El Camino Health

# AGENDA
## REGULAR MEETING OF THE
## EL CAMINO HOSPITAL BOARD OF DIRECTORS

**Wednesday, June 23, 2021 – 5:30 pm**
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

**1-669-900-9128, MEETING CODE: 928-9223-7717#. No participant code. Just press #.**

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

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

| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|---|
| **1.** | **CALL TO ORDER/ROLL CALL** | Lanhee Chen, Board Chair | | **5:30 – 5:31pm** |
| **2.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Lanhee Chen, Board Chair | | **information 5:31 – 5:32** |
| **3.** | **PUBLIC COMMUNICATION**<br>a. Oral Comments<br>*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.*<br>b. Written Correspondence | Lanhee Chen, Board Chair | | **information 5:32 -5:34** |
| **4.** | **QUALITY COMMITTEE REPORT** | George Ting, MD, Quality Committee Vice-Chair | | **discussion 5:34 – 5:49** |
| **5.** | **FY21 PERIOD 10 FINANCIALS** | Carlos Bohorquez, CFO | *public comment* | **motion required 5:49 – 5:55** |
| **6.** | **ADJOURN TO CLOSED SESSION** | Lanhee Chen, Board Chair | *public comment* | **motion required 5:55– 5:56** |
| **7.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Lanhee Chen, Board Chair | | **information 5:56 – 5:57** |
| **8.** | **CONSENT CALENDAR**<br>*Any Board Member may remove an item for discussion before a motion is made.* | Lanhee Chen, Board Chair | | **motion required 5:57 – 6:00** |
| | ***Approval***<br>*Gov't Code Section 54957.2 and 54957.6:*<br>a. Minutes of the Closed Session of the Hospital Board Meeting (05/12/2021)<br>b. Minutes of the Closed Session of the Hospital Board Meeting (05/22/2021)<br>c. FY22 Individual Executive Performance Incentive Goals<br>***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee***<br>*Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: | | | |

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at (650) 988-8254 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|---|
| | d. Quality Committee Report<br>(i) Medical Staff Credentials and Privileges Report<br>(ii) Quality Council Minutes | | | |
| | | | | |
| **9.** | Report involving *Gov't Code Section 54957.6* for a report and discussion on personnel matters:<br>- Potential Amendment to CEO Employment Agreement | Bob Miller, Executive Compensation Committee Chair | | **motion required 6:00 – 6:15** |
| | | | | |
| **10.** | *Gov't Code Section 54957.6* for a report and discussion on personnel matters:<br>- Executive Performance Incentive and Benefit Plan Design | Bob Miller, Executive Compensation Committee Chair | | **motion required 6:15 – 6:30** |
| | | | | |
| **11.** | *Gov't Code Section 54957.6* for a report and discussion on personnel matters:<br>- Proposed CQO Salary | Dan Woods, CEO | | **motion required 6:30 – 6:35** |
| | | | | |
| **12.** | *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets<br>- FY22 Strategic Goal Metrics | Dan Woods, CEO | | **discussion 6:35– 6:50** |
| | | | | |
| **13.** | *Gov't Code Section 54956.9(d)(2)* – conference with legal counsel – pending or threatened litigation; *Gov't Code Section 54957* and *54957.6* for discussion and report on personnel matters:<br>- CEO Report on Legal Update and Personnel Matters<br>a. Update (verbal)<br>b. Pacing Plan | Dan Woods, CEO | | **discussion 6:50 – 7:05** |
| | | | | |
| **14.** | Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management:<br>- Executive Session | Lanhee Chen, Board Chair | | **discussion 7:05 – 7:10** |
| | | | | |
| **15.** | **ADJOURN TO OPEN SESSION** | Lanhee Chen, Board Chair | | **motion required 7:10 – 7:11** |
| | | | | |
| **16.** | **RECONVENE OPEN SESSION/ REPORT OUT** | Lanhee Chen, Board Chair | | **information 7:11 – 7:12** |
| | To report any required disclosures regarding permissible actions taken during Closed Session. | | | |
| | | | | |
| **17.** | **CONSENT CALENDAR ITEMS:**<br>*Any Board Member or member of the public may remove an item for discussion before a motion is made.* | Lanhee Chen, Board Chair | *public comment* | **motion required 7:12 – 7:17** |

| AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|
| ***Approval***<br>a. Hospital Board Minutes (05/12/21) Open Session Minutes<br>b. Hospital Board Minutes (05/22/21) Open Session Minutes<br>c. FY22 Master Calendar<br>d. FY22 Committee Goals<br>e. FY22 Committee and Liaisons Appointments<br>f. FY22 Community Benefit Plan<br>g. FY22 Organizational Performance Incentive Plan Goals<br>h. New Enterprise Anesthesia Services Agreement, MV Nighttime Intensivist Services Agreement and Line of Credit Agreement<br>***Reviewed and Recommended for Approval by the Finance Committee***<br>i. FY21 Period 9 Financials<br>j. Infection Control Medical Director Agreement<br>***Reviewed and Recommended for Approval by the Medical Executive Committee***<br>k. Medical Staff Report<br>***Information***<br>l. MV Major Projects Update | | | |
| **18. CONSIDERATION OF BENEFITS COVERAGE FOR BOARD MEMBERS RECLASSIFIED AS W-2 EMPLOYEES FOR IRS PURPOSES** | Dan Woods, CEO | *public comment* | **possible motion 7:17 – 7:32** |
| **19. CEO REPORT** | Dan Woods, CEO | | **information 7:32 – 7:37** |
| **20. BOARD COMMENTS** | Lanhee Chen, Board Chair | | **information 7:37 – 7:40** |
| **21. ADJOURNMENT** | Lanhee Chen, Board Chair | *public comment* | **motion required 7:40 – 7:41pm** |

**Upcoming Regular Meetings**: August 18, 2021, September 15, 2021, and October 13, 2021

El Camino Health

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

**To:** El Camino Hospital Board of Directors
**From:** George Ting MD, Quality Committee Vice-Chair
Mark Adams, MD, CMO
**Date:** June 23, 2021
**Subject:** Quality, Patient Care and Patient Experience Committee Report

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

**Summary:**

1. Cheryl Reinking RN, CNO, presented a patient story submitted by a recent patient who is also an El Camino Health employee. This patient recently had surgery at MV. She had two complaints. One involved the registration process whereby she had to wait unexpectedly and the other pertained to poor diabetic glucose control. Steps have been taken to address these issues to prevent any recurrence. Overall, however, the patient reported that her experience was "awesome" and she would not hesitate to return for further care as needed.

2. Mark Adams MD, CMO, presented the most recent readmission dashboard. This included five years of readmission data segregated into the seven diagnostic categories used by CMS to score hospitals in the Hospital Readmission Reduction Penalty Program (HRRP). So far this fiscal year the three categories that are above 1.0 include Coronary Artery Bypass Graft (CABG), Total Hip and Knee Arthroplasty, and Stroke. All of the readmissions were reviewed with no finding of any common causes but there will be ongoing monitoring and potential mitigations deployed.

3. Mark Adams presented the most recent Patient Safety Indicators data as of Q3 FY21. The results were highlighted as follows:

    **a.** PSI-03 Pressure Ulcer – 6 in Q1-3; each has had a root cause analysis. Several of these involve COVID pts, with proning and general debility being contributing factors
    **b.** PSI-09 Perioperative hemorrhage or hematoma – 5 occurrences, no trends just sporadic instances
    **c.** PSI-06 Iatrogenic Pneumothorax – 2 occurrences in one patient
    **d.** PSI-18 and PSI-19 OB Vaginal trauma with & without instrument – both being addressed by Maternal Child Health Medical Leadership with case review and education on documentation of injury as well as newer techniques to avoid vaginal trauma. Nonetheless, the rate has remained above Premier Mean and effectively unchanged from FY20. The high proportion of Asian and South Asian births continue to be a significant driver of these results.

PSI rates that are better than Premier mean are highlighted in green on the dashboard.

4. Mark Adams reviewed the proposed annual Quality Assurance and Performance Improvement Plan (QAPI) for FY22. The Quality Improvement and Patient Safety Plan provides the blueprint for quality and safety improvement at El Camino Hospital and is required as the "QAPI Plan" in CMS Conditions of Participation and Joint Commission Standards. CDPH also requires hospitals to have a Patient Safety Plan. This plan defines the structure, function, and processes utilized to accomplish the overall quality and safety strategy of the organization. The progress and success of the plan is measured by the many quality and safety metrics that are tracked and trended. With the Joint Commission triennial survey due in 2021 and the California General Acute Care Survey also due in 2021, this updated plan needs to be approved and distributed across the organization. The Quality Committee discussed the plan and approved it to be forwarded and approved by the Board of Directors.

**Attachments:**

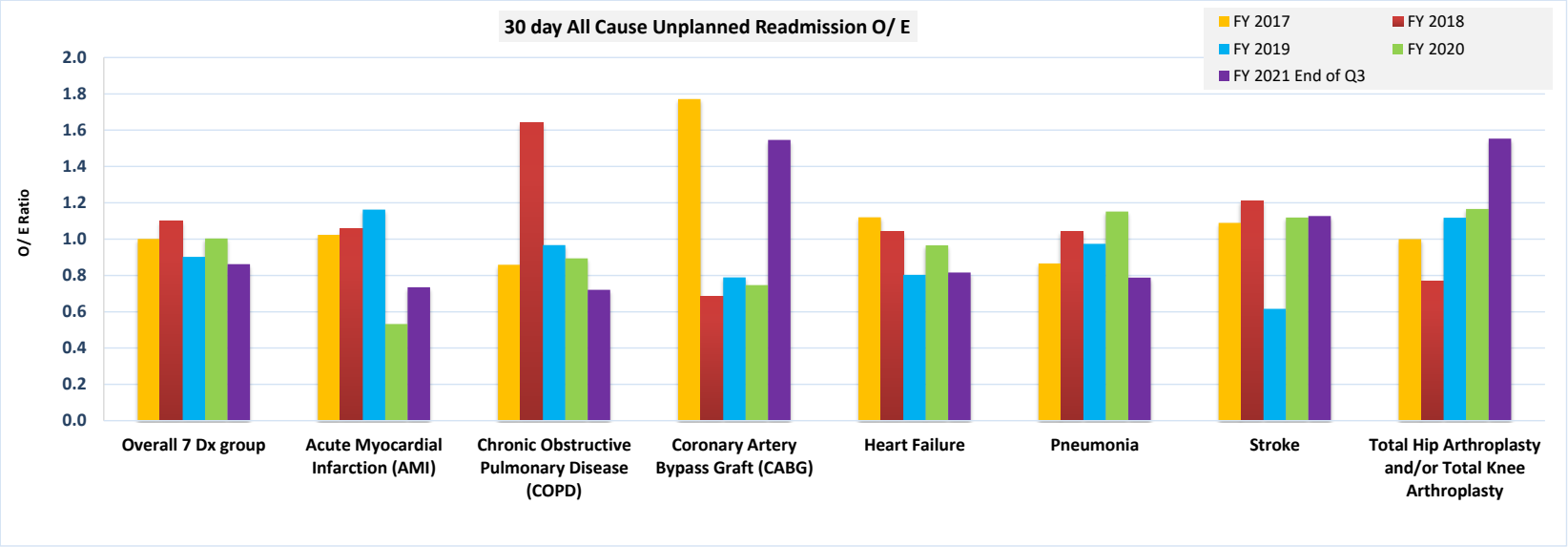
a. Readmission dashboard
b. PSI dashboard
c. FY22 QAPI
d. IBM/Watson Health El Camino Health specific Performance and Improvement Matrix

El Camino Health

# FY 2021 End of Q3, 30 Day All-Cause Readmission Dashboard - ACA Dx.

Premier Risk Adjusted, All Payer, All Cause, Unplanned Readmits
Patient Type: Inpatient

| | FY 2017 | | | FY 2018 | | | FY 2019 | | | FY 2020 | | | FY 2021 End of Q3 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Observed Rate | Expected Rate | O/E Ratio | Observed Rate | Expected Rate | O/E Ratio | Observed Rate | Expected Rate | O/E Ratio | Observed Rate | Expected Rate | O/E Ratio | Observed Rate | Expected Rate | O/E Ratio |
| **Overall 7 Dx group** | **9.08%** | **9.08%** | **1.00** | **10.02%** | **9.11%** | **1.10** | **8.95%** | **9.92%** | **0.90** | **10.64%** | **10.60%** | **1.00** | **10.17%** | **11.81%** | **0.86** |
| Acute Myocardial Infarction (AMI) | 7.69% | 7.51% | 1.02 | 7.72% | 7.30% | 1.06 | 8.75% | 7.53% | 1.16 | 3.92% | 7.36% | 0.53 | 6.08% | 8.27% | 0.74 |
| Chronic Obstructive Pulmonary Disease (COPD) | 14.14% | 16.48% | 0.86 | 26.97% | 16.41% | 1.64 | 14.88% | 15.40% | 0.97 | 14.97% | 16.75% | 0.89 | 12.99% | 18.01% | 0.72 |
| Coronary Artery Bypass Graft (CABG) | 11.24% | 6.34% | 1.77 | 4.63% | 6.76% | 0.69 | 5.38% | 6.81% | 0.79 | 5.33% | 7.15% | 0.75 | 10.53% | 6.81% | 1.55 |
| Heart Failure | 17.79% | 15.89% | 1.12 | 16.17% | 15.52% | 1.04 | 13.39% | 16.67% | 0.80 | 16.44% | 17.03% | 0.97 | 13.77% | 16.88% | 0.82 |
| Pneumonia | 10.31% | 11.92% | 0.87 | 12.82% | 12.30% | 1.04 | 12.50% | 12.84% | 0.97 | 14.41% | 12.51% | 1.15 | 10.20% | 12.94% | 0.79 |
| Stroke | 7.17% | 6.58% | 1.09 | 8.20% | 6.77% | 1.21 | 4.56% | 7.41% | 0.62 | 8.15% | 7.29% | 1.12 | 8.30% | 7.36% | 1.13 |
| Total Hip Arthroplasty and/or Total Knee Arthroplasty | 2.06% | 2.08% | 1.00 | 1.63% | 1.99% | 0.77 | 2.54% | 2.27% | 1.12 | 2.83% | 2.42% | 1.17 | 3.91% | 2.52% | 1.55 |




*Report updated: 5/20/21*

*Source: Premier Quality Advisor, Standard CareScience Risk Calculation, All-Cause Hospital-Wide 30-Day Readmissions*

# Patient Safety Indicator Report (AHRQ) all patients FY20 compared to FY21 (Q1-3)

**Rate Measures**

| Patient Safety Indicator | | Numerator (FY21 Q1-3) | Denominator (FY21 Q1-3) | Rate/1000 (FY21 Q1-3) | Premier Mean* (FY21 Q1-3) | Numerator (FY2□, Q1-4) | Denominator (FY2□, Q1-4) | Rate/1□□□ (FY2□, Q1-4) | Premier Mean□ (FY2□, Q1-4) |
|---|---|---|---|---|---|---|---|---|---|
| PSI-02 | Death in Low Mortality DRGs | 0 | 305 | 0.00 | 1.18 | 0 | 674 | 0.00 | 0.54 |
| PSI-03 | Pressure Ulcer | 6 | 5,295 | 1.13 | 0.44 | 5 | 6,924 | 0.72 | 0.46 |
| PSI-04 | Death in Surgical Pts w Treatable Complications | 9 | 75 | 120.00 | 121.71 | 17 | 104 | 163.46 | 120.99 |
| PSI-06 | Iatrogenic Pneumothorax | 2 | 8,527 | 0.23 | 0.12 | 2 | 11,594 | 0.17 | 0.14 |
| PSI-07 | Central Venous Catheter-Related Blood Stream Infection | 0 | 7,285 | 0.00 | 0.10 | 0 | 10,136 | 0.00 | 0.10 |
| PSI-08 | In Hospital Fall with Hip Fracture | 0 | 7,254 | 0.00 | 0.11 | 2 | 9,781 | 0.20 | 0.10 |
| PSI-09 | Perioperative Hemorrhage or Hematoma | 5 | 2,637 | 1.90 | 1.68 | 3 | 3,911 | 0.77 | 1.84 |
| PSI-10 | Postoperative Acute Kidney Injury Requiring Dialysis | 0 | 1,457 | 0.00 | 0.76 | 1 | 2,317 | 0.43 | 0.75 |
| PSI-11 | Postop Respiratory Failure | 4 | 1,156 | 3.46 | 5.20 | 2 | 1,894 | 1.06 | 4.18 |
| PSI-12 | Perioperative PE or DVT | 6 | 2,793 | 2.15 | 2.48 | 7 | 4,091 | 1.71 | 2.61 |
| PSI-13 | Postop Sepsis | 4 | 1,454 | 2.75 | 4.21 | 4 | 2,289 | 1.75 | 3.46 |
| PSI-14 | Postop Wound Dehiscence | 0 | 930 | 0.00 | 0.79 | 0 | 1,252 | 0.00 | 0.65 |
| PSI-15 | Unrecognized Abdominopelvic Accidental Puncture or Laceration | 1 | 2,471 | 0.40 | 0.71 | 6 | 3,177 | 1.89 | 0.82 |
| PSI-17 | Birth Trauma Injury to Neonate | 9 | 3,082 | 2.92 | 3.78 | 17 | 4,332 | 3.92 | 4.02 |
| PSI-18 | OB Trauma Vaginal Delivery with Instrument | 31 | 158 | 196.20 | 103.67 | 45 | 237 | 189.87 | 107.66 |
| PSI-19 | OB Trauma Vaginal Delivery without Instrument | 74 | 2,037 | 36.33 | 17.55 | 83 | 2,822 | 29.41 | 15.45 |

**Count**

| Patient Safety Indicator | | Cases (FY21 Q1-3) | Premier Mean Cases* | Cases (FY220, Q1-4) | Premier Mean Cases* |
|---|---|---|---|---|---|
| PSI-05 | Retained Surgical Item or Unretrieved Device Fragment | 0 | 0.07 | 0 | 0.16 |

Green = better than Premier comparative mean

El Camino Health

| | |
|---|---|
| **Origination:** | *05/2018* |
| **Effective:** | *N/A* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *N/A* |
| **Next Review:** | *N/A* |
| **Owner:** | *Catherine Carson: Senior Director Quality* |
| **Area:** | *Quality, Risk & Patient Safety* |
| **Document Types:** | *Plan* |

# Quality Improvement & Patient Safety Plan (QAPI)

## PURPOSE

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

## ORGANIZATION OVERVIEW



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

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

## EI CAMINO HEALTH MISSION

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

## EI CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

## EI CAMINO HOSPITAL VALUES

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

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

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

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

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

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

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

# HIGH RELIABILITY

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



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

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

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

# DEFINITIONS:

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

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

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

# SERVICES/PROGRAMS

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

| **Acute Inpatient Services:** | **Emergency Services:** | **Outpatient Services:** |
|---|---|---|
| Intensive & Critical Care Unit | Basic Emergency | Behavioral Services – Outpatient |
| Progressive Care Unit (PCU) (Step-down) | | Cancer Center |
| Operating Room (OR) | | Cardio Pulmonary Wellness Center |
| Post-Anesthesia Care Unit (PACU) | | Outpatient Surgical Units |
| Telemetry/Stroke | | Endoscopy |
| Medical/Surgical/Ortho | | Interventional Services |
| Pediatrics | | Pre-op/ Short Stay Unit (2B) |
| Ortho Pavilion | | Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI) |
| Labor and Delivery (L&D) | | Radiation Oncology |
| Mother/Baby | | Rehabilitation |
| Neonatal Intensive Care Unit (NICU)<br>Level II and Level III | | Infusion Services (MV & LG) |
| Mental Health and Addiction Services (Inpatient Psychiatry) | | Nuclear Medicine |
| Acute Rehabilitation | | Wound Care Clinic |
| Cardiac Catheterization Services | | Occupational Therapy/Physical Therapy |
| Cardiovascular Surgery | | Speech Therapy |



# OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).

2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.
6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating or accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.



# ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

## A. Governing Board

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

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

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

Other specific responsibilities with regard to quality improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the Governing Board.

# B. Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.5, the Medical Executive Committee is responsible for the quality and effectiveness of patient care and competent clinical performance rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

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

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

# C. Medical Staff Departments and Divisions



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

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

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

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

# D. Leadership and Support

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

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

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

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

# E. Medical Staff, Employees, and Contracted Services

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

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

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

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

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

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

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



# G. Quality Services Department

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

The Quality Services Department is also responsible for:

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

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



# H. Improving Organizational Performance

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

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

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

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

# I. Performance Processes

**Design**

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

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




safety firstmission zero

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

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

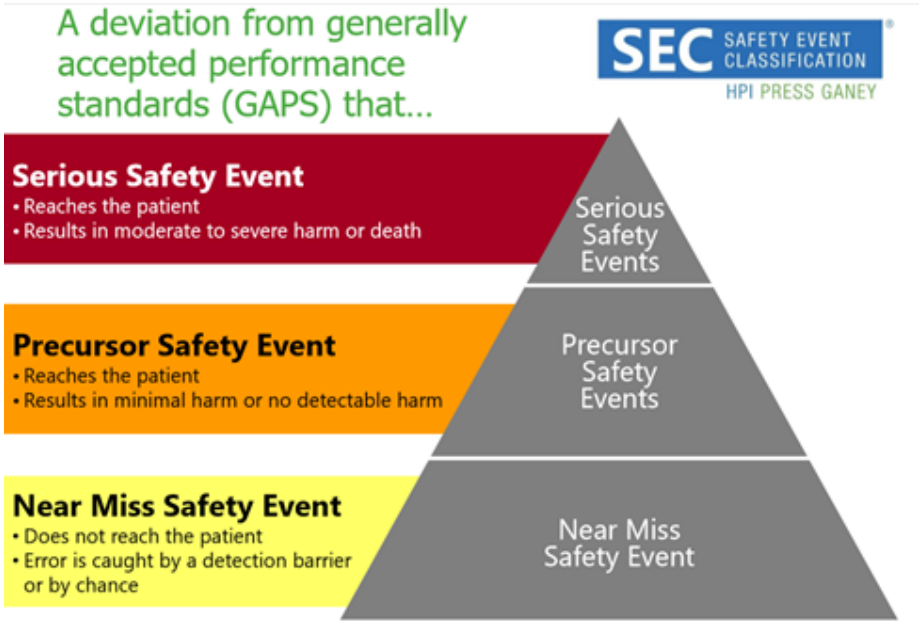
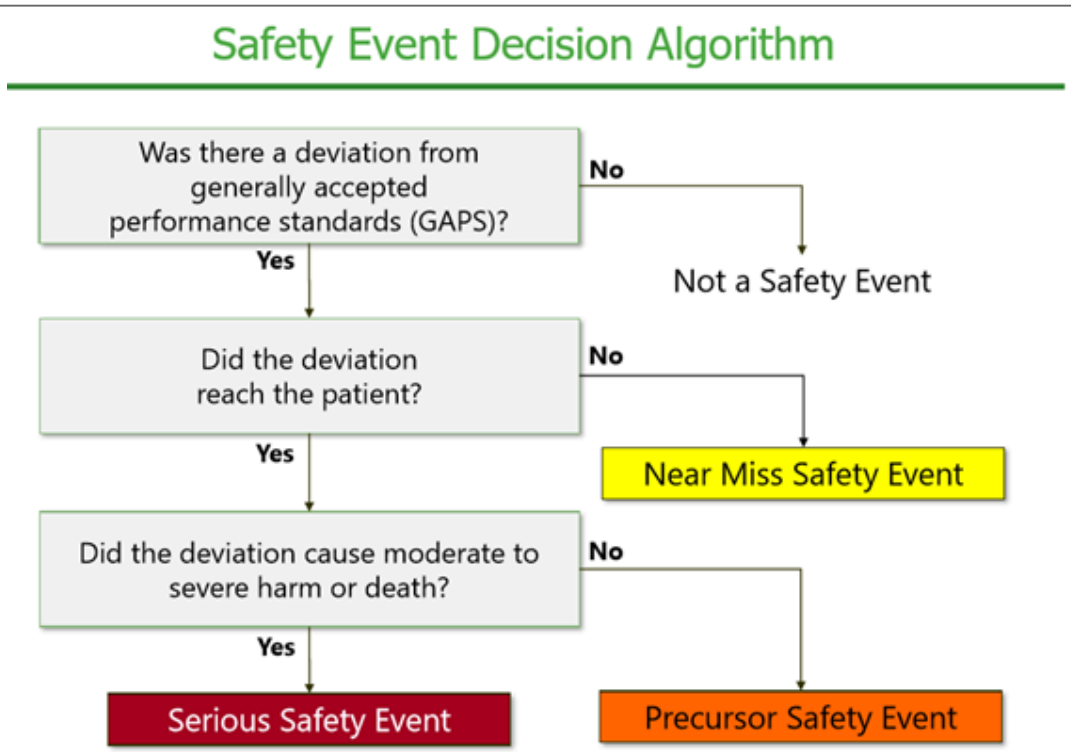



Table 1. HPI SEC Levels of Harm

| HPI SEC | Code | Level of Harm |
|---|---|---|
| Serious Safety Event (SSE) | SSE 1 | Death |
| | SSE 2 | Severe Permanent Harm |
| | SSE 3 | Moderate Permanent Harm |
| | SSE 4 | Severe Temporary Harm |
| | SSE 5 | Moderate Temporary Harm |
| Precursor Safety Event (PSE) | PSE 1 | Minimal Permanent Harm |
| | PSE 2 | Minimal Temporary Harm |
| | PSE 3 | No Detectable Harm |
| | PSE 4 | No Harm |
| Near Miss Safety Event (NME) | NME 1 | Unplanned Catch |
| | NME 2 | Last Strong Barrier Catch |
| | NME 3 | Early Barrier Catch |






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

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

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

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

collection is systematic and is used to:

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

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

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

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

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



# J. Improvement Model And Methodology

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

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

The model has two parts:

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

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

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

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

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

**Step 1: Plan**

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

**Step 2: Do**

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

**Step 3: Study**

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

Summarize and reflect on what was learned.

**Step 4: Act**

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

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


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

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

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

**S – Specific**

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

**M – Measurable**

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

**A – Achievable**

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

**R – Relevant**

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

**T – Time-Bound**

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

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

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

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

# K. Performance Improvement and the El Camino Health Operating System

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



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

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

**ECHOS: El Camino Health Operating System**

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

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

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

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

# L. Quality improvement Link With Organizational Goals

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

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

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

# M. Commitment to Patient Experience

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

# N. Allocation of Resources

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

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

# O. Confidentiality

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

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



# P. Annual Evaluation

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

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

# Cross References:

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

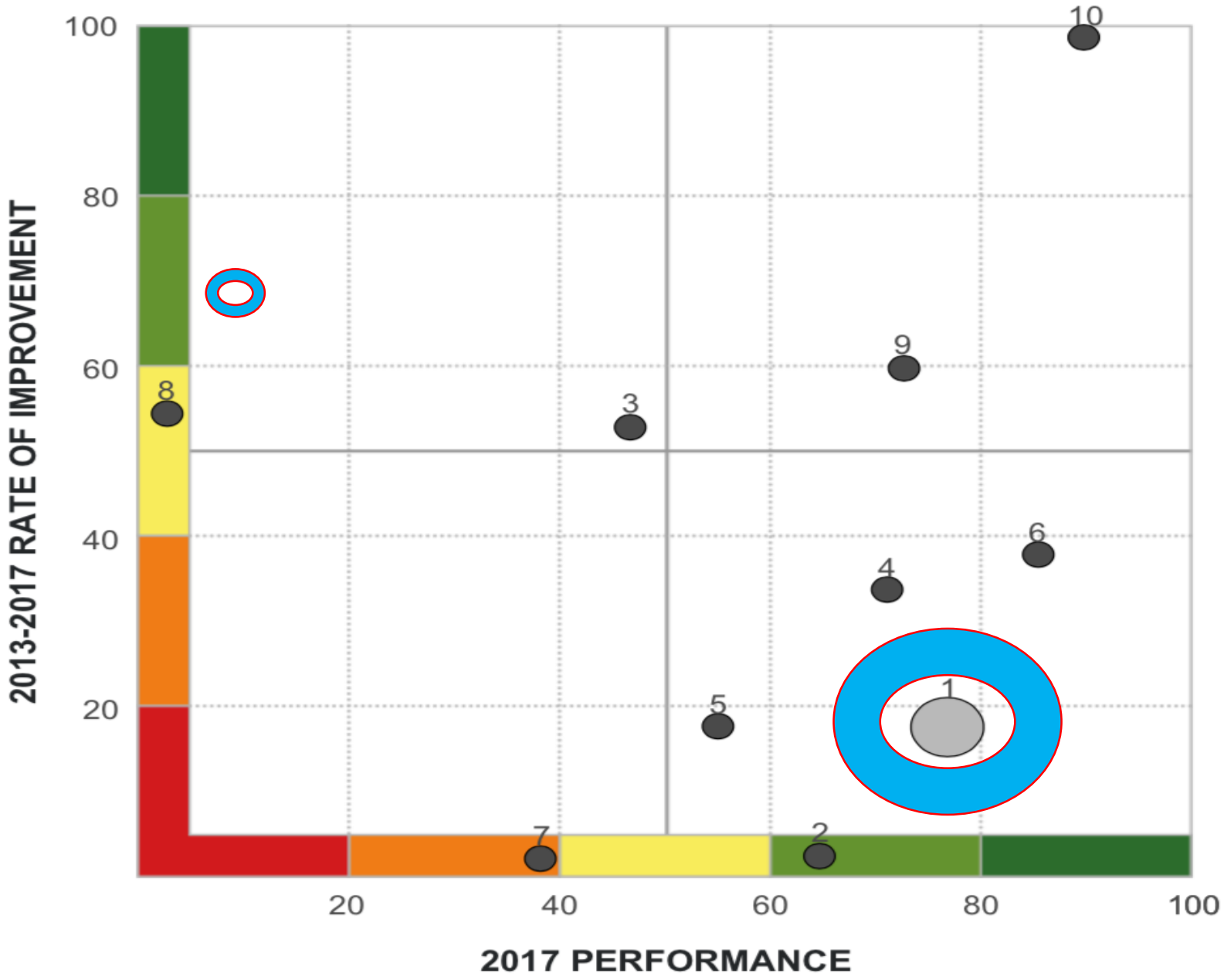
*NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.*

## Attachments

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

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

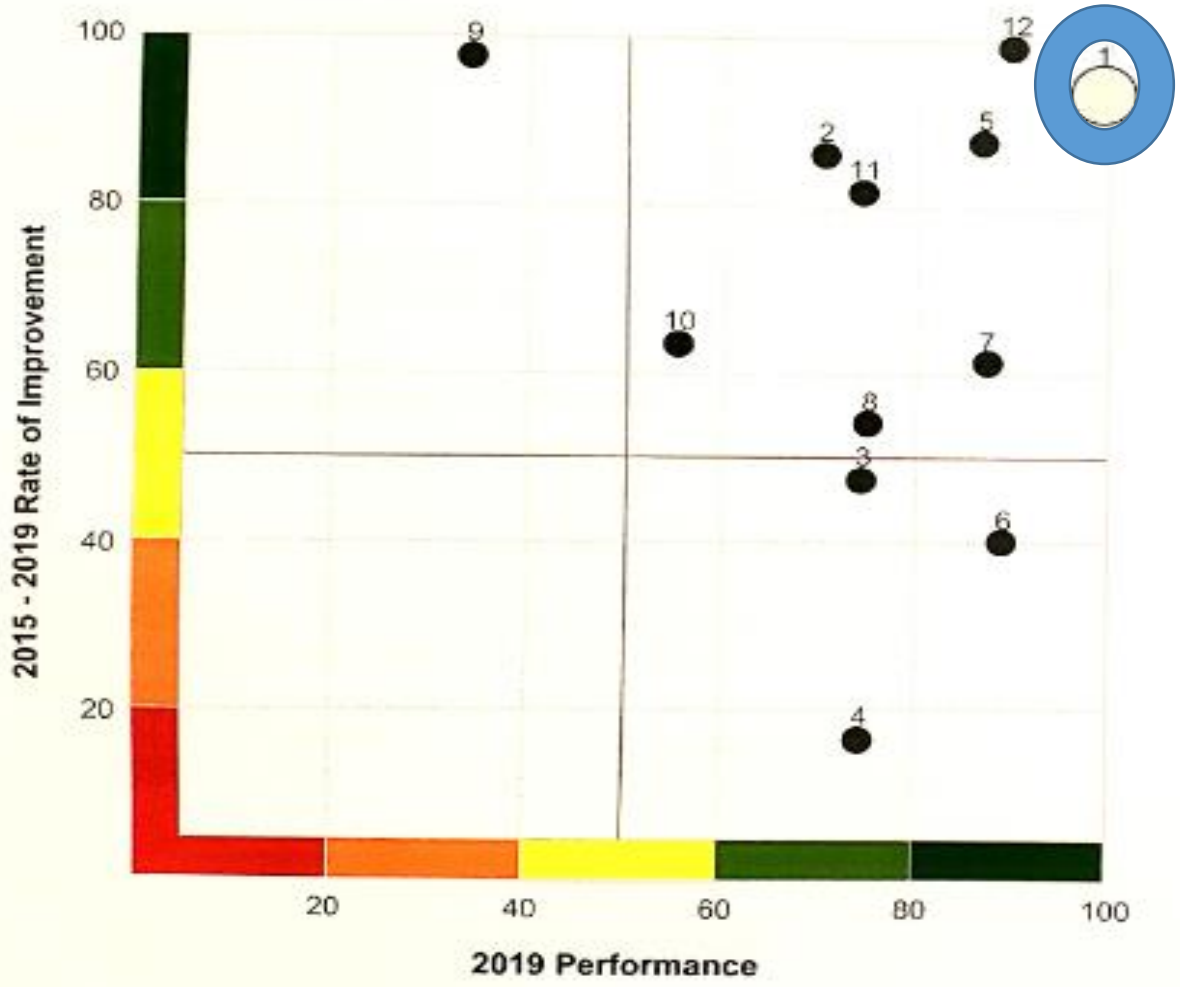
# 2□1□ Performance:  Watson Top 1□□ Score




**DATA POINT KEY**

| | |
|---|---|
| 1 | **OVERALL** |
| 2 | Inpatient Mortality |
| 3 | Complications |
| 4 | 30-Day Mortality |
| 5 | 30-Day Readmit |
| 6 | ALOS |
| 7 | ED Measures |
| 8 | IP Expense/Disch |
| 9 | Oper Profit Margin |
| 10 | HCAHPS |

# 2019 Performance and Five-Year Rate of Improvement Matrix




**DATA POINT KEY**

| | |
|---|---|
| 1 | OVERALL |
| 2 | Inpatient Mortality |
| 3 | Complications |
| 4 | HAI |
| 5 | 30-Day Mortality |
| 6 | 30-Day H-W Readmit |
| 7 | ALOS |
| 8 | ED Measures |
| 9 | IP Expense/Disch |
| 10 | MSPB |
| 11 | Oper Profit Margin |
| 12 | HCAHPS |

- 80 to 100
- 60 to 80
- 40 to 60
- 20 to 40
- 0 to 20

**PROFILED HOSPITAL compared to:**

2019 large community hospitals: n = 254

2015-2019 large community hospitals: n = 248

El Camino Health

# Summary of Financial Operations

*Fiscal Year 2021 – Period 10*

*7/1/2020 to 04/30/2021*

# Executive Summary - Overall Commentary for Period 1□

- Strong operating / financial results for Period 10 were attributed to the following:
  - Positive impact of vaccination campaign on the number of Covid-1□ patients
  - Strong volumes for outpatient surgical and interventional procedures
  - Focus on management of OT / premium pay and variable e□penses
- Total gross charges, a surrogate for volume, were favorable to budget by □□0.2M / 2□.0□ and □1□4.□M / □□.□□ higher than the same period last year
- Net patient revenue was favorable to budget by □15.2M / 1□.1□ and □41.0M / □□.0□ higher than the same period last year
- Operating e□penses were □□.□M /11.□□ unfavorable to budget, which is primarily attributed to higher than e□pected volume versus budget and significant number of procedural cases performed in April
- Operating margin was favorable to budget by □5.□M / 2□1.□□ and □□1.□M / 12□.□□ higher than the same period last year
- Operating EBIDA was favorable to budget by □5.□M / □□.5□ and □□1.□M / 1□2.□□ higher than the same period last year

# Operational / Financial Results: Period 1□ – April 2□21 (as of 4/3□/2□21)

**PERIOD 1□ - RESULTS**

*($ thousands)*

| | | Current Year | Budget | Variance to Budget | Performance to Budget | Prior Year | Variance to Prior Year | Variance to Prior Year | Moody□s Medians | | Performance to □A1□ Medians |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | □A1□ | □Aa3□ | |
| **Activity / Volume** | ADC | 2□5 | 22□ | □ | □.4□ | 1□4 | □1 | □4.□□ | --- | --- | --- |
| | Total Discharges | 1,□24 | 1,5□□ | □□ | 5.□□ | 1,12□ | 4□□ | 44.1□ | --- | --- | --- |
| | Ad□usted Discharges | □,2□□ | 2,□41 | 442 | 15.□□ | 1,□□4 | 1,□□□ | □□.□□ | --- | --- | --- |
| | Emergency Room □isits | 4,□50 | 4,1□□ | 552 | 1□.2□ | 2,5□□ | 2,1□□ | □□.□□ | --- | --- | --- |
| | OP Procedural Cases | 15,0□□ | □,211 | □,□□□ | □□.□□ | 4,0□5 | 11,0□4 | 2□4.2□ | --- | --- | --- |
| | Gross Charges □□□ | □□5,4□0 | □05,2□□ | □0,202 | 2□.0□ | 200,□5□ | 1□4,□21 | □□.□□ | --- | --- | --- |
| **Operations** | Total FTEs | 2,□□4 | 2,□0□ | 1□1 | □.1□ | 2,□20 | 2□4 | 10.5□ | --- | --- | --- |
| | Productive Hrs. / APD | □0.□ | □2.□ | □1.4□ | □4.4□ □ | 4□.5 | □12.□□ | □2□.1□ □ | --- | --- | --- |
| | Cost Per Ad□usted Discharge | 15,□□□ | 1□,40□ | □1,41□□ | □□.1□ □ | 25,02□ | □□,0□□□ | □□□.1□ □ | --- | --- | --- |
| | Net Days in A/R | 51.□ | 4□.0 | 2.□ | 5.5□ | 4□.□ | □.□ | 1□.1□ | 4□.□ | 4□.1 | |
| **Financial Performance** | Net Patient Revenue □□□ | □4,□0□ | □□,□□□ | 15,2□0 | 1□.1□ | 5□,□2□ | 40,□□□ | □□.0□ | 10□,□2□ | 25□,000 | |
| | Total Operating Revenue □□□ | □□,5□5 | □□,□□5 | 14,□00 | 1□.4□ | 5□,0□5 | 41,5□0 | □2.□□ | 11□,□□4 | □14,□4□ | |
| | **Operating Income (□)** | **□,2□4** | **1,□□3** | **□,331** | 2□1.□□ | **(24,4□□)** | **31,**□□□ | 12□.□□ | **3,□4□** | **1□,13□** | |
| | **Operating EBIDA (□)** | **14,3□1** | **□,43□** | □,□□□ | □□.5□ | **(1□,3□□)** | **31,**□□□ | 1□2.□□ | **11,3□1** | **2□,**□□□ | |
| | Net Income □□□ | □□,445 | 5,2□□ | □1,14□ | 5□□.1□ | □1,1□1 | 5,254 | 1□.□□ | □,21□ | 1□,□2□ | |
| | **Operating Margin (□)** | **□.4□** | **2.3□** | **□.1□** | 21□.□□ | **(42.□□)** | **□□.3□** | 11□.2□ | **2.□□** | **3.□□** | |
| | **Operating EBIDA (□)** | **14.□□** | **1□.□□** | **4.□□** | 44.4□ | **(3□.4□)** | **4□.□□** | 14□.□□ | □.□□ | □.□□ | |
| | DCOH □days□ | 5□2 | 4□5 | 1□□ | □1.□□ | 4□□ | □□ | 1□.□□ | 254 | 2□4 | |

Moody’s Medians: Not-for-profit and public healthcare annual report□September □, 2020. Dollar amounts have been ad□usted to reflect monthly averages.

El Camino Health

| |
|---|
| □nfavorable □ariance □ 0.□□□ |
| □nfavorable □ariance 1.00□ - 4.□□□ |
| □nfavorable □ariance □ 5.00□ |

# Operational / Financial Results: YTD FY2□21 (as of 4/3□/2□21)

**YTD FY2□21 - RESULTS**

*($ thousands)*

| | | Current Year | Budget | Variance to Budget | Performance to Budget | Prior Year | Variance to Prior Year | Variance to Prior Year | Moody□s Medians | | Performance to □A1□ Medians |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | □A1□ | □Aa3□ | |
| **Activity / Volume** | ADC | 241 | 20□ | □4 | 1□.□□ | 2□1 | 10 | 4.4□ | --- | --- | --- |
| | Total Discharges | 15,□44 | 14,20□ | 1,441 | 10.1□ | 1□,1□2 | □5□□ | □□.□□ □ | --- | --- | --- |
| | Ad□usted Discharges | 2□,51□ | 2□,□4□ | □,1□1 | 12.0□ | □0,0□0 | □5□0 | □1.□□ □ | --- | --- | --- |
| | Emergency Room □isits | 41,□□□ | □□,44□ | 5,□□5 | 14.□□ | 4□,2□2 | □□,454□ | □15.1□ □ | --- | --- | --- |
| | OP Procedural Cases | 1□4,5□4 | □5,0□4 | □□,510 | 41.□□ | 10□,245 | 2□,□□□ | 2□.□□ | --- | --- | --- |
| | Gross Charges □□□ | □,51□,2□1 | 2,□0□,5□□ | □15,□22 | 25.5□ | □,0□□,4□5 | 4□2,□5□ | 14.0□ | --- | --- | --- |
| **Operations** | Total FTEs | 2,□25 | 2,□00 | 225 | □.□□ | 2,□□□ | □□ | 1.4□ | --- | --- | --- |
| | Productive Hrs. / APD | □1.□ | □4.1 | □2.□□ | □□.2□ □ | □2.□ | □1.0□ | □□.2□ □ | --- | --- | --- |
| | Cost Per Ad□usted Discharge | 1□,0□0 | 1□,□□□ | □1,□10□ | □□.1□ □ | 1□,1□4 | □□5□ | □0.□□ □ | --- | --- | --- |
| | Net Days in A/R | 51.□ | 4□.0 | 2.□ | 5.5□ | 4□.□ | □.□ | 1□.1□ | 4□.□ | 4□.1 | |
| **Financial Performance** | Net Patient Revenue □□□ | □00,1□1 | □□0,□□2 | 1□□,□□□ | 2□.2□ | □11,020 | □□,110 | 11.0□ | 1,0□□,225 | 2,5□□,□□□ | |
| | Total Operating Revenue □□□ | □□□,4□1 | □□□,25□ | 1□2,212 | 20.□□ | □55,240 | □□,2□0 | □.□□ | 1,1□□,□40 | □,14□,4□1 | |
| | **Operating Income (□)** | **□4,□□□** | **(2□,□1□)** | **□3,□□□** | 2□□.4□ | **2□,3□□** | **2□,3□3** | 100.2□ | **3□,4□4** | **1□1,34□** | |
| | **Operating EBIDA (□)** | **124,□□□** | **3□,□□□** | **□□,1□□** | 2□1.1□ | **□□,3□□** | **44,41□** | 55.□□ | **113,□□□** | **2□□,□□□** | |
| | Net Income □□□ | 25□,□□1 | □1□□□ | 25□,□□0 | 1442□□.4□ | □5,□22 | 22□,1□□ | □2□.5□ | □2,1□5 | 1□□,25□ | |
| | **Operating Margin (□)** | □.□□ | **(3.□□)** | □.□□ | 255.□□ | **3.2□** | **2.□□** | □2.4□ | **2.□□** | **3.□□** | |
| | **Operating EBIDA (□)** | **13.3□** | **4.□□** | □.4□ | 1□□.□□ | □.4□ | **3.□□** | 41.5□ | □.□□ | □.□□ | |
| | DCOH □days□ | 5□2 | 4□5 | 1□□ | □1.□□ | 4□□ | □□ | 1□.□□ | 254 | 2□4 | |

Moody's Medians: Not-for-profit and public healthcare annual report□September □, 2020. Dollar amounts have been ad□usted to reflect 10 month totals.

□nfavorable □ariance □ 0.□□□

□nfavorable □ariance 1.00□ - 4.□□□

□nfavorable □ariance □ 5.00□

El Camino Health

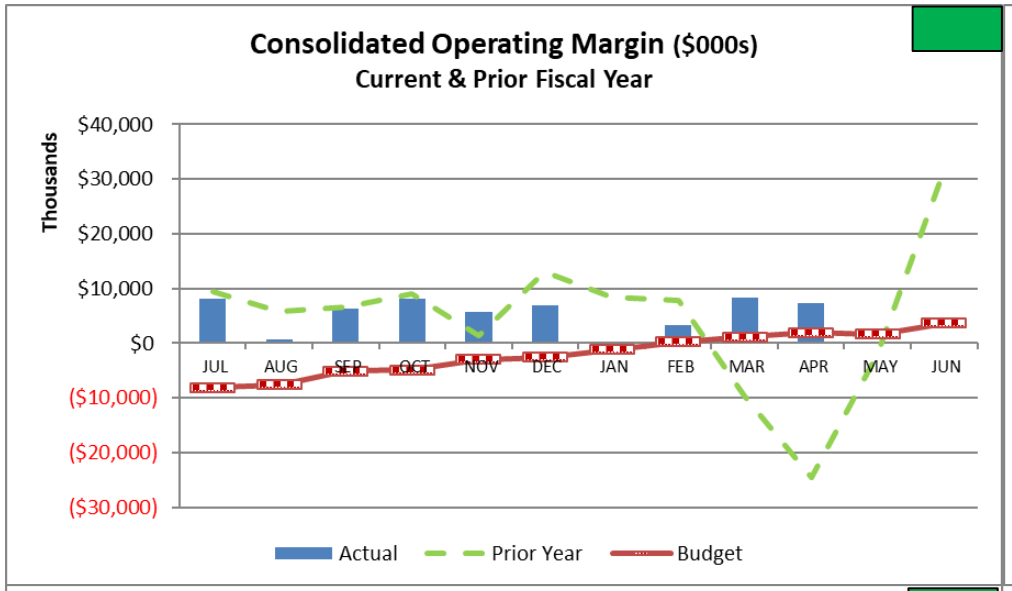
# Income Statement: Current Fiscal Year Monthly Trend *($000s)*

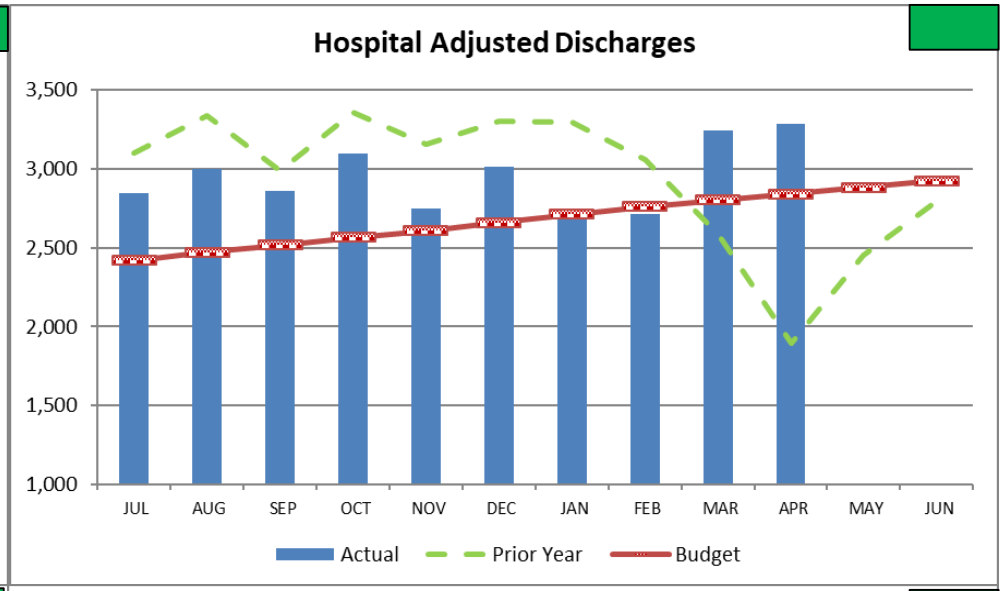
| | Period 1 Jul-20 | Period 2 Aug-20 | Period 3 Sep-20 | Period 4 Oct-20 | Period 5 Nov-20 | Period 6 Dec-20 | Period 7 Jan-21 | Period 8 Feb-21 | Period 9 Mar-21 | Period 10 Apr-21 | Period 11 May-21 | Period 12 Jun-21 | YTD FY2021 | YTD Monthly Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Operating Revenues:** | | | | | | | | | | | | | | |
| Gross Revenue | 333,228 | 339,121 | 357,838 | 366,453 | 341,648 | 367,494 | 335,788 | 314,620 | 387,620 | 375,480 | - | - | 3,519,291 | 351,929 |
| Deductions from Revenue | (247,360) | (253,449) | (267,829) | (275,898) | (253,051) | (275,206) | (245,993) | (229,347) | (290,449) | (280,577) | - | - | (2,619,160) | (261,916) |
| Net Patient Revenue | 85,868 | 85,672 | 90,009 | 90,554 | 88,597 | 92,289 | 89,795 | 85,273 | 97,171 | 94,903 | - | - | 900,131 | 90,013 |
| Other Operating Revenue | 4,667 | 4,331 | 3,996 | 4,024 | 3,234 | 3,079 | 4,427 | 3,352 | 3,537 | 3,692 | - | - | 38,340 | 3,834 |
| **Total Operating Revenue** | **90,535** | **90,003** | **94,005** | **94,578** | **91,831** | **95,368** | **94,222** | **88,625** | **100,708** | **98,595** | **-** | **-** | **938,471** | **93,847** |
| **Operating Expenses:** | | | | | | | | | | | | | | |
| Salaries, Wages and Benefits | 46,431 | 47,739 | 48,136 | 49,061 | 47,222 | 48,774 | 53,636 | 48,592 | 52,025 | 50,616 | - | - | 492,231 | 49,223 |
| Supplies | 12,820 | 16,893 | 12,798 | 13,496 | 13,641 | 14,519 | 13,888 | 13,587 | 15,421 | 14,256 | - | - | 141,317 | 14,132 |
| Fees & Purchased Services | 12,918 | 14,366 | 14,949 | 12,982 | 14,264 | 14,035 | 15,825 | 14,770 | 15,139 | 15,761 | - | - | 145,008 | 14,501 |
| Other Operating Expenses | 3,583 | 3,596 | 4,498 | 3,721 | 3,512 | 4,100 | 3,819 | 1,097 | 3,536 | 3,662 | - | - | 35,124 | 3,512 |
| Interest | 1,428 | 1,431 | 1,428 | 1,429 | 1,428 | 1,428 | 1,428 | 1,392 | 1,399 | 1,400 | - | - | 14,192 | 1,419 |
| Depreciation | 5,231 | 5,328 | 5,795 | 5,798 | 6,068 | 5,591 | 5,689 | 5,903 | 4,931 | 5,606 | - | - | 55,938 | 5,594 |
| **Total Operating Expenses** | **82,411** | **89,352** | **87,604** | **86,487** | **86,136** | **88,446** | **94,284** | **85,341** | **92,450** | **91,301** | **-** | **-** | **883,812** | **88,381** |
| **Operating Margin** | **8,124** | **651** | **6,401** | **8,091** | **5,695** | **6,922** | **(62)** | **3,285** | **8,258** | **7,294** | **-** | **-** | **54,659** | **5,466** |
| Non-Operating Income | 27,718 | 28,642 | (9,557) | (27,499) | 64,968 | 57,357 | 39 | 14,349 | 18,965 | 29,151 | - | - | 204,132 | 20,413 |
| **Net Margin** | **35,842** | **29,293** | **(3,156)** | **(19,408)** | **70,663** | **64,279** | **(23)** | **17,633** | **27,223** | **36,445** | **-** | **-** | **258,791** | **25,879** |
| **Operating EBIDA** | **14,783** | **7,410** | **13,624** | **15,318** | **13,192** | **13,940** | **7,055** | **10,580** | **14,588** | **14,301** | **-** | **-** | **124,789** | **12,479** |
| Operating Margin (%) | 9.0% | 0.7% | 6.8% | 8.6% | 6.2% | 7.3% | -0.1% | 3.7% | 8.2% | 7.4% | | | 5.8% | |
| **Operating EBIDA Margin (%)** | **16.3%** | **8.2%** | **14.5%** | **16.2%** | **14.4%** | **14.6%** | **7.5%** | **11.9%** | **14.5%** | **14.5%** | | | **13.3%** | |

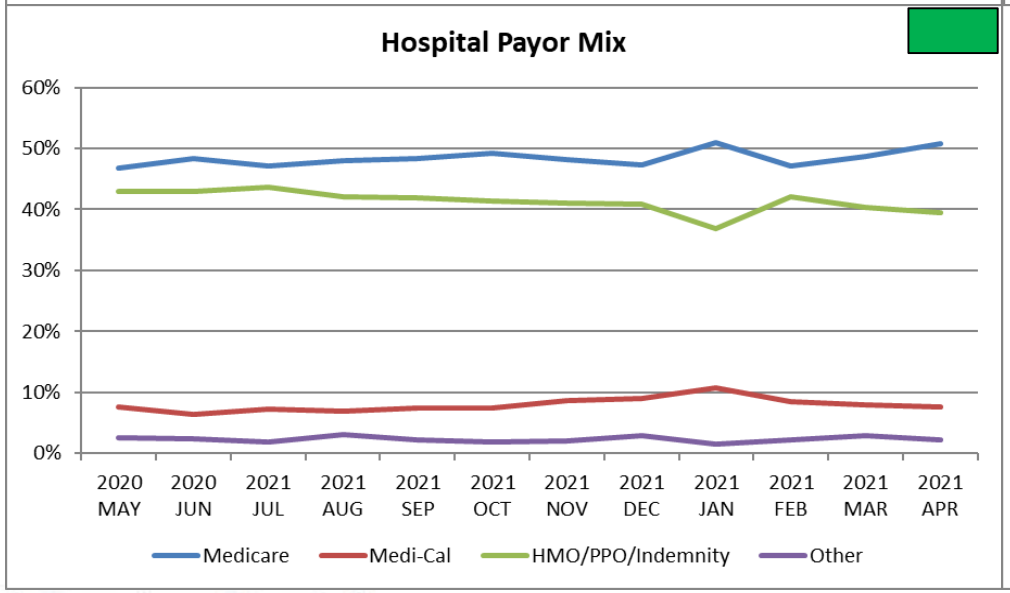
El Camino Health

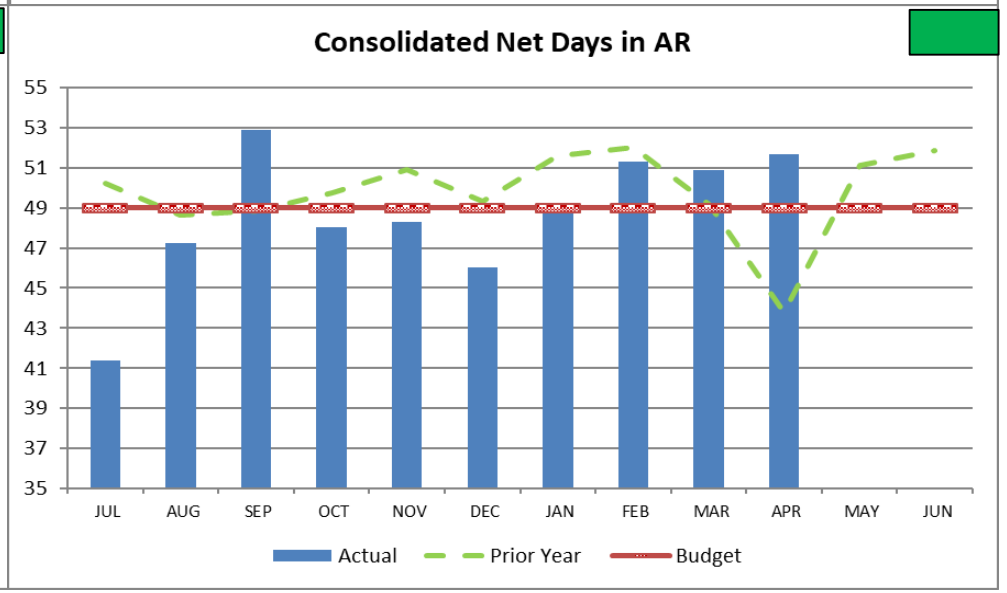
# APPENDI□

# YTD FY2□21 Financial KPIs – Monthly Trends




El Camino Health

# Period 1□ and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 4/3□/2□21)

*($000s)*

| | Period 10- Month | | | Period 10- FYTD | | |
|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Actual | Budget | Variance |
| **El Camino Hospital Operating Margin** | | | | | | |
| Mountain View | 5,513 | 2,895 | 2,619 | 58,014 | (12,895) | 70,910 |
| Los Gatos | 4,904 | 1,704 | 3,199 | 28,540 | 14,750 | 13,790 |
| **Sub Total - El Camino Hospital, excl. Afflilates** | **10,417** | **4,599** | **5,818** | **86,554** | **1,855** | **84,699** |
| **Operating Margin %** | **11.2%** | **5.9%** | | **9.7%** | **0.3%** | |
| **El Camino Hospital Non Operating Income** | | | | | | |
| **Sub Total - Non Operating Income** | **28,085** | **3,028** | **25,057** | **196,740** | **25,801** | **170,939** |
| **El Camino Hospital Net Margin** | **38,502** | **7,627** | **30,875** | **283,294** | **27,656** | **255,638** |
| **ECH Net Margin %** | **41.3%** | **9.8%** | | **31.9%** | **3.8%** | |
| Concern | 394 | 36 | 358 | 474 | 308 | 166 |
| ECSC | 0 | 0 | 0 | (3) | 0 | (3) |
| Foundation | 772 | (109) | 882 | 5,349 | (86) | 5,435 |
| El Camino Health Medical Network | (3,224) | (2,258) | (966) | (30,324) | (28,057) | (2,267) |
| **Net Margin Hospital Affiliates** | **(2,057)** | **(2,331)** | **274** | **(24,504)** | **(27,835)** | **3,332** |
| **Total Net Margin Hospital & Affiliates** | **36,445** | **5,296** | **31,149** | **258,791** | **(179)** | **258,970** |

# Consolidated Balance Sheet (as of □4/3□/2□21)

*($000s)*

**ASSETS**

| CURRENT ASSETS | April 30, 2021 | Audited June 30, 2020 |
|---|---|---|
| Cash | 193,232 | 228,464 |
| Short Term Investments | 297,330 | 221,604 |
| Patient Accounts Receivable, net | 157,543 | 128,564 |
| Other Accounts and Notes Receivable | 27 | 13,811 |
| Intercompany Receivables | 20,880 | 72,592 |
| Inventories and Prepaids | 24,215 | 101,267 |
| **Total Current Assets** | **693,226** | **766,303** |
| | | |
| **BOARD DESIGNATED ASSETS** | | |
| Foundation Board Designated | 19,636 | 15,364 |
| Plant & Equipment Fund | 237,588 | 166,859 |
| Women's Hospital Expansion | 30,401 | 22,563 |
| Operational Reserve Fund | 122,902 | 148,917 |
| Community Benefit Fund | 20,665 | 17,916 |
| Workers Compensation Reserve Fund | 16,482 | 16,482 |
| Postretirement Health/Life Reserve Fund | 31,637 | 30,731 |
| PTO Liability Fund | 32,007 | 27,515 |
| Malpractice Reserve Fund | 1,960 | 1,919 |
| Catastrophic Reserves Fund | 24,851 | 17,667 |
| **Total Board Designated Assets** | **538,128** | **465,933** |
| | | |
| **FUNDS HELD BY TRUSTEE** | **8,531** | **23,478** |
| | | |
| **LONG TERM INVESTMENTS** | **502,530** | **372,175** |
| | | |
| **CHARITABLE GIFT ANNUITY INVESTMENTS** | **731** | **680** |
| | | |
| **INVESTMENTS IN AFFILIATES** | **33,443** | **29,065** |
| | | |
| **PROPERTY AND EQUIPMENT** | | |
| Fixed Assets at Cost | 1,777,827 | 1,342,012 |
| Less: Accumulated Depreciation | (732,373) | (676,535) |
| Construction in Progress | 103,984 | 489,848 |
| **Property, Plant & Equipment - Net** | **1,149,438** | **1,155,326** |
| | | |
| **DEFERRED OUTFLOWS** | 21,225 | 21,416 |
| **RESTRICTED ASSETS** | 29,353 | 28,547 |
| **OTHER ASSETS** | 88,609 | 3,231 |
| **TOTAL ASSETS** | **3,065,215** | **2,866,153** |

**LIABILITIES AND FUND BALANCE**

| CURRENT LIABILITIES | April 30, 2021 | Audited June 30, 2020 |
|---|---|---|
| Accounts Payable | 21,797 | 35,323 |
| Salaries and Related Liabilities | 42,798 | 35,209 |
| Accrued PTO | 32,697 | 28,124 |
| Worker's Comp Reserve | 2,300 | 2,300 |
| Third Party Settlements | 12,348 | 10,956 |
| Intercompany Payables | 21,903 | 70,292 |
| Malpractice Reserves | 1,565 | 1,560 |
| Bonds Payable - Current | 9,430 | 9,020 |
| Bond Interest Payable | 4,976 | 8,463 |
| Other Liabilities | 11,845 | 3,222 |
| **Total Current Liabilities** | **161,658** | **204,469** |
| | | |
| **LONG TERM LIABILITIES** | | |
| Post Retirement Benefits | 31,637 | 30,731 |
| Worker's Comp Reserve | 16,482 | 16,482 |
| Other L/T Obligation (Asbestos) | 6,278 | 4,094 |
| Bond Payable | 485,137 | 513,602 |
| **Total Long Term Liabilities** | **539,534** | **564,908** |
| | | |
| **DEFERRED REVENUE-UNRESTRICTED** | **77,123** | **77,133** |
| | | |
| **DEFERRED INFLOW OF RESOURCES** | **31,009** | **30,700** |
| | | |
| **FUND BALANCE/CAPITAL ACCOUNTS** | | |
| Unrestricted | 2,030,786 | 1,771,854 |
| Board Designated | 193,979 | 188,457 |
| Restricted | 31,126 | 28,631 |
| **Total Fund Bal & Capital Accts** | **2,255,891** | **1,988,942** |
| | | |
| **TOTAL LIABILITIES AND FUND BALANCE** | **3,065,215** | **2,866,153** |

El Camino Health

El Camino Health

**Minutes of the Open Session of the**
**El Camino Hospital Board of Directors**
**Wednesday, May 12, 2021**

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

| Board Members Present | Board Members Absent | Members Excused |
|---|---|---|
| **Lanhee Chen,** Chair** | **Julia E. Miller,** Secretary/Treasurer | None |
| **Peter C. Fung, MD**** | | |
| **Julie Kliger**** | ****via teleconference | |
| **Jack Po, MD, PhD**** | | |
| **Bob Rebitzer**** | | |
| **George O. Ting, MD**** | | |
| **Carol A. Somersille, MD**** | | |
| **Don Watters**** | | |
| **John Zoglin**, Vice Chair** | | |

| 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 5:30 pm by Chair Chen. A verbal roll call was taken; Director Miller was absent, and all other Board members were present. 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 California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020. | |
| **2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES** | Chair Chen asked if any Board members may have a conflict of interest with any of the items on the agenda. None were noted. | |
| **3. PUBLIC COMMUNICATION** | None. | |
| **4. QUALITY COMMITTEE REPORT** | Director Kliger, Quality Committee Chair, opened by highlighting recognitions concerning ECH's quality and safety work as follows:<br>• Leapfrog issued Grade A for Mountain View campus and Grade B for Los Gatos campus.<br>• 5 Star rating from CMS (Center for Medicare & Medicaid Services),<br>• Fortune IBM/Watson 100 Top hospitals in the U.S. announced this week that El Camino Health's hospital was named the only hospital in California to qualify for this prestigious award.<br><br>Director Kliger also highlighted a few areas of opportunity for improvement: timeliness through the emergency department, C-section rates, and HCAHPS scores. She also spoke briefly about the data regarding all-cause mortality and sepsis mortality which have been in an upward trend over the last few months. She noted these areas continue to be explored with the leadership team to understand better the reasoning behind the data, the plan of correction, and the timeline for such a plan. | |

| | | |
|---|---|---|
| | Director Kliger reported that there had been much improvement within the El Camino Medical Health Network physician organization structure. In addition, internal committee oversights are being developed, which will help mature the organization.<br><br>Mark Adams, CMO, provided more context regarding the quality dashboard metrics. He noted the fluctuation in serious safety events and reported other contributing factors regarding the sepsis index rate, citing patients not accessing healthcare at an earlier stage, making it more difficult for providers to intervene. Dr. Adams also spoke about overhauling the intervention process and educating the public to understand when to seek attentive care.<br><br>Dan Woods, CEO, added that the ER visits have fluctuated. People, in general, have been avoiding hospitals on a nationwide scale. He agreed with Dr. Adams's assessment that having public education would indeed help.<br><br>Dr. Adams further clarified that a special committee designed to do analysis focuses on the tools used for measurements to continuously improve the sepsis issue. He also mentioned that to impact health equity, more attention needs to shift to the outer environment of the hospital, with a multidisciplinary point of view as opposed to being the focus of the quality committee or social services. | |
| **5. BOARD OFFICERS NOMINATION AND SELECTION PROCEDURES FOR FY21** | Chair Chen addressed a minor modification to the board officers' nomination and selection procedures to reflect a simultaneous electronic vote and the addition of nominations from the floor.<br><br>**Motion:** To approve Board Officer Nominations and Selection Procedures for FY21.<br>**Movant:** Po<br>**Second:** Watters<br>**Ayes:** Chen, Fung, Kliger, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** Miller<br>**Absent:** None<br>**Recused:** None | |
| **6. BOARD OFFICER ELECTIONS** | Director Zoglin explained that Director Chen was the only Director that declared interest in serving as Board Chair.<br><br>Director Zoglin called for a vote regarding the selection of Director Chen as Board Chair for the upcoming term, and the Directors responded as follows:<br><br>**Chen:** Abstain<br>**Fung:** Aye<br>**Kliger:** Aye<br>**Miller:** Absent<br>**Po:** Aye<br>**Somersille:** Aye<br>**Rebitzer:** Aye<br>**Ting:** Aye<br>**Watters:** Aye<br>**Zoglin:** Aye | ***Board Officers Selected*** |

| | | |
|---|---|---|
| | **Motion:** To select Lanhee Chen as ECH Board Chair for a one-year term of service, effective July 1, 2021.<br>**Movant:** Watters<br>**Second:** Ting<br>**Ayes:** Fung, Kliger, Po, Somersille, Rebitzer, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** Chen<br>**Absent:** Miller<br>**Recused:** None<br><br>Director Chen requested nominations or declarations of interest from the floor for the position of Vice-Chair.<br><br>Director Watters nominated Director Rebitzer.<br><br>A brief discussion about the term limit ensued among the directors. Mary Rotunno, General Counsel, clarified that the Vice-Chair position is for a two-year term and that Board elections decisions for the future Board Chair cannot be binding. It is the intention that the vice-chair will assume the position of the chair if or when there is a vacancy or an election for the chair, and the Board will need to ratify that with a formal vote.<br><br>**Motion:** To select Director Rebitzer as ECH Board Vice-Chair for a two-year term of service, effective July 1, 2021.<br>**Movant:** Po<br>**Second:** Watters<br>**Ayes:** Chen, Fung, Kliger, Po, Somersille, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** Rebitzer<br>**Absent:** Miller<br>**Recused:** None<br><br>Director Chen requested nominations or declarations of interest from the floor for the position of Secretary/Treasurer.<br><br>Director Po nominated Director Miller.<br><br>**Motion:** To select Director Miller as ECH Board Secretary/Treasurer for a two-year term of service, effective July 1, 2021.<br>**Movant:** Ting<br>**Second:** Somersille<br>**Ayes:** Chen, Fung, Kliger, Po, Somersille, Rebitzer, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Miller<br>**Recused:** None | |
| **7. FY21 PERIOD 9 FINANCIALS** | Carlos Bohorquez, CFO, provided an overview of the FY21 Period 9 Financials highlighting a strong rebound attributed to decreased COVID-19 patients and a significant upward trend in procedural cases. Mr.Bohorquez further noted that the impact of the pandemic is still being managed as far as productivity and discharge rates. However, from an operational standpoint, the budget was favorable compared to the prior year.<br>Mr. Bohorquez also anticipated that the following months would present us with an upward trend from a utilization standpoint. | ***FY21 Period 9 Financials approved*** |

| | | |
|---|---|---|
| | **Motion:** To approve FY21 Period 9 Financials.<br>**Movant:** Zoglin<br>**Second:** Somersille<br>**Ayes:** Chen, Fung, Kliger, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Miller<br>**Recused:** None | |
| **8. ADJOURN TO CLOSED SESSION** | **Motion:** To adjourn to closed session at 6:31pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (04/07/2021), Minutes of the Closed Session of the Hospital Board Meeting (04/14/2021), and Minutes of the Closed Session of the Hospital Board Meeting (04/28/2021); pursuant to *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Quality Committee Report (Medical Staff Credentials and Privileges Report, Quality Council Minutes); pursuant to *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report; pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: Semi-Annual ECHMN Report, FY21 Strategic Plan Q3 Metrics Update and Draft FY22 Strategic Plans and Goals, and FY22 Budget Review (Assumptions); pursuant to *Gov't Code Section 54956.9(d)(2)* – conference with legal counsel – pending or threatened litigation and *Gov't Code Section 54957* and *54957.6* for a discussion and report on personnel matters: CEO Report on Legal Services and Personnel Matters; and pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: Executive Session.<br><br>**Movant:** Fung<br>**Second:** Ting<br>**Ayes:** Chen, Fung, Kliger, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Miller<br>**Recused:** None | ***Adjourned to closed session at 6:31 pm*** |
| **9. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT** | The open session was reconvened at 8:21 pm by Chair Chen. Agenda Items 9-15 were addressed in the closed session.<br><br>During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (04/07/2021, 04/14/2021, 04/28/2021), Quality Committee Report, including the Medical Staff Credentials and Privileges Report, and the Quality Council Minutes by a unanimous vote in favor of all members present and participating in the meeting (Directors Chen, Fung, Kliger, Po, Rebitzer, Somersille, Ting, and Zoglin). | |
| **10. AGENDA ITEM 18: CONSENT CALENDAR** | Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. None were removed.<br><br>**Motion:** To approve the consent calendar. | ***Consent calendar approved*** |

| | | |
|---|---|---|
| | Minutes of the Open Session of the Hospital Board Meeting (04/07/2021, 04/14/2021, 04/28/2021); FY21 Period 8 Financials; Urology Call Panel; and the Medical Staff Report.<br><br>**Movant:** Fung<br>**Second:** Watters<br>**Ayes:** Chen, Fung, Kliger, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** Miller<br>**Recused:** None | |
| **11. AGENDA ITEM 19: CEO REPORT** | Dan Woods, CEO, reported that we received final approval from The Joint Commission for new performance measures for its disease-specific certification programs in Hip Replacement, Knee Replacement, Hip Fracture, and Spine Fusion.<br><br>He further recognized the outstanding contribution of all our nurses in honor of Nurses Week in May (the American Nurse Association has designated the whole month of May to honor nurses).<br><br>Mr. Woods concluded with the various awards and recognitions that ECH has received as detailed in the packet materials. | |
| **12. AGENDA ITEM 20: BOARD COMMENTS** | None. | |
| **13. AGENDA ITEM 21: ADJOURNMENT** | **Motion**: To adjourn at 8:30 pm.<br>**Movant:** Po<br>**Second:** Ting<br>**Ayes:** Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin<br>**Noes:** None<br>**Abstentions:** None<br>**Absent:** None<br>**Recused:** None | ***Meeting adjourned at 8:30 pm*** |

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

_____ _____

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Diksha Jagga, Contracts Administrator and Governance Services

El Camino Health

**Minutes of the Open Session of the**
**Special Meeting to Conduct a Study Session of the**
**El Camino Hospital Board of Directors**
**Saturday, May 22, 2021**

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

| Members Present | Members Absent | Others Present |
|---|---|---|
| **Lanhee Chen,** Chair□□ | □one | |
| **Peter C. Fung, MD**□□ | | |
| **Julie Kliger, MPA, BSN**□□ | □□via videoconference | |
| **Julia E. Miller**□Secretary/□reasurer□□ | | |
| **Jack Po, MD, PhD**□□ | | |
| **Bob Rebitzer**□□ | | |
| **Carol A. Somersille, MD**** | | |
| **George O. Ting, MD**□□ | | |
| **Don Watters**** | | |
| **John Zoglin**□□ice□Chair□□ | | |

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER** | Chair Chen called the open session meeting of the El Camino Hospital □oard of □irectors to order at 9:00am. A □uorum □as present pursuant to State of California E□ecutive Orders □□25□20 dated □ arch 12□2020 and □□29□20 dated □ arch 18□2020.<br><br>**Director Miller joined @ 9:10am.* | |
| **2. ADOURN TO CLOSED SESSION** | **Motion**: to ad□ourn to closed session at 9:03 am.<br><br>**Movant:** □ atters<br>**Second:** Po<br>**Ayes:** Chen□□ung□□liger□Po□Re□it□er□Somersille□□ing□□ atters□□oglin<br>**Noes:** □one<br>**Abstentions:** □one<br>**Absent:** □ iller<br>**Recused:** □one | ***Adjourned to Closed Session at 9:03 am.*** |
| **3. AGENDA ITEM 7: RECONVENE OPEN SESSION/REPORT OUT** | Open session □as reconvened at 10:58 am □y Chair Chen. Agenda Item 3□6 □ere addressed in closed session.<br><br>□uring the closed session□no actions □ere ta□en. | |
| **4. AGENDA ITEM 8: BOARD COMMENT** | □o comments □ere noted. | |
| **5. AGENDA ITEM 9: ADJOURNMENT** | **Motion**: to ad□ourn at 10:58 am.<br><br>**Movant:** □ iller<br>**Second:** □liger<br>**Ayes:** Chen□□ung□□liger□□ iller□Po□Re□it□er□Somersille□□ing□□ atters□□oglin<br>**Noes:** □one<br>**Abstentions:** □one<br>**Absent:** □one<br>**Recused:** □one | ***Meeting adjourned at 10:58 am.*** |

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

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□

□anhee Chen
Chair□ECH □oard of □irectors

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

Prepared □y: Stephanie Il□in□Supervisor of E□ecutive Administration

**DRAFT FY22 ECHD and ECH Board & Committee Master Calendar**
June 23, 2021

*The Finance Committee will have its own separate meeting following the Joint Meetings on 1/31/2022 (with IC) and 5/23/2022 (with ECHB).

*Federal Holiday

*School Dates

## JULY 2021

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 27 | 28 | 29 | 30 | 1 | 2 | 3 |
| 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 |

## AUGUST 2021

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 1 | **2 QC** | **3 GC** | 4 | 5 | 6 | 7 |
| 8 | **9 FC** | 10 | 11 | **12** | 13 | 14 |
| 15 | **16 IC** | 17 | **18 ECHB** | **19 CAC** | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | 1 | 2 | 3 | 4 |

## SEPTEMBER 2021

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 29 | 30 | 31 | 1 | 2 | 3 | 4 |
| 5 | 6 Labor Day | **7 QC** | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | **15 ECHB** | 16 | 17 | 18 |
| 19 | 20 | 21 | **22 ECC** | 23 | 24 | 25 |
| 26 | **27 FC** | 28 | 29 | **30 CAC** | 1 | 2 |

## OCTOBER 2021

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 26 | 27 | 28 | 29 | 30 | 1 | 2 |
| 3 | **4 QC** | **5 GC** | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | **13 ECHB** | 14 | 15 | 16 |
| 17 | 18 | **19 ECHD** | 20 | 21 | 22 | 23 |
| 24/31 | 25 | 26 | **27 Education** | 28 | 29 | 30 |

## NOVEMBER 2021

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 31 | **1 QC** | 2 | 3 | **4 ECC** | 5 | 6 |
| 7 | **8 IC** | 9 | **10 ECHB** | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | **18 CAC** | 19 | 20 |
| 21 | **22 FC** | 23 | 24 | 25 Thanksgiving | 26 | 27 |
| 28 | 29 | 30 | 1 | 2 | 3 | 4 |

## DECEMBER 2021

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 28 | 29 | 30 | 1 | 2 | 3 | 4 |
| 5 | **6 QC** | 7 | **8 ECHB** | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 Xmas Eve | 25 Xmas |
| 26 | 27 | 28 | 29 | 30 | 31 NYE | 1 |

## JANUARY 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 26 | 27 | 28 | 29 | 30 | 31 | 1 NYD |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 MLK | 18 | 19 | **20** | 21 | 22 |
| 23 | 24 | **25 ECHD** | 26 | **27 CAC** | 28 | 29 |
| 30 | **31 IC \| FC*** | 1 | 2 | 3 | 4 | 5 |

## FEBRUARY 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 30 | 31 | **1 GC** | 2 | 3 | 4 | 5 |
| 6 | **7 QC** | 8 | **9 ECHB** | 10 | 11 | 12 |
| 13 | **14 IC** | 15 | 16 | 17 | 18 | 19 |
| 20 break | 21 Pres. Day | 22 | **23 Retreat** | 24 | 25 | 26 |
| 27 | 28 | 1 | 2 | 3 | 4 | 5 |

## MARCH 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 27 | 28 | 1 | 2 | **3 ECC** | 4 | 5 |
| 6 | **7 QC** | 8 | 9 **ECHB** | 10 | 11 | 12 |
| 13 | 14 | **15 ECHD** | 16 | 17 | 18 | 19 |
| 20 | 21 | **22 GC** | 23 | **24 CAC** | 25 | 26 |
| 27 | **28 FC** | 29 | 30 | 31 | 1 | 2 |

## APRIL 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 27 | 28 | 29 | 30 | 31 | 1 | 2 |
| 3 | **4 QC** | 5 | 6 | 7 | 8 | 9 |
| 10 break | 11 | 12 | **13 ECHB** | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | **25 FC** | 26 | **27 Education** | 28 | 29 | 30 |

## MAY 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 1 | **2 QC** | 3 | 4 | 5 | 6 | 7 |
| 8 | **9 IC** | 10 | **11 ECHB** | 12 | 13 | 14 |
| 15 | 16 | **17 ECHD** | **18 ECC** | **19 CAC** | 20 | 21 |
| 22 | **23 ECHB \| FC*** | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 Mem. Day | **31 GC** | 1 | 2 | 3 | 4 |

## JUNE 2022

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| 29 | 30 | 31 | 1 | 2 | 3 | 4 |
| 5 | **6 QC** | 7 | **8 ECHB** | 9 | 10 | 11 |
| 12 | 13 | **14 ECHD** | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 1 | 2 |

| District Board \| ECHD | Hospital Board \| ECHB | Compliance \| CAC | Executive Comp \| ECC | Finance \| FC | Governance \| GC | Investment \| IC | Quality \| QC | Educational Sessions | Board Retreat |
|---|---|---|---|---|---|---|---|---|---|
| 5x per year<br>3rd Tuesday | 10x per year<br>2nd Wednesday | 6x per year<br>3rd Thursday | 4x per year<br>Thursdays | 7x per year<br>4th or Last Monday | 5x per year<br>1st Tuesday | 4x per year<br>2nd Monday | 10x per year<br>1st Monday | 2x per year<br>4th Wednesday | 1x per year |

El Camino Health

# FY22 COMMITTEE GOALS

## Compliance and Audit Committee

**PURPOSE**

The purpose of the Compliance and Audit Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its exercise of oversight of Corporate Compliance, Privacy, Internal and External Audit, Enterprise Risk Management, and Information Technology (IT) Security. The Committee will accomplish this by monitoring the compliance policies, controls, and processes of the organization and the engagement, independence, and performance of the internal auditor and external auditor. The Committee assists the Board in oversight of any regulatory audit and in assuring the organizational integrity of ECH in a manner consistent with its mission and purpose.

**STAFF**: **Diane Wigglesworth**, Sr. Director, Corporate Compliance (Executive Sponsor)

The Sr. Director, Corporate Compliance shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team or outside consultants may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review the Hospital and SVMD Compliance Work Plans for FY 2022. | Q1 FY22 | Committee reviews and provides recommendations to the Compliance Officer. |
| **2.** Receive education on new OIG guidance regarding compliance programs and fraud alerts. | Q2 FY22 | Committee receives education and recommends information that should be presented to the Board. |
| **3.** Review identified cyber risks for the organization in the context of critical business functions and how the cybersecurity plan and initiatives are protecting critical business activities. | Q3 FY22 | Committee reviews and provides recommendations to the CIO. |
| **4.** Review ECH's IT Security Strategic Plan. | Q4 FY22 | Committee reviews and provides recommendations to the CIO. |

**SUBMITTED BY**:

**Chair**: Sharon Anolik Shakked
**Executive Sponsor**: Diane Wigglesworth

El Camino Health

# FY22 COMMITTEE GOALS

## Executive Compensation Committee

The purpose of the Executive Compensation Committee (the "Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Committee will advise the Board to meet all legal and regulatory requirements as it relates to executive compensation.

**STAFF**: **Kathryn Fisk**, Chief Human Resources Officer (Executive Sponsor); Director, Total Rewards

The CHRO shall serve as the primary staff to support the Committee and is responsible 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. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

| GOALS | TIMELINE | METRICS/PACING PLAN |
|---|---|---|
| **1.** Provide oversight and approvals for compensation-related decisions, including performance incentive goal-setting and plan design | Q1 | - Review and approve FY22 executive base salaries<br>- Review and recommend FY21 Organizational Incentive Score<br>- Review and approve FY21 individual incentive scores<br>- Review and approve FY21 executive payout amounts (pending Board approval of incentive score) |
| | Q2 | - Review and approve of letter of reasonableness *(ECC's future role to be determined)* |
| | Q3 | - Recommend FY23 Committee goals<br>- Receive update leadership development<br>- Receive update on strategic plan<br>- Review potential policy changes |
| | Q4 | - Review and recommend proposed FY23 organizational incentive goals<br>- Review and approve FY23 individual executive incentive goals |
| **2.** Evaluate the effectiveness of the independent compensation consultant | Q2/Q4 | - Conduct semi-annual evaluation of ECC consultant |

**SUBMITTED BY**: **Chair**: Bob Miller | **Executive Sponsor**: Kathryn Fisk

Recommendations to be made to the El Camino Hospital Board of Directors

Last revised: 5-10-21

El Camino Health

# FY2022 COMMITTEE GOALS

## Finance Committee

**PURPOSE**

The purpose of the Finance Committee (the "Committee") is to provide oversight, information sharing, and financial reviews related to budgeting, capital budgeting, long-range financial planning and forecasting, and monthly financial reporting for the El Camino Hospital (ECH) Hospital Board of Directors ("Board"). In carrying out its review, advisory, and oversight responsibilities, the Finance Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

**STAFF**: **Carlos Bohorquez**, Chief Financial Officer (Executive Sponsor)

The CFO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review of Medical Directorships – Benchmark analysis for ECH compared to similar health systems | Q3 | January 2022 |
| **2.** Marketing – Correlation of plan with service line development | Q2 | November 2021 |
| **3.** Review Progress on Opportunities / Risks identified by Management for FY2022 and Managed Care Update | Q2, Q3 | Progress on Opportunities / Risks (November 2021), Managed Care update (January 2022) |
| **4.** Review strategy, goals, and performance of business affiliates and service lines: 1) Joint Venture – Satellite Healthcare, 2) Orthopedics, 3) Cardiology, 4) Joint Venture – Pathways, 5) ECHMN, 6) CONCERN, 7) Hospital Community Benefits Program, 8) Foundation Performance to Target and 3-5 year strategic plan | Q1 | Joint Venture - Satellite (August 2021), ECHMN (September 2021) |
| | Q2 | Orthopedics (November 2021) |
| | Q3 | Cardiology and ECHMN (January -2022), Foundation (January 2022), CONCERN (March 2022), Hospital Community Benefits Program (March 2022), |
| | Q4 | ECHMN (April 2022), Joint Venture – Pathways (May 2022) |
| **5.** Review and evaluate ongoing customer service/patient experience tactics / metrics and use of AI to improve the process and customer experience for the Revenue Cycle | Q3 | Monitor customer service and patient satisfaction metrics (March 2022) |

**SUBMITTED BY**: **Chair**: John Zoglin | **Executive Sponsor**: Carlos Bohorquez, CFO

El Camino Health

# FY22 COMMITTEE GOALS
## Governance Committee

**PURPOSE**

The purpose of the Governance Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition, *i.e.*, the nomination and appointment/reappointment process. The Governance Committee ensures the Board and Committees are function at the highest level of governance standards.

**STAFF**: **Dan Woods**, Chief Executive Officer (Executive Sponsor)

The CEO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review the governance structure of the Hospital Board, conduct research, and make recommendations on preferred competencies | Q1 FY22<br><br>Q4 FY22<br><br>Q1 FY22 | - Recommendation for high-priority Hospital Board member competencies made to Hospital and District Board<br>- Chair nominates Governance Committee member to serve on District Board Ad Hoc Committee and participate in the Non-District Board Member recruitment/interview process as requested by the District Board<br>- Assess implementation of changes to ECH Board Structure and make recommendations |
| **2.** Promote, enhance, and sustain competency-based, efficient, effective governance | Q4 FY21 –Q1 FY23<br><br>Q2- FY22 | - FY21 Self-Assessment Survey Completed (Q1 FY22)<br>- FY22 Self-Assessment Tool recommended to the Board (Q3) and survey completed (Q4 FY22 – Q1 FY23)<br>- Reports are completed and made available to the Board and the District Board (Q1)<br>- Develop FY22 Board Action Plan (Q2) |
| **3.** Develop Board and Committee Education Plan for FY21 | Q2 FY22<br><br>Q1 FY22 | - Develop and recommend FY22 Board and Committee Education Plan<br>- Recommend FY22 Annual Retreat Agenda to the Board |

**SUBMITTED BY**:

**Chair**: Peter C. Fung, MD
**Executive Sponsor**: Dan Woods

To be approved by the ECH Board of Directors June 2021

El Camino Health

# FY2022 COMMITTEE GOALS

Investment Committee

## PURPOSE

The purpose of the Investment Committee is to develop and recommend to the El Camino Hospital (ECH) Board of Directors ("Board") the investment policies governing the Hospital's assets, maintain current knowledge of the management and investment funds of the Hospital, and provide oversight of the allocation of the investment assets.

**STAFF**: Carlos Bohorquez, Chief Financial Officer (Executive Sponsor)

The CFO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team or hospital staff may participate in the meetings upon the recommendation of the CFO and at the discretion of the Committee Chair. The CEO is an ex-officio member of this Committee.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review performance of consultant recommendations of managers and asset allocations | Each quarter - ongoing | Committee to review selection of money managers and make recommendations to the CFO |
| **2.** Education Topic: Investment Allocation in Uncertain Times | FY2022 Q1 | Complete by the August 2021 meeting |
| **3.** Asset Allocation, Investment Policy Review and ERM framework including Efficient Frontier | FY2022 Q3 | Completed by March 2022 |

**SUBMITTED BY:**
**Chair**: Brooks Nelson
**Executive Sponsor**: Carlos Bohorquez, CFO

El Camino Health

# FY22 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

## PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Committee helps to assure that exceptional patient care and patient experiences are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods, and assuring appropriate resource allocation to achieve this purpose.

**STAFF**: **Mark Adams, MD**, Chief Medical Officer (Executive Sponsor)

The CMO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives and members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality | - FY21 Achievement and Metrics for FY22 (Q1 FY22)<br>- FY23 Goals (Q3 – Q4) | Review management proposals; provide feedback and make recommendations to the Board |
| **2.** Alternatively (every other year) review peer review process and medical staff credentialing process; include OPPE and FPPE education | Q2, Q3 | - Receive update on implementation of peer review process changes (FY22)<br>- Receive update on OPPE and FPPE (FY22) |
| **3.** Review Quality, Patient Care and Patient Experience reports and dashboards | - FY22 Quality Dashboard (Q1-Q2 review; monthly consent for review and discussion, if needed)<br>- CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS),<br>- Leapfrog, CMS Star, Readmission Penalty, HAC penalty, VBP results annually | Review reports per Pacing Plan timeline – |
| **4.** Review Board Dashboard using STEEEP Methodology and propose changes as appropriate | Semi – Annually Q2 and Q4 | Review Dashboard and Recommend Changes to the Board |
| **5.** All committee members regularly attend and are engaged in committee meeting preparation and discussions | Using closing wrap up time, review quarterly at the end of the meeting | Attend 2/3 of all meetings in person<br>Actively participate in discussions at each meeting |

**SUBMITTED BY**: **Chair**: Julie Kliger, MPA, BSN
**Executive Sponsor**: Mark Adams, MD, CMO

Pending approval by the Board June 2021

El Camino Health

**Approved by Hospital Board of Directors | 6/23/2021**

# FY22 El Camino Hospital Board of Directors
# Advisory Committee & Liaison Appointments

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

| Liaison Appointments | |
|---|---|
| **ECH FOUNDATION BOARD OF DIRECTORS (Liaison)** | **Julia E. Miller** |
| **COMMUNITY BENEFIT ADVISORY COUNCIL (CBAC) (Liaison)** | **John Zoglin** |

**LEGEND**

***Board Members**
***Community Members**

Updated: 6/15/21

El Camino Health

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

**From:** □ar□ara Avery□□irector□Community □enefit
**Date:** □une 23□2021
**Subject:** □□22 Community □enefit Plan

**Purpose:**

□o update the □oard on the Finance Committee's approval of the FY22 Community Benefit Plan.

**Summary:**

**1.** Situation: □□22 Community □enefit Plan (Plan) totals □3□541□000 and includes funding for □rants□ Sponsorships and Placeholder.
- □he Plan outlines strategies to address the top unmet health needs identified in the 2019 ECH Community Health □eeds Assessment (CH□A)
- □rant proposals in the Plan set metrics aimed at reducing these unmet health needs
- Sponsorships and Placeholder funds are separate from □rants and approved in aggregate amounts

**2.** Authority: Per the Community □enefit □rants Policy approved □y the ECH □oard of □irectors□the □inance Committee is revie□s and approves the annual ECH Community □enefit Plan.

**3.** □ac□ground: Plan includes □rant Proposals□Sponsorships and Placeholder.
**Grant proposals review process:**
- □ecem□er 15□2020: Community □enefit (C□) □□22 application template and □rant □uide released online □ith announcement to community and current grantees
- □e□ruary 26□2021: Su□mission deadline
- □ arch□April: Staff proposal assessment and summary development
- April 23: Hospital Community □enefit Committee reached consensus on funding recommendations
- □ ay 24: □inance Committee approved □□22 ECH Community □enefit Plan

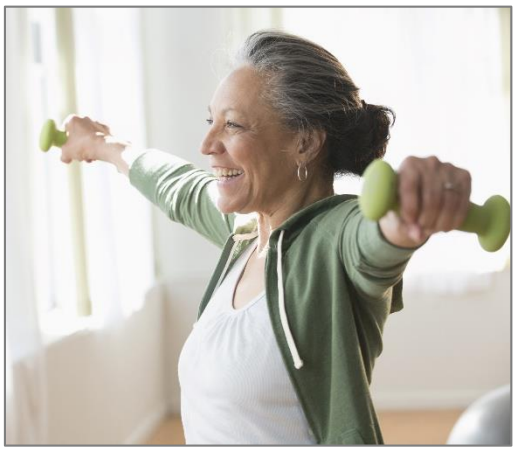
**ECH CB Approved Plan Total: $3,541,000 – Components include:**
**Grants:** 44 approved at □3□236□000
**Sponsorships:** □85□
**Placeholder:** □220□

**4.** Other Revie□s:
- Hospital Community □enefit Committee revie□ed provided funding recommendations on 4/23
- ECH □oard □inance Committee revie□ed and approved Plan on 5/24

**5.** **List of Attachments:**
- □□22 Community □enefit Plan

# Fiscal Year 2022

# Community Benefit Plan



El Camino Health

## Table of Contents

# Financial Summary

## Plan Approved by ECH Finance Committee, May 24, 2021

FY22 ECH Community Benefit Plan: $3,541,000
Approved Funding:

- Grants: $3,236,000
- Sponsorships: $85,000
- Placeholder: $220,000

## Grant Overview

Requested Grant Funding: $6,127,821
Approved Grant Funding: $3,236,000
Grants: 44

## Acknowledgement

El Camino Health especially recognizes the contribution of the Hospital Community Benefit Committee (HCBC) for its guidance with the FY22 Plan.

# Introduction

## ABOUT EL CAMINO HEALTH

El Camino Health includes two nonprofit acute care hospitals in Los Gatos and Mountain View and urgent care, multi-specialty care and primary care locations across Santa Clara County. Hospital key medical specialties include cancer, heart and vascular, lifestyle medicine, men's health, mental health and addictions, lung, mother-baby, orthopedic and spine, stroke and urology. Affiliated partners include Silicon Valley Medical Development, El Camino Health Foundation and Concern.

## MISSION

It is the mission of El Camino Health to be an innovative, publicly accountable and locally controlled comprehensive healthcare organization that cares for the sick, relieves suffering, and provides quality, cost-competitive services to improve the health and well-being of the community.

## COMMUNITY BENEFIT PLAN

Per state and federal law, a Community Health Needs Assessment (CHNA) must be conducted every three years by nonprofit hospitals. In 2019, El Camino Health Community Benefit staff conducted a Community Health Needs Assessment in collaboration with the Santa Clara County Community Benefit Coalition. This assessment resulted in the identification of community health needs. The 2019 CHNA serves as a tool for guiding policy and program planning efforts and is available to the public. For a copy of the full CHNA, see https://www.elcaminohealth.org/community-benefit.

The documented needs in the 2019 CHNA served El Camino Health in developing this Community Benefit Plan for establishing implementation strategies pursuant to the Affordable Care Act of 2010 and California State Senate Bill 697. This plan outlines El Camino Health's funding for fiscal year 2022.

The main steps of this planning process are:

1. Conduct a countywide Community Health Needs Assessment (CHNA)
2. Select health needs and establish health priority areas
3. Grants process; Development of Annual Plan

These steps are further described below.

Step 1: Conduct a Countywide Community Health Needs Assessment

El Camino Health is a member of the Santa Clara County Community Benefit Coalition ("the Coalition"), a group of organizations that includes seven nonprofit hospitals, the Hospital Council of Northern and Central California, a nonprofit multispecialty medical group, and the Santa Clara County Public Health Department. The Coalition began the 2019 CHNA planning process in Summer 2017. The Coalition's goal for the CHNA was to collectively gather community feedback and existing data about health status to inform the member hospitals' respective community health needs prioritization and selection. Since its formation in 1995, the Coalition has worked together to conduct regular, extensive Community Health Needs Assessments (CHNA) to identify and address critical health needs of the community. The 2019 CHNA builds upon those earlier assessments.

The Coalition began the 2019 CHNA process in the fall of 2017. The collective goal for the assessment was to gather community feedback and existing data about local health needs to inform how each member hospital prioritizes and selects specific issues to address with community benefits in its service area. The Coalition engaged Actionable Insights, a local consulting firm with expertise in community health needs assessments.

Between January and May 2018, community feedback was gathered through interviews with eight local experts and discussions with eight focus groups. The experts were individually asked to: identify and discuss the top needs of their constituencies, including barriers to health; give their perceptions of access to healthcare and mental health needs; and share which solutions may improve health (such as services and policies).

The focus group discussions centered around five questions, which were modified appropriately for each audience:

- What are the most important health needs that you see in Santa Clara County? Which are the most pressing among the community? How are the needs changing?

## DEFINITIONS

**Health condition:** A disease, impairment, or other state of physical or mental health that contributes to a poor health outcome.

**Health driver:** A behavioral, clinical, environmental, social, or economic factor that impacts health outcomes.

**Health indicator:** A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.

**Health need:** A poor health outcome and its health driver, or a health driver associated with a poor health outcome that has not yet arisen as a need.

**Health outcome:** The measurable impact — morbidity (quality of life) and mortality (death) — of a disease within a community.

- What drivers or barriers are impacting the top health needs?
- To what extent is healthcare access a need in the community? If certain groups are identified as having less access than others, what are the barriers for them?
- To what extent is mental health a need in the community? How do mental health challenges affect physical health?
- What policies or resources are needed to impact health needs?

The focus groups comprised local residents and people who serve them. Participants represented low-income, minority, and/or medically underserved populations in the community.

Secondary data were obtained from a variety of sources, including the Community Commons public data platform and the Santa Clara County Public Health Department.

Health needs described in this report fall into three categories, as described in the Definitions box on the previous page:

- Health condition
- Health driver
- Health outcome

El Camino Health generated a list of health needs reflecting the priorities in its service area based on community input and secondary data, which were filtered using the following criteria:

1. Must fit the definition of a "health need" (*See Definitions box, page 5.*)
2. Is suggested or confirmed by more than one source of secondary and/or primary data
3. Meets qualitative threshold:
   (a) Two of eight key informants identified the need, or
   (b) The community prioritized it over other health issues in at least two of eight focus groups

In addition, available statistical data for some health needs failed benchmarks by 5 percent or more. The benchmarks used for comparison came from Healthy People 2020 or, when unavailable, the California state average.

Step 2: Select health needs and establish Health Priority Areas

El Camino Health selected nine health needs, including all identified health needs from the work of the Coalition and will continue to address chronic conditions and violence/injury prevention health needs. These needs were mapped to the following priority areas: Healthy Body, Healthy Mind and Healthy Community.


- Diabetes & Obesity
- Chronic Conditions (other than Diabetes & Obesity)
- Healthcare Access & Delivery
- Oral Health


- Behavioral Health
- Cognitive Decline


- Violence & Injury Prevention
- Economic Stability
- Housing & Homelessness

Step 3: Grants process; Development of Annual Plan

El Camino Health released the 2021 – 2022 grant application with the requirement for proposals to address needs in the three health priority areas. Staff provided a comprehensive summary of each proposal received to the Hospital Community Benefit Committee (HCBC), which met in April 2021 to discuss grant proposals. The HCBC is comprised of five El Camino Health representatives who have knowledge about local community disparate health needs. The Committee provided funding recommendations, which are described for each proposal in the hospital's Community Benefit Plan. The Plan also describes the health needs identified through the Coalition's CHNA process and how the hospital plans to address these health needs. Findings from the CHNA are provided to illustrate the status of health needs and related disparities in Santa Clara County. El Camino Health used comparisons to Healthy People 2020 objectives (HP2020) where available, and state data where they were not.


*To improve health and prevent the onset of disease in the community through enhanced access to primary care, chronic disease management and oral health.*

The maintenance of healthy bodies is affected by a variety of factors including the environment in which we live, social and economic factors, and personal choices and health behaviors. Poor health can be experienced as diseases and conditions such as stroke or diabetes, and their related drivers such as hypertension or lack of adequate nutrition. Access to comprehensive, quality healthcare services is important for the achievement of health equity, to improve health, and to enhance quality of life for all. Healthcare access requires gaining entry into the healthcare system, accessing a healthcare location where needed services are provided, and finding a medical provider with whom the patient can communicate and trust.

### 2019 CHNA DATA FINDINGS: DIABETES / OBESITY

Rates are per 100,000 unless otherwise specified.

- Diabetes/Obesity was identified as a top health need in half of key informant interviews and one-third of focus groups.
- The community discussed factors that contribute to diabetes and obesity, such as the built environment, stress and poverty.
- The county has a significantly higher proportion of fast-food restaurants (86.7 per 100,000) than California overall (78.7).
- Santa Clara County has lower proportions of grocery and WIC-authorized[1] stores to residents than state benchmarks. For example, there are 9.5 WIC-authorized stores per 100,000 residents in the county compared to 15.8 in the state overall.
- Diabetes prevalence is higher in Santa Clara County (9.8 percent) than in California overall (9.1 percent) — and trending up both locally and statewide.
- A significant number of LGBTQ survey respondents report being overweight or obese.
- 28 percent of youth are physically inactive.

[1] The Women, Infants and Children (WIC) Program is a federally funded health and nutrition program that provides assistance to pregnant women, new mothers, and children aged 0–5. The California Department of Public Health approves the grocers and other vendors statewide who accept program vouchers. https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx

- Disparities in Santa Clara County include:
  - Males are almost twice as likely as females to be obese (18 percent compared to 10 percent).
  - Although obesity rates overall do not fail benchmarks, the overweight and obesity rates among Latinx youth (about 20 percent each) are significantly higher than state averages (about 17 percent), possibly driven by physical inactivity (42 percent).
  - Being overweight or obese is also a problem among youth who identify as Pacific Islanders (about 25 percent each).
  - African ancestry[2] youth have higher rates of physical inactivity (33 percent) and inadequate fruit and vegetable consumption (73 percent) than the state benchmarks (38 percent and 47 percent, respectively).

### 2019 CHNA DATA FINDINGS: CHRONIC CONDITIONS (OTHER THAN DIABETES/OBESITY)

Rates are per 100,000 unless otherwise specified.

- Health conditions such as cardiovascular disease, cancer and respiratory problems are among the top 10 causes of death in the service area.
- The proportion of hospitalization discharges due to asthma for children, youth and older adults are all higher than the state.
- The county's prostate cancer incidence rate (127.3) is significantly higher than that of the state (109.2).
- Disparities in chronic conditions in Santa Clara County include:
  - Cancer incidence and mortality rates for various cancer sites are higher for African ancestry and White residents than for those of other ethnicities. For example, overall incidence of cancer is 22 percent higher for African ancestry residents than the county overall, and 51 percent higher than Asian residents. Also, overall cancer mortality for African ancestry residents is 71 percent higher than in than the county overall, and 67 percent higher than Asian residents.
  - African ancestry residents are hospitalized for asthma at a rate (1.7 percent) that is disproportionately higher than the rates for residents of other ethnicities (all of which are below 1 percent, such as 0.7 percent for White residents).

[2] African ancestry refers to all people of African descent, whether they are recent immigrants or have been in the U.S. for generations. This term is in keeping with a 2015 report by the Black Leadership Kitchen Cabinet of Silicon Valley, in conjunction with the Santa Clara Public Health Department. See http://blkc.org for the full report. Many original data sources alternately use the category Black/African-American or African-American.

## 2019 CHNA DATA FINDINGS: HEALTHCARE ACCESS & DELIVERY

Rates are per 100,000 unless otherwise specified.

- Healthcare access and delivery was identified as a top health need by half of focus groups and key informants.
- The community expressed concern that healthcare is unaffordable, especially for people who do not receive health insurance subsidies, such as undocumented immigrants.
- Approximately one in every 13 people (8 percent) is uninsured countywide.[3]
- The community expressed concern about the ability of older adults to pay for healthcare (including long-term care) if they are not eligible for Medi-Cal.
- Meets quantitative threshold. (*See #3 on page 8 of 2019 CHNA*)
- Two in 10 Santa Clara County residents speaks limited English, which can restrict healthcare access.
- The county's rate of Federally Qualified Health Centers and access to mental-health care fall below state averages.
- Health clinic professionals expressed concern about attracting and retaining talent (especially bilingual staff) in the healthcare sector due to the high cost of living in the Bay Area.

## 2019 CHNA DATA FINDINGS: ORAL HEALTH

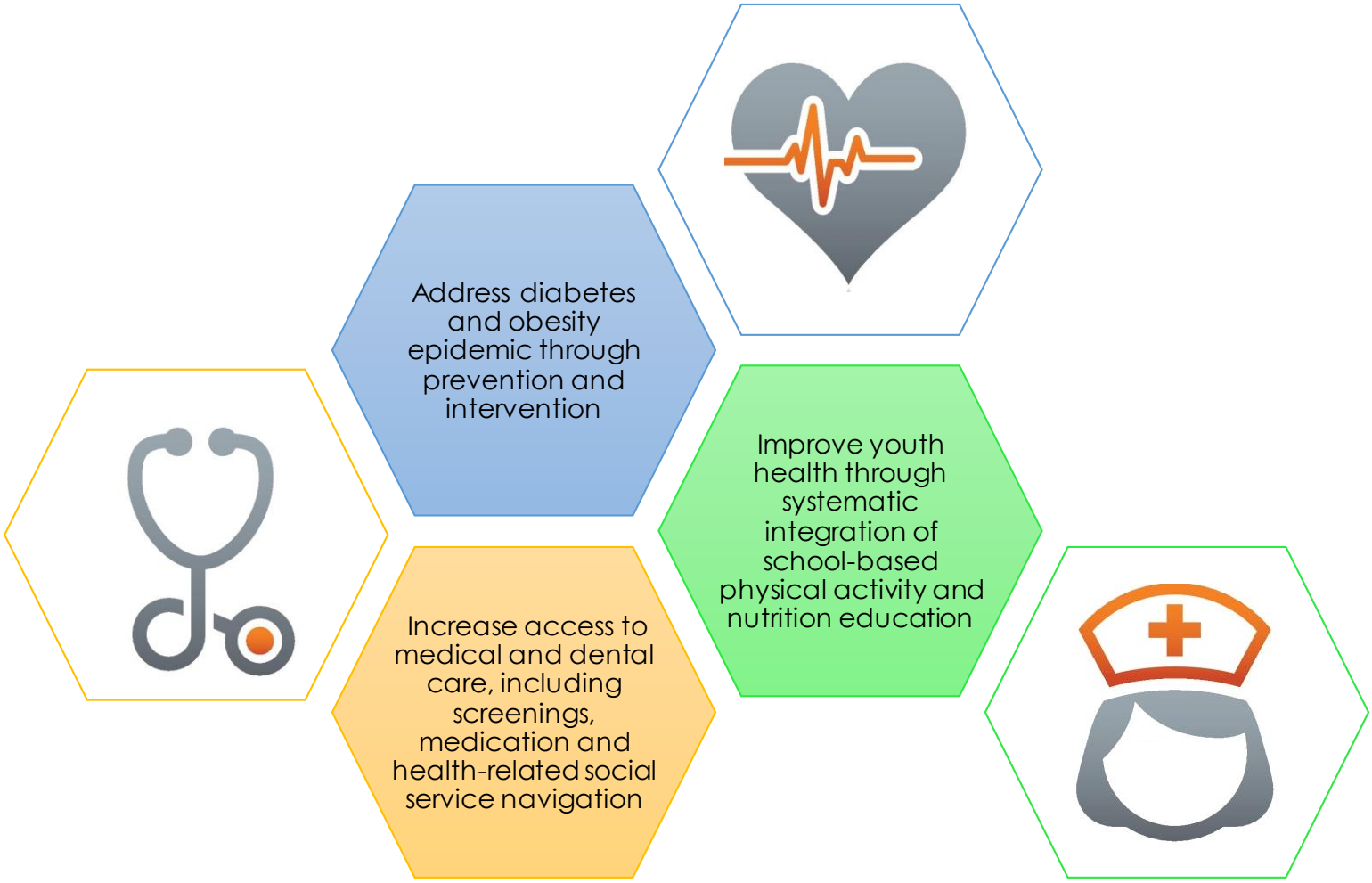
Rates are per 100,000 unless otherwise specified.

- Oral Health was identified as a top health need in two interviews and one focus group.
- There is a perceived lack of access to dental insurance in the community.
- More than one-third of adults in Santa Clara County do not have dental insurance.
- Nearly one-third (30 percent) of county children aged 2–11 have not had a recent dental exam, which is 61 percent worse than the state. The rates were the worst among White (31 percent) and Latinx (52 percent) children.
- More than half of residents of African, Asian and Latinx ancestry have had dental decay or gum disease, which is worse than the county overall (45 percent).

[3] U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012–2016.

## STRATEGIES TO IMPROVE HEALTHY BODIES

**Note on COVID:** As Santa Clara County and California lift COVID restrictions, programs will return to regular service delivery, as possible and monitor the continuation of adaptations, as needed.



## HEALTHY BODY GRANTS

| Program Partner | Dual Requested | Requested | Approved | FY21 Board Approved |
|---|---|---|---|---|
| 5-2-1-0 Health Awareness Program | X | $25,000 | $20,000 | $25,000 |
| African American Community Service Agency | | $28,364 | $28,000 | $25,000 |
| Asian Americans for Community Involvement (AACI) | | $100,000 | $100,000 | $85,000 |
| Bay Area Women's Sports Initiative (BAWSI) - Girls Program | X | $24,500 | $15,000 | $15,000 |
| Better Health Pharmacy | | $75,000 | $75,000 | $50,000 |
| Breathe California - Children's Asthma Program | | $40,000 | $40,000 | $40,000 |
| Cambrian School District - School Nurse Program | | $200,000 | $125,000 | $125,000 |
| Campbell Union School District - School Nurse Program | | $215,000 | $215,000 | $215,000 |
| Community Health Partnership | | $50,000 | $40,000 | $61,000 |
| Cupertino Union School District - School Nurse Program | X | $294,792 | $100,000 | $90,000 |
| Gardner Family Health Network | | $242,369 | $230,000 | $225,000 |
| GoNoodle | X | $114,000 | $113,000 | $113,000 |
| Health Mobile | X | $150,000 | $55,000 | $75,000 |
| Healthier Kids Foundation | X | $30,000 | $30,000 | $30,000 |
| Indian Health Center | | $87,000 | $87,000 | $80,000 |
| Latinas Contra Cancer | | $35,000 | $35,000 | $25,000 |
| Mt. Pleasant School District - School Nurse Program | | $122,000 | $122,000 | $125,000 |
| Playworks | X | $86,000 | $86,000 | $86,000 |
| Vista Center for the Blind and Visually Impaired | X | $75,965 | $40,000 | $40,000 |
| Healthy Body Priority Area Total: $1,556,000 | | | | |


*To improve the mental health and wellbeing of the community by providing services and increasing access to services that address serious mental illness, depression, and anxiety related to issues such as dementia, domestic violence, substance use, and bullying.*

Healthy minds are essential to a person's wellbeing, family functioning, and interpersonal relationships. Good brain function and mental health directly impact the ability to live a full and productive life. People of all ages with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide. Those affected by dementia experience a decline in mental ability, which affects memory, problem-solving, and perception. The resulting confusion often also leads to depression, aggression, and other mental health issues.[4] Caregivers of those with dementia also experience depression.[5] Mental health disorders can also impact physical health and are associated with the prevalence, progression, and onset of chronic diseases, including diabetes, heart disease, and cancer.

## 2019 CHNA DATA FINDINGS: BEHAVIORAL HEALTH

Rates are per 100,000 unless otherwise specified.

- Behavioral Health ranked high as a health need, with the community prioritizing it in more than two-thirds of discussions.
- The co-occurrence of mental health and substance use emerged as a common theme.
- The community expressed concern about a lack of services for behavioral health, including preventive mental-health care and detox centers.
- Professionals who work in behavioral health described experiencing challenges with health systems that were established to serve people with these conditions.
- LGBTQ residents expressed a need for mental health and suicide prevention assistance.
- Meets quantitative threshold. (*See #3 on page 8 of 2019 CHNA.*)
- Disparities in Santa Clara County include:

[4] Alzheimer's Association. https://www.alz.org/care/alzheimers-dementia-depression.asp.

[5] Alzheimer's Association. https://www.alz.org/care/alzheimers-dementia-caregiver-depression.asp

- Hospitalization rates for attempted suicide are 73 percent higher among females than males, whereas men nationwide are 3.5 times more likely than women to commit suicide.
- Adult men are more likely to binge drink than women, but adolescent females are more likely to binge drink (15 percent) than adolescent males (13 percent).
- 21 percent of Latinx adults binge drink, compared to 15 percent of Whites and 8 percent of other ethnic groups.
- Adults of White or Latinx ancestry are most likely to use marijuana (12 percent and 13 percent, respectively).

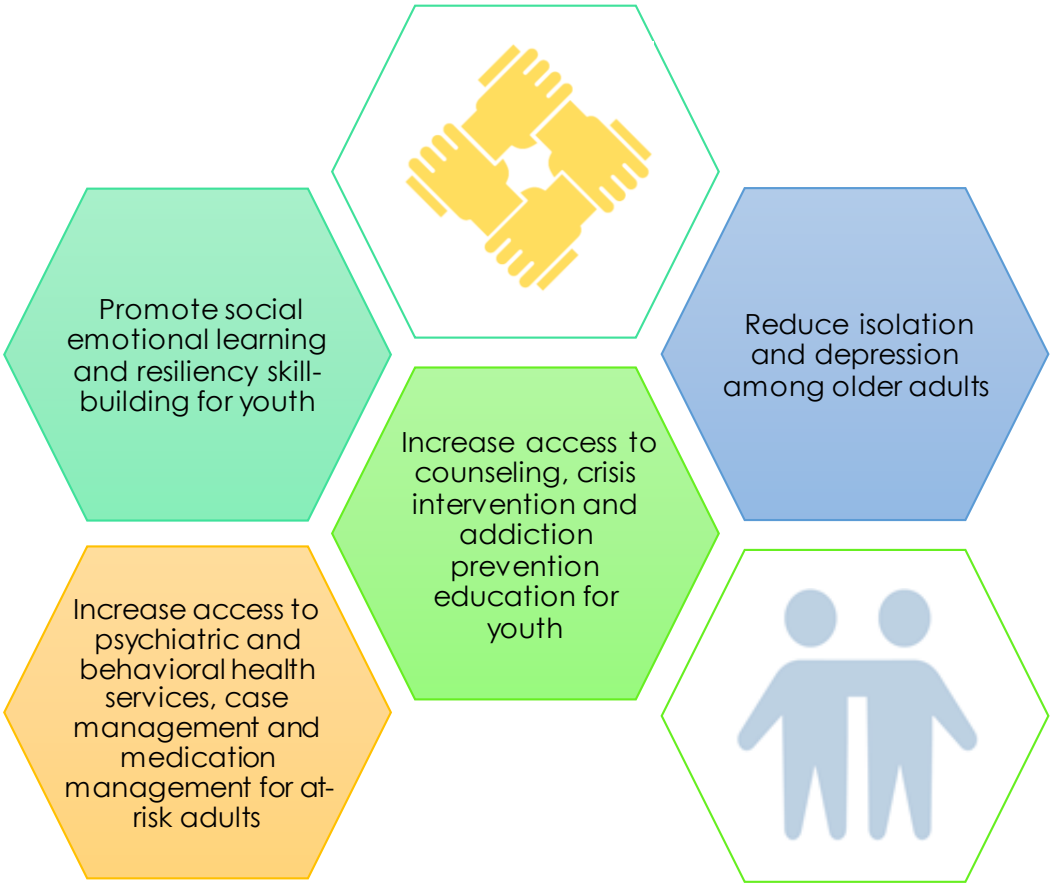
### 2019 CHNA DATA FINDINGS: COGNITIVE DECLINE

- Cognitive decline was mentioned in half of focus groups and two interviews with experts.
- One in nine Californians is experiencing subjective cognitive decline.
- The median age in Santa Clara County (36.8 years) is higher than the median age of California (35.8).
- The county death rate due to Alzheimer's disease (35.9 per 100,000) is nineteen percent higher than the state's rate (30.1).
- Community said that serving individuals who are cognitively impaired is difficult for providers.
- Professionals who serve people experiencing chronic homelessness and abusing substances report cases of early dementia and increased difficulty with treating and housing people with these impairments.
- Community expressed concern about the ability of older adults to pay for healthcare, including long-term care, if not Medi-Cal eligible.

Professionals rely on family members to coordinate care for their loved ones, which can affect the health, well-being, and economic stability of those family members.

## STRATEGIES TO IMPROVE HEALTHY MINDS

**Note on COVID:** As Santa Clara County and California lift COVID restrictions, programs will return to regular service delivery, as possible and monitor the continuation of adaptations, as needed.



## HEALTHY MIND GRANTS

| Program Partner | Dual Requested | Requested | Approved | FY21 Board Approved |
|---|---|---|---|---|
| ACT for Mental Health | | $62,355 | $60,000 | Not Current Grantee |
| Almaden Valley Counseling Service | | $80,000 | $70,000 | $70,000 |
| Alzheimer's Disease and Related Disorders Association | | $70,000 | $70,000 | $65,000 |
| Bill Wilson Center | | $25,000 | $25,000 | $25,000 |
| Cancer CAREpoint | | $30,240 | $30,000 | $22,000 |
| Child Advocates of Silicon Valley | | $40,000 | $40,000 | $30,000 |
| Cupertino Union School District - Mental Health Counseling Program | X | $135,000 | $120,000 | $120,000 |
| Jewish Family Services of Silicon Valley | | $85,000 | $82,000 | $80,000 |
| LifeMoves | X | $65,000 | $60,000 | $60,000 |
| Los Gatos Union School District - Mental Health Counseling Program | | $177,298 | $110,000 | $110,000 |
| Momentum for Mental Health | X | $57,127 | $46,000 | $51,000 |
| Peninsula Healthcare Connection - Psychiatric Services & Medication Management | | $90,000 | $90,000 | $90,000 |
| Uplift Family Services | | $230,000 | $210,000 | $230,000 |
| Healthy Mind Priority Area Total: $1,013,000 | | | | |


*To improve the overall health of the community by providing services and increasing access to services that improve safety, provide transportation, and educate the community about health and wellbeing.*

A healthy community can impact health positively by providing safe places to live, work, and be educated. When a community lacks affordable and sufficient transportation, lacks awareness of health issues and risk for chronic diseases, and is not able to access culturally competent services, its residents experience poor health.

### 2019 CHNA DATA FINDINGS: VIOLENCE & INJURY PREVENTION

Rates are per 100,000 unless otherwise specified.

- Violence is a major driver of poor behavioral health. Preventing violence in the service area will affect behavioral health.
- The rate of rape (22.8 per 100,000 people) in Santa Clara County is 8.5 percent higher than the state rate (21.0).
- Preventable unintentional injuries are a leading cause of death in the county (5 percent of all deaths) and the state (4 percent).
- 67 percent of all unintentional injury deaths are due to senior falls. This is higher compared to deaths due to accidental falls among the total population (31 percent).
- Disparities in violence and injury in the county include:
  - The mortality rate (43.0 deaths per 100,000 people) from all unintentional injuries is highest for African ancestry residents.
  - Community safety data — including homicides, violent assault, youth assault and self-harm, and school suspensions and expulsions — are all higher for Latinxs and African ancestry residents than for those of other ethnicities.

### 2019 CHNA DATA FINDINGS: ECONOMIC STABILITY

Rates are per 100,000 unless otherwise specified.

- Economic security was identified as a top health need by one-third of focus groups and key informants.
- Meets quantitative threshold (*See #3 on page 8 of 2019 CHNA*)

- The very high cost of living in Santa Clara County and concern about the low-income population emerged as common themes of community input.
- The 2018 Self-Sufficiency Standard for a family of two adults, one infant, and one preschool-aged child is over $120,600, which is more than four times higher than the 2018 Federal Poverty Level ($25,100).
- Almost four in 10 people in Santa Clara County experiencing food insecurity do not qualify for federal food assistance because of their household incomes. (This includes 46 percent of all food-insecure children.)
- The cost of long-term care for older adults with fixed incomes who are ineligible for Medi-Cal is a concern of the community.
- Cost of mental health care is also difficult for middle-income parents according to focus group participants.
- Economic security is crucial to stable housing. (*See Housing and Homelessness health need description)*.
- Disparities in Santa Clara County include:
  - The rates of poverty among residents of African ancestry and Other[6] races fail benchmarks.
  - One in four Latinx households and more than one in 10 African ancestry households received food from a food bank in recent years.
  - More than nine in 10 (93 percent) White high school students graduate, while only seven in 10 Latinx and Native American students graduate. Almost eight in 10 African ancestry students graduate.
  - Fourth-grade reading proficiency is a predictor of high school graduation.[7] About 27 percent of White fourth-grade students are reading below proficiency. This proportion is significantly worse for other children: African ancestry (60 percent), Latinx (67 percent), Pacific Islander (61 percent) and Native American ancestry (58 percent)

## 2019 CHNA DATA FINDINGS: HOUSING & HOMELESSNESS

Rates are per 100,000 unless otherwise specified.

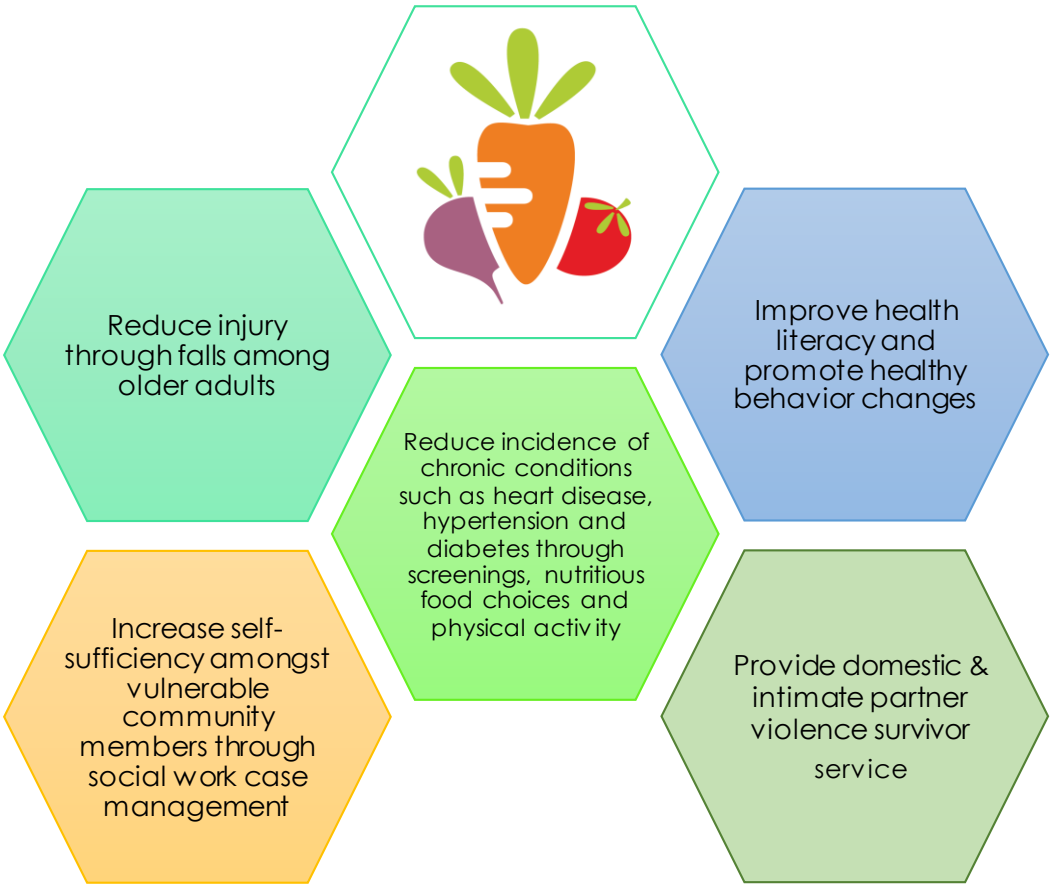
- Housing and Homelessness was identified as a top health need by more than half of focus groups and key informants.
- The community described stress about the high costs of housing and the lack of affordable rent as a major priority.

[6] "Other" is a U.S. Census category for ethnicities not specifically called out in data sets.
[7] The Campaign for Grade-Level Reading (https://gradelevelreading.net) and Reading Partners (https://readingpartners.org/blog/why-reading-by-fourth-grade-matters-for-student-success/)

- Professionals who serve families report an increase in families seeking help from food banks and making difficult choices about how to spend remaining funds (healthy food, medicine, doctor visits, therapeutic services).
- The community reports that families often move to a different home or leave the area due to the increased cost of living.
- The 2018 Santa Clara County Self-Sufficiency Standard indicates that a family of two adults, one infant, and one preschool-aged child requires $120,600 in annual income to be self-sufficient.
- There are approximately 7,400 people experiencing homelessness in the county (15 percent of whom are aged
  0–17), which is the highest number since 2013.
- In Mountain View, the number of people experiencing homelessness (416) increased 51 percent since 2015.

## STRATEGIES TO IMPROVE HEALTHY COMMUNITIES

**Note on COVID:** As Santa Clara County and California lift COVID restrictions, programs will return to regular service delivery, as possible and monitor the continuation of adaptations, as needed.



## HEALTHY COMMUNITY GRANTS

| Program Partner | Dual Requested | Requested | Approved | FY21 Board Approved |
|---|---|---|---|---|
| American Heart Association | X | $80,000 | $50,000 | $50,000 |
| Chinese Health Initiative | X | $42,000 | $42,000 | Not Current Grantee |
| Downtown Streets Team | | $30,000 | $30,000 | Not Current Grantee |
| First Community Housing | | $30,000 | $30,000 | Not Current Grantee |
| Los Gatos Saratoga Recreation | | $58,530 | $20,000 | $20,000 |
| Next Door Solutions | | $95,000 | $90,000 | $85,000 |
| Pink Ribbon Girls | | $25,000 | $25,000 | Not Current Grantee |
| Rebuilding Together Silicon Valley | X | $30,000 | $30,000 | $30,000 |
| South Asian Heart Center | X | $100,000 | $100,000 | $75,000 |
| Valley Verde | | $60,000 | $45,000 | $45,000 |
| West Valley Community Services – Community Access to Care & Resources (CARE) | | $213,650 | $160,000 | $153,000 |
| West Valley Community Services – CARE Senior Services | | $45,000 | $45,000 | $45,000 |
| Healthy Community Priority Area Total: $667,000 | | | | |

## Conclusion

El Camino Health's CHNA identified health needs based on community input, secondary data and other qualitative thresholds. The nine health needs mapped to three priority areas overlap with one another, in that community members having one of these health needs are likely to face challenges in another. El Camino Health's Community Benefit grant portfolio is targeted to address the needs in and across each of the three health priority areas through integrated and coordinated funding.

The grants proposed in this plan have been carefully screened based on their ability to impact at least one of the three priority areas. The Finance Committees' support of this Community Benefit plan will allow El Camino Health to continue responding to the most pressing needs faced by vulnerable residents in our communities.

The premise — and the promise — of community benefit investments is the chance to extend the reach of hospital resources beyond the patient community, and address the suffering of underserved, at-risk community members. These annual community grants provide direct and preventive services throughout the service area. Community Benefit support addresses gaps by funding critical, innovative services that would otherwise not likely be supported. The Community Benefit Plan aims to improve the health and wellness of the entire community, far beyond hospital walls.

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

**To:** El Camino Hospital □oard of □irectors

**From:** □o□□iller□Chair E□ecutive Compensation Committee

**Date:** □une 23□2021

**Subject:** Proposed □□ 2022 Organi□ational Performance Incentive Plan □oals

**Recommendation(s):**

□o approve the proposed □□ 2022 organi□ational goals for the E□ecutive Performance Incentive Plan.

**Summary:**

**1.** Situation: Each year the E□ecutive Compensation Committee along □ith the other □oard Committees review leadership's proposed organizational goals. The Committee has revie□ed and recommends that the □oard approve the organi□ational goals as part of the E□ecutive Performance Incentive Plan.

**2.** Authority: As the governing □ody of El Camino Hospital□the □oard of □irectors approves ECH's organizational goals to ensure management is progressing toward achieving the strategic plan of the organi□ation.

**3.** □ac□ground: □he leadership team spent several months on the strategic frame□or□for goals and initiatives for □□ 2022. □he proposed □□ 2022 Organi□ational Performance Incentive Plan goals are a su□set of the larger frame□or□ Achievement to□ards the goals and metrics defined □ill □e the □asis of performance a□ards□if any□for □□ 2022.

**4.** Assessment: Each goals aligns □ith one of the five pillars and the metrics determined □ased on a com□ination of internal and e□ternal □enchmar□s.

**5.** Other Revie□s: □he □inance and Quality Committees have revie□ed their respective areas and recommended them for approval.

**6.** Outcomes: □he organi□ational goals approved □y the □oard of □irectors □ill □e used for the management performance incentive plan and employee engagement and recognition program as □ell as for e□ecutive performance incentive plan.

**List of Attachments:**

**1.** Proposed □□22 Organi□ational □oals

**Suggested Board Discussion Questions:**

**1.** □oes the □oard have any □uestions a□out the goals□□enchmar□s□or measurements□

# Proposed Fiscal Year 2□22 Organizational Performance Goals
# As Recommended by the Executive Compensation Committee

| True North Pillar | Weight | GOAL | OBJECTIVES/OUTCOMES | Benchmark | | Measurement Defined | | | Measurement Period |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Internal Benchmarks | External Benchmark | Minimum | Target | Stretch | |
| **Threshold** | | Operating EBIDA Margin | Maintain positive EBIDA Margin | FY2019: 16.9%<br>FY2020: 12.7%<br>FY2021 through April: 13.2%<br>Draft Budget FY2022: 13.7% | Moody's: Median for 'A1': 9.7%<br>Median for 'Aa3': 8.9% | ≥ 11% Operating EBIDA Margin (80% of budget) | | | FY2022 |
| **Quality and Safety** | 45.0% | Zero Preventable Harm | Serious Safety Event (SSEs) Rate | FY2021 SSER | External Baseline – best practice is to reduce to zero | Maintain Baseline | Improve by 1/10K adj. pt. days | Additional 10% improvement over target | FY2022 |
| | | | Risk-Adjusted Readmission Index | FY2021 Internal Calculation June 2022 | Premier top 15% | 0.93 | 90% of top performers | Top performers | FY2022 |
| | | | Healthcare Effectiveness Data and Information Set (HEDIS) Composite Score | FY2021 composite score system | Internal Calculation; limited external benchmarks | Maintain baseline (3.3) | 3.6 | 4.0 | FY2022 |
| **Service** | 45.0% | Exceptional Personalized Experience, Always | Likelihood to Recommend (LTR) – Inpatient | FY2020: 82.8<br>FY2021 through April : 79.9 | Press Ganey | Maintain FY21 baseline | 50% of improvers | 30% of improvers | FY2022 |
| | | | LTR – El Camino Health Medical Network | FY2020 73.2<br>FY2021 through April: 76.1 | NRC Net Promoter or change to Press Ganey | Maintain FY21 baseline | 50% of improvers | 30% of improvers | FY2022 |
| **Finance** | 10.0% | Sustainable Strength and Vitality | Operating EBIDA Margin | Actual FY2019-20: 16.9% and 12.7%<br>Actual FY2021 through April: 13.2%<br>Budgets for FY2019-21: 15.3%, 14.2%, and 5.9%<br>Draft Budget FY2022: 13.7% | Moody's: Median for 'A1': 9.7%<br>Median for 'Aa3': 8.9% | 90% of budget | 100% of budget | 110% of budget | FY2022 |

El Camino Health

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

**To:** Board of Directors

**From:** Mark Adams, MD FACS, Chief Medical Officer

Carlos Bohorquez, Chief Financial Officer

Jim Griffith, Chief Operating Officer

**Date:** June 23, 2021

**Subject:** Approval of new Enterprise Anesthesia Services Agreement, MV Nighttime Intensivist Services Agreement, and Line of Credit Agreement

**Recommendation**: Board of Directors to approve delegating to the Chief Executive Officer the authority to execute the following three new agreements with a new group formed by our current physicians who provide anesthesia and intensivist services to be effective July 1, 2021 with the following terms:

- Exclusive Enterprise Anesthesia Services Agreement
  - No compensation associated with this exclusive agreement
  - 37 physicians provide 24/7/365 on-site and/or on-call coverage
  - Three-year term

- MV Nighttime Intensivist Services Agreement
  - Not to exceed $889,015 per year, approximately $2,435.66 per 12-hour shift *(same compensation as in current agreement)*
  - 2 FTE critical care intensivist 12-hour on-site nighttime coverage provided by 6 physicians
  - Three-year term

- Line of Credit Agreement
  - Not to exceed $6.0 million. To be drawn as needed to cover start-up operating expenses of new group.
  - Draw period shall be 9 months
  - Repayment shall be for 24 months starting on the 10th month
  - Interest rate will be Prime plus one (1%) percent. Prime Rate (as of 6/18/2021) is 3.25% (Fed Funds Rate 0.25% + 3.0%)

**Summary:**

**1.** Situation:

- The current anesthesia services agreement with Envision Physician Services (EPS) is ending June 30 and will not be renewed. ECH is awaiting written confirmation from Envision to extend services through July 31st.
- Our current group of anesthesiologists are resigning from EPS and are forming a new separate group.
- El Camino Health plans to contract with this newly formed group, El Camino Anesthesia, to provide anesthesia and nighttime intensivist services.
- The Medical Executive Committee has been informed of the termination of the anesthesia contract with EPS and has formally approved a motion to support creating a new exclusive anesthesia services contract with a newly formed group consisting of the current anesthesiologists on the medical staff who are now providing services.

**2.** Authority: According to Physician Financial Arrangements Administrative Policy, Finance Committee approval is required prior to the Chief Executive Officer signature of physician agreements that exceed $250,000 in annual compensation. This is an urgent request and cannot wait until the next Finance Committee on August 7, 2021 and therefore we are requesting Board approval.

**3.** Background: The majority of our current group of anesthesiologists have provided excellent anesthesia services to our patients and medical staff since 2010. The medical group that employs the anesthesiologists and that ECH contracts with was acquired by various entities over the years. Since September 2018, some of the same physicians that provide services under the anesthesia services agreement have also provided nighttime intensivist services.

**4.** Fair Market Value Assessment:

- MV Nighttime Intensivist Services Agreement: As approved by General Counsel, a third party consultant will review the proposed compensation and determine if the proposed arrangement is commercially reasonable and within fair market value prior to execution. The proposed rate is unchanged from the current rate that has been in effect for the past several years.
- Line of Credit Agreement: The line of credit ("LOC") amount is not to exceed $6.0 million with an twenty-four (24) month payback starting the 10th month after the first draw, interest rate shall be prime rate plus one percent (1.0%). This loan to the new anesthesia group is necessary to provide working capital to bridge the gap between billing/collections and the start of operations. Draws on the LOC will be on a monthly basis to support operating expenses of the group which includes physician compensation and administrative fees (billing and collections). The LOC $6.0 million is based on the group's funding requirement during the startup period for 37 physician FTEs with estimated annual compensation of $525K per physician. This estimated compensation level is based on 2020 Pinnacle Fair Market Value Consulting Guide for Anesthesia Specialty, using the local market data for annual employed physician compensation rate at the 50th percentile.

**5.** Legal and Compliance Review: Legal and Compliance will review the final agreements prior to execution.

**6.** Outcomes: The proposed agreements with the new group will ensure stable, uninterrupted anesthesia and intensivist services to our patients and medical staff and secure the relationship between ECH and the anesthesiologists. Physicians will participate in the peer review process for consultations related to anesthesia and intensivist coverage services.

**List of Attachments:** N/A

El Camino Health

# Summary of Financial Operations

*Fiscal Year 2021 – Period 9*

*7/1/2020 to 03/31/2021*

# Executive Summary - Overall Commentary for Period □

- Strong operating / financial results for Period □ were attributed to the following:
  - Significant decrease of Covid-1□ patients
  - Rebound in procedural volumes due to pent up demand from January and February
  - Focus on management of OT / premium pay, A□OS and variable e□penses
  - Stable payor mi□
- Total gross charges, a surrogate for volume, were favorable to budget by □□□.□M / 2□.1□ and □105.□M / □□.□□ higher than the same period last year
- Net patient revenue was favorable to budget by □1□.□M / 21.□□ and □24.1M / □2.□□ higher than the same period last year
- Operating e□penses were □□.□M /11.2□ unfavorable to budget, which is primarily attributed to higher than e□pected volume versus budget and significant number of procedural cases performed in March
- Operating margin was favorable to budget by □□.1M / □1□.□□ and □1□.□M / 1□5.5□ higher than the same period last year
- Operating EBIDA was favorable to budget by □□.□M / □0.□□ and □1□.4M / 4□□.□□ higher than the same period last year

# Operational / Financial Results: Period □ – March 2□21 (as of 3/31/2□21)

**PERIOD □ - RESULTS**

*($ thousands)*

| | | Current Year | Budget | Variance to Budget | Performance to Budget | Prior Year | Variance to Prior Year | Variance to Prior Year | Moody□s Medians | | Performance to □A1□ Medians |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | □A1□ | □Aa3□ | |
| **Activity / Volume** | ADC | 2□1 | 21□ | 15 | □.□□ | 21□ | 1□ | □.1□ | --- | --- | --- |
| | Total Discharges | 1,□□□ | 1,□□□ | □2 | □.□□ | 1,□10 | 12□ | □.1□ | --- | --- | --- |
| | Ad□usted Discharges | □,244 | 2,□02 | 442 | 15.□□ | 2,5□4 | □□0 | 25.5□ | --- | --- | --- |
| | Emergency Room □isits | 4,2□1 | 4,0□□ | 1□4 | 4.□□ | 4,□24 | □□5□□ | -□.□□ | --- | --- | --- |
| | OP Procedural Cases | 15,□□5 | □,1□□ | □,52□ | □2.5□ | □,□1□ | □,□4□ | 114.1□ | --- | --- | --- |
| | Gross Charges □□□ | □□□,□20 | □00,□1□ | □□,□02 | 2□.1□ | 2□1,□2□ | 105,□□□ | □□.□□ | --- | --- | --- |
| **Operations** | Total FTEs | 2,□□5 | 2,□55 | 20 | 0.□□ | 2,□2□ | 4□ | 1.□□ | --- | --- | --- |
| | Productive Hrs. / APD | □1.□ | □□.4 | □1.□□ | -4.□□ | □□.1 | □□.□□ | -1□.5□ | --- | --- | --- |
| | Cost Per Ad□usted Discharge | 1□,50□ | 1□,□01 | □1,□□2□ | -□.□□ | 20,1□□ | □□,□2□□ | -1□.0□ | --- | --- | --- |
| | Net Days in A/R | 50.□ | 4□.0 | 1.□ | □.□□ | 4□.1 | 1.□ | □.5□ | 4□.□ | 4□.1 | |
| **Financial Performance** | Net Patient Revenue □□□ | □□,1□1 | □□,□□□ | 1□,2□5 | 21.□□ | □□,105 | 24,0□□ | □2.□□ | 10□,□2□ | 25□,000 | |
| | Total Operating Revenue □□□ | 100,□0□ | □4,2□5 | 1□,444 | 1□.5□ | □□,□45 | 2□,□□4 | □0.2□ | 11□,□□4 | □14,□4□ | |
| | Operating Margin □□□ | □,25□ | 1,14□ | □,110 | □1□.□□ | □□,□5□□ | 1□,□1□ | 1□5.5□ | □,□4□ | 10,1□5 | |
| | **Operating EBIDA (□)** | **14,**□□□ | □,□**41** | □,□**4**□ | □0.□□ | **(3,**□□□**)** | **1**□**,43**□ | 4□□.□□ | **11,3**□**1** | **2**□,□□□ | |
| | Net Margin □□□ | 2□,22□ | 4,4□2 | 22,□42 | 50□.4□ | □□1,4□0□ | 10□,□□4 | 1□□.4□ | □,21□ | 1□,□2□ | |
| | Operating Margin □□ □ | □.2□ | 1.4□ | □.□□ | 501.□□ | -12.5□ | 20.□□ | 1□5.□□ | 2.□□ | □.□□ | |
| | **Operating EBIDA Margin (□)** | **14.**□□ | □.**1**□ | □.**4**□ | 5□.□□ | **-**□.□□ | **1**□.□□ | □□1.0□ | □.□□ | □.□□ | |
| | DCOH □days□ | 5□□ | 4□5 | 1□0 | 2□.□□ | 4□2 | 1□4 | □1.0□ | 254 | 2□4 | |

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

El Camino Health

□nfavorable □ariance □ 0.□□□

□nfavorable □ariance 1.00□ - 4.□□□

□nfavorable □ariance □ 5.00□

# Operational / Financial Results: YTD FY2□21 (as of 3/31/2□21)

**YTD FY2□21 - RESULTS**

*($ thousands)*

| | | Current Year | Budget | Variance to Budget | Performance to Budget | Prior Year | Variance to Prior Year | Variance to Prior Year | Moody□s Medians □A1□ | Moody□s Medians □Aa3□ | Performance to □A1□ Medians |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity / Volume** | ADC | 241 | 205 | □□ | 1□.□□ | 2□□ | 4 | 1.□□ | --- | --- | --- |
| | Total Discharges | 1□,□□0 | 15,□1□ | 1,21□ | □.□□ | 1□,15□ | □1,22□□ | -□.□□ | --- | --- | --- |
| | Ad□usted Discharges | 2□,25□ | 2□,50□ | 2,□50 | 11.□□ | 2□,1□5 | □1,□2□□ | -□.□□ | --- | --- | --- |
| | Emergency Room □isits | □□,□15 | □2,245 | 4,□□0 | 14.5□ | 4□,□0□ | □□,□□4□ | -21.0□ | --- | --- | --- |
| | OP Procedural Cases | 11□,4□1 | □0,22□ | 4□,2□□ | □0.1□ | □4,□22 | □4,□□□ | 41.0□ | --- | --- | --- |
| | Gross Charges □□□ | □,14□,□11 | 2,4□□,2□1 | □45,520 | 25.□□ | 2,□□5,5□5 | 25□,2□□ | □.□□ | --- | --- | --- |
| **Operations** | Total FTEs | 2,□1□ | 2,□41 | □2□□ | -0.□□ | 2,□04 | 14 | 0.5□ | --- | --- | --- |
| | Productive Hrs. / APD | □1.4 | □□.4 | □2.0□ | -5.□□ | □1.5 | □0.0□ | -0.2□ | --- | --- | --- |
| | Cost Per Ad□usted Discharge | 1□,1□□ | 1□,45□ | □1,2□0□ | -□.□□ | 1□,21□ | □□5 | □.1□ | --- | --- | --- |
| | Net Days in A/R | 50.□ | 4□.0 | 1.□ | □.□□ | 4□.1 | 1.□ | □.5□ | 4□.□ | 4□.1 | |
| **Financial Performance** | Net Patient Revenue □□□ | □05,22□ | □50,□□□ | 154,5□□ | 2□.□□ | □5□,0□□ | 4□,1□5 | □.4□ | □□0,50□ | 2,□12,□□□ | |
| | Total Operating Revenue □□□ | □□□,□□□ | □□2,2□□ | 14□,□12 | 21.□□ | □□□,1□□ | 41,□00 | 5.2□ | 1,051,□□□ | 2,□□1,□□□ | |
| | Operating Margin □□□ | 4□,□□5 | □□0,□□0□ | □□,□45 | 252.□□ | 51,□□2 | □4,41□□ | -□.5□ | □5,5□□ | □1,211 | |
| | **Operating EBIDA (□)** | **11□,4□□** | **2□,2□3** | **□1,23□** | 2□□.□□ | □□,□**44** | **12,□44** | 1□.0□ | **1□1,**□□□ | **2□1,**□1□ | |
| | Net Margin □□□ | 222,□4□ | □5,4□□□ | 22□,□21 | 41□0.□□ | 4,4□0 | 21□,□15 | 4□1□.□□ | □□,□□□ | 1□□,5□□ | |
| | Operating Margin □□ □ | 5.□□ | -4.5□ | 10.1□ | 22□.0□ | □.5□ | -0.□□ | -1□.1□ | 2.□□ | □.□□ | |
| | **Operating EBIDA Margin (□)** | **13.2□** | **4.2□** | □.□□ | 211.□□ | **12.2**□ | □.□□ | □.4□ | □.□□ | □.□□ | |
| | DCOH □days□ | 5□□ | 4□5 | 1□0 | 2□.□□ | 4□2 | 1□4 | □1.0□ | 254 | 2□4 | |

Moody’s Medians: Not-for-profit and public healthcare annual report□September □, 2020. Dollar amounts have been ad□usted to reflect □ month totals.

El Camino Health

□nfavorable □ariance □ 0.□□□
□nfavorable □ariance 1.00□ - 4.□□□
□nfavorable □ariance □ 5.00□

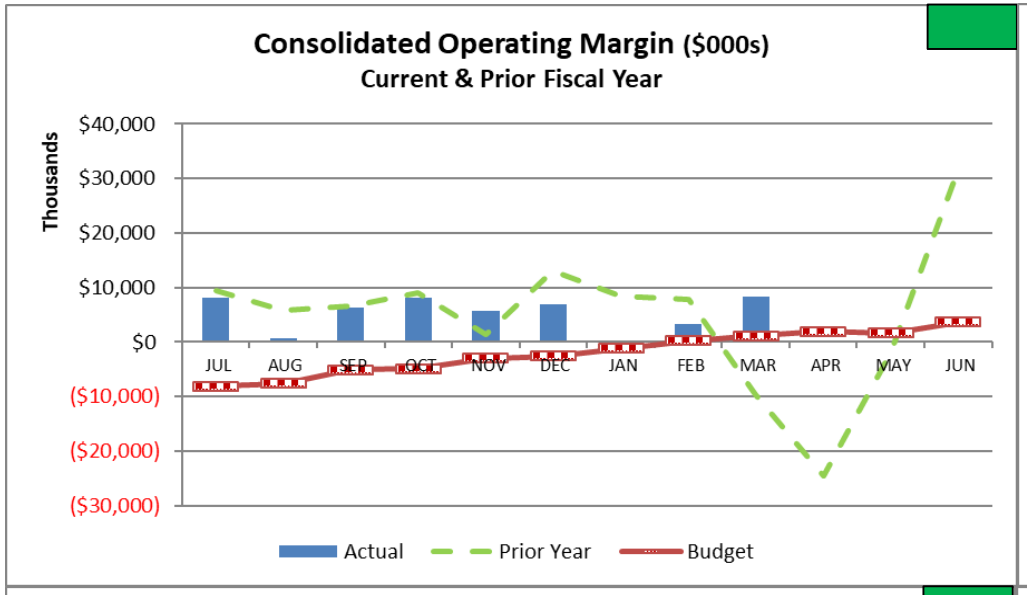
# Income Statement: Current Fiscal Year Monthly Trend *($000s)*

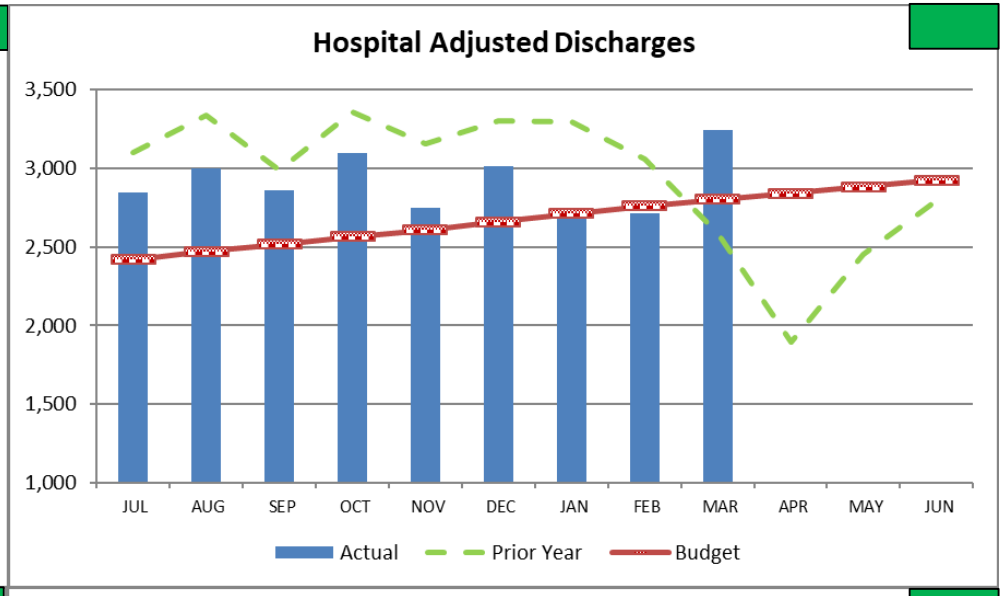
| | Period 1 Jul-20 | Period 2 Aug-20 | Period 3 Sep-20 | Period 4 Oct-20 | Period 5 Nov-20 | Period 6 Dec-20 | Period 7 Jan-21 | Period 8 Feb-21 | Period 9 Mar-21 | Period 10 Apr-21 | Period 11 May-21 | Period 12 Jun-21 | YTD FY2021 | YTD Monthly Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Operating Revenues:** | | | | | | | | | | | | | | |
| Gross Revenue | 333,228 | 339,121 | 357,838 | 366,453 | 341,648 | 367,494 | 335,788 | 314,620 | 387,620 | - | - | - | 3,143,811 | 349,312 |
| Deductions from Revenue | (247,360) | (253,449) | (267,829) | (275,898) | (253,051) | (275,206) | (245,993) | (229,347) | (290,449) | - | - | - | (2,338,582) | (259,842) |
| Net Patient Revenue | 85,868 | 85,672 | 90,009 | 90,554 | 88,597 | 92,289 | 89,795 | 85,273 | 97,171 | - | - | - | 805,228 | 89,470 |
| Other Operating Revenue | 4,667 | 4,331 | 3,996 | 4,024 | 3,234 | 3,079 | 4,427 | 3,352 | 3,537 | - | - | - | 34,647 | 3,850 |
| **Total Operating Revenue** | **90,535** | **90,003** | **94,005** | **94,578** | **91,831** | **95,368** | **94,222** | **88,625** | **100,708** | **-** | **-** | **-** | **839,876** | **93,320** |
| **Operating Expenses:** | | | | | | | | | | | | | | |
| Salaries, Wages and Benefits | 46,431 | 47,739 | 48,136 | 49,061 | 47,222 | 48,774 | 53,636 | 48,592 | 52,025 | - | - | - | 441,616 | 49,068 |
| Supplies | 12,820 | 16,893 | 12,798 | 13,496 | 13,641 | 14,519 | 13,888 | 13,587 | 15,421 | - | - | - | 127,062 | 14,118 |
| Fees & Purchased Services | 12,918 | 14,366 | 14,949 | 12,982 | 14,264 | 14,035 | 15,825 | 14,770 | 15,139 | - | - | - | 129,248 | 14,361 |
| Other Operating Expenses | 3,583 | 3,596 | 4,498 | 3,721 | 3,512 | 4,100 | 3,819 | 1,097 | 3,536 | - | - | - | 31,462 | 3,496 |
| Interest | 1,428 | 1,431 | 1,428 | 1,429 | 1,428 | 1,428 | 1,428 | 1,392 | 1,399 | - | - | - | 12,791 | 1,421 |
| Depreciation | 5,231 | 5,328 | 5,795 | 5,798 | 6,068 | 5,591 | 5,689 | 5,903 | 4,931 | - | - | - | 50,332 | 5,592 |
| **Total Operating Expenses** | **82,411** | **89,352** | **87,604** | **86,487** | **86,136** | **88,446** | **94,284** | **85,341** | **92,450** | **-** | **-** | **-** | **792,511** | **88,057** |
| **Operating Margin** | **8,124** | **651** | **6,401** | **8,091** | **5,695** | **6,922** | **(62)** | **3,285** | **8,258** | **-** | **-** | **-** | **47,365** | **5,263** |
| Non-Operating Income | 27,718 | 28,642 | (9,557) | (27,499) | 64,968 | 57,357 | 39 | 14,349 | 18,965 | - | - | - | 174,981 | 19,442 |
| **Net Margin** | **35,842** | **29,293** | **(3,156)** | **(19,408)** | **70,663** | **64,279** | **(23)** | **17,633** | **27,223** | **-** | **-** | **-** | **222,346** | **24,705** |
| **Operating EBIDA** | **14,783** | **7,410** | **13,624** | **15,318** | **13,192** | **13,940** | **7,055** | **10,580** | **14,588** | **-** | **-** | **-** | **110,488** | **12,276** |
| Operating Margin (%) | 9.0% | 0.7% | 6.8% | 8.6% | 6.2% | 7.3% | -0.1% | 3.7% | 8.2% | | | | 5.6% | |
| **Operating EBIDA Margin (%)** | **16.3%** | **8.2%** | **14.5%** | **16.2%** | **14.4%** | **14.6%** | **7.5%** | **11.9%** | **14.5%** | | | | **13.2%** | |

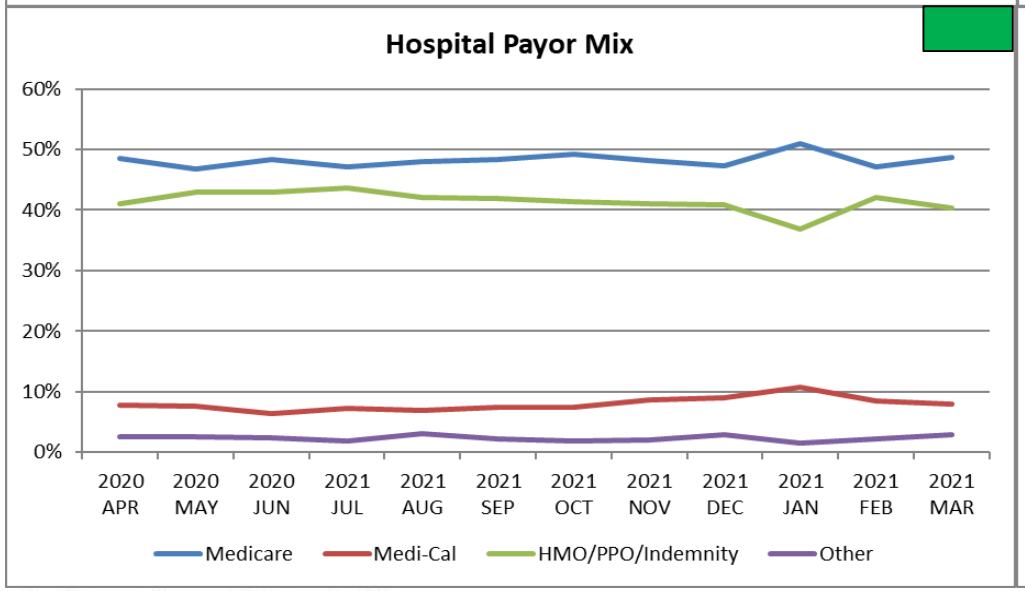
El Camino Health

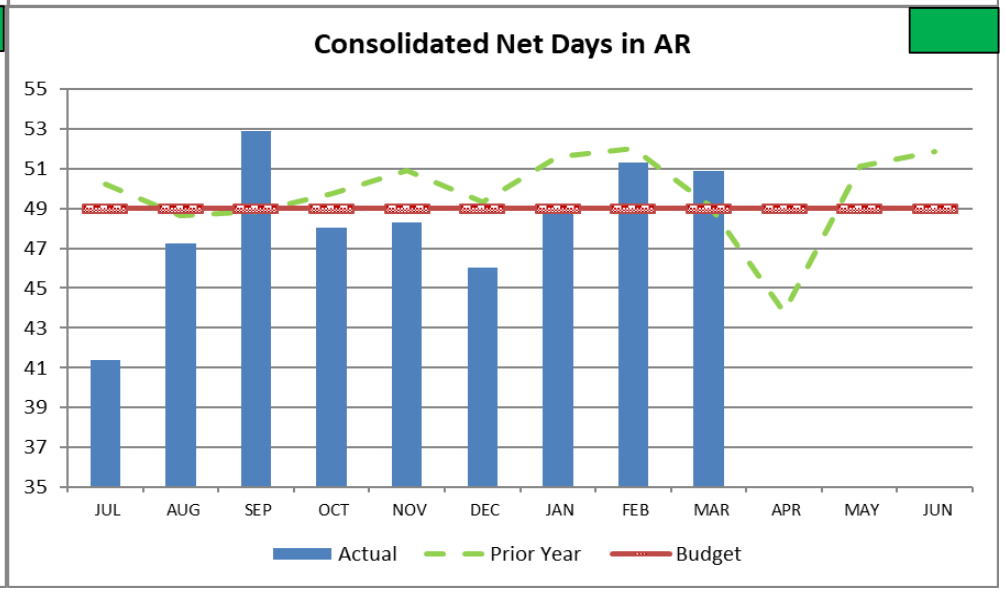
# APPENDI□

# YTD FY2□21 Financial KPIs – Monthly Trends




El Camino Health

# Period □ and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 3/31/2□21)

*($000s)*

| | Period 9- Month | | | Period 9- FYTD | | |
|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Actual | Budget | Variance |
| **El Camino Hospital Operating Margin** | | | | | | |
| Mountain View | 11,118 | 2,345 | 8,773 | 52,501 | (15,790) | 68,291 |
| Los Gatos | 295 | 1,475 | (1,180) | 23,636 | 13,046 | 10,590 |
| **Sub Total - El Camino Hospital, excl. Afflilates** | **11,413** | **3,820** | **7,593** | **76,137** | **(2,744)** | **78,881** |
| **Operating Margin %** | **11.9%** | **4.9%** | | **9.6%** | **-0.4%** | |
| **El Camino Hospital Non Operating Income** | | | | | | |
| **Sub Total - Non Operating Income** | **18,149** | **3,028** | **15,120** | **168,655** | **22,773** | **145,882** |
| **El Camino Hospital Net Margin** | **29,562** | **6,849** | **22,713** | **244,792** | **20,029** | **224,763** |
| **ECH Net Margin %** | **30.9%** | **8.8%** | | **30.8%** | **3.1%** | |
| Concern | (208) | 24 | (232) | 80 | 272 | (192) |
| ECSC | (0) | 0 | (0) | (3) | 0 | (3) |
| Foundation | 782 | 21 | 762 | 4,577 | 24 | 4,553 |
| El Camino Health Medical Network | (2,912) | (2,412) | (500) | (27,100) | (25,800) | (1,301) |
| **Net Margin Hospital Affiliates** | **(2,338)** | **(2,367)** | **29** | **(22,446)** | **(25,504)** | **3,058** |
| **Total Net Margin Hospital & Affiliates** | **27,223** | **4,482** | **22,742** | **222,346** | **(5,476)** | **227,821** |

# Consolidated Balance Sheet (as of □3/31/2□21)

*($000s)*

| ASSETS | | |
|---|---|---|
| **CURRENT ASSETS** | **March 31, 2021** | **Audited June 30, 2020** |
| Cash | 197,255 | 228,464 |
| Short Term Investments | 275,289 | 221,604 |
| Patient Accounts Receivable, net | 152,190 | 128,564 |
| Other Accounts and Notes Receivable | (817) | 13,811 |
| Intercompany Receivables | 35,428 | 72,592 |
| Inventories and Prepaids | 25,310 | 101,267 |
| **Total Current Assets** | **684,655** | **766,303** |
| **BOARD DESIGNATED ASSETS** | | |
| Foundation Board Designated | 18,989 | 15,364 |
| Plant & Equipment Fund | 230,810 | 166,859 |
| Women's Hospital Expansion | 30,401 | 22,563 |
| Operational Reserve Fund | 159,902 | 148,917 |
| Community Benefit Fund | 19,459 | 17,916 |
| Workers Compensation Reserve Fund | 16,482 | 16,482 |
| Postretirement Health/Life Reserve Fund | 31,365 | 30,731 |
| PTO Liability Fund | 30,394 | 27,515 |
| Malpractice Reserve Fund | 1,965 | 1,919 |
| Catastrophic Reserves Fund | 23,802 | 17,667 |
| **Total Board Designated Assets** | **563,568** | **465,933** |
| **FUNDS HELD BY TRUSTEE** | **8,589** | **23,478** |
| **LONG TERM INVESTMENTS** | **470,027** | **372,175** |
| **CHARITABLE GIFT ANNUITY INVESTMENTS** | **712** | **680** |
| **INVESTMENTS IN AFFILIATES** | **33,443** | **29,065** |
| **PROPERTY AND EQUIPMENT** | | |
| Fixed Assets at Cost | 1,769,269 | 1,342,012 |
| Less: Accumulated Depreciation | (726,689) | (676,535) |
| Construction in Progress | 102,389 | 489,848 |
| **Property, Plant & Equipment - Net** | **1,144,969** | **1,155,326** |
| **DEFERRED OUTFLOWS** | 21,275 | 21,416 |
| **RESTRICTED ASSETS** | 29,191 | 28,547 |
| **OTHER ASSETS** | 87,665 | 3,231 |
| **TOTAL ASSETS** | **3,044,093** | **2,866,153** |

| LIABILITIES AND FUND BALANCE | | |
|---|---|---|
| **CURRENT LIABILITIES** | **March 31, 2021** | **Audited June 30, 2020** |
| Accounts Payable | 29,390 | 35,323 |
| Salaries and Related Liabilities | 38,274 | 35,209 |
| Accrued PTO | 32,251 | 28,124 |
| Worker's Comp Reserve | 2,300 | 2,300 |
| Third Party Settlements | 13,418 | 10,956 |
| Intercompany Payables | 35,494 | 70,292 |
| Malpractice Reserves | 1,560 | 1,560 |
| Bonds Payable - Current | 9,430 | 9,020 |
| Bond Interest Payable | 3,317 | 8,463 |
| Other Liabilities | 11,444 | 3,222 |
| **Total Current Liabilities** | **176,877** | **204,469** |
| **LONG TERM LIABILITIES** | | |
| Post Retirement Benefits | 31,547 | 30,731 |
| Worker's Comp Reserve | 16,482 | 16,482 |
| Other L/T Obligation (Asbestos) | 6,100 | 4,094 |
| Bond Payable | 485,447 | 513,602 |
| **Total Long Term Liabilities** | **539,575** | **564,908** |
| **DEFERRED REVENUE-UNRESTRICTED** | **77,200** | **77,133** |
| **DEFERRED INFLOW OF RESOURCES** | **31,009** | **30,700** |
| **FUND BALANCE/CAPITAL ACCOUNTS** | | |
| Unrestricted | 1,994,341 | 1,771,854 |
| Board Designated | 194,031 | 188,457 |
| Restricted | 31,060 | 28,631 |
| **Total Fund Bal & Capital Accts** | **2,219,432** | **1,988,942** |
| **TOTAL LIABILITIES AND FUND BALANCE** | **3,044,093** | **2,866,153** |

El Camino Health

El Camino Health

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

**To:** Hospital □oard of □irectors
**From:** □ ar□Adams□□ □ □ACS□Chief □ edical Officer
**Date:** □une 23□2021
**Subject:** Infection Control □ edical □irector Rene□al Agreement (Enterprise)

**Recommendation**: □inance Committee to recommend that the □oard of □irectors approve delegating to the Chief E□ecutive Officer the authority to e□ecute a rene□al amendment to the Enterprise Infection Control □ edical □irector Agreement at a not to e□ceed annual compensation of □99□960 for a t□o year term.

**Summary:**

1. Situation:

   - Infection Control (IC) oversight □y a physician is a □itle 22 regulatory re□uirement. □he IC □ edical □irector agreement □ith Palo Alto □ edical □oundation (PA□ □) e□pires □une 30□2021.
   - □pon □oard approval□effective □uly 1□2021□the IC □ edical □irector □ill provide a ma□imum of 40 hours per month of administrative services at an hourly rate of □170□for a not to e□ceed annual compensation of □99□960□10□ of □hich is □ithheld and released upon successfully meeting IC □ edical □irector annual □uality goals.

2. Authority: According to Administrative Policies and Procedures 51.00□□inance Committee recommendation for □oard approval is re□uired prior to Chief E□ecutive Officer e□ecution of physician agreements that e□ceed the 75th percentile for fair mar□et value.

3. □ac□ground

   - □he PA□ □Infectious □isease specialist has □een ECH's IC □ edical □irector for the past t□enty years.
   - On □ arch 23□2020□the □oard approved an additional 204 hours per year for a total not to e□ceed annual compensation of □134□640 for the e□pertise of the IC □ edical □irector to support ECH's efforts in response to CO□I□□19 to provide the safest possi□le environment for ECH employees□visitors□and patients.

4. □air □ ar□et □alue Assessment:

   - □he hourly rate of □170 is □et□een the 75th percentile (□160) and 90th percentile (□190) according to the 2021 □ □ Ranger Infection Control □ edical □irection San □rancisco □ay Area report. □he hourly rate is at the 90th percentile according to the 2021 □ □ Ranger Infection Control □ edical □irection All □acilities report *(hourly rate was approved by ECH Board of Directors on June 12, 2019*).
   - □he total annual compensation of □99□960 is □et□een the 50th percentile (□90□625) and 75th percentile (□130□369) according to the 2021 □ □ Ranger Infection Control □ edical □irection San □rancisco □ay Area report using the multi□facility allo□ance calculation and □et□een the 50th percentile (□66□582) and 75th percentile (□112□829) according to the 2021 □ □ Ranger Infection Control □ edical □irection All □acilities report using the multi□facility calculation.

5. Other Revie□s: □he Sr. □irector Quality/Chief Quality Officer and □irector of Infection Prevention support this recommendation. □egal and Compliance □ill revie□ the final amendment and compensation terms prior to Chief E□ecutive Officer e□ecution.

6. Outcomes:

- □he e□pertise□leadership and guidance □y the IC □ edical □irector significantly contri□uted to the safety of our patients and employees amidst CO□I□□19. □he IC □ edical □irector □as continually called upon and responded □ith her input on re□uired changes for the ECH visitor policy□guidelines for personal protective e□uipment□and changes in CO□I□□19 recommended treatments□from □e□ruary 2019 to current.

- □ue to the outstanding efforts and the coordinated response to CO□I□□19□ECH received special commendation from □he Centers for □isease Control (C□C)□the Santa Clara County Pu□lic Health □epartment (SCCPH□) and the California □epartment of Pu□lic Health (C□PH).

- □he IC □ edical □irector co□authored a manuscript for pu□lication □ith the County Pu□lic Health □epartment □hich has □een accepted for pu□lication in the □ournal of Infectious □iseases.

- A 10□ annual □ithhold is released upon successful completion of annual □uality goals□at least one of □hich is aligned □ith ECH's annual organi□ation□performance and strategic goals.

**List of Attachments:** □one

**Suggested Committee Discussion Questions:** □one

El Camino Health

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

**To:** El Camino Hospital □oard of □irectors
**From:** Apurva □ arfatia□□ □□Enterprise Chief of Staff
□ ichael □an□□ □ Chief of Staff □os □atos
**Date:** □une 23□2021
**Subject:** □ edical Staff Report – Open Session

**Recommendation:**

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

**Summary:**

**1.** Situation: □he □ edical E□ecutive Committee met on □ ay 27□2021

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

a) Quality Council – □he Quality Council met on April 7□2021. Reports and performance dash□oards □ere revie□ed and approved from the follo□ing ECH □epartments/Service □ines:

1. C□ 2020 Annual PI Report Core □ easures
2. C□ 2020 Core □ easures □ash□oard
3. Annual PI Report H□IPS
4. Annual PI Report CPR Committee
5. CPR □ash□oard for Quality Council □ ay 2021
6. □a□Path Annual Report 4□2021
7. Clinical □a□s – □□ 2021 Quality Council □ash□oard

□) □eadership Council – □he □eadership Council met on □ ay 11□2021 and discussed the follo□ing:

1. Physician Portal □pdate
2. Provisional □ em□ers □pdate
3. Credentials Committee Charter
4. I□□E□ (□iversity) Committee
5. Rules and Regulations
6. ER□IC□ Handoff
7. Sepsis □ ortality Inde□
8. □ edical □irector □ist

c) □he COO Report □as provided and included the follo□ing updates:

1. Introduction□Los Olivos Women's Medical Group
2. Anthem □pdate
3. 2021 Healthgrades Patient E□perience A□ard
4. □3.3 □illion □ ireless □pgrade

d) □he C□ O Report □as provided and included the follo□ing updates:

1. Enterprise Quality □ash□oard
2. □op Readmission Reasons
3. CO□I□ □pdate
4. □ atson □op 100 Score

5. 2019 Performance and □ive□□ear Rate of Improvement Inde□

e) □he C□O Report □as provided and included the follo□ing updates:

6. CO□I□ □pdate
7. □ ulti□Site International Research Study Participant
8. Si□□ransition □urses Started in □&□ □ ay 17th

**List of Attachments:** Policies and Procedures

**Suggested Board Discussion Questions:** □one

# BOARD
# Policies for Approval
# June 2021

| Department | Policy/Procedure Name | Type of Change | Type of Document | Notes | Committee Approvals |
|---|---|---|---|---|---|
| Patient Rights | 1. Patient Rights | Revised | Policy | Grammatical edits to make it easier to understand | Dept. of Medicine |
| Interventional Services | 1. Scope of Service | None | Scope of Service | | Dr. Rommohan |
| Corporate Compliance | 1. Scope of Service | Revised | Scope of Service | Updated to reflect all areas of responsibility | |
| Emergency Management | 1. COVID-19 Control Plan | Revised | Plan | Added section on potential exposure of fully vaccinated health care worker, updated COVID capacity section related to revised designated COVID areas | Emergency Management Committee, Infection Prevention |

El Camino Health

| | |
|---|---|
| **Origination:** | *04/1998* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *03/2021* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Christine Cunningham: Exec Director Patient Exp & Perf Improvement* |
| **Area:** | *Patient Rights* |
| **Document Types:** | *Policy* |

# Patient Rights

## COVERAGE:

All El Camino Hospital staff

## PURPOSE:

To outline patient rights and responsibilities identified by state, federal and Joint Commission regulations and standards.



## STATEMENT

It is the policy of El Camino ~~Hospital~~Healthcare to respect a patient's rights and to inform all patients or their designated representative of their patient rights. If a patient has designated a patient representative, the patient representative shall be able to e□ercise the same rights as would the patient. The patient/patient representative has the right to e□ercise these rights without regard to se□, race, color, age, religion, ancestry, national origin, disability, medical condition, marital status, se□ual orientation, educational background, economic status, the source of payment for care, gender identity/e□pression, registered domestic partner status, genetic information, citizenship, primary language or immigration status □e□cept as required by federal law□

## PROCEDURE:

A. All Patients □inpatients ~~and outpatients~~/outpatient□receiving services at ~~ECH~~El Camino Health shall ~~be given~~have notice of their ~~patient rights~~Patient Rights.

B. A patient has the right to designate another person to serve as his/her representative either orally or in writing and that person shall receive notice of the patient's rights. The patient's designation of the representative shall continue throughout the inpatient stay or outpatient visit unless the patient requests differently.

   1. If the patient is incapacitated, staff shall identify the appropriate representative for notification. The following hierarchy shall be observed when identifying the patient representative:

      a. Whether the patient has an advance directive or other written designation by the patient identifying the patient's representative.

      b. Whether the patient has available family members who are able to make decisions for the patient. This includes spouses, domestic partners, and parents. If more than one family member

asserts that s/he is the patient's representative and there is no advance directive

2. If there is confusion with identifying who the appropriate patient representative is, staff shall consult with Risk Management. The final decision regarding designation of the patient's representative and the hospital's rationale shall be documented in the medical record. A refusal to treat an individual as the patient's representative shall also be documented in the medical record along with the specific basis for refusal.

C. Patient Rights are posted in English and Spanish in public facing areas of the hospital~~, in~~ and outpatient departments / areas ~~and~~in Spanish and English in accordance to regulatory guidelines. Patients Rights information is also made available on the hospital website and included in the inpatient handbook as well as inpatient admission folder. ~~Inpatients are also given a copy of the~~If a patient ~~rights in their "Your Hospital Stay Booklet"in the Hello-Goodbye Folder provided to the patient upon admission. If a patient~~ needs the Patient Rights in another language or needs assistive devices such as hearing or visually impaired, an appropriate interpreter should be called.

D. Along with ~~rights and responsibilities shall be~~Patient Rights and Responsibilities, included are phone numbers which patients, family and /~~or guardians~~ or caregivers may call to ask for assistance in resolution of conflicts regarding care.

# REFERENCES:


1. The Joint Commission
2. Title 22, Section "0"0" Patient's Rights
". CMS Code Section 12""4"42CFR Section 4"2.1" and 42 CFR 4"".102
4. Federal Register/"ol."5, No. 22", November 1", 2010/Rules and Regulations




*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

Derechos Del Paciente
Patient Rights

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Jeanne Hanley: Policy and Procedure Coordinator | pending |
| MEC | Catherine Carson: Senior Director Quality "JH" | 04/2021 |
| ePolicy Committee | Jeanne Hanley: Policy and Procedure Coordinator | 04/2021 |
| | Christine Cunningham: E"ec Director Patient E"p " Perf Improvement | 0"/2021 |

El Camino Health

| | |
|---|---|
| **Origination:** | *06/2016* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *05/2021* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Sara Carmack: Dir Interventional Services* |
| **Area:** | *Scopes of Service* |
| **Document Types:** | *Scope of Service/ADT* |

# Interventional Services-Mountain View Scope of Service

## Types and Ages of Patients Served

The Interventional Services (IS) serves adult inpatients and outpatients, and adolescent patients who are at least 12 years of age AND weigh 80 pounds (36.4 kg) or more.

## Assessment Methods

The diagnostic and therapeutic Interventional Services provided to patients that are assessed by cardiologists, nephrologists, cardiac and peripheral-vascular surgeons, interventional radiologists, cardiac cath lab technicians, and registered nurses (RNs) who monitor patients' response to procedures, contrast reactions, complications, and internal quality controls and external proficiency testing for equipment.



## Scope and Complexity of Services Offered

The IS provides care and services for Diagnostic and interventional cardiac, peripheral-vascular and neurological procedures, Cardiac Rhythm management procedures including electrophysiology studies and cardiac ablations, interventional radiological procedures including line placements, drains, tubes, kyphoplasty and vertebralplasty and embolizations.
The IS has provisions for the routine and emergency transfer of patients for cardiac surgery.

## Appropriateness, Necessity and Timeliness of Services

The lab assesses the appropriateness and necessity of diagnostic and therapeutic procedures by reviewing specific criteria for each procedure prior to initiation of the procedure. Cases, which do not meet criteria, are subject to review by the Interventional Services Leadership Committee. The IS adheres to contraindications for scheduling as defined in the department's policies and procedures to ensure that no other inappropriate cases are scheduled.

The timeliness of lab services is addressed in departmental policies and procedures which describe the hours of operation as well as performance of routine procedures.

# Staffing

The IS has five procedural rooms each staffed by registered nurses and cardiac cath lab technicians as needed. Types of staff providing care and services include invasive cardiologists, nephrologists, cardiac and peripheral-vascular surgeons, interventional radiologists, registered nurses, cardiac cath lab technicians, qualified respiratory care practitioners and pro□ect specialist.

# Level of Service Provided

The levels of services provided by the department are consistent with the diagnostic and therapeutic needs of the patients as determined by the medical staff.

The Interventional Services are designed to meet patient needs by accurately performing and interpreting diagnostic and therapeutic procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which the IS meets patient needs.

# Standards of Practice

The Interventional Service is governed by state regulations as outlined in Title 22 and standards established by the Joint Commission on Accreditation of Healthcare Organizations. The department also follows guidelines set forth by the American College of Cardiology. Additional practices are described in the Patient Care Policies and Procedures, departmental policies and procedures, and Clinical Practice Standards.

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



## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| BOD | Jeanne Hanley: Policy and Procedure Coordinator | pending |
| MEC | Catherine Carson: Senior Director Quality □JH□ | 05/2021 |
| ePolicy Committee | Jeanne Hanley: Policy and Procedure Coordinator | 05/2021 |
| Department Medical Director | Sara Carmack: Dir Interventional Services | 0□/2021 |
| | Sara Carmack: Dir Interventional Services | 12/2020 |

El Camino Health

| | |
|---|---|
| **Origination:** | *10/2015* |
| **Effective:** | *Upon Approval* |
| **Last Approved:** | *N/A* |
| **Last Revised:** | *04/2021* |
| **Next Review:** | *3 years after approval* |
| **Owner:** | *Diane Wigglesworth: Sr Dir Corporate Compliance* |
| **Area:** | *Scopes of Service* |
| **Document Types:** | *Scope of Service/ADT* |

# Corporate Compliance Scope of Service

## Types and Ages of Clients Served

The Corporate Compliance Department provides services to El Camino Hospital management, staff, physicians, patients, and members of the hospital community.

## Scope and Complexity of Services Offered

The Corporate Compliance Department provides services, analyses, and audits to enhance El Camino Hospital's Corporate Compliance program in the areas of billing and coding, patient privacy and IT security, enterprise risk management, organizational governance, ~~finance~~financial reporting, ~~and~~ business ethics and compliance. Functions provided include, but are not limited to:

- Developing and revising administrative policies and procedures related to scope areas.
- Developing and enhancing compliance program infrastructure or controls to promote prevention and detection of non compliance within the organization.
- Conducting education and training ~~on~~related to scope areas.
- Conducting internal audits ~~to~~for high risk areas, providing follow-up to affected areas, and supporting corrective action based on results.
- Monitoring high-risk areas and ~~advising departments for~~recommending corrective action based on results.
- Responding to the Corporate Compliance hotline. Investigating all concerns, complaints or potential issues resulting from hotline calls or directly reported that may result in compliance risk to the hospital.
- Chairing and participating in related committees, including ~~Corporate~~Board Compliance~~/Privacy and Internal~~ and Audit Committee, ~~Corporate~~IT Security, Privacy and Compliance Decision Committee, Clinical ~~Trials Operations~~Research Committee, and Revenue Integrity Committee.
- Evaluating strategic, business development, and other organizational proposals for potential compliance issues. Recommending strategies to mitigate compliance or enterprise risk.
- Recommending to affected departments, Human Resources, Administration, and other affected areas appropriate corrective action due to compliance violations.

## Staffing

The staff providing services includes ~~nurse auditors~~managers of compliance and privacy, internal ~~auditors~~auditor, ~~and internal audit~~compliance analyst , and a Director of Corporate Compliance who also serves as El Camino Hospital's ~~Corporate~~ Compliance/Privacy Officer.

# Level of Service Provided

The Corporate Compliance department provides services under hospital and departmental policy and procedure guidelines.

# Standard of Practice

Where applicable, the ~~Corporate~~ Compliance department is governed by state and federal regulations, including the state Department of Health Services, Department of Health and Human Services, the Office of Inspector General, the Office of Civil Rights, and Joint Commission on Accreditation of Healthcare Organizations requirements.

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

## Attachments

No Attachments

## Approval Signatures



| Step Description | Approver | Date |
|---|---|---|
| MEC | Catherine Carson: Senior Director Quality | pending |
| ePolicy Committee | Jeanne Hanley: Policy and Procedure Coordinator | 05/2021 |
| Department Medical Director | Diane Wigglesworth: Sr Dir Corporate Compliance | 04/2021 |
| | Diane Wigglesworth: Sr Dir Corporate Compliance | 04/2021 |

El Camino Health

| | |
|---|---|
| **Origination:** | *09/2020* |
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| **Last Revised:** | *05/2021* |
| **Next Review:** | *1 year after approval* |
| **Owner:** | *Steve Weirauch: Mgr Environmental Hlth&Safety* |
| **Area:** | *Emergency Management* |
| **Document Types:** | *Plan* |

# COVID-19 Control Plan

## COVERAGE:

All El Camino Health staff, medical staff and volunteers

## PROGRAM ADMINISTRATION:

The El Camino Health Infection Prevention and Emergency Management groups are responsible for designing, implementing, evaluating, and maintaining the El Camino Health COVID-19 Control Plan. The team collaborates with representatives from Employee Wellness and Health Services, Nursing, Hospital Administration, Emergency Department, Facilities, and Clinical Laboratories. Input from other departments/ individuals with required expertise is sought as needed.



## REFERENCES:

- Center for Disease Control (CDC) Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

## DEFINITION:

COVID-19 is an illness caused by the SARS-CoV-2 virus. Person to person transmission is widespread throughout the globe and community transmission in California and the United States is occurring.

## PROCEDURE:

A. Identification and evaluation of patients with possible COVID-19 infection
*Early identification of a Patient Under Investigation (PUI):*

1. Rapid identification of individuals with compatible symptoms and relevant travel/exposure history and institution of appropriate isolation measures are critical in reducing the risk of COVID-19 transmission.
2. The criteria are intended to serve as guidance for evaluation and testing for coronavirus. Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19. COVID-19 has a wide range of symptoms, ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. These include the following: cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat or new loss of taste and smell.

B. COVID-19 testing

1. Rapid SARS-CoV-2, RT-PCR (Cepheid - done at El Camino Health Clinical Lab)
    a. An order is placed in the EHR
    b. This is performed at ECH Clinical Laboratory and does not require a signed requisition.
    c. Place surgical mask on the patient.
2. Appropriate PPE to wear during test collection
    a. N-95 respirator plus face shield/ goggles OR PAPR (powered air-purifying respirator)
    b. Gown
    c. Gloves
3. A nasopharyngeal (NP) swab should be collected to test for COVID-19.

C. Management of Emergency Department Patients

1. Triage: Rapid identification and isolation of patients who may be infectious follow Respiratory Screening Criteria which includes: cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat or new loss of taste and smell, or exposure to COVID-19 person.
2. Patients meeting any of these criteria:
    a. Place surgical mask on the patient.
    b. Patients with respiratory symptoms will be triaged in the respiratory assessment area of the ED.
    c. Patients will be roomed in designated COVID containment area.
    d. Notify the charge nurse immediately.
    e. Once the patient is in an isolation room, keep the door to the room closed.
    f. Contact Facilities Engineering to verify negative/neutral airflow in the room.
    g. Implement Airborne and Contact Isolation and ensure that everyone entering the room is wearing appropriate PPE as required.
    h. Place an "**AIRBORNE AND CONTACT ISOLATION**" sign on the door.
    i. All persons entering the room must perform hand hygiene and then don:
        i. Powered Air-Purifying Respirator [PAPR] or N-95 Mask (staff must be fit-tested before wearing an N-95).
        Note: If an aerosol-inducing procedure (i.e., intubation, nebulized medication, nasal pharyngeal swabbing) is planned, maintain airborne precautions.
        ii. Gloves
        iii. Isolation Gown
        iv. Face shield if using N-95 mask
3. COVID tested patients, with pending results, discharged from ED:
    a. Teach the patient about infection control practices to use at home including good handwashing, cough etiquette, and wearing a surgical mask during close contact with others in the home.
    b. Patient should remain at home pending COVID-19 results.
    c. Give the patient a surgical mask to wear as they leave the hospital, and several surgical masks

to take home

d. Give the patient a copy of the two handouts found on the ECH Toolbox:
    i. SCCPHD Suspected-Case Information Sheet
    ii. SCCPHD Confirmed-Case Information Sheet

4. After the patient leaves the ED
    a. Keep exam room empty with door closed with appropriate isolation signage for 1 hour after the last aerosol-generating procedure was performed (including nebulized medication). Obtaining an NP swab does not require the room to be empty for one hour.
    b. Clean room with approved hospital disinfectant including blood pressure cuff, stretcher, counters, bedside table etc. Discard contaminated supplies.

D. Management of Suspected or Positive Inpatients

1. Suspected COVID inpatients - patient remains in current room while ECH testing is conducted.
    a. Door to room is kept closed until COVID result obtained
    b. Patient's assigned RN will collect COVID swab under Airborne Contact precautions
    c. If positive, patient to be transferred to COVID containment unit.
2. Patients being admitted who are positive for COVID-19
    a. Prior to admission the accepting primary nurse must
        i. Contact Facilities Engineering to ensure the room is verified as "Negative Airflow/Pressure" or "Neutral Aiflow/Pressure."
        ii. Airborne and Contact Isolation: required for all patients
    b. Preferably, patients are to be placed in a single patient room with the door closed.
    c. Patients may be be cohorted in semi-private rooms if the following criteria are meet:
        i. No other infection isolation in place (examples: RSV, MRSA, CRE)
        ii. Both patients are in the same phase of COVID infection; Phase 1 being 0-10 days and Phase 2 being 10-21 days.
        iii. Patient is not suspected to be false positive for COVID
        iv. Follow general cohorting principles; same gender, similar age and mental status. Patient from same household, related, partners, may be cohorted.
        v. Review patient criteria with Assistant Hospital Manager prior to cohorting.
    d. Post the "**appropriate isolation**" signage on the door of the patient's room.
    e. **Only essential staff** should enter the room (attending physician, assigned RN, RT). Instruct non-essential personnel not to enter the patient room.
        i. Staff that should not enter the room includes, nutrition and food services staff, social work, and care coordination such as case management.
    f. All staff must wear appropriate PPE for type of isolation and use proper donning and doffing sequence when entering and exiting the room.
    g. Patients must remain in a negative/neutral air pressure room until COVID is no longer suspected or positive. The decision to discontinue precautions should be made in consultation

with Infection Prevention.

h. Educate patients about the reasons for isolation precautions. In addition, they should be instructed to cover their mouth and nose with a tissue when coughing or sneezing.

i. The patient should remain in his/her room at all times with the doors closed unless emergency diagnostic or therapeutic procedures (e.g., CAT scan, surgery, etc.) are urgently required and cannot be performed in the patient's room.

j. When leaving his/her room, the patient must disinfect hands, put on a clean hospital gown, and a surgical mask.

k. Notify the Pathology Department prior to autopsy procedures for deceased patients with suspected or confirmed COVID.

l. The isolation room where the patient has resided is considered contaminated for 1 hour (>99.9% removal efficiency) after the patient leaves and should remain vacant with doors closed for that interval of time. The room must remain vacant for 1 hour, followed by discharge cleaning of the room for isolation patients

3. Maternal Child Health specific work flows - see Elemeno
4. Code blue and crash cart management for positive COVID patients (see attachment, **Crash Cart Management Code Blue for COVID-19 Patient**).
5. Trash and Linen
   a. Place a trash receptacle into the anteroom or in hallway.
   b. Place trash, including discarded gowns and gloves, into the anteroom or in room trash receptacle.
   c. Place discarded N-95 respirators, PAPR visors, and face shields into the regular trash receptacle outside of the patient's room, if soiled or damaged.
   d. Trash will be transported by EVS per normal protocol.
   e. Sharps and non-hazardous pharmaceutical containers will be collected by assigned staff.
   f. Soiled linen is transported and laundered in the same manner as all hospital linen. It is placed in a bag designated for soiled linen and must remain in the patient's room or anteroom until it is transported for laundering.
6. Cleaning and disinfection of environment
   a. Room Pre-Occupancy Preparation
      i. Place soiled linen collection container in anteroom, or in patient room if no anteroom.
      ii. EVS to place dedicated cleaning equipment in anteroom or in patient room for nursing staff to utilize. Nursing staff will request additional supplies or disinfectant as needed.
   b. Room Occupancy / Daily Room Cleaning Procedures & Personal Protective Equipment (PPE)
      i. EVS/Unit Support to perform one cleaning/entry modified daily occupied room cleaning.
      ii. EVS to wear airborne (PAPR) and contact precautions while in patient's room.
      iii. EVS staff to perform modified, <15 min cleaning high touch areas in close proximity to the patients, bathroom and floor.
      iv. EVS will perform terminal room clean when patient is transferred or discharged.

c. Discharge or transfer Room Cleaning

i. EVS/Unit Support follow designated procedures for specialized discharge cleaning of COVID+ patient rooms. EVS will adhere to designated room closure time requirements prior to entering room.

ii. Personal Protective Equipment

- Perform hand hygiene prior to entering room and immediately after removing PPE.
- Entry after designated room closure, EVS staff must wear gown, gloves, surgical mask, and eye protection.
- Immediate entry (no room closure), EVS staff must wear gown, gloves, PAPR.
- Remove and discard PPE in anteroom.
- If there is no anteroom, remove gloves, gown, eye protection, PAPR in room.

iii. Following cleaning, EVS will notify supervisor to report that cleaning is complete. The supervisor must visually inspect the room then will remove the isolation signage and inform nursing unit staff that the room has been cleaned and is ready for re-occupancy.

iv. Notify Facilities Engineering that the room no longer requires negative/neutral airflow.

7. Cleaning and disinfection of equipment – Cleaned/disinfected equipment should remain in room until UV Disinfection is complete.

a. Equipment and/or devices that are not disposable must be cleaned to remove any blood or body fluids and disinfected with the approved hospital disinfectant. Cleaning, disinfection, and UV Disinfection must be completed before the equipment is stored in the clean equipment area and before being used for other patients.

b. Clean and disinfect equipment in the room or in the anteroom.

c. Equipment surface(s) must be THOROUGHLY WET with the disinfectant agent and allowed to remain undisturbed for the contact time specified by the surface disinfectant.

d. Persons cleaning/disinfecting equipment in a room housing a suspected or positive COVID patient must wear appropriate PPE. If cleaning/disinfecting equipment in the anteroom, wear a gown and gloves.

8. Transport of suspected or positive COVID patients – Nursing staff always accompany the patient

a. Place a surgical mask on the patient during transport.

b. The patient should remain in his/her room at all times with the doors closed unless emergency diagnostic or therapeutic procedures (e.g., CAT scan, surgery, etc.) are required and cannot be performed in the patient's room.

c. Before leaving the room, the patient should disinfect his/her hands, put on a clean hospital gown, and put on a surgical mask.

d. Nursing staff transfers the patient to a wheelchair or gurney.

e. Use a clean sheet that was not stored in the room to completely cover the patient before leaving the room.

f. Transporters should follow the recommended sequence of donning PPE prior to entering the patient's room. The transporter should follow the recommended sequence of doffing PPE and eye protection, but should keep his/her surgical mask on during transport.

g. The transporter should continue to wear surgical mask and eye protection during transport.

h. Bring a clean surgical mask in the event the patient's mask becomes wet during transport.

i. Notify the area to which the patient is being transported that the patient is a suspected or positive for COVID so that appropriate accommodations can be made. If possible, schedule suspected or positive COVID patients at the end of the day.

   i. Notify Facilities Engineering so that proper precautions can be implemented (e.g., placement of a HEPA filter in area).

j. Staff in receiving location are to wear appropriate PPE prior to patient contact.

k. Surgery patients must be transported directly from their room to Operating Room.

9. Visitor Restriction

   a. Visitor restrictions will be put into place following state and county recommendations.

   b. All requests for patient visitors will be directed to the Assistant Hospital Manager/Hospital Supervisor (AHM/HS). The AHM/HS will determine if the visitation meets exceptions criteria and will coordinate visit with requesting department. The AHM/HS will ensure that visitor restrictions are followed, including visitation time limitations.

   c. COVID positive patients

      i. No visitors

      ii. Exception: Compassionate visit

      - Approved by Infectious Disease physician
      - Appointment time in advance
      - Visitor must be accompanied by Infection Prevention (IP) RN or RN designee
      - Visitor must wear appropriate PPE as instructed by IP RN
      - Visit will be time limited

   d. Non-COVID patients

      i. Visitors will be allowed per current hospital visitation guidelines posted in The ECH Toolbox under COVID

      ii. Exceptions:

      - Pediatric patients will be allowed one support person.
      - Maternal-Child will be allowed one support person.
      - End of Life
        - Patient must have a DNR and a notation from the physician that the patient has <48 hours to live.
        - Only immediate family is allowed in the room, defined as a sibling, spouse, offspring, or parents
        - Visits are limited to 2 hours
        - Up to three people at a time
      - Patients with Physical, Intellectual, and/or Developmental Disabilities and/or Cognitive Impairments

- One support person be allowed to be present with the patient when medically necessary
- Must stay in the room and be asymptomatic for COVID
- Support persons may be screened prior to entering the clinical areas

e. The patient's care team will provide education on visitor restrictions to the family and designated visitors.

f. Encourage video and phone call visits

g. All approved visitors are required to be screened and remain in patient room during visit. Visitor time limits will apply.

10. Potential health care worker and patient exposures process

a. Definition of Exposure: Any unprotected (no PPE used) contact with a patient diagnosed with or suspect for COVID before initiation of appropriate isolation precautions.

b. Infection Prevention responsibilities:

i. Review the medical record for any suspicion of COVID to ascertain whether proper isolation measures were instituted.

ii. Review the patient's status with an attending physician or designee.

iii. Determine whether any potential exposure to hospital personnel occurred.

iv. Determine whether any potential exposure to patients occurred.

v. Report exposures to Employee Health and Wellness Services.

c. Responsibilities of Employee Health and Wellness Services (EWHS):

i. Supervisors are required to submit a list of the names and employee ID numbers of employees that meet exposure criteria to Employee Health by the end of the business day on which the supervisor is notified. .

ii. Follow up on employees that meet the exposure criteria

iii. Contact the supervisors of departments with exposed employees. The supervisors are emailed an exposure follow-up form which states that a COVID exposure has occurred in their department, giving the name and MRN of the patient.

iv. Provide self-monitoring instructions to all health care personnel that meet exposure criteria.

v. Record all exposures and exposed employee information.

vi. Arrange for post-exposure education and monitoring.

vii. Exposed employees must measure their own temperatures twice daily and can continue to work as long as they do not have either fever >100.4°F or respiratory symptoms such as (e.g. cough, shortness of breath or trouble breathing, muscle pain, new loss of sense of smell)

d. Potential Exposure of Fully Vaccinated Health Care Worker

i. Fully vaccinated is defined as ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine.

ii. During critical staffing shortages employees can continue to work after a high risk exposure at work or at home if they meet the criteria below:

a. The staff are fully vaccinated

b. They remained asymptomatic since the current COVID-19 exposure.

E. Employees diagnosed with COVID-19 are restricted from work for ~~14~~10 days from the positive test date or ~~7 days~~24 hours after the resolution of symptoms whichever is longer.

1. Employees must obtain Employee Wellness and Health Services (EWHS) clearance prior to returning to work.

F. Employee Masking and Monitoring

1. All employees will complete Employee Wellness Monitoring for at the beginning of each on-site work day.
2. All employees will participate in the Universal Masking Program.

G. Engineering Controls

1. **Mountain View:**

a. Patient Care Units:

i. There are designed Airborne Isolation Rooms (AIRs), with anterooms and alarms, dispersed throughout the facility that meet all of the code requirements in place when they were constructed. They each provide 100% Exhaust and do not return air to the building. These rooms are always “negative/neutral” to the surrounding spaces and are the preferred spaces for isolation needs. Nursing is responsible to advise Engineering before use. Engineering will verify and document performance and will continue to do so daily until the isolation is lifted.

ii. Under normal conditions, air handlers introduce a combination of Outside Air (OSA) and Recirculated Air (RA) into the facility. Some air is captured, filtered, and returned to the building and a percentage is exhausted and replaced with fresh OSA. These percentages were set by code requirements.

iii. In the event that it becomes desirable to prevent air from being recirculated in the building, the air handlers can be automatically adjusted to provide 100% OSA to the Patient Care Areas and to exhaust all air to the outdoors. The individual patient rooms can also be adjusted to provide a “negative/neutral” airflow to the surrounding spaces. It is worthy to note, that while the patient room can be made “negative/neutral”, the air changes will not be equivalent to those in a designed AIR. Also, of note, there would be no proper anteroom, and no automated alarm mechanism.

iv. It is critical that any rooms that are converted be meticulously tracked so that admitting and nursing are fully aware of their status. In this scenario, Engineering assumes responsibility for documenting daily pressure checks to ensure that the rooms remain “negative/neutral” to the surrounding areas, regardless of whether they are in use.

b. Emergency Department:

i. There is a designed Airborne Isolation Room (AIR), with anteroom, that meets all of the code requirements in place when it was constructed. It provides 100% Exhaust and does not return air to the building. This room is always “negative” to the surrounding spaces and is the preferred space for isolation needs. ED is responsible to advise Engineering before each use. Engineering will then verify and document performance.

ii. Under normal conditions, air handlers introduce a combination of Outside Air (OSA) and Recirculated Air (RA) into the facility. Some air is captured, filtered, and returned to the building and a percentage is exhausted and replaced with fresh OSA. These percentages were set by code requirements.

iii. In the event that it becomes desirable to prevent air from being recirculated in the building, the air handlers can be adjusted to provide 100% OSA to the Emergency Department and to exhaust all air to the outdoors. Additionally, the Clinical Decision Unit (CDU) Exam Rooms can also be adjusted to provide a "negative/neutral" airflow to the surrounding spaces. It is worthy to note, that while these exam rooms can be made "negative/neutral," the air changes will not be equivalent to those in a designed AIR. Also, of note, there would be no proper anteroom, and no automated alarm mechanism.

iv. Again, it is critical that any rooms that are converted be meticulously tracked so that ED staff and nursing are fully aware of their status. In this scenario, Engineering assumes responsibility for documenting daily pressure checks to ensure that the rooms remain "negative/neutral" to the surrounding areas, regardless of whether they are in use.

2. **Los Gatos**:

a. Patient Care Units:

i. There are designed Airborne Isolation Rooms (AIRs), some with anterooms and alarms, dispersed throughout the facility that meet all of the code requirements in place when they were constructed. They each provide 100% Exhaust and do not return air to the building. These rooms are always "negative" to the surrounding spaces and are the preferred spaces for isolation needs. Nursing is responsible to advise Engineering before use. Engineering will verify and document performance and will continue to do so daily until the isolation is lifted.

ii. Under normal conditions, air handlers introduce a combination of Outside Air (OSA) and Recirculated Air (RA) into the facility. Some air is captured, filtered, and returned to the building and a percentage is exhausted and replaced with fresh OSA. These percentages were set by code requirements.

iii. In the event that it becomes desirable to prevent air from being recirculated in the building, the air handlers can be manually adjusted and retrofitted to provide 100% OSA to the Patient Care Areas and to exhaust all air to the outdoors. However, because of the lack of sophistication of the equipment, this will interfere significantly with our ability to maintain temperature control in the facility during extreme temperatures, both high and low. The individual patient rooms can be retrofitted using HEPA scrubbers exhausted through the windows and manually blocking off air return diffusers to provide a "negative/neutral" airflow to the surrounding spaces. It is worthy to note, that while the patient room can be made "negative/neutral", the air changes will not be equivalent to those in a designed AIR. Also, of note, there would be no proper anteroom, and no automated alarm mechanism.

iv. It is critical that any rooms that are converted be meticulously tracked so that admitting and nursing are fully aware of their status. In this scenario, Engineering assumes responsibility for documenting daily pressure checks to ensure that the rooms remain "negative/neutral" to the surrounding areas, regardless of whether they are in use.

b. Emergency Department:

i. There are no designed Airborne Isolation Rooms (AIRs) in the Emergency Department.

However, there are two rooms each split into two “bays” that have manual controls that can make each room “negative/neutral” to the corridor. There are no anterooms, no automatic alarms, and only a manual gauge.

H. Sputum Induction and Bronchoscopy Procedures

1. During these procedures, staff in the patient room must wear a PAPR (not an N-95 respirator).
2. Sputum Induction
    a. The patient must wear a surgical mask during transport to and from sputum induction booths.
    b. Cough- and aerosol-inducing procedures such as nebulizer treatments, sputum induction, bronchoscopy and endotracheal intubation may facilitate transmission of the COVID virus to health care workers.
    c. Sputum induction should be performed on COVID patients only when medically necessary.
    d. Patients with diagnosed or suspected COVID must undergo sputum induction in the patient’s airborne isolation room or in a HEPA-filtered sputum induction booth.
3. Bronchoscopy
    a. Cough- and aerosol-inducing procedures such as nebulizer treatments, sputum induction, bronchoscopy and endotracheal intubation may facilitate transmission of the COVID virus to health care workers.
    b. Bronchoscopy should be performed on suspected COVID patients only when medically necessary.
    c. Patients with diagnosed or suspected COVID requiring bronchoscopy must have the procedure performed in an airborne Isolation Room or area or HEPA-filtered room (e.g., Endoscopy Suite).
    d. Patients must remain in the room until coughing has subsided. Advise the patient to cover his/her mouth and nose with a tissue when coughing.
    e. A surgical mask must be worn by the patient during transport.
    f. The procedure room must not be used for at least 1 hour following bronchoscopy to allow sufficient time for appropriate ventilation.

I. Clinical Laboratory Procedures

1. COVID Testing
    a. Send specimens to Clinical Laboratory via transport and NOT the pneumatic tube.
    b. The Clinical Laboratory will perform a COVID PCR test and will call all positive results.
2. Other Clinical Laboratory Tests
    a. Do NOT order viral isolation (culture) to be performed at ECH. Specimens will not be accepted for viral isolation/culture.
    b. PCR testing (rapid influenza/RSV and Respiratory Panel) may be ordered.

J. Coordination with the Santa Clara County Public Health Department (SCCPHD)

1. All Positive, Negative and Indeterminate COVID results are immediately sent to SCCPHD via the CALREDIE / ECH Epic interface.
2. Upon notification of a COVID positive patient, Infection Prevention (IP) will report case to SCCPHD.

K. Supply Management Procedures

1. Extended use of PPE to ensure supply during surge.
2. Departments bring 24-hour Supply Request form to Central Supply to obtain allocated PPE.
3. Central Supply will monitor PPE levels and report out shortages.
4. As requested report supply levels to SCCPHD.

L. ~~COVID Capacity~~

~~1. There are designated COVID areas that will be activated in order of need.~~

~~a. MV – POD 3 CCU, 3CW (only tele/med/surg level pts), 4A (med/surg only) and one L&D room.~~

~~b. LG - Ortho Pavilion 10 identified rooms (only tele/med/surg level pts) one L&D room.~~

~~i. LG ICU isolation room 1078 will be held when any COVID patients admitted.~~

COVID Capacity

1. Designated COVID areas

a. MV: CCU rooms 3114, 3125 -3132; PCU rooms 3117 & 3123; 3C room 3309, 3323 & 3324; 2C rooms 2309, 2323, 2324, 2328, & 2329; and one L&D room.

M. Surge Plan – see attachment - *Patient Surge for COVID* for order of patient placement.

1. MV hospital will be the primary location for all admitted COVID positive patients
2. COVID positive patients admitted or being admitted in LG will be transferred to MV campus to designated COVID area
3. If the MV hospital reaches maximum capacity for admitted COVID positive patients, LG hospital will utilized.
4. Nursing Documentation Standards for High Surge

a. If an active 'All Facilities Letter' allowing temporary waiver for hospital surge documentation requirement is available through the local CDPH, then the organization shall seek approval to limit nursing documentation requirements.

b. In the event of a severe staffing shortages impact the entire organization, nursing assessment and care documentation will be reduced to essential items for the safe care of the patient.

c. The intent of modified documentation standards is to allow nurses to prioritize direct patient care in the event of patient surge and diminished resources to meet patient care needs. The priorities of documentation are to support safe and effective patient care and communicate information among health care team members to promote continuity of care.

d. Only the chief nursing officer (CNO) or designee can authorize the implementation of modifications to usual documentation standards based on patient census and nurse availability. The CNO may choose to implement modified standards for a service line or an individual unit(s) (such as the CCU).

e. Modified documentation for High Surge shall be authorized by the CNO or designee for specific conditions, such as:

i. Nursing assignments over California mandated nurse to patient ratios for majority of shifts.

ii. Alternative nursing assignment models or Team based nursing assignments or sustained utilization of nursing staff from other departments to support patient care (*i.e. OR, Cath*

*Lab, Women's Hospital RNs assisting in CCU to Med/Surg areas*)

f. The surge standards will remain in place until the CNO or designee revokes them. The CNO shall revoke the surge standards when available nursing resources are sufficient to carry out the usual and customary documentation standards.

g. The organization's Director of Quality and Public Reporting will keep record of when High Surge documentation standards are implemented and discontinued.

h. The Nursing Documentation Standards for High Surge represent the minimum required documentation. When feasible, additional documentation above the minimum standard should be completed.

i. The time period that the surge documentation standards are in effect should be noted in the patient's medical record.

j. Nursing staff should utilize the HIGH Surge Documentation option within EPIC.

- See attachment, **Documentation Standards for HIGH SURGE: Tipsheet for EPIC** for full details.

i. Modified documentation standards will applied to:

- Admission assessment
- Vital sign & hemodynamic monitoring
- Shift assessments
- Rounding
- Fall Risk
- Lines, Drains and Airways (LDAs)
- Intake and Output
- Discharge Instructions

ii. Care will be continued, but documentation will not be required for:

- Plan of Care
- Patient Teaching
- Hygiene (baths, oral care, cath care, etc.)
- Turning or repositioning
- Infection control practices

iii. Continue to follow current documentation policies for:

- Pain assessment and management
- Medication administration
- Restraints
- Blood Administration
- Critical Labs / Critical Values



*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

Documentation Standards for HIGH SURGE-Guidelines for Disater Doumentation.pdf
Documentation Standards for HIGH SURGE.pdf
COVID 19 Contact Tracing.pdf
Patient Surge for COVID Plan
Crash Cart Management Code Blue for COVID-19 Patient

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Board | Jeanne Hanley: Policy and Procedure Coordinator | pending |
| MEC | Catherine Carson: Senior Director Quality [JH] | 05/2021 |
| ePolicy Committee | Jeanne Hanley: Policy and Procedure Coordinator | 05/2021 |
| Infection Prevention Committee | Jeanne Hanley: Policy and Procedure Coordinator | 05/2021 |
| Emergency Management Committee | Steve Weirauch: Mgr Environmental Hlth&Safety | 04/2021 |
| | Steve Weirauch: Mgr Environmental Hlth&Safety | 04/2021 |

El Camino Health

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

**To:** Board of Directors
**From:** Ken King, CAO
**Date:** June 23, 2021
**Subject:** Major Capital Projects in Process

**Purpose:** To keep the Board of Directors informed on the progress of major capital projects in process.

**Summary:**

**A.** Situation/Status

**Taube Pavilion** (aka OHS): This project now in the close out phase with only a few minor punch list items needed to close out the contract and the permit. The projected final cost remains $992,000 over the project budget.

**Sobrato Pavilion** (aka IMO): This project is now is in the close out phase with only a few minor punch list items needed to close out the contract and permit. The projected final cost remains $984,000 below the project budget.

**Women's Hospital**: The demolition of the 2nd and 3rd floors and the installation of a materials lift is complete and construction activities are proceeding according to plan.

**M.V. Campus Completion Project** (Phases 1 and 2) which includes the demolition of the old main hospital has received OSHPD plan approval. We are making preparations to begin the Phase 1 demolition and Temp Service Yard construction in late July 2021. Efforts to finalize the Phase 3 plan objectives are in progress and a recommendation to fund and proceed is expected in the coming months.

**Radiation Oncology Equipment Replacement Project:** The HDR Brachytherapy Unit and the new Ethos linear accelerator have been installed and put into service and the construction/installation preparations for the third and final room are underway. The target date to begin the equipment installation in the third room is August 16th. To date $9.99 million of the $10.3 million budget has been committed.

**Interventional Equipment Replacement Project:** The plans have been approved by OSHPD and we are currently finalizing the Contractors GMP Amendment for the initial construction phase. Start of Construction is targeted for later this summer.

**Imaging Equipment Replacement Project:** The early cost estimates for this project has caused us to reconsider the scope of work and we are now looking to scale back on some of the requested modifications within the department. We are also reprioritizing the sequence of equipment replacements to reduce costs. Once plan modifications are made we will submit to OSHPD for plan review. UPDATE: Revised plans are due to be completed by the end of June. Upon completion they will be submitted for OSHPD plan review and construction cost estimates for the revised project scope will be updated.

**B.** Authority

□his memo is to □eep the □oard of □irectors informed of the progress to□ards completion of the ma□or development pro□ects □ithin the □ ountain □ie□ Campus □evelopment Plan and other ma□or capital pro□ects**.**

**C.** □ac□ground

□he □oard of □irectors approved the □ ountain □ie□ Campus □evelopment Pro□ects □hich consist of the follo□ing:

| Step I: | Status |
|---|---|
| □orth Par□ing □arage E□pansion □ | Complete |
| □ehavioral Health Services □uilding □ | Complete □Occupied |
| Integrated □ edical Office □uilding □ | Complete □Occupied |
| Central Plant □pgrades □ | Complete |
| **Step II:** | |
| Women's Hospital Expansion □ | Construction Phase 1 of 3 |
| □emolition of Old □ ain Hospital □ | Pre□construction □Phases 1&2 |
| **Other Capital Pro□ects:** | |
| Radiation Oncology E□uipment Replacement | Construction □inal Phase |
| Interventional E□uipment Replacement | Pre□construction – Phase 1 |
| Imaging E□uipment Replacement | Construction □ocuments |

**D.** Assessment

□A

**E.** Other Revie□s

□one

**F.** Outcomes

As stated in the status updates.

El Camino Health

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

**From:** an oods CEO
**Date:** une 23 2021
**Subject:** Consideration of enefits coverage for ECH oard em ers Reclassified as 2 Employees for IRS purposes

**Purpose:**

o present to the ECH oard for consideration hether oard em ers Reclassified as 2 Employees for IRS purposes should receive enefits coverage paid y the Hospital.

**Summary:**

**1.** Situation:

**Reclassification of hospital board members as W2 employees for tax purposes.** he IRS has ta en the position that oard mem ers of a pu lic agency should e treated as employees for purposes of ithholding income ta from their stipends even though oard mem ers are not treated as employees for almost all other purposes. Although the Hospital is organi ed as a 501(c)(3) pu lic enefit corporation the IRS considers it an instrumentality of the istrict and ould li ely treat hospital oard mem ers as employees for ta purposes. herefore the Hospital has decided to reclassify its oard mem ers as employees for ta purposes.

**Board member benefits.** Hospital oard mem ers currently do not receive group health dental or vision benefits under the Hospital's group benefit plans. iven the change of oard mem ers as 2 employees for ta purposes consideration for providing enefits should e revie ed. Although the Hospital is not currently re uired to provide enefits to oard mem ers and treating oard mem ers as employees for ta purposes does not re uire the Hospital to provide enefits the oard can approve enefit coverage to its mem ers.

he current estimated cost to provide enefit coverage for each oard mem ers ould range from 950 2 900 per month depending if the coverage is for individual plus spouse or family.

**2.** Other Revie s: /A

**3.** ist of Attachments: /A

**4.** Suggested oard iscussion Questions:

Should the ECH oard mem ers receive enefits coverage paid y the Hospital for irectors and/or their spouses and dependents

# OPEN SESSION CEO Report
# June 23, 2021
# Dan Woods, CEO

**Nursing Services**

ECH Nursing Division was selected to participate in an international multi-site research project called Magnet4Europe. Sponsored by the University of Pennsylvania, the study is the largest initiative to improve hospital work environments. There are 10 US and 10 European hospitals participating in the study. Through a twinning model, US hospitals are paired with a "non-Magnet" hospital in Europe. The Magnet hospitals will be assisting the non-Magnet hospitals with supporting the redesign of work environments to improve clinician well-being through a learning collaborative. ECH has been paired with North Care Alliance NHS Group in Manchester, England. Participating in this research is a significant method for ECH to meet the Magnet standard related to nursing research participation requirements. The study will be conducted over a three-year period.

**Patient Experience**

El Camino Health has achieved the Healthgrades 2021 Outstanding Patient Experience Award™. This distinction places El Camino Health among the top 15 percent of hospitals nationwide for patient experience, according to Healthgrades, the leading marketplace that connects patients and providers.

For this annual analysis, Healthgrades evaluated 4,200 hospitals that submitted at least 100 patient experience surveys to the Centers for Medicare and Medicaid Services (CMS), covering admissions from January 2017 to December 2017. Of those hospitals evaluated, 417 hospitals outperformed their peers—based on their patients' responses—to achieve this award.

Healthgrades evaluates performance by applying a scoring methodology to ten patient experience measures, using data collected from a 27-question survey of the hospital's own patients. The survey questions focus on patients' perspectives of their care in the hospital. Question topics range from cleanliness and noise levels in patient rooms to medication explanations, and hospital staff responsiveness to patients' needs. The measures also include whether a patient would recommend the hospital to friends or family and their overall rating of the hospital.

**Ortho/Neuro/Spine**

Both El Camino Health hospitals' stroke programs were re-certified by the Joint Commission with favorable survey findings. The stroke program at Mountain View was re-certified for the first time as a thrombectomy-capable center and the stroke program in Los Gatos was re-certified as a primary stroke center. Both programs had fewer findings than during the previous certification cycle.

**Ambulatory Care (Silicon Valley Medical Development – SVMD)**

SVMD continues to operate the mass vaccine clinic in Sunnyvale, but the number of doses delivered, particularly first doses is tapering off. The site is scheduled to close at the end of June. El Camino Health has administered more than 44,000 doses of the Pfizer and Moderna vaccines to community members. We continue to work closely with community benefit organizations to vaccinate underserved and technically challenged populations. Clinic visits continue at an above average rate in May, but did not match the record set in March, in large part because of fewer business days in May. With support from Google, an El Camino Health mobile vaccine clinic initiated operations on June 7, and will continue operations as long as community demand warrants.

**Human Resources**

We launched our annual Employee □oice Survey in May as managers encouraged employee participation by reinforcing the message of “speak up, we’re listening.” As a result, El Camino Health achieved a high participation rate of □5 percent with results available in late June.

**Information Services**

California/Blue Shield’s MyTurn application and El Camino Health’s Epic system are now integrated for online vaccine scheduling and appointment communications. Te□t messages provide updates regarding appointment timeframes at the vaccination clinic locations.

The ability to share radiology images electronically from e□ternal organizations to El Camino Health has been implemented. This capability provides safe and efficient patient care by reducing the need for patients or organizations to manually transport files when a patient arrives at one of our facilities.

In an effort to facilitate efficiency and an improved work e□perience for our employees, ED Nurses are now able to access Epic on smartphone devices and receive important alerts via □ocera.

MyChart activation rates continue to improve with El Camino Health now ranking in the top 10th percentile of all Epic organizations regarding the timeliness of patient sign up once they receive the activation notice on their phone or via email.

**Marketing and Communications**

The new mother-baby health website pages following the mother’s pregnancy journey with easier to engage with call to actions launched. SEM □search engine marketing□advertising campaigns were optimized, linked to online scheduling, and e□panded for mother-baby health, oncology, Aspire program, emergency care □□G, M□□, cardiology, and primary care. New breast cancer outcomes report completed and posted on website.

Communications completed Spring Town Hall events with higher employee turnouts.

**Philanthropy**

El Camino Health Foundation held Taking Wing, a virtual spring celebration benefiting the Orchard Pavilion renovation and e□pansion. The event launched what is anticipated to be a three-year fundraising effort. Guests en□oyed virtual wine tasting presided over by a master sommelier and bid on silent auction packages, purchased raffle tickets and made online donations.

In May, the foundation received a □10,000 gift from a grateful patient for the new Nurse □eader Scholar Program (this donor’s largest gift to date□and a □□0,000 ma□or gift for the Chinese Health Initiative challenge. In early June, the foundation closed a □50,000 gift from Google.org for the mobile CO□ID-1□ vaccine clinic. This gift combined with a previously received □□5,000 private donation and corporate matching gift, will cover the first two months of the vaccine van’s operation.

**Corporate & Community Health Services**

Concern launched a new mindfulness solution partner and integrated the suite of services with Concern’s digital platform. The South Asian Heart Center has enrolled 22□ participants into the Aim to Prevent Diabetes program. Dr. Jane Lombard highlighted the Women’s Heart Center at a presentation to the CHI Advisory Council. CHI coordinated an event with the Scrivner Center on “Barriers to Seeking Mental Health Treatment.”

**Auxiliary**

The Au□iliary donated 1000 volunteer hours for the month of April.