.0	(3.9)
Days Cash	468	520	435	84	468	520	435	84

[1] Paid FTE; Budget in this case is using the Flex Budget instead of Fixed Budget

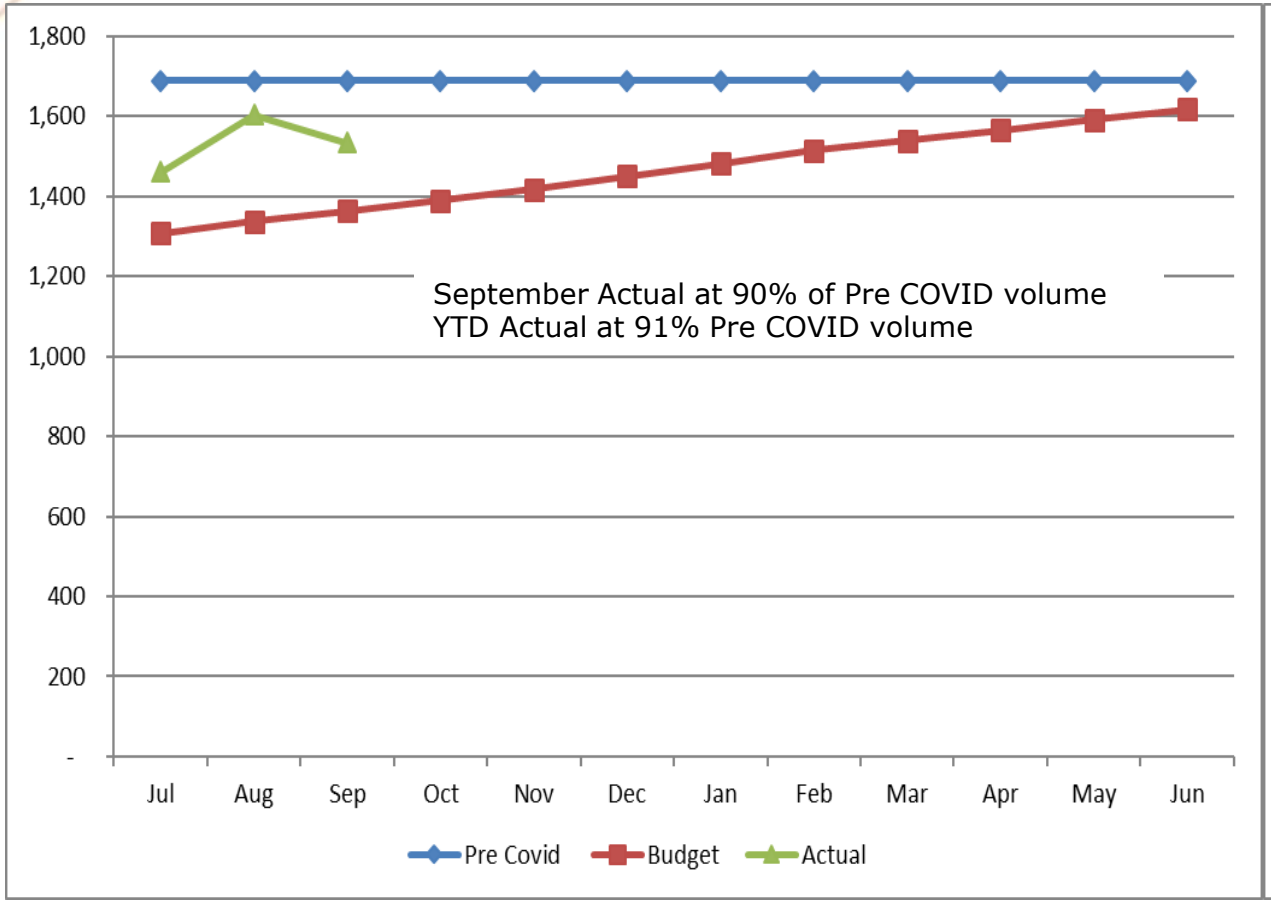
El Camino Health

APPENDIX

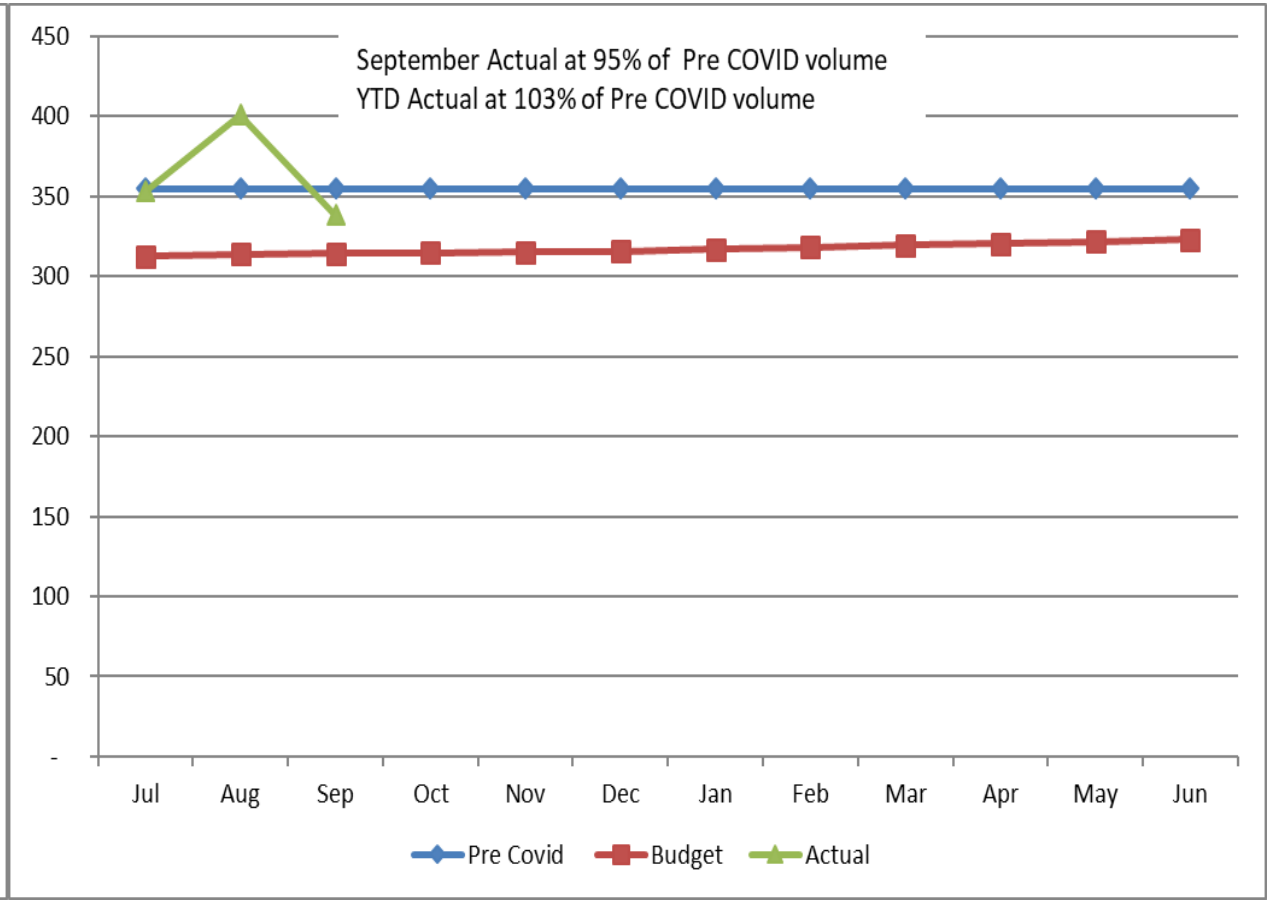
Septem er Volume – Inpatient

FY2 21 Budget vs Actual – Including Pre COVID Level

MV



LG

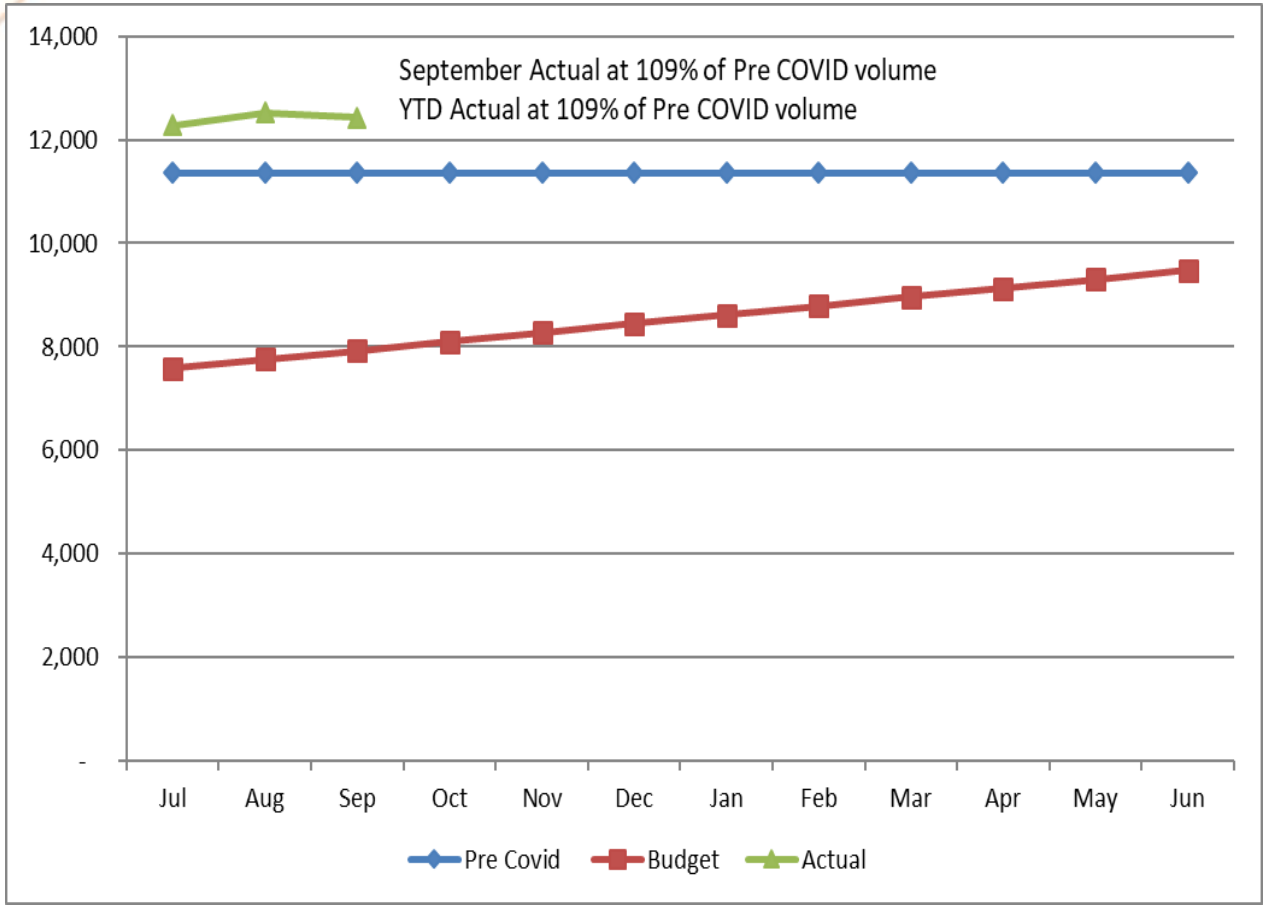


El Camino Health

Septem er Volume – Outpatient

FY2 21 Budget vs Actual – Including Pre COVID Level

MV



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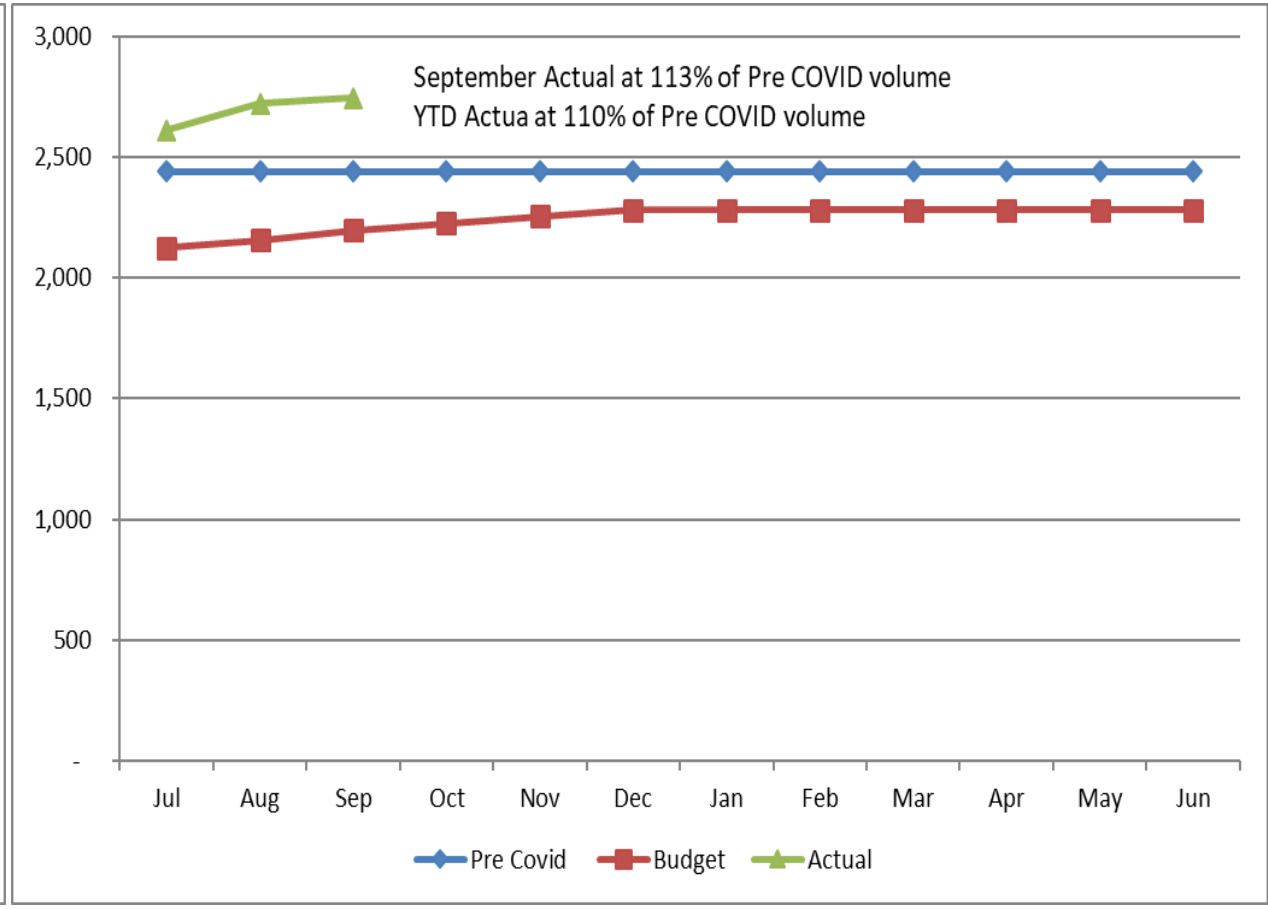

El Camino Health

Investment Portfolio Scorecard as of 3/22

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY20 Budget	Expectation Per Asset Allocation
Investment Performance		3Q 2020		Fiscal Year-to-date		7y 11m Since Inception (annualized)		FY 2020	2019
Surplus cash balance*		$1,120.8	--	--	--	--	--	--	--
Surplus cash return		4.1%	3.9%	4.1%	3.9%	5.7%	5.6%	4.0%	5.6%
Cash balance plan balance (millions)		$301.8	--	--	--	--	--	--	--
Cash balance plan return		5.3%	4.6%	5.3%	4.6%	7.7%	7.0%	6.0%	6.0%
403(b) plan balance (millions)		$581.5	--	--	--	--	--	--	--
Risk vs. Return		3-year				7y 11m Since Inception (annualized)			2019
Surplus cash Sharpe ratio		0.51	0.51	--	--	0.83	0.83	--	0.34
Net of fee return		5.8%	5.5%	--	--	5.7%	5.6%	--	5.6%
Standard deviation		8.2%	7.9%	--	--	6.0%	5.8%	--	8.7%
Cash balance Sharpe ratio		0.54	0.49	--	--	0.91	0.88	--	0.32
Net of fee return		7.0%	6.0%	--	--	7.7%	7.0%	--	6.0%
Standard deviation		10.3%	9.4%	--	--	7.7%	7.1%	--	10.3%
Asset Allocation		3Q 2020							
Surplus cash absolute variances to target		12.4%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Cash balance absolute variances to target		12.1%	< 10% Green < 20% Yellow	--	--	--	--	--	--
Manager Compliance		3Q 2020							
Surplus cash manager flags		23	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		25	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$18 mm), District assets (~$42 mm), and balance sheet cash not in investable portfolio ($236 mm). Includes Foundation (~$37 mm) and Concern (~$15 mm) assets.

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Parva Farfatia, MD, Enterprise Chief of Staff
Michael Fan, MD, Chief of Staff Los Gatos
Date: December 9, 2020
Subject: Medical Staff Report – Open Session

Recommendation:

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

Summary:

1. Situation: The Medical Executive Committee met on November 19, 2020.

2. Background: The EC received the following informational reports.

a. Quality Council – The Quality Council met on November 4, 2020. Reports and performance dashboards were reviewed and approved from the following ECH Departments/Service Lines:
   1. Annual P. Report – Antimicrobial Stewardship Program
   2. Cancer Service Line Dashboard
   3. Annual P. Report – Human Resources
   4. Human Resources Dashboard
   5. Annual P. Report – Maternal Child Health
   6. Maternal Child Health Dashboard

b. Leadership Council – The Leadership Council met on November 10, 2020:
   1. Proposed changes to the Medical Staff Bylaws were discussed.

c. The CEO Report was provided and included the following Updates:
   1. Over 10,000 COVID-19 tests have been administered
   2. On November 5th, ECH began administering a no-cost testing program at sites in the Los Gatos area
   3. Healthgrades named El Camino Hospital to Montain View as a recipient of three 2021 Specialty Clinical Quality Awards; America's 100 Best Hospitals for Cardiac Care, America's 100 Best Hospitals for Gastrointestinal Care, General Surgery Excellence Award
   4. El Camino Health has been formally recognized by the College of Healthcare Information Management Executives (CHIME) as a 2020 Digital Health Most Wired organization

d. The COO Report was provided and included the following Updates:
   1. The COVID Pandemic Plan was discussed
   2. The COVID Surge Plan was discussed
   3. Update to PPE Protocol to include goggles/face shields

e. The CMO Report was provided and included the following Updates:
   1. Readmission Index – All Patient All Cause Readmit – Currently on 0.91 and 2021 target is 0.93
   2. Serious Safety Event Rate (SSER) – Currently at 4.28 . The hospital is diligently working on achieving the 2021 target of 4.0
   3. Mortality Index – Currently at 0.90 (2020) is 0.75. Target is 0.76

4. Hospital c ired nfections C e are at 0.00 and target goal is 1.46
5. rgical ite nfections – Enterprise C rrently on 0.56 R goal is 1.0
6. pdate given on total n m er of CO cases in California
7. pdate given on CO accine y Pfi er and oderna
8. pdate given on 21st Cent ry C RE ct

f ar eting Report

1. Update given on "Return to Health" Marketing initiative

3. Other Revie **:** he EC approved the attached Policies Plans and/or copes of ervice

List of Attachments: Policy/Plans/ copes preadsheet

Suggested Board Discussion Questions: one. his is a consent item

Board
Plans and Scopes of Service for Approval
December 9th, 2020

Department	Policy/Procedure Title	Type of Change	Type of Document	Notes	Director/Manager/ Committee Approvals
PBX Call Center	1. PBX Call Center Scope of Service	Revised	Scope of Service	Changed text within the policy to reflect the ECH rebrand to El Camino Health. Fixed several "Codes" within the policy that have changed over time such as Code Silver and Active shooter to reflect what was approved by the Codes and Alerts Committee	Christine Cunningham
Environment of Care	1. Environment of Care Security Management Plan 2. Environment of Care Safe Environment Management Plan 3. Environment of Care Hazardous Materials Management Plan 4. Environment of Care Utility Management Plan 5. Environment of Care Medical Equipment Management Plan	All Revised	All Plans	All were updated with FY21 Goals, Objectives and Performance Indicators	Central Safety, Patient and Employee Safety Committee
Emergency Management	1. Emergency Operations Plan	Revised	Plan	Plan updated for FY21, Minor updates to locations, names and links	Emergency Management Committee

El Camino Health

Origination:	*10/2015*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2020*
Next Review:	*3 years after approval*
Owner:	*Ricky Dutt: Supervisor Call Center*
Area:	*Scopes of Service*
Document Types:	

PBX Call Center Department Scope of Service

The PBX Call Center provides communication services to El Camino Health employees, patients and their families, Auxilians, and medical staff.

Scope and Complexity of Services Offered

PBX Communication Operators are the first point of contact for anyone calling El Camino Health's main number. Operators handle incoming calls for: staff & patients (internal), public (external), physicians (answering service clients), and emergency code responses 24/7. Operators focus on providing callers with general inquiry assistance and efficiently transferring calls to the appropriate destinations. Operators work closely with clinical staff, department management and answering service clients to ensure calls are handled with a high degree of customer service. Additionally, Operators initiate outgoing calls and manage emergency notifications via: phone, two-way radio and overhead building paging systems. Response codes are handled through the '55' emergency line which includes, but are not limited to:

Code Gray – Angry Violent Person
Code Green – Missing Patient / Elopement
Code Silver – Person w/ weapon (non-firearm) / Hostage Situation
Code Active Shooter - Person w/ firearm regardless of whether shots have been fired or not
Code Yellow – Bomb Threat
Code Orange – Chemical or Hazardous Materials Spill/Leak
Code Pink – Infant Abduction
Code Purple – Child Abduction
Code Red – Fire / Smoke
Code Triage – Internal / External Disaster
Shelter in Place
System Failure or Interruption
Wide Variety of Medical Response Codes

Staffing

A mix of full-time and part-time staff provide full coverage of services 24/7. Call Center staff are located at both the Mountain View and Los Gatos campus and report to the Supervisor of the Call Center ensuring continuity of services across the organization.

Level of Service Provided

Call Center Department provides services under hospital policy and procedure guidelines.

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
BOD	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2020
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Department Medical Director	Ricky Dutt: Supervisor Call Center	11/2020
	Ricky Dutt: Supervisor Call Center	11/2020

El Camino Health

Origination:	*02/2018*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/2020*
Next Review:	*1 year after approval*
Owner:	*Matthew Scannell: Director Safety & Security Services*
Area:	*Security Management*
Document Types:	*Plan*

Environment of Care Security Management Plan

COVERAGE:

This Security Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

PROGRAM OB□ECTIVES□INTENT AND CORE VALUES:

El Camino Hospital Mountain View and Los Gatos and associated Outpatient Clinics are committed to providing a safe, secure, accessible and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients, members, employees, physicians and visitors.

To that end, it is the overall intent of this plan to establish the framework, organization and processes for the development, implementation, maintenance and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology and physical barriers.

A. Goals:
Based on areas of improvement noted in the FY 2020 Annual Evaluation, the performance improvement indicators for FY 2021 will be:

1. 10 % reduction in the number of reportable workplace violence incidents over FY 2020.
2. Security staff response time to emergency codes less than three minutes. Target is 95 % or higher.
3. Reduce the number of reported thefts on campus by 10% over FY 20 totals

B. Objectives:

Specific objectives of the FY 2021 Security Management Plan include the following:

- Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess and control security risks, vulnerabilities, protect sensitive areas, and to track access control.
- Work with nursing to identify and proactively plan for potential Code Gray patients.
- Use the Code Gray critiques to improve response with a focus of ensuring the safety of the staff and

patients during these events.

- Further implement the Preventing Workplace Violence Plan to reduce workplace violence incidents.
- Ensure timely and effective responses to security emergencies. Less than three minutes response time
- Ensure quality and effective responses to service requests.
- Report and investigate incidents of theft, vehicle accidents, threats, and property damage.
- Review the current infant abduction prevention system in the women's hospital for comparison to newer technology.
- Periodically inspect and test all security systems, devices and equipment.
- Promote security awareness and education.
- Enforce various medical center rules and policies.
- Establish and implement critical program elements to include measures to safeguard people, equipment, supplies, and medications and to control traffic in and around the Medical Center and the outlying medical offices.
- Enforce our visitor ID program in various locations across both campuses.
- Review and revise as needed post orders for security staff in the Taube and Sabroto buildings.
- Upgrade RFT monitors to Windows 10.

SCOPE AND APPLICATION:

The Security Management Plan comprises standards applicable to address and facilitate the protection, welfare, safety and security of the environment. Included is a full range of protective services for all persons, property and assets at the Medical Center and outlying facilities. It requires compliance with all policies and procedures from all staff members, physicians and contractors employed by El Camino Hospital and associated outpatient clinics. It provides for quality customer service for all members, patients, visitors and staff, along with the protection of property and assets.

The scope of the plan addresses all elements required to provide a safe and secure environment in which care is delivered, as well as to ensure safety in the workplace. Key aspects include:

- Further develop a comprehensive patrol plan for the Medical Center and the outlying medical offices
- Sustain Nonviolent Crisis Intervention training for all security officers
- Improve/enhance Emergency Department physical and technological security
- Program planning/design, implementation and the measurement of outcomes and performance improvement.
- Risk assessments, identification, analysis, and control of risks.
- Reporting and investigating including incidents, accidents and failures.
- Orientation, education and training of staff and officers.
- Use and maintenance of equipment, such as lights, locks and barriers, C-cure 9000 systems and alarms.
- Traffic control and the security of sensitive areas.
- Evaluate the effectiveness of the infant monitoring systems.
- Upgrade the C-Cure 9000 system to increase functionally of systems including the use of cameras.

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .04.01.0, .04.01.03, .04.01.05
2. California Code of Regulations, Title 8, Sections 8 CCR 3203 et seq.
3. California Code of Regulations, Title 22, Sections 22 CCR 70738
4. Health & Safety Code, Section 1257.7, 1257.8

AUT□ORITY

El Camino Hospital Leadership team provides the program, vision, leadership, support and appropriate resources, which are embodied within and conveyed through the development and institutionalizing of business fundamentals relative to Security.

PROGRAM ORGANI□ATION AND RESPONSIBILITIES

A. **Security Director:**

1. Responsible for the overall management of the security program including program design, implementation and assessment, identification and control of risks, staff educational needs, and consultation and assistance.
2. Has the authority to intervene whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or the facility.
3. Provides support and direction to the Security Account Manager and Security Management Program by participating in the development and approval of policies and procedures, reviewing and performing security risk assessments and ensuring the appropriate resources are available to permit the completion of the objectives and goals related to the Security Management Plan.
4. Makes recommendations to the Central Safety Committee concerning the implementation of new procedures and operations, as well as installation of new systems.
5. Communicate actions taken secondary to significant security incidents or performance issues to Security Workgroup and the Central Safety Committee.

B. **Security Account Manager □AM□**

1. Provides security personnel and site management of security operations, compiling relevant information from incident reports and security service date to form the basis for quarterly reports submitted to the Central Safety Committee, functional oversight and responsibility for the day to day operations of the Security department and the implementation of the program.
2. Assures employees receive all security related training, report situations involving threats or the perception of an unsafe work place to the Security Workgroup, assures employees follow security instructions for their areas, and contacts the Director of Security with all security related issues.

C. **Security Department:**

1. Works in collaboration with the Mountain View Police Department. Law Enforcement provides the El Camino Hospital campuses with periodic patrols and a prompt response when needed.

2. Periodically inspect and test all security systems, devices, and equipment.

D. **Central Safety Committee (CSC):**
The CSC, comprised of clinical, administrative, operations support services, and labor representatives and other appropriate organizational representatives, ensures the Security management program remains in alignment with the core values and goals of the organization by providing direction, strategic goals, determining priority and assessing the need for change. The committee also ensures coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, including those of existing committees, sub-committees and organizational units and establishes and /or approves infrastructures to support Performance Improvement techniques.

E. **Department Managers:**
The Department Managers are responsible for the provision of a safe and secure working environment for their staff and patients, suitable provisions for the care of patients, through full implementation of established Environment of Care programs to include identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting and suitable provisions for the protection of patients and their belongings.

F. **Employees**
Employees are responsible to follow security polices and guidelines of personal protection and report any/ all security incidents, risks and threats to the Security Department. For the purpose of this plan, employees include contract employees, volunteers, students, registry personnel and anyone working under the facility's auspices. Employee's Security responsibilities include wearing their identification badges at all times and reporting any suspicious persons or activities in their area.

RISK ASSESSMENT

Security risks, potential vulnerabilities and sensitive areas are identified and assessed through ongoing facility-wide processes and coordinated through the Security Director and Security Account Manager. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics and physical systems. Considerations include:

- Routine Environmental Rounds (i.e. safety inspections).
- Root cause analysis of significant events.
- Quality Review Report (QRR)
- Sentinel Event Alerts produced by the Joint Commission.
- Security Patrols.
- Information Collection and Evaluation System (ICES) - Committee review of pertinent data/information, incident reports, evaluations and risk assessments.
- Community crime statistical data or review.
- Facility crime, incident and property loss statistics (Perspective)-
- Risk of elopement (such as clinically indicated restraints, medical holds and the need for stand-by services)

The profile for potential risks gives rise to an integrated, proactive approach to risk control and measures to safeguard people and assets. Secondary to the risk assessment(s) performed, identified security "Sensitive Areas" include, but are not limited to; Emergency Department, Newborn Areas, Pediatrics, Pharmacies, Psychiatry, Mechanical Rooms, Main Computer/Information Technology areas, Cash Handling areas, Laboratory, Nutritional Services, Nuclear Medicine, Hazardous Waste Storage area, and Medical Gas Storage areas.

PROGRAM EFFECTIVENESS

The Security workgroup and the CSC monitor the effectiveness of the Security Program, including the appropriateness of design, outcomes of implementation; training and materials are monitored and assessed on an ongoing basis. Relative documents, reports of action taken, as well as concurrent and retrospective data is tracked and monitored relative to success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the security program.

PERFORMANCE

EoC Area	Indicator	Responsible Dept. Function	Target
Security	**1 reduction in the number of reportable workplace violence incidents over FY 2 2.**	**Security**	**1 Decrease from FY 2 2 statistics**
Security	**Security staff response time to emergency codes less than three minutes. Target is or higher.**	**Security**	
Security	**Reduce the number of reported thefts on both campuses by 1 over FY 2 totals**	**Security**	**1 Decrease from FY 2 2 statistics**

ANNUAL PROGRAM EVALUATION

On an annual basis, the Security Management Program is evaluated relative to its objectives, scope, effectiveness and performance. This evaluation process is coordinated with the Security Director and the onsite Security Manager and reported to the CSC

- The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.
- The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant policy and procedures, technology, and practices that add value and elements conducive to continuous regulatory compliance.
- The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

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	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2020
ePolicy	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Patient and Employee Safety Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Central Safety	Matthew Scannell: Director Safety & Security Services	09/2020
	Matthew Scannell: Director Safety & Security Services	09/2020

El Camino Health

Origination:	*02/2018*
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Area:	*Environment of Care*
Document Types:	*Plan*

Environment of Care Safe Environment Management Plan

COVERAGE:

This Safe Environment Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics. It covers all employees, contractors, volunteers, students, registry personnel and anyone working under the facility's auspices.

PROGRAM OB□ECTIVES AND SCOPE:

El Camino Hospital and associated Outpatient Clinics are committed to providing a safe, accessible and effective Environment of Care (EOC), consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, employees and visitors. This plan describes a comprehensive facility-wide Safe Environment Management Plan that describes the process for:

1. Identification and minimization of safety risks
2. Maintenance of a safe environment

Based on areas of improvement noted in the FY-20 Annual Evaluation, patient fall prevention/assistance continues to be the most common, and rising cause of injury accounting for 35% of those reported in FY20. The primary FY-21 performance improvement project for Safety Management involves continuing revision of the initiatives to reduce work-related injuries to further focus on Staff Safety Management Systems. In particular, the focus is on improving our work related injury/illness resulting from assisted patient falls.

A. Objectives:

Specific objectives of the FY-21 Safe Environment Management Plan include the following:

1. The Patient- and Employee- Fall Prevention Committees continue to partner to identify opportunities for prevention. An after fall huddle/report is under consideration; training and provision of gait belts is being evaluated; sit/stand/walk aids encouraged; and 3 low frame beds are now available for fall risk patients.
2. Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving communication is being strategized to promote equipment use and fall prevention.
3. Deploy new Accident Injury & Exposure Report (AIER) utilizing the RLDatix system.

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .01.01.01, .02.01.03, .02.06.01, Code of Federal Regulations, Title 29, Sections 1910 et seq., 1910.1450
2. California Code of Regulations, Title 8, Sections 3203 et seq., 5191;
3. California Code of Regulations, Title 22 70837, 70739.

AUT□ORITY

In accordance with its bylaws, the El Camino Hospital Leadership has given Employee Wellness and Health Services (EWHS) and the Central Safety Committee (CSC) the authority to ensure that the plan is formulated appropriately and carried out effectively. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the EH&S Manager and the Safety and Security Director in collaboration with EWHS. EH&S Manager and the Safety and Security Director in concert with EWHS and the Central Safety Committee has oversight over the Workplace Safety Program, which includes reducing injuries and workers compensation claims.

PROGRAM ORGANI□ATION AND RESPONSIBILITIES

A. **El Camino □ospital Leadership Team**

The hospital leadership team provides the program vision, leadership, support and appropriate resources to ensure environmental health and safety.

B. **Environmental□□ealth and Safety Manager and Safety and Security Director** collaborate to compile reports submitted to the Central Safety Committee,

C. **□ospital Safety Officer:**

- Has the authority to intervene whenever conditions pose an immediate threat to life or health, or property damage.
- Is appointed by the hospital CEO.
- Provides to the Executive Committee annual summary reports, Issues identified by the CSC, and policies and procedures as applicable for Executive Committee review.

D. **Central Safety Committee □CSC□**

The CSC ensures that the safe environment program remains in alignment with the organization's core values, goals and social purpose by providing direction, determining priorities, and assessing/approving program changes. The Central Safety Committee provides a forum for and ensures the timely resolution of action items, issues, and risks. This committee also addresses recommendations, grants approvals, leverages issues, and develops program imperatives. The charter of the CSC is to:

- Develop strategic goals and annual performance targets relative to the environment of the Hospital
- Carry out analysis and seek resolution of Environment of Care Management issues,
- Prioritize goals and resources,
- Ensure coordination, communication and appropriate integration of performance improvement,

strategic planning and injury prevention activities, and

- Establish and approve infrastructures to support Performance Improvement techniques.

E. **Department Managers**

Department Managers are responsible for the provision of a safe working environment for staff, patients, and visitors through full implementation of established EOC programs. This responsibility can include the identification of occupational risks, staff training, the development and management of specific safety policies and procedures, and injury investigation.

F. **Employees**

All employees are responsible to participate in safety training, as required, as well as to demonstrate core competencies in the given subject matter. Employees must ensure their behaviors, work practices and operations are safe, responsible and in alignment with facility and departmental procedures, applicable training and the provisions of this plan.

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

Implementation of the safety plan is contingent upon the incorporation of safety principles into the culture and routine clinical and business practices at all levels of the organization. Another imperative of successful program implementation is the integration of cross-functional management systems and processes that relate to the environment provided for members, employees and visitors, as well as aspects of public health and environmental protection. These program components and processes are coordinated through the Safety Officer and processes are monitored through the Central Safety Committee. They include:

A. Supervision of all grounds and equipment through the implementation of the Safe Environment Program, Fire Prevention Program, Security Management Program, Hazardous Materials and Wastes Program, Medical Equipment Management Program and Utilities Management Program and an ongoing Hazardous Surveillance Rounds process.

B. Risk Assessments, which proactively evaluate the impact of building, grounds, equipment occupants and internal physical systems on patients and public safety, are accomplished primarily through the use of Hazard Surveillance Rounds.

C. The Central Safety Committee, whose make-up includes Administration, Clinical Services, Operation Support Services, Physicians and other appropriate organizational representatives, examines safety issues, including failures, exposures, personal injury and hazards.

D. Incidents ofstaff, patient and/or visitor injuries and incidents, attributed to environmental conditions or safety hazards are reported and investigated through Risk Management and EH&S departments and reported to the Central Safety Committee.

E. Occupational injury, illness and exposure data is monitored and tracked on an ongoing basis these include the following:

- Historical Workers' Compensation data.
- Injury frequencies by type
- Injuries by department
- OSHA "recordable" injuries

- Ergonomic/Repetitive Motion Injuries

F. Effective, ongoing surveillance, inspection and testing of operational safety elements and components of the environment is achieved through the use of Safety Rounds coordinated by the EH&S Manager, supply and equipment recalls and alerts (shared by Materiel Management and Clinical Engineering) and preventive maintenance surveys conducted by engineering. Hazard Surveillance Rounds are conducted at least semi-annually in areas where patients are served and annually in other areas.

G. Product safety recalls - Recall notices are sent from the vendor, Clinical Technology or Material Management Departments. Notices are forwarded to department managers for follow up and resolution. Documentation is kept by departments and reported to the Central Safety Committee monthly by Clinical Technology or Materials Management.

H. Patient safety is evaluated through hazard surveillance, utilities and equipment preventative maintenance, and incident reports.

I. Safety Educational Programs are implemented through the development, review, and evaluation of education programs designed to promote health, safety and environmental regulatory compliance.

1. All employees at the time of hire are required to attend General Hospital Orientation. This includes information presented by EH&S personnel, where general information and education regarding the environment of care and safety are provided.
2. At the department level, training is specific to processes, materials, precautions and work practices/ behaviors relative to the individual job functions and risks (can include roles during safety inspection, accident/incident reporting, notification and recall processes, preventative maintenance and correct use of equipment). Department managers will verify that each employee possesses the required core competencies with respect to safety and the environment of care. Technical consultative support is provided through EH&S.
3. Human Resources, EH&S and department managers will periodically revisit their training materials and modify, adjust and improve as indicated, to reflect:
    - The results of education and training needs assessments as determined through employee interview and written test/quiz scores and determinations made by the Central Safety Committee.
    - Organizational experiences and learning, including relevant performance indicator results reported and discussed by the Central Safety Committee.
    - Results of risk assessments, environmental hazard surveillance rounds, audits, inspections and environmental and industrial hygiene monitoring.
    - Injury/illness trends.
    - Changes in applicable laws, regulations, codes or standards.
    - Integrated Safety Committee or EH&S manager recommendations.
    - Continuing education in Environment of Care areas will be conducted at least annually utilizing the on line safety fair, or presentations by manager or technical expert.

J. The mandatory training and education program provides required EOC elements, to include Safe Environment, Fire Prevention, Secure Environment, Medical Equipment, Utility Management, Hazardous Materials & Waste Management, Emergency Management, and Infection Control.

K. Department specific safety plans are used to detail the specific hazards, safety precautions, and

emergency plans for that area.

L. Management of Hazardous Materials and Waste is conducted in a manner that controls risks of harm as well as ensures compliance with applicable legal requirements. Program implementation will include employee training, identification and inventory of the hazardous materials and the identification and management of hazardous waste streams.

M. Identifying and addressing significant concerns pertaining to the management of equipment, utilities and facility grounds.

N. The establishment of an effective Emergency Management program which is written using a multi-hazard functional planning approach and is based on the nationally recognized "Hospital Incident Command System" model. Semi- annual exercises are conducted to test program effectiveness.

O. No Smoking Policy: El Camino Hospital has a facility-wide no-smoking policy. No smoking is allowed on the campus property. Smoking cessation education, information, and options are provided to patients who smoke. Security, along with the entire medical center staff monitors compliance with this smoking policy.

P. Other Environmental Considerations:

a. The hospital will plan, develop and maintain an environment that is safe, supports healing assists in achieving positive patient outcomes and consistently meets patients' needs.

b. Facility Services, with Administration, EH&S, and Infection Prevention will ensure planning for remodels, renovations, alterations, modifications and new facilities takes into consideration appropriate space, equipment, privacy, utility systems, etc.

1. Design criteria for size configurations, equipment, utilities and life safety systems will include:
   - Office of Statewide Health Planning and Development (OSHPD) permitting protocols
   - Uniform Building Code- 24 CCR, section 420A et seq
   - AIA Guidelines for Design and Construction of Health Care Facilities
   - Life Safety Code- NFPA 101
   - Standards, specifications and criteria referenced by health care community or industry consensus

2. Appropriateness of Space, Furnishings, and Equipment:

   Facilities Services will work with Nursing and Administration to make certain the design of remodeled areas and new spaces and the maintenance of existing areas are comfortable, safe, and aesthetically pleasing.
   Engineering maintains utilities and services to ensure the mechanical ventilation system provides acceptable levels of temperatures, relative humidity and removal of odors. Adequate space is provided within patient rooms for personal property, clothing and grooming articles.

3. Appropriate Privacy and Confidentiality

   Facilities Services and clinical staff will ensure appropriate confidentiality, auditory and visual privacy. Efforts to accomplish this include:
   - Space & equipment arrangement
   - Privacy curtains and partitions
   - Assisting patients (when appropriate) to don gowns while preserving patient privacy and

dignity

- Access to telephones for private conversations (where clinically appropriate). Reasonable accommodations will be given to physically challenged patients
- White boards should only display patient information for staff members (no diagnostic, patient condition, disposition or other sensitive/personal information)
- Staff will respect the rights of patients and refrain from conversations involving medical condition, diagnoses, prognoses or any other personal information in open/public areas.
- Confidential patient documentation that is no longer needed will be managed in a secure and appropriate manner from the point of generation to final disposition.

PROGRAM PERFORMANCE

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Central Safety Committee recommendations.

A. Intent and Requirement
To monitor, assess and improve staff knowledge, skills and competencies with respect to their roles and responsibilities to the Safe Environment Management Plan.

B. Performance Standard
The FY-21 Performance Improvement Indicators are:

EOC Area	Indicator	Responsible Dept. Function	Target
Safety	Reduce employee injuries related to assisted patient falls.	EWHS / Fall Committee	Reduce injuries related to assisted patient falls by 25%.
Safety	Deploy new AIER injury reporting system under RLDatix	EWHS	We expect this implementation will increase end user satisfaction. Increase injury investigation completion within 3 days after the injury by 10%.

C. Frequency of Measurement and Process
All injury data is collected through Accident Injury and Exposure Reports (AIER). Incidents will be reviewed by the applicable committee as appropriate for corrective actions and then reported to the Central Safety committee monthly.

EVALUATION OF PROGRAM EFFECTIVENESS

Through the Safety Trends report and the Central Safety Committee, the effectiveness of the program, including the appropriateness of design, outcomes of implementation, training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the safety program to include: hazardous surveillance reports, occupational

illness/injury investigation reports, staff educational surveys, security incidents, medical device incidents, fire drills, and disaster exercises

ANNUAL PERFORMANCE EVALUATION

On an annual basis, the safe environment program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Safety Officer and approved by the Central Safety Committee.

- The continued appropriateness and relevance of program Objectives are assessed, as well as whether or not these objectives were met.
- The Scope is evaluated relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- The year is reviewed retrospectively to determine the extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The Performance dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2020
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Patient and Employee Safety Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2020
	Matthew Scannell: Director Safety & Security Services	09/2020

El Camino Health

Origination:	*02/2018*
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Next Review:	*1 year after approval*
Owner:	*Lorna Koep: Director Environmental Svcs*
Area:	*Hazardous Materials Management*
Document Types:	*Plan*

Environment of Care □□a□ardous Materials Management Plan

COVERAGE:

This Hazardous Materials Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

PROGRAM OB□ECTIVES□INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, accessible and effective Environment of Care, consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, visitors, employees and staff. The intent of this plan is to protect human health and the environment from risks related to hazardous materials and waste by identifying materials that need special handling and implementing processes to minimize the risk of unsafe use and improper disposal of hazardous materials.

A. Goals:
Based on areas of improvement noted in the FY-20 Annual Evaluation, the performance improvement indicators for FY-21 will be:

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes
2. Staff knowledge on proper labeling of biohazardous waste containers.

B. Objectives:
Specific objectives of the FY-21 Hazardous Materials and Waste Management Plan include the following:

1. All employees will have access to Safety Data Sheets (SDS) on line.
2. All Hazardous Materials Business plans will be submitted to the Santa Clara County Department of Environmental Health.
3. Refresher and initial decontamination training will be offered to staff at least one time in FY 21.
4. Initial and annual HAZWOPER training will be offered to identified individuals in FY 21.
5. Develop, educate and implement the Handling of Hazardous Drugs (USP 800) plan in FY 21.
6. Review, revise and educate staff on the changes to the hospital container waste guide based on

opportunities for improvement identified during the hazardous waste inspections with the county

7. Spill response training will be offered to staff who respond to spills and code orange events (e.g., EVS, Engineering, Lab etc.).
8. Any corrective actions from the 2020/21 Santa Clara County medical and biohazardous waste inspections will be tracked through the Central Safety Committee.
9. Implement a controlled substances non retrievable waste container program in FY 21.

SCOPE AND APPLICATION:

The Hazardous Materials and Waste Management Plan apply to patients, employees, and visitors at all areas of El Camino Hospital. This plan applies to all operations, processes, activities and departments involved in the selection, procurement, handling, storage and disposal of hazardous materials. For the purposes of this plan, the term "hazardous materials" may apply to the following:

- Hazardous substances (as listed and defined under CERCLA , 40 CFR 300),
- Hazardous Materials (as addressed in the OSHA Hazard Communication Standard & Director's list 8 CCR 339),
- Designated wastes under the federal and state regulations,
- Listed carcinogens and reproductive hazards, under 22 CCR 12000 (Prop. 65),
- Compressed gases,
- Chemotherapeutic agents (CYTOTOXIC),
- Radioactive materials,
- Potentially infectious materials (as defined in the Blood borne Pathogen Standard) and Medical wastes (as defined in the Medical Waste Management Act),
- Pesticides (Title 3, Division 6, Health & Safety Code, Section 25500),
- Universal Waste (batteries, fluorescent light bulbs), or
- Any other material which the user or Administering Agency has reasonable basis to classify as harmful to living organisms or the environment.

This plan addresses all elements required to provide a safe and healthy environment in which care is delivered, as well as to ensure safety in the workplace. Key aspects include:

- Program planning/design, implementation, the measurement of outcomes and performance improvement;
- Risk Assessments; Identification, analysis and control of risks;
- Reporting and investigating including incidents, accidents and failures;
- Occupational health and safety;
- Control of exposures to potentially harmful conditions/industrial hygiene;
- Orientation, education and training;
- Environmental maintenance, testing and inspection;
- Examining and addressing safety issues

The hazardous materials and waste management plan and associated policies, procedures and programs are instituted by the Central Safety Committee through a multi-disciplinary approach which integrates the efforts of key functional areas, including but not limited to EVS, Infection Control (IC Committee), Engineering, Laboratory, Nursing, and Security

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC.02.02.01

2. Code of Federal Regulations, Title 29, Sections 1910.101-106, 120, 1000, 1030, 1200, 1450;
3. Code of Federal Regulations, Title 40, Section 261 et seq.;
4. California Code of Regulations, Title 8, Sections 3203, 4650, 5076, 5144, 5155, 5191, 5193, 5194;
5. Title 22, Sections 66261 et seq., 12000;
6. Title 17, Section 30100;
7. Title 3, Section 6145 et seq., 6600 et seq.;
8. California Health and Safety Code, Sections 117600 et seq.;
9. NFPA 30.

AUT□ORITY

The El Camino Hospital Leadership Team provides vision, leadership, support, and appropriate resources to the program. In accordance with its bylaws, the El Camino Hospital leadership has given the Central Safety Committee the authority to ensure that this plan is developed and implemented. The authority and responsibility for program design as well as strategic and operational oversight has been delegated to the Hazardous Materials and Waste Work Group.

PROGRAM ORGANI□ATION AND RESPONSIBILITIES

A. **Clinical La□oratory:** Hazardous material and waste management in the Pathology and Clinical Laboratories, and the implementation of the Chemical Hygiene Plan, is the responsibility of the Laboratory Director/Manager.

B. **Radiation Safety Committee:** Radioactive materials and waste management is the responsibility of the site Radiation Safety Officer and the Radiation Safety Committee.

C. **□a□ardous Materials and □ aste Management □ or□group:** The Hazardous Materials and Waste Management Workgroups or designee in collaboration with the Central Safety Committee is responsible for the overall management of the hazardous materials and waste program. These include:

   - Coordinating the initial assessment of risks,
   - Program design,
   - Developing the facility's written plan and program objectives for each year,
   - Establishing, monitoring and assessing Performance Improvement dimensions
   - Identifying training needs,
   - Regulatory tracking/interpretation□
   - Assistance with departmental implementation,
   - Initial response investigation and reporting of significant events, and
   - Program evaluations.

D. **Central Safety Committee □CSC□:** The CSC, as part of the standing agenda, receives and reviews reports and summaries of actions taken related to Hazardous Materials and Waste Management. The Committee also identifies and analyzes issues and seeks there timely resolution. Agenda items include**:**

- Issues requiring action, recommendations or approval,
- Issues requiring monitoring/periodic or ongoing review,
- Needs that are multi-disciplinary in nature,
- Regulatory updates, and
- Performance Data review.

RIS ASSESSMENT

Risks associated with the management of hazardous materials and wastes are typically identified and assessed through facility-wide processes, such as routine safety rounds , product inventory management, the facility's Safety Trends reports, Central Safety Committee review, and the incident reporting application. The risk profile with respect to hazardous wastes includes, but is not limited to: risk of occupational and occupant exposures; fires and chemical reactions; releases; nosocomial infections; and legal exposures.

Key factors driving the level of relative risk include the likelihood of an unwanted event coupled with the magnitude of the consequences. These factors are typically associated with the volume of chemical substances, constituents, inherent physical or chemical properties, concentration and handling practices, as well as invasive procedures involving blood or other potentially infectious materials and waste handling. Identified high risk areas to which additional resources and attention are directed are listed below.

- Clinical Laboratories and the Pathology department
- The Operating Room
- Sterile Processing department
- Material Management
- Facility Engineering
- Pharmacies
- Environmental Services (EVS)
- Gastroenterology (GI)
- Oncology/Hematology
- Radiology
- High volume patient care areas

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

The plan provides processes for the following.

A. The facility developed and maintains an inventory that identifies hazardous materials and waste used, stored, and generated using criteria consistent with applicable laws and regulations as follows:
   - A Hazardous Materials Business Plan is kept current in accordance with local and state regulations and ordinances.
   - The facility's policy and procedure requires each department to update a department chemical inventory.

B. Selection, handling, and use of hazardous materials and waste: Products and substances containing chemical constituents deemed to be hazardous will be identified, evaluated and listed by recognizable names within department-specific inventories. Department managers (in conjunction with the EH&S

Manager) will evaluate waste streams to ensure waste materials from all processes, procedures and operations are correctly characterized and classified, per regulatory criteria. Department programs include waste minimization components, such as procurement and inventory control. For each hazardous material used and handled, the department manager will provide a corresponding Safety Data Sheet (SDS). These documents will remain readily available to employees at all times and should form the basis for department-specific training and written procedures for proper handling, storage, safe use and spill procedures. Containers of hazardous substances are labeled in accordance with applicable regulations with appropriate hazard communication and expiration dates.

C. The facility monitors use and disposal of hazardous gases and vapors including, but not limited to:
    - Formaldehyde
    - Various compressed gas cylinders, including oxygen, medical air, nitrous oxide and nitrogen.

D. Hazardous Materials and waste emergency procedures address the following:
    - Incidental and major spills: Emergency procedures and materials are implemented that provide preventative, precautionary measures, response procedures, and appropriate personal protective equipment (PPE). The EH&S Manager participates with department managers in the development and implementation of emergency procedures.
    - Small, relatively innocuous hazardous material spills: These spills are addressed by the individual causing or discovering the spill or appropriately trained staff. The containment materials will be used for proper spill cleanup.
    - Large spills: These spills will be handled by contracted vendor and/or emergency response agency personnel. In the event of a release or exposure involving radioactive materials, the Radiation Safety Officer will immediately be notified and will coordinate the response.
    - Clean-up procedures: Department managers will ensure that appropriate spill procedures and spill control materials are readily available for use within close proximity of where hazardous substances are stored, used or handled. Additionally, facilities engineering maintains a chemical spill cart to supplement existing spill materials and PPE.
    - Personal protective equipment: Department managers will ensure that appropriate personal protective equipment (PPE) is readily available for use within close proximity of where hazardous substances are stored, used or handled. Exposure management equipment, materials, suppression systems, alarm systems and other features of the hazardous materials and waste management program are inspected and maintained primarily through Facilities Services, in concert with the EH&S Manager. Examples include, but are not limited to:
        - Mechanical ventilation
        - Administrative controls
        - Personal Protective Equipment (PPE)
        - Periodic exposure monitoring for operations that involve the handling of solvents, reagents, fixatives and other chemicals that may produce fugitive emissions, volatilize or otherwise off-gas into occupied spaces and/or work areas. **See PM records and monitoring records**.
    - Personnel monitoring, system assessments, local exhaust ventilation/scavenger units and alarm systems for the control of waste anesthetic gases (including nitrous oxide).
    - Reporting and investigation of hazardous materials incidents:

The EH&S Manager will ensure all releases and exposure incidents are duly investigated and reported to the Central Safety Committee and appropriate agencies.

E. Documentation is maintained that includes required permits and licenses in Facility Services

F. As prescribed by governmental standards, hazardous waste is manifested for transport to a permitted, licensed treatment, storage and disposal facility (TSDF), by a licensed contracted hazardous waste hauler in accordance with applicable regulations (See Manifests).

G. Hazardous materials and waste are properly labeled in accordance with pertinent laws and regulations i.e. DOT shipping requirements, NFPA Placards, Title 22, etc.

H. Hazardous materials and waste storage and processing areas are separated from other areas of the facility as follows:

- Where hazardous materials or wastes are stored, physical barriers separate incompatible materials. Applied release prevention measures include diversionary structures, bins, tubs, berms, secondary containment, etc. Hazardous materials are used and stored under adequate general ventilation or local exhaust ventilation.
- Hazardous wastes are collected and accumulated on site in a main accumulation area and in satellite accumulation areas near the point of generation. These accumulation areas are provided with structural features, containers, signage, equipment, and supplies conducive to occupational safety, spill prevention and control, and environmental protection **Hazardous waste storage area inspection checklist**.
- Bio-hazardous waste is contained within rigid, leak resistant, labeled containers; accumulated on-site within secured and designated areas. Sharps waste is transported by a licensed hauler and incinerated by a permitted facility. Regulated medical (bio-hazardous and sharps) waste is segregated from solid municipal wastes at the point of generation.

I. Education and Training:

All employees attend General Hospital Orientation at the time of hire and annual training where general information and education regarding the management of hazardous materials and wastes is provided. Departments will also conduct training that is specific to processes, materials; precautions and relative risk associated with job function and work practices, to include:

1. Elements of the written programs, interpretation of labeling and hazard warning systems, specific SDS information (physical and health hazards, precautions), proper storage, waste Management, emergency procedures and incident reporting (including spills, releases and exposures);
2. Department manager(s) will verify that each employee possesses the required core competencies relative to the safe and effective use of products and substances deemed hazardous;
3. Technical consultative support is provided through the Safety and Security Services Department, as requested;
4. The education department and each department manager will periodically revisit their training materials and modify, adjust and improve, as indicated, to reflect:
   - Organizational experiences and learning
   - Results of risk assessments, hazard surveillance rounds, audits, inspections
   - Changes in pertinent regulations, codes or standards

- Recommendations from the Central Safety Committee or the Safety and Security Services Department

PERFORMANCE

The standards and metrics by which performance relative to this plan will be measured are predicated upon organizational experiences, discerned risks, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or Integrated Safety Committee recommendations.

A. Intent and Requirement: To monitor, assess and improve staff knowledge, skills and competencies with respect to hazardous materials and waste.

B. The FY-21 Performance Improvement Indicators are as follows:

EOC Area	Indicator	Responsible Dept. Function	Target
Hazardous Materials Management	Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes	Safety	>90%
Hazardous Materials Management	Staff knowledge on proper labeling of biohazardous waste containers.	Safety	>90%

C. Process and Frequency of Measurement

Data will be collected through safety rounds.

PROGRAM EFFECTIVENESS

The Central Safety Committee evaluates the effectiveness of the program, including the appropriateness of design, outcomes of implementation; training and materials are monitored and assessed on an ongoing basis. Relevant documents reporting action(s) taken, as well as concurrent and retrospective data is tracked and monitored relative to the success of problem identification and resolution and program improvement.

Such evaluations include the review of established performance standards and reports that are indicative of the effectiveness of all elements of the hazardous materials and waste program to include: hazardous surveillance results; inspections by regulatory agencies; spills, releases or other emergencies; management of the hazardous waste accumulation area; occupational exposures to hazardous materials; and hazardous materials and waste reduction efforts.

ANNUAL PROGRAM EVALUATION

On an annual basis, the Hazardous Materials and Waste program is evaluated relative to its *objectives, scope, effectiveness and performance*. This evaluation process is conducted by the Integrated Safety Committee and the Safety Officer.

- The continued appropriateness and relevance of program **Objectives** are assessed, as well as whether or not these objectives were met.
- The **Scope** is evaluated relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.

- The year is reviewed retrospectively to determine the extent to which the program was **Effective** in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The **Performance** dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

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	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2020
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Patient and Employee Safety	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety [JH]	10/2020
Hazardous Materials Work Group	Steve Weirauch: Mgr Environmental Hlth&Safety [JH]	10/2020
	Lorna Koep: Director Environmental Svcs [JH]	10/2020
	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2020

El Camino Health

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Environment of Care Utility Management Plan

COVERAGE:

This Security Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

PROGRAM OB□ECTIVES□INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, secure, accessible and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients, members, employees, physicians and visitors.

To that end, it is the overall intent of this plan to establish the framework, organization and processes for the development, implementation, maintenance and continuous improvement of a comprehensive Utility Management Program. The program objectives include:

- Promoting a safe, controlled, and comfortable environment
- Ensuring operational reliability of utility systems
- Reducing the potential for health care organization-acquired illness to be transmitted through the utility systems
- Assessing the reliability of utility systems and minimizing potential risks of utility system failures.

A. Goals:
Based on areas of improvement noted in the FY-20 Annual Evaluation, the performance improvement indicators for FY-21 will be:

1. Staff can describe the proper way to store oxygen cylinders as well as the amount per smoke compartment
2. Staff can describe who has the authorization to turn off medical gas controls.

B. Objectives:
Specific objectives of the FY-21 Utility Management Plan include the following:

1. Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new Sobrato and Taube buildings.
2. Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

3. Develop a periodic equipment replacement or renovation plan for both Mountain View and Los Gatos.

SCOPE AND APPLICATION:

A. This plan applies to utility systems, components and the uses thereof, for the purposes of providing:
   - Environmental control/comfort ventilation
   - Mechanical ventilation for the purposes of infection/exposure control
   - Life support
   - Support to the diagnostic and therapeutic environments
   - Communication systems
   - Support to other critical processes and equipment

B. The items, processes and critical functions addressed in this plan include, but are not limited to the following:
   - Heating, Ventilation and Air Conditioning (HVAC);
   - Electrical distribution and emergency power;
   - Vertical transport;
   - Domestic Water and plumbing;
   - Boiler/steam;
   - Medical gases (Oxygen, Medical Air, Nitrous Oxide, Nitrogen, Vacuum); and
   - Communications (Phones, Nurse Call systems, Public Address).

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC .02.05.01, .02.05.03, .02.05.05, .02.05.07, .02.05.09, (lighting and ventilation), .02.06.01
2. California Code of Regulations, Title 22, Sections 70837, 70841, 70849, 70851, 70853, 70855;
3. California Code of Regulations, Title 24 (UMC), Sections 330, 412, 413;
4. California Code of Regulations, Title 8, Sections 5141, 5142, 5143, and 5154.

AUT□ORITY

The authority and responsibility for program strategic design, and the operational oversight has been assigned to the Facilities Director. Program implementation and day-to-day operational management has been delegated to the Chief Engineer under the authority of the Chief Administrative Officer (CAO).

The Chief Engineer works in concert with the Environmental Health and Safety (EH&S) Manager, and the Central Safety Committee to ensure the Utility Systems Management Program is in alignment with the direction of the comprehensive EOC program.

PROGRAM ORGANI□ATION AND RESPONSIBILITIES

A. **Leadership Team:**
The El Camino Hospital Leadership Team (i.e. the organization's governing body) provides the program vision, leadership, support and appropriate resources through the development, communication and institutionalizing of business fundamentals relative to environmental health and safety.

B. **Facilities Engineering and Safety□Security Department**
Facilities Engineering and the Safety/Security department have been given the responsibility for the design, implementation and oversight of the Utility Systems Management Program. These responsibilities include:

- Coordination of the initial and ongoing risk assessments
- Development of written plans and operating procedures
- Identifying training needs
- Providing technical consultation and assistance with utilities end users, and emergency response training
- Planning for and organizing initial response to utility failures
- Investigation and reporting of related incidents and significant events
- Evaluating overall program efficacy and performance

C. **Environmental□□ealth & Safety Manager□Clinical La□oratory□Chief Engineer**
The EH&S Manager works together with the Laboratory Departments and Chief Engineer to assess life safety issues and fire hazards within the Pathology and Clinical Laboratories, and ensure that these hazards are addressed through appropriate procedures, processes, and systems.

D. **Central Safety Committee**
The Central Safety Committee (CSC) ensures the utility management program remains in alignment with the core values, direction and goals of the organization by providing leadership, determining priority and assessing the need for changes to the program. The CSC acts as a clearinghouse for action items, recommendations, leveraging issues and the development of program requirements and improvements.

The Central Safety Committee meets regularly and as part of the standing agenda, receives and reviews reports and summaries of action taken relative to Fire Prevention Management on a quarterly basis. Agenda items include:

- Issues requiring action, recommendations or approval;
- Issues requiring monitoring/periodic or ongoing review; and
- Needs that are multi-disciplinary in nature.

E. **Employees**

Employees are responsible for participating in utilities training and demonstrating core competencies relative to safe, effective utility systems operations pertinent to their department. Employees must ensure their work practices, operations, and behaviors are safe, and in accordance with departmental procedures, the provisions of this plan, sound infection control principles, hygiene practices and clinical

judgment.

Applicable employees are also responsible for knowing the locations of the shut off apparatus for critical utility system components, the proper use, capabilities and limitations of utility systems, and procedures for failures and outages.

RIS□ ASSESSMENT

The risks associated with the management of Utility Systems are assessed and controlled through the following facility-wide processes:

- Ongoing Utilities management/Quality Control methods and protocols, including those designed to address user errors and system failures;
- Incident Report review/evaluation through the incident reporting system and the Central Safety Committee;
- Identifying and mapping the layout of utility systems, and taking inventory of operating components, relative to their impact on critical systems and potential risks associated with system failure;
- Dust Control risk assessments through Infection Control
- Monitoring of ILSM and Methods of Procedures (MOP'S) during construction projects and planned utility shutdowns.
- Environmental rounds and hazard surveillance surveys;
- Communications with end users of utility systems; and
- Results of education and training skills assessments.

The profile of potential physical risks with respect to utilities management includes, patient impact/adverse outcomes, occupational hazards (electrical, mechanical, etc.), and compromised system function/integrity.

Risks are evaluated and controlled through the review of risk management/incident reports, examination and analysis of pertinent data through the incident reporting system, and the response to and correction of utility failures, systemic issues and user errors.

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

The following describes the implementation of El Camino Hospitals utility management program:

A. The establishment of criteria for identifying, evaluating and taking inventory of critical operating components for inclusion in the utility management system. The basic criteria for designating systems that will be included in the management program are established through collaborative efforts between both Mountain View and Los Gatos campuses. This process begins with the identification of systems that are involved with sustaining a safe, homogenous environment within the facility. These criteria also address utility systems with impact on
    - Life safety systems;
    - Infection Control systems;
    - Environmental support systems;
    - Equipment support systems; and
    - Communication systems

Specific systems addressed in this maintenance plan include:

- HVAC systems (e.g. comfort ventilation, general dilution and local exhaust ventilation, temperature and relative humidity, air balance and pressure relationships, Indoor Environmental Quality (IEQ))
- Medical vacuum, air, oxygen, nitrogen and nitrous oxide
- Electrical distribution
- Emergency Power/UPS
- Boiler/steam systems
- Water distribution
- Waste water, drains and vents
- Nurse Call
- Overhead page
- Vertical lifts

B. Inspection, testing and maintaining critical operating components falls under the purview of the Engineering Department. For utility components that meet the above criteria, an equipment file form is completed. Each component included in the program is assigned a unique identification number. From there, it is included within scheduled preventive maintenance and testing activities, as indicated. Specific written procedures (instruction sets) are designed for utility inspection, testing and maintenance (**EC.□2.□□.□1□.□2.□□.□3**)

1. All critical components of the facility's Piped Medical Gas system are inspected, maintained and tested through the engineering department. The general and routine inspection and maintenance of medical gas systems include:
   - Visual inspections performed daily to monitor medical gas levels by Engineering. Engineers log and respond to any system alarms;
   - Signaling panels and area alarm devices, inspected periodically by Engineering;
   - Valves, pressure switches connectors and end-user service outlets, inspection by Engineering;
   - Cross connection testing, purity testing and pressure testing will be coordinated through Engineering whenever the system is modified, repaired or otherwise breached, or at least annually (***22 CCR 70849***). Testing will be conducted in accordance with NFPA 99, section 4-5.
2. As part of the internal system to periodically verify the reliability of the Emergency Power Supply System (EPSS), monthly tests of the emergency generators and transfer switches for 30 continuous minutes are conducted under load by Engineering once per month. Each month, each generator will be exercised for at least 30 continuous minutes under a dynamic load that is at least 30% of the nameplate rating. If this requirement cannot be met, the following conditions shall be implemented (See below). (***EC.02.05.01)***
   a. As an additional proactive measure to better ensure adequate exercising of the engines and to ensure the requirements for wet stacking are met: A "load bank" test will be performed to test each generator with a graduated process of supplemental loads, in accordance with the Joint Commission standard annually on any engine not under a load of 30% or more during each monthly test. Every 36 months a four hour load bank test will be performed per the prescribed requirements.

b. These generator tests are documented and any discovered problem of deficiency is promptly addressed, reported through the safety function, as needed and tracked where applicable to overall system performance metrics.(***EC.02.05.01)***

3. The Engineering Department implements procedures to effectively reduce the risk of organizational-acquired illnesses through the control of biological agents in water sources (such as cooling towers) and other aerosolized water systems as indicated. Refer to **Reducing Environment□Ac□uired Illnesses** for more information. (***EC.02.05.01)***

   This aspect of the utilities program is fashioned after applicable portions of existing standards for the environmental control of *Legionella*. Effective *Legionella* control measures will also impact the colonization and proliferation of other water borne pathogens.

4. Mechanical ventilation systems designed for optimal control of airborne contaminants are maintained through Engineering.

5. General air balancing and verification are conducted by Facilities Engineering. Engineering ensures the maintenance and verification of specific air pressure relationships and air exchange ratios, through routine systems maintenance and corrective actions. These specified conditions will be maintained to meet established standards for:

   - Negative pressure isolation rooms
   - Positive pressure rooms
   - Atmospheric isolation relative to preventing the transmission of TB
   - Required pressure relationships for certain health facility areas

   Additionally, Engineering periodically ensures the verification and efficacy of:

   - Dilution air ventilation to limit the concentration of potential airborne contaminants
   - Air flow patterns within a room (such as laminar flow in the OR)
   - Proper Air flow direction (such as "clean" to "soiled" in Central Processing)
   - Filters

C. The Engineering Department has developed a Building Maintenance Program to address routine maintenance and inspection of site utility systems. In accordance with this program, Preventive Maintenance/Inspection schedules and instruction sets, P.M. completion rates, system reliability and functionality is ensured and relative risks controlled through routine preventive maintenance, testing and the identification and correction of deficiencies. (**EC.□2.□□.□1**)

D. Mapping the Layout of Utility Systems and Labeling Controls - A complete set of current mechanical drawings of utility systems are maintained in the Engineering Department, to help ensure system reliability, reduce failures and provide for effective response. The Engineers ensure system controls are consistently marked throughout the facility to ensure appropriate recognition for partial or complete emergency shutdown. Examples include valve tags, labeling of shut-off valves, numbering air handlers, distribution/disconnect panels and mechanical equipment, marking of overhead pipes, etc. (***EC.02.05.01)***

E. Utility system problems, failures and user errors are investigated through Engineering. Each event as well as the corrective actions implemented is documented and reviewed by the Chief Engineer. From this process, training needs, significant events, true leveraging issues and information pertinent to the department's given performance dimensions are collected and communicated to the Central Safety

Committee, as needed. (***EC.02.05.01)***

F. Education and Training for end users of utilities is provided through the individual department manager.

Training programs address the following:

- System capabilities, limitations and applications;
- Emergency procedures in the event of failure;
- Information needed to perform assigned maintenance duties;
- Location and instructions for emergency shut-off controls;
- Processes for reporting problems, failures or errors

Technical consultative support is provided through the Engineering Department.

PERFORMANCE

The standards and metrics by which Utility Management performance will be measured are based upon organizational experiences, customer expectations/satisfaction, regulatory requirements, discerned risks, Central Safety Committee and Quality Committee recommendations, and/or observed work practices and behaviors.

A. **Performance Standard**
Based on opportunities for improvement identified in the FY-20 EOC Annual Evaluation the FY-21 Performance Improvement Indicators are as follows:

EOC Area	Indicator	Responsible Dept. Function	Target
Utility Systems	Staff can describe the proper way to store oxygen cylinders as well as the amount per smoke compartment	Engineering & Department Managers	> 90%
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%

B. **Process and Frequency of Measurement**

Progress for this project will be reported out quarterly at the Central Safety Committee. Data will be collected during Hazard Surveillance rounds and Engineering Life Safety rounds.

PROGRAM EFFECTIVENESS

The effectiveness of the utility management program includes the appropriateness of the program design, training, maintaining systems integrity, failures, emergency generator testing and performance and other pertinent issues will be monitored and assessed on an ongoing basis.

Relevant incident reports, failures and concurrent and retrospective data relative to the management of Utility Systems will be gathered and tracked through Engineering and the Central Safety Committee. The Central Safety Committee will receive periodic reports and give approvals or make recommendations, as indicated. Substance of reports includes, but is not limited to:

- Summaries of monitoring results relative to established Utility Systems Management performance

dimensions and standards, including emergency power system performance levels and preventative maintenance; and
- Reports of system failures or sentinel events, issues, investigation and follow-up.

ANNUAL PROGRAM EVALUATION

On an annual basis, the Utility Systems Management Plan/Program is evaluated relative to its ***objectives, scope, effectiveness and performance.*** This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

- The continued appropriateness and relevance of program objectives, as well as whether or not these objectives were met.
- The Scope of the program, relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- The extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given scope and objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The performance dimensions, to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2020
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Patient and Employee Safety Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety [JH]	10/2020
	Nick Stoliar: Chief Engineer [JH]	10/2020

El Camino Health

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Environment of Care Medical E□uipment Management Plan

COVERAGE:

This Medical Equipment Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

PROGRAM OB□ECTIVES□INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, accessible and effective Environment of Care (EOC), consistent with its mission, services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, employees and visitors. This plan describes a comprehensive facility-wide Medical Equipment Management Plan that describes the process for: The Mountain View and Los Gatos campuses as well as all associated clinics where El Camino patients are cared for. To that end, it is the intent of this plan to describe a comprehensive facilities-wide management system that promotes safe and effective use of medical equipment, the objectives of which include:

- Maintaining a current accurate ***inventory*** of equipment included in the program
- Ensuring all equipment receives an ***initial inspection*** prior to use
- Ensuring ***preventive maintenance*** is performed pursuant to a risk-based equipment maintenance strategy and schedule
- Providing timely and effective ***corrective maintenance services***
- ***Reporting, investigating and resolving*** incidents, problems and failures involving equipment in a timely and effective fashion
- Assist in the development and/or provide training materials in coordination with Hospital Educator
- Ensuring equipment is ***cybersecurity*** safe and providing support for medical ***device integration***.

Developing and providing training materials in coordination with Hospital Educator

SCOPE AND APPLICATION:

This plan applies to select medical equipment, devices and technology and the uses thereof, which are generally included within a designed environment of care management program.

The items, processes, and critical functions addressed in this plan include, but are not limited to the following:

- Program planning/design, implementation, and the measurement of outcomes and performance improvements
- Medical equipment which is purchased, rented, leased, borrowed, cosigned and supplied for demonstration
- Equipment identification, risk assessment, inventory and maintenance
- Equipment Device-related hazard alerts and product recalls
- Equipment involved in incidents that have, or may have, contributed to death, serious injury or illness pursuant to the Safe Medical Device Act (SMDA)
- Clinical and technical consultative services relative to equipment pre-purchase evaluation, end user training, and equipment life cycle analysis.
- Oversight of the hemodialysis equipment service refer to Chief of Dialysis

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC.02.04.01, EC.02.04.03
2. California Code of Regulations, Title 22, sections 70837, 70853
3. NFPA 99,2012
4. HITRUST
5. NIST

AUT□ORITY

In accordance with its bylaws, the Central Safety Committee the authority to ensure this plan is formulated, appropriately set forth and carried out. The authority and responsibility for program strategic design and operational oversight has been delegated to the Director of Clinical Engineering.

PROGRAM ORGANI□ATION AND RESPONSIBILITIES

A. Executive Management (i.e. the organization's governing body, the facility Leadership Team) provides the program vision, leadership, support and appropriate resources through the development, communication and institutionalizing of pertinent business fundamentals.

B. The Clinical Engineering Department, has been given the responsibility for:

   1. Cataloging all medical devices and equipment and determining which devices are deemed critical and to be included in the scheduled maintenance program
   2. Maintaining an accurate inventory of all the devices deemed critical
   3. Performing initial safety tests and inspections of all medical equipment
   4. Inspecting and maintaining equipment that does not meet the criteria to be listed individually in the maintenance program through a series of scheduled environmental inspections and testing
   5. Performing and documenting maintenance activities through the design and implementation of the equipment management program, to include coordination of the initial risk assessments
   6. Developing written plans and operating procedures
   7. Identifying training needs

8. Providing technical consultation and assistance with equipment end user training
9. Initial response to, investigation and reporting of incidents, potential Safe Medical Devices Act issues and Sentinel Events

C. Each Department Manager/Director is responsible to develop and manage department specific elements the equipment management program to include:
   1. Ensuring all equipment, regardless of the type or ownership, receives an initial inspection before being introduced into the patient care environment and is functionally tested prior to each use insofar as it is recognized that each use of the device constitutes a functional test.
   2. Maintaining equipment through the development and management of department-specific elements of the equipment management program, including user training, and assessing program effectiveness.
   3. Implementation of procedures to address failed devices:
      a. How to respond to equipment failure
      b. How staff should contact Clinical Engineering when equipment repair is required
      c. How to pro-actively identify equipment that is in disrepair or in need of assessment
      d. How to ensure failed equipment is properly tagged and taken out of service
      e. Assurance before use that the proper maintenance has been performed

D. A multi-disciplinary Central Safety Committee (CSC) ensures that the program remains in alignment with the core values, direction, and goals of the organization by providing leadership, determining priority and assessing the utility and efficacy of changes to the program. The CSC maintains and tracks all applicable information through the Safety Trends report and acts as a clearinghouse for action items and recommendations, as well as a forum for leveraging issues, and developing program imperatives. The CSC meets regularly throughout the year and, as part of the standing agenda, receives and reviews reports and summaries of actions taken, deficiencies, issues and performance improvement relative to equipment management, as well as several other pertinent functions and disciplines.

E. Employees (all those who use equipment, to include contract employees, registry/on-call personnel, etc.) are responsible to participate in equipment training and demonstrate core competencies relative to safe, effective equipment operations (including the performance of routine functional testing of equipment to verify integrity with each use). Employees must ensure their work practices and processes are safe and are in accordance with departmental procedures, training, provisions of this plan, and sound clinical judgment.

RIS□ ASSESSMENT

The clinical and physical risks associated with the management of medical equipment are discerned through the following facility-wide processes:

- Risk-based initial & scheduled inspections, testing and maintenance
- Ongoing Equipment Safety Management methods and protocols, including those designed to address operator/user errors and equipment failures
- Incident Report review/evaluation through the applicable Information Collection and Evaluation System and the EM/ISC
- Device-related hazard alerts and product recalls
- Environmental and Hazard Surveillance rounds

- Communications with customers (end users)
- Root Cause Analysis of medical equipment related significant events
- Information Technology Security

PROGRAM IMPLEMENTATION AND PROCESSES OF PERFORMANCE

A. The selection and acquisition of medical equipment is accomplished through local and clinical specialty evaluation committees and through the utilization of medical technology and product line manuals. Conformance to pre-established standards, as appropriate, is ensured through the purchasing process.

B. The risk-based criteria for inclusion in the medical equipment preventive maintenance (PM) program includes:

   - Equipment function/clinical application (e.g. diagnostic, therapeutic, or monitoring)
   - Physical/clinical risks associated with use and/or failure
   - Maintenance requirements
   - Equipment classification incident history
   - Environment of equipment use (areas of equipment use)
   - Information / Network Security

   Clinical Engineering is responsible for establishing appropriate PM schedules based upon the foregoing risk criteria, experience, and ongoing monitoring and evaluation of equipment performance, reliability and use. All medical equipment, regardless of the type ownership, receives inspection, maintenance and testing at appropriate frequencies using approved methodologies, commensurate with relative risk, criticality and priority.

C. Medical device product recalls and alert notifications are managed through a system involving Clinical Engineering, Facility Services, Materials Management, Safety, Risk and the equipment user departments. As medical equipment alerts, product recalls and manufacturer letters are received, they are researched through the Clinical Engineering department. When the alert or the recall involves equipment supported by Clinical Engineering, the equipment/product user department and Clinical Engineering check inventory and take action, as prescribed in the notice. Clinical Engineering provides the CSC with relevant data where it is tracked and monitored for follow up on the alert.

D. The investigation and reporting of device-related incidents involving death, serious injury, serious illness, or posing a significant impact on care or an occupational hazard are managed through an ad hoc administrative investigation team (Incident Reporting System). The Team is comprised of individuals who collectively possess the technical, clinical, and operational skill sets necessary to effectively evaluate the surrounding circumstances and determine the need for reporting under the Safe Medical Devices Act (SMDA) requirements.
   The SMDA investigation process and ensuing investigative reports are instrumental in discovering user error issues that provide impetus for training improvements. In instances when the governmental criteria are met, the investigation and root cause analysis is documented on the FDA "*MedWatch"* report form, in accordance with the SMDA policy. In addition, the user's department under the direction of Risk Management completes an incident report. This report is used to document user errors; as well as other equipment use management issues such as cannot duplicate problem, equipment abuse, and unsafe practices.

E. Clinical and physical risks relative to the use of equipment are identified and assessed through processes involving periodic performance assessment, user feedback, safety rounds, and incident reporting/review.

F. Education and Training for the end users of equipment (including use, reporting failures, emergency procedures, etc.) is area/department specific and provided through the individual department manager. Educational topics include:

- Capabilities, limitations and special applications of equipment
- Basic operations and safety precautions
- Emergency procedures
- Skills necessary to perform equipment maintenance
- Processes for reporting program problems, failures, and user errors.

Clinical Engineering will provide technical consultation, as appropriate. Department managers/ Administrators, in concert with the Education Department will verify that each employee possesses the required core competencies relative to the safe and effective use and maintenance of equipment, as required. Education and training for maintainers of equipment (e.g. Clinical Engineering) is provided through the equipment vendors and ongoing technical, educational and professional development programs. An engineer's equipment training is based upon a training needs assessment and coordinated through the Director of Clinical Engineering. Required competencies are established, monitored and documented through the Director of Clinical Engineering.

Training materials and programs are developed and periodically revised to reflect:

- Assessment of educational needs
- Organization-wide experiences
- New technologies, equipment, and systems
- Results of risk assessments, environmental rounds, audits, and inspections
- Changes in pertinent laws, codes, and standards
- CSC recommendations

G. Procedures are developed by the Clinical Engineering Department in conjunction with the user Departments. They include processes to ensure failed or deficient devices are immediately taken out of service. In these cases, the user enters pertinent information onto a repair tag and Clinical Engineering is notified, without delay. Other aspects included within the user-specific departmental procedures address failure procedures, emergency clinical interventions in the event of critical equipment failure, and obtaining emergency back-up equipment and repair services.

PERFORMANCE MEASURE

FY□21 Performance Indicators

This year the performance improvements will be:

- Raise confidence level of the active assets in the inventory to greater than 90%. Currently we are at an 84% confidence level of assets active in the database. This will be accomplished by tracking scheduled work orders on an asset by various sub status codes to assure the asset is a valid active asset and should remain in the inventory

- Develop 2 network indicators that will alert potential monitoring network failures. These indicators will provide solutions to preemptively resolve potential issues within the networked monitoring system.

PROGRAM EFFECTIVENESS

The effectiveness of the equipment management program, including the appropriateness of the program design, training, maintaining equipment integrity, issues, and behaviors will be monitored and assessed on an ongoing basis. Relevant reports and concurrent and retrospective data relative to the management of equipment will be garnered and tracked through the CSC in the meeting minutes and the Safety Trends Report. The CSC will receive periodic reports and give approvals or make recommendations, as indicated. These reports include summaries of monitoring results relative to performance standards, but are not limited to:

- Reports of SMDA issues, investigations, and follow up
- Relevant device/product related hazard alerts/product recalls and follow up
- Reports of equipment related significant events
- Trends or clusters of; cannot duplicate reported equipment problems, user errors, and equipment that cannot be located for scheduled preventive maintenance
- Efficient scheduled and corrective maintenance completion

ANNUAL PROGRAM EVALUATION

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued effectiveness of program on an annual basis, the Utility Systems Management Plan/Program is evaluated relative to its ***objectives, scope, effectiveness and performance.*** This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

- The continued appropriateness and relevance of program objectives, as well as whether or not these objectives were met.
- The Scope of the program, relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- The extent to which the program was Effective in meeting the needs of the customer, the patients and the organization, within the parameters of the given scope and objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.
- The performance dimensions, to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

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

Medical Equipment Risk Level Assignment Form.doc

Approval Signatures

Step Description	Approver	Date
Board of Directors	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2020
ePolicy	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Patient and Employee Safety Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Central Safety	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2020
	Jeff Hayes: Dir Clinical Engineering IT	09/2020

El Camino Health

Origination:	*03/2018*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2020*
Next Review:	*1 year after approval*
Owner:	*Steve Weirauch: Mgr Environmental Hlth&Safety*
Area:	*Emergency Management*
Document Types:	*Plan*

Emergency Operations Plan

I. COVERAGE:

This Emergency Operations Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics as listed below.

Mountain View	Los Gatos
• Main Hospital • Old Main Hospital • Advanced Radiotherapy & CyberKnife Radiosurgery Center (125 South Dr.) • Cedar Pavilion (2660 Grant Road) • Melchor Pavilion (Lab - 1st Floor; Concern, Community Benefits, Chinese Health Initiative, and South Asian Heart Center - 3rd Floor) • Oak Pavilion • Orchard Pavilion (Women's Hospital) • Park Pavilion (excludes YMCA) • *Sobrato Pavilion (Ground, 1st & 2nd floor)* • *Taube Pavilion (MHAS Services)* • Willow Pavilion	• Main Hospital • Cancer/Infusion Center • Rehabilitation Center (355 Dardanelli Ln.) • PPI (555 Knowles Dr., Suite 100) • OATS/Aspire (825 Pollard Rd.) • Men's Clinic (825 Pollard Rd.)

II. PURPOSE:

This Emergency Operations Plan at El Camino Hospital describes how the organization ensures effective response to disasters or emergencies affecting the safe operation of the hospital. The Emergency Management Committee implements processes for developing, implementing and monitoring the Emergency Management Plan.

III. POLICY STATEMENT:

The Plan describes a comprehensive "all hazards" command system for coordinating the six critical areas: communications, resources and assets, safety and security, staffing, utilities, and clinical activities. The overall response procedures include single emergencies that can temporarily affect demand for services, along with multiple emergencies that can occur concurrently or sequentially that can adversely impact patient safety and the ability to provide care, treatment, and services for an extended length of time.

El Camino Hospital has established the necessary policies and procedures to achieve preparedness and respond to and recovery from an incident. These current plans and procedures are exercised and reviewed to determine and measure functional capability. The Emergency Operations Plan complies with the National Incident Management System (NIMS) components.

IV. RESPONSIBILITIES:

A. Leadership

The hospital's leaders are involved in the planning activities and the development of the Emergency Operations Plan. The administrators, and department heads are represented in the Emergency Management Committee.

B. Emergency Program Management

The Hospital Safety Officer provides overall support to the hospital's preparedness efforts, including developing needed procedures, coordinating production or revision of the Emergency Operations Plan, planning and executing training and exercises, and coordinating the critiquing of the events and preparing the After Action Reports (AAR).

C. The Emergency Management Committee

The Emergency Management Committee is a group of multidisciplinary hospital representatives, including leadership, clinical and non-clinical representatives from key departments.

The committee meets regularly. The chairperson sets each meeting's agenda and facilitates the committee's work to achieve an annually established set of objectives. Subcommittees or task groups are appointed to accomplish identified projects or to plan training and exercises. Minutes of each meeting are published and available to for review by hospital.

D. Hospital Incident Command System

The hospital utilizes the Hospital Incident Command System (HICS) to manage and direct hospital operations during incidents that could impact hospital operations. Information on HICS and its utilization are available in the Emergency Management Policies and Procedures located online (Electronic Policy Database: Emergency Management)

V. PLANNING

A. Hazard Vulnerability Analysis

Hazard Vulnerability Assessments (HVAs) are conducted annually at each hospital campus to identify the potential emergencies that could affect the ability of the organization to provide normal services. This assessment identifies the likelihood of those events occurring and the consequences of those events. The assessment provides a realistic understanding of the vulnerabilities and to help focus the resources and planning efforts.

The HVA's of other area hospitals and health-care agencies are shared and summarized to help develop a list of priorities on a county-wide basis. This summary is updated annually.

B. Community Involvement

A strong relationship has been established between other hospitals and agencies within Santa Clara County. The combined group meets regularly to share information and resources and to work together to identify and meet the needs and vulnerabilities of each facility.

C. Mitigation & Preparedness

Specific emergency response plans have been established to address needs based on priorities from the HVA. Each plan addresses the four phases of emergency management activities:

1. Mitigation: Activities designed to reduce the risk of and potential damage due to an emergency (i.e., the installation of stand-by or redundant equipment, training).
2. Preparedness: Activities that organize and mobilize essential resources (i.e., plan-writing, employee education, preparation with outside agencies, acquiring and maintaining critical supplies).
3. Response: Activities the hospital undertakes to respond to disruptive events. The actions are designed with strategies and actions to be activated during the emergency (i.e., control, warnings, and evacuations).
4. Recovery: Activities the hospital undertakes to return the facility to complete business operations. Short-term actions assess damage and return vital life-support operations to minimum operating standards. The long-term focus should be on returning all hospital operations back to normal or an improved state of affairs.

D. Hospital Command Center

The Hospital Command Center (HCC) will be established according to procedures designated in HICS. See the following documents for additional information:

- Hospital Command Center (HCC)
- HICS Chart
- HICS Position Mission Statements

E. Inventory & Monitoring of Assets & Resources

The resources and assets that are available on-site and/or elsewhere to respond to an emergency are maintained and inventoried. This includes, but is not limited to the following assets and resources: as:

- Food
- Fuel
- Medical supplies
- Medications
- Personal protective equipment (PPE)
- Water

The current equipment inventory can be found in the ***Emergency Supply and Equipment Plan***

The organization will establish threshold on resources quantities that trigger a resupply actions. These

levels will be the Par Levels, a quantity at a midpoint between extremes on a scale of normal availability.

VI. Emergency Operations Plans

A. Response

A response procedure to an emergency can include the following:

- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the hospital to new patients
- Staged evacuation
- Total evacuation.

1. HICS shall be activated as outlined in: HICS - Activation and Termination
2. Staff respond to the emergency as outlined in: Code Triage

B. Sustainability

A process has been developed for determining the sustainability of the organization during an emergency. The end-point in planning for sustaining an emergency is 96-hours without the support of the local community. The planning on sustainability is coordinated with the Emergency Management Committee and the appropriate departments. The organization will continually monitor the availability and consumption rate of resources and assets to determine the length of time the organization can provide services. When necessary, the organization will adjust the consumption of the resources to extend the sustainability period. When it is determined the organization cannot provide services at an acceptable level of services, safety, and protection, a partial or total evacuation will be considered.

C. Recovery Procedures

The return to normal operations from an emergency will utilize the procedures outlined in HICS - Activation and Termination.

D. Incident Levels and Phases

1. **Emergency Response Level 1:** Potential Emergency - An unusual event or potential emergency effecting a single department of a single building area. The situation is an isolated incident. Life safety is not threatened and patients are not adversely affected.
2. **Emergency Response Level 2:** Localized Emergency - An emergency situation affecting multiple departments or buildings. Patients may be affected and life safety may be threatened.
3. **Emergency Response Level 3:** Major Disaster – A major disaster affecting buildings, utilities and patient care. Life safety may be threatened. Code Triage is in effect. Multiple Casualty Incident (MCI) patients are arriving at hospital Emergency Department at a time when buildings and utilities are damaged or disrupted and personnel are affected.

An "All Clear" may be called while the recovery efforts continue until the hospital is back to normal

operations.

Details on the levels of incidents and phases are outlined in HICS - Activation and Termination .

E. Alternate Care Site

In a major emergency situation, there is a possibility that the buildings or spaces in which patient care is normally provided will be rendered unusable. In this event, an alternate care site will designated as a location on the facility grounds or within the community. More information on the selection of Alternate Care Sites is available in EM – Surge Plan - 03.00 Hospital Surge Capacity Plan – Alternate Care Sites.

- 1135 Waiver
  When the President declares an emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency, the Secretary may temporarily waive certain EMTALA sanctions during the emergency period. The hospital may request the waiver after implementing a disaster protocol. Refer to procedure HICS - Alternate Care Sites - Requesting 1135 Waiver for details.

VII. Communication Management

A. Internal Communication & Staff Notification

1. Staff shall be notified of an incident utilizing overhead pages through the Fire Alarm System (FAS) or through other methods as outlined in EM - Internal Communications Plan. This plan also includes back-up communications systems within the hospital.

B. Notification & Communication with External Authorities

When an emergency plan is initiated, the appropriate external authorities and community resources will be notified. Contact information can be found in: ***HICS - Communication with Hospitals, City, County and State***.

C. Communication with Patients & Family

1. A family support center may be established to coordinate the needs and information to family members of patients, to coordinate the information on the location of patients, and to provide critical incident stress debriefings.
2. These activities will be managed by the Logistics Section with the Support Branch and the Family Unit Leader.
3. There will be direct communication with the Patient Tracking Manager for tracking of patients.
4. If the emergency contact family member is not present with the patient, they will be contacted with the location of the patient once they are moved or evacuated.
5. Additional information on communications with family in the event of a patient discharge or transfer is available in Patient Discharge - Transfer Plan.

D. Communication with Media

1. The Public Information Officer (PIO) is responsible for interacting with media and public information.
   a. For internal events, the PIO will develop communications to staff and community with the authorization of the Incident Commander in the HCC.
   b. If the event is external to the hospital, the county Joint Information Center (JIC) will coordinate

with the PIO to develop a unified message.

E. Communication with Suppliers

A list of suppliers, including vendors, contractors, and consultants that can provide specific services before, during, and after an emergency event is available in the Command Center. The list will be maintained by the individual that normally interacts with the purveyor. Where appropriate, Memoranda of Understandings (MOUs) are developed as needed to help facilitate services during the time of a community event.

F. Communication with other Health care Organizations

1. A working relationship has been established with other healthcare organizations within Santa Clara County. A Memorandum of Understanding (MOU) is in place to share resources as needed and available.
2. Key information to share with the other healthcare organizations includes:
    a. Command systems & other command center information
    b. Names & roles of command center system
    c. Resources & assets to be potentially shared
    d. Process for the dissemination of patient & deceased individual names for tracking purposes
    e. Communication with third parties
3. Inter-agency communications is maintained through several channels:
    - Telephone
    - 2-Way Command Radio
    - EM-Resources – online hospital status reporting in real-time
    - WebEOC – web-based system for sharing status and requesting resources
    - Amateur Radio - volunteer radio operator system
4. Patient information that must be shared with the other healthcare organizations, local or state health departments, or other law enforcement authorities on the whereabouts on patients during an emergency will be transmitted in accordance with applicable laws and regulations.

G. Alternate Care Site Communications

The Command Center will maintain communications with the Alternate Care Site (ACS). Once an ACS has been established, the site will initiate contact with the HCC and may establish an Alternate Care Command Center (ACCC).

VIII. RESOURCE & ASSET MANAGEMENT

A. Obtaining & Replenishing Medical, Non-Medical & Medication Supplies

The amounts, locations, processes for obtaining and replenishing of medical and non-medical pharmaceutical supplies, are evaluated to determine how many hours the facility can sustain before replenishing. The inventory of resources and assets is the starting point of par levels.

Mutual Aid Agreements have been developed to expedite receipt of items when needed. The MOU

Agreements references the agreement with the other healthcare organizations on response of assets.

B. Monitoring Resources and Assets

During the emergency, the Logistics Chief will monitor the overall quantities of assets and resources. This information will be communicated to the HCC and to those in the community.

IX. SECURITY & SAFETY MANAGEMENT

A. Managing Hazardous Waste

The hazardous waste generated after decontamination and during isolation procedures, including biological, chemical, and radioactive waste will be stored in the appropriate location and with sufficient security. This would also include the waste that would accumulate during an emergency, but not removed because of vendor issues. A list of alternate vendors will be maintained.

B. Biological, Radiological & Chemical Isolation & Decontamination

For contagious patients in need of isolation, consult the Infection Control guidelines located in the Infection Control Manual for isolation and standard precautions. For contaminated patients, Decontamination Procedures would be implemented.

C. Access & Egress Control

The facility "lock down" procedures will be implemented when deemed appropriate by the Incident Commander (IC) to provide the proper control of access and egress to the facility.

D. Traffic Control

The IC will initiate a Traffic Control Plan to manage the movement of personnel, vehicles, and patients both inside and on the grounds of the facility if deemed appropriate.

1. Security staff will assist in the movement of vehicles, including cars, and emergency and commercial vehicles, on the grounds.
2. When appropriate, local law enforcement will be contacted for assistance in the management of traffic on the grounds of facility.

X. STAFF MANAGEMENT

A. Roles and Responsibilities

When HICS is established, the HICS Chart and Job Action Sheets are used to assure critical task positions are filled first. As other staff members become available, they are assigned to the most critical jobs remaining.

If staff is not available for handling critical tasks defined by the Job Actions Sheets, staff will be drawn from the appropriate departments or, if none are available, from the labor pool.

As staff is called in, they will replace personnel on tasks they are better qualified to perform. If questions arise, the Section Leaders will determine who will perform the task. The tasks are evaluated frequently to assure the most appropriate staff members available are being used, burnout or incident stress problems

are identified, and staff members in these jobs are rotated as soon as possible.

B. Managing Staff Support Activities

During activations of the Emergency Operation Plan (EOP), the following accommodations are authorized:

1. Where necessary because of conditions, the hospital will accommodate staff that need to sleep, eat, and/or other services in order to be at the hospital to provide needed services.
2. The Logistics Chief with the Service Branch Staff Food and Water Leader will handle the needs of staff during the emergency. The Logistics Chief is authorized to modify the normal use of hospital space and to work with local hotels and motels to provide accommodations for staff. Meal service for staff is authorized where approved by the Logistics Chief.
3. Preparation is made for incident stress debriefings. These areas will be staffed by Concern, the hospitals EAP and/or staff from community mental health services, clergy, and others trained in incident stress debriefing.
4. Communication to staff family members will also be arranged through the Staff Family Support Leader.

C. Managing Staff Family Support Activities

During activations of the EOP, the IC will determine if various accommodations may be made for staff's families to assist staff availability for providing their services.

D. Training and Identification of Staff

1. Training: The staff identified in the critical areas will receive the appropriate training in HICS and NIMS prior to an event.
2. Identification:
   a. HICS identification apparel is issued to the appropriate roles in the HICS.
   b. Employees will wear their hospital identification badges at all times during the emergency.
   c. Additional identification will be distributed, as needed to all serving in specific roles during the emergency.

XI. MANAGING UTILITIES

During an emergency, alternate means will be provided for essential utility systems as identified in the plan. These utility systems are identified as well as alternate means for providing the services. The organization will assess the requirements needed to support these systems such as fuel, water, and supplies for a period of time identified. This assessment includes the requirements for 96 hours without community support.

The alternative utility systems and supplies networks shall include, but not be limited to the following:

- Emergency power supply system
- Water supplies for consumption and essential care activities
- Water supplies for equipment and sanitary usage
- Fuel supplies for building operations, generators, and essential transportation services
- Medical gas systems
- Ventilation systems, Vacuum systems and Steam

- Other essential utilities

XII. MANAGING PATIENT CLINICAL & SUPPORT ACTIVITIES

A. Clinical Activities

Clinical activities for the treatment of patients during an emergency include triage, scheduling, assessment, treatment, and discharge. Whenever possible, the routine policies for patient services will be utilized.

B. Evacuation Activities

An evacuation of the hospital for a situation, which renders the facility no longer capable of providing the necessary support patient care, treatment and services, will be directed by the IC. The evacuation will be handled in cooperation with local police, fire departments and county EMS agency.

C. Vulnerable Patients

The policy on the clinical services includes providing for treatment of special patients during an emergency includes pediatrics, geriatrics, and disabled. This may also include patients with serious chronic conditions such as mental health or addiction.

D. Personal Hygiene and Sanitation Requirements

The HCC will determine appropriate alternative for personal hygiene. This can include baby wipes, personal wipes, or alcohol-based rubs. Family members can also assist to clean the patient during an event. If toilets are inoperable, bags in toilet, bucket brigade, other appropriate alternatives can be used.

E. Mental Health Services

During an emergency, mental health services will be provided to the patients when deemed necessary. Mental Health and Addiciton Services (MHAS) will track these patients receiving these services during the emergency.

F. Mortuary Services

In the event of deceased patients, the local medical examiner will be contacted for the appropriate clearance and procedures.

G. Patient Tracking: Internal & External

Patients will be tracked using current policies of the department. This includes discharge or transfer patient. That information will be given to the Patient Tracking Manager who will track all the patients within the facility during disaster. The form to use for patient tracking will be the *HICS* 254 – Disaster Victim Patient Tracking Form. Staff shall follow internal procedures for tracking patients and notifying patient families.

If patients are evacuated, the following HICS forms should be utilized:

- *HICS* 260 – Patient Evacuation Tracking Form, for individual patients.

- HICS 255 – Master Patient Evacuation Tracking Form should be used to gain a master copy of all those that were evacuated.

XIII. DISASTER PRIVILEGES

A. Volunteer Licensed Independent Practitioners (LIP)

Disaster privileges may be granted to volunteer licensed independent practitioners (LIP) when the EOP has been activated and the hospital is unable to meet immediate patient needs.

The Medical Staffing Office is responsible for granting disaster privileges to volunteer LIP and will distinguish volunteer LIP from other LIP's. Refer to Policy/Procedure: Medical Staff- Privileging Licensed Independent Practitioners During Disaster Events.

B. Other Licensed Volunteers (non-LIP)

Disaster responsibilities may be assigned to volunteers that are licensed, certified and/or registered in a skilled healthcare position when the EOP has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

The hospital identifies the individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not a LIP and will distinguish volunteer practitioners who are not LIP's from its staff. The hospital will oversee the performance of volunteer practitioners who are not LIPs who are assigned disaster responsibilities by direct observation, mentoring, or medical record review. Refer to ***HICS - Volunteer Credentialing***.

XIV. EMERGENCY RESPONSE PLANS

Emergency Plans for the incident types listed below can be found in the Emergency Management section of the Safety Tab on the Toolbox.

- Closed Point of Dispensing (POD)
  - This plan coordinates the hospital planning and response actions during a public health emergency requiring medical countermeasures given to a group of people at risk of exposure to a disease in accordance with public health guidelines or recommendations.
- Earthquake
- Hospital Evacuation / Shelter in Place
  - This plan provides a framework for sheltering-in-place and evacuation when hazardous conditions develop to the degree that the facility and/or first responders must take action to protect patients, visitors and staff.
- Hospital Surge
  - This plan is intended to assist the hospital in thinking through critical issues related to healthcare surge in emergency situations
- Mass Fatality
- Pandemic
  - This plan is intended to protect employees, physicians, volunteers, patients, contractors, and visitors minimizing exposure to a pandemic influenza event

Additional plans and procedures are available through Facilities, Nutrition Services and Material Management.

XV. PLAN EVALUATION AND PERFORMANCE IMPROVEMENT

A. The following events will be reviewed and critiqued to determine the effectiveness of the Emergency Management Plans.
    1. Planned exercises
    2. Actual events impacting or having the potential to impact hospital operations.

B. Assessment is conducted through the analysis of the information and reports that create an overall critique of the disaster event or exercise to determine:
    1. If plans and job actions are appropriately designed.
    2. The level of performance of systems and individuals.
    3. The level of improvement from prior events.
    4. The effectiveness of redesigned plans and job actions.

C. Opportunities for improvement are continuously evaluated and implemented through the Emergency Management Committee.

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	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2020
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2020
Emergency Management Committee	Steve Weirauch: Mgr Environmental Hlth&Safety	10/2020
	Steve Weirauch: Mgr Environmental Hlth&Safety	10/2020

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Ben Inglis, COO
Date: December 9, 2020
Subject: Major Projects Update – For Information

Purpose: To keep the Finance Committee and the Board informed on the progress of major capital projects in process.

Summary:

1. Situation: **Taube Pavilion** (aka BHS): Upon receipt of the special safety glass for the "Life Safety" barrier wall the project will be 100% complete. We have been able to open two of the six rooms impacted and once the safety glass has been installed the remaining rooms will be put into service. The close out of the construction contract is nearly complete and the projected final cost is approximately $992,000 over the project budget.

Sobrato Pavilion (aka MOB): The only two remaining scopes of work are nearly complete. The right turn lane from Grant Road needs stripping to be done and the completion of the 3 hour wall upgrade in the connector is pending inspections and approvals. The close out of the construction contract is nearly complete and the projected final cost is approximately $984,000 below the project budget.

Women's Hospital: The plans and specifications for the project are nearing the end of the OSHPD review process and we expect plan approval in early January. The General Contractor has been receiving competitive bids for the work of the project and we will have a final GMP proposal in early December. The plan is to bring the final funding request forward to the Finance Committee in January 2021 and to the Board in February 2021.

M.V. Campus Completion Project (Phases 1 and 2) which includes the demolition of the old main hospital has received OSHPD plan approval. We have delayed the start of this project until the early spring of 2021. In addition to slowing spend of capital dollars this will allow more time to explore and consider the Phase 3 development options which are still under consideration.

Radiation Oncology Equipment Replacement Project: The preparations are underway to install the first piece of new treatment equipment the HDR Brachytherapy Unit in early December. The CyberKnife equipment has been removed and construction activities are underway to prepare the room for the new treatment equipment. Everything is currently on schedule and there are no issues.

Interventional Equipment Replacement Project: The plans are working their way through the OSHPD plan review process and we anticipate bringing the final funding request forward to the Finance Committee in January 2021 and to the Board in February 2021.

Imaging Equipment Replacement Project: We plan on submitting the plans for OSHPD plan review in January 2021 and anticipate plan approval in early Fall.

2. Authority: This memo is to keep the Finance Committee and the Board informed of the progress towards completion of the major development projects within the Mountain View Campus Development Plan.

□a□or Pro□ects □pdate
□ecem□er 9□2020

3. □ac□gro□nd: □he □oard of □irectors approved the □o□ntain □ie□ Camp□s □evelopment Pro□ects □hich consist of the follo□ing:

□tep □:	□tat□s
□orth Par□ing □arage E□pansion □	Complete
□ehavioral Health □ervices □□ilding □	□□□stantially Complete □Occ□pied
□ntegrated □ edical Office □□ilding □	□□□stantially Complete □Occ□pied
Central Plant □pgrades □	Complete
□tep □□:	
Women's Hospital Expansion □	Plan Revie□/Permit
□emolition of Old □ ain Hospital □	On Hold □Phases 1 □2

4. □ssessment: □n addition to the constr□ction activities□all impacted departments are □or□ing on the activation□training□move planning and □□dgeting for the f□t□re state of operations.

5. Other Revie□s: □he □inance Committee revie□ed this report at its □ovem□er 23□2020 meeting.

6. O□tcomes: □s stated in the stat□s □pdates.

EL CAMINO HOSPITAL
DRAFT RESOLUTION 2020-12

APPOINTMENT OF SPECIAL COMMITTEE FOR LIMITED PURPOSE AND LIMITED DURATION

WHEREAS, the Board of Directors has determined it is critical to the future of El Camino Hospital to review and further define its appropriate strategic directions,

WHEREAS, such work can be undertaken by a special committee for presentation to and consideration by the Board of Directors at a future meeting; now, therefore, be it

RESOLVED, that a temporary special committee, consisting of four members is hereby established pursuant to Section 7.2 of the Bylaws of El Camino Hospital, to work with management to update the strategic plan for presentation to, discussion with and consideration by the Board of Directors during fiscal year 2021, be it further

RESOLVED, that the members of the temporary special committee shall determine the time, place, date and frequency of such committee meetings; be it further

RESOLVED, that the chairperson and the members of the temporary special committee are hereby appointed pursuant to Section 7.4 of the Bylaws of El Camino Hospital as follows:

Chairperson: _____

Members:

_____

_____

_____

_____

DULY PASSED AND ADOPTED at a regular meeting held on December 9, 2020, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
Julia E. Miller, Secretary
ECH Board of Directors

El Camino Health

OPEN SESSION CEO Report
December 9, 2020
Dan Woods, CEO

Quality and Safety

The hospitals in Santa Clara County are collaborating to manage the impact of the COVID-19 pandemic on delivery of care in our county. All hospitals currently operate under a voluntary County of Santa Clara Hospital Mutual Aid System Memorandum of Understanding, which outlines the framework for a Hospital Mutual Aid System (H-MAS), provides the means for the hospitals to coordinate among themselves and work as a unit during an emergency event, and signifies their commitment to support partner facilities in our community.

As of December 1, 2020, El Camino Health (1) has not been asked to accept transfers of COVID-19 positive patients outside our health system, (2) is currently managing our COVID-19 patient population while continuing to schedule surgeries and elective procedures as usual, and (3) has adequate Personal Protective Equipment, ICU and Medical-Surgical bed capacity. Also, except for the Emergency Department, we are operating our Los Gatos Hospital as a COVID-19-free facility. Our overall system-wide COVID-19 test positivity rate is 2.6%. We have created plan for managing a larger number of COVID positive patients and will implement this plan should need arise.

We continue to make every effort to provide a safe environment for patients, staff and visitors, including the establishment of a separate waiting area for our emergency patients with non-COVID and non–respiratory symptoms. Visitors are screened at our entrances for COVID-19 symptoms, all employees are screened daily and required to wear medical grade masks while on site and eye protection in clinical areas. In addition, we dramatically reduced seating capacity in the cafeteria and breakrooms and are almost exclusively using teleconferencing for meetings. Unfortunately, we reinstated the previous "no visitor" policy with modest exceptions for maternal child health, pediatric and end of life patients as well as patients with cognitive impairments.

Operations

CathLab Digest, a product, news and clinical update for the cardiac catheterization laboratory specialist, spotlighted ECH's structural heart program for its accomplishment of attaining Valve Center of Excellence Certification from the American College of Cardiology in its December issue (see attached).

The Heart & Vascular Institute (HVI) attained a 4-Star rating, the highest rating possible, from the American College of Cardiology for public reporting for All Heart Attack Care and Urgent Heart attack care and saw its first cardio-oncology patients in the Advanced Care and Diagnostic Center in November 2020. This collaboration with

the Cancer Center ensures patients undergoing specific types of cardio-toxic chemotherapy drugs are adequately diagnosed and treated for cardiac disease that could develop as a result of their cancer treatment.

Community COVID-19 Testing

ECH continues to provide testing through the El Camino Healthcare District Community COVID-19 Testing Program. Over 12,000 tests have been administered at sites throughout the District, including our Mountain View campus, public school sites and downtown retail locations. Students, in addition to school employees, are offered testing at public school sites where requested. Capacity at the Mountain View campus is still 100 tests per day and 200 tests per day at the pop-up sites, but we are working to expand capacity due to high demand. We continue to bill insurance, but use District funds where insurance is not available. In addition to supporting the District Program, ECH began administering a no-cost testing program at sites in the Los Gatos area on November 5, 2020.

Corporate and Community Health Services

The NASA Ames Research Center (ARC) Employee Health and Wellness Program which includes CONCERN, is receiving the NASA Group Achievement Award, which is one of the most prestigious awards a group can receive by making outstanding contributions to the NASA mission. ARC received the highest score among 180 worksites.
Our webinars reached 1,500 participants in the last 60 days. The most popular topics are Managing Emotions During Turbulent Times, Survival Strategies for Remote Workers, Mindful Self Awareness, and Five Strategies for a Safe and Enjoyable Holiday Season.

Community Benefit staff launched the 2022 Community Health Needs Assessment triennial process with local nonprofit hospitals and Sutter Health/ Palo Alto Medical Foundation. We also reached out via e-mail to promote the FY20 Community Benefit Report with elected officials including school board members, the ECH and ECHD Boards, the El Camino Health Foundation Board, internal leadership, corporate social responsibility staff at local companies, grant partners and community stakeholders.

The South Asian Heart Center (SAH) hosted a virtual huddle with Dr. Alka Kanaya, on the MASALA study on heart disease with 67 attendees and a Healthy Diwali Treats online demonstration with ASAWA organization with 69 attendees. SAH also introduced "AIM to New Beginnings," a diabetes prevention program for new parents with Dr. Packard for the Los Gatos OB/GYNs.

The Chinese Health Initiative (CHI) concluded the Diabetes Learning Series with 74% of participants meeting their target BMI goal and distributed an updated digital version of "Health Resource Guide for Chinese Seniors" to help seniors navigate the healthcare

system and access community resources. CHI also hosted an Ask-A-Doctor webinar, conducted by Dr. Xiao Wan (Allergy) on "Asthma during Pandemic, Fire, and Flu Season."

Marketing and Communications

El Camino Health, along with approximately 120 others, participated in a national hospital/health system masking campaign lead by the Cleveland Clinic "Every Mask Up" to inspire consumers to wear masks to reduce the spread of COVID-19 (https://www.elcaminohealth.org/newsroom/el-camino-health-joins-top-us-hospitals-encourage-everyone-maskup?s=ech_homepage). The campaign included national print and digital media. In addition, ECH participated in a regional health system version of this campaign for the week of Thanksgiving in regional print media including The San Jose Mercury News, The San Francisco Chronicle, The East Bay Times, and The Marin Independent Journal.

To improve access to the El Camino Healthcare District's COVID-19 Testing Program, we added directions in Spanish and Chinese to further support the diverse needs in our communities.

Our search engine marketing and social media campaigns continue to support awareness about what ECH does to ensure safe care as well as our key service lines. We updated visibility of the Annual Community Benefit Report to the newest version and added upcoming El Camino Health Foundation events to our website. We also published 7 blog articles for the November HealthPerks newsletter covering holiday safety, active living for seniors, healthy lungs, skin care, a roasted vegetables recipe, an overview of antibacterial soap, and other health tips.

Media Coverage for November 2020

- November 1, 2020 Patch (Los Gatos) No-Cost Coronavirus Testing At El Camino Health's Los Gatos Hospital On November 5 and 19, 2020
- November 4, 2020 Silicon Valley Business Coronavirus roundup: NFL puts San Francisco 49ers under the microscope for COVID cases
- November 4, 2020 Los Altos Town Crier LASD rolls out free COVID-19 testing for students
- November 11, 2020 AiThority ScoreData and NTT DATA Announce Multi-Year Agreement
- November 15, 2020 Washington Post South Asian Americans face disproportionately higher risks of heart disease, other cardiovascular ailments
    - Picked up by 200+ outlets
- November 16, 2020 Healthcare Design Photo Tour: Integrated Medical Office Building Sobrato Pavilion

Philanthropy

The El Camino Health Foundation secured $358,236 in period 4 of fiscal year 2021, bringing total fundraising thus far in FY21 to $1,229,196, which is on par with last year and is 15 percent of goal. A full report is attached.

Auxiliary

Auxiliary volunteer hours for the month of November were not available as of the date of publication of this report.

Cath Lab Digest

A product, news & clinical update for the cardiac catheterization laboratory specialist

PROGRAM SPOTLIGHT

El Camino Health

Amy Maher, Executive Director
Norma Melchor Heart & Vascular Institute, El Camino Health, Mountain View, California

Can you give us an overview of the structural heart program at your hospital?

El Camino Health is proud to offer one of the top structural heart programs in the country, one of many specialized offerings within our Norma Melchor Heart and Vascular Institute.

Every year within our 24-bed coronary care unit, we perform an average of 100 aortic and mitral valve repair or replacement surgeries, 100 transcatheter aortic valve replacements (TAVRs), 25 Watchman (Boston Scientific) procedures and 55 MitraClip (Abbott Vascular) procedures, the volume of which continues to grow as indications for the intervention expand.

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In This Issue

CUTTING-EDGE SYSTEMS

Robotic-Assisted Intervention at the University of Virginia Cath Labs

Michael Ragosta, MD, Director of the Cardiac Catheterization Laboratories and Director of Interventional Cardiology, University of Virginia Health System, Charlottesville, Virginia

Could you describe your work and cath lab?

I am the Director of the Cardiac Catheterization Laboratories and Director of Interventional Cardiology at the University of Virginia Health System (UVA). We have a very busy cath lab with five labs and offer the whole spectrum of interventional procedures. We have a robust, high risk and complex coronary intervention program, a heart failure transplant service treating heart failure and offering percutaneous mechanical circulatory support, and a busy structural heart program. In addition, we treat pediatric and congenital patients, and of course, offer standard coronary diagnostic and interventional procedures. My practice is focused on complex coronary disease intervention and structural heart work. UVA is a referral center, so we get a number of referrals for rotational atherectomy, left main intervention, patients who were turned down for coronary bypass surgery, and patients with multivessel coronary disease, calcified coronaries, and chronic total occlusions.

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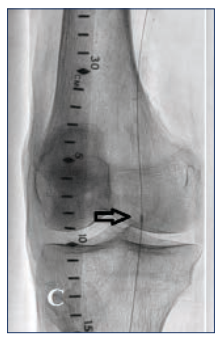
CASE REPORT

Treatment of Totally Occluded Popliteal Artery With the Auryon Laser Via Pedal Access in a Patient With Critical Limb Ischemia



Nicolas W. Shammas, MD, MS; W. John Shammas, BA, MBA, Midwest Cardiovascular Research Foundation, Davenport, Iowa

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Continued from cover

El Camino Health

Amy Maher

Our team is also experienced in catheter-based tricuspid valve intervention, paravalvular leak closure and atrial septal defect (ASD)/patent foramen ovale (PFO)/patent ductus arteriosus (PDA) transcatheter closure. Our structural heart program leverages cutting-edge imaging capabilities for 3D valve modeling and adheres to nationally recognized echocardiography standards.

This summer, El Camino Health was recognized by the American College of Cardiology (ACC) with the first Transcatheter Valve Center of Excellence Certification in the state of California. The Society of Thoracic Surgeons also awarded El Camino Health with three-star performance for aortic valve replacement (AVR) and mitral valve replacement (MVR) procedures based on the quality of our patient outcomes — the highest rating possible for these procedures, which places us in the top two percent of hospitals in the nation performing these procedures.

Can you tell us about your heart team?

Our team is made up of a multidisciplinary group of physicians, advanced practice nurses, coordinators, and data analysts reviewing every case concurrently to ensure we provide high quality, appropriate care for each patient. An outcomes review team scrutinizes each case thoroughly, immediately identifying any opportunity for improvement in care. We consistently assess the quality of life of each patient prior to and after every procedure to ensure we are tracking toward improvement. Because we believe in continual growth, we offer our physicians quarterly education on quality of care and appropriate patient selection.

How many procedure rooms do you have? Can you tell us about your scheduling and volume?

El Camino Health offers five hybrid cath labs — with a sixth for additional structural heart procedures to be built in 2021. We can accommodate both same-day scheduling and advanced block scheduling. Our team performs an average of 300 catheter procedures or more every month, in addition to about 350 open heart surgeries annually.

How has your structural heart program evolved over the past few years?

In terms of mitral procedures, our early involvement with multiple clinical trials allowed us to help evaluate the expanding indications for the therapy. These include the EVEREST II REALISM trial dating back to 2009, and more recently the COAPT trial, both of which studied the effectiveness of the MitraClip implant. El Camino Health has also been participating in TAVR national clinical trials dating back to 2011. Thanks in part to these innovative trials, we have successfully grown the structural heart program each year, treating patients at all levels of risk.

Can you talk about your involvement with any clinical research?

Thanks to the presence of the MitraClip physician-pioneer Frederick St. Goar, MD, El Camino Health had early clinical access to the device, helped drive its research and development, and helped progress the technology to make it available around the globe for transcatheter mitral valve repair.

FIGURE 1. XXxxxxx

FIGURE 2. xxxxxxx

FIGURE 3. xxxxxxx

We have been participating in the TAVR national clinical trials since inception and have found it incredibly valuable for our program.

El Camino Health has had an active clinical research program dating back to the early 1990s, when our physicians were lead investigators in early acute myocardial infarction percutaneous coronary intervention (PAMI and CADILLAC) trials, as well as early intravascular ultrasound trials (CLOUT), establishing a tradition of high-quality clinical research that is still maintained. Trial efforts also included TRILUMINATE tricuspid valve repair with the TriClip (Abbott Vascular), and we will be participating in the upcoming CHAMPION trial evaluating the CardioMEMS device (Abbott Vascular).

Tell us more about your TAVR procedures and some of the changes that you have seen as TAVR has grown.

El Camino Health was one of the early adopters and investigators in the Medtronic TAVR trials and, at this point, offers the full portfolio of approved TAVR devices. We were also early innovators in

El Camino Health First in California to Be Recognized for Excellence With ACC Transcatheter Valve Certification

El Camino Health has been recognized with the Transcatheter Valve Certification from the American College of Cardiology (ACC), acknowledging its exceptional program, physician leadership, quality patient outcomes, and team-based care. El Camino Health is the first health care organization in the state of California to receive this certification.

"We are especially proud of this certification from the American College of Cardiology, as the entire transcatheter valve team has worked tirelessly to ensure our program is one of the best in the country," said Frederick St. Goar, MD, medical director of the Heart and Vascular Institute. "As with everything we do at El Camino Health, our number-one goal remains centered around delivering the safest, highest quality care and outcomes for our patients, and our cardiac programs are no exception."

The ACC's Transcatheter Valve Certification is an external review and certification process that identifies hospitals that are currently implementing best practices and clinical excellence in transcatheter valve procedures, which include replacing the aortic valve or repairing the mitral or tricuspid valves using minimally invasive techniques. El Camino Health's Norma Melchor Heart and Vascular Institute is recognized for its uniquely high quality, pioneering work in the heart valve space and offers advanced cardiac and vascular care at every stage of the health care continuum.

El Camino Health is advancing cardiology programs for patients with the recently opened, highly specialized Women's Heart Center — one of the only clinics of its kind in the region that offers comprehensive heart care for women. Heart disease is the leading cause of death for women in the U.S., but symptoms often go undiagnosed or untreated. Through the new Center, El Camino Health is addressing gender disparities by taking a personalized and prescriptive approach to treatment, considering lifestyle, stress and other factors with a heavy emphasis on prevention.

El Camino Health has also launched a Cardio-Oncology Program, which specifically treats patients at risk for developing heart issues as a result of cancer treatment. This program is the only community-based cardio-oncology clinic in the Bay Area, with only two others in the western U.S.

To learn more about El Camino Health's Norma Melchor Heart and Vascular Institute and the services it offers, visit www.elcaminohealth.org/services/heart-vascular. ■

FIGURE 4. Blexxxxx

minimalist TAVR, involving moderate sedation, percutaneous access, no Foley or neck lines or radial A-lines, early removal of pacemakers, and bypassing the intensive care unit.

What is the typical path of pre procedural testing for TAVR patients?

Patients are seen in the multidisciplinary valve clinic jointly by a structural interventionalist, a cardiac surgeon, coordinators, and nurse specialists. Computed tomgraphy angiography (CTA), echocardiograms, and electrocardiograms are then performed. The Kansas City Cardiomyopathy Questionnaire (KCCQ) is given, followed by a six-minute walk. A full workup is completed in just one visit.

Tell us more about your transcatheter mitral valve repair (TMVr) procedures and some of the changes that you have seen as TMVr has grown.

Our Heart and Vascular Institute medical director, Frederick St. Goar, MD, participated in the first-in-human MitraClip procedure in 2003, and he has, over the course of his involvement with this therapy, witnessed dramatic evolution in the technology, the way the procedure is performed, and its effective application in a growing population of patients. The new G4 MitraClip that we now routinely use facilitates exceptional outcomes far beyond what was imagined when he started the project 21 years ago. Volume has grown year over year with efficiencies in procedural time and improved outcomes, and consistent mild residual mitral regurgitation.

What is the typical path of pre procedural testing for mitral valve repair patients?

This begins with a dedicated transesophageal echocardiogram by our structural echocardiographer, and a visit with both an interventional cardiologist and cardiothoracic surgeon. The patient's history and objective data are discussed in a multispecialty meeting to determine the preferred, optimal care recommendation. Transcatheter-based therapy versus surgical mitral valve intervention versus medical therapy are all discussed.

Do you have a structural heart coordinator? Can you describe their role?

Yes, we have a clinical nurse specialist whose sole focus is the quality and outcomes review of every structural heart patient treated at El Camino Health. This role is also responsible for patient education and shared decision making. We also have a valve coordinator team, whose members follow each patient through the care continuum and ensure the coordination of all pre-hospital and post-hospital evaluation, as well as the completion of a quality of life survey.

What are some of the supplemental technologies that accompany structural heart disease and how have you incorporated them into your program?

At El Camino Health, we use quite a few supplemental technologies to treat structural heart disease, including:

- Extracorporeal membrane oxygenation (ECMO);
- Impella heart pump (Abiomed) for protected PCI/cardiogenic shock;
- 3D personalized valve modeling technology;
- HeartFlow FFR_{CT} non-invasive personalized coronary artery modeling (technology that was developed on the El Camino Health campus) to help us understand the presence and impact of coronary artery disease as we plan our treatment approach.

In addition, our echocardiography program is nationally accredited through the Intersocietal Accreditation Commission (IAC), and we are able to stay at the forefront of technology and device innovation thanks to our relationship with the Fogarty Institute for Innovation.

What do you see as the potential future of the structural heart program?

A few things come to mind for the future of our structural heart program at El Camino Health. We hope to see expanded indications for currently approved therapies, like left atrial appendage occlusion (LAAO) procedures for patients who are not at high risk for bleeding and transcatheter mitral valve replacement for de novo mitral valve disease. In addition, we expect to see even better tools for patient selection and promising advancements in imaging. ■

"The structural heart and transcatheter valve journey over the last 11 years has been exciting and rewarding. Being in Silicon Valley, we have and will continue to participate in the amazing journey from idea to helping patients. El Camino Health has been a great place to build a program that incorporates technology but always keeps the patient at the center. I tell my patients daily that I'm excited to see what we have to offer 10 years from now."

— Chad Rammohan, MD, Medical Director Cardiac Cath Lab, El Camino Health

Amy Maher
Executive Director, Norma Melchor Heart & Vascular Institute, El Camino Health, Mountain View, California

El Camino Health

EL CAMINO HOSPITAL BOARDFO DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: John Conover, Chair, El Camino Health Foundation Board of Directors
Andrew Cope, President, El Camino Health Foundation
Date: December 9, 2020
Subject: Report on El Camino Health Foundation Activities FY21 Period 4

Purpose: For information.

Summary:

1. Situation: El Camino Health Foundation secured $358,236 in period 4 of fiscal year 2021, bringing total fundraising thus far in FY21 to $1,229,196, which is on par with last year and is 15 percent of goal.

2. Authority: N/A

3. Background:

Major & Planned Gifts
In October, the foundation received a $300,000 gift from Pamela and Ed Taft to support nursing excellence for five years, including funds for the Magnet re-designation process. This brings cumulative FY21 major and planned giving to $1,063,567.

Annual Giving
In October, the foundation raised $43,585 in annual gifts from direct mail appeals, the 2021 Employee Giving Campaign, Circle of Caring grateful patient program, Hope to Health membership, matching gifts, online donations, and unsolicited gifts. This brings cumulative FY 21 annual giving thus far to $151,029.

Special Events
The El Camino Heritage Golf Tournament was postponed until next year but the foundation sent a 25th anniversary appeal message to golfers and tournament sponsors. We received $14,600 in September. Proceeds will benefit the patient family residence. Additional donations will be reflected in the next fundraising report.

Upcoming Events

- *Healthy Connections*, - a series of three virtual events featuring El Camino Health leaders and healers to help keep our donors connected to our hospitals and foundation. The first, Cardio-Oncology: A New, Multi-Disciplinary Approach to Health and Healing, was held on November 17 and featured Dr. Jiali Li, Dr. Jane Lombard, and Dr. Shyamali Singhal, with Dr. Mark Adams moderating. The two remaining events are:
    - *Finding Balance During Difficult Times* – January 20, 2021
    - *Building for the Future* – March 31, 2021

- *Norma's Literary Luncheon,* Thursday, February 4, 2021. The beneficiaries will be Lifestyle Medicine, South Asian Heart Center and Chinese Health Initiative. This will be a virtual event.

- *Allied Professionals Seminar*, Tuesday, February 9, 2020, featuring Erik Dryburgh, a principal in the law firm of Adler & Colvin, who specializes in charitable gift planning, endowments, and nonprofit organizations. The event will be held virtually.

- *Taking Wing*, a gala benefit for the Women's Hospital renovation, Saturday, May 1, 2021 at Los Altos Golf and Country Club.

COVID-19 Emergency Response Fund

The laboratory is validating the new high throughput analyzer and associated equipment purchased with donations to the response fund and anticipates full implementation in December. Because this equipment will significantly increase testing capacity, other providers are contracting to outsource COVID-19 testing to El Camino Health. The foundation will continue to allocate these donations as new COVID-19-related needs arise.

El Camino Health Foundation

FOUNDATION PERFORMANCE

FY21 Fundraising Report through 10/31/20 - Period 4

ACTIVITY		FY21 YTD (7/1/20 - 10/31/20)	FY21 Goals	FY21 % of Goal	Difference Period 3 & 4	FY20 YTD (7/1/19 - 10/31/19)
Major & Planned Gifts		$1,063,567	$6,500,000	16%	$300,051	$790,697
Annual Gifts*		$151,029	$650,000	23%	$43,585	$121,817
Special Events	Chinese Health Initiative Event	$0	$125,000	0%	$0	$12,045**
	Golf	$14,600	$325,000	4%	$14,600	$168,327
	Norma's Literary Luncheon	$0	$200,000	0%	$0	$120,950
	Taking Wing Gala	$0	$350,000	0%	$0	$22,500
TOTALS		**$1,229,196**	**$8,150,000**	**15%**	**$358,236**	**$1,236,336**

* Employee giving payroll deductions will be included as they are received beginning CY21/EGC21

** South Asian Heart Center Event

Highlighted Assets through 10/31/20 - Period 4

Board Designated Allocations	$595,927
Donations - Restricted	$14,590,226
Donations - Unrestricted	$3,605,744
Endowments - Donor	$7,133,009
Endowments - Operational	$14,057,832
Investment Income	$143,847
Pledge Receivables	$3,664,115