El Camino Health

AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, November 11, 2020 – 5:30pm
El Camino Hospital 2500 rant Road Mountain ie C 4040

P R O E OF C FOR E EC E OR ER -2-20 E M RCH 18 2020 El C M 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 MEE E E ECO FERE 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 pu lic comment please use the phone num er listed a ove.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	anhee Chen oard Chair		**5:30 – 5:31pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	anhee Chen oard Chair		**information 5:31 – 5:32**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.* ritten Correspondence	anhee Chen oard Chair		**information 5:32 -5:35**
4.	**BOARD RECOGNITION** *Resolution 2020-10* **ATTACHMENT 4**	en ing C O	*public comment*	**motion required 5:35 – 5:40**
5.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 5**	ulie liger uality Committee Chair Mar dams M CMO		**discussion 5:40 – 5:55**
6.	**ADJOURN TO CLOSED SESSION**	anhee Chen oard Chair	*public comment*	**motion required 5:55 – 6:05**
7.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	anhee Chen oard Chair		**information 6:05 – 6:06**
8.	*Gov't Code Section 54957.6* for a conference ith la or negotiator anhee Chen: - FY21 CEO ase alary	anhee Chen oard Chair o Miller E ecutive Compensation Committee Chair		**discussion 6:06 – 6:16**
9.	*Gov't Code Section 54957.6* for a conference ith la or negotiator anhee Chen: - FY20 CEO ncentive Compensation ndividual core and Payout	anhee Chen oard Chair o Miller E ecutive Compensation Committee Chair		**discussion 6:16 – 6:26**
10.	**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**

copy of the agenda for the Regular oard Meeting ill e posted and distri uted at least seventy t o 2 hours prior to the meeting. n o servance of the mericans ith isa ilities ct please notify us at 650 88- 504 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
	Approval *Gov't Code Section 54957.2:* a. Minutes of the Closed □ession of the Hospital □oard Meeting □10/14/2020□ □ Minutes of the Closed □ession of the □pecial Meeting to Conduct a □tudy □ession of the Hospital □oard Meeting □10/28/2020□ ***Reviewed and Recommended for Approval by the Executive Compensation Committee*** c. Minutes of the Closed □ession of the E□ecutive Compensation Committee Meeting □□/28/2020□ d. Minutes of the Closed □ession of the E□ecutive Compensation Committee Meeting □□/22/2020□ *Health & Safety Code Section 32155* for a report of the Medical □taff□deli□erations concerning reports on Medical □taff □uality assurance matters*:* ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** e. □uality Committee Report □i□ Medical □taff Credentials and Privileges Report □ii□ □uality Council Minutes ***Information*** *Gov't Code Section 54957.6* for a conference □ith la□or negotiator □an □ oods*:* f. FY20 E□ecutive Performance □ncentive □cores and Payouts *Gov't Code Section 54956.9(d)(2)* – conference □ith legal counsel – pending or threatened litigation: g. ECHM□ Compliance Report			
11.	*Health & Safety Code Section 32155* for a report of the Medical □taff□deli□erations concerning reports on Medical □taff □uality assurance matters: - Medical □taff Report	□purva Marfatia□M□□ Enterprise Chief of □taff□ Michael □an□M□□ □os □atos Chief of □taff		**motion required 6:28 – 6:43**
12.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: - FY21 □1 □trategic Plan □mplementation □pdate	□an □ oods□CEO		**discussion 6:43 – 7:03**
13.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: - □emi-□nnual ECHM□ Report	□ruce Harrison□President□ □□M□□ □an □ oods□CEO		**discussion 7:03 – 7:48**
14.	*Gov't Code Section 54956.9(d)(2)* – conference □ith legal counsel – pending or threatened litigation□*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: - CEO Report on □egal □ervices and □e□ Programs and □ervices	□an □ oods□CEO		**discussion 7:48 – 7:53**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
15.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – □enior Management: - E□ecutive □ession	□anhee Chen□□oard Chair		**discussion 7:53 – 8:03**
16.	**ADJOURN TO OPEN SESSION**	□anhee Chen□□oard Chair		**motion required 8:03 – 8:04**
17.	**RECONVENE OPEN SESSION/ REPORT OUT** □o report any re□uired disclosures regarding permissi□le actions ta□en during Closed □ession.	□anhee Chen□□oard Chair		**information 8:05 – 8:06**
18.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.*	□anhee Chen□□oard Chair	*public comment*	**motion required 8:06 – 8:08**
	Approval a. Minutes of the Open □ession of the Hospital □oard Meeting □10/14/2020□ □ Minutes of the Open □ession of the □pecial Meeting to Conduct a □tudy □ession of the Hospital □oard □10/28/2020□ c. Election of Carlos □ohor□ue□and □e□Muro to Path□ays Home Health and Hospice □oard of □irectors d. Path□ays FY21 □udget e. □oard □ction Plan ***Reviewed and Recommended for Approval by the Executive Compensation Committee*** f. Minutes of the Open □ession of the E□ecutive Compensation Committee Meeting □□/22/2020□ ***Reviewed and Recommended for Approval by the Governance Committee*** g. □raft Revised Policy and Procedures for □omination and □ppointment of Community Members to the Board's Advisory Committees h. □oard Retreat □genda ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** i. □nnual □afety Report for the Environment of Care ***Reviewed and Recommended for Approval by the Medical Executive Committee*** □ Medical □taff Report			
	Information □ E□ecutive Compensation Committee Report l. FY21 Period 3 Financials			
19.	**FY21 CEO BASE SALARY**	□anhee Chen□□oard Chair	*public comment*	**possible motion 8:08 – 8:10pm**
20.	**FY20 CEO INCENTIVE COMPENSATION PAYOUT**	□anhee Chen□□oard Chair	*public comment*	**possible motion 8:10 – 8:12pm**
21.	**CEO REPORT** **ATTACHMENT 21**	□an □ oods□CEO		**information 8:12 – 8:14**
22.	**BOARD COMMENTS**	□anhee Chen□□oard Chair		**information 8:14 – 8:15**

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
23. ADJOURNMENT	□anhee Chen□□oard Chair	*public comment*	**motion required 8:15pm**

Upcoming Regular Meetings: □ecem□er □□2020□Fe□ruary 10□2021□March 10□2021□□pril □□2021□May 12□2021□ □une □□2021

El Camino Hospital Board

RESOLUTION 2020 - 10

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

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

WHEREAS, the Board wishes to honor and recognize Brian Richards for his steadfast audio visual support of El Camino Hospital Board meetings and unique audio visual needs as a result of the COVID-19 pandemic.

Since the beginning of the pandemic in March, the El Camino Hospital Board has held board and committee meetings using remote technology which adds complexity to the audio visual support for these meetings. Not only has Brian provided critical support to the Board, he has also assisted individual members ensuring they can effectively attend remote meetings. In addition to Board support, Brian supports remote meetings for El Camino Health, which often involve several hundred participants. These meetings, which require a heavy reliance on technology, are held without problems due in large part to Brian's knowhow and flawless support. Brian is available, respectful, professional and a true problem solver, especially in high profile situations.

WHEREAS, the Board would like to acknowledge Brian Richards for his unwavering commitment to supporting the audio visual needs of the El Camino Hospital Board and El Camino Health during these extraordinary times.

NOW THEREFORE BE IT RESOLVED that the Board does formally and unanimously pay tribute to:

Brian Richards

FOR YOUR COMMITMENT AND DEDICATION CRITICAL TO ENABLING THE BOARD TO EFFECIVELY GOVERN DURING THE COVID-19 PANDEMIC.

IN WITNESS THEREOF, I have here unto set my hand this **11TH DAY OF NOVEMBER, 2020.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee J. Chen, JD, PhD
Julie Kliger, MPA, BSN, RN
Bob Rebitzer
John L. Zoglin
Peter C. Fung, MD, MS, FACP, FAAN, FAHA
Julia E. Miller
George O. Ting, MD
Gary Kalbach
Jack Po, MD, PhD
Don Watters

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

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital □oard of □irectors
From: □ulie □liger□MP□□□□□□uality Committee Chair
Mar□□dams□M□□CMO
Date: □ovem□er 11□2020
Subject: □uality□Patient Care and Patient E□perience Committee Report

Purpose:

□o inform the □oard of the □or□of the □uality Committee.

Summary:

1. □he Clinical □ocumentation □ntegrity □C□□□report □as e□tracted from the consent agenda for further discussion. Proper clinical documentation is essential to maintaining an accurate medical record that is fundamental to good patient care. The CDI team's □or□is trac□ed □ith a dash□oard containing □ey performance metrics. For FY21 FY□□□88□ of Medicare patient charts and 82□ of all payor charts have □een revie□ed. Physician □uery response rate continues to □e 100□ □ith a very impressive agreement rate of 83□. Co-mor□idities-standard and ma□or-capture rates are a□ove national 80th percentile □enchmar□s.

   □he Committee was provided with a reference entitled: "The High-Performing Medical □roup□ From □ggregation of Employed Practices to an □ntegrated Enterprise□" □hich includes case studies from other organizations' experiences in this area.

2. Cheryl Rein□ing□R□□C□O□presented a recent patient e□perience letter from an individual □ho had an orthopedic procedure. □he patient □as very satisfied □ith the outcome□□ut felt that □etter communication regarding procedures prior to surgery could have □een improved.

3. □he first □uarter □oard □□EEEP □uality dash□oard □as presented to the Committee. Particular attention was placed on those metrics showing "red". There □as one C□□□□in □1 in our □cute Reha□□nit□□hich □as investigated and mitigation measures deployed. C. diff infections □ere □ust out of target □ith four cases so far in □1. Continued efforts to provide thorough cleaning/sanitation□hand □ashing□and preemptive identification of pre-e□isting C. diff in admitted patients are in progress. E□ throughput measures are at or □etter than □aseline □ut □elo□ target for FY21. □EP-1 □sepsis □undle□compliance is □etter than □aseline □ut still □elo□ target. □here □as one pre-term induction □hich put the PC-01 measure a□ove target. PC-02 □□□□ C-section rate □as higher than e□pected and this may □e due to several ne□ O□ practitioners entering our system □ut nonetheless □ill re□uire more emphasis to reduce this rate. □he □rithmetic O□served □O□/ □eometric E□pected □O□inde□is elevated □ut the previous □aseline of 1.0 has no□ □een recali□rated to 1.3 e□uivalent secondary to a change in ho□ this is calculated □ased on a different data e□tract methodology. □□ata field mapping□ Finally□several of the patient e□perience measures are □elo□ target at this point □ut countermeasures are □eing applied including more vigorous and consistent leader rounding. □he Committee as□ed a□out potential CO□□□-1□impact □ased on the severe restriction to visitors□since that is a clear dissatisfier for patients in the hospital or E□ and the Committee as□ed management to develop goals for the e□uity measures so that □e can measure ourselves. □he □□M□ □et Promoter □core is improving and is a□ove target.

4. Mar□ □dams M□, □MO, presented the □uarterly SV MD □uality update □ith the assistance of □ruce Harrison, President of SV MD, and □te □urness, □P for □uality for SV MD. □he Committee □as provided □ith □ac□ground pre-read material. □his included a revie□ of the corporate structure—□□M□ is a separate su□sidiary □ith a separate ta□ ID and its o□n □oard of Managers, □hich is responsi□le for monitoring SV MD performance including □uality. □t □as noted that in the ac□uisition of the □an □ose Medical □roup (□M□), not all physicians □ere included □ased on prior performance and that since the ac□uisition, □uite a fe□ ne□ physicians have □een recruited and added to the group. □s a result 40% of the □□M□ are recent additions essentially creating a ne□ group of high □uality physicians. □here are three □ey areas of focus for SV MD □ith respect to □uality and service:

a. HE DIS □Healthcare Effectiveness □ata and □nformation □et
b M□P□ □CM□ Merit □ased □ncentive Payment □ystem
c. NPS (□et Promoter □core

□oals have □een esta□lished as follo□s: For □uality, achieve top decile HE DIS Composite score □y 2023 and achieve M□P□ composite e□ceptional rating annually. □ hile there are many HE DIS and even more M□P□ measures, it is important to esta□lish a □asic set to □uild the processes and ha□its necessary to succeed into the future. For patient e□perience, the □ey measure is NPS □hich is a measure used □y many industries □ecause it correlates □ith gro□th and profita□ility. A comparison among regional medical group □uality scores produced □y □ntegrated Healthcare □ssociation (H□) □as provided to the committee □hich sho□s a □ide variation (SV MD □as not rated.) □here □as a ro□ust discussion among the committee mem□ers regarding the current state, future state, and the essential elements needed to move the □uality performance for□ard for SV MD. □he Committee also discussed □hether the lo□ measures on the HE DIS metrics is due to underperformance or incomplete capture of data in the EMR and re□uested that management provide clarity on this in the ne□t report. □t □as also emphasi□ed that □ust relying on metrics alone is not enough—the culture of the physician group is also critically important.

5. □en □ing, □□O, revie□ed the highlights of the annual Evaluation of the Environment of Care and Emergency Management. The rate of OSHA reportable incidents per 100 FTE's continue to decline in FY20 compared to FY19 □he total num□er of events decreased from 145 to 120. □here □ere no reporta□le Ha□ardous Materials incidents or □ aste □ ater □ischarge violations in FY20. □here □ere five loss of po□er incidents □ith no negative impact to operations. □he □au□e Pavilion, the □o□rato Pavilion and the □ illo□ Outpatient □urgery □epartment □ere all opened □ith proper training and education according to standards. □he response to COVID -19 placed an added strain on the environment of care □ut all challenges □ere met satisfactorily. □here has □een a continued increase in Code □ray (angry/violent person) incidents and the num□er of reporta□le □or□place violence episodes increased □y 23% year over year. Preventive maintenance of high-ris□ medical e□uipment □as only 88% compliant □ith a goal of 100%.

Attachments:

1. FY21 □oard □□EEEP □uality □ash□oard
2. FY21 Enterprise □uality □ash□oard

El Camino Health

Month to Quality Committee of the Board: November 2020

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 21, Q1 (unless otherwise specified by *)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 20	FY 21	FYTD21, Q1	FYTD21, Q2	FYTD21, Q3	FYTD21, Q4	FYTD21 Total
Safe Care	Risk Adjusted Mortality Index	0.74	0.76	*0.75				**0.75**
	Sepsis Mortality Index	0.96	0.9	0.76				**0.76**
	Serious Safety Events Rate (SSER) (baseline Dec'19 to Jun' 20)	4.28	4.00	*4.05				**4.05**
	Surgical Site Infections (SSI)	0.36	1.0 (SIR)	0.56				0.56
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.47	<= 0.48	0.51				**0.51**
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.15	<= 0.2	0.0				**0.0**
	Clostridium Difficile Infection (CDI) - HAI	1.46	<= 1.46	1.6				**1.6**
	Modified PSI-90 CMS HAC Reduction Program	0.919	0.90	0.898				**0.898**
Timely	Patient Throughput - ED Door to Admit Order	190 min	181 min	188 min				**188 min**
	Patient Throughput - Median Time Arrival to ED Departure	284 min	245 min	255				**255**
	ED Arrival to Direct Discharge for ED Patients	151 min	145 min	152 min				152 min
Effective	Risk Adjusted Readmissions Index	0.96	0.93	*0.89				**0.89**
	CMS SEP-1 Compliance Rate	70.9%	86%	74.6%				**74.6%**
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 1.29%	1.3%	*1.8% (1/57)				**1.8%**
	PC-02 NTSV C-Section	ENT: 24.0%	23.5%	*29.2% (103/353)				**29.2%**
	ECMN: CMS 165 Controlling High Blood Pressure	51.20%	63	59.0%				**67.0%**
	ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.30%	<45	31.0%				**30.4%**
	HEDIS: Composite	NA	3.0	3.25				3.25
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.32	1.00	1.316				**1.316**
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 18)	0.99	0.99	None updated annually, January			**0.99**
Equitable	Hospital Charity Care Support	20.5 mil	NA	66.2k				**66.2k**
	Clinic Charity Care Support	44.3k	NA	8.5k				**8.5k**
	Language Line Unmet Requests (data collection started Q2)	0.34%	NA	0.39%				**0.39%**
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.05	NA	3.98				**3.98**
		White: 3.79		3.81				**3.81**
		Asian: 3.64		3.54				**3.54**
Patient-centered	IP Enterprise - HCAHPS Likelihood to Recommend	83.1	83.6	80.7				**80.7**
	ED - HCAHPS Likelihood to Recommend	75.7	78.2	73.9				**73.9**
	ECHMN - HCAHPS Likelihood to Recommend	73.2	75.7	76.2				**76.2**
	MCH - HCAHPS Likelihood to Recommend	84.1	84.6	82.9				**82.9**
	OAS - HCAHPS Likelihood to Recommend	84.7	86.4	83.5				**83.5**
	NRC Net Promoter Score (NPS)	72.3	75	76.2				**76.2**

Report updated 10/28/20

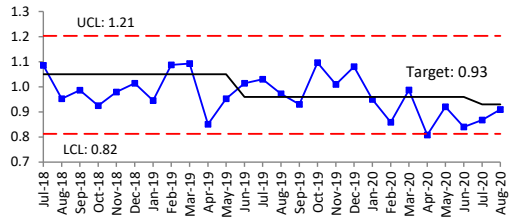
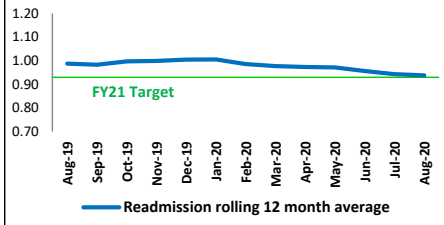
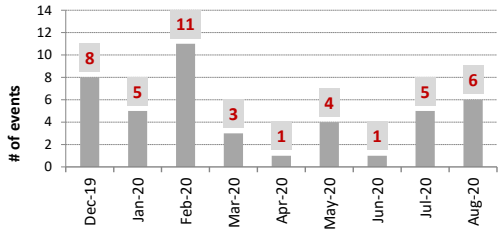
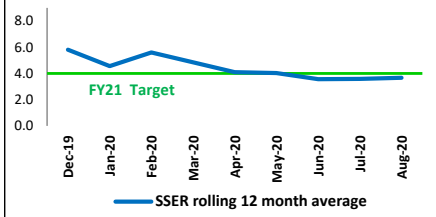
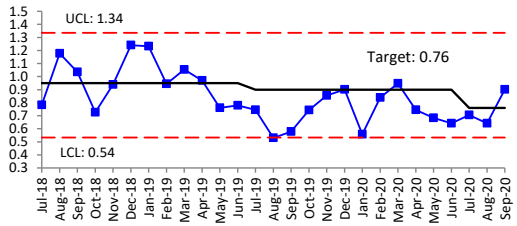
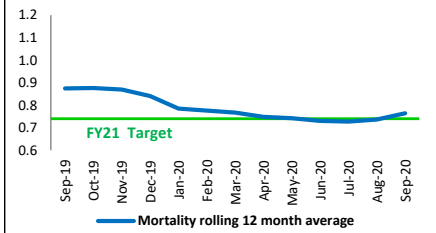
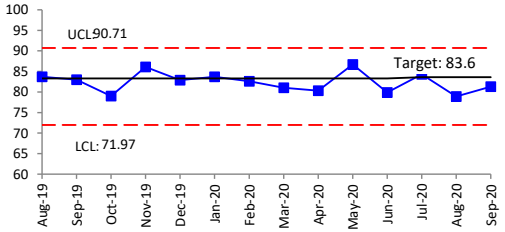
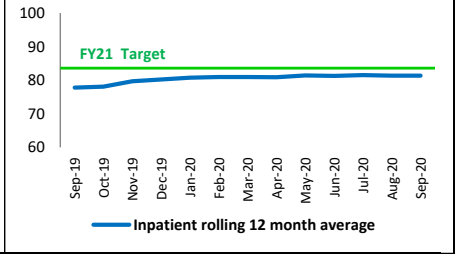
* data available FYTD 21 up to August only

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2020 (unless otherwise specified)

Month to Board Quality Committee:
November, 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: August 2020	0.91 (7.17%/7.88%)	0.89 (7.10%/7.99%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** **# of events** ***Latest data month: August 2020	6	11	4.28	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: September 2020*	0.90 (1.68%/1.86%)	0.75 (1.41%/1.89%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: September 2020*	81.3	80.7	83.1	83.6		

Definitions and Additional Information

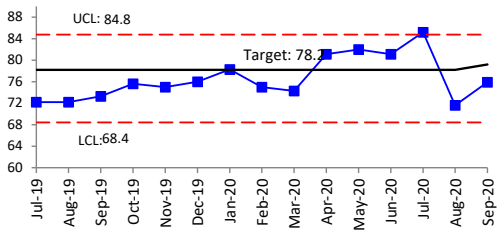
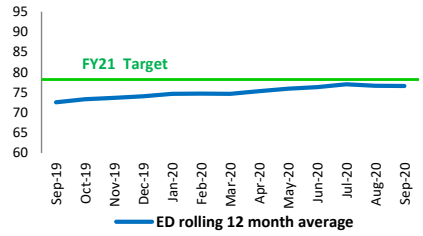
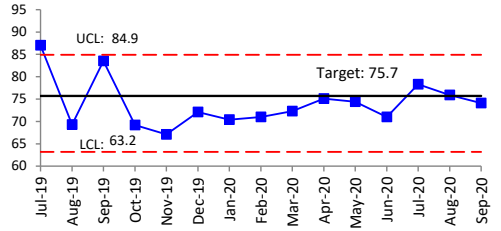
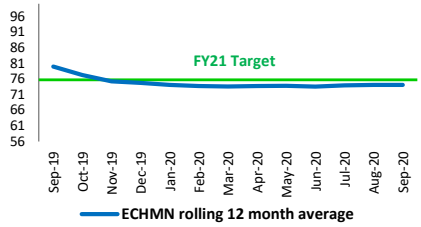
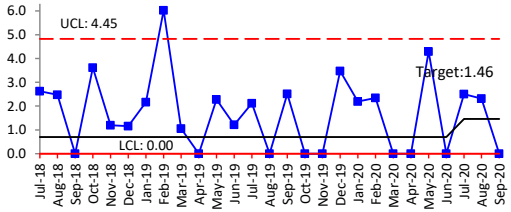
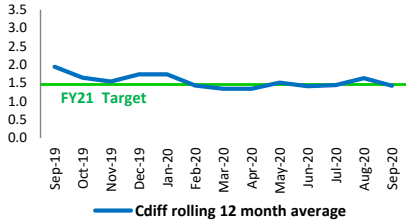
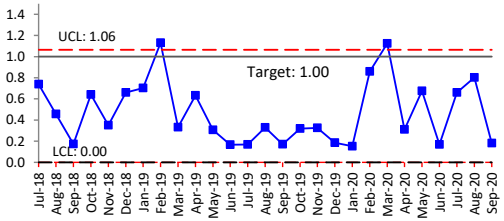
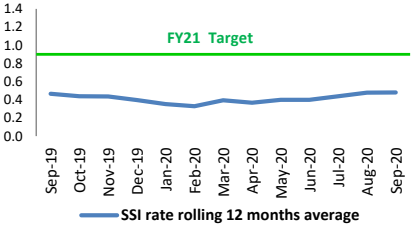
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)	ECH observed a higher number of readmissions in August (95) when compared to July (84). The Weekly Readmissions Team also noted an increase in August readmisisions due to refusal of palliative care in 7 cancer patients at end of life. These patients will be readmitted for symptom management that is not controlled at home and until they expire.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). Includes Inpatient and Psych patients. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2. Serious Safety Event Rate (SSER)	The # of Serious Safety Events in July and August are related to the increase in Surgical Site Infections (which by definitioin are SSEs). ECH has 5 SSEs in July of which 4 were SSIs, 6 in August of which 5 were SSEs. See the comments under metric #8 for more details. The remaining SSE involved a hypoglycimic event and was reported to CDPH.	Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI**
3. Mortality Index (Observed/Expected)	One reason for this increase in this index is the reduction in the expected mortality in September @ 1.89. In August, physician documentaiton of the severity of illness in the mortallity was very high at 2.14 . There were also more deaths in September (29) as compared to August (24).	Catherine Carson	Updated 7/1/19 (JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
4. Inpatient - HCAHPS Likelihood to Recommend Top Box Rating of 'Always' % , Unadjusted	Inpatient Total – Incentive Goal that includes Inpatient and MBU – 80.7 against a target of 83.6 This metric saw an increase in the month of September from the previous month but is still below the yearly target. The lack of visitation policy due to Covid-19 is driving this metric. Increased leader and nurse leader rounding and the roll out of our WeCare Behavioral Standards will help improve this metric.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2020 (unless otherwise specified)

Month to Board Quality Committee:
November, 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: September 2020*	75.9	73.9	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: September 2020*	74.1	76.2	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: September 2020*	0.00 (0/8329)	1.60 (4/24957)	1.46	<= 1.46		
8	Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: September 2020*	0.18 (1/550)	0.56 (10/1779)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

Definitions and Additional Information

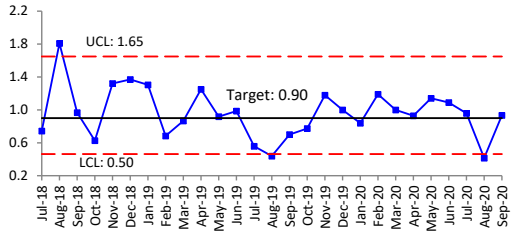
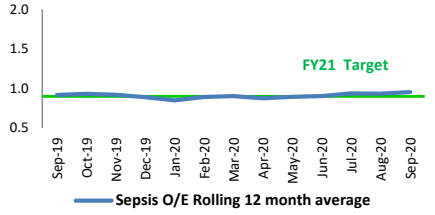
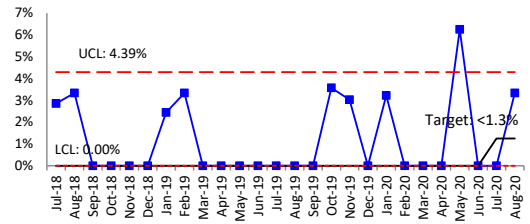
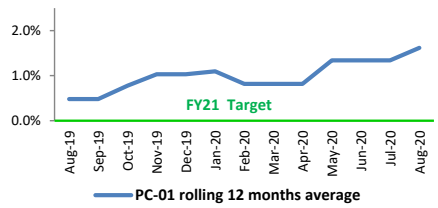
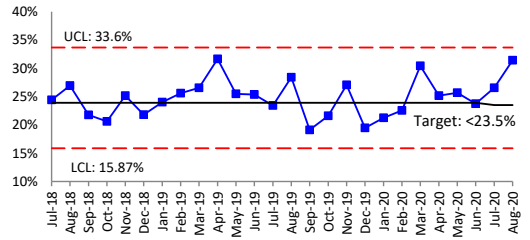
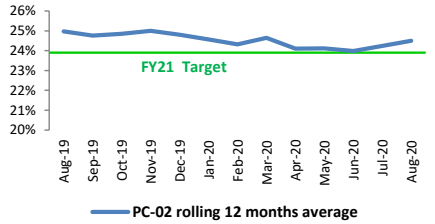
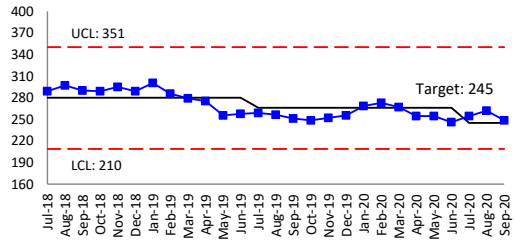
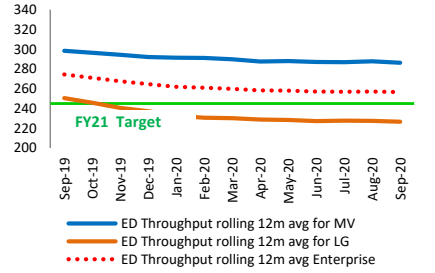
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
5. ED - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	ED- Incentive Goal 73.9 against a target of 78.2 Both Mountain View and Los Gatos are below our FY21 target despite an increase in the metric over the last 12 months. The lack of visitation, which is contributing to communications issues is being reviewed as this is a concern with our patients and families. Increased text options as well as a new revised visitor policy will help in the future.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
6. ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	8. SVMD –incentive goal 76.2 against a target of 75.7 Our SVMD Clinics are above target for Q1 FY21. We are currently focusing on the WeCare Rollout for SVMD which will occur for both leaders, staff and physicians in mid-November.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
7. Hospital Acquired Infection- C. Diff (Clostridium Difficile Infection)	No C.Difficile infections in the month of September!	Catherine Carson/Catherine Nalesnik	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN database - Inf. Control**
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	1 new SSI in MB in September; pt with robotic laparoscoic distal pacreatectomy developed abdominal abscess. October Quality Council briefed on increase of SSIS to 10 in 1st qtr of FY21. SSI taskforce reformed; OR managers/directors/educators met to develop an action plan to address issue with causal organisms, all but 1 are skin flora. OR action plan focusing on Handwashing, traffic in/out of Operating rooms, and audit/observaiton of surgical scrubs by nursing, physicains, techs and PA/NPs to begin in November. OB and Cath Lab to be included as 3 SSIs were involving Hysterectomies and Pacermaker insertion.	Catherine Carson/Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average .Lower Control Limit is not visible if it is less than or equal to zero .*	**CDC NHSN database - Inf. Control**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2020 (unless otherwise specified)

Month to Board Quality Committee:
November, 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: September 2020*	0.93 (11.71%/12.55 %)	0.76 (8.43%/11.04%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) ***Latest data month: August 2020*	MV: 0.00% (0/21) LG: 11.1% (1/9) **ENT: 3.33%** (1/30)	MV: 0.00% (0/39) LG: 0.0% (1/18) **ENT: 1.75%** (1/57)	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: August 2020*	MV: 31.3% (47/150) LG: 31.7% (13/41) **ENT: 31.4%** (60/191)	MV: 30.7% (43/140) LG: 20.00% (0/22) **ENT: 29.18%** (103/353)	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: September 2020*	MV: 271 min LG: 226 min **Ent: 249 min**	MV: 279 min LG: 231 min **Ent: 255 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

** updated up tp August

Report updated: 10/27/20

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
9. Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Though increased, Sepsis mortality index remains below the target. All mortalities are reivewed for bundle failures, for serioius safety events and may also be sent to Peer review.	Jessica Harkey, Catherine Carson	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	All scheduled cases are reviewed proactively. Data is also reviewed retrospectively. o Olny one case of ealry elective delivery at LG with clear indicaiton for an early delivery in a patient with significant autoimmune disease and recent complication of oligohydramnios.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
11. PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	New providers at LG. Service Line Leader and Medical Director are reviewing each case and sharing information with MCH medical staff.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
12. Patient Throughput- Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns	The Patient Throughput Value Stream for FY21 was kicked off with a 9 month scope of work focused on optimizing the Capacity Management Center and the entire patient throughput journey, from ED exit to ECH exit.To address Enterprise admit order to ED departure first set of work is focused on the patient Handoff and Transport process. We have posted positions for full-time Patient Flow Coordinators and the CMC is functional. Track and Status boards are up and optimized. The electronic SBAR handoff tool for ED transfers went live on 10/20/20. his change eliminates the need for a voice to voice transfer between the ED and the accepting floor RN, and removes the barrier of the RN's playing phone tag while helping to reduce the patient wait time in the ED. The entire nursing leadership team has been supporting the go-live, and all RN's have been trained and are starting this new handoff process. We are collecting feedback to optimize and stabilize the process throughout November.	Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, October 14, 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/reasurer **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. irectors Po and Re it er oined the meeting at 5:32pm during the call to order. ll other oard mem ers ere present at roll call. ll mem ers participated via videoconference pursuant to anta Clara County's shelter in place order. Chair Chen revie ed the logistics for the meeting. uorum as present pursuant to tate of California E ecutive Orders -25-20 dated March 12 2020 and -2 -20 dated March 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 2020-09*	an oods CEO and ohn Conover President El Camino Health Foundation oard of irectors recogni ed the El Camino Health Foundation for responding to the needs of the organi ation and coordinating ith grateful community mem ers to support front line health or s during the CO -1 pandemic. ndre Cope President El Camino Health Foundation commended the team for going a ove and eyond during this time. **Motion:** o approve *Resolution 2020-09* recogni ing the El Camino Health Foundation. **Movant:** al ach **Second:** Miller **Ayes:** Chen Fung al ach liger Miller Po Re it er ing atters oglin **Noes:** one **Abstentions:** one **Absent:** one **Recused:** one he oard commended the Foundation leadership and staff for its efforts and	***Resolution 2020-09***

	successes during this time.	
5. FY21 PERIOD 2 FINANCIALS	Carlos □ohor□ue□□CFO□provided an overvie□ of the FY21 Period 2 Financials: - □npatient and outpatient volumes have re□ounded□the Emergency □epartment □E□□□as the only area as of □ugust 31□2020 that had not returned to pre-CO□□□ volumes. - □et patient revenue e□ceeded □udget □y 26□ or □18 million. - □otal operating revenue □as □□0 million favora□le to □udget □y □1□□million□year over year□it □as a slight increase of □2.□ million. - □alaries□□ ages□and □enefits □□□ □□□□ere unfavora□le to □udget. - □upplies □ere unfavora□le to □udget □y □6.2 million□primarily due to personal protective e□uipment □PPE□e□penses and catch up from the prior month. Mr. □ohor□ue□commented that he e□pects this to flatten out in the coming months. - Operating margin □as favora□le to □udget □y □8.2 million. - Year-Over-Year income from operations □as □8.8 million□a□out □6.4 million less than the same period last fiscal year□□hich demonstrates recovery□but also the pandemic's impact on the organi□ation and the need to continue to manage e□penses and preserve li□uidity. - □here □as a slight deterioration to the payor mi□in □ugust□□hich staff □ill continue to monitor. Mr. □ohor□ue□e□plained that 1□□ays Cash On Hand includes Medicare □dvance payments□received in □pril 2020 and 2□ne□ legislation e□tended the recoup period□so those payments □ill remain on the □alance sheet until 2021. □n response to □irector □oglin's comment□Mr. □ohor□ue□reported that staff is in the process of updating the financial forecast□□hich □ill □e presented to the Finance Committee in □ovem□er 2020 and the □oard in □ecem□er 2020. □n response to □uestions from the □oard□Mr. □ohor□ue□commented that 1□ unless re□uired□there is no plan to return C□RE□□ct funding at this time and 2) the "other" category for the payor mi□includes individuals □ho do not □ualify for Medi-Cal and/or do not have insurance. **Motion:** □o approve the FY21 Period 2 Financials. **Movant:** □al□ach **Second:** □ atters **Ayes:** Chen□Fung□□al□ach□□liger□Miller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***FY21 Period 2 Financials approved***
6. FY20 FINANCIAL AUDIT	□oelle Pulver from Moss □dams revie□ed the scope of services □consolidated audit for the □istrict□Hospital□Foundation□□□M□□and CO□CER□□separate engagement for the □u□iliary□ □he e□plained that Moss □dams is providing non-attest services to ECH related to lean consulting and consolidated financial statements□□ut that Moss □dams	

	remains independent of the organi□ation for audit purposes. Ms. Pulver reported that the opinion given is an unmodified one□□hich is the highest level of assurance that can □e given. □he outlined the FY20 audit results including: - □ignificant increase in cash and investments□in FY20□there □as □152 million in positive cash flo□s from operations. - Purchases of □10□million in capital assets□offset □y □50 million in depreciation related to ongoing construction pro□ects - Other assets increased driven by the organization's pension plan □□38 million increase□□ased on a valuation date of □ecem□er 31□ 201□□ - Current lia□ilities include Medicare □dvanced payments□□hich due to ne□ legislation □ill not □e recouped until 2021 and may need to □e reclassified as long-term lia□ilities - □et Patient □ervice Revenue/□ccounts Receiva□le□□hich is revie□ed and tested in detail as it is the largest estimate on the □alance sheet. □he noted that the process for developing the model is consistent with others in the industry, and ECH's valuation was slightly conservative□□uite close to actual collections□and right □ithin e□pectations. - □ncome □tatement Year-over-Year: each e□pense category increased in dollar amount□□ut is very consistent year over year □et□een categories of □here revenue is spent□Ms. Pulver noted that SVMD's ac□uisition e□penses only impacted three months of FY1□versus the entirety of F20 - Community □enefit e□pense of □ust over □12 million Ms. Pulver e□plained that 1□Moss □dams does not opine on operating effectiveness of internal controls□2□there □ere no significant accounting policy changes□and 3□management □udgements and accounting estimates are reasona□le. □he reported that there □ere t□o audit ad□ustments related to 1□□12 million increase to □et Patient □ccounts Receiva□le and □et Patient Revenue due to □□million in unreconciled □ad de□t e□pense□□hich □as reversed and □5 million from additional reserves □2□ □□uilt into the forecasting modeling□ □hich □as not removed prior to □oo□ing the final year-end ad□ustments and 2□an investment that □as recorded t□ice□so the investments □ere overstated □y □14 million. □he noted that the total investment portfolio is □1.2 □illion. Ms. Pulver noted that there is a significant internal control deficiency related to the financial close reporting process and reconciliations. Management has provided a response and is re□or□ing the reconciliation process. □here □ere no further □uestions from the □oard.	
7. ADJOURN TO CLOSED SESSION	**Motion:** □o ad□ourn to closed session at 6:03pm pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – □enior Management: FY20 Financial □udit□pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed □ession of the Hospital □oard Meeting □/□/2020□□pursuant to *Health and Safety Code Section 32155* for a report of the Medical □taff□deli□erations concerning reports on Medical □taff □uality assurance matters: □uality Committee Report □Medical □taff Credentials and Privileges Report□□uality Council Minutes□□pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets and *Gov't Section Code 54957.6* for a conference □ith la□or negotiator □an □ oods: FY21 □ndividual	***Adjourned to closed session at 6:03pm***

	E□ecutive □oals□pursuant to *Health and Safety Code Section 32155* for a report of the Medical □taff□deli□erations concerning reports on Medical □taff □uality assurance matters: Medical □taff Report□pursuant to *Gov't Code Section 54956.9(d)(2)* – conference □ith legal counsel – pending or threatened litigation: FY20 Compliance Program □ummary Report□pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: CEO Report on □e□ Programs and □ervices□and pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – □enior Management: E□ecutive □ession. **Movant:** Miller **Second:** □al□ach **Ayes:** Chen□Fung□□al□ach□□liger□Miller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	
8. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT	Open session □as reconvened at □:32pm □y Chair Chen. □genda □tems □-15 □ere addressed in closed session. □uring the closed session□the □oard approved the Minutes of the Closed □ession of the Hospital □oard Meeting □□/□/2020□□and Closed □ession □uality Committee Report□including the Medical □taff Credentials and Privileges Report and the □uality Council Minutes □y a vote in favor of all mem□ers present and participating in the meeting □□irectors Chen□□al□ach□ □liger□Miller□Po□Re□it□er□□ing□□ atters□and □oglin□. □irector Fung recused himself for those approvals. □he □oard also approved the Medical □taff Report □y a unanimous vote in favor of all mem□ers present and participating in the meeting □□irectors Chen□Fung□□al□ach□□liger□Miller□ Po□Re□it□er□□ing□□ atters□and □oglin□.	
9. AGENDA ITEM 17: CONSENT CALENDAR	Chair Chen as□ed if any mem□er of the □oard or the pu□lic □ished to remove an item from the consent calendar. □o items □ere removed. **Motion:** □o approve the consent calendar: Minutes of the Open □ession of the Hospital □oard Meeting □□/□/2020□□Minutes of the Open □ession of the □pecial Hospital □oard Meeting □□/23/2020□□FY21 Readmissions □Organi□ational Performance □oal Metrics□□Compliance and □udit Committee Report: FY20 403□□□Plan □udit□FY20 Cash □alance Plan □udit□Minutes of the Open □ession of the E□ecutive Compensation Committee Meeting □□/28/2020□□FY20 Organi□ational Performance □oal □core□□euro-□nterventional Call Panel□Medical □irector□Cardiac Reha□ilitation□Medical □taff Report□and for information: FY20 Community □enefit Report□□uality Committee Report. **Movant:** □al□ach **Second:** □ atters **Ayes:** Chen□Fung□□al□ach□□liger□Miller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Consent calendar approved***

10. AGENDA ITEM 18: FY20 FINANCIAL AUDIT	**Motion:** □o approve the FY20 Financial □udit. **Movant:** □al□ach **Second:** □ing **Ayes:** Chen□Fung□□al□ach□□liger□Miller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***FY20 Financial Audit approved***
11. AGENDA ITEM 19: CEO REPORT	□an □ oods□CEO□provided the follo□ing updates: - He commended the sustained improvement for t□o hospital-ac□uired infections□it has □een 256 days □in Mountain □ie□□and 122 days □in □os □atos□since the last Catheter □ssociated □rinary □ract □nfection □C□□□□□and 254 days in M□ and 1□445 in □□ since the last Center □ine □ssociated □lood □tream □nfection □C□□□□□□. - □he site visit for the Magnet □esignation is scheduled for □ovem□er 10-12□2020. - ECH is the second site in the □orld to open the Phase □CO□□□-1□ clinical trial □ith Pfi□er. - □he first employee pulse survey on □uality□safety□colla□oration□ and leadership □as launched on □eptem□er 30th and additional surveys □ill □e conducted throughout the year. - ECH achieved Cum Laude in Epic's Honor Roll Program and was awarded CHIME's "Most Wired" designation for the fourth year in a ro□. - □he El Camino Healthcare □istrict Community CO□□□-1□□esting Program has provided over 6□000 tests. □ue to the program's success□the Hospital is sponsoring a similar program in □os □atos. Mr. □ oods emphasi□ed that it is safe to return to health and urged those in need to see□medical care. Mr. □ oods than□ed donors for □304□3□□donated to the Foundation in FY21 Period 2 and □elcomed □ac□the small group of the □u□iliary providing onsite services. In response to Director Miller's question, Jim Griffith□COO□further descri□ed the □uest dual diagnosis intensive outpatient program□□hich focuses on adolescent su□stance a□use issues. □irector □ing commended staff for the incredi□le □or□on hospital-ac□uired infections.	
12. AGENDA ITEM 19: BOARD COMMENTS	□one.	
13. AGENDA ITEM 20: ADJOURNMENT	**Motion**: □o ad□ourn at □:41pm. **Movant:** Po **Second:** □al□ach **Ayes:** Chen□Fung□□al□ach□□liger□Miller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Meeting adjourned at 7:41pm***

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

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□anhee Chen
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□ulia E. Miller
□ecretary□ECH □oard of □irectors

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

Minutes of the Open Session of the Special Meeting to Conduct a Study Session of the El Camino Hospital Board of Directors
Wednesday, October 28, 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.

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

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30pm by Chair Chen. A verbal roll call was taken. Director Po joined during the closed session. All other Board members were present at roll call. All members participated via videoconference pursuant to Santa Clara County's shelter in place order. Chair Chen reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 5:33pm pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: Report on FY21 Strategic Plan Metrics and Plan for New Strategic Planning Process. **Movant:** Kalbach **Second:** Miller **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Rebitzer, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Po **Recused:** None	***Adjourned to closed session at 5:33pm***
3. AGENDA ITEM 6: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 5:58pm by Chair Chen. Agenda Items 3-5 were addressed in closed session. The Board took no action during the closed session.	
4. AGENDA ITEM 7: PANEL DISCUSSION ON STRATEGIC PLANNING	Keri Eyre, PhD, facilitated a remote panel discussion with Ken Alvares, PhD, Peter Moran, Bob Rebitzer, Pat Wadors, and Don Watters about strategic planning processes. The panelists discussed learning about competitors in the market, engaging stakeholders, culture, and the use of a strategic planning ad hoc committee. Members of the Board's Advisory Committees and the Executive Leadership Team observed the panel discussion remotely.	

5. AGENDA ITEM 8: ADJOURNMENT	**Motion**: □o ad□ourn at □:01pm. **Movant:** □al□ach **Second:** Miller **Ayes:** Chen□Fung□□al□ach□□liger□Miller□Po□Re□it□er□□ing□□ atters□ □oglin **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Meeting adjourned at 7:01pm***

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

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□anhee Chen
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□ulia E. Miller
□ecretary□ECH □oard of □irectors

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

EL CAMINO HOSPITAL
DRAFT RESOLUTION 2020-11

ELECTION OF EL CAMINO HOSPITAL CHIEF FINANCIAL OFFICER CARLOS BOHORQUEZ AND RE-ELECTION OF EL CAMINO HOSPITAL CHIEF INFORMATION OFFICER DEBORAH MURO TO PATHWAYS HOME HEALTH AND HOSPICE BOARD OF DIRECTORS

WHEREAS, El Camino Hospital, a California nonprofit public benefit corporation is a Class A member (hereafter "Class A Member") of Pathways Home Health and Hospice, also a California nonprofit public benefit corporation (hereafter "the Corporation"),

WHEREAS, pursuant to Section 3.02 of the Corporation's Bylaws, the Class A Member has the right to vote for one half of the Corporation's authorized Directors other than the East Bay representative,

WHEREAS, pursuant to Section 4.01 of the Corporation's Bylaws, the Class A Member is required to elect a Director or Directors at a regular meeting of the Class A Member,

WHEREAS, the current number of the Corporation's authorized Directors is nine, including the East Bay representative,

WHEREAS, pursuant to Section 3.02 of the Corporations Bylaws the Class A member has the right to vote for four of the Corporation's Directors,

WHEREAS, there is a Class A vacancy for a term expiring on November 1, 2021 on the Corporation's Board of Directors,

WHEREAS, El Camino Hospital CIO Deborah Muro's first term of service as a Class A Director expires on April 26, 2021,

BE IT RESOLVED, that El Camino Chief Financial Officer Carlos Bohorquez is hereby elected to the Corporation's Board of Directors for a term of one year, effective immediately and expiring on November 1, 2021, renewable for additional three year terms, be it further

RESOLVED, that El Camino Chief Information Officer Deborah Muro is hereby re-elected to the Corporation's Board of Directors for a second term of three years effective April 26, 2021.

DULY PASSED AND ADOPTED at a regular meeting held on November 11, 2020, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____

Julia E. Miller, Secretary
ECH Board of Directors

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD COVER MEMO

To: El Camino Hospital Board of Directors
From: Carlos Bohorquez, CFO
Date: November 11, 2020
Subject: Approval of Pathways Home Health and Hospice FY2021 Operating and Capital Budget

Recommendation(s):

To approve the Pathways Home Health and Hospice ("Pathways") FY2021 Operating and Capital Budget.

Summary:

1. Situation and Background: Common Spirit Health at Home ("CSHH") has been the current manager of Pathways effective 11/1/2019. CSHH prepared the attached FY2021 Budget and the Pathways Board approved it on June 25, 2020. The FY2021 Budget reflects a $5.3 million improvement in operating income from FY2020 audited results and positive operating income of $1.8 million. The improvement is primarily attributed to the following:

- Volume growth / Covid-19 recovery is expected to yield $2.0 million in additional revenue
- Reduction of $1.5 million in salaries, wages and benefits
- Elimination of a one-time transition expense of $3.3 million

Based on YTD FY2021 as of 7/30 results, Pathways operating income of $672 is favorable to Budget by $333.

2. Authority: Section 5.01(f) of the Pathways Bylaws requires approval of the Budget by both classes of corporate members.

3. Assessment: This action is pursuant to the Pathways Bylaws.

4. Other Reviews: The Pathways Board approved the Budget on June 25, 2020.

5. Outcomes: Pathways FY2021 Operating and Capital Budget approved by the ECH Board.

List of Attachments:

1. Pathways FY2021 Budget

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

PATHWAYS
Moving Care Forward

Operating Budget
FY 2021

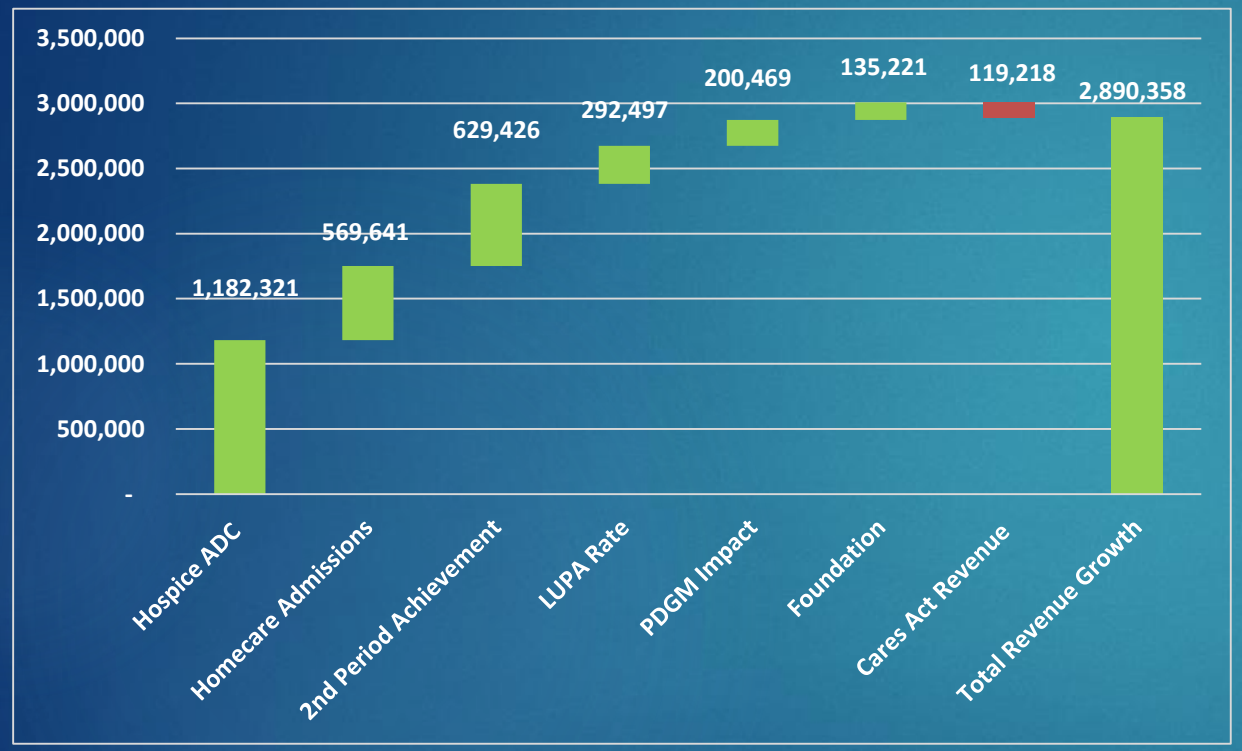
Budget Summary

Revenue	FY20 Projected	FY21 Budget	Variance
Patient service revenue	$ 33,159,936	$ 35,915,073	$ 2,755,137
Gifts, contributions and grants	1,864,779	2,000,000	135,221
Net Revenue	35,024,715	37,915,073	2,890,358
Expense			
Salaries and benefits	24,773,322	23,260,455	1,512,867
Other patient direct expense	3,892,501	3,805,330	87,171
General and administrative expense	6,835,557	8,488,548	(1,652,992)
Operating Expense	35,501,380	35,554,333	(52,953)
EBITDA	(476,665)	2,360,740	2,837,405
Depreciation and amortization	804,089	593,702	210,387
Total Expense	36,305,469	36,148,035	157,434
Operating Income (Loss)	(1,280,754)	1,767,038	3,047,792
Transition expense	3,942,094	312,291	3,629,803
Operating Income (Loss) less transition expense	(5,222,848)	1,454,747	6,677,595
Non-operating income and (gains) / losses	(240,854)	(826,831)	585,977
Net Income (Loss)	$ (4,981,995)	$ 2,281,578	$ 7,263,572

PATHWAYS
Moving Care Forward

- Cares Act Revenue
  - FY20 - $998 Thousand
  - FY21 - $879 Thousand
- Non-operating income does not assume any changes in market value
- FY21 Transition Expenses
  - Write off of former IT Infrastructure assets - $154 Thousand
  - Labor for installation of new IT Infrastructure - $158 Thousand

Revenue Growth



- Revenue Growth: $2.0M
  - Hospice Growth: $1.3 Million
    - ADC from 222 to 235 $1.2 Million
  - Homecare Growth: $1.5M
    - 107 admissions
      - $569 Thousand
    - Increase 2nd period achievement to 75.4% from 61.6%
      - $629 Thousand
    - LUPA rate: 9.4% from 14.6%
      - $292 thousand
    - PDGM 3.2% Increase started January 2020
      - $200 Thousand
  - Foundation Growth - $135 Thousand
  - CARES Act – ($119 thousand)

Operating Expense

Expense	FY20 Projected	FY21 Budget	Variance
Salaries and benefits	24,773,322	23,260,455	1,512,867
Other patient direct expense	3,892,501	3,805,330	87,171
General and administrative expense	6,835,557	8,488,548	(1,652,992)
Operating Expense	35,501,380	35,554,333	(52,953)

- Total Expenses are increasing $53 Thousand
  - Salaries and Benefits decreasing $1.5 million
    - Budget matches current staffing levels. FTE Reductions have taken place throughout transitional period as administrative functions are being covered by the management fee.
    - Allocations between Hospice and Homecare adjusted to more accurately reflect work performed.
  - Other patient direct expenses decreasing $87 thousand.
    - $133 thousand decrease – Room and Board utilization
    - $46 thousand increase – Medical Supplies for Homecare
  - General and Administrative expenses increasing $1.7 Million
    - Management fee increasing $1.7 Million
      - Replacing administrative functions

Budget Summary

Hospice

Revenue	FY20 Projected	FY21 Budget	Variance
Patient service revenue	$ 24,337,149	$ 25,597,980	$ 1,260,831
Gifts, contributions and grants	-		-
Net Revenue	24,337,149	25,597,980	1,260,831
Expense			
Salaries and benefits	16,772,376	14,982,791	1,789,585
Other patient direct expense	3,714,738	3,582,096	132,642
General and administrative expense	4,973,400	5,843,940	(870,541)
Operating Expense	25,460,513	24,408,827	1,051,687
EBITDA	(1,123,364)	1,189,153	2,312,517
Depreciation and amortization	579,038	421,442	157,595
Total Expense	26,039,551	24,830,269	1,209,282
Operating Income (Loss)	(1,702,402)	767,710	2,470,113

Budget Summary

Homecare

Revenue	FY20 Projected	FY21 Budget	Variance
Patient service revenue	$ 8,822,787	$ 10,317,093	$ 1,494,307
Gifts, contributions and grants	-		-
Net Revenue	8,822,787	10,317,093	1,494,307
Expense			
Salaries and benefits	7,383,063	7,824,555	(441,493)
Other patient direct expense	177,763	223,234	(45,471)
General and administrative expense	1,536,212	2,262,908	(726,696)
Operating Expense	9,097,038	10,310,697	(1,213,660)
EBITDA	(274,251)	6,396	280,647
Depreciation and amortization	223,682	169,860	53,822
Total Expense	9,320,720	10,480,557	(1,159,837)
Operating Income (Loss)	(497,933)	(163,464)	334,469

Budget Summary
Foundation

PATHWAYS
Moving Care Forward

Revenue	FY20 Projected	FY21 Budget	Variance
Patient service revenue	$ -		$ -
Gifts, contributions and grants	1,864,779	2,000,000	135,221
Net Revenue	1,864,779	2,000,000	135,221
Expense			
Salaries and benefits	617,884	453,109	164,775
Other patient direct expense	-	-	-
General and administrative expense	325,945	381,700	(55,755)
Opertating Expense	943,829	834,809	109,020
EBITA	920,951	1,165,191	244,241
Depreciation and amortization	1,370	2,400	(1,030)
Total Expense	945,199	837,209	107,990
Operating Income (Loss)	919,581	1,162,791	243,210

Capital Request
Fiscal Year 2021 Budget

PATHWAYS
Moving Care Forward

Description	Budget
Network Transition	244,000
Contingency	50,000

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Dan Woods, CEO; Cindy Murphy, Director, Governance Services
Date: November 11, 2020
Subject: Approval of Proposed FY21 Board Action Plan

Recommendation:

To approve the Proposed FY21 Board Action Plan as presented in the attached document.

Summary:

1. Situation: On September 23, 2020, the Board met to discuss the findings of the FY20 Board and Committee Self-Assessments. Following the meeting, Dan Woods, CEO, and Cindy Murphy, Director, Governance Services, worked with Erica Osborne of Via Healthcare Consulting to prepare a Proposed Board Action Plan for FY21 that will address the findings.

2. Authority: N/A

3. Background: As discussed during the September 23rd meeting, the self- assessments revealed a desire to address and/or improve the following:

- The Board's role and engagement in the upcoming strategic planning process
- Increase time for strategic discussion at Board meetings
- Continue to improve executive summaries in Board and Committee materials
- Ensure the Advisory Committee Structure is appropriate for the organization's governance needs and responsibilities.
- Communication between the Board and Committees
- Diversity of the governing bodies – both the Board and its Advisory Committees

4. Assessment: N/A

5. Other Reviews: None

6. Outcomes: The Proposed Board Action Plan will address the most important findings of the Board and Committee Self-Assessment as determined by the Board

List of Attachments:

1. Proposed FY21 Board Action Plan

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

Proposed FY21 El Camino Hospital Board Action Plan

	What	Who	By When	Current Status
Strategic Oversight				
1.	Define the role and establish process for Board oversight and engagement of the upcoming strategic planning process.	Board Chair, CEO	12/9/20 Board	
Clarify Governance Processes and Structures				
2.	Review pacing plan and past agendas to identify items that could be placed on the consent agenda or delegated to create more time for strategic discussion.	Chair, CEO, Dir. Gov. Services	12/30/20	
3.	Continue to provide executive summaries and framing questions for each agenda item to focus attention and stimulate discussion.	CEO, Executives, Dir. Gov. Services	12/30/20	
4.	Conduct a review of the current committee structure to determine if it is still in alignment with current governance responsibilities.	Governance Committee	2/2/21 GC 2/10/21 Board	
5.	Work with committee leadership and executive sponsors to develop a more effective mechanism for communication between the board and committees.	Chairs, Vice Chairs, Executives, Dir. Gov. Services	1/15/21	
Increase the Board's Diversity				
6.	Request the Governance Committee develop a set of recommendations to increase the representation of diversity on our governing bodies as reflected from the communities we serve.	Governance Committee	3/23/20 GC 4/7/21 Board	

El Camino Health

Minutes of the Open Session of the
Executive Compensation Committee
of the El Camino Hospital Board of Directors
Tuesday, September 22, 2020

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

Members Present	Members Absent
Teri Eyre	one
Jaison Layney	
Julie Kliger ice Chair	via teleconference
Bob Miller Chair	
George Ting, MD	
Pat Wadors	

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	he open session meeting of the E ecutive Compensation Committee of El Camino Hospital (the "Committee") was called to order at 4:01pm y Chair o Miller. ver al roll call as ta en. ll Committee mem ers ere present and participated via teleconference and videoconference pursuant to Santa Clara County's shelter in place order. uorum as present pursuant to tate of California E ecutive Orders -25-20 dated March 12 2020 and -2 -20 dated March 18 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Miller as ed if any Committee mem ers had a conflict of interest ith any of the items on the agenda. o conflicts ere noted.	
3. PUBLIC COMMUNICATION	one.	
4. CONSENT CALENDAR	Chair Miller as ed if any mem er of the Committee or the pu lic ished to remove an item from the consent calendar. o items ere removed. **Motion:** o approve the consent calendar: Minutes of the Open ession of the E ecutive Compensation Committee Meeting /28/2020 and for information: Progress gainst FY21 Committee oals rticle of nterest. **Movant:** ing **Second:** ayney **Ayes:** Eyre liger ayney Miller ing ators **Noes:** one **Abstentions:** one **Absent:** one **Recused:** one Chair Miller re uested adding the olded language to the Progress gainst Committee oals document to recogni e the efforts of staff: he CHRO shall serve as the primary staff to support the Committee and is responsi le for drafting the Committee meeting agenda for the Committee Chair's consideration "**and for developing and disseminating in a timely manner management's recommendations to the Committee and appropriate supporting information to facilitate the Committee's deliberations and exercise of its responsibilities**."	***Consent calendar approved*** ***Goals document to be updated***
5. REPORT ON BOARD ACTIONS	Ms. liger ice Chair reported on the uality Committee activities and strategic plan update discussed at the eptem er 2020 Hospital oard meeting. he and r. ing highlighted Committee and oard discussion	

	including the desire to monitor CO□□□-19-related metrics and ongoing □or□to define Committee and □oard governance oversight roles for ECH's physician net□or□.	
6. EXCISE TAX OVERVIEW	Heidi O'Brien from Mercer provided an overvie□ of part of the Tax Reform □ct effective in 2018 that re□uires non-profit employers to pay a 21% e□cise ta□on any compensation over $1 million for their top five employees. □he e□cise ta□is largely counting ta□a□le pay, □ut e□cludes □enefits from □ualified plans (403(b), □ash □alance plans) and unvested 457(f) plans (□ERP). □t ECH, □he CEO is the only e□ecutive that has reached the $1 million threshold. □he also descri□ed the separate e□cise ta□related to parachute payments, □hich currently does not apply to ECH given the organization's ma□imum severance period. Ms. O'Brien reviewed the alternative that other organi□ations are considering to address the e□cise ta□: split dollar loan arrangements (significant comple□ity and ris□), □ERP vesting changes (ECH's schedule is already spread over several years), and □ong-□erm □ncentive (LTI) Plans (ECH does not currently have one) In response to Ms. Eyre's question, Ms. O'Brien explained that deferred compensation covered □y 457(f) (most deferred compensation at non-profits) is counted □y the e□cise ta□□□ut deferred compensation into a 457(b), □hich ECH has, □scapes the e□cise ta□calculation. Chair Miller commented that the purpose of this discussion □as to ma□e sure the Committee had an opportunity to revie□ this ta□and to note that the alternatives to paying it are not feasi□le or desira□le at this time.	
7. FY20 ORG PERFORMANCE GOAL SCORES	Mr. □oods descri□ed the proposed recali□ration of the FY20 Organi□ational Performance □oal □core □ith an 8-month measurement period; □he methodology assumes linear improvement e□cept for the service goals, □hich □ere determined in consultation □ith Press □aney. He revie□ed the proposed changes to target and stretch as further outlined materials for a total proposed score of 122.1% of target. He noted that payouts □ill □e prorated for eight months. □he Committee re□uested that staff frame proposed scores as a percentage of target, □ot ma□imum and to eliminate any references to percentage of ma□imum in materials going for□ard. **Motion:** □o recommend that the □oard approve 1) recali□ration of the target and stretch metrics to reflect an eight-month goal period and 2) the proposed FY20 Organi□ational Performance □oal □core of 122.1%. **Movant:** Eyre **Second:** □ayney **Ayes:** Eyre, □liger, □ayney, Miller, □ing, □ adors **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***FY20 Organizational Goal Score recommended for approval***
8. FY20 CEO PERFORMANCE REVIEW PROCESS AND FY21 RECOMMENDATIONS	Ms. O'Brien reported that the feed□ac□on the FY20 CEO Performance Revie□ Process □as largely positive. Proposed changes include to: 1) start the process after the end of the fiscal year and 2) allo□ more time (four rather than t□o □ee□s) for the CEO to fill out his assessment.	

9. EXECUTIVE COMPENSATION COMMITTEE SELF-ASSESSMENT	Cindy Murphy□□irector of □overnance □ervices□descri□ed the timing and participation levels for the self-assessment surveys□noting that the Committee mem□ers as of □une 30□2020 filled out the survey. □he Committee revie□ed the results. Chair Miller suggested more education and conte□t for non-healthcare-□ased committee mem□ers on hospital operations and □uality. He also suggested providing an educational overvie□ on e□ecutive compensation principles to the □oard. Chair Miller than□ed the Committee for their time and effort.	
10. ADJOURN TO CLOSED SESSION	**Motion:** □o ad□ourn to closed session at 4:45pm. **Movant:** □ayney **Second:** □ adors **Ayes:** Eyre□□liger□□ayney□Miller□□ing□□ adors **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Adjourned to closed session at 4:45pm***
11. AGENDA ITEM 22: RECONVENE OPEN SESSION/ REPORT OUT	Open session □as reconvened at 6:14pm. □genda items □-13 □ere addressed in closed session. □uring the closed session□the Committee approved the FY20 □ndividual Performance □oal □cores and FY21 □ndividual Performance □oals □y unanimous vote in favor of all mem□ers present □y teleconference □Eyre□ □liger□□ayney□Miller□□ing□□ adors□.	
12. AGENDA ITEM 23: GEOGRAPHIC DIFFERENTIAL	□he Committee did not ta□e any action on this item.	
13. AGENDA ITEM 24: PROPOSED FY20 PERFORMANCE GOAL PAYOUTS	**Motion**: □o approve the FY20 Performance □oal Payouts under the E□ecutive Performance □ncentive Plan noted □elo□ su□□ect to □oard approval of the FY20 organi□ational performance goal score: **Movant:** □ayney **Second:** □ing **Ayes:** Eyre□□liger□□ayney□Miller□□ing□□ adors **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***FY20 Executive Performance Goal Payouts approved***
14. AGENDA ITEM 25: PROPOSED FY21	**Motion**: □o approve the Proposed FY21 E□ecutive □ase □alaries:	***FY21 Executive Base Salaries***

Position	**Payout**
President□Foundation	□3□6□□
President□□□M□	□□8□286
□P□Corporate □ Community Health □ervices/ President□CO□CER□□:E□P	□38□□05
Chief □ursing Officer	□64□822
Chief □nformation Officer	□62□2□3
Chief Operating Officer	□□2□3□0
□P□Payor Relations	□48□885
Chief □dministrative □ervices Officer	□4□□160
Chief Medical Officer	□84□118
□eneral Counsel	□□4□36□
Chief Human Resources Officer	□56□852

Position	**FY21 Base Salary**

EXECUTIVE BASE SALARIES	President□Foundation	□2□1□200	***approved***
	President□□□M□	□543□100	
	□P□Corporate □ Community Health □ervices/ President□CO□CER□:E□P	□283□300	
	Chief □ursing Officer	□3□3□□00	
	Chief □nformation Officer	□40□300	
	Chief Operating Officer	□583□500	
	□P□Payor Relations	□28□□□00	
	Chief □dministrative □ervices Officer	□321□500	
	Chief Medical Officer	□610□000	
	□eneral Counsel	□440□100	
	Chief Human Resources Officer	□381□500	

Movant: □ ado□s
Second: □ing
Ayes: Eyre□□liger□□ayney□Miller□□ing□□ ado□s
Noes: □one
Abstentions: □one
Absent: □one
Recused: □one

15. AGENDA ITEM 26: PROPOSED FY21 CEO BASE SALARY	□here □as no action or discussion on this item.	
16. AGENDA ITEM 27: RFP AD HOC COMMITTEE REPORT	□aison □ayney□□d Hoc Committee Chair□reported that he□Ms. □ohnston□ and Ms. Murphy participated on a □□□ call □ith three of the interested firms. Five of si□solicited firms intend to su□mit a response□one firm declined due to concerns a□out the pu□lic nature of the Committee meeting materials. Proposals are due Octo□er 2□2020. □he □d Hoc Committee □ill select finalists for the entire Committee to revie□ at its □ovem□er 2020 meeting. Chair Miller than□ed the □d Hoc Committee for their □or□	
17. AGENDA ITEM 28: FY21 PACING PLAN	Chair Miller commented that there is a policy revie□ paced in at the March 2021 meeting.	
18. AGENDA ITEM 21: CLOSING COMMENTS	□here □ere no additional comments from the Committee.	
19. AGENDA ITEM 22: ADJOURNMENT	**Motion**: □o ad□ourn at 6:23pm. **Movant:** □ ado□s **Second:** Eyre **Ayes:** Eyre□□liger□□ayney□Miller□□ing□□ ado□s **Noes:** □one **Abstentions:** □one **Absent:** □one **Recused:** □one	***Meeting adjourned at 6:23pm***

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

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□
□o□Miller
Chair□E□ecutive Compensation Committee

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□ulia E. Miller
□ecretary□ECH □oard of □irectors

Prepared □y: □arah Rosen□erg□Contracts □dministrator/□overnance □ervices E□

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Cindy Murphy, Director of Governance Services
Date: November 11, 2020
Subject: Approval of Draft Revised Advisory Committee Community Member Nomination and Selection Policy and Procedure (P&P)

Recommendation:

To approve the attached P&P, as revised.

Summary:

1. Situation: The Governance Committee and the Board last reviewed the attached P&P in 2015. Best practices suggest that policies and procedures should be reviewed regularly to confirm relevance and efficiency. ECH reviews its operational policies and procedures every three years.

2. Authority: It is within the Governance Committee's Charter to (a) monitor and recommend improvements or changes to the on-going governance process and procedures of the Hospital Board in order to enhance overall efficiency of the Board and Advisory Committee Structure and (2) recommend updates to the organization's governance policies where necessary and as required by legal and regulatory agencies.

3. Background: The Governance Committee developed the P&P and the Board approved them in 2013. Subsequently, in FY2015, the Board approved the Committee's proposed revisions to reduce inefficiencies in the procedures. The P&P have been implemented numerous times in recruitments for each of the Board's Advisory Committees.

4. Assessment: The proposed revisions reflect how the P&P has been implemented (*i.e.*, the appointment of an ad hoc committee to initiate the recruitment efforts followed by interviews before the whole committee and finally Board approval). The revisions also clarify that the P&P are only applicable to the Community Members of the Committees as defined in the Committee Charters.

5. Other Reviews: At is October 13, 2020 meeting, the Governance Committee voted to recommend Board approval of the proposed revisions.

6. Outcomes: Additional consistency for and clarity of the Policy and Procedure for Nomination and Selection of Community Members of the Board's Advisory Committees.

List of Attachments:

1. Draft Revised Policy
2. Draft Revised Procedures

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION POLICY

XX.XX HOSPITAL BOARD ADVISORY COMMITTEE COMMUNITY MEMBER NOMINATION AND SELECTION POLICY

A. Coverage:

El Camino Hospital Board Advisory Committees

B. Adopted:

June 12, 2013;

C. Policy:

It is the policy of ECH that appointment of Hospital Board Advisory Committee Community Members to vacant or newly created positions follow the procedure set forth in the attached Document entitled:

Hospital Board Advisory Committee Community Member Nomination and Selection Procedure

1. Length of Service and Term Limits for Committee Members

As provided in the Committee Charters, Committee Community Members will serve a term of one (1) year, renewable annually.

D. Reviewed:

Governance Committee March 31, 2015; October 13, 2020
ECH Board Approved April 8, 2015

El Camino Health

EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE COMMUNITY MEMBER NOMINATION AND SELECTION PROCEDURES
Adopted February 12, 2014
Revised (Approved) April 8, 2015
Draft Revised October 13, 2020

01.07 HOSPITAL BOARD ADVISORY COMMITTEE COMMUNITY MEMBER NOMINATION AND SELECTION PROCEDURES

A. Coverage: El Camino Hospital Board Advisory Committees

B. Adopted: 2/12/2014

C. Procedure Summary:

The nomination and selection of each Hospital Board Advisory Committee (Advisory Committee) member (Member) shall follow the procedures below.

D. Procedure for Nominating and Appointing an Advisory Committee Community Member:

1. Eligibility and Qualifications

Each Advisory Committee shall determine minimum qualifications and competencies for its Members. In addition, the Governance Committee will periodically conduct a strategic assessment of the respective Advisory Committee's membership needs and ensure that it evolves with the Hospital's strategy.

2. Nomination and Declaration

a. Nominations for Advisory Committee Community M~~m~~embership may be received from any source.
b. The Director, Governance Services~~Board Liaison~~ will notify the Board, the Advisory Committee members, the Executive Leadership Team and the public of all vacancies for which new Advisory Committee Community Members are being recruited.
c. A candidate shall submit an application to the Director, Governance Services~~Board Liaison~~ that includes reason(s) the candidate wishes to serve, the candidate's relevant experience and qualifications, potential conflicts of interest including any personal or professional connections to ECH, a release to permit ECH Human Resources to conduct a background check, and specifies which Advisory Committees that the candidate wishes to be considered for.
d. ~~-~~If the interested candidate is currently serving on another Advisory Committee at ECH, the candidate shall notify the Chair(s) of the Advisory Committee with a vacancy and the Advisory Committee on which they are serving. The interested candidate shall also notify the Director, Governance Services~~Board Liaison~~,

provide all application materials, and be subject to all other requirements of this procedure.

e. All candidates will be considered in the candidate due diligence process.

f. In the event that no qualified candidates can be found through the routine recruitment procedures of the Hospital, the CommitteeBoard may, in its discretion, obtain the services of a recruiting firm to identify qualified candidates.

3. **Review of Candidates and Selection of New Members.**

a. Any committee recruiting new members shall appoint an Ad Hoc Committee comprised of two members to recruit new members. The Committee Chair shall be given first right of refusal to serve as a member of the Ad hoc Committee,

b. The Director, Governance ServicesBoard Liaison will forward the names and resumes of all applicants to the Executive Sponsor and the members of the Chair of the Advisory Committee with any vacancy or, if appointed by the Committee, to the members of an Ad hoc Committee for review.

c. The Ad hoc Committee, in consultation with the Executive Sponsor, shall (1) select and interview first round candidates and (2) select finalsistfinalists for interview by the full Committee.

a. The Committee will interview finalsistsfinalists and recommend appointments to the Board for approval

b.d. At the request of the Chair of the Advisory Committee, current Advisory Committee Members, and the Advisory Committee Chair shall select and interview the final slate of candidates and will recommend the top finalist(s) to the Board.

c.e. The Board shall appoint the Advisory Committee Members in accordance with the Hospital Bylaws.

4. **Obtaining Approval to Increase the number of Community Members of an Advisory Committee**

a. If an Advisory Committee Chair proposes to increase the number of Community Members of such Chair's Advisory Committee, then the Advisory Committee Chair must submit a brief description of the need (e.g., gap in skill-set) for an increase in membership to the Governance Committee.

b. Upon review of the request, the Governance Committee shall make a recommendation to the Board whether the Community membership of such Advisory Committee should be increased.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital □oard of □irectors
From: Cindy Murphy□□irector of □overnance □ervices
Date: □ovem□er 11□2020
Subject: □nnual □oard Retreat

Recommendation(s):

□o approve the agenda for the □nnual □oard Retreat in Fe□ruary 2021.

Summary:

1. □ituation: □he □oard continues to re□uest ongoing education to support its □or□ □s □ell□ ongoing □oard education is considered a □est practice□vital to effective □oard functioning.

2. □uthority: □t is □ithin the □overnance Committee's chartered responsibilities to recommend educational activities□Hospital □oard education□training and development.

3. □ac□ground: □t its last meeting□the □overnance Committee suggested that the annual □oard Retreat □e focused on the follo□ing topics:

- **a.** □tatus of and □oard Engagement on the □trategic Planning □ or□
- **b.** □nderstanding □ystemness
- **c.** Promoting □ystem □lignment

4. □ssessment: □/□

5. Other Revie□s: □overnance Committee□Octo□er 13□2020

6. Outcomes: □/□

List of Attachments: □one.

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

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Quality Committee
From: Ken King, CASO
Date: November 11, 2020
Subject: Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): To approve the Annual Report, Evaluation of the Environment of Care & Emergency Management.

Summary:

1. Situation: Despite the challenges presented by a global pandemic the management of the environment of care, the safety program with all its elements and the emergency management plan produced solid results. Highlights include:

a) The rate of OSHA recordable incidents per 100 FTE continue to **decline in FY20 to 4.7 as compared to 5.9 in FY19.** The total *number* of recordable incidents decreased to 120 compared to 145 in FY19. **Another record low!**

b) No reportable Hazardous Material incidents or Waste Water Discharge violations occurred during FY20.

c) There were five loss of power incidents (4 in Los Gatos, 1 in Mountain View) with no negative impact to operations. Emergency systems performed as designed.

d) The education and training associated with the activation the Taube Pavilion, the Sobrato Pavilion and the Willow Outpatient Surgery Department was completed in accordance with standards and solid planning.

e) The response to the COVID-19 pandemic and shelter in place orders presented many challenges that were faced head on and while significant effort was required the measures taken ensured a safe environment of care.

There were also elements of the safety program that warrant continued effort and attention.

a) We continue to see an increase in Code Gray incidents and the number of reportable workplace violence incidents increased 23% from last year.

b) Due to multiple factors the preventive maintenance of high risk medical equipment was only 88% compliant with the goal of 100%.

2. Authority: Policy requires Board approval of this report annually to maintain compliance with Joint Commission and CMS standards.

3. Background: This report is a required element for compliance with Joint Commission and CMS standards annually.

4. Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement. The resources and prior planning and drilling helped to ensure a positive

response to an unprecedented situation with a global pandemic and concurrently identifying areas in which we can improve our preparations for future events.

5. Other Reviews: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committee. The Quality Committee reviewed and recommended this Report for approval at its November 2, 2020 meeting.

6. Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY21.

List of Attachments:

1. Full Report – Evaluation of the Environment of Care & Emergency Management

Suggested Board Discussion Questions: None, this is a consent item.

El Camino Health

FY-2020 Evaluation of the Environment of Care and Emergency Management

Prepared by:

Steve □ eirauch
Manager, Environmental, Health & Safety

Matt Scannell
Director, Safety and Security

Created: 08/26/2020

Table of Contents

Program Overview

The Joint Commission (TJC) standards provide the framework for the Safety Program for Managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing and Human Resources.

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on the Safety Trends (See Attachment 2a). The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2020. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

EC 1.0 - Safety Management

Work Group Chair: ***Mari Numanlia-Wone***

Scope

Safety Management is the responsibility of hospital leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

- Employee Wellness & Health Services
- Education Services
- Quality and Patient Safety
- Infection Prevention
- Security Management
- Environmental Services
- Facilities Services
- Patient Care Services
- Human Resources
- Radiation Safety

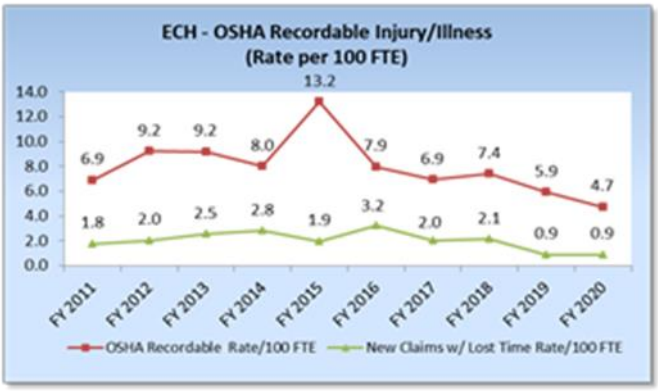
Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-20. This includes data from both the Mountain View and Los Gatos campuses.

[See Attachment 1 for a definition of terms and formulas used to calculate in this report.]

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE continue to **decline in FY-20 to 4.7 as compared to 5.9 in FY-19.** The total *number* of recordable incidents decreased to 120 compared to 145 in FY-19. **Another record low!**



The rate of lost work days for all open claims (per 100 FTEs) **sustained at 0.9 in FY-20 compared to 0.9 in FY-19. This is the lowest rate in the last ten years!**

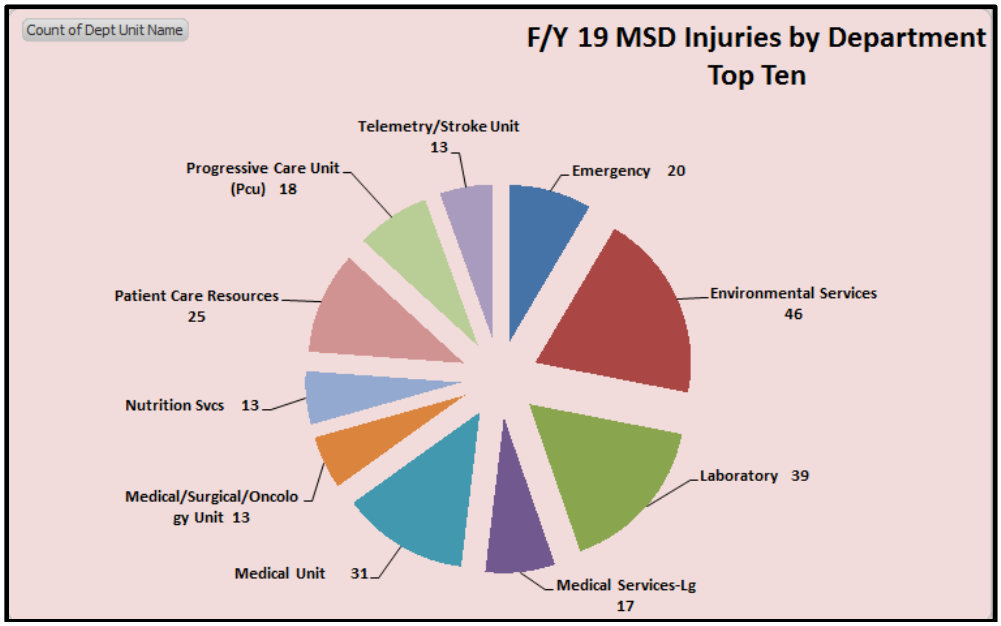
Analysis

- In FY-20 we had a **17% reduction** in OSHA recordable injuries compared to FY-19.
- The decreased in injuries are in part due to another great year with our Safe Patient Handling Program and partnership with Environmental Services. This will be explained in detail in the section below.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were **Musculoskeletal Disease (MSD)-not related to patient handling at 33%**, exposures at 30% followed by slips/trips/falls at 12%.

EC 1.0 - Safety Management

Improvement Strategies:

In FY-19 we had 235 musculoskeletal disorder (MSD) injuries not related to patient handling under total injuries. Among the improvement strategies for FY-20 we targeted MSD injuries not related to patient handling within the Environmental Services Department. The graph below depicts the departments with the highest numbers of MSD injuries not related to patient handling in FY-19. It was not a surprise that our Environmental Services (EVS), due to the nature of the work they do, had the highest incident of these types of injuries.



In FY-20 we partnered with the EVS Department in efforts to reduce MSD injuries. We conducted an initiative in collaboration with an outside vendor that included the following deliverables:

1. Completed a musculoskeletal injury risk analysis for primary tasks within the Environmental Services department.
2. Reviewed pertinent injury data related to sprain/strain or other musculoskeletal injuries sustained in the environmental services department over the past 3 years.
3. PowerPoint based training deck that details job/task specific musculoskeletal risk potential, risk reducing controls and employee expectations. This training was delivered in person to all EVS staff.

In FY-20 EVS had 7 MSD injuries not related to patient handling for an 85% reduction and OVERALL total of 2 days of loss time!

EC 1.0 - Safety Management

B. OSHA Recordable Injury/Illness Rates as Compared to U.S. & CA Hospitals

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California[1].

The ECH injury/illness rate in *calendar year 2019* was 5.1 which is below the state and national averages in 2018 (the most recent year available from the BLS). The ECH lost work cases rate was 0.5 which is below national average and below state average. Our lower rate in loss time cases is due to our Safe Patient Handling Program and our success in reducing injuries among our Environmental Services staff.

El Camino Health's robust Transitional Work Assignment Program shows a commitment to getting people back to work as quickly as possible after an injury or illness explaining our slight above average transitional work cases (2.4) compared to the national and state averages.

C. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- **Injury Rates**: The rate of OSHA recordable SPHM injuries per 100 FTEs **decreased further in FY-20, from 0.7 in FY-19 to 0.4 in FY-20!** This is a significant accomplishment, since the previous fiscal year was the first time the rate was under 1.0. This is the first year that the rate of all SPHM injuries reported (both OSHA and first aid types) is under 1.0.
- **Total Injuries**: A persistent downward trend in the total number of patient handling injuries reported over the last 4 years has continued, including another record low number of all SPHM injuries reported and the percentage of those that are OSHA recordable.

SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 14-20)

SPHM Injuries	2014	2015	2016	2017	2018	2019	2020
Total Reported	53	38	48	44	41	29	23
OSHA-recordable	35	29	34	29	23	16	10
% OSHA	66%	76%	71%	66%	56%	55%	43%

- **Lost Days due to SPHM Injuries:** The record low number of lost days (5 during the fiscal year) was achieved again this year; 98% fewer than in FY-18.

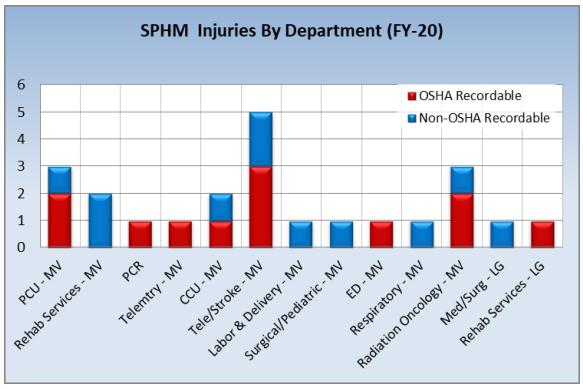
[1]The BLS data is calculated by calendar year. Data for the last full year is typically not available until fall.

EC 1.0 - Safety Management

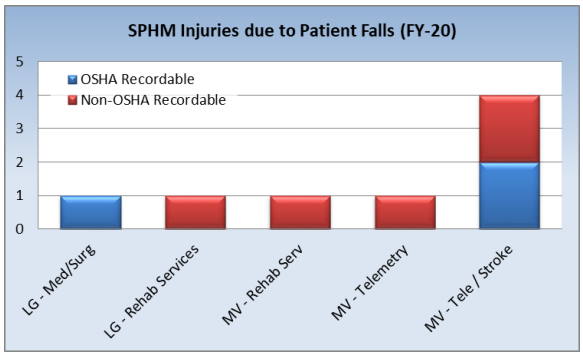
SPHM Injuries by Type Fiscal Years 15 – 20

Activity	2015	2016	2017	2018	2019	2020
Combined Transfer	6	8	6	5	5	**2**
Cumulative Pt Handling	5	1	5	4	0	**1**
Lateral Transfer	8	6	8	1	5	**3**
Patient fall/prevention	5	6	5	9	8	**8**
Car extraction	0	0	0	0	0	**1**
Pt Holding	2	3	2	3	2	**1**
Turning/Pulling	12	12	12	16	5	**6**
Vertical Transfer	5	12	5	3	4	**1**
Grand Total	**43**	**48**	**43**	**41**	**29**	**23**

- Injuries by Department
  - Inpatient Rehabilitation continues to shine. Once the department with the most SPHM injuries, there were none in FY-20 due to manager and on-site therapy collaboration, support and training of SPHM equipment.



  - CCU had also historically been in the top 3 departments with SPHM injuries. They have continued to show improvement, with reduction to 1 OSHA recordable in FY-20. Active involvement with their educator, additional sit/stand/walk aids, and adoption of repositioning sheets has proven successful.
  - Following an upward trend in SPHM injuries in the Women's Hospital that spurred active intervention and training, new equipment, and HoverMatt use policy, there were no patient handling injuries reported in FY-20.
  - The Imaging department reported the highest rate of SPHM injuries in FY-19: 4, all OSHA recordable. Since targeted education and practice using SPHM equipment, and collaboration with patient transfers from the ED, none were reported in FY-20.
  - Patient fall prevention/assistance continues to be the most common, and rising, cause of injury, accounting for 35% of those reported in FY 20.



EC 1.0 - Safety Management

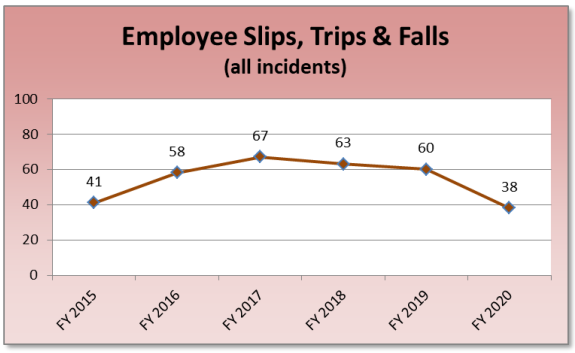
Improvement strategies:

- 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.
- Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving communication is being strategized to promote equipment use and fall prevention.
- A bariatric task force accomplished goals set to standardize, publicize, and normalize safe care with equipment for patients of size.
- Partnership with management and education on the Tele/Stroke unit, where the most injuries occurred, is planned.
- The organization is confronted with identifying means to train and empower Safe Patient Handling Unit champions to continue progress in injury reduction during a pandemic demanding social distancing.

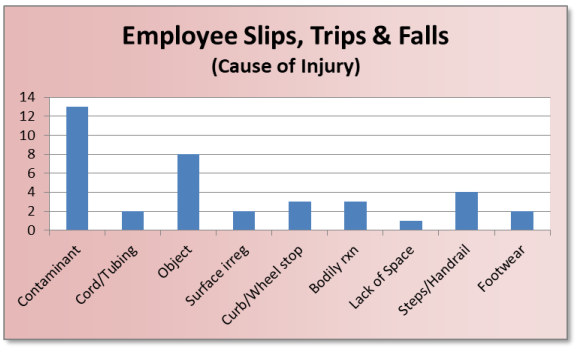
D. Slips, Trips, Falls Injuries

Analysis

- **Injury Incidence**: Interventions initiated in FY 17 due to a steady annual increase of employee slips, trips and falls (STFs) have been successful. There was a 36% reduction of STFs in FY 20, as compared to FY 19.



- **Injury Types:**



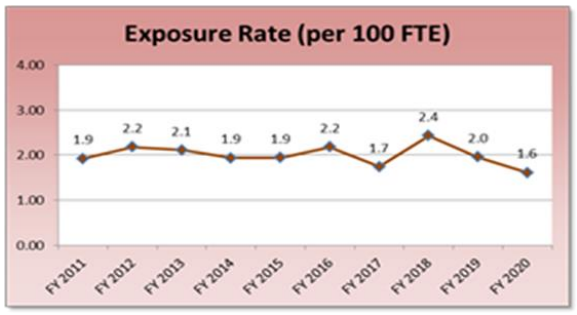
EC 1.0 - Safety Management

Improvement Strategies:

- Task force continues to meet remotely monthly, to investigate all accidents. Manager of each department with a STF injury reviews the cause and strategizes prevention efforts.
- Partnership with Facilities for prompt identification and correction of hazards; annual outside stair maintenance.
- Signage on stairs and landscaping to promote safety measures and safe routes, with 50% reduction in falls on stairs and 20% reduction in STFs outside.
- Awareness campaign promoting culture of safety, "good catches" and reminder to "Keep a Lid on It."
- "Cover Your Cup" campaign promoted on patient care units, now stocking lids for hot cups.
- Cord clamps trialed and encouraged, with 60% reduction in STFs due to cords/tubes.
- Contaminants/slippery floor continue to be the most common hazard. Promote "No Pass Zone" to encourage responsibility to all to pick up debris/clean spills.

E. Blood-borne Pathogen (BBP) Exposures

The rate of blood-borne pathogen exposures per 100 FTE **decreased to 1.6 in FY-20 compared to 2.0 in FY-19.** The total number of exposures for both campuses decreased to 41 exposures in FY-20 compared to 48 in FY-19. Of these, 36 were percutaneous exposures and 5 were body fluid exposures due to splashes.



Analysis:

- In October, 2019 a full needle conversion was implemented at both campuses, based on findings by our Sharp Taskforce and to reduce variation among floors and among campuses.
- In FY-19, 33% of exposures due to needle sticks were the result of handling subcutaneous needles; mostly insulin syringes. In FY-20 we saw a 4% reduction in overall needle sticks compared to FY-19 and a 22% reduction in needle stick by insulin syringes.
- The implementation of our universal masking and eye protection programs due to COVID-19 the blood-borne pa BBP exposures due to splashes were reduced by 72%.

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO
- Continue to meet with 1:1 with injured employees to identify preventable root causes
- We found that nursing new grads account for some of the injuries. EWHS will partner with Clinical Education to explore ways to increase awareness and possible education among our nursing new grads.

F. TB Conversions

There were no known occupational exposure conversions at either campus during FY-20.

EC 1.0 - Safety Management

G. Safety Training Indicators

Ensuring staff receive the necessary and required training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-based training is required for all employees. The Life Safety courses required for all employees and provided as on-line modules on topics including fire, evacuation, hazardous materials, and other safety topics. These are:

- New employee orientation: 100% (Target: 100%)
- Life Safety - Non-Clinical: 95% (Target: 95%)
- Life Safety - Clinical: 93% (Target: 95%)

H. Safety Inspections

Safety inspections (Environmental Tours) are conducted monthly. Clinical departments are inspected twice per year, once by the Safety Inspection team, and once by the unit. Nonclinical areas are inspected annually by the Safety Inspection team. Problems noted are documented and delegated to the department manager and remain open until corrected.

The most noted problems in calendar year 2019 involved:

Problem Type	Category
• Are all ceiling tiles in place and in good condition (unbroken, free of dirt, mold, dust, water stains)?	*General Safety*
• Are items stored at least 18 inches below sprinkler heads?	*Fire Safety*
• Are clean linen carts covered (no linen on top of cart) or is linen stored in a separate linen closet?	*Hazardous Material Mgmt.*
• Are all electrical panels accessible – not blocked by carts, boxes, trash cans, or other items?	*Utility Management*
• Are all walls in good condition (undamaged, free of holes or water damage)?	*General Safety*
• Are all outlets / electrical box cover plates in good shape, not damaged or missing?	*Utility Management*
• Is paper signage laminated or in plastic sleeves?	Infection Prevention

Effectiveness

Key indicators were identified to establish goals for FY-19 with opportunities to improve Safety Management within the Environment of Care.

FY 20 Goals

1) Reduce Bloodborne Pathogen (BBP) exposures related to needle sticks

   Measurement of success: Reduce BBP exposures related to needle sticks by 5%

   This goal was accomplished. In FY-20 we reduced BBP exposure related to needle sticks by 10% compared to FY-19.

2) Reduce Musculoskeletal Disease injuries among our EVS population

   Measurement of success: Seek assistance from an outside consultant to assess and implement an EVS Ergonomic & Injury Prevention Program with the goal of reducing MSD injuries among our EVS population by 5%.

   This goal was accomplished. In FY-20 EVS had 7 MSD injuries not related to patient handling for an 85% reduction and OVERALL total of 2 days of loss time!

EC 2.0 - Security Management

Work Group Chair: ***Matt Scannell***

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime Data Analysis
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events Review

Workplace Violence Prevention Plan

Workplace violence (WPV) prevention has been a focus of the health care community for many years. In 1993 the California Health and Safety Code adopted Sections 1257.7 and 1257.8, requiring hospitals to conduct annual security and safety assessments and implement a security plan to protect employees, patients and visitors from aggressive and violent behavior at work. The laws require hospitals to report injuries sustained by personnel to law enforcement, and to provide training to hospital employees regularly assigned to the emergency department and other high-risk areas, as identified by the hospital.

In October, 2016, an additional health care workplace violence prevention regulation, Section 3342 of Title 8 of the California Code of Regulations, was adopted with full compliance required by April 1, 2018. A task force was created to oversee the implementation of the hospital's Workplace Violence Prevention Plan. All required elements of the program have been implemented. The task force has disbanded and oversight and update has been given to the Workplace Violence Committee.

Plan Element: Written Plan	**Status: COMPLETED**
• The written plan has been completed and approved. • The plan requires annual review / update by the Workplace Violence Committee. The plan was reviewed, revised and approved by the Workplace Violence Committee in July of FY 2020.	

Plan Element: **Response:** Investigate violent incidents	**Status: Completed**
• This is being completed through the Workplace Violence Committee. The plan includes a comprehensive violent incident investigation process.	

Plan Element:	**Training (annual)**	**Status: ONGOING**
• The hospital has developed two levels of training. 1. AVADE – Computer based training module assigned to most staff. 2. Nonviolent Crisis Intervention (NCI) training – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to: ○ Behavioral Health ○ Assistant Hospital Managers (Hospital Supervisors)		

EC 2.0 - Security Management

- Emergency Department
- Facilities Engineering
- Charge Nurses/Clinical Managers
- Security
- Course is also available as an option to all staff.

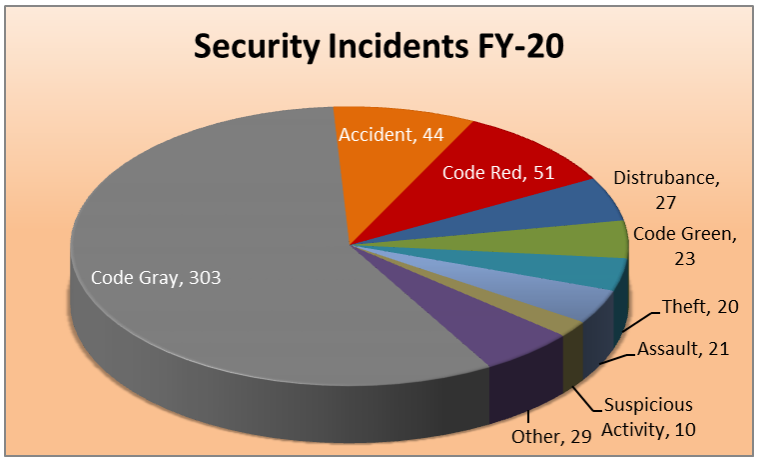
Plan Element: **Reporting:** All physical assaults against staff to OSHA	**Status:** **ONGOING**

- An ongoing WPV Reporting team is ensures reporting is completed as required.
- In FY-20, 63 incidents were reported to OSHA.
  - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
- 51% (32) of incidents resulted in no injury. The remaining events were minor injuries with 71% being bruises or abrasions. No major injuries were reported.

EC 2.0 - Security Management

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY-20. The data includes activity from both campuses.



There were a total of 528 reported security incidents for FY-20 requiring immediate response. This is an increase from the FY-19 total of 462.

Review of the major FY-20 incidents showed:

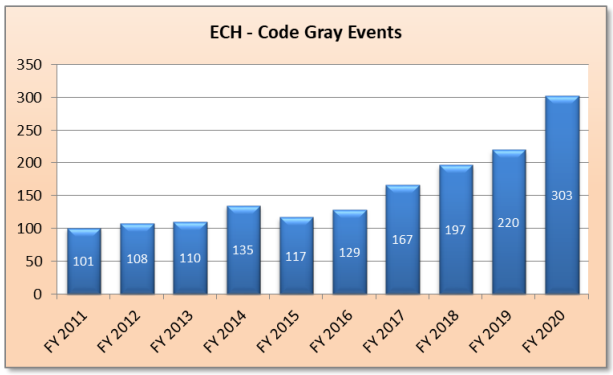
- There were 63 Workplace Violence (WPV) incidents reported to CA-OSHA. This is a 23% increase from FY-19. Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
  - Patients that are medicated sometimes become combative.
  - Increased incidents of elderly dementia patients acting out and incidents of younger chemical dependent patients becoming combative.
  - Restricted visitation due to COVID-19 precautions raised patients level of anxiety.

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY-20 was 303 compared to 220 in FY-19.

Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- MV Emergency Department (ED) – 21%
- MV Progressive Care unit (PCU) – 17%
- MV Medical Unit (2C) – 15%
- MV Telemetry/Stroke (3C) 15%



Responses are tracked through the Code Gray critique form and monitored to help identify possible improvements to the process.

The Hospital utilizes the **Non-violent Crisis Intervention® (NCI)** training program for all staff who deals with angry or agitated persons. This is part of the Workplace Violence Prevention program and is required for staff in designated high-risk areas. Staff in other departments is encouraged to take this training as an optional course.

B. Bulletins, Alerts & Presentations

EC 2.0 - Security Management

Security Services issued 1 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 4,866 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 1,968 patient watches, standbys and restraints. This was a significant increase over FY-19 which was 1,667 & FY-18 which was 956. Hospital Supervisors notify Security of these events which can last several hours. They primarily occur in the Emergency Department, Behavioral Health and on the Medical Units. Patient watches are also handled by the ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 100 fire drills and are 100% up-to-date. A total of 2 fire watches were performed in FY-20.

F. General Assistance

Security Officers performed 74,943 service requests including but not limited to main lobby greeter assistance, directional requests, door locks/unlocks, escorts, issuance of one-day passes.

G. ID Badges

Security Services issued 1,895 Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 2,032 temp badges were issued.

H. Investigations & Audits

Security Services performed 91 investigations and audits including but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Lost And Found

Security Officers performed 479 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 15,297 (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

K. Loitering

Security Officers responded to 191 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

L. Parking Compliance & Services

EC 2.0 - Security Management

In addition to daily parking control and 'space availability' counts, Security Officers performed 134 vehicle-related services including jump-starts, door unlocks and tows. 750 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 49 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

N. Statistics –Police Department Crime Data

	Mountain View (Source: 2019 MVPD Annual Report)	**Los Gatos** (Source: 2018 LGPD Annual Report)
Square Miles:	12	11.25
Population:	83,377 (County of Santa Clara 1,945,940)	30,516
Personnel:	148	59 (39 sworn & 20 non-sworn)
Total Calls for Service	6,860	35,524
Statistics ***UCR data includes attempts and actual crimes***		
Part I UCR:	2,274 (2103 Property vs. 171 Violent)	488 (477 Property vs. 11 Violent)
Previous Year	2,164 (1976 Property vs. 188 Violent)	598 (583 Property vs. 15 Violent)
Part II UCR:	2,497	Not Collected
Previous Year	2,800	Not Collected
Arrests-Misdemeanor:	1,235 (1177 Adult vs. 58 Juvenile)	Not Collected
Previous Year	1,553 (1465 Adult vs. 88 Juvenile)	Not Collected
Arrests-Felony:	386 (347 Adult vs. 39 Juvenile)	Not Collected
Previous Year	375 (353 Adult vs. 22 Juvenile)	Not Collected
Traffic Collisions:	467	281
Previous Year	550	Not Collected
Moving Violations:	Not Collected	Not Collected
Previous Year	1,827	Not Collected
Non-Moving Violations:	Not Collected	Not Collected
Previous Year	2,199	Not Collected
Indexes ***Per 1,000 current year population***		
Violent:[2]	2.11	0.35
Previous Year	2.33	0.48
Property:[3]	26.29	15.53
Previous Year	24.46	18.98

[2] Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery
[3] Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson

EC 2.0 - Security Management

Effectiveness

Key performance indicators were identified in the FY-20 to improve Security Management within the Environment of Care.

FY-20 Goals

1) 90% non-medical emergency security response time less than 3 minutes.

   This goal was accomplished.

2) 10% reduction in number of reportable workplace violence incidents. In FY-20 there was a 23% increase in the number of Workplace Violence reports submitted to CAL-OSHA.

   This goal was not met.

EC 3.0 - Hazardous Materials & Waste Management

Work Group Chair: ***Lorna Koep***

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Hospital. The work group chair serves as the central contact point for the reporting and documentation for the Hazardous Materials & Waste Management work group and provides regularly scheduled reports to the Central Safety Committee.

Performance

A. Hazardous Material Incidents

Facilities Services maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

- **Recordable Hazardous Material Incidents[4]:**

1) Chemo spill – Mountain View Infusion Center: IV tubing malfunction, disconnected during infusion. Cleanup was handled safely.
2) Chemo spill - 4B: IV tubing malfunction, disconnected during infusion. Cleanup was handled safely.
3) Gram Stain waste spill: Microbiology staff failure to monitor and manage waste containers used to catch stain waste under sink. The secondary container was full and overflowed. RCA performed, gap identified, staff re-trained and leak detector/sensor was purchased and installed.
4) Formalin spill in Los Gatos OR #2: spilled quantity of Formalin due to container lid failure (leaking). Spill was cleaned up. Reviewed procedures for Formalin handling and reviewed secondary containment for process improvement.
5) Formalin spill in Mountain View Imaging, CT #2: Specimen container knocked over during biopsy procedure. Reviewed procedures for Formalin handling for improvement process.
6) Medication spill – In-Patient Pharmacy: The storage bag of the medication had a hole in the bottom. Reviewed procedures to inspect the condition of the storage container bag prior to use.

- **Reportable Hazardous Material Incidents[3]** – No reportable spills.

B. Waste Water Discharge Violations:

- **No Waste Water Discharge Violations**

[4] Reportable and recordable hazardous material incidents are defined by state and federal regulations and are determined based on the quantity and hazard of the spill.

C. Monitoring and Inspections

- **Hazardous Waste Inspections**-No Inspections for FY-19
- **Santa Clara County Annual Medical Waste Inspections**-No Inspections for FY-20
  - Continued monitoring and education to ensure waste segregation compliance :
    - Annual Waste Management education for staff
    - Daily rounds by EVS supervisors
    - Monthly Safety Rounds that include observation of waste segregation practices
    - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.

D. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly.

E. Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[5] training course.

Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve hazardous materials & waste management.

FY-20 Goals:

1) Controlled Substance Diversion Program – CsRx Program partnership with Stericycle established February with a plan, education material, and containers ready offsite to address diversion and mitigation of pharmaceutical contamination of the environment.
   - **Measurement of success**: Complete partnerships, draft a plan, and educate nursing/pharmacy staff to implement the utilization of controlled substance waste containers and service.
   - ***This goal was accomplished.***
     - Due to extenuating circumstances with the COVID-19 Pandemic, delivery of the containers was delayed, resulting in pushing the installation date to August, 2020. However, the plan was complete and ready to implement by the end of FY-20.
2) Review and update Health Stream Education/Test module for EVS and Clinical Staff
   - ***Measurement of Success:*** Update the annual education materials to reflect current and best practices for safe handling of waste and to update assignments to appropriate staff
   - ***This goal was accomplished.***
     - 2 modules/tests and an updated assignment list are live in Health Stream.

[5] HAZWOPER: Hazardous Waste Operations and Emergency Response

EC 4.0 - Fire Safety Management

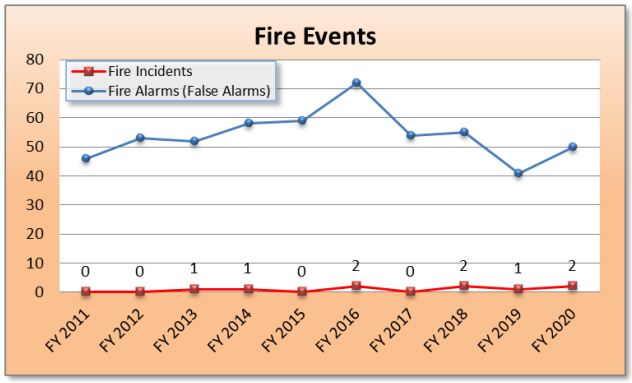
Work Group Chair: ***John Folk***

Scope

The Fire Safety Management Plan is designed to assure appropriate, effective response to a fire emergency situation that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management during FY-20.



A. Fire Incidents

There were 2 reported fire incidents in FY-20.

1. **Smoke Detector – MV Hospital Penthouse (September)**: At approximately 1:30 in the afternoon, a smoke detector activated in the New Main Penthouse for Elevator #8. Upon responding the alarm, it was found that the room was filled with smoke caused by the elevator motor brake overheating. The Fire Department responded, and the elevator was secured by Engineering until Otis Elevator made the required repairs.
2. **Fire in Conference Room C food cart** (November 21): At approximately 12:30 PM staff notified security and facilities of smoke in the Physician's Dining Room. The source was determined to be from lit, gel-fuel containers used for heating chafing dishes being put into the food transport cart. The cart was quickly removed from the building. There was no damage or injury.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All cases are evaluated for potential opportunities for improvement.

The total number of events in FY-20 (51) was an increase compared to FY-19 (41). There were 51 events in Mountain View and 0 in Los Gatos. This increase can be attributed to the heavy construction activity requiring the connection, and integration of the Sobrato Pavilion, Taube Pavilion, and the New Main Connector new fire alarm systems to the existing hospital fire alarm system during FY-20.

C. Fire Drills Completed / Scheduled

All required fire drills (total of 100) were completed in FY-20. For all drills, there were 4 required actions by staff. All issues were fully corrected either on the spot or with further education by the dept. Manager.

Effectiveness

Key indicators were targeted to establish goals for FY-20. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 20 Goals

1) Educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new Sobrato and Taube pavilions.

   This goal was accomplished. Initial training for all Engineering staff was completed and additional training will continue as the buildings continue to be occupied.

2) Identify staff to attend NFPA code classes to further their knowledge and applications of fire safety codes.

   Ongoing: We will continue to Schedule Engineers to receive the recommended **NFPA** training.

3) Develop an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.

   This goal was accomplished. Ongoing monitoring is in place with the new Sobrato and Taube pavilions to ensure compliance with the Life Safety and NFPA codes.

4) Increase oversight and improve mechanisms for the monitoring of above ceiling work that includes contractors, project management and facilities.

   This goal was accomplished. Continued ongoing monitoring and education of contractors is still in place.

EC 5.0 - Medical Equipment Management

Work Group Chair: ***Jeff Hayes***

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

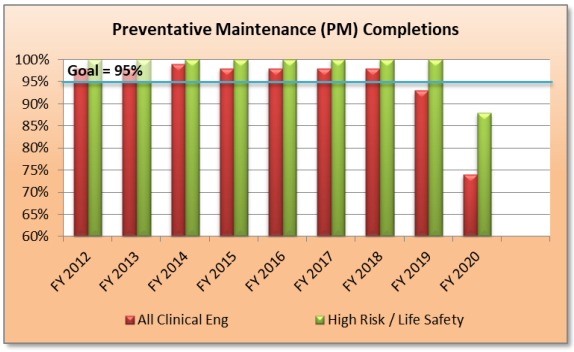
Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-20.

A. Reports to the FDA –

There were 8 reports through the Medwatch[6] system in FY-20. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage



The PM completion rate did not meet compliance for the target of 95% in all areas. Additionally, high risk equipment was maintained at 88% a completion. The goal for high risk equipment is 100%.

- The completion rate for Clinical Engineering achieved 74% for FY-20.
- All high risk, life safety equipment was maintained at 88% completion rates

C. Product Recalls Percentage Closed / Received

For FY-20, there were 64 recorded medical equipment related recalls.

Effectiveness

Key indicators are targeted to established goals for the fiscal year. A deep dive into the Clinical Engineering database found inconsistencies with the inventory and data present. Through this evaluation year equipment generating PM schedules were found to be removed from service thus generating a higher than normal number of unable to locate devices. Through a process of data management, department assistance of locating or correcting inventory and a strong effort to clean up the inventory, standardize equipment and schedules in the database which assisted to identify

[6] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

all device appropriately was develop to address these inconsistencies. Continued monitoring of this process will improve the effectiveness of the program.

EC 6.0 - Utilities Management

Work Group Chair: ***Nick Stoliar***

Scope

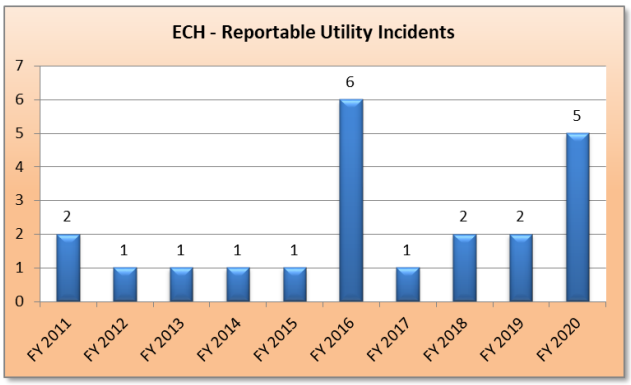
The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-20.

A. Utility Reportable Incidents

There were 5 reportable incidents in FY-20. All were electrical outages or voltage fluctuations.



- In August, April, May, and June, Los Gatos had a momentary loss of electrical utility (PG&E) campus wide.
    - The August, April and May events activated the emergency generators on.
- In March, Mountain View had a loss of electrical to the campus due to a PG&E mechanical malfunction.

B. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was **95%,** meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

C. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

EC □.0 - □tilities Management

Effectiveness

Key indicators were targeted to establish goals for FY-19. The following goals presented opportunities to improve Utility Management within the Environment of Care.

Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 20 Goals

1) Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.

   In progress **-** Ongoing education and familiarization for all engineering staff will occur over the course of the next few months as the new buildings come on line **and are occupied**.

2) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

   This goal was accomplished. Process in place for access control, ongoing monitoring for effectiveness is in place.

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

   In progress **- There will continue to be** some equipment that needs to be added to the renovation and or replacement plan for both sites.

FY 21 Goals

1) **Continue to work** with PG&E to improve communication related to Planned/Unplanned utility disruption events
2) **Continue to educate** all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.
3) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.
4) **Increase review of procedures and protocols for utility outage response.**

EM – Emergency Management

Committee Chair: ***Steve Weirauch***

Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal and external emergencies impacting the El Camino Health environment of care. The Emergency Management Committee ensures an effective response to these events. The hospital actively participates with state and local emergency management entities to coordinate community planning efforts and response. Emergency Management is a separate chapter under The Joint Commission; however the annual reporting is being combined with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported through the monthly committee meetings. Significant events are presented quarterly to the Central Safety Committee. The following Emergency Management indicators were reported in FY-19.

A. Activation of Hospital Incident Command System (HICS)

There were two recorded events and/or emergencies during FY-20 requiring activation of HICS and opening of the Hospital Command Center (HCC).

1. **Power Outage – Los Gatos Campus (08/23/2019, 09:45)** – A PG&E power failure occurred on the morning of August 23rd. Command team met in the HCC to ensure all systems were operational. One piece of equipment in the lab was affected, but no other operations were impacted. The incident was closed at 10:45 AM.

2. **COVID-19 Pandemic** – The outbreak of COVID-19 critically impacted El Camino Health as the pandemic quickly spread across the world. Upon the first indications that the Novel Coronavirus was beginning to spread across the globe, a limited activation of HICS was done beginning on February 4th. The HICS team met each morning to discuss hospital status including staffing and supplies. At the time it was decided that enterprise operations of HICS would be run from Mountain View with remote connections to the Los Gatos campus.

   The first patient was admitted to the Mountain View campus on February 27th. It was decided to fully activate HICS at that time and the Hospital Command Center (HCC) was opened in Mountain View on Friday, February 28th. The HCC remained open until Sunday May 10th, an unprecedented 72 days.

   See the attached **Mid-Response Action Report** at the end of this section for more information on the COVID-19 response.

B. Events / Emergencies

The hospital responded to additional emergency incidents that did not activate the Hospital Command Center. These included:

1. **Public Safety Power Shutoff (10/09/19 and 10/25/19) –** PG&E implemented a *Public Safety Power Shutoff* (PSPS) program in 2019 to proactively shut off electrical power in key areas where weather conditions could cause powerline failure and ignite wildfires. Two PSPS events were initiated in the local area during October of 2019. Neither campus was directly in the area of the power shut off; however transmission lines to the hospitals did cross some

of the impacted areas. Key staff drafted plans for continued operations should power be interrupted. Communications were sent to all staff informing them of the situations and providing critical information. Fortunately, neither incident caused an impact to hospital operations.

2. **Hazardous Chemical Spill in Microbiology (12/15/2019) –** approximately 1 – 2.5 gallons of gram stain waste was spilled in the microbiology area of the Clinical Lab. The waste collection container under a sink overflowed. The sink is used only for the disposal of stain materials. Due to hazardous waste requirements, this sink cannot be connected to the drain so a container is used to collect the waste. Staff failed to monitor the waste container, leading to the overflow. The spill was contained and cleaned up. Several action items were implemented to prevent a recurrence. This includes additional training for staff to understand the system and the installation of high liquid level alarms.

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY-20, this was met through separate planned exercises at both campuses (see below) and the COVID-19 pandemic response. The exercises are summarized below. Action items were created to improve future responses.

Note, during most years, the hospitals participate in a statewide medical and health exercise in November. Due to the PSPS events, this was postponed until March, 2020. However, with the COVID-19 pandemic in progress, neither facility participated in the reschedule exercise.

a. **Mountain View Functional Exercise in Taube Pavilion (10/30/2019)** – in preparation for the opening of the new behavioral health facility, a series of functional exercises was conducted to test procedures and familiarize staff with the new building.

b. **Los Gatos Functional Exercises (11/21/2019)** – A functional exercise was conducted involving response to a wildfire. HICS was activated and the HCC was opened. The hospital had a surge of patients with injuries related to the wildfires, the possibility of a shortage of medical supplies due to supply routes being closed, and the potential for a hospital evacuation.

Additional Exercises were conducted to assess and test our preparedness to other emergency events

c. **Code Pink Drills – Mountain View & Los Gatos (12/2019)** - Exercises were conducted at both campuses to test staff's ability to respond to an infant security band alert.

D. Emergency Management Training

- **New hire orientation** (100% for all employees)
- **Safety coordinator meetings** (40% attendance overall for the quarterly meetings). Safety Coordinators unable to attend the meetings are provided with detailed notes and information and are expected to complete all assignments.
- **CHA Disaster Preparedness Conference –** the CHA hosts an in-depth conference related to disaster response and preparedness each year in September. The hospital has always sent a contingent to this conference. This year, the conference was streamed live so additional staff were able to attend remotely.

EM – Emergency Management

E. Community Involvement

The hospital continues to be an active participant in the Santa Clara County Hospital Emergency Preparedness Partnership (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives of all Santa Clara County hospitals and the county EMS. The emphasis is creating a collaborative county-wide emergency response and disaster plan. The group also organizes and facilitates county-wide disaster exercises in which the hospital actively participates.

The EPHC expands many of the same elements of the SCCHEPP to all healthcare facilities in the county including clinics, skilled-nursing facilities and dialysis clinics. This group meets quarterly and shares information and provides training to help all healthcare facilities prepare for emergencies. Steve Weirauch is currently the Education Committee chairperson of Santa Clara County EPHC and has participated in several conferences sharing the experiences and benefits of developing regional coalitions.

F. Hazard Vulnerability Assessment (HVA)

The HVA is an assessment of each facilities risk for various emergency situations. The HVA is reviewed and revised annually. Separate HVA's are completed for the Los Gatos and Mountain View campuses to account for physical differences in the locations and facilities. Efforts are then focused on attempting to minimize the highest risks during the fiscal year.

- There were several changes to the HVAs at both campuses in FY-20. The top five hazard s by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Mass Casualty - Medical/Infectious	(2) Information System Failure
(3) Person with a Weapon	(3) Communication System Failure
(4) Cyberattack	(4) Electrical Power Failure
(5) Information Management System Failure	(5) Seasonal Influenza

- Note: the 2020 HVA was completed prior to the COVID-19 pandemic.

EM – Emergency Management

G. Effectiveness

Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve emergency management.

FY-20 Goals

1. Expand the use of mass notification system (Everbridge) to all employees
    a. Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
    b. Evaluate and set up logical groups and rules for notifications.
    c. Train key staff to be able to use/send alerts

    This goal was partially accomplished. Expanded funding for this was finally secured and work is underway with IT and HR to incorporate automatic upload of staff information.
2. Revise and distribute the Emergency Management Guides for both campuses.
    a. Revision of content to include latest information.
    b. Roll out of app for the guide on Android and iOS devices in addition to wall-mounted guides.

    This goal was accomplished. The revised guides were distributed in all areas by the end of 2019. The MyEOP app was launched in early 2020. The app contains all of the elements of the wall-guides for easy reference on smart devices (Apple and Android).
3. Train staff on emergency procedures in new Taube and Sobrato Pavilions.

    This goal was accomplished. A multi-department effort was undertaken to provide training for all staff. This consisted of numerous live tour/training sessions, online modules and practice scenarios. Both building opened during the fourth quarter.

FY-21 Goals

1. Expand the use of mass notification system (Everbridge) to all employees (continued from FY-20)
    a. Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
    b. Evaluate and set up logical groups and rules for notifications.
    c. Train key staff to be able to use/send alerts
2. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.
3. Revise Hospital Surge Plan.

El Camino Health

Novel Coronavirus (COVID-19)

Mid-Response Action Report

February 28 – May 10, 2020

El Camino Health

2500 Grant Road | Mountain View, CA 94040 | 650-940-7000
815 Pollard Road | Los Gatos, CA 95032 | 408-378-6131
elcaminohealth.org

EM – Emergency Management: COVID-1 Mid-Response Action Report

Overview

Event Name	Novel Coronavirus (COVID-19)
Dates	February 28, 2020 – May 12, 2020
Key Issues	1. Provide adequate supplies of Personal Protective Equipment for staff as needed to ensure safety. 2. Rapid dissemination of updated and changing recommendations to protect staff 3. Long-term Operation of Labor Pool 4. Just-in-Time PPE Training 5. Just-in-Time N-95 Fit testing 6. Sharing of resources between hospitals/agencies 7. Communications with community 8. Tracking and acceptance of donations from the community 9. Facility access 10. Staff Well-Being 11. Negative Air Flow Rooms
Threat or Hazard	Pandemic

EM – Emergency Management: COVID-1 Mid-Response Action Report

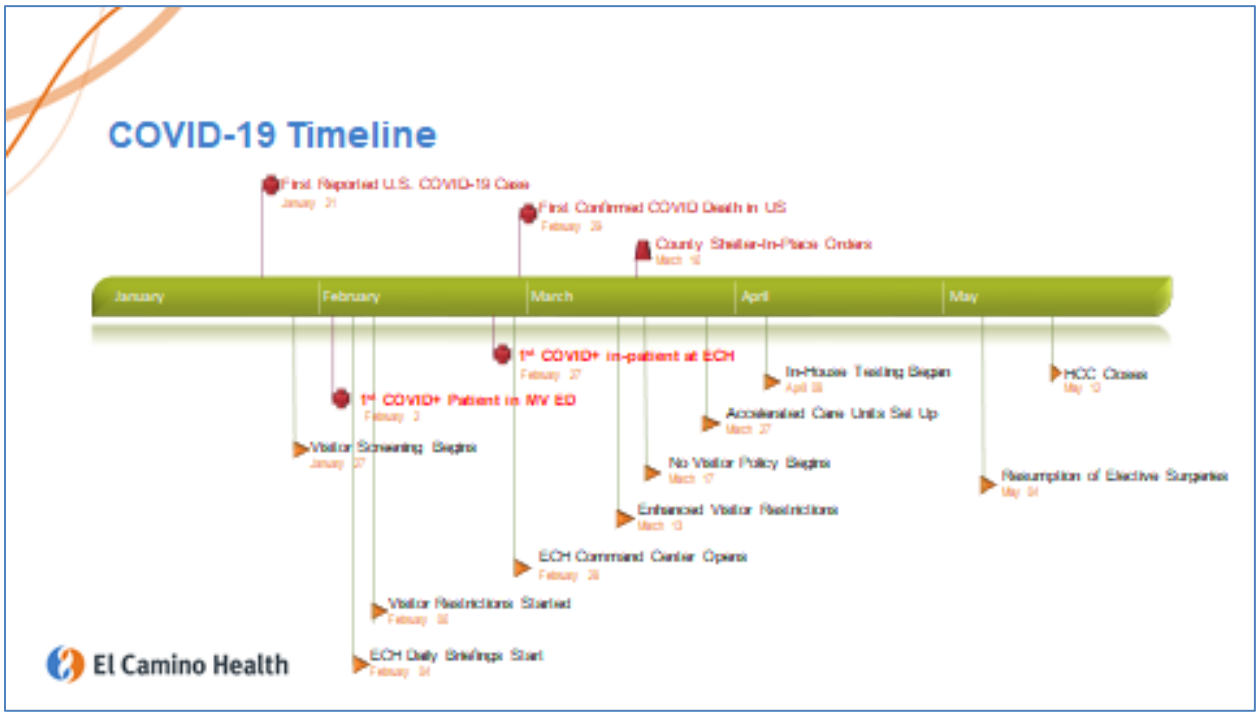
Event Summary

The Novel Coronavirus (COVID-19) was first identified in early 2020. The first known case presenting to El Camino Health presented to the Mountain View Emergency Department on February 2nd, 2020. The patient was not admitted to the hospital. At this time the hospital began conducting daily briefings to prepare for additional cases which may arise. Key leaders were involved in discussing appropriate care and safety for patients, visitors and staff, and to monitor equipment and supplies.

The first confirmed patient was admitted to the Mountain View hospital on February 27th, 2020. In response to this, it was decided to open a Hospital Command Center in Mountain View to coordinate the response for both campuses. The HCC activated on February 28th and was operational until May 12th, a total of 72 days.

During this time, as more was learned about the virus and how to care for patients and protect everyone there were continual updates to procedures. This sometimes led to confusion and increased stress for staff, patients and visitors.

A simple timeline is included below for the event as it unfolded at El Camino Health.



During this period, El Camino Health had the following number of patients:

	Los Gatos	Mt. View	Enterprise
COVID+ Patients Admitted	5	50	55
COVID Deaths	1	7	8

Analysis of Issues

Table 1 includes the issues, aligned core capabilities, and performance ratings for each core capability as observed during the COVID-19 period through the closure of the Hospital Command Center on May 12th.

Issue	Core Capability	Performed without Challenges (P)[7]	Performed with Some Challenges (S)[8]	Performed with Major Challenges (M)[9]	Unable to be Performed (U)[10]
Provide adequate supplies of Personal Protective Equipment for staff as needed to ensure safety.	Equipment			x	
Rapid dissemination of updated and changing recommendations to protect staff.	Organization		x		
Long-term Operation of Labor Pool	Planning		x		
Just-in-Time PPE Training	Training		x		
Just-in-Time N-95 Fit testing	Training			x	
Sharing of resources between hospitals/agencies	Planning		x		
Communications with community	Organization		x		
Tracking and acceptance of donations from the community	Planning	x			
Facility access	Organization		x		
Staff Well being	Planning		x		
Negative Pressure areas	Equipment		x		

Table 1. Summary of Core Capability Performance

The following sections provide an overview of the performance related to each issue and associated core capability, highlighting strengths and areas for improvement.

[7] **Performed without Challenges (P):** The critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

[8] **Performed with Some Challenges (S):** The critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.

[9] **Performed with Major Challenges (M):** The critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

[10] **Unable to be Performed (U):** The critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).

EM – Emergency Management: COVID-1 Mid-Response Action Report

Issue 1: Provide adequate supplies of Personal Protective Equipment for staff as needed to ensure safety.

Strengths:

- Rapidly realized need for additional equipment and PPE. Supply chain began efforts to secure equipment from alternative sources.
- Daily (or more) meetings to report equipment supplies and develop plan to ensure adequate usage.

Areas for improvement

- Not all staff aware of the critical equipment shortages.
- Some PPE was stolen from unattended carts and departments
- Tracking of par levels for key equipment was not initially part of the HCC operations
- Inconsistent information on the use and types of equipment caused confusion among the staff.

Analysis

The HCC and command team tracked supplies and daily usage. As it became apparent that orders of some equipment was not able to be fulfilled by suppliers, the supply chain began searchong for other sources. In addition, additonal measures were taken to conserve supplies. The HCC became directly involved with the deployment of critical equipment. This did help in getting the hospital through the most difficult times. Procedures and information changed frequently and this was shared with manager in the daily briefings. However, some staff were unaware of the severe shortages and became frustrated with the inability to get the quantities of suppleis requested.

Issue 2: Rapid dissemination of updated and changing recommendations to protect staff

Strengths

- Creation of SharePoint site for centralized location of all COVID-19 infomration to staff
- Frequent updates by Executive staff to employees
- Implementation of Elemeno.
- Use of Zoom meetings to quickly and safely inform staff of hospital status and changes

Areas for Improvement

- Outdated information was not always removed completely causing confusion, especially with the rapidly changing situation
- Multiple formats and undated documents caused confusion
- Critical information was not disseminated to ALL staff on ALL shifts.

Analysis

As new information became available about the virus, there were continual, frequent changes to procedures for keeping staff and patients safe. This resulted in multiple updates tp guidelines and procedures. Revised documents were created and distributed. However, initially it was difficult to ensure outdated information was removed. To address this, a SharePoint site (COVID-19) was created as a repository for the latest information. Updates were also shared at the daily briefings. While this helped, there were still some gaps in ensuring old documents were removed promptly.

Issue 3: Long-term Operation of Labor Pool

Strengths

- Once operational, labor pool was able to coordinate staff deployment
- Utilization of staff that would otherwise be off work.

Areas for Improvement

- Took several days to implement the Labor Pool operations.

Analysis

During course of the response, there were needs identified for key staff to assist in the response. This included runners to transport supplies, lab specimens and food, screeners to conduct health monitoring of persons entering the hospital. As the needs arose, the labor pool was able to meet these needs utilizing staff who would otherwise have not been working due to departments being closed or having limited patient needs. This did take some time to put into place.

Issue 4: Just-in-Time PPE Training

Strengths

- Nursing Education team coordinated training and information sharing through InTouch nursing newsletters.
- Training procedures posted on COVID-19 SharePoint and Elemeno sites.

Areas for Improvement

- Non-nursing staff did not have access to all the critical training information. InTouch only emailed to nurses.

Analysis

Due to the rapidly changing procedures updates and training infroamtion was shared with clinical staff utilizing the InTouch Nursing Newsletter. However, it was noted that this email does not reach non-nursing, clinical staff. A plan needs to be adopted to ensure all the staff are notified.

Issue 5: Just-in-Time N-95 Fit testing

Strengths

- EWHS able to coordinate N-95 fit testing for all required staff. Fit testing was done on multiple shifts and at multiple locations.

Areas for Improvement

- Had to bring in outside contract help to conduct fit testing.

Analysis

We had moved away from N-95 masks for most airborne isolation patients, opting instead for using MaxAir PAPRs. This removed the need for annual fit testing to the N-9r respirators. However, a shortage of the disposable lens cuffs for the PAPRs occurred requiring a change to using N-95 masks. This required a massive effort to fit test all employees who would need to care for positive and suspect patients. A plan for dealing with this sort of situation if it should arise again is needed.

Issue 6: Sharing of resources between hospitals/agencies

Strengths

- Frequent teleconferences with public health and other facilities to share and obtain current information.
- Executive contacts with government officials to assist in locating potential resources.
- Shared equipment between hospitals – HEPA filters, PPE swaps, etc.

Areas for Improvement

- Initial confusion over using WebEOC for resource requests vs. direct communications with the Resource Request form.

Analysis

Initially, the county instructed hospitals to utilized the resource request options on WebEOC. However there were delays and issues using the program and facilities were then instructed to use the 213 RR (Resource Request) form instead. A determination needs to be made county-wide over the use of one or the other systems.

Issue 7: Communications with community

Strengths

- Updates to social media of hospital status

Areas for Improvement

- More frequent updates were requested by community
- Consistent messaging to screeners and staff about visitation policy changes.

Analysis

During the rapidly changing situations, we sometime lagged behind in updating and providing current infromation to the community.

Issue 8: Tracking and acceptance of donations from the community

Strengths

- Generous community donated large quantities of supplies and food for staff

Areas for Improvement

- Develop plan handling donations of equipment and food early

Analysis

During the early weeks of the pandemic, the shortage of PPE was pusblicized through the media. The community responded in unexpected ways with an outpouring of donated supplies, equipment and food. Initially we did not have a way to track this to ensure the donors were appropriately thanked and to ensure the supplies were properly inventoried for future use. The Foundation stepped up to oversee this program. A plan should be drafted to handle this from the start in the future.

Issue 9: Facility access

Strengths

- Ability to limit access to facility.
- Addition of badge readers in Los Gatos to secure facility.
- Deployed screeners to entry points to hospitals.

Areas for Improvement

- Ensure consistent procedures and training for screeners.

Analysis

As the pandemic worsened and we had to limit access to the facilities, there was confusion and some issues surrounding the screening and access of visitors, contractors and others that did not have badges. This process has been developed and should be formalized for use in the event of future events.

Issue 10: Staff Well-Being

Strengths

- Providing child care for staff at local YMCA facilities.
- Nutrition Services offering essential grocery items for staff out of cafeteria.
- Access to Concern EAP.

Areas for Improvement

- Formalize the process for setting up childcare and sleeping spaces for staff

Analysis

Providing resources for staff and their families in the form of contacts for childcare and the use of the local YMCA facilities was greatly appreciated by staff. We have plans for this in our Emergency Operations Procedures, but should review/revise the plans now that they have been put into actual use.

Issue 11: Negative Air Flow Rooms

Strengths

- Ability to convert air flow to negative in rooms to allow flexibility for COVID-19 patient care. Cohorting patients in one area better use of resources than utilizing negative pressure rooms scattered throughout the hospital.
- Deployment of HEPA filters to provide additional negative airflow in rooms.

Areas for Improvement

- Provide better method for tracking equipment (HEPA) filters.
- Formalize process for air flow changes to allow more rapid set up in the future.

Analysis

The abilitiy to convert patient rooms and areas to negative air flow was a major benefit for ensuring a safe environment for patients and staff. The procedures should be formalized in procedures for rapid deployment in the future.

Appendix A: Improvement Plan

Core Capability	Issue/Area for Improvement	Corrective Action	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Organization	1. Communication with all Staff	Expand hospital-wide communications to all staff using all available platforms to ensure staff are aware of critical issues	Talent Development	Tamara Stafford	08/01/2020	
Organization	2. Update of information on media platforms	Develop plan to ensure Toolbox, Elemeno and other documented information is continually reviewed and updated.	Talent Development	Tamara Stafford	08/01/2020	
Training	3. Plan for rapid N-95 fit testing	Develop a plan to conduct wide-spread fit testing as needed.	Employee Wellness and Health Services	Mari Numanlia-Wone	08/01/2020	
Planning	4. Consistent process for requesting resources from the community	Work with SCC to decide upon one process for the reporting and requesting of resources.	Safety	Steve Weirauch	08/01/2020	
Training	5. Define the role and oversight of screeners	Standardize the process for screening of public at entries	Patient Experience	a) Christine Cunningham b) Stefanie Shelby c) Jody Charles	08/01/2020	
Organization	6. Formalize the process for setting up employee and family support	Document the processes used for childcare system at YMCA and other staff support sites for future reference.	Human Resources	Beth Shafran-Mukai	08/01/2020	
Equipment	7. Document process for creating negative air flow rooms	Document the procedures for converting, maintaining negative airflow rooms.	Facilities Engineering	John Folk	08/01/2020	
Equipment	8. Develop process to better track equipment. HEPA filters and PAPRs were difficult to track in facilities	a) Develop a procedure to inventory and track PAPRs on a daily basis. b) Develop an inventory and tracking system for HEPA filters	a) Supply Chain b) Facilities Engineering	a) Manny Hernandez b) John Folk	08/01/2020	

This IP has been developed specifically for El Camino Health as a result of the response to the COVID-19 Pandemic from March – May, 2020.

Executive Summary

Safety Management

Effectiveness

- Key indicators were identified to establish goals for FY-20 with opportunities to improve Safety Management within the Environment of Care.

FY 20 Goals

1) Reduce Bloodborne Pathogen (BBP) exposures related to needle sticks
   - **Measurement of success:** Reduce BBP exposures related to needle sticks by 5%
   - **This goal was accomplished.** In FY-20 we reduced BBP exposure related to needle sticks by 10% compared to FY-19.
2) Reduce Musculoskeletal Disease injuries among our EVS population
   - **Measurement of success:** Seek assistance from an outside consultant to assess and implement an EVS Ergonomic & Injury Prevention Program with the goal of reducing MSD injuries among our EVS population by 5%.
   - **This goal was accomplished.** In FY-20 EVS had 7 MSD injuries not related to patient handling for an 85% reduction and OVERALL total of 2 days of loss time!

Security Management

Effectiveness

- Key performance indicators were identified in the FY-20 to improve Security Management within the Environment of Care.

FY-20 Goals

1) 90% non-medical emergency security response time less than 3 minutes.
   - **This goal was accomplished.**
2) 10% reduction in number of reportable workplace violence incidents. In FY-20 there was a 23% increase in the number of Workplace Violence reports submitted to CAL-OSHA.
   - **This goal was not accomplished.**

Executive Summary

Hazardous Material Management

Effectiveness:

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve hazardous materials & waste management.

FY-20 Goals

1. Controlled Substance Diversion Program – CsRx Program partnership with Stericycle established February with a plan, education material, and containers ready offsite to address diversion and mitigation of pharmaceutical contamination of the environment.
   - **Measurement of success**: Complete partnerships, draft a plan, and educate nursing/pharmacy staff to implement the utilization of controlled substance waste containers and service.
   - **This goal was accomplished.** Due to extenuating circumstances with the COVID-19 Pandemic, delivery of the containers was delayed, resulting in pushing the installation date to August, 2020. However, the plan was complete and ready to implement by the end of FY-20.
2. Review and update Health Stream Education/Test module for EVS and Clinical Staff.
   - **Measurement of Success:** Update the annual education materials to reflect current and best practices for safe handling of waste and to update assignments to appropriate staff.
   - **This goal was accomplished.** 2 modules/tests and an updated assignment list are live in Health Stream.

Fire Safety Management

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 20 Goals

1) Educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new Sobrato and Taube pavilions.
   - **This goal was accomplished**. Initial training for all Engineering staff was completed and additional training will continue as the buildings continue to be occupied.
2) Identify staff to attend NFPA code classes to further their knowledge and applications of fire safety codes.
   - **Ongoing.** We will continue to Schedule Engineers to receive the recommended NFPA training.
3) Develop an internal auditing process to ensure contract fire system companies are meeting all contractual obligations.
   - **This goal was accomplished.** Ongoing monitoring is in place with the new Sobrato and Taube pavilions to ensure compliance with the Life Safety and NFPA codes.
4) Increase oversight and improve mechanisms for the monitoring of above ceiling work that includes contractors, project management and facilities.
   - **This goal was accomplished.** Continued ongoing monitoring and education of contractors is still in place.

Executive Summary

Medical Equipment

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve medical equipment management within the Environment of Care.

FY 20 Goals

1. PM completion rate of 95% in all areas with 100% completion for all high risk equipment.
   - **This goal was not accomplished.**
     - The completion rate for Clinical Engineering achieved 74% for FY-20.
     - All high risk, life safety equipment was maintained at 88% completion rates.
   - **Action Item-** Key indicators are targeted to established goals for the fiscal year. A deep dive into the Clinical Engineering database found inconsistencies with the inventory and data present. Through this evaluation year equipment generating PM schedules were found to be removed from service thus generating a higher than normal number of unable to locate devices. Through a process of data management, department assistance of locating or correcting inventory and a strong effort to clean up the inventory, standardize equipment and schedules in the database which assisted to identify all device appropriately was develop to address these inconsistencies. Continued monitoring of this process will improve the effectiveness of the program.

Utility Systems

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 20 Goals

1) Educate all engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.
   - **In progress:** Ongoing education and familiarization for all engineering staff will occur over the course of the next few months as the new buildings come on line and are occupied.
2) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.
   - **This goal was accomplished.** Process in place for access control, ongoing monitoring for effectiveness is in place.
3) Develop a periodic equipment replacement or renovation plan for both Mountain View and Los Gatos.
   - **In progress:** There will continue to be some equipment that needs to be added to the renovation and or replacement plan for both sites.

Executive Summary

Emergency Management

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve emergency management.

FY-20 Goals

1. Expand the use of mass notification system (Everbridge) to all employees
   - **This goal was partially accomplished.** Expanded funding for this was finally secured and work is underway with IT and HR to incorporate automatic upload of staff information.
2. Revise and distribute the Emergency Management Guides for both campuses.
   a. Revision of content to include latest information.
   b. Roll out of app for the guide on Android and iOS devices in addition to wall-mounted guides.
   - **This goal was accomplished.** Revised guides were distributed in all areas. The **MyEOP** app was launched in early 2020. The app contains all of elements of the wall-guides for easy reference on smart devices.
3. Train staff on emergency procedures in new Taube and Sobrato Pavilions.
   - **This goal was accomplished.** A multi-department effort was undertaken to provide training for all staff, consisting of live tour/training sessions, online modules and practice scenarios. Both building opened during the fourth quarter.

Attachment 1 - Employee Health Services Definitions

1. OSHA Recordable Injuries / Illnesses per 100 FTEs	Number of injuries/illnesses multiplied by 200K divided by the number of Productive Hours* during the reported quarter. [# of OSHA recordable injuries ∗ 200,000 / Productive Hrs.]
2. Lost Work Day NEW cases per 100 FTEs	Total number of new injuries occurring in this fiscal year quarter multiplied by 200K divided by the number of Productive Hours* during the reported quarter. [# new cases in qtr. w/ lost work days ∗ 200,000 / Productive Hrs.]
3. Patient Lift / Transfer Injuries per 100 FTEs	Number of OSHA recordable injuries resulting from a specific event involving the lifting and transferring of patients and/or pulling up in bed multiplied by 200K and divided by Productive Hours*. Does not include pushing patients in beds, gurneys, wheelchairs, or other transport devices. [# patient lift injuries ∗ 200,000 / Productive Hrs.]
4. Exposures to Blood and Body Fluids per 100 FTEs	Number of exposures to blood/body fluids during a quarter or year x 200K divided by Productive Hours*. [# BBPs ∗ 200,000 / Productive Hrs.]
5. Productive Hours	Total number of hours worked for the quarter or year by all organizational employees. Includes overtime but does not include education, vacation, PTO, ESL, or other non-productive time. This does not include outside labor.

Attachment 2a - Safety Trends

Indicators		FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
E.C. 1.0 - SAFETY MANAGEMENT								
Employee Safety								
1.	Total Injury/Illness Incident Reports	458	618	428	470	411	439	305
2.	OSHA Recordable Injury/Illness (Total)	171	306	193	164	176	145	120
	a. Lost Time	61	38	78	45	51	22	22
	b. No Lost Time	110	268	113	119	125	133	98
3.	Patient Lift/Transfer Injuries (OSHA Recordable)	36	27	37	28	23	16	23
4.	Patient Lift/Transfer Injuries	54	37	48	43	41	29	10
5.	Trip/Slip/Fall	50	41	58	67	63	60	38
Infection Control								
8.	TB Conversions (mo.)/qtr. %	0	0	0	0	0	0	0
9.	Blood & Body Fluid Exp.	44	45	53	42	58	48	41
	a. Percutaneous	28	38	39	30	36	30	36
	b. Skin/Mucus Membrane Contact	16	7	14	12	22	18	5
E.C. 2.0 - SECURITY MANAGEMENT								
1.	Code Grey Incidents	135	117	129	167	197	222	303
2.	Security Response Time < 3minutes (Goal: >90%)	N/A	N/A	N/A	N/A	N/A	82%	98%
3.	Reportable Workplace Violence Incidents	N/A	N/A	N/A	N/A	61	51	63
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT								
1.	Reportable Hazardous Material Incidents	0	0	0	0	0	0	0
2.	Recordable Hazardous Material Incidents	0	4	0	0	1	5	6
3.	Waste Water Discharge Violations	0	0	0	0	0	1	0
4.	Staff ability to locate SDS online	N/A	N/A	N/A	N/A	N/A	95%	100%
5.	Staff know eyewash rinse time if exposure is 15 minutes	N/A	N/A	N/A	N/A	N/A	79%	100%
E.C. 4.0 LIFE SAFETY								
Fire Safety								
1.	Fire Incidents -Actual	1	0	2	0	2	1	2
2.	Fire Alarm Events	58	59	72	54	55	41	50
3.	Fire Drills comp/scheduled	97%	100%	100%	103%	103%	118%	113%
4.	Staff ability to define RACE and PASS	94%	100%	100%	100%	100%	91%	100%
5.	Staff ability to locate fire extinguishers and pull stations						96%	100%
6.	Staff can define horizontal and vertical evacuations						91%	99%
Life safety & Regulatory Compliance Goals: Performance data - TMS								
1.	Utility Reportable Incidents	1	1	6	1	2	2	4
2.	% of Life Safety Work Order Completions	100%	100%	100	100	100%	90%	100%
3.	PM Completion Rate % completed/scheduled	92.7%	90.9%	97%	90%	89%	95%	95%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT								
1.	Reports to FDA	2	6	3	6	15	16	8
2.	PM Completion Rate %							
	a. ECH High Risk/Life Support PMs*	N/A	N/A	N/A	N/A	N/A	N/A	88%
	b. ECH Non High Risk/Life Support PMs*		N/A	N/A	N/A	N/A	N/A	74%
	c. ECH Overall PM completion*	N/A	N/A	N/A	N/A	N/A	N/A	75%
3.	Equipment Unable to Locate	98%	88%	78%	95%	82%	10%	23%

*New trend in FY-20. No previous year's data.

Attachment 2b - Safety Trends Definitions

E.C. 1.0 SAFETY MANAGEMENT	
Employee Safety	
1. Injury/Illness Reports	Total number of injuries/illnesses reported on *Report of Accident, Injury, Incident or Exposure*, (Form 309) and followed up by Employee Health Services. Includes first aid cases that do not meet the criteria as OSHA Recordable.
2. OSHA Recordable Injury and Illness	Total number of employee injuries and illnesses meeting the OSHA recordable definition and as recorded on the OSHA 300 log.
a. OSHA Recordable: Lost Time	Number of injuries/illnesses with days away from work.
b. OSHA Recordable: No Lost Time	Number of injuries/illnesses with no lost work time, includes cases with transitional work (modified work) when there is no lost work time.
3. Patient Lift/Transfer Injury (OSHA Recordable)	Number of OSHA recordable injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital. Does not include reported injuries with no specific lift/transfer incident.
4. Patient Lift/Transfer Injury (All)	Total number of injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital.
5. Trip/Slip/Fall (all incidents reported)	Number of Trip/Slip/Fall incidents resulting from the unintended or unexpected change in contact between the feet or footwear and the walking or working surface.(All incidents)
6. TB Conversion Rate (Monthly number/quarterly rate)	The number of work related* PPD converters by month and quarterly, total of conversions divided by the number of persons receiving PPDs.*Work related PPD conversion is a HCW PPD conversion after contact with a known TB + active case.
a. Percutaneous	
b. Skin, Mucous Membrane Contact	
Infection Control	
1. TB Conversion Rate (Monthly number / quarterly rate)	The number of work related* PPD converters by month and quarterly, total of conversions divided by the number of persons receiving PPDs.*Work related PPD conversion is a HCW PPD conversion after contact with a known TB + active case.
2. Blood & Body Fluid Exposures a. Percutaneous b. Skin, Mucous Membrane Contact	A percutaneous injury (e.g., a needle stick or cut with a sharp object), contact of mucous membranes or non-intact skin (e.g., when the exposed skin is chapped, abraded, or non-intact due to dermatitis), or contact with intact skin when the duration of contact is prolonged, (i.e., several minutes or more) or involves an extensive area, with blood, tissue or other body fluids. Body fluids include: a) Semen, vaginal secretions or other body fluids contaminated with visible blood that have been implicated in the transmission of blood borne pathogens b) Cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids which have an undetermined risk for transmitting HIV.
E.C. 2.0 SECURITY MANAGEMENT	
1. Code Gray Incidents	Code Grey is called when immediate assistance is required to respond to potential or actual violent situations involving visitors, patients, or family members.
2. Security Response Time < 3minutes (Goal: >90%)	The percentage of security responses within 3 minutes of receiving the request for assistance. The goal is >90%.
3. Reportable Workplace Violence Incidents	The number of workplace violence incidents - patient assault of staff that was reported to CA-OSHS during the year.

Safety Trends Definitions

E.C. 3.0 HAZARDOUS MATERIALS MANAGEMENT	
1. Reportable Hazardous Materials Incidents	Any unauthorized discharge which is determined not to be recordable and must be reported to the City of Mountain View (subsection 24.5.0.a.1 (a) of Mountain View Health and Safety Code) or the Town of Los Gatos.
2. Recordable Hazardous Materials Incidents	An unauthorized discharge of hazardous or other regulated material defined as a discharge from a primary to a secondary container, cleanup of a discharge to a secondary container requiring greater than 8 hours, no increase of fire or explosion nor production of poisonous gas or flame, or no degradation of secondary container, the discharge does not exceed one (1) ounce by weight or can be cleaned up in 15 minutes following deterioration of the primary container.
3. Waste Water Discharge Violations	Monthly sampling analysis > than the Maximum Limit (mg/L): Zinc 2.0; Total Toxic Organic 1.0; Single Toxic Organic 0.75; Formaldehyde 5.0; Copper 0.25.
4. Staff ability to locate SDS online	Staff able to demonstrate ability to look up a Safety Data Sheet through the Toolbox and MSDS Online program.
5. Staff know eyewash rinse time if exposure is 15 minutes	Staff able to state the minimum required time required to flush a person's eyes after exposure to a hazardous chemical. The requirement is a minimum of 15 minutes.
E.C. 4.0 FIRE PREVENTION MANAGEMENT	
Fire Safety	
1. Fire Incidents	Number of actual fire incidents/month.
2. Fire Alarm Events	Number of fire/smoke alarms activated by an event not classified as an actual fire or false alarm (example: burnt toast, dust, steam, etc.)
3. Fire Drills Completed/Scheduled	Number of fire drills completed/number scheduled.
4. Staff ability to define RACE and PASS	Staff should be able to define RACE (Remove, Alarm, Confine, Extinguish) for responding safely to a fire and PASS (Pull, Aim, Squeeze, Sweep) when using a fire extinguisher.
5. Staff ability to locate fire extinguishers and pull stations	During regularly scheduled fire drills, staff can locate the nearest fire extinguisher and pull station to their normal work area.
6. Staff can define horizontal and vertical evacuations	Staff are able to define the two types of evacuations • Horizontal - evacuate staff to another smoke compartment on the same floor • Vertical - evacuate the building, floor by floor, starting with the upper levels and proceeding until everyone is out of the building.
Life Safety & Regulatory Compliance Goals: Performance data - TMS	
1. Utility Reportable Incidents	Utility System incidents with actual or potential significant impact on safe patient care, staff health and safety or resource/property loss.
2. % of Life Safety Work Order Completions	The percentage of life safety work orders submitted to Facilities that have been completed.
3. PM Completion rate % Completed	Scheduled preventive maintenance completed with 28 days of the prescribed interval/items scheduled for maintenance. Reported quarterly.
E. C. 5.0 MEDICAL EQUIPMENT MANAGEMENT	
1. Reports to FDA	Number of reports to FDA as defined by Safety Medical Device Act requirements. Reported quarterly.
2. PM % Completion	Scheduled preventive maintenance completed. Reported quarterly.
a. ECH High Risk/Life Support PMs*	All critical, life safety equipment PMs completed by ECH Clinical Engineering
b. ECH Non High Risk/Life Support PMs*	Other equipment PMs completed by ECH Clinical Engineering Department
c. ECH Overall PM completion*	Overall completion rate for all equipment PMs
3. Equipment unable to locate	The % of equipment on Clinical Engineering's inventory that is not able to be found.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital oard of irectors
From: purva Marfatia M Enterprise Chief of taff
Michael an M Chief of taff os atos
Date: ovem er 11 2020
Subject: Medical taff Report – Open ession

Recommendation:

o approve the Medical taff Report including Policies and copes of ervice identified in the attached list.

Summary:

1. ituation: he Medical E ecutive Committee met on Octo er 22 2020.

2. ac ground: MEC received the follo ing informational reports.

a uality Council – he uality Council met on Octo er 2020. Reports and performance dash oards ere revie ed and approved from the follo ing ECH epartments/ervice ines:

1. nnual P Report ntimicro ial te ardship Program
2. ntimicro ial te ardship ash oard
3. nnual P Report H M
4. H M ash oard
5. Orthopedic ervice ine ash oard
6. nnual P Report Patient E perience
7. Patient E perience ash oard

eadership Council – he eadership Council met on Octo er 13:

1. eadership Council revie ed and discussed:
    1. R Finances ere discussed hospital ill pay the 30 000 to the research department and they ill e responsi le for paying the R Chair
    2. Medical taff udget as discussed
    3. Corrective ctions Policy as discussed Policy approved and to e sent to ePolicy Committee MEC and oard for approval

c he CEO Report as provided and included the follo ing updates:

1. he virtual site visit for ECH's fourth Magnet Designation is scheduled for ovem er 10-12 2020
2. he Clinical Research Program has active studies. econd site in the orld to open the Phase CO -1 Clinical rial ith Pfi er. lso participating in a Phase outpatient CO -1 treatment study partnering ith ilead
3. ECH is or ing ith the community. Over 000 CO -1 tests have een administered at sites throughout the district including our Mountain ie campus pu lic school sites and do nto n retail locations.

d. The CMO Report was provided and included the following updates:

1. The FY2021 Organizational Goal and Quality Dashboard Update was presented.
   - Readmission Index – All Patient All Cause Readmit - Currently on 0.86 and FY21 target is 0.83
   - Serious Safety Event Rate (SSER) - Currently at 3.[illegible]. The hospital is diligently working on achieving the FY21 target of 4.0 by working on reducing medication errors reduce fall etc.
   - Mortality Index – Currently at 0.61 (CY[illegible] is 0.65. Target is 0.76
   - Inpatient HCAHPS Likelihood to Recommend – Currently at [illegible] target is 83.3
   - Hospital Acquired Infections (CAUTI) - We are at 2.31 and target goal is [illegible]1.46
   - Surgical Site Infections ([illegible] – Enterprise - Currently on 0.32 [illegible]R goal is [illegible]1.0

2. Physician Burnout:
   - We are seeing stress on physicians especially Emergency Medicine physicians
   - All physicians may use the ECH Employee Assistance Program through the end of the year

3. Influenza Vaccinations:
   - ECH is extending their RiteAid vouchers for the influenza vaccine to our ECH Medical Staff physicians and Allied Health Care Professionals.
   - If providers have private health insurance the insurance will be billed
   - If no insurance information is available at the time of the visit ECH will be billed
   - Physicians need to provide the vaccine date to the MAO office to be counted. Survey Money will also be utilized.
   - Influenza vaccinations must be reported to the state

3. Other Review:

a. The MEC approved the attached policies and procedures

List of Attachments: Policies and Procedures Spreadsheet

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

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

BOARD
Policies for Approval
November 11th, 2020

Updates					
Policy Dept.	**Policy Name**	**Type of Change**	**Type of Document**	**Notes**	**Committee Approvals**
Pharmacy	1. Drug Supply Chain Security Act (DSCSA) 2. Multidisciplinary Drug Diversion Surveillance 3. MERP – Medication Error Reduction Plan FY 2020	Revised New New	Policy Policy Plan	1. Added definition	P&T

El Camino Health

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*7 months after approval*
Owner:	*Poopak Barirani: Asst Director Pharmacy*
Area:	*Pharmacy*
Document Types:	*Plan*

MERP - Medication Error Reduction Plan - FY2021

I. Coverage

El Camino Hospital Mountain View & Los Gatos

II. MERP (Medication Error Reduction Plan) Overview:

In 2001 the California legislature passed legislation resulting in HSC 1339.63 which required every general acute care hospital to adopt a formal plan to eliminate or substantially reduce medication-related errors. Ensuring that our patient population receives quality health care is and always has been of utmost importance to El Camino Hospital in Mountain View(MV) and Los Gatos (LG).

Medication error reduction is one of our key areas of focus. This plan is an opportunity to reevaluate our strategies for safe medical practices related to professional practice, or health care product, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

This plan outlines multiple methods for reducing medication errors and will address each of the following strategies:

1. Evaluate, assess, and include a method to address the 11 elements: prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.
2. Annual review of the plan to assess the effectiveness of the implementation of procedures and systems related to the 11 elements.
3. Modify the plan as warranted when vulnerabilities or deficiencies are noted to achieve the reduction of medication errors.
4. Evaluate and assess ability and progress in implementing information technology requirements and how technology implementation is expected to reduce medication-related errors.
5. Include a system or process to proactively identify actual or potential medication-related errors. The system or process shall include concurrent and retrospective review of clinical care.
6. Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals,

nursing, medical, information technology and administration to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.

7. Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate e.g., ISMP and medication safety publications.

III. References:

1. SB1875 & HSC 1339.63(g)

IV. Objectives:

1. Create a common understanding of the current state of medication errors in the healthcare industry and to create a non-punitive system of reporting errors.
2. Define medication processes that support medication safety throughout the 11 elements.
3. Improve the clinical decision making process related to medication use.
4. Improve communication among the health professionals and patients.
5. Monitor Medication error events.
6. Enterprise Medication Safety Committee, RN-RX Council MV and RN-RX Council LG and Pharmacy & Therapeutics Committee (P&T) review and evaluate various components of medication management: practices, processes, and usage, compliance and safety concerns.

V. Structure:

A. A collaborative multidisciplinary approach has been organized to ensure adequate participation of hospital personnel. Each of the following participate in the medication safety improvement process:

   1. care staff. Pharmacy and Nursing Leadership coordinate the meetings. The councils make recommendations, advise, and provide guidance and recommendations related to nursing practice and operationalizing initiatives. RN-RX reviews ISMP newsletters as part of the agenda. RN-RX is also the approving body for Automated Dispensing Machines (ADM) override requests.
   2. Medication Safety Committee: The members of the committee include representatives of medical staff, pharmacy, nursing, and quality/patient safety and adhoc members. The committee is responsible for the evaluation and implementation of the MERP and reports directly to P&T. The Medication Safety Committee analyzes medication error reports, medication usage, medication shortages and participates in MERP. This is a committee that proposes action plans for process improvement and makes recommendations to P&T.
   3. MERP subcommittee: The members include: Pharmacy, Nursing and other ad hoc members. MERP subcommittee will be directly working on the Medication Error Reduction Plan and will report to Medication Safety. Responsible for monitoring compliance and developing action plans related to 11 MERP elements.
   4. Pharmacy and Therapeutics (P&T) Committee: Medical Staff Committee consisting of Physicians, Chief Nursing Officer (CNO), Senior Director of Quality , pharmacists, dietician, pharmacy informatics staff, nursing leadership and ad hoc members. P&T reviews a summary of medication error/event reports and adverse drug reactions, approves/monitors formulary deletions and additions, reviews recalls/medications in short supply, MERP plan, and approves policies and procedures.

5. Hospital Quality Committee & Patient/Employee Safety Committee: Medication Safety and Pharmacy Department reports medication safety activities to these committees.
6. Medical Executive Committee: Reviews P&T reports, reviews and approves policies and procedures.
7. Pharmacy Department: Review of medication use related to procedures and systems: prescribing, prescription order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use; medication errors.

B. Medication Error Reporting process:

1. Errors, near misses, safety and system issues are reported by hospital staff using the electronic system for reporting of unusual occurrence and patient safety issues.
2. The reports are reviewed by risk management and clinical leadership. Trends for medication errors will be identified and analyzed by Med Safety and MERP committee on a regular basis and takes actions as appropriate.
3. Medication error trends and MERP plans are reported to P&T for review and approval.
4. P&T refers physician specific issues to appropriate Medical Staff committees and process issues to Hospital Quality Committee as needed.

C. Communication of Medication Safety Information:

1. Staff and Department Meetings
2. Departmental or organizational newsletters such as Pharmacy Newsletter, and InTouch (nursing newsletter), Pharmacy-Nursing Connection Newsletter
3. Resources provided include computer based drug information programs (e.g., UpToDate, Micromedex/Lexicomp , as well as other available references in the intranet “Tool Box”)
4. Policies and Procedures: Policies and procedures are available online on the hospital’s intranet.
5. Director of Pharmacy sends monthly Nursing ISMP and biweekly overall Institute of Safe Medication Practices Acute Care Edition to all pharmacy and nursing staff.
6. External sources of information will be reviewed and shared with staff as appropriate. Examples of sources include but are not limited to the following: FDA Medwatch list serve, California State Board of Pharmacy list serve, The Joint Commission Sentinel Event Alert list serve, the ASHP Patient Safety News list serve, the Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI).

VI. Medication Error Reporting and Monitoring:

A. Definition: A “medication-related error” means any preventable medication-related event that adversely affects a patient and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to:

1. Prescribing
2. Prescription order communications
3. Product labeling
4. Packaging and nomenclature
5. Compounding

6. Dispensing
7. Distribution
8. Administration
9. Education
10. Monitoring
11. Use

B. Proactive identification of actual and potential medication related errors:

1. Medication Safety Committee: Continuous performance improvement review mechanism for medication errors both potential and actual. Reviews medication errors, performs regular assessments, and conducts ongoing evaluation of the medication systems and procedures.
2. Identification of the potential medication-related errors are done by reviewing a variety of patient safety related publications such as ISMP Medication Safety Newsletter, FDA MedWatch, The Joint Commission Sentinel Event Alerts, ASHP Patient Safety List-Serve and California Board of Pharmacy e-mail alerts, identifying any issues that are pertinent at the facility and then implementing suggested changes.

C. Voluntary Non-Punitive Reporting System:

1. Potential or actual medication-related errors are primarily identified via non-punitive unusual occurrence reporting system by hospital staff, which can be submitted anonymously.
2. Actual or potential (near miss) medication-related errors are identified by all staff and physicians.
3. Adverse Drug Reaction (ADR) reports may be done via unusual occurrence system, telephone hot-line or by pharmacy generating reports on reversal agents.

VII. Process:

A. Plan Development Process:

1. Multidisciplinary MERP subcommittee members evaluate the current plan and facilitate the assessment of MERP. Potential or actual medication errors and adverse medication events are discussed at Medication Safety Committee and then reported to Pharmacy & Therapeutics.
2. Analysis of Medication Errors: MERP sub-committee reviews medication errors to identify trends, categorize, and identified the opportunities for reductions of errors.
3. MERP Subcommittee is responsible for identifying annual goals for MERP.

B. Assessment:

1. Baseline assessment of medication related problems and annual review of the effectiveness of the plan are performed using an objective based critical review. If the plan is not effective in reducing medication errors, MERP will be revised to redesign actions to achieve goals.

C. Requirements for Assessing the Effectiveness of MERP:

1. Evaluate, assess, and include a method to address each of the procedures and systems listed under 1339, H&S, subdivision (d) to identify weaknesses or deficiencies that could contribute to errors in the administration of medications.
2. Categorize and focus on evaluating 11 elements of the MERP implementation for ongoing

improvement.

Refer to ECH detailed Fiscal Year MERP Crosswalk (Medication Safety 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

MERP Trends and Accomplishments FY2020.pdf

Approval Signatures

Step Description	Approver	Date
Board	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2020
ePolicy Committee	Jeanne Hanley: Projects Coordinator	10/2020
P & T Committee	Mojgan Nodoushani: Manager Clinical Pharmacy	09/2020
Medication Safety Committee	Poopak Barirani: Asst Director Pharmacy	09/2020
	Poopak Barirani: Asst Director Pharmacy	09/2020

Current Status: *Pending* **PolicyStat ID:** *8599085*

Origination:	*N/A*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Jen Huang: Interim Director Pharmacy*
Area:	*Pharmacy*
Document Types:	*Policy*

Multidisciplinary Drug Diversion Surveillance

COVERAGE:

All El Camino Health Staff, Anesthesiologists and Patient Care Providers.

PURPOSE:

To have a MultiDisciplinary Team (MDT) for Medication Diversion Prevention that is charged with developing a coordinated and systematic approach to prevent, detect and report medication diversion. MDT must meet, at a minimum, on a monthly basis.

- To ensure patient safety related to Controlled Substances (CS) administration with appropriate dosing regimen and assessments.
- To provide a consistent process for surveillance of early detection of drug diversion, medication control irregularities and effective actions taken.
- To describes measures to ensure safe controlled substance management for all processes related from procurement to wastage.
- To monitor controlled substances by utilizing technology tools such as Diversion Detection software.
- To train employees on their roles in CS management and diversion prevention.
- To comply with federal and state controlled substance laws and regulation. The MDT Committee has the responsibilities and oversight on CS management at El Camino Health.

Establishing a sustainable drug diversion prevention program requires engaged leadership oversight that promotes a culture of organizational awareness, implements and evaluates the effectiveness of systems and processes, and works toward continuous improvement. With this approach, we will improve patient and provider safety and benefit the community we serve.

DEFINITIONS:

MDT: MultiDisciplinary Team

CS: Controlled Substances per FDA Scheduled medication

ADCs: Automated Dispensing Cabinets

EHR: Electronic Health Record

Drug Diversion: the transfer of a prescription drug from a lawful to an unlawful channel of distribution or use.

Chain-of-custody: Chain-of-custody procedures and documentation are utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations.

REFERENCES:

Condition of Participation: (State Operations Manual Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals)

§482.13 (c)(2) – The patient has the right to receive care in a safe seting– Hospital must protect vulnerable patients and identify and evaluate problems and patterns of incidents.

§482.25(a)(3) – Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.

DEA: https://www.deadiversion.usdoj.gov/crim_admin_actions/

Use of Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis) PolicyStat ID: 7660821 Revised 5/2020

Pyxis Anesthesia System PolicyStat ID: 7624626 Revised 5/2020

Reporting by Pharmacy Personnel of Theft of Controlled Substances or Impairment PolicyStat ID: 7380242

PROCEDURE:

System specific and appropriate actions required to effective management of ALL stages of medication use process to prevent drug diversion prevention.

A. MDT must meet, at a minimum, on a monthly basis. .

B. The following individuals are required MDT members: Administration, Physician (anesthesiologists), Nursing Leadership, Pharmacy, Risk Management and Compliance. Mandatory MDT members that are unable to attend an MDT meeting must notify the Director of Pharmacy or designee prior to the meeting and ensure an alternate member is present.

C. The following individuals are Ad Hoc members: HR & Employee Health, Diversion Specialist, Environmental Care and Security,

D. MDT meeting minutes clearly capture discussion about events, actions to be taken, and follow-up of prior month's unresolved issues. MDT meeting minutes, including ad hoc meetings, are documented on most up-to-date MDT Meeting Minutes Template and capture all required audits/reviews.

E. Proactive Diversion Reporting and Reviews utilizing Diversion Detection Software are conducted pursuant to the Medication
Diversion Prevention MDT.

F. All suspected, active, and confirmed diversions are reported immediately to the Pharmacist in Charge, DEA registrant, and MDT.

G. Surveillance of Controlled Substance Procurement: The receiving process includes a reconciliation of controlled substances received against the invoice of purchase and subsequently load to the Narc Vault. Note and document any shortage, breakage, or discrepancy on the invoice / Controlled Substance received.

    1. Maintaining the purchasing summary available from drug suppliers, or a written history of all

controlled substance purchases made by the facility for the month, sorted by date

H. Surveillance of Controlled Substances Storage:

1. Controlled substances and PCA keys in patient care areas, pharmacy and/or designated storage areas are maintained in Automated Dispensing Cabinets (ADCs), or mobile storage device (clear box secured on IV pole for IVPBs containing Controlled Substances).
2. Controlled substances administered via Patient-Controlled Analgesia (PCA) pumps and epidural pumps are administered in locked systems.
3. During delivery of Controlled Substances to the units, the cart is lockable and the technicians attend to the cart.

I. Surveillance of Controlled Substances Dispensing:

1. Override Monitoring: Controlled substances removed utilizing the override functionality are reviewed and reconciled daily by the pharmacy staff designee to ensure the existence of a valid corresponding order. (also refer to Policy: PolicyStat ID: 7660841: Use of Automated Dispensing Cabinets (ADC) and ADC Profile Med-station (e.g. Pyxis)
2. Chain of Custody Documentation: only conducted in rare situations and fully document in the EHR.
3. Anesthesia Audit: Assess medication dispensed, medication documented, dose documented, amount wasted, witness signature, Chain of Custody (if appropriate), appropriate variance reporting and follow up if necessary.

J. Surveillance of Chain-of-custody: Documentation of chain-of-custody is utilized when controlled substances are removed by one person and passed to another health care provider. This practice is limited and only used in unusual situations of Controlled Substances Administration

1. Timely Administration of CS: Ensure the time retrieval from ADC to the administration to the patients meet the policy requirement (within 30 minutes for stat medication and within 60 minutes for routine medication).
2. Monitoring Patients' Response: Ensure medication administered in compliance with pain scale prescribed.
   Conduct pain assessments per pain assessment policy.
3. Pain score assessments and documentations to be recorded timely and accurately in iCare.

K. Surveillance of Controlled Substances Wastage, Returns and Disposal.

1. Non-retrievable Waste Container in compliant with TJC Standards and DEA non-retrievable requirement. Pro-actively swap out as needed or no longer than every 90 days by the vendor per agreement regardless of fill levels.
2. Expired controlled substances removed from the inventory are placed in a designated expired controlled substances drawer/bin in a locked area separate from non-controlled medications until the time of removal.
3. Expired controlled substances are reconciled by the person holding a DEA Power of Attorney (POA) with the DEA-222 form provided by the reverse distributor.

L. Resolution of unreconciled CS discrepancies:

1. Unreconciled discrepancies resulted from dosage administered, wastage or documentations are reviewed daily.

2. Contact users and nursing manager with screen shots from the EHR complete with relevant information on transactions provided.
3. Provide a period of 24-48 hours for user to follow up and respond.
4. A second reminder is sent to user and nursing manager. For anesthesiologists, a second reminder will also be sent to Medical Director of Anesthesiology.
5. A report on the onliEl Camino Health on-line incident reporting system, will be filed if no response received after 24 hours of the second reminder.

M. Patient's Own Medication: Patient-owned controlled substances must have a documented chain of custody from the
time of receipt to the time of return. Logging the patient's controlled substances consists of counting and verifying the
controlled substances by two licensed workforce members count and verification of the medications.

N. Surveillance of Controlled Substances Inventory Count: The compliance rates will be reported to the monthly MDT meetings.
1. Weekly nursing inventory is completed by the unit's Nurse Manager/Supervisor or designee. Inventory is completed for all accessed controlled substances. If the unit is closed, notify pharmacy to deactivate access and notify pharmacy for opening. Without deactivation, weekly inventory count is still required on units that are temporarily closed.
2. Monthly CS Inventory Count:CII Safe/ Pharmacy Vault Monthly Inventory, including keys, conducted with two authorized
witness: signature and date of inventory is documented.

O. Resources of hardware deterrent for drug diversion prevention and surveillance
1. Current hardware deterrent:
   a. Secured waste containers, badges system for medication room entry for retrievable entry history, IV-to Pole secured CS IVPBs and secured CS transportation carts are utilized for CS security.
   b. Community drug take back to limit unnecessary access in community, a secured medication take back kiosk is located at El Camino Health Outpatient Pharmacy for secure disposal of CS for the customers.
2. Next phase in the planning stage: camera video surveillance as deterrent and also to support investigation:
   a. Ensure all stationary ADCs have cameras installed at the appropriate angle to visualize actions being taken at the station, the scope captures return bin activities.
   This does not include Pyxis placed in patient care areas (Surgical, ER Trauma, patient rooms…) in compliance with HIPPA.
   b. Within the pharmacy department, ensure all areas of packaging, storage, waste and areas where medications are placed to be checked, or pending delivery are under adequate camera surveillance.
   c. Ensure camera video is recording 24 hours per day and retention is set to 90 days

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

RoadmapSummary.pdf
SoftwareOnePageInstruction.pdf

Approval Signatures

Step Description	Approver	Date
Board of Directors	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2020
ePolicy Committee	Jeanne Hanley: Projects Coordinator	10/2020
P & T Committee	Mojgan Nodoushani: Manager Clinical Pharmacy	09/2020
	Jen Huang: Interim Director Pharmacy	09/2020

El Camino Health

Origination:	*07/2017*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*10/2020*
Next Review:	*3 years after approval*
Owner:	*Poopak Barirani: Asst Director Pharmacy*
Area:	*Pharmacy*
Document Types:	*Policy*

Drug Supply Chain Security Act (DSCSA)

COVERAGE:

All El Camino Hospital Pharmacy staff

PURPOSE:

- To ensure that pedigree requirements regarding drug supply transfers are protected
- To aid trading partners in identifying a suspect pharmaceutical product
- To initiate notifications regarding illegitimate product

POLICY STATEMENT:

Starting January 1, 2015, section 582 of the FD&C Act requires trading partners, upon determining that a product in their possession or control is illegitimate, to notify FDA and all immediate trading partners (that they have reason to believe may have received the illegitimate product) not later than 24 hours after making the determination.

On 7/1/15, dispensers are required to receive TH/TI/TS and must capture information and maintain documentation for 6 years. In addition, dispensers must respond to requests for information regarding suspect or illegitimate product within two business days.

DEFINITIONS:

Dispenser:
A retail pharmacy, hospital pharmacy, a group of chain pharmacies under common ownership and control that do not act as a wholesale distributor, or any other person authorized by law to dispense or administer prescription drugs, and the affiliated warehouses or distribution centers of such entities under common ownership and control that do not act as a wholesale distributor, and does not include a person who dispenses only products to be used in animals in accordance with section 512(a)(5).
EXCEPTION: *The dispenser requirements for product tracing and verification shall not apply to* ***licensed health care practitioners*** *authorized to prescribe or administer medication under State law or* ***other licensed individuals under the supervision or direction of such practitioners who dispense or administer product in the usual course of professional practice****.*

Suspect/Illegitimate product: A product for which there are several reason to believe that such product is potentially counterfeit, diverted, or stolen; intentionally adulterated such that the product would result in serious

adverse health consequences or death to humans; is potentially the subject of a fraudulent transaction; or appears otherwise unfit for distribution such that the product would result in serious adverse health consequences or death to humans.

Trading Partners: Trading partners are manufacturers, repackagers, wholesale distributors, or dispensers including physician offices.

PROCEDURE:

A. On November 27, 2013, the Drug Quality and Security Act (DQSA) was signed into law, and Title II of the DQSA, the Drug Supply Chain Security Act (DSCSA) sets forth new definitions and requirements related to product tracing.

B. Beginning in 7/1/2015, trading partners (defined as manufacturers, wholesale distributors, repackagers, and dispensers) are required to provide the subsequent purchaser with product tracing information when engaging in transactions involving certain prescription drugs. Trading partners are also required to capture the product tracing information and maintain that data for not less than six years after the transaction occurs.

C. DSCSA Traceability requirements:

1. Apply to Products = Prescription drugs in finished dosage form that are for human use. No OTC, medical devices, API, or drugs indicated for animal use.
2. A number of prescription drugs are exempted from the definition of product, including:
    a. Blood and blood components intended for transfusion
    b. Radioactive drugs and radioactive biologics
    c. Imaging drugs
    d. Intravenous products
    e. Medical gases
    f. Homeopathic drugs
    g. Compounded drugs.
3. Transaction is the transfer of product in which a change of ownership occurs.
4. A number of transfers are exempted from the definition of transaction, including:
    a. Dispensing of prescription drugs to patients
    b. Intercompany distribution between members of an affiliate
    c. Distributions of product among hospitals or health care entities under common control
    d. Distribution of minimal quantities of products by a license retail pharmacy to a licensed practitioner for office use.
    e. Distribution of combination products (device+ drug/device/biologic)
    f. Distribution for emergency medical reasons
    g. Distribution of medical convenience kits

D. Trading partners must have systems in place that enable them, upon determining that a product in their possession or control is suspect or upon receiving a request for verification from the FDA, to quarantine

suspect product and promptly conduct an investigation, in coordination with other trading partners, as applicable, to determine whether a suspect product is illegitimate.

E. Starting on January 1, 2015 manufacturers, repackagers, wholesale distributor ("trading partner") are required to provide the subsequent purchaser with product tracing information each time the drug is sold in the U.S market. This transaction document has three required pieces:

1. **TRANSACTION HISTORY (TH)**—The term "transaction history" means a statement, in paper or electronic form, including the transaction information for each prior transaction going back to the manufacturer of the product.
2. **TRANSACTION INFORMATION (TI)**—The term "transaction information" means the:
   A. proprietary or established name or names of the product;
   B. strength and dosage form of the product;
   C. National Drug Code number of the product;
   D. container size;
   E. number of containers;
   F. lot number of the product;
   G. date of the transaction;
   H. date of the shipment, if more than 24 hours after the date of the transaction;
   I. business name and address of the person from whom ownership is being transferred; and
   J. business name and address of the person to whom ownership is being transferred.
3. **TRANSACTION STATEMENT (TS)**—The "transaction statement" is a statement, in paper or electronic form, that the entity transferring ownership in a transaction:
   A. is authorized as required under the Drug Supply Chain Security Act;
   B. received the product from a person that is authorized as required under the Drug Supply Chain Security Act;
   C. received transaction information and a transaction statement from the prior owner of the product, as required under section 582;
   D. did not knowingly ship a suspect or illegitimate product;
   E. had systems and processes in place to comply with verification requirements under section 582;
   F. did not knowingly provide false transaction information.

REFERENCES:

1. Guidance for Industry Drug Supply Chain Security Act Implementation: Identification of Suspect Product and Notification Guidance for the Drug Industry.pdf
2. Drug Quality and Security Act – Overview and Implementation DQSA - Drug Quality and Security Act Title II Track and Trace.ppt.pdf
3. Draft Guidance for Industry DSCSA Implementation: Identification of Suspect Product and Notification Drug Quality and Security Act - Identification of Suspicious Products and Notification Guidance FDA July 1, 2014.pdf

4. Drug Supply Chain Security Act (DSCSA) – Updates and Actions for Health System Pharmacy GAD.SPPM DSCSA_Final-1.pdf
5. Following Pharmaceutical Products Through the Supply Chain Following-Pharmaceutical-Product Through Supply Chails.pdf
6. Impact of the Drug Supply Chain Security Act on Pharmacy Management: 2015 to 2023 (ASHP) DSCSA-Compliance(ASHP).pdf
7. DSCSA Implementation: Product Tracing Requirements — Compliance Policy Guidance for Industry DSCSA_ Product_Tracing_Requirements_Compliance_Policy.pdf
8. Impact of the Drug Supply Chain Security Act on Pharmacy Management: 2015 to 2023 DSCSA-Compliance(ASHP).pdf

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board of Directors	Sarah Rosenberg: Contracts Admin Gov Svcs EA	pending
MEC	Catherine Carson: Senior Director Quality [JH]	10/2020
ePolicy Committee	Jeanne Hanley: Projects Coordinator	10/2020
P & T Committee	Mojgan Nodoushani: Manager Clinical Pharmacy	09/2020
	Poopak Barirani: Asst Director Pharmacy	09/2020

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Bob Miller, Executive Compensation Committee Chair
Date: November 11, 2019
Subject: Executive Compensation Committee Report

Purpose:

To update the Board on the FY21 Executive Base Salaries approved by the Executive Compensation Committee (the "Committee").

Summary:

1. Situation: The Committee approved the FY21 Base Salaries for the executive team at its September 22, 2020 meeting.

2. Authority: The Committee has the authority to approve executive base salaries (excluding the CEO).

3. Background: The Committee delayed approval of the base salary increases from May 2020 due to COVID-19 and to move the salary review process after the annual focal review period of June-August.

4. Assessment: Mercer, the Committee's independent executive compensation consultant, provided market data that informed the decisions on base salaries for FY21.

5. Other Reviews: N/A

6. Outcomes: Salary increases were effective October 18, 2020

List of Attachments:

1. FY21 Base Salary Summary

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

FY21 EXECUTIVE BASE SALARIES
APPROVED BY EXECUTIVE COMPENSATION COMMITTEE
9-22-20

Job Title	FY21 Base Salary (in 000)
Chief Admin Svcs Officer	$321.5
Chief HR Officer	$381.5
Chief Information Officer	$407.3
Chief Medical Officer	$610.0
Chief Nursing Officer	$393.9
Chief Operating Officer	$583.5
General Counsel	$440.1
President Foundation	$291.2
President SVMD	$543.1
VP Corp & Comm Hlth Svcs President Concern	$283.3
VP Payor Relations	$287.9

El Camino Health

Summary of Financial Operations

Fiscal Year 2021 – Period 3

7/1/2020 to 9/30/2020

Overall Commentary for September

- For both ECH and SVMD the volumes continue to exceed budget
- Overall gross charges, a surrogate for volume, was exceeded budget by 34% in the month of September (Net Patient Revenue exceeded budget by 30%)
- Operating Expenses were $8.6M 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 $9.6M 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

Financial Overview – September

Financial Performance

Enterprise

- The primary drivers of favorable operating income continue to be volumes which in most cases exceed pre-covid levels:
  - Volumes and Revenues continue to be stronger than budget as demonstrated by:
    - Adjusted Discharges were 344 cases or 14% favorable to budget
    - Gross charges were $91M or 34% favorable to budget
      - Inpatient Charges up $49M or 35% driven by OR, Cath Lab, Critical Care areas, and related Ancillary services
      - Outpatient Charges up $42M or 34% driven by Cath Lab, OR, Emergency Room, and related Ancillary services
  - Operating Expenses were unfavorable to budget by $8.6M or (11%), due to increased patient activity
    - SWB were unfavorable by $5.0M or (11.5%)
    - Supplies were unfavorable by $1.4M or (19%)
    - Purchased Services were unfavorable by $1.3M or (27%)
    - All other discretionary non volume driven expenses were unfavorable by $0.9M

Financial Overview – September cont.

Financial Performance

Hospital

- Adjusted Discharges (AD) favorable to budget by 344 ADs or (14%) and unfavorable to prior year by 127 AD's or (-4%)
    - Mountain View: Favorable to budget by 309 ADs (16%) and unfavorable to prior year by 164 AD's or (-7%)
    - Los Gatos: Favorable to budget by 35 ADs (6%) and favorable to prior year by 37 AD's or (7%)
- Operating Expense* Per Adjusted Discharge was $24,976 which is 1.4% below budget
    - Excluding Depreciation and Interest

El Camino Health Medical Network

- Total visits were 12.7% favorable to budget with Urgent Care Visits making up 68% of the favorable variance in the month of September
- ECHMN net income was 2% favorable to budget in the month and is 11% favorable for the first quarter of FY2021

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

Consolidated Balance Sheet

(in thousands)

ASSETS

CURRENT ASSETS	September 30, 2020	Audited June 30, 2020
Cash	234,907	228,464
Short Term Investments	228,879	221,604
Patient Accounts Receivable, net	150,338	128,564
Other Accounts and Notes Receivable	12,973	13,811
Intercompany Receivables	73,779	72,592
Inventories and Prepaids	24,480	101,267
Total Current Assets	**725,357**	**766,303**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	16,070	15,364
Plant & Equipment Fund	176,154	166,859
Women's Hospital Expansion	30,401	22,563
Operational Reserve Fund	159,684	148,917
Community Benefit Fund	16,197	17,916
Workers Compensation Reserve Fund	16,482	16,482
Postretirement Health/Life Reserve Fund	30,913	30,731
PTO Liability Fund	29,121	27,515
Malpractice Reserve Fund	1,955	1,919
Catastrophic Reserves Fund	18,727	17,667
Total Board Designated Assets	**495,703**	**465,933**
FUNDS HELD BY TRUSTEE	**17,558**	**23,478**
LONG TERM INVESTMENTS	**390,230**	**372,175**
CHARITABLE GIFT ANNUITY INVESTMENTS	**689**	**680**
INVESTMENTS IN AFFILIATES	**30,939**	**29,065**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,345,563	1,342,012
Less: Accumulated Depreciation	(692,889)	(676,535)
Construction in Progress	500,823	489,848
Property, Plant & Equipment - Net	**1,153,497 #**	**1,155,326**
DEFERRED OUTFLOWS	21,575	21,416
RESTRICTED ASSETS	27,951	28,547
OTHER ASSETS	83,019	3,231
TOTAL ASSETS	**2,946,518**	**2,866,153**

LIABILITIES AND FUND BALANCE

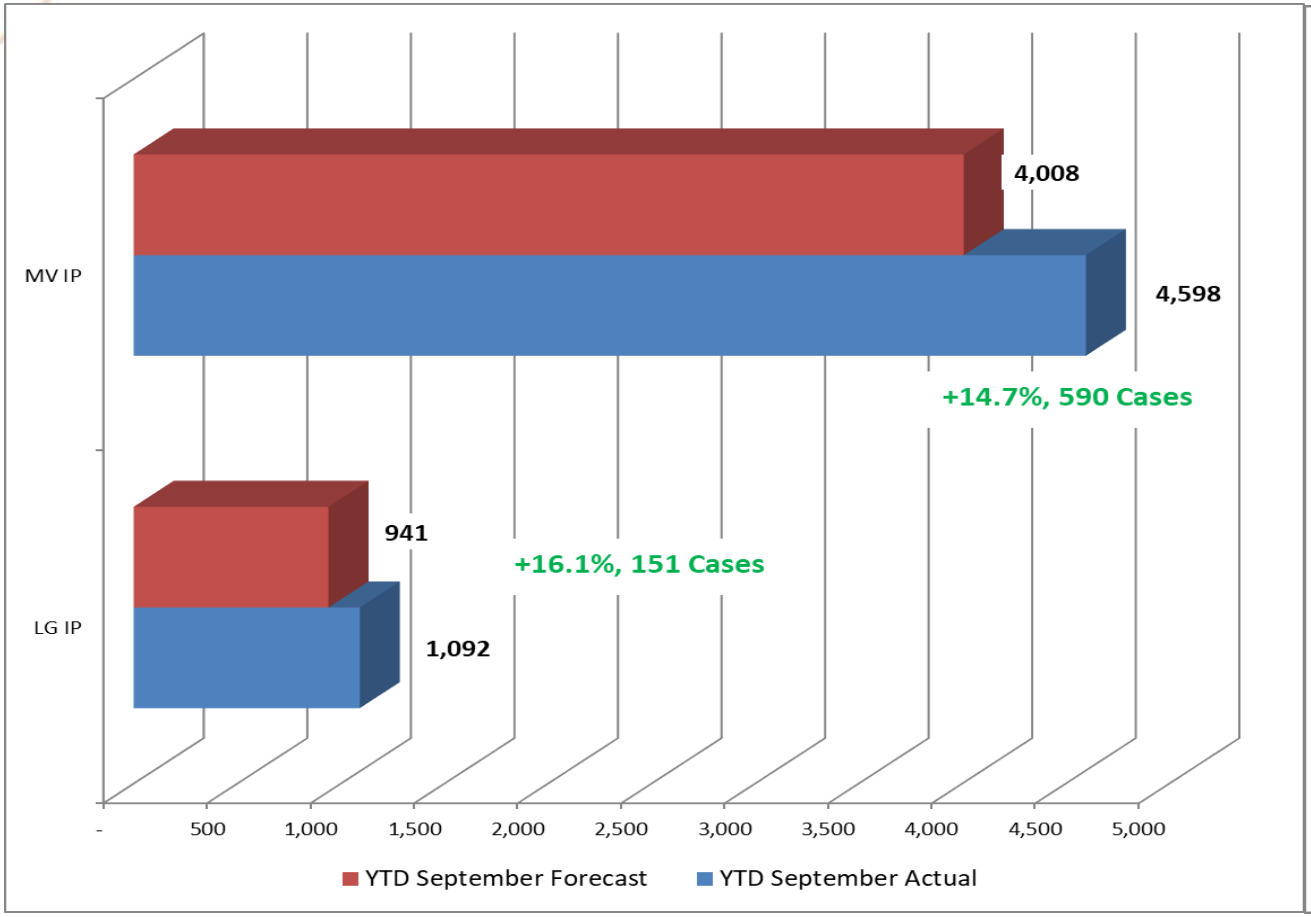
CURRENT LIABILITIES	September 30, 2020	Audited June 30, 2020
(Accounts Payable	38,711	35,323
Salaries and Related Liabilities	37,849	35,209
Accrued PTO	29,816	28,124
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	11,060	10,956
Intercompany Payables	71,634	70,292
Malpractice Reserves	1,560	1,560
Bonds Payable - Current	9,020	9,020
Bond Interest Payable	3,385	8,463
Other Liabilities	2,417	3,222
Total Current Liabilities	**207,752 #**	**204,469**
LONG TERM LIABILITIES		
Post Retirement Benefits	31,003	30,731
Worker's Comp Reserve	16,482	16,482
Other L/T Obligation (Asbestos)	4,124	4,094
Bond Payable	520,697	513,602
Total Long Term Liabilities	**572,306**	**564,908**
DEFERRED REVENUE-UNRESTRICTED	77,081	77,133
DEFERRED INFLOW OF RESOURCES	31,009	30,700
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	1,835,457	1,771,854
Board Designated	194,544	188,457
Restricted	28,370	28,631
Total Fund Bal & Capital Accts	**2,058,371**	**1,988,942**
TOTAL LIABILITIES AND FUND BALANCE	**2,946,518**	**2,866,153**

El Camino Health

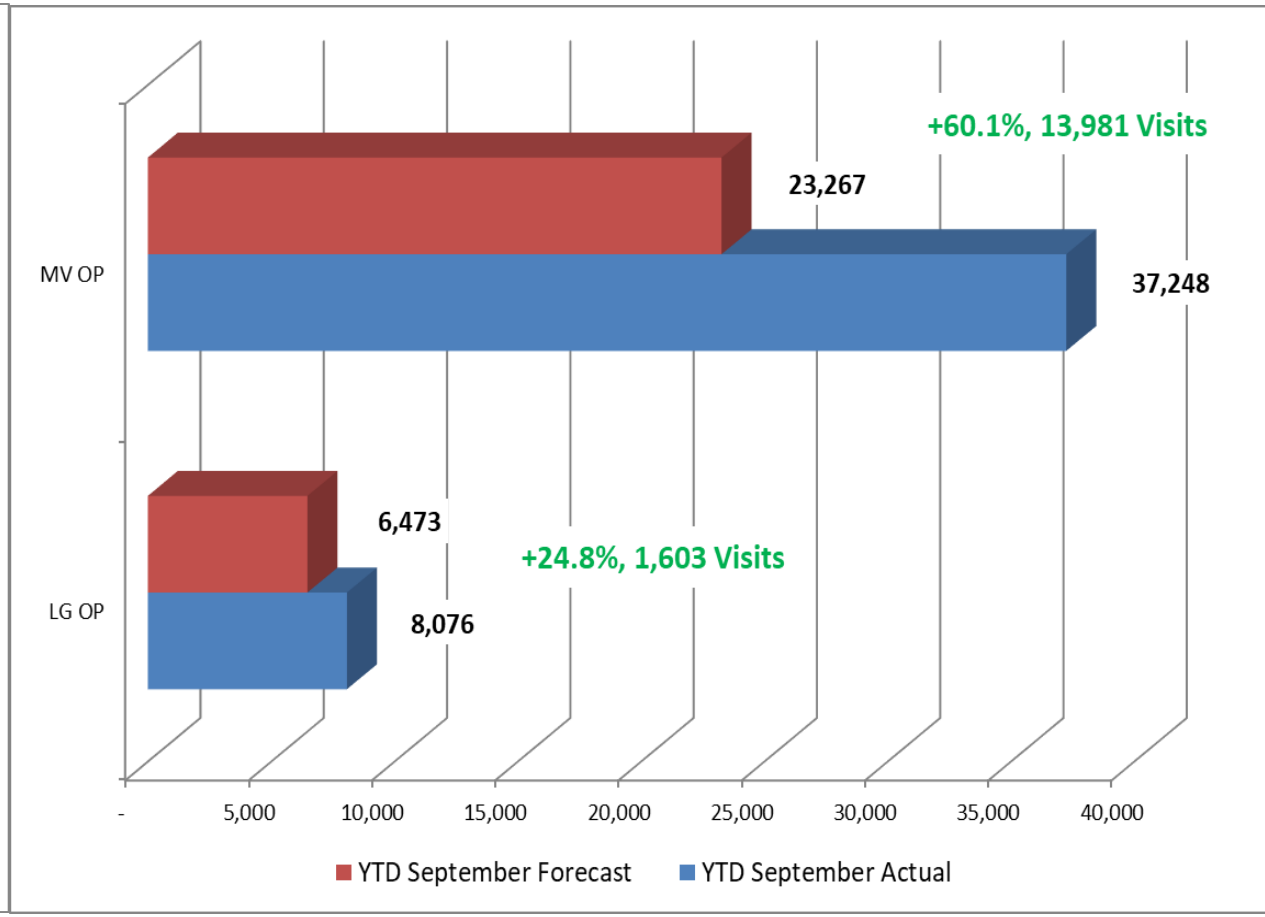
Year to Date September Volume Performance

FY2021 Budget vs Actual

INPATIENT



OUTPATIENT

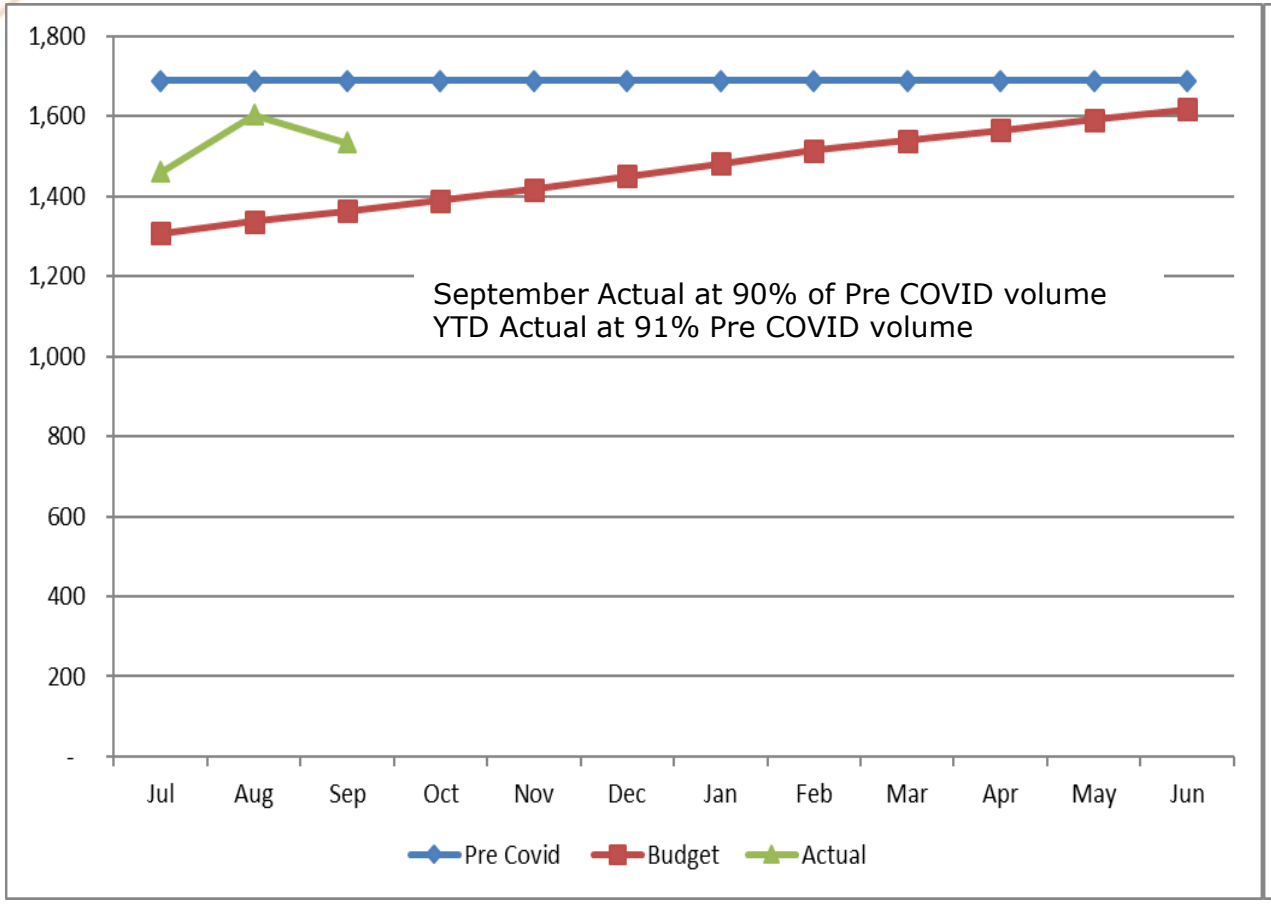


El Camino Health

September Volume – Inpatient

FY2021 Budget vs Actual – Including Pre COVID Level

MV



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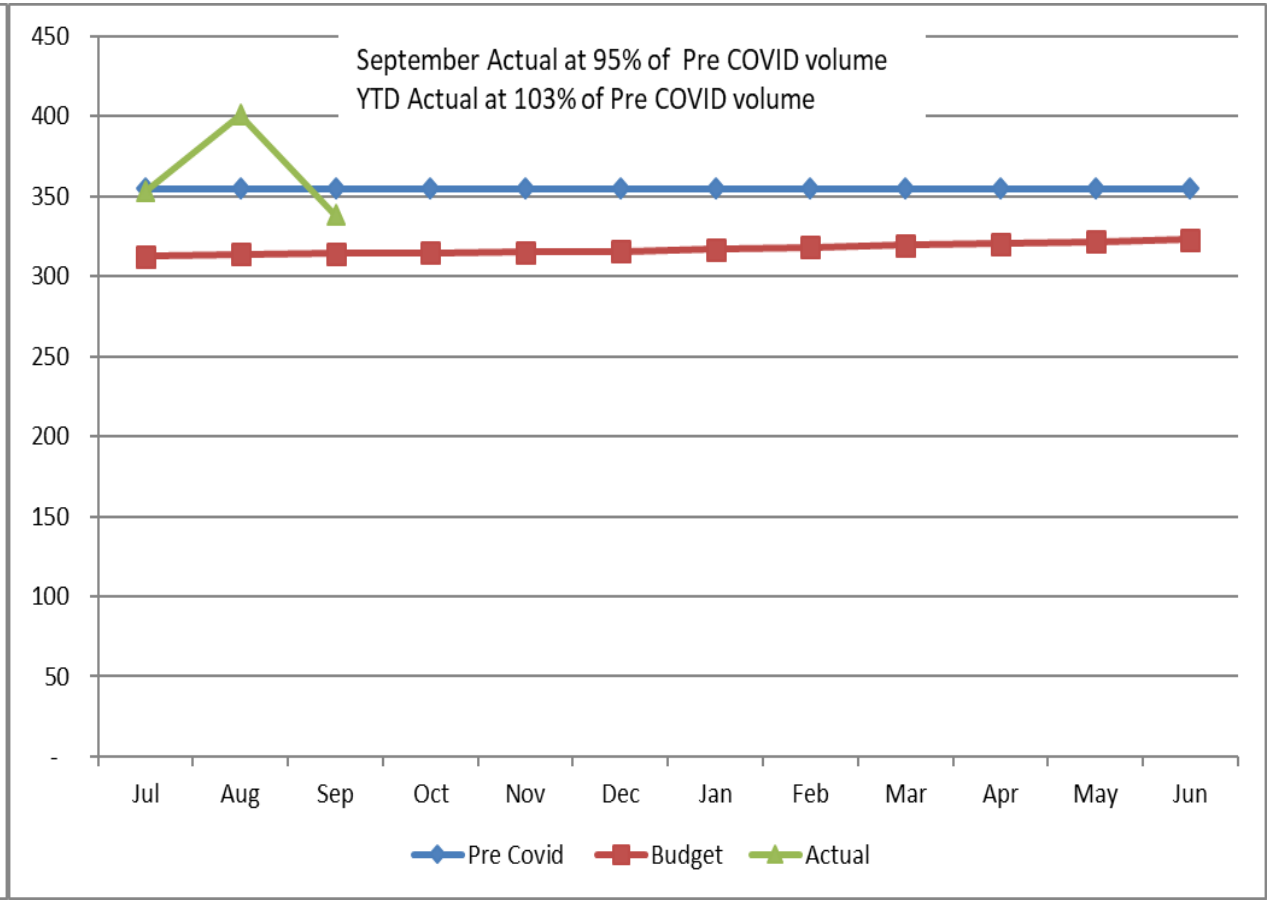
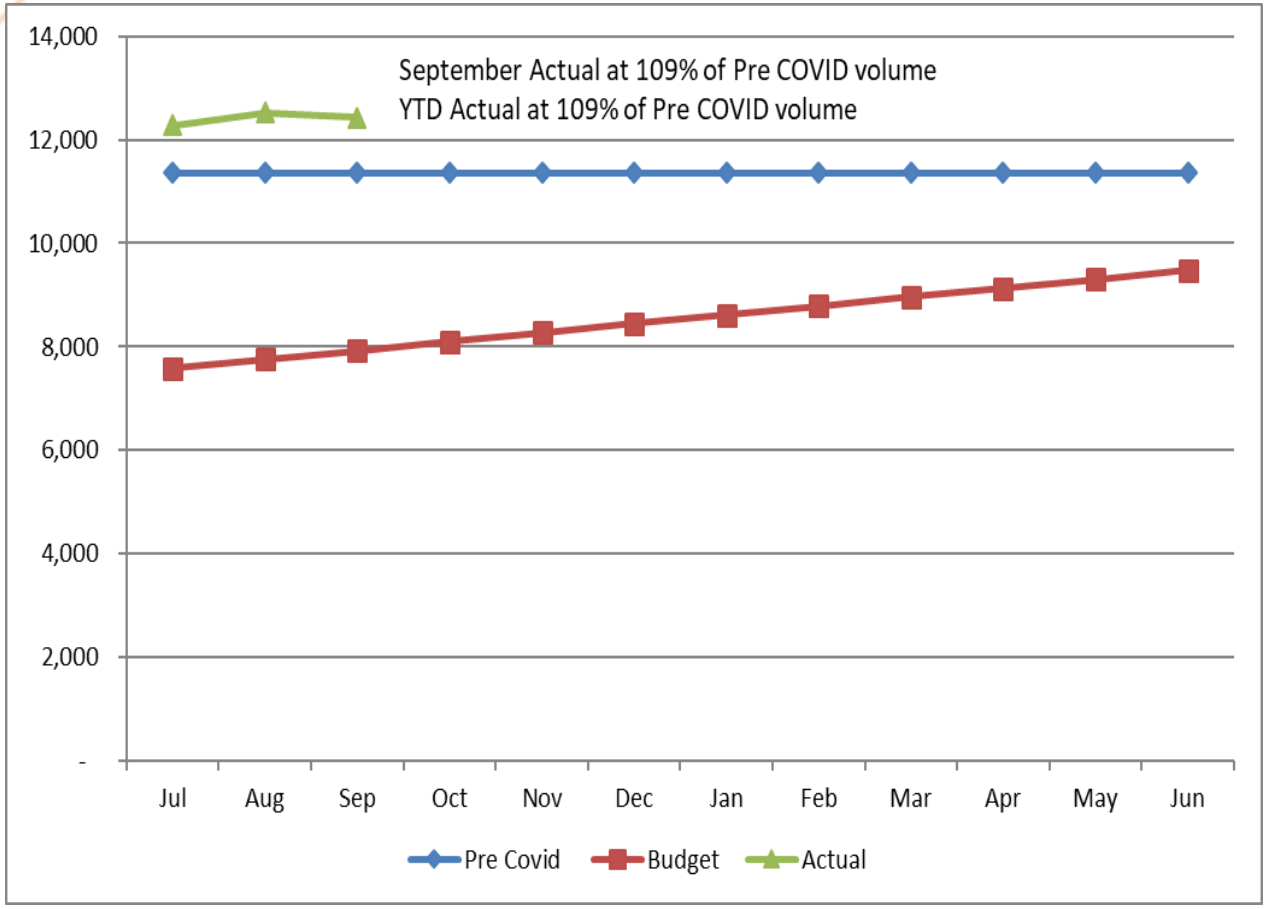


September Volume – Outpatient

FY2021 Budget vs Actual – Including Pre COVID Level

MV



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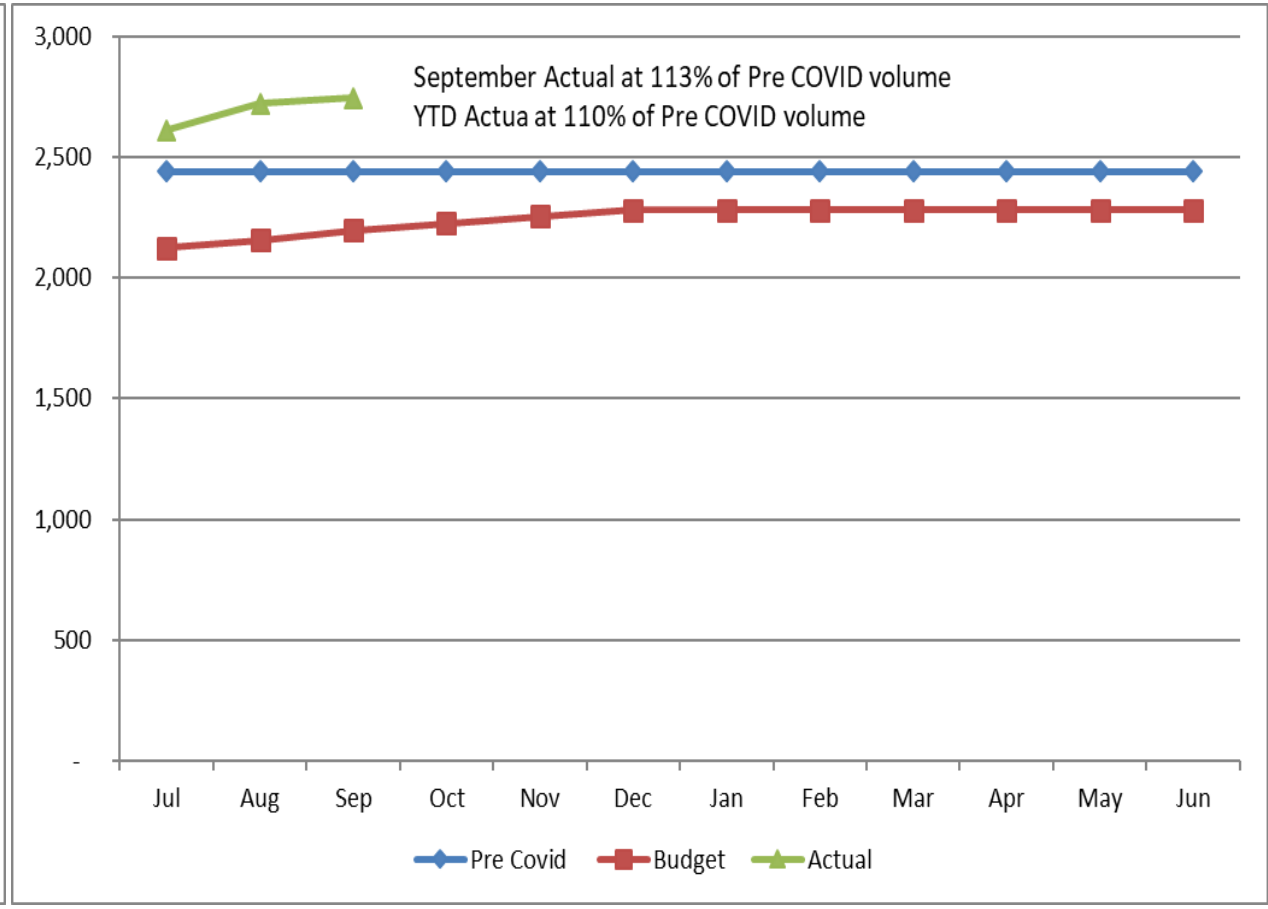
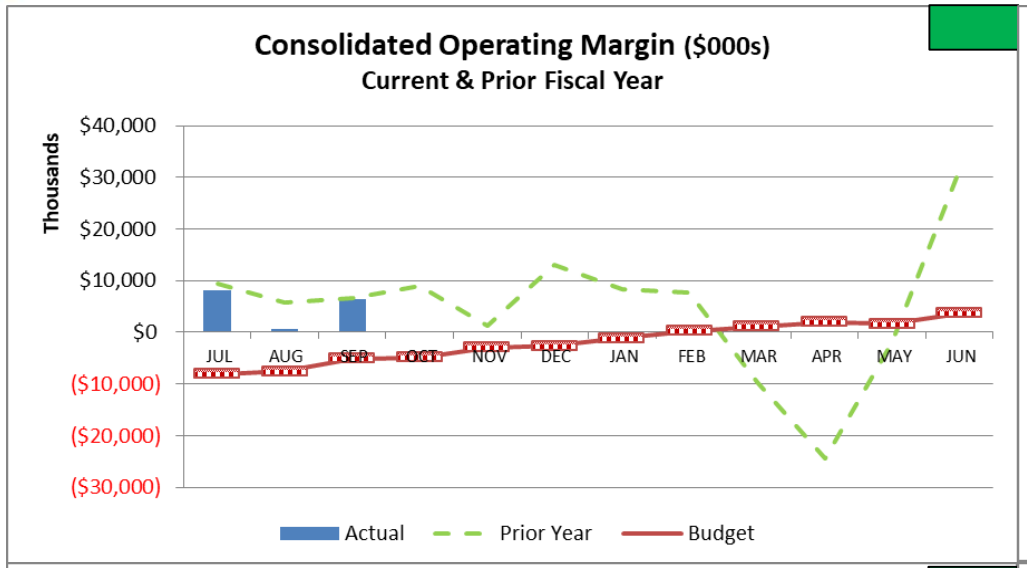
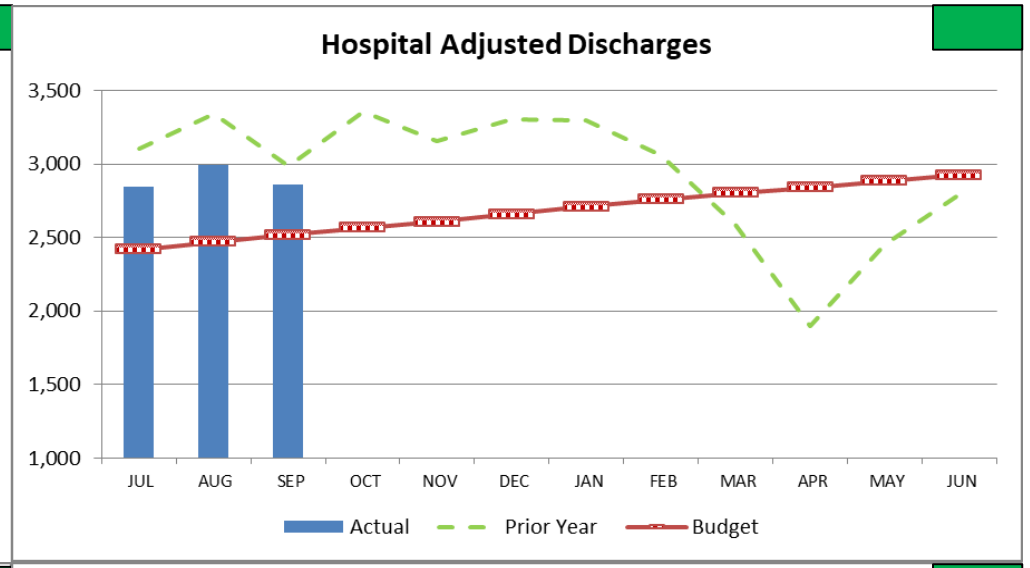


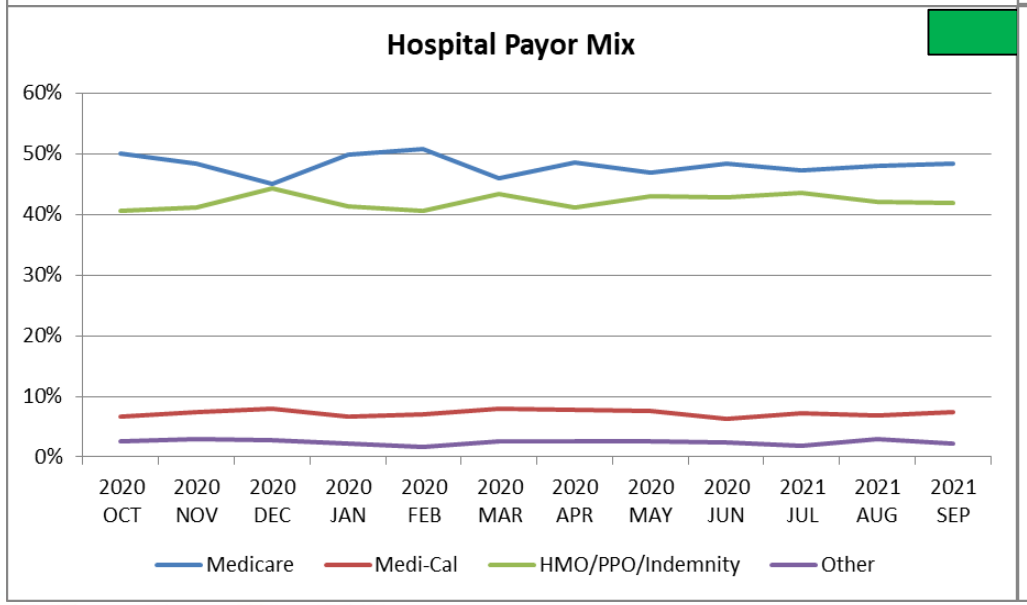
El Camino Health

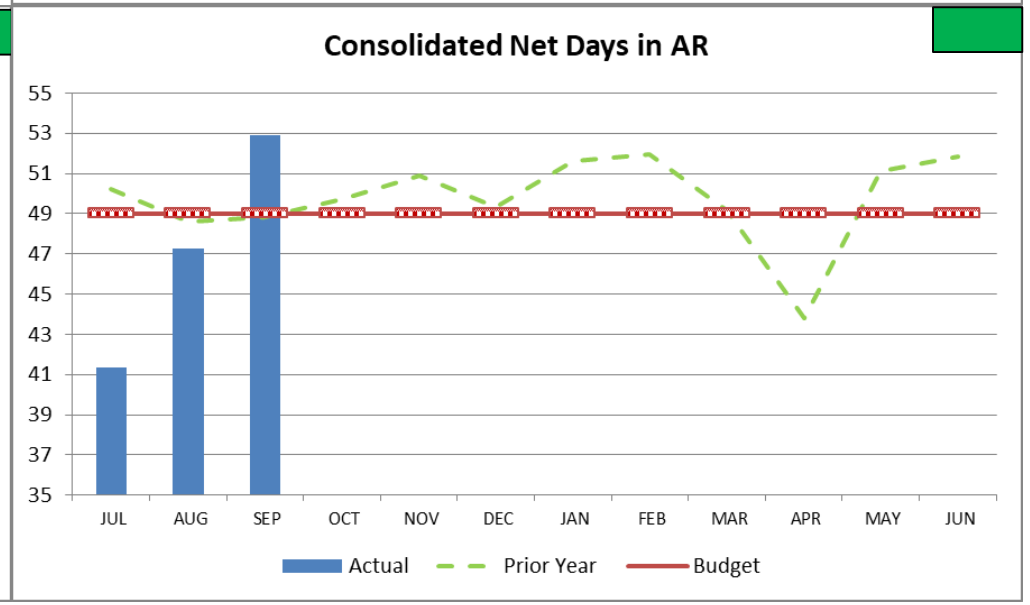
APPENDIX

Monthly Financial Trends









El Camino Health

Investment Portfolio Scorecard (as of 9/30/2020)

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.

El Camino Health

Non Operating Items and Net Margin by Affiliate

$ in thousands

	Period 3- Month			Period 3- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	7,001	(3,310)	10,311	20,837	(13,719)	34,556
Los Gatos	2,698	1,535	1,163	3,992	3,703	289
Sub Total - El Camino Hospital, excl. Afflilates	**9,698**	**(1,775)**	**11,474**	**24,828**	**(10,016)**	**34,845**
Operating Margin %	**11.0%**	**-2.6%**		**9.6%**	**-5.0%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**(9,418)**	**3,029**	**(12,447)**	**45,225**	**6,926**	**38,299**
El Camino Hospital Net Margin	**281**	**1,254**	**(973)**	**70,053**	**(3,090)**	**73,143**
ECH Net Margin %	**0.3%**	**1.8%**		**27.1%**	**-1.5%**	
Concern	(128)	(85)	(44)	(39)	(14)	(25)
ECSC	(0)	0	(0)	(2)	0	(2)
Foundation	(339)	(29)	(310)	823	25	798
El Camino Health Medical Network	(2,969)	(3,025)	56	(8,856)	(9,999)	1,144
Net Margin Hospital Affiliates	**(3,437)**	**(3,139)**	**(298)**	**(8,074)**	**(9,989)**	**1,915**
Total Net Margin Hospital & Affiliates	**(3,156)**	**(1,884)**	**(1,272)**	**61,979**	**(13,079)**	**75,058**

El Camino Hospital – Mountain View ($000s)

Period ending 9/30/2020

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					
255,491	275,631	202,052	73,579	36.4%	**Gross Revenue**	758,020	797,771	591,404	206,366	34.9%
(189,393)	(206,164)	(149,687)	(56,476)	(37.7%)	**Deductions**	(555,749)	(591,726)	(438,134)	(153,592)	(35.1%)
66,098	**69,467**	**52,365**	**17,102**	**32.7%**	**Net Patient Revenue**	**202,271**	**206,045**	**153,270**	**52,775**	**34.4%**
2,274	1,238	1,492	(253)	(17.0%)	**Other Operating Revenue**	5,169	4,237	4,437	(199)	(4.5%)
68,373	**70,706**	**53,857**	**16,849**	**31.3%**	**Total Operating Revenue**	**207,441**	**210,282**	**157,707**	**52,575**	**33.3%**
					OPERATING EXPENSE					
35,745	37,953	34,022	(3,931)	(11.6%)	**Salaries & Wages**	107,731	111,841	102,261	(9,580)	(9.4%)
10,046	9,660	8,082	(1,578)	(19.5%)	**Supplies**	31,092	32,922	23,945	(8,978)	(37.5%)
5,489	6,881	6,880	(2)	(0.0%)	**Fees & Purchased Services**	19,166	19,323	20,664	1,341	6.5%
2,361	3,019	2,405	(614)	(25.5%)	**Other Operating Expense**	7,380	7,814	7,461	(353)	(4.7%)
525	1,428	926	(501)	(54.1%)	**Interest**	1,590	4,287	2,775	(1,512)	(54.5%)
3,516	4,763	4,852	88	1.8%	**Depreciation**	10,796	13,258	14,320	1,062	7.4%
57,682	**63,705**	**57,167**	**(6,538)**	**(11.4%)**	**Total Operating Expense**	**177,754**	**189,445**	**171,426**	**(18,019)**	**(10.5%)**
10,691	**7,001**	**(3,310)**	**10,311**	**(311.5%)**	**Net Operating Margin**	**29,686**	**20,837**	**(13,719)**	**34,556**	**(251.9%)**
2,281	(9,418)	3,029	(12,447)	(410.9%)	**Non Operating Income**	4,426	45,225	6,926	38,299	553.0%
12,972	**(2,417)**	**(281)**	**(2,136)**	**760.9%**	**Net Margin**	**34,112**	**66,061**	**(6,793)**	**72,855**	**(1072.4%)**
21.5%	18.7%	4.6%	14.1%		**EBIDA**	20.3%	18.3%	2.1%	16.1%	
15.6%	9.9%	-6.1%	16.0%		**Operating Margin**	14.3%	9.9%	-8.7%	18.6%	
19.0%	-3.4%	-0.5%	(2.9%)		**Net Margin**	16.4%	31.4%	-4.3%	35.7%	

El Camino Hospital – Los Gatos ($000s)

Period ending 9/30/2020

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					
50,337	72,668	56,665	16,003	28.2%	**Gross Revenue**	167,836	207,037	167,663	39,374	23.5%
(38,291)	(55,665)	(42,242)	(13,423)	(31.8%)	**Deductions**	(126,333)	(159,897)	(125,112)	(34,785)	(27.8%)
12,046	**17,003**	**14,423**	**2,580**	**17.9%**	**Net Patient Revenue**	**41,503**	**47,140**	**42,551**	**4,589**	**10.8%**
410	423	271	152	56.3%	**Other Operating Revenue**	1,175	1,218	811	407	50.2%
12,456	**17,426**	**14,694**	**2,732**	**18.6%**	**Total Operating Revenue**	**42,678**	**48,358**	**43,362**	**4,995**	**11.5%**
					OPERATING EXPENSE					
7,001	8,028	6,985	(1,043)	(14.9%)	**Salaries & Wages**	21,788	24,247	21,115	(3,132)	(14.8%)
1,865	2,564	2,309	(254)	(11.0%)	**Supplies**	6,481	8,046	6,721	(1,325)	(19.7%)
2,662	2,743	2,661	(82)	(3.1%)	**Fees & Purchased Services**	8,141	8,495	7,998	(497)	(6.2%)
386	576	358	(218)	(61.0%)	**Other Operating Expense**	953	1,122	1,360	238	17.5%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
798	818	847	29	3.4%	**Depreciation**	2,401	2,456	2,466	10	0.4%
12,713	**14,728**	**13,159**	**(1,569)**	**(11.9%)**	**Total Operating Expense**	**39,763**	**44,366**	**39,659**	**(4,707)**	**(11.9%)**
(257)	**2,698**	**1,535**	**1,163**	**75.7%**	**Net Operating Margin**	**2,915**	**3,992**	**3,703**	**289**	**7.8%**
0	0	0	0	0.0%	**Non Operating Income**	0	0	0	0	0.0%
(257)	**2,698**	**1,535**	**1,163**	**75.7%**	**Net Margin**	**2,915**	**3,992**	**3,703**	**289**	**7.8%**
4.3%	20.2%	16.2%	4.0%		**EBIDA**	12.5%	13.3%	14.2%	(0.9%)	
-2.1%	15.5%	10.4%	5.0%		**Operating Margin**	6.8%	8.3%	8.5%	(0.3%)	
-2.1%	15.5%	10.4%	5.0%		**Net Margin**	6.8%	8.3%	8.5%	(0.3%)	

El Camino Health Medical Network ($000s)

Period ending 9/30/2020

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					
6,277	9,539	7,960	1,579	19.8%	**Gross Revenue**	17,399	25,380	22,969	2,410	10.5%
(4,582)	(6,001)	(5,330)	(671)	(12.6%)	**Deductions**	(12,325)	(17,015)	(15,602)	(1,414)	(9.1%)
1,695	**3,538**	**2,630**	**908**	**34.5%**	**Net Patient Revenue**	**5,074**	**8,364**	**7,368**	**997**	**13.5%**
2,032	1,660	1,938	(278)	(14.4%)	**Other Operating Revenue**	4,936	5,403	5,815	(412)	(7.1%)
3,726	**5,198**	**4,568**	**630**	**13.8%**	**Total Operating Revenue**	**10,009**	**13,767**	**13,182**	**585**	**4.4%**
					OPERATING EXPENSE					
1,782	1,724	1,664	(60)	(3.6%)	**Salaries & Wages**	5,234	4,882	5,160	278	5.4%
398	571	430	(141)	(32.7%)	**Supplies**	1,117	1,474	1,308	(166)	(12.7%)
4,613	4,836	4,474	(362)	(8.1%)	**Fees & Purchased Services**	11,999	13,103	13,638	536	3.9%
660	836	764	(72)	(9.5%)	**Other Operating Expense**	1,906	2,563	2,292	(271)	(11.8%)
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
52	200	261	61	23.3%	**Depreciation**	155	601	784	182	23.3%
7,505	**8,167**	**7,593**	**(575)**	**(7.6%)**	**Total Operating Expense**	**20,411**	**22,623**	**23,182**	**559**	**2.4%**
(3,779)	**(2,969)**	**(3,025)**	**56**	**(1.8%)**	**Net Operating Margin**	**(10,401)**	**(8,856)**	**(9,999)**	**1,144**	**(11.4%)**
0	0	0	0	0.0%	**Non Operating Income**	0	0	0	0	0.0%
(3,778)	**(2,969)**	**(3,025)**	**56**	**(1.8%)**	**Net Margin**	**(10,401)**	**(8,856)**	**(9,999)**	**1,144**	**(11.4%)**
-100.0%	-53.3%	-60.5%	7.2%		**EBIDA**	-102.4%	-60.0%	-69.9%	10.0%	
-101.4%	-57.1%	-66.2%	9.1%		**Operating Margin**	-103.9%	-64.3%	-75.9%	11.5%	
-101.4%	-57.1%	-66.2%	9.1%		**Net Margin**	-103.9%	-64.3%	-75.9%	11.5%	

El Camino Health

OPEN SESSION CEO Report
November 11, 2020
Dan Woods, CEO

Quality and Safety

I am pleased to report that Healthgrades named El Camino Hospital Mountain View as a recipient of three 2021 Specialty Clinical Quality Awards.

- America's 100 Best Hospitals for Cardiac Care Award: Recognizes superior clinical outcomes for heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment and heart valve surgery.
- America's 100 Best Hospitals for Gastrointestinal Care Award: Recognizes superior clinical outcomes in colorectal surgeries, gallbladder removal, esophageal/stomach surgeries, small intestine surgeries, and treating bowel obstruction, gastrointestinal bleeds, and pancreatitis.
- General Surgery Excellence Award: Recognizes superior clinical outcomes in bowel obstruction treatment, colorectal surgeries, gallbladder removal, esophageal/stomach surgeries, and small intestine surgeries.

Operations

ECH Los Gatos acquired a new image-guided, navigated, robotic bone cutting-guide on a computer-controlled arm for total knee arthroplasty surgery. The acquisition of this equipment, which integrates with x-ray-based software to model artificial joint fit in advance, allows more surgeons to utilize robotic technology for their patient's joint replacements.

In October, ECH has acquired two new computer vision software modules recently approved by the FDA for use with potential stroke patients. These new automated CT scan reads provide quick information as to the potential benefits and risks of thrombectomy (clot removal) based on the current damage to the brain, allowing for quicker decision-making to activate the catheterization lab teams. Evidence shows that millions of brain cells die each minute, and the ability to heal is correlated to more timely intervention.

A verbal update will be provided to the Board on the status of the virtual site visit for our 4th Magnet designation, which will take place November 10th – 12th.

Workforce

In October, we established a Diversity and Inclusion Committee, comprised of physicians, managers, and staff members. The work of the Committee is to acknowledge the perspectives, life experiences, and social/cultural identities that our

care providers and other staff members bring to the Hospital, as these bring great value to the healthcare environment and increase our ability to provide compassionate, innovative, and culturally competent care. Embracing diversity and equity in our workforce creates an inclusive work and care environment for employees and the community we serve.

The pandemic has potential impact on wellness throughout the organization. In response, we are regularly reminding our employees that counseling services are available through CONCERN: EAP. As well, we are offering those services to ECHMN and hospital-based physicians free of charge.

The El Camino Health Human Resources division is working with the City of Mountain View to develop an outdoor fitness court at Cuesta Park. The City's consultant designed a proposed fitness zone with 9 stations that could serve up to 37 people at a time. Discussions are focused on a potential partnership where the entities would split construction costs in order to provide this benefit to the entire community. City staff is tentatively planning to take the proposed outdoor fitness court to the City Council for project approval on December 8, 2020. If the City Council approves the project, ECH will target the approval of our financial support for the project in January 2021.

Facilities

Management engaged an architectural firm to provide a feasibility assessment for a Patient/Family Residence for consideration on the Healthcare District property located at 530 South Drive. We anticipate bringing a recommendation to you in the coming months regarding this concept that has already garnered significant interest from ECH Foundation donors since the initial concept was presented.

Information Services

MyChart adoption is currently at 51% and continues to climb. 76,700 of our patients have a MyChart account. We made significant progress over the past year (doubling the percentage) to move from 21% of patients seen 3+ times having a MyChart Account to the current status of 51% of patients having a MyChart account. We are in the middle 50%/median range of Epic customers with the goal of top 25% and ultimately the top 10%. We expect to make dramatic improvement in the next 3-6 months as the Epic data is the last 12 month average and due to the significant increases recently we will move into the higher ranges as the older less positive months drop off.

Community COVID-19 Testing

ECH continues to provide testing through the El Camino Healthcare District Community COVID-19 Testing Program. Over 9,000 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 now offered testing at public school sites where requested. Capacity at the Mountain View campus is 100 tests per day and 200 tests per day at the pop-up sites. 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 5th.

Corporate and Community Health Services

CONCERN: EAP will be providing EAP services to 25 new customers, covering 30,000 employees by January 2021.

Community Benefit staff requested an informational report from all grant partners requesting an update on the impact of the pandemic on their operations and use of grant funds, an added assessment step for the pandemic.

The South Asian Heart Center hosted three talks on "A Lifetime on Meds or a Lifestyle of MEDS" with 26 attendees, started a new monthly Diabetes Prevention Program and hosted an evening huddle regarding "Secrets of Self-Healing from Ayurveda" with 79 attendees. The Chinese Health Initiative translated Safe Care videos with Chinese voiceover and disseminated them through an enewsletter and social media channels, revised the bilingual "Health Resource Guide for Chinese Seniors in Santa Clara County" and continues its "Ask-a-Doctor" and "Emotional Well-Being" webinars. CHI also held an annual appreciation for Chinese-speaking physician's event with 22 physicians attending. Dr. Adams gave a presentation to the attendees on the "Journey to High Reliability."

Marketing and Communications

The recovery brand advertising campaign, Return to Health, continues to perform well. Since its launch in April, we have had over 73,000 page views with the Trade Desk ads as the main driver of website traffic, followed by Facebook, and then paid search.
In collaboration with the COVID-19 workgroup, we launched online appointment scheduling for Los Gatos and an interactive map with our testing facilities on our website. We also added (1) new pharmacy content supporting the mobile app and medication use instruction and (2) online class support for Lifestyle Medicine by expanding online class offerings and to SAHC's AIM as well as New Beginnings mother-baby classes.

Media Coverage for October 2020 included the following:

- October 1, 2020 Patch (Campbell) Coronavirus Live Blog: Santa Clara County Says Private Hospitals Have To Do More Testing
- October 2, 2020 Los Altos Town Crier School districts, ECH offer on-campus COVID testing for teachers
- October 3, 2020 Patch (Campbell) Coronavirus Live Blog Binational Health Week Goes Online
- October 4, 2020 Patch (Campbell) Coronavirus Live Blog: County to Allow Indoor Dining if it Moves to Lower-Risk Reopening Tier
- October 13, 2020 Patch (Campbell) Coronavirus Live Blog: Gardner Health Center and County Increase Testing at Mexican Heritage Plaza
- October 27, 2020 The McMurrow Reports Facility Management & Design Insights: VirtualCast Healthcare releases seven episodes of 1 Hour (Ken King)

Government Relations

On October 26, the U.S. Department of Health and Human Services released its first report on hospital reporting compliance in regards to submitting COVID-19 data. In the first report, El Camino Health is shown as reporting at 100% for all seven days. This compared favorably to other regional hospitals which were shown at a lower level of compliance ranging from 63.4% - 99.3%.

To maintain stability in the EMS system, the Santa Clara County Board of Supervisors extended the contract with its current vendor to provide ambulance services through June 30, 2024. The County had previously been working toward a competitive bidding process for the ambulance contract, but given the COVID-19 pandemic and other challenges in 2020, this was put on hold. For Santa Clara County residents and hospitals, this will provide important stability for EMS services.

El Camino Health was a community sponsor of the Silicon Valley Council of Nonprofits "Be Our Guest" event. The organization helps nonprofits grow their capacity to build thriving and equitable communities. This event has heavy participation from important city, county, and state elected officials.

El Camino Health was the presenting sponsor of the Los Gatos Chamber of Commerce and the Saratoga Area Senior Coordinating Council's first-ever Drive-Thru Senior Resource Fair. Our Chief Nursing Officer and Director of Infection Prevention also provided COVID-19 safety guidance to the event organizers. As the presenting sponsor, El Camino Health was recognized in a radio ad as well as an advertisement, which ran in the Los Gatos Weekly. ECH staff handed out information on our services and programs to approximately 150 seniors during the event on October 28.

El Camino Health

Philanthropy

Edward and Pamela Taft gifted $300,000 to the nursing division for nursing research. We will use the funds for evidenced based projects and will disseminate the results of our work globally.

El Camino Health Foundation secured $28,514 in Period 3 of fiscal year 2021, for a total of $870,960 YTD, which is 11% percent of goal for the year. A detailed report is attached.

Auxiliary

The Auxiliary has contributed 4,892 volunteer hours in FY21, 1450 of those in the month of October.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING 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: October 28, 2020
Subject: Report on El Camino Health Foundation Activities FY21 Period 3

Purpose: For information.

Summary:

1. Situation: El Camino Health Foundation secured $28,514 in period 3 of fiscal year 2021, which is 11 percent of goal.

2. Authority: N/A

3. Background:

Major & Planned Gifts
In September, the foundation received a $10,000 gift to the Cancer Center in memory of a friend and in honor of the exceptional care given. This brings cumulative FY21 major and planned giving to $763,516.

Annual Giving
In September, the foundation raised $18,514 in annual gifts from direct mail appeals for the COVID-19 Emergency Response Fund, 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 to date to $107,744.

Upcoming Events

- *Donor Appreciation virtual reception*, Wednesday, November 4, 2021
- *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.
  - *Cardio-Oncology: A New, Multi-Disciplinary Approach to Health and Healing* – November 17, 2021
  - *Finding Balance During Difficult Times* – January 20, 2021
  - *Building for the Future* – March 31, 2021
- *Norma's Literary Luncheon,* Thursday, February 4, 2021, featuring Cathy comic strip artist and author Cathy Guisewite. 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 Foundation Executive Committee, in consultation with hospital leadership, continues to carefully allocate donations to help meet emerging COVID-19 related needs. To date, 50 employees have received financial assistance of up to $5,000 each. The laboratory is validating the new high throughput analyzer and associated equipment, and anticipates full implementation by the end of November. Several El Camino Health families have gratefully enrolled their school-age children in the Y Super Scholars Program at the YMCA with scholarships provided by the donations to the fund. Most recently the foundation made a grant so the emergency department can provide oxygen sensors to discharged patients for home monitoring.

El Camino Health Foundation

FOUNDATION PERFORMANCE

FY21 Fundraising Report through 9/30/20 - Period 3

ACTIVITY		FY21 YTD (7/1/20 - 9/30/20)	FY21 Goals	FY21 % of Goal	Difference Period 2 & 3	FY20 YTD (7/1/19 - 9/30/19)
Major & Planned Gifts		$763,516	$6,500,000	12%	$10,000	$583,450
Annual Gifts*		$107,444	$650,000	17%	$18,514	$87,987
Special Events	Chinese Health Initiative Event	$0	$125,000	0%	$0	$12,045**
	Golf	$0	$325,000	0%	$0	$129,002
	Norma's Literary Luncheon	$0	$200,000	0%	$0	$70,000
	Taking Wing Gala	$0	$350,000	0%	$0	$22,500
TOTALS		**$870,960**	**$8,150,000**	**11%**	**$28,514**	**$904,984**

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

** South Asian Heart Center Event

Highlighted Assets through 9/30/20 - Period 3

Board Designated Allocations	$595,927
Donations - Restricted	$14,425,306
Donations - Unrestricted	$3,949,011
Endowments - Donor	$7,161,188
Endowments - Operational	$13,920,522
Investment Income	$469,271
Pledge Receivables	$3,364,115

El Camino Hospital Auxiliary

Membership Report to the Hospital □oard
Meeting of November 11□2020

Combined Data as of October □1□2020 for Mountain View and Los □atos Campuses

Membership Data:

Senior Members

Active Members	236	0 Net change compared to previous month
Dues Paid Inactive	45	(Includes Associates & Patrons)
Leave of Absence	8	
Subtotal	**2□□**	

Resigned in Month	29
Deceased in Month	0

□unior Members

Active Members	164	0 Net Change compared to previous month
Dues Paid Inactive	0	
Leave of Absence	6	
Subtotal	**1□0**	

Total Active Members **□00**

Total Membership **□□□**

Combined Auxiliary Hours from Inception (to October □1□2020): □0□□□□1

Combined Auxiliary Hours for FY2021 (to October □1□2020): □□□2

Combined Auxiliary Hours for October □1□2020: 1□□0