

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

**Wednesday, September 14, 2022 – 5:30 pm**  
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040

PURSUANT TO GOVERNMENT CODE SECTION 54953(e) (1), EL CAMINO HEALTH WILL NOT BE PROVIDING A PHYSICAL LOCATION TO THE PUBLIC FOR THIS MEETING. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

**1-669-900-9128, MEETING CODE: 994-0528-9739# 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
<b>1. CALL TO ORDER/ROLL CALL</b>	Bob Rebitzer, Board Chair		<b>5:30 – 5:31 pm</b>
<b>2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Bob Rebitzer, Board Chair		<b>information 5:31 – 5:32</b>
<b>3. PUBLIC COMMUNICATION</b> a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.</i> b. Written Correspondence	Bob Rebitzer, Board Chair		<b>information 5:32 – 5:35</b>
<b>4. <u>FY22 ANNUAL BOARD ASSESSMENT</u></b>	Dan Woods, Chief Executive Officer George Anderson, Spencer Stuart		<b>discussion 5:35 – 5:50</b>
<b>5. MEDICAL STAFF REPORT</b>	Prithvi Legha, MD MV Chief of Staff		<b>information 5:50 – 6:05</b>
<b>6. <u>QUARTERLY QUALITY COMMITTEE REPORT</u></b>	Carol Somersille, MD Quality Committee Chair; Holly Beeman, MD Chief Quality Officer		<b>discussion 6:05 – 6:45</b>
<b>7. ADJOURN TO CLOSED SESSION</b>	Bob Rebitzer, Board Chair	<i>public comment</i>	<b>motion required 6:45 – 6:46</b>
<b>8. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Bob Rebitzer, Board Chair		<b>information 6:46 – 6:47</b>
<b>9. Health and Safety Code Section 32106(b) for a report and discussion involving health care facility trade secrets: YEAR IN REVIEW AND STRATEGY FORWARD</b>	Dan Woods, Chief Executive Officer		<b>discussion 6:47 – 7:02</b>
<b>10. Report involving Gov't Code Section 54957(b) and 54956.9(d) for discussion and report on personnel matters and conference with Legal Counsel: CEO REPORT</b>	Dan Woods, Chief Executive Officer		<b>discussion 7:02 – 7:12</b>
<b>11. Report involving Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management: EXECUTIVE SESSION</b>	Bob Rebitzer, Board Chair		<b>discussion 7:12 – 7:22</b>
<b>12. CONSENT CALENDAR</b> <i>Any Board Member may remove an item for discussion before a motion is made.</i>	Bob Rebitzer, Board Chair		<b>motion required 7:22 – 7:23</b>

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
<p><b><u>Approval</u></b>  <i>Gov't Code Section 54957.2:</i>            a. Minutes of the Closed Session of the Joint Hospital Board and Finance Committee (05/26/2022)            b. Minutes of the Closed Session of the Hospital Board (08/17/2022)  <b>Reviewed and Recommended for Approval by the Quality, Patient Care, and Patient Experience Committee</b>  <i>Health &amp; Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters:</i>            c. Credentialing and Privileges Report</p>			
<p><b>13. ADJOURN TO OPEN SESSION</b></p>	Bob Rebitzer, Board Chair		<p><b>motion required</b>  <b>7:23 – 7:24</b></p>
<p><b>14. RECONVENE OPEN SESSION/ REPORT OUT</b></p>	Bob Rebitzer, Board Chair		<p><b>information</b>  <b>7:24 – 7:25</b></p>
<p>To report any required disclosures regarding permissible actions taken during Closed Session.</p>			
<p><b>15. CONSENT CALENDAR ITEMS:</b>  <i>Any Board Member or member of the public may remove an item for discussion before a motion is made.</i></p>	Bob Rebitzer, Board Chair	<p><i>public comment</i></p>	<p><b>motion required</b>  <b>7:25 – 7:26</b></p>
<p><b><u>Approval</u></b>            a. <a href="#">Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings</a>            b. <a href="#">Minutes of the Open Session of the Joint Hospital Board and Finance Committee (05/26/2022)</a>            c. <a href="#">Minutes of the Open Session of the Hospital Board (08/17/2022)</a>            d. <a href="#">Exception to Physician Financial Arrangements Policy</a>            e. <a href="#">Neuro-Interventional Call Panel (MV)</a>  <b>Reviewed and Recommended for Approval by the Medical Executive Committee</b>            f. <a href="#">Policies, Plans, and Scope of Services</a>  <b><u>Information</u></b>            g. <a href="#">Article of Interest</a>  <b>Reviewed by the Finance Committee</b>            h. <a href="#">FY2023 Period 1 Financials</a></p>			
<p><b>16. CEO REPORT</b>            a. <a href="#">Update</a>            b. <a href="#">Pacing Plan</a></p>	Dan Woods, Chief Executive Officer		<p><b>information</b>  <b>7:26 – 7:36</b></p>
<p><b>17. BOARD COMMENTS</b></p>	Bob Rebitzer, Board Chair		<p><b>information</b>  <b>7:36 – 7:39</b></p>
<p><b>18. ADJOURNMENT</b></p>	Bob Rebitzer, Board Chair	<p><i>public comment</i></p>	<p><b>motion required</b>  <b>7:39 – 7:40 pm</b></p>

**Upcoming Regular Meetings:** October 12, 2022; November 9, 2022; December 7, 2022; February 15, 2023; April 5, 2023; May 10, 2023; June 14, 2023

**Special Sessions:** January 18, 2023 (Joint Board and Committee Education); March 8, 2023 (Board Retreat)

# El Camino Health Board Survey

August 2022

Prepared for the El Camino Health Governance Committee

# Board Review Process

- » Spencer Stuart was engaged by the Chief Executive Officer of El Camino Health to assist with a survey-based review of the board's effectiveness.
- » The online survey was open from August 13 – 23, 2022. All Board Members (10) completed the survey in that timeframe. The survey results are presented on an unattributed basis in this report.
  - Questions about the Board as a whole have an “n” of 10.
  - Individual Committee questions were only answered by Board Members on those Committees:
    - Compliance and Audit, “n” = 3
    - Finance, “n” = 4
    - Investment, “n” = 2
    - Executive Compensation, “n” = 2
    - Governance, “n” = 3
    - Quality, Patient Care and Patient Experience, “n” = 4
- » Participants were asked to answer a series of questions on a 4-point Likert scale, where a rating of “1” indicates strong disagreement and a rating of “4” indicates strong agreement. Participants were also given the option to respond “N/A”, indicating “no opportunity to observe.”
- » This report will be reviewed by the Governance Committee at its August 31, 2022 meeting.

# Survey Findings

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# Strengths and Opportunity Areas

The highest and lowest rated items by the Board about the Board as a collective. Scores were given on a 1-4 scale, from “Strongly Disagree” to “Strongly Agree.”

Area of Strength	Avg. Score	Opportunity Area	Avg. Score
Aggregated responses on individual contributions to the board (see page 23).	3.84	The Board actively plans for its own succession including identifying potential appointed board members and committee members and developing a pipeline of potential candidates who are qualified based on defined criteria.	2.4
The Board has an effective working relationship with the Chief Executive Officer and leadership team.	3.8	The Board frequently evaluates the organization's performance in relation to community healthcare needs.	2.7
Board Members receive meeting notices, written agendas, minutes and other appropriate materials well in advance of meetings with appropriate time to review and prepare for meetings.	3.6	During the course of the year, the Board effectively monitors performance against its goals and provides feedback regarding any needed course correction, including through regular reports of the appropriate committees tasked with specific oversight responsibilities.	3
The Board and executive management exhibit mutual trust and respect and foster transparency in the working relationship.	3.5	Board members are organized properly into appropriate committees based on background and expertise of each member.	3
The Board effectively assesses the organization's financial performance in relation to its goals.	3.5	The Board is composed of members with optimal subject matter expertise and appropriate competencies.	3
The Board has a defined procedure in place for establishing the Chief Executive Officer's yearly objectives.	3.5	Board Members possess strong communication skills, knowing when to listen and when to speak up.	3
The Board, through its committees, also provides effective oversight in the key areas of Compliance and Audit; Finance; Investment; Executive Compensation; Governance; Quality, Patient Care and Patient Experience.	3.5		
The organization's strategic planning processes are effective, and the Board provides appropriate input into the strategic planning process, taking into account all key stakeholders.	3.5		

Note: Given the small sample size of individual Committee responses, average scores for those corresponding questions are not included in the above summary. Please see pages 17 - 22 for each committee.

# Areas of Most Agreement

## Distribution

The Board has an effective working relationship with the Chief Executive Officer and leadership team.



Board Members honor the professional boundaries between governance and management.



Board materials contain information at the appropriate level of detail and are aligned with the board's governance responsibility.



Board Members engage in productive and meaningful discussion.



Board meetings focus on appropriate topics, such as areas of oversight and related Board education.



The Board has established procedures to effectively oversee quality.



Strongly disagree Disagree Agree Strongly agree

# Areas of Least Agreement

Distribution

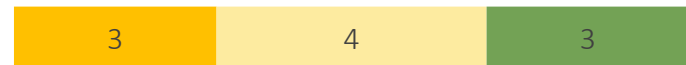
The Board actively plans for its own succession including identifying potential appointed board members and committee members and developing a pipeline of potential candidates who are qualified based on a defined criteria.



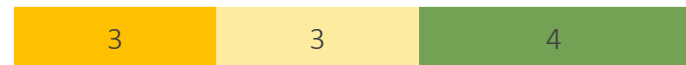
The Board frequently evaluates the organization's performance in relation to community healthcare needs.



Board Members are organized properly into appropriate committees based on background and expertise of each member.



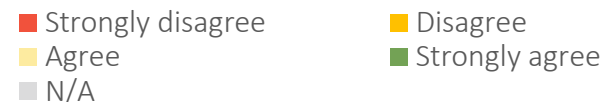
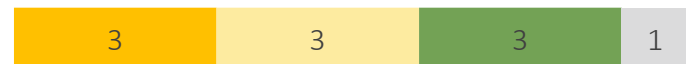
The Board membership comprises diversity of thought, experience, gender, race and ethnic representation, and perspective in order to add greater value to the Board's deliberations.



The time commitment board members are asked to make is reasonable and appropriate for fulfilling our duties.

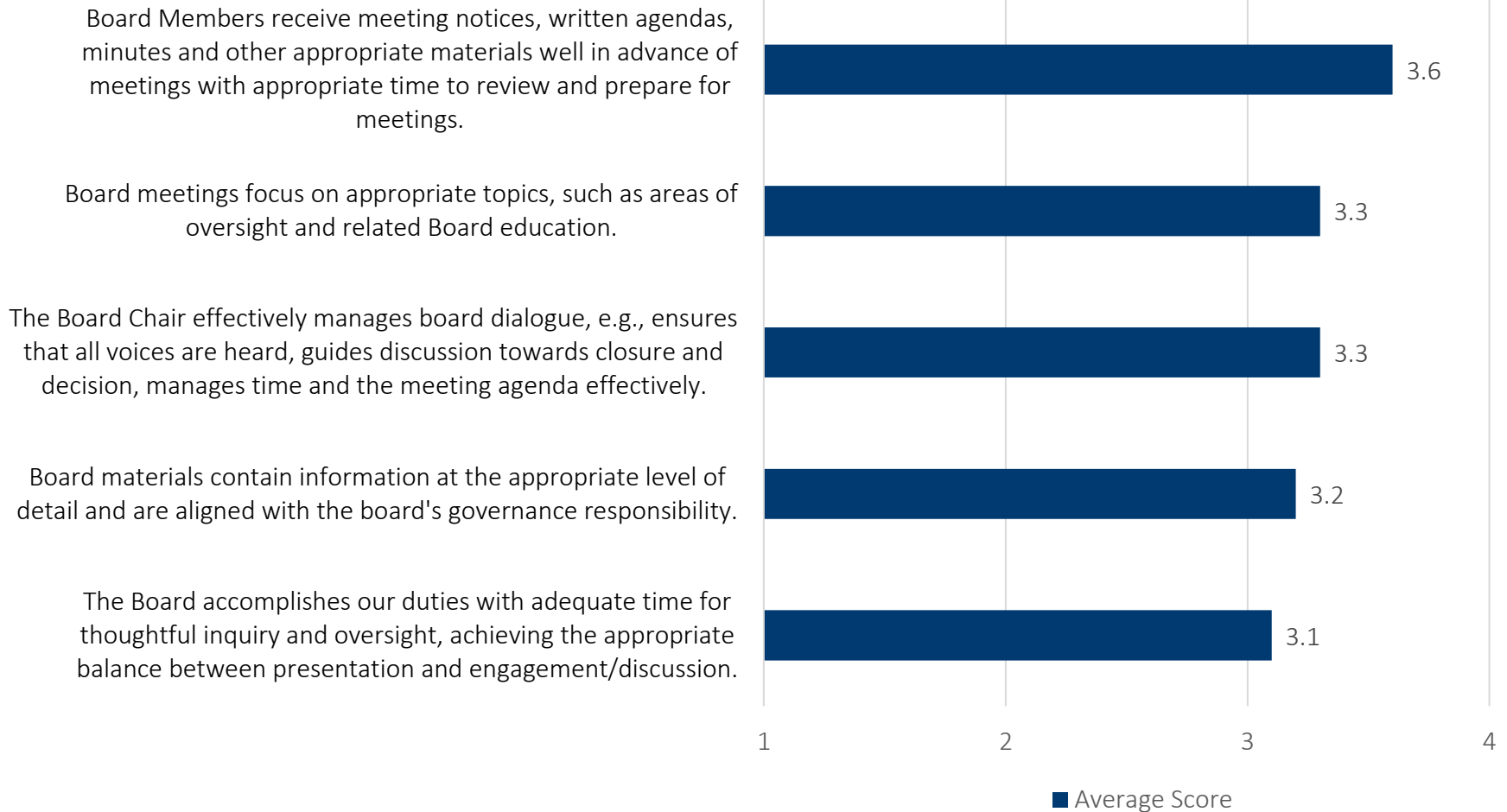


The Board effectively monitors performance against its goals and provides feedback regarding any needed course correction, including through regular reports of the appropriate committees tasked with specific oversight responsibilities.





# Board Meetings



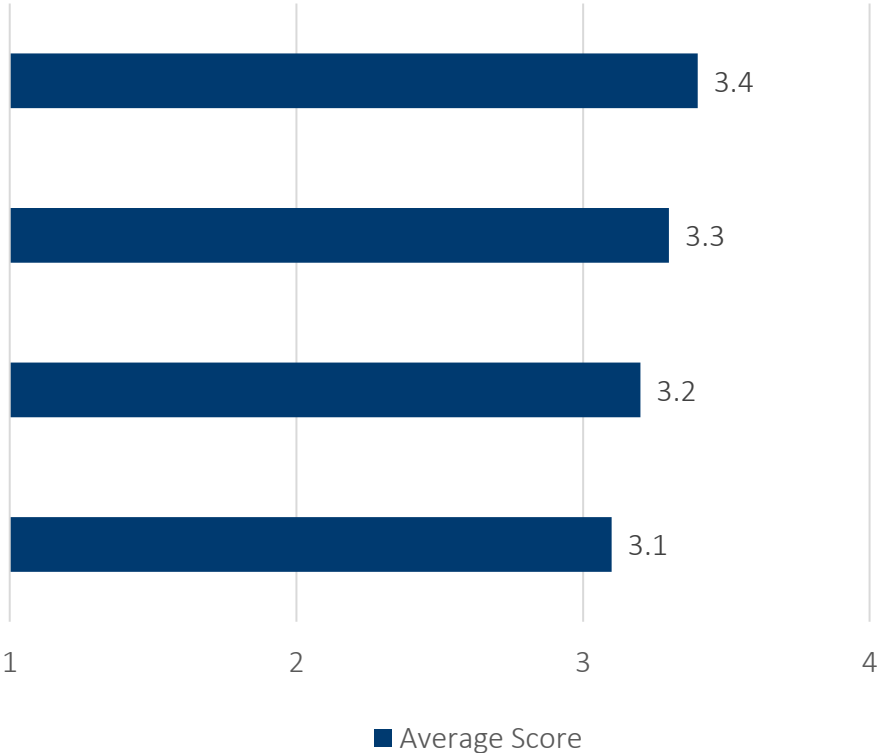
# Board Role

The Board makes appropriate adjustments and effectively exercises its judgement in unique circumstances, such as the COVID-19 pandemic.

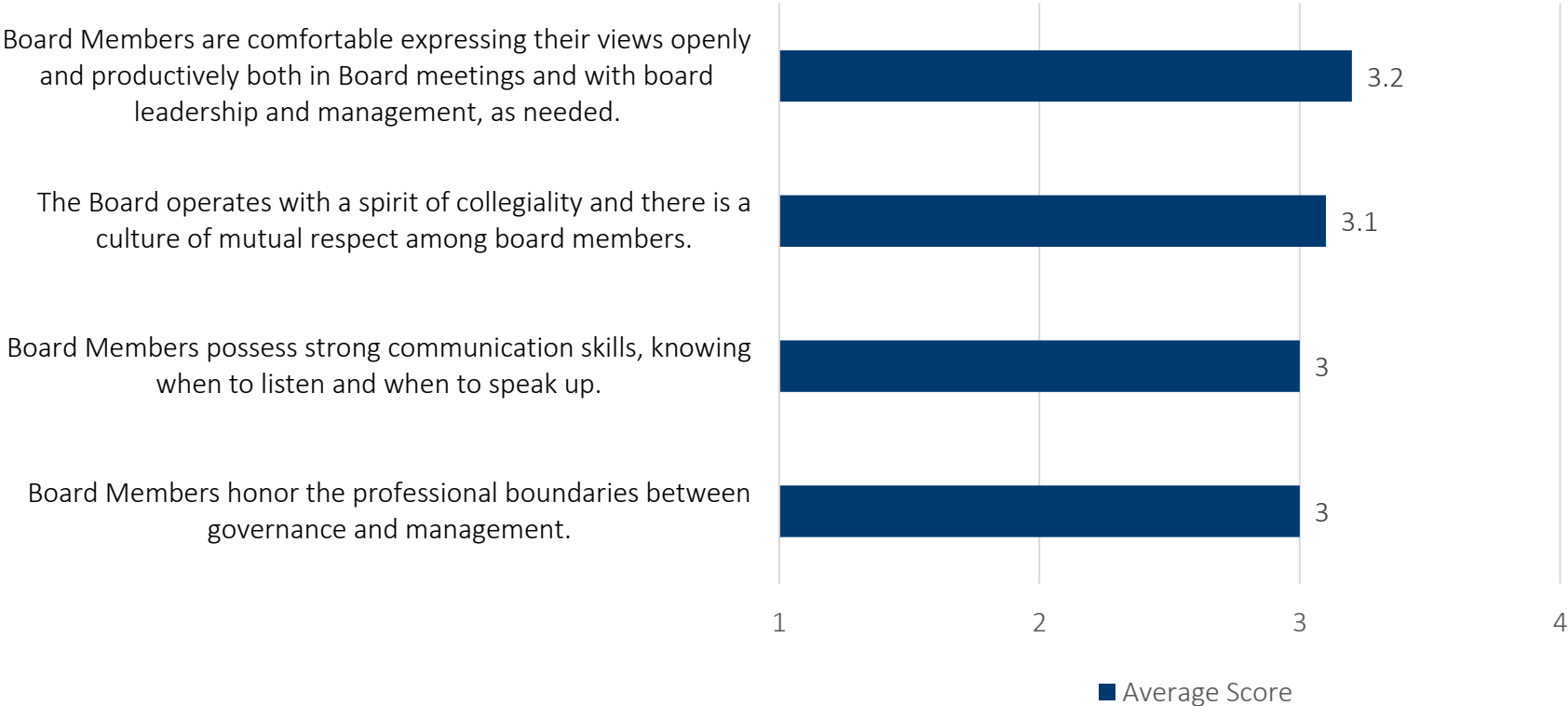
The expectations for board service are clearly articulated and well understood by board members.

Board Members engage in productive and meaningful discussion.

The time commitment Board Members are asked to make is reasonable and appropriate for fulfilling our duties.



# Board Culture and Dynamics

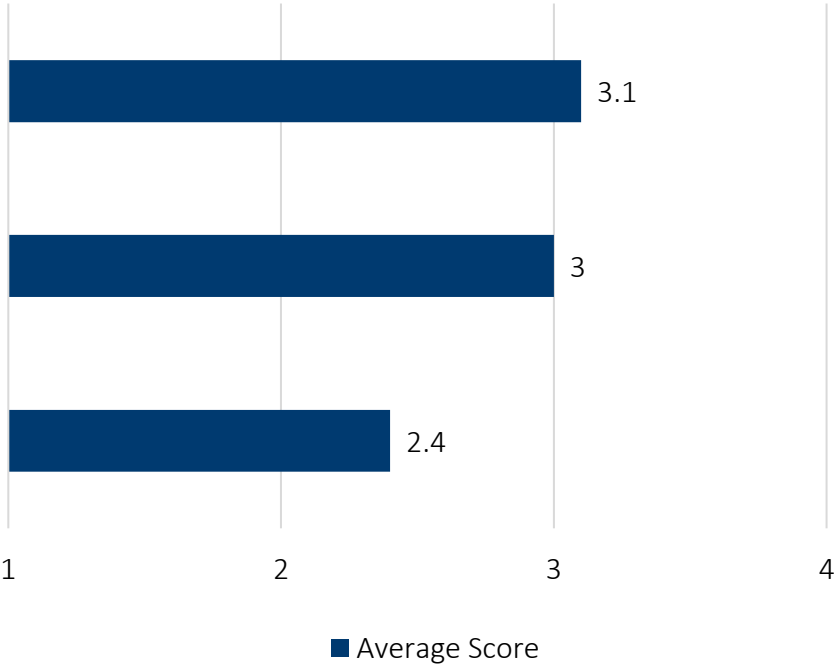


# Board Skills, Experiences, and Attributes Including Diversity

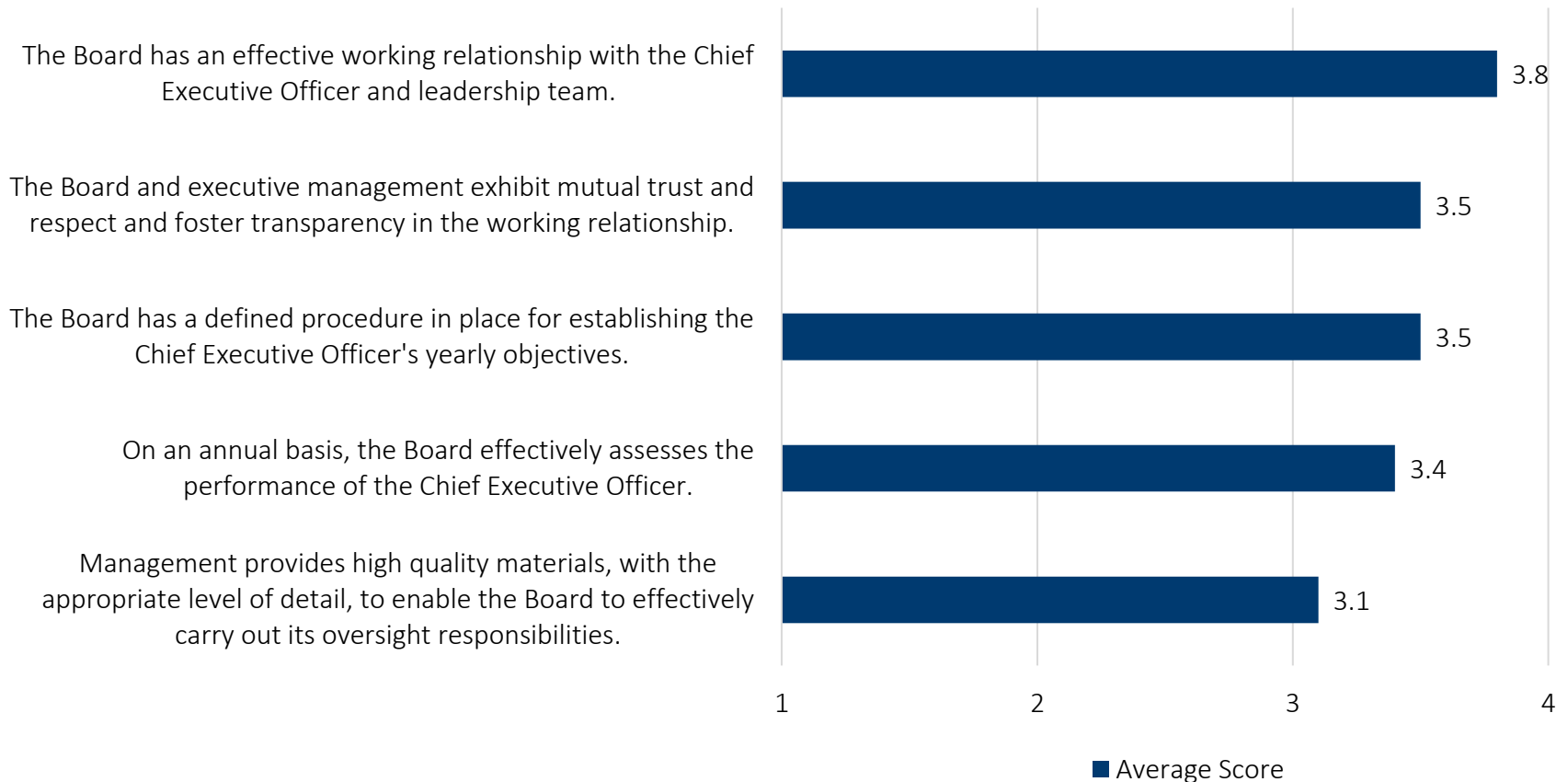
The Board membership comprises diversity of thought, experience, gender, race and ethnic representation, and perspective in order to add greater value to the Board's deliberations.

The Board is composed of members with optimal subject matter expertise and appropriate competencies.

The Board actively plans for its own succession including identifying potential appointed board members and committee members and developing a pipeline of potential candidates who are qualified based on defined criteria.



# Relationship with Management



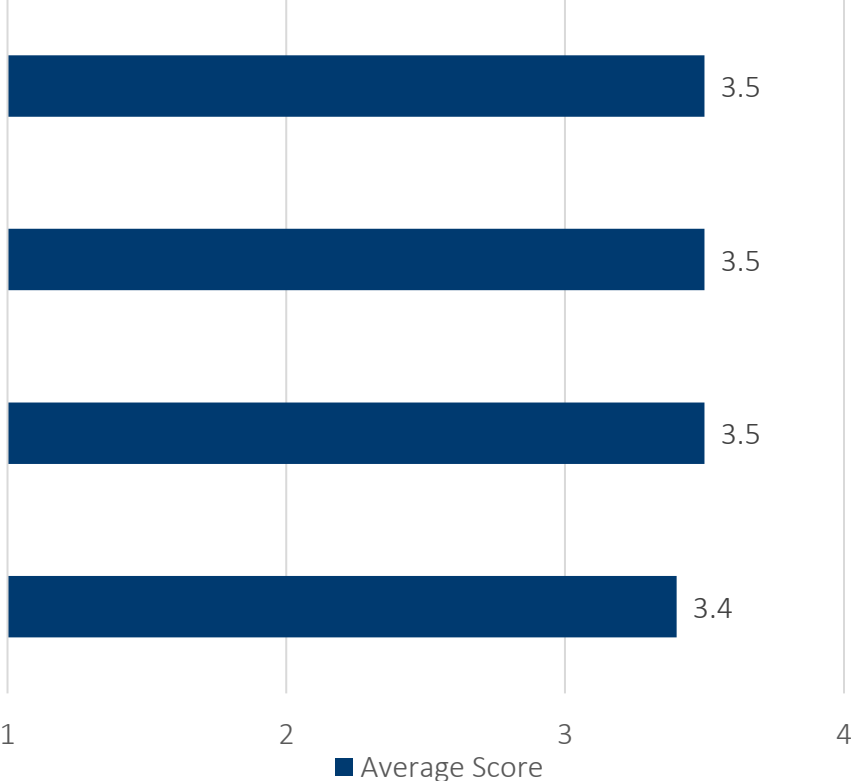
# Execution of Board's Oversight Responsibilities

The organization's strategic planning processes are effective, and the Board provides appropriate input into the strategic planning process, taking into account all key stakeholders.

The Board effectively assesses the organization's financial performance in relation to its goals.

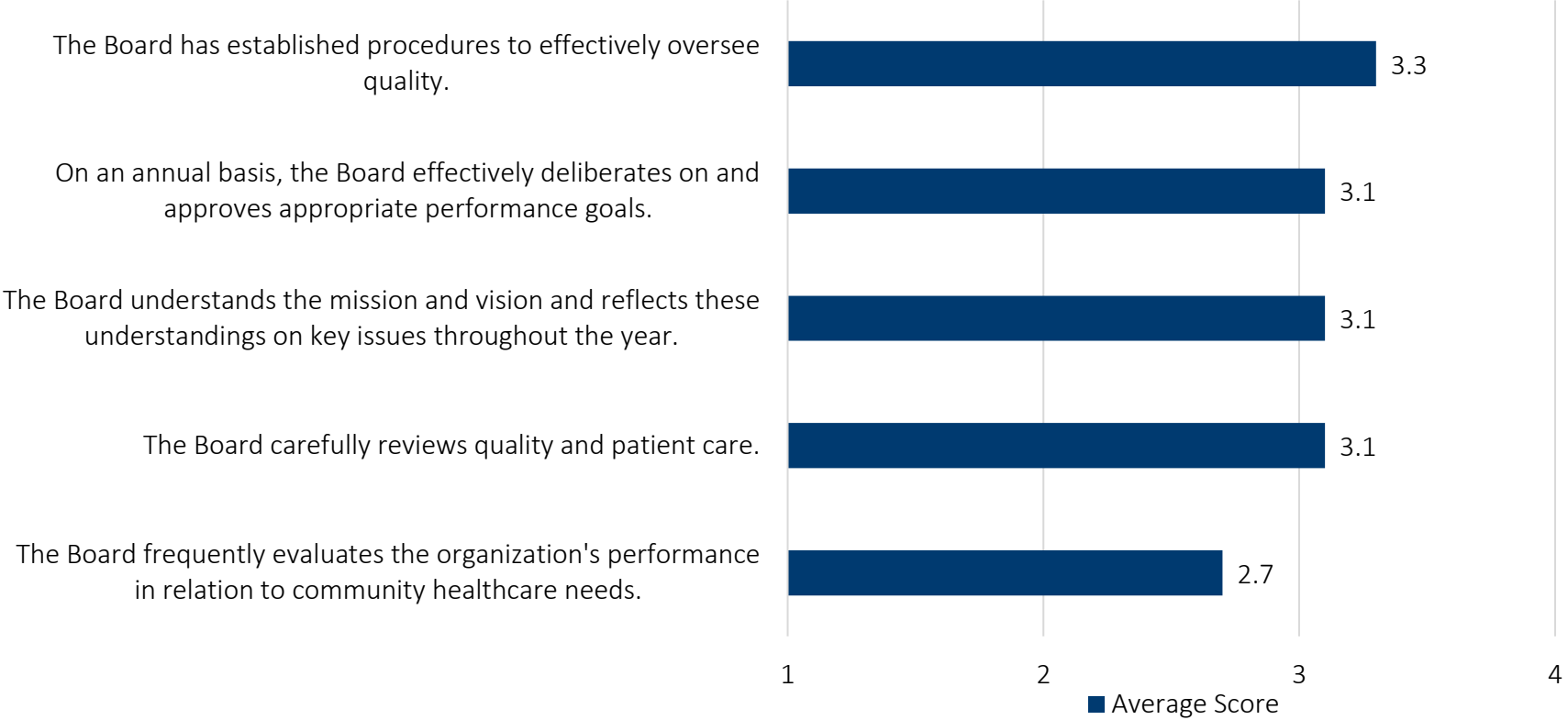
The Board, through its committees, also provides effective oversight in the key areas of Compliance and Audit; Finance; Investment; Executive Compensation; Governance; Quality, Patient Care and Patient Experience.

The Board has an effective mechanism in place for resolving potential conflicts of interest.

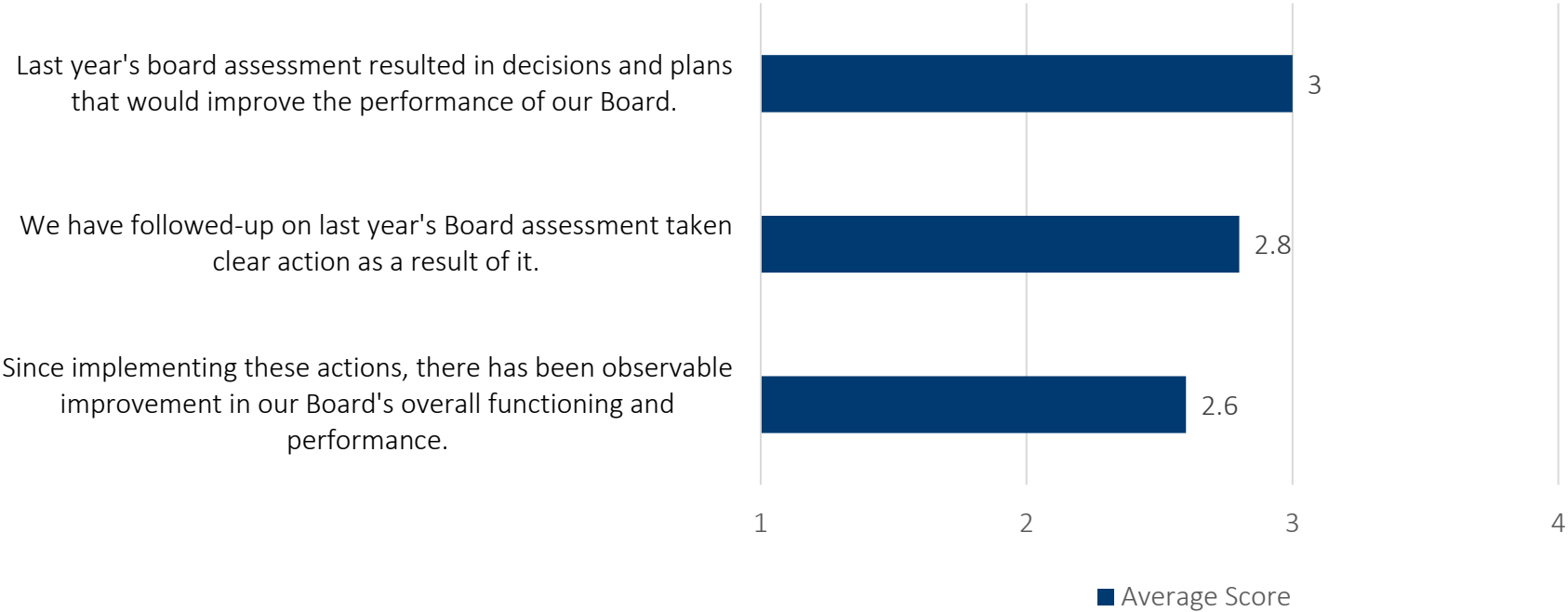




# Execution of Board's Oversight Responsibilities, continued



# Reflections on 2021 Board Assessment



# Committee Results in the Appendix

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

**To:** El Camino Hospital Board of Directors  
**From:** Carol Somersille, MD, Chair  
Holly Beeman, MD, MBA, Chief Quality Officer  
**Date:** September 6, 2022 (Date of Quality Committee Meeting)  
**Subject:** Quality, Patient Care, and Patient Experience Committee

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

**Summary:**

- I. Consent calendar items--The committee members approved the consent calendar;
  - a. Minutes of the open session of the Quality Committee Meeting (6/6/2022)
  - b. Report on board actions
  - c. FY23 Enterprise Quality Dashboard
  - d. Progress against FY23 Committee Goals
  - e. Quality Committee follow-up items
  
- II. Chair's Report
  - a. Dr. Somersille encouraged in-person participation of Committee Members, and underscored that most effective communication and collaboration is nonverbal and occurs in person.
  
- III. Patient Story
  - a. Cheryl Reinking shared feedback from a patient's written feedback in the Press Ganey survey. The patient expressed frustration with the care she received for a skin infection. After being seen by her PCP and then in Urgent Care, she felt her condition was not improving. She was referred to LG Emergency Dept from Urgent Care. Once in the ED, the patient felt she received excellent care. "All I can say is El Camino hospital and the ER team restored my faith in the medical community." Committee members discussed how this feedback underscores our opportunities to better coordinate and escalate care within our enterprise.
  
- IV. Patient Experience
  - a. Christine Cunningham, Chief Experience Officer, presented a review of our patient experience performance focusing on three topics; Today's patients, FY22 performance, and focus for FY23. Please see attached document "Patient Experience Review."
  
- V. High-Reliability Update
  - a. Dr. Mark Adams provided an update on the deployment of High Reliability. The acronym "SAFETY" is the framework for training staff on the tools utilized in our HRO journey.
    - S—"Speak up for safety"
    - A—"Accurate communication"
    - F—"Focus on the task"
    - E—"Embrace a questioning attitude"
    - T—"Take thoughtful action"
    - Y—"You and me together"
  
- VI. Health Equity Metrics
  - a. Dr. Holly Beeman facilitated a discussion on Health Equity and provided recommendations for metrics to track our progress providing equitable and high-quality care to our patients. A three-step process is in progress. Step 1; identify where disparities exist across patients. Step 2; direct resources to intervene and address disparities. Step 3; measure and monitor progress towards achieving health equity.
  - b. Based on a review of the medical literature and best practices defined by WHO (World health organization), CDC (centers for disease control), IHI (Institute for healthcare improvement), AHA (American Hospital Association, the following four categories of information will be collected from our patients.

September 6, 2022 Quality Committee

1. REAL—race, ethnicity, language
  2. SDOH—Social determinants of health; transportation, employment, financial security, housing, access to nutritional food.
  3. SOGI—sexual orientation, gender identity
  4. Ability—hearing, sight, mobility, cognitive functions
- c. The process and method of who, where and when this information will be collected will be codified.

**Attachment:**

1. [Patient experience review](#)

**EL CAMINO HOSPITAL BOARD QUALITY COMMITTEE  
BOARD MEETING MEMO**

**To:** El Camino Hospital Board Quality Committee  
**From:** Holly Beeman, MD, MBA – Chief Quality Officer  
**Date:** September 14, 2022  
**Subject:** Readmission Index Improvement

1. Situation: During the August 2022 Quality Report, the quarterly Quality STEEEP dashboard was reviewed. The board requested a presentation describing our performance improvement process to improve patient care when a particular quality indicator is not meeting targets. Dr. Beeman will share with the board the process, approach and teams engaged in decreasing hospital readmissions.

2. Background:

The 30-day all cause hospital readmission index was an organization goal in Fiscal Year 2022. The FY22 target for readmissions was to achieve an index of 0.92. This was not achieved. Our ECH FY22 index was 1.05. This metric is a measure of the quality of care provided in the hospital and how care is coordinated for our patients beyond hospital discharge. A review of our data shows that the care quality part of this equation is consistent and excellent. Thus, our improvement focus is to better understand the unique needs of our patients around discharge transition handoffs and post-acute coordination support.

**List of Attachments:**

1. [Readmission Improvement presentation](#)





## **ECH Readmissions Index Performance Improvement**

*Holly Beeman, MD, MBA, Chief Quality Officer*

*September 14, 2022*

# Situation

## Fiscal Year 2022

More patients than expected are being readmitted compared to prior years (risk-adjusted)

**FY22 Readmission Index Target = 0.92**

**Month of May 2022 = 1.10**

**FY22 Readmission Index YTD = 1.05**

## Readmission Index--Measure Definition

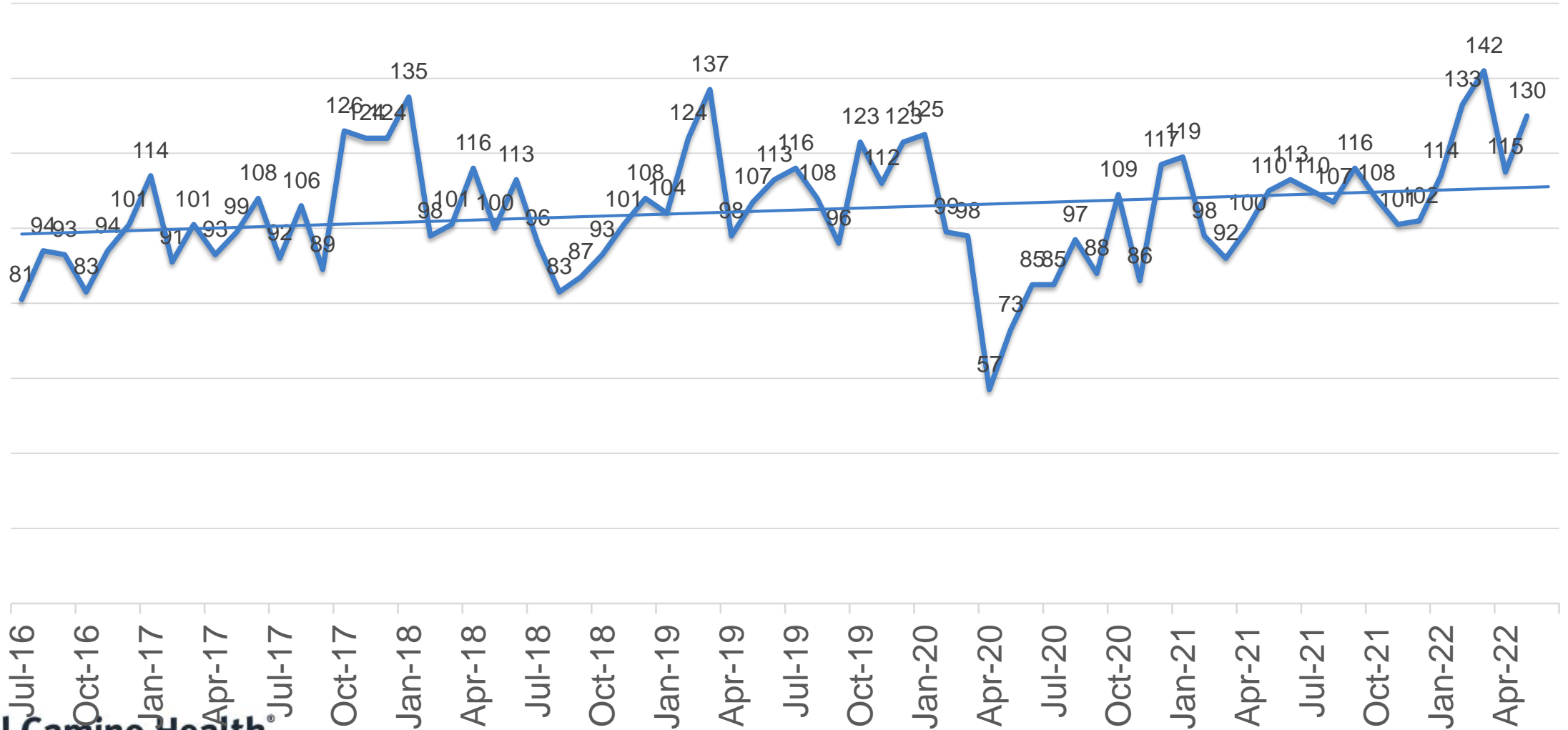
The outcome for this measure is unplanned all-cause 30-day readmission after an admission for any condition.

A readmission is a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission.

Any readmission is eligible to be counted as an outcome except those that are considered planned.

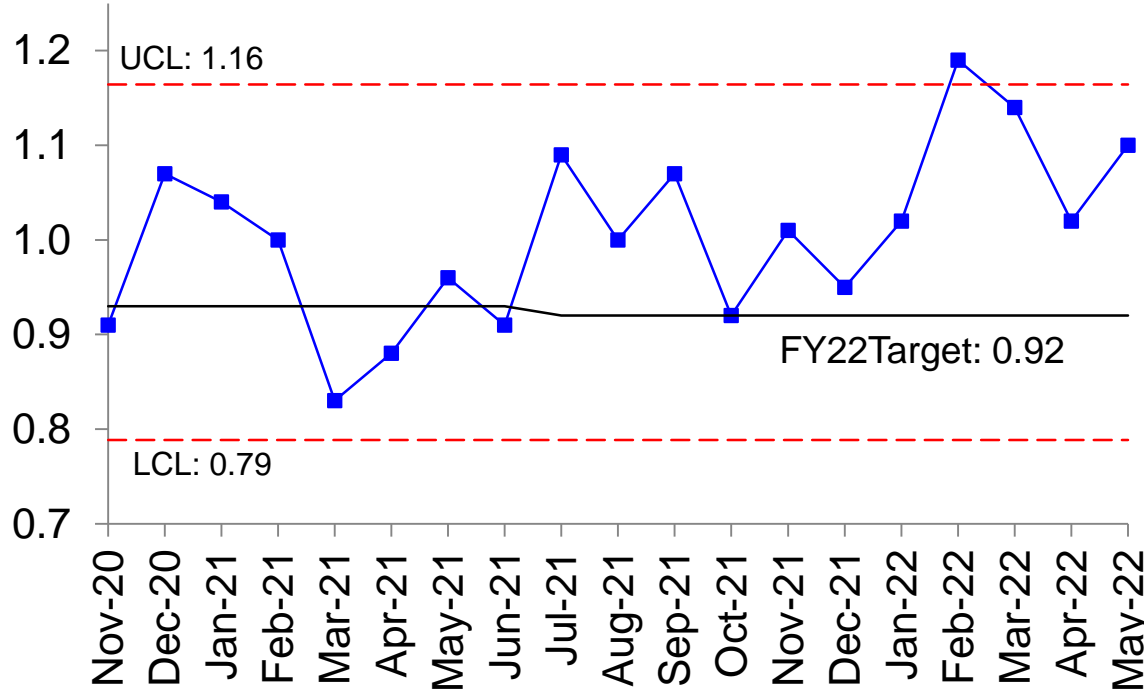
# El Camino Health performance

## Number of Patients Readmitted per Month

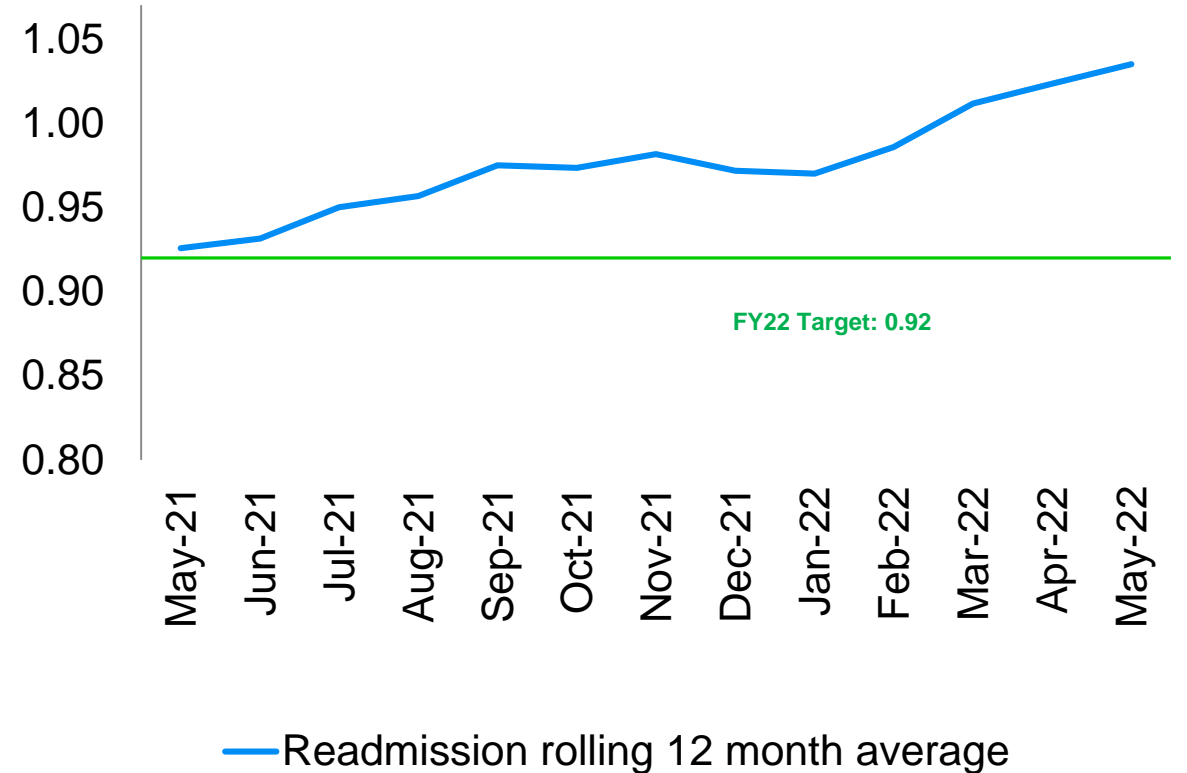


# Readmission Observed/Expected Index Trends

Trend

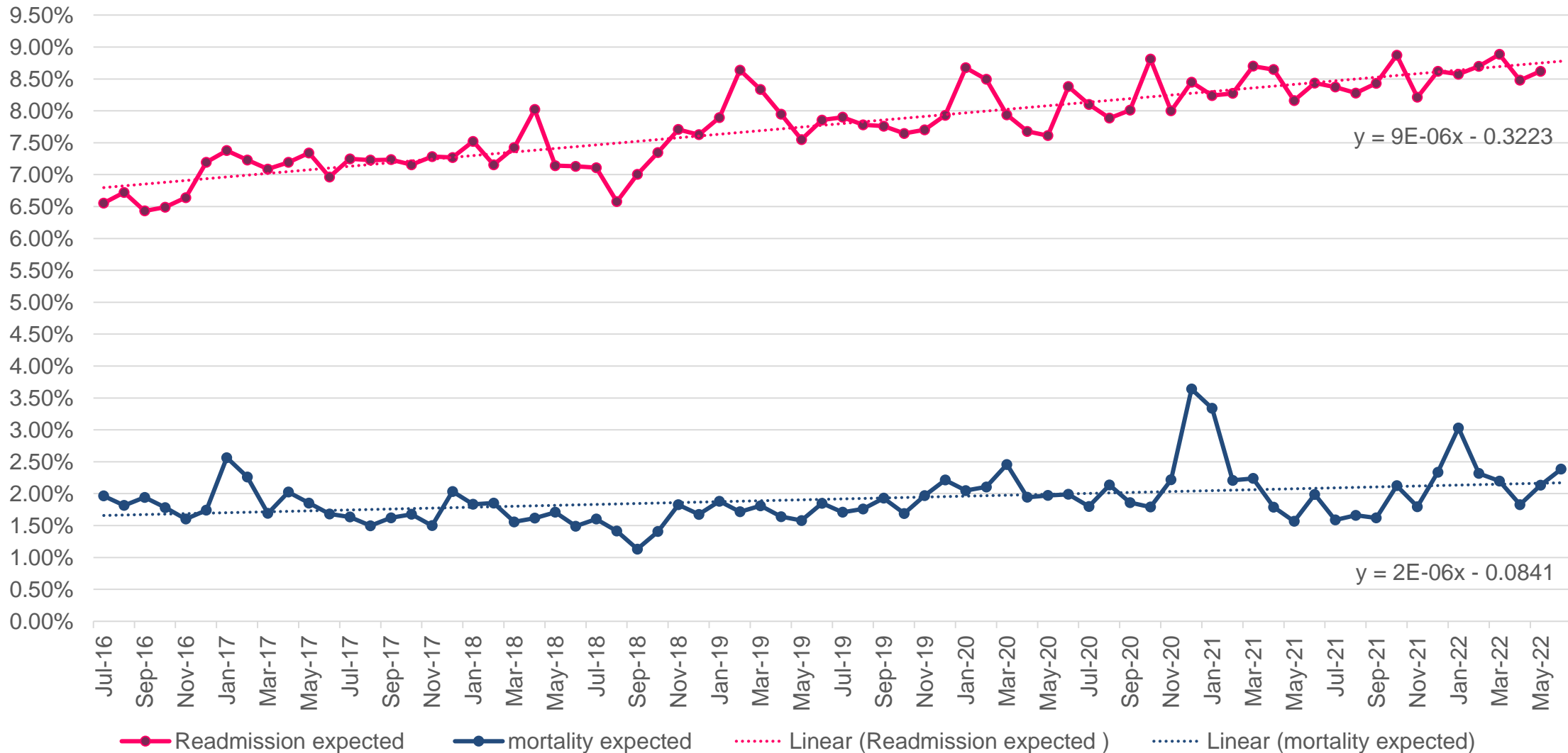


Rolling 12 Month Average

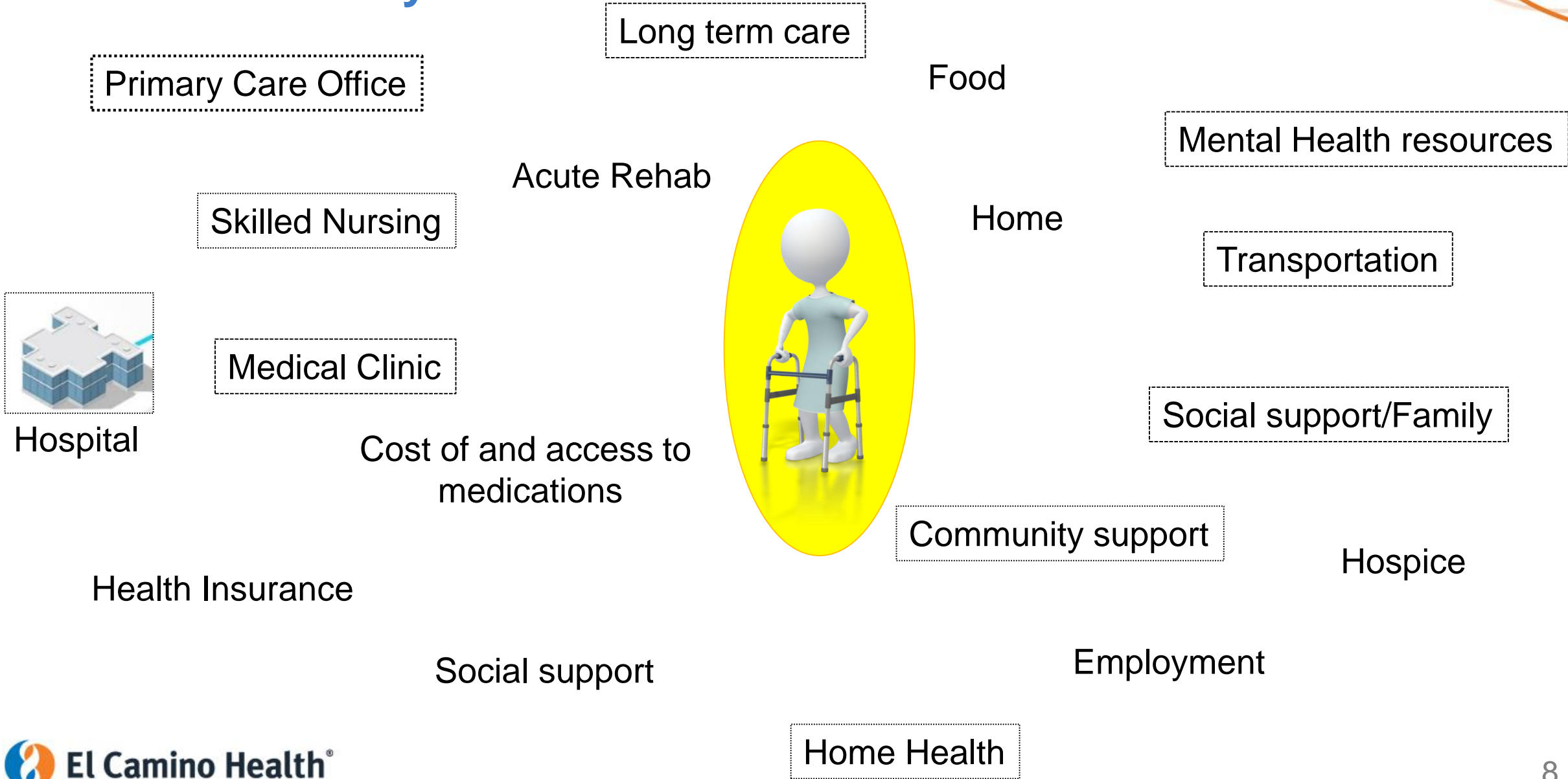




# Mortality and Readmissions "Expected Rate" Trends ECH 2016-2022



# Healthcare Ecosystem



# Why this matters?




**Important**

~20% preventable

# Performance Improvement Efforts

Index Admission

An elderly woman with white hair is lying in a hospital bed, looking towards the camera with a slight smile. The background is a plain, light-colored wall.

Post Acute

A small, two-story house with a red exterior and a white roof. The house has several windows and a chimney.

E.D.

The entrance to an emergency department, featuring a red sign above the glass doors that reads "EMERGENCY". The doors have the El Camino Health logo on them.



# Index Admission

- Inpatient stay
  - Disease/condition education
  - Medication reconciliation and education
  - Care-giver identification and collaboration
  - Begin discharge planning at time of admission
  - Goals of care discussion
  - Palliative care consultation (if appropriate)
- Discharge
  - Timing and location of discharge = clinically appropriate
  - **Discharge education of patient and their care-giver**
  - **Warm hand off and sharing of information with primary care team, and, accepting facility**



- Discharge education of patient and their care-giver
  - Plan
    - » Observe and audit discharge patient teaching on units
    - » Compare to best practices (Project RED)
  
- Warm hand off and sharing of information with primary care team, and, accepting facility—
  - Plan
    - » Assess current state of readmission rate by SNF
    - » Evaluate current state of SNF/ECH collaboration and communication



## Post-Acute

What are the transitional needs from inpatient to outpatient care for patients based on specific populations?

Based on detailed review, slicing and dicing of ECH readmission data, these four populations require further study to understand WHY they are being readmitted

- Patients readmitted for less than 48 hours
- Alcohol/drug dependence
- Vulnerable population (patients with => 4 hospital admissions per 12 months)
- Sepsis





# Post Acute patient outreach and support

## Possible solutions to support patients after discharge

1. Complex care clinic
2. Medication compliance support
3. Patient phone calls and out reach (Conversa, Cipher)
4. Connect at Home
5. Outpatient hospice
6. Home grown virtual post acute care staffed by nurse (local vs remote)



# What is happening in the SNFs?

1. Staffing
  1. Less experienced staff quicker to readmit
  2. Decrease in compliance with patient care standards
  
2. Resource constrained
  1. Sitters
  2. PPE
  3. Infection prevention experts, training, presence

(Hypotheses, not confirmed with data)



# Patients not able to be 'home' come to the ED

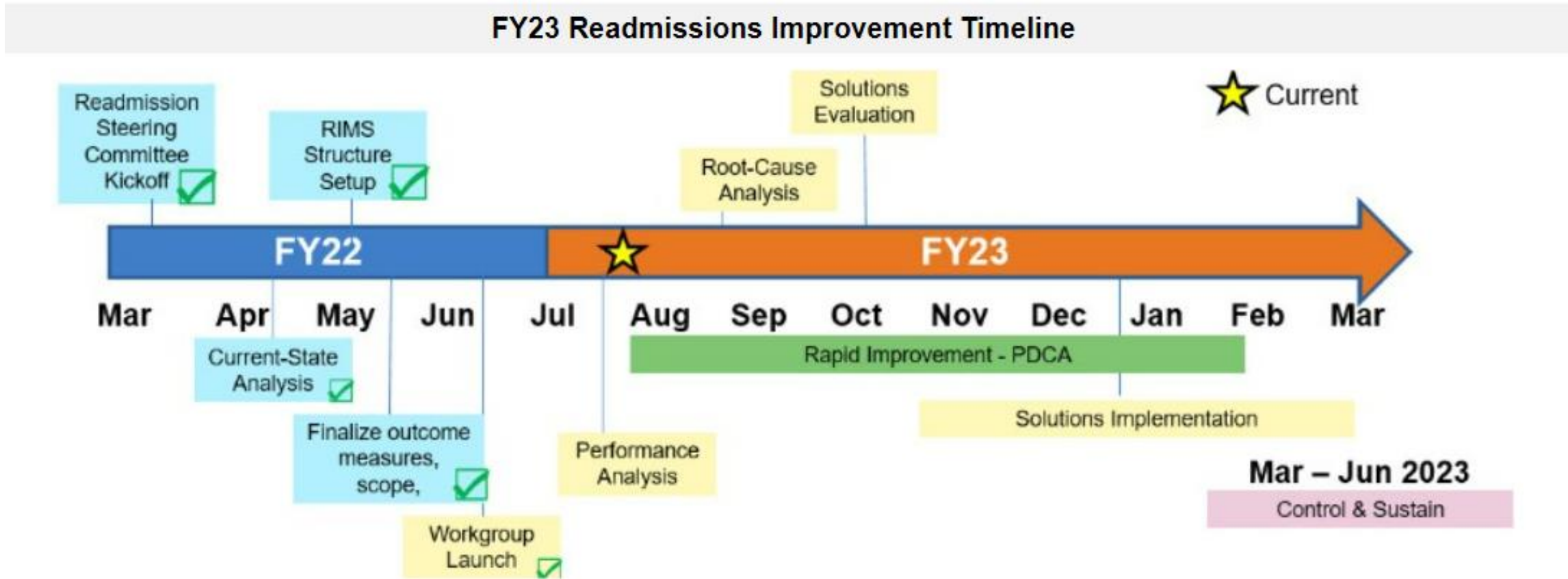
## 1. Goal

Intervene BEFORE a patient (their caregivers) feel the best choice is to return to the ED

## 2. Decision making support in the ED

1. Medical vs social support gaps
2. Social work for patients with substance abuse
3. Case management staffing
4. Evaluation and adjustment of patients admitted to observation vs inpatient
5. Automatic palliative care consultation ordered in ED?

# Plan Review



## Discussion....

*"...the secret of the care of the patient  
is in caring for the patient."*

Francis Peabody, MD (1881-1927)

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

**To:** El Camino Hospital Board of Directors  
**From:** Mary Rotunno, General Counsel  
**Date:** September 14, 2022  
**Subject:** Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings

**Recommendation:**

To continue the determination made by the Board of Directors at its meeting on October 13, 2021, in Resolution 2021-10 acknowledging that there still exists a state of emergency due to the COVID-19 pandemic and to continue the findings by the Board of Directors to allow continued public participation by teleconference in Board and Advisory Committee meetings in accordance with the recommendation of the Santa Clara County Health Officer.

**Summary:**

1. **Situation:** At the October 13, 2021 Board Meeting, the Board of Directors adopted Resolution 2021-10, which made findings to continue holding virtual public meetings under the Ralph M. Brown Act based on the continued state of emergency due to the COVID-19 pandemic and that either (a) the state of emergency continues to directly impact the ability to meet safely in person, or (b) state or local officials continue to impose or recommend measures to promote social distancing.

This Resolution relies on the September 21, 2021, recommendation by the Health Officer of the County of Santa Clara that public bodies continue to meet remotely due to their unique characteristics, such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to fully participate in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other recommendations at such meetings.

2. **Authority:** On March 17, 2020, in response to the COVID-19 pandemic, Governor Newsom issued Executive Order N-29-20, suspending specific provisions of the Brown Act in order to allow local legislative bodies to conduct meetings telephonically or by other means. On June 11, 2021, Governor Newsom issued Executive Order N-08-21, which placed an end date of September 30, 2021, for agencies to meet remotely.

On September 16, 2021, Governor Newsom signed Assembly Bill 361 (2021) ("AB 361"), which allows for local legislative and advisory bodies to continue to conduct meetings via teleconferencing if the Board of Directors, by majority vote, makes the findings set forth in paragraph 1 above, not later than thirty (30) days after teleconferencing for the first time under the AB 361 rules, and every 30 days thereafter.

3. **Legal and Compliance Review:** ECH, outside counsel at Best Best & Krieger, LLP ("BB&K"), reviewed the legislation and prepared Resolution 2021-10.

**Attachment:**

1. Resolution 2021-10 - Resolution of the Board of Directors of El Camino Hospital Making Findings and Determinations Under AB 361 for Teleconference Meetings.

**RESOLUTION 2021-10**

**RESOLUTION OF THE BOARD OF DIRECTORS OF  
EL CAMINO HOSPITAL  
MAKING FINDINGS AND DETERMINATIONS  
UNDER AB 361 FOR TELECONFERENCE MEETINGS**

WHEREAS, all meetings of the El Camino Hospital's Board of Directors and Advisory Committees are open and public, as required by the Ralph M. Brown Act (Cal. Gov. Code §§ 54950 – 54963), so that any member of the public may attend, participate, and watch the Board of Directors and its Advisory Committees conduct their business;

WHEREAS, such meetings ordinarily take place on the campus of the Hospital, located at 2500 Grant Road, Mountain View, California, 94040, in the County of Santa Clara;

WHEREAS, ordinarily, the Ralph M. Brown Act imposes certain requirements on local agencies meeting via teleconference;

WHEREAS, the Legislature recently enacted Assembly Bill 361 (AB 361), which amended Government Code section 54953 to allow local agencies to use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) of section 54953 of the Government Code if the legislative body holds a meeting during a proclaimed state of emergency and determines by majority vote that, as a result of the emergency, either (a) meeting in person would present imminent risks to the health and safety of attendees, or (b) state or local official continue to impose or recommend measures to promote social distancing;

WHEREAS, the Governor issued a proclamation declaring a state of emergency on March 4, 2020 due to the COVID-19 pandemic, pursuant to section 8625 of the California Emergency Services Act, and this proclaimed state of emergency currently remains in effect;

WHEREAS, on August 2, 2021, in response to the Delta variant, the Health Officer of the County of Santa Clara ordered all individuals to wear face coverings when inside public spaces;

WHEREAS, on September 21, 2021, the Health Officer of the County of Santa Clara issued a recommendation that public bodies continue to meet remotely due to their unique characteristics, such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to fully participate in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other recommendations at such meetings;

WHEREAS, AB 361 requires compliance with separate procedures for teleconference meetings during a state of emergency, found in subdivision (e) of Government Code section 54953;

WHEREAS, AB 361 requires that the legislative body using the teleconferencing procedures of AB 361 make renewed findings by majority vote, not later than every thirty (30) days, that the legislative body has reconsidered the circumstances of the state of emergency, and that either (a) the state of emergency continues to directly impact the ability of the members to meet safety in person,

or (b) state or local officials continue to impose or recommend measures to promote social distancing;

WHEREAS, the Board of Directors of the Hospital desires to make findings and determinations for meetings of the Board of Directors and its Advisory Committees consistent with AB 361 to utilize the special procedures for teleconferencing provided by AB 361 due to imminent risks to the health and safety of attendees, as well as Hospital staff and patients;

WHEREAS, in response to the COVID-19 pandemic, Hospital staff has set up hybrid in-person/teleconference public meetings, whereby members of the Board of Directors and Advisory Committee members and staff that can attend the meeting in-person on the campus of the Hospital can do so, while members of the public have the full ability to observe and comment on the meetings off-campus through the Hospital's virtual meeting platforms;

WHEREAS, the Board of Directors fully supports the public's right to participate in all meetings of the Board of Directors and its Advisory Committees, but acknowledges that it cannot require members of the public who wish to attend meetings in-person to submit proof of vaccination or negative test results;

WHEREAS, it is important that the Board of Directors ensure that Board members, Advisory Committee members and Hospital staff have a safe workplace and Hospital patients have a safe environment to receive care, to the maximum extent possible; and

WHEREAS, the Board of Directors desires to balance the rights of members of the public to participate in meetings of the Board of Directors and its Advisory Committees with the rights of the Board of Directors, Advisory Committee members and Hospital staff to conduct the meetings in a safe environment.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of El Camino Hospital, that:

1. The Board of Directors finds and determines that, as a result of the COVID-19 pandemic emergency, meetings of the Board of Directors and its Advisory Committees in which the public attends in-person on the campus of the Hospital would present imminent risks to the health and safety of the Board of Directors, Hospital staff, members of the public and patients of the Hospital.
2. The Board of Directors finds and determines that conducting such meetings in a hybrid in-person/teleconference model provides the safest environment for the Board of Directors, Advisory Committee members and Hospital staff to conduct business, while allowing for maximum public participation.
3. The Board of Directors finds and determines that the Health Officer of the County of Santa Clara has recommended measures to promote social distancing as one means to reduce the risk of COVID-19 transmission.



4. The Board of Directors and its Advisory Committees shall conduct teleconference meetings under AB 361 in accordance with the requirements of AB 361, found in subdivision (e) of Government Code section 54953.
5. Through the duration of the state of emergency, if the Board of Directors desires to continue utilizing teleconferencing meetings under the special provisions of AB 361, the Board of Directors will make findings by majority vote not later than thirty (30) days after this meeting (or, if there is no meeting within thirty (30) days of this meeting, at the start of the next meeting), and not later than every thirty (30) days thereafter (or, if there is no meeting within thirty (30) days thereafter, at the start of the next meeting), that the Board of Directors has reconsidered the circumstances of the state of emergency and that either (a) the state of emergency continues to directly impact the ability of the public to meet safely in person, or (b) that state or local officials continue to impose or recommend measures to promote social distancing.
6. The findings of the Board of Directors set forth above apply to all meetings of the Board of Directors and its Advisory Committees, including, without limitation, the October 4, 2021 meeting of the Quality, Patient Care and Patient Experience Committee, which predated this Resolution.

PASSED AND ADOPTED at the regular meeting of the Board of Directors of El Camino Hospital held on October 13, 2021 by the following vote:

AYES: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin

NOES: None

ABSENT: None

ABSTAIN: None

ATTEST:

DocuSigned by:

*Lanhee Chen*

71D3D3DB297E475

Chair,  
El Camino Hospital Board of Directors

DocuSigned by:

*Julia Miller*

30CE6DD9439C4ED...

Secretary,  
El Camino Hospital Board of Directors



**Minutes of the Open Session of the  
Joint Finance Committee &  
El Camino Hospital Board of Directors  
Thursday, May 26, 2022**

**El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040**

**Members Present**

*Hospital Board Members:*

**Bob Rebitzer**, Vice Chair  
**Peter C. Fung, MD**  
**Julia E. Miller**  
**Jack Po, MD, PhD\*\***  
**George O. Ting, MD**  
**Don Watters**  
**John Zoglin**

*Finance Committee Members:*

**Joseph Chow\*\***  
**Wayne Doiguchi**  
**Bill Hooper**  
**Cynthia Stewart**

**Board Members Absent**

**Lanhee Chen**, Chair  
**Carol Somersille, MD**  
**Julie Kliger, MPA, BSN**

\*\*via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
<p><b>1. CALL TO ORDER/ ROLL CALL</b></p>	<p>The open session meeting of the Joint Meeting of the Finance Committee and the Board of Directors of El Camino Hospital was called to order at 5:33 pm by Vice-Chair Rebitzer and a verbal roll call was taken. All Board and Committee members were present and attended in person except for Chair Chen, Director Somersille and Director Kliger were absent and Director Po participated telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.</p>	
<p><b>2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES</b></p>	<p>Vice-Chair Rebitzer asked if any Board and/or Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.</p>	
<p><b>3. PUBLIC COMMUNICATION</b></p>	<p>Vice-Chair Rebitzer asked if there were any public communication, no public communication was reported.</p>	
<p><b>4. FY2023 OPERATING &amp; CAPITAL BUDGET</b></p>	<p>Dan Woods, Chief Executive Officer, and Carlos Bohorquez, Chief Financial Officer presented an overview of the FY2023 Operating and Capital Budget.</p> <p>During the presentation, the following was discussed as further detailed in the materials:</p> <ul style="list-style-type: none"> <li>• FY2023 budget hospital division: Key volume, revenue, expense and other operating assumptions</li> <li>• FY2023 budget income statements for the following:               <ul style="list-style-type: none"> <li>○ Hospitals, Concern and Foundation</li> <li>○ ECHMN</li> <li>○ Consolidated enterprise</li> </ul> </li> <li>• Sensitivity analysis on key volume, revenue and expense assumptions</li> <li>• FY2023 enterprise capital budget</li> </ul> <p>Mr. Bohorquez continued the discussion and highlighted the</p>	

	<p>following as further detailed in the materials:</p> <p>The FY2023 Budget plan includes the following to maintain the El Camino Health’s strong performance and make investments across the enterprise:</p> <ul style="list-style-type: none"> <li>• Approved additional FTEs / funding for important needs:             <ul style="list-style-type: none"> <li>○ Cybersecurity</li> <li>○ Expansion of clinical education</li> <li>○ Human resources support to manage workforce shortages</li> <li>○ High-reliability organization initiative</li> <li>○ Service line growth initiatives</li> <li>○ Performance improvement</li> </ul> </li> <li>• Includes funds for Phase I of the 2027 strategic plan</li> <li>• Maintains sufficient funding to support top quality and patient experience</li> <li>• Continues deployment of capital to support the following:             <ul style="list-style-type: none"> <li>○ Replacement of clinical / IT equipment</li> <li>○ Facility projects to ensure continuous operations and compliance with regulatory mandates</li> <li>○ Strategic growth and service line expansion</li> <li>○ Development of the ambulatory / physician network</li> </ul> </li> <li>• Maintains revenue cycle initiatives to ensure collections are consistent with expected reimbursement</li> <li>• Reflects management efforts to manage inflation through effective cost management and driving efficiency throughout the organization</li> <li>• Supports investment in supply chain initiatives to mitigate disruptions and supply shortages</li> </ul> <p>Vice-Chair Rebitzer and Mr. Woods deferred to Priya Shah, Assistant General Counsel on how this can be approached to make sure all legal requirements are followed. Ms. Shah stated a motion to postpone the motion is required.</p> <p><b>Motion:</b> to postpone the motion of the approval of the FY2023 Capital &amp; Operating Budget in the second open session</p> <p><b>Movant:</b> Po  <b>Second:</b> Zoglin  <b>Ayes:</b> Rebitzer, Fung, Miller, Po, Ting, Watters, Zoglin, Chow, Doiguchi, Hooper, Stewart  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen, Kliger, Somersille  <b>Recused:</b> None</p>	
<p>5. <b>ADJOURN TO CLOSED SESSION</b></p>	<p><b>Motion:</b> to adjourn to closed session at 6:05 pm.</p> <p><b>Movant:</b> Miller  <b>Second:</b> Watters  <b>Ayes:</b> Rebitzer, Fung, Miller, Po, Ting, Watters, Zoglin, Chow, Doiguchi, Hooper, Stewart  <b>Noes:</b> None  <b>Abstentions:</b> None</p>	

	<p><b>Absent:</b> Chen, Kliger, Somersille  <b>Recused:</b> None</p>	
<p><b>6. AGENDA ITEM 9:                  RECONVENE                  OPEN                  SESSION/REPORT                  OUT</b></p>	<p><b>Motion:</b> To approve the FY2023 Operating &amp; Capital Budget  <b>Movant:</b> Fung  <b>Second:</b> Watters  <b>Ayes:</b> Rebitzer, Fung, Miller, Po, Ting, Watters, Zoglin, Chow, Doiguchi, Hooper, Stewart  <b>Noes:</b> Zoglin, Chow, Doiguchi, Hooper, Stewart  <b>Abstentions:</b> None  <b>Absent:</b> Chen, Kliger, Somersille  <b>Recused:</b> None</p> <p><b>Motion:</b> To approve the FY2023 Operating Budget</p> <p><b>Movant:</b> Miller  <b>Second:</b> Watters  <b>Ayes:</b> Rebitzer, Fung, Miller, Po, Ting, Watters, Zoglin, Chow, Doiguchi, Hooper, Stewart  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen, Kliger, Somersille  <b>Recused:</b> None</p> <p><b>Motion:</b> To postpone the approval of the FY2023 Capital Budget no later than the September Board Meeting.</p> <p><b>Movant:</b> Miller  <b>Second:</b> Watters  <b>Ayes:</b> Rebitzer, Fung, Miller, Po, Ting, Watters, Zoglin, Chow, Doiguchi, Hooper, Stewart  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen, Kliger, Somersille  <b>Recused:</b> None</p>	
<p><b>7. AGENDA ITEM 10:                  CLOSING                  COMMENTS</b></p>	<p>No closing comments.</p>	
<p><b>8. AGENDA ITEM 11:                  ADJOURNMENT</b></p>	<p><b>Motion:</b> To adjourn at 6:52 pm  <b>Movant:</b> Fung  <b>Second:</b> Miller  <b>Ayes:</b> Rebitzer, Fung, Miller, Po, Ting, Watters, Zoglin, Chow, Doiguchi, Hooper, Stewart  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen, Kliger, Somersille  <b>Recused:</b> None</p>	<p><b>Meeting                  adjourned                  at 6:52 pm</b></p>

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

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Bob Rebitzer  
Vice Chair, ECH Board of Directors

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Julia E. Miller  
Secretary, ECH Board of Directors

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John Zoglin  
Chair, ECH Finance Committee

Prepared by: Samreen Salehi, Executive Assistant II Administrative Services

DRAFT



**Minutes of the Open Session of the  
El Camino Hospital Board of Directors  
Wednesday, August 17, 2022**

Pursuant to Government code section 54953(e)(1), El Camino Health did not provide a physical location to the public for this meeting. Instead, the public was invited to join the open session meeting via teleconference.

**Board Members Present**

**Bob Rebitzer**, Chair  
**Jack Po, MD, Ph.D.**, Vice-Chair  
**Lanhee Chen, JD, Ph.D.** \*\*  
**Peter C. Fung, MD**  
**Julie Kliger, MPA, BS**  
**Julia E. Miller**, Secretary/Treasurer  
**Carol A. Somersille, MD**  
**George O. Ting, MD**  
**Don Watters**  
**John Zoglin**

**Board Members Absent**

None

**Staff Members Present**

**Dan Woods**, Chief Executive Officer  
**Carlos Bohorquez**, Chief Financial Officer  
**Meenesh Bhimani, MD**, Chief Operating Officer  
**Mark Adams, MD**, Chief Medical Officer  
**Cheryl Reinking**, Chief Nursing Officer  
**Holly Beeman, MD**, Chief Quality Officer  
**Diane Wigglesworth**, Sr. Director of Corporate Compliance  
**Deb Muro**, Chief Information Officer  
**Ken King**, Chief Admin Svcs. Officer  
**Priya Shah**, Assistant General Counsel  
**Stephanie Iljin**, Manager, Administration  
**Omar Chughtai**, Chief Growth Officer\*\*  
**Andreu Reall**, Sr. Director of Strategy\*\*  
**Christine Cunningham**, Chief Experience Officer\*\*  
**Vineeta Hiranandani**, Vice President of Marketing and Communications\*\*

**Guests Present**

**Erica Osborne**, Principal, Via Healthcare Consulting\*\*  
**Marianne Vicencio**, Via Healthcare Consulting\*\*  
**Abigail Suarez**, Via Healthcare Consulting\*\*

**(\*\*via zoom)**

Agenda Item	Comments/Discussion	Approvals/ Action
<p><b>1. CALL TO ORDER/ ROLL CALL</b></p>	<p>The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30 p.m. by Chair Bob Rebitzer. A verbal roll call was taken. All Board members were present at roll call. Chair Rebitzer reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.</p> <p>Dan Woods, CEO, introduced Meenesh Bhimani, M.D., as the new chief operating officer for El Camino Health.</p> <p>Mr. Woods introduced Erica Osborne, principal, Via Healthcare Consulting, and announced that Via would perform interim outsourced board management (board liaison) services.</p>	
<p><b>2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b></p>	<p>Chair Rebitzer asked the Board for declarations of conflict of interest with any items on the agenda. None were reported.</p>	
<p><b>3. PUBLIC COMMUNICATION</b></p>	<p>Chair Rebitzer invited the members of the public to address the Board, and no comments were made.</p>	
<p><b>4. QUALITY COMMITTEE REPORT</b></p>	<p>Director Carol A. Somersille, M.D., chair of the Quality Committee, invited Holly Beeman, M.D., MBA, chief quality officer, to present the quality report. Dr. Beeman noted the following:</p> <ul style="list-style-type: none"> <li>The Quality Committee will be focusing on health equity, ambulatory quality, and patient experience and service excellence in FY2023</li> </ul>	

	<ul style="list-style-type: none"> <li>• A deep dive into health equity will be the topic at the next board meeting</li> </ul> <p>Dr. Beeman reviewed the Q4 FY22 Board Quality (Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered &gt; STEEEP) Dashboard. She highlighted several areas of opportunity, including catheter-associated urinary tract infections (CAUTI), PSI-90 HAC infections, and emergency department (ED) patient throughput (median time arrival to ED departure).</p> <p>Dr. Beeman provided details on the drivers behind these metrics and implemented strategies to improve performance. She also highlighted the 100% positive performance for timely care of the heart attack patient.</p> <p>The Board held an in-depth discussion regarding work being done to improve performance in stroke, CAUTI, and ED throughput metrics. Members asked questions, which Dr. Beeman and Cheryl Reinking, CNO, answered. Director Somersille described efforts by the Quality Committee around committee member recruitment. These include the formation of an ad-hoc committee and the identification of three attributes/types of experience the committee will seek in candidates, including patient satisfaction and customer service, health equity, and the social determinants of health (SDOH).</p>	
<p><b>5. FY22 PRE-AUDIT FINANCIAL RESULTS</b></p>	<p>Carlos Bohorquez, CFO, provided the FY22 pre-audit financial results and shared the following observations:</p> <ul style="list-style-type: none"> <li>• Activity/Volume: The past year saw a significant rebound in volumes, with all volume metrics better than the budget for the year. The ED, outpatient surgery, and maternal services were the main drivers of the increased volumes.</li> <li>• Operations:             <ul style="list-style-type: none"> <li>○ Total FTEs (full-time equivalents) were essential as budgeted (-0.5%), despite the significant increases in patient volume.</li> <li>○ Net days in A/R (accounts receivable) were unfavorable due to being out of contract with a major payer for part of the year and an increase in overall denials.</li> </ul> </li> <li>• Financial Performance:             <ul style="list-style-type: none"> <li>○ Total operating revenue was up year over year due to increased patient volumes.</li> <li>○ Operating EBITDA (earnings before interest, depreciation, and amortization) was better than budget by \$122M.</li> <li>○ Non-operating revenue has been challenged by volatilities in the stock market and equities.</li> <li>○ Net income was unfavorable to budget and worse than the prior year. This impacted liquidity, but even with capital expenditures and Medicare advanced payments from April 2020 being fully repaid, the overall liquidity of the organization is solid.</li> </ul> </li> </ul> <p>Discussion followed wherein questions were asked and answered. A board member asked a question regarding fluctuation in performance in June versus the rest of the year. Mr. Bohorquez explained that this resulted from a positive pension and workers compensation liability adjustment.</p>	

<p><b>6. DIVERSITY, EQUITY, AND INCLUSION</b></p>	<p>Dan Woods, CEO, facilitated a conversation regarding work being done on inclusion-diversity, equity, and belonging (I-DEB). He reported highlights from the work of the consultants and the incoming chief human resource officer. He also indicated that ECH is in the process of hiring a new director of diversity.</p> <p>The group discussed community demographics; Mr. Woods then discussed the work done to promote diversity within leadership. Board members asked for clarification about the data and how it was calculated, which Mr. Woods provided.</p>	
<p><b>7. ADJOURN TO CLOSED SESSION</b></p>	<p>Motion to adjourn to closed session at 6:12 pm pursuant to Gov't Code Section 54957.2 for approval of the Minutes of the Closed Session of June 8, 2022, Hospital Board Meeting; 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 Credentialing &amp; Privileges Report); pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, an Executive Session with the CEO, and a CEO Report.</p> <p><b>Motion:</b> to adjourn to closed session at 6:12 pm.</p> <p><b>Movant:</b> Miller  <b>Second:</b> Po  <b>Ayes:</b> Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen  <b>Recused:</b> None</p>	<p><b>Adjourned to closed session at 6:12 pm.</b></p>
<p><b>8. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT</b></p>	<p>Open Session reconvened at 7:39 pm by Chair Rebitzer. Agenda Items 8-15 were addressed in closed session.</p> <p>During the closed session, the El Camino Hospital Board of Directors approved the Closed Session Minutes of June 8, 2022, Hospital Board and the Credentials and Privileges Report, by a unanimous vote of all Directors present (Directors Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, and Zoglin). Directors Chen and Fung were absent at the roll call vote.</p>	
<p><b>9. AGENDA ITEM 17: CONSENT CALENDAR ITEMS</b></p>	<p>Chair Rebitzer asked if any member of the Board or the public wished to remove an item from the consent calendar for discussion.</p> <p>Director Ting asked to remove item 17b - the Open Session minutes of the 6/8/2022 Hospital Board meeting for discussion. Director Ting asked that section 5 be amended as follows: "the hospital does not use the skills of the medical staff to the extent that they could for quality improvement activities."</p> <p><b>Motion:</b> to approve the consent calendar to include:</p> <ol style="list-style-type: none"> <li>a. Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings</li> <li>b. Minutes of the Open Session of the Hospital Board (06/08/2022)</li> <li>c. CHRO Base Salary</li> <li>d. Silicon Valley Medical Development Board Appointments</li> <li>e. Third Amended and Restated Limited Liability Company Operating Agreement of Silicon Valley Medical Development, LLC</li> <li>f. Enterprise EKG Reading Panel Renewal Agreements</li> </ol>	<p><b>Consent calendar approved with requested revisions to item 17b: Section 5.</b></p> <p><b>Follow up: Director Ting will submit the requested revisions to Stephanie Iljin.</b></p>



	<p>g. Enterprise Vascular Surgery ED and Inpatient On-Call Panel Renewal                  h. MV &amp; LG Gastroenterology ED and Inpatient Call Panel Renewal                  i. MV NICU Medical Director Renewal                  j. LG General Surgery ED and Inpatient On-Call Panel Renewal                  k. Real Estate Acquisition / APN: 264-09-57                  l. Policies, Plans, and Scope of Services                  m. Executive Compensation Philosophy Policy</p> <p><b>Movant:</b> Miller  <b>Second:</b> Somersille  <b>Ayes:</b> Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen  <b>Recused:</b> None</p>	
<p><b>10. AGENDA ITEM 18:                  FY23 CAPITAL BUDGET</b></p>	<p><b>Motion:</b> to approve the FY23 Capital Budget.</p> <p><b>Movant:</b> Watters  <b>Second:</b> Fung  <b>Ayes:</b> Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen  <b>Recused:</b> None</p>	<p><b><i>FY23 Capital Budget approved</i></b></p>
<p><b>11. AGENDA ITEM 19:                  CEO REPORT</b></p>	<p>Mr. Woods stated that quality is the focus at El Camino Hospital. He reported that the clinical and operational teams achieved full re-certification for the orthopedics and spine program from The Joint Commission. El Camino Health launched a telehealth on-demand lactation program in Women's Care.</p> <p>Regarding corporate and community health services, the Chinese Health Initiative hosted an Ask-a-Doctor workshop on diabetes prevention. The South Asian Heart Center engaged participants in screening, education, and coaching programs to prevent heart disease and diabetes.</p> <p>Regarding information technology, Mr. Woods reported the steps taken to enhance cybersecurity at ECH.</p> <p>Mr. Woods reported that the committee achieved 106% of the goal regarding philanthropy.</p> <p>In closing, Mr. Woods recognized Director Fung and Director Ting for their unopposed reelection to El Camino Hospital District Board.</p>	
<p><b>12. AGENDA ITEM 20:                  BOARD COMMENTS</b></p>	<p>No comments were made.</p>	
<p><b>13. AGENDA ITEM 21:                  ADJOURNMENT</b></p>	<p><b>Motion:</b> to adjourn at 7:50 p.m.</p> <p><b>Movant:</b>  <b>Second:</b>  <b>Ayes:</b> Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen</p>	<p><b><i>Meeting adjourned at 7:50 p.m.</i></b></p>

	<b>Recused:</b> None	
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**Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Hospital:**

\_\_\_\_\_  
Bob Rebitzer  
Chair, ECH Board of Directors

\_\_\_\_\_  
Julia E. Miller  
Secretary, ECH Board of Directors

Prepared by: Marianne Vicencio, Via Healthcare Consulting  
Reviewed by: Stephanie Iljin, Manager of Administration

Owner / Dept.	Policy Name	Revised	Doc Type	Notes	Committee Approvals
<b>New Business</b>					
Patient Experience	1. <a href="#">Interpreting Services</a>	Revised	Policy	<ul style="list-style-type: none"> <li>Updated Sections: Purpose, Policy Statement, Reference, Procedure</li> </ul>	<ul style="list-style-type: none"> <li>ePolicy</li> <li>MEC</li> </ul>
Acute Rehab	2. <a href="#">Scope of Service – Acute Rehab Center</a>	Revised	Policy	<ul style="list-style-type: none"> <li>Updated Standards of Practice title</li> </ul>	<ul style="list-style-type: none"> <li>Dept Med Dir</li> <li>ePolicy</li> <li>MEC</li> </ul>
Patient Care Svcs	3. <a href="#">Stroke Program</a>	Revised	Scope of Svc	<ul style="list-style-type: none"> <li>Updated Sections: Scope of Complexity of Services Offered, Staffing/Staff Mix</li> </ul>	<ul style="list-style-type: none"> <li>Dept Med Dir</li> <li>ePolicy</li> <li>MEC</li> </ul>
NICU	4. <a href="#">NICU: Admission, Discharge, and Transfer Criteria (ADT) – MV Only</a>	Revised	Scope of Svc	<ul style="list-style-type: none"> <li>Updated Sections: Coverage, Purpose, Statement, References, Procedure</li> </ul>	<ul style="list-style-type: none"> <li>UPC</li> <li>Peds Dept</li> <li>MCH Exec</li> <li>ePolicy</li> <li>MEC</li> </ul>
Supply Chain	5. <a href="#">Vendor Sanction Screening Policy</a>	New	Policy	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>ePolicy</li> </ul>



Origination 12/1993  
Last Approved N/A  
Effective Upon Approval  
Last Revised 08/2022  
Next Review 1 year after approval

Owner Christine Cunningham  
Area Patient Experience  
Document Policy  
Types

## Interpreting Services

### ~~I. COVERAGE:~~

### COVERAGE:

All El Camino Hospital ~~staff and medical staff~~ Staff and Medical Staff

### ~~II. PURPOSE:~~

### PURPOSE:

To ensure that effective communication is facilitated for all-patients, family members, and or hospital visitors in a manner consistent with state and federal law laws, including the Americans with Disability Act.

### ~~III. POLICY STATEMENT:~~

### POLICY STATEMENT:

~~Whenever~~ Communication is a cornerstone of patient safety and quality care, and every patient has the right to receive information in a manner s/he understands. By facilitating effective communication between patients and care teams, interpreter services ensure safe and quality care. It allows for patient to become a participant in their care and treatment decision. It is the policy of El Camino Hospital that when a language or communication barrier prevents effective communication, interpreting services will be facilitated. This El Camino Hospital's interpreter services policy includes non-takes into account people who speak limited or no English speaking and people with disabilities, including but not limited to visual and or speech and hearing impaired patients, limited-English-speaking patients, visual and hearing impaired patients. The patient. Every patient is informed of the availability of interpreter services or may choose to use a family member or friend who volunteers to interpret.

Hospital employees will be notified of the hospital commitment to provide interpreters to all patients who

need and request them through hospital-wide communications, such as employee newsletters, and department communications. New employees will be informed during the New Employee Orientation Process.

## **IV. PROCEDURE:**

- A. ~~Any patient who requires or requests interpreting services will be informed of the availability of the interpreter service.~~
- B. ~~Primary consideration will be given to the individual's chosen communication method or interpreter.~~
- C. ~~Information on interpreting services shall be given to patients on admission. Whenever possible, patients are asked to notify Patient Registration staff of interpreting needs prior to admission.~~
- D. ~~Use of interpreting services shall be documented in the EHR or on relevant consent forms.~~
- E. ~~The hospital has a contractual agreement with the following for language interpretation:~~
  - 1. ~~Language Line which provides video and audio interpreting services, including American Sign Language. Directions on how to access Language Line can be found on the Toolbox.~~
  - 2. ~~In-person Mandarin language translation: Information on how to access this person is available on the ECH Toolbox.~~
  - 3. ~~Dual headset phones can be found in many departments. If a dual headset phone is needed and not available in a particular area of the hospital, please contact the Assistant Hospital Manager/Hospital Supervisor.~~
- F. ~~Hearing Impaired Patients:~~
  - 1. ~~At the patient's request, a T.D.D. phone will be installed at the patient's bedside for use during the hospital stay. It is obtained from the Telecommunications Department.~~
  - 2. ~~Sign Language Interpreting Services are listed in the ECH Toolbox under "Hearing Impaired Patients". Language Line also offers American Sign Language interpreting.~~
  - 3. ~~Hearing impaired patients will also be identified on admission and documented in the patient's medical record. The patient's ability to use other forms of communication will be recorded in the medical record, including lip reading, written notes and hearing devices.~~
  - 4. ~~Document the name of the person or agency used to interpret for consent issues on the consent form, as well as the interpreter's ID number (when using Language Line).~~
  - 5. ~~For additional services related to interpreting services, please contact Patient Experience and/or Assistant Hospital Manager/Hospital.~~

## **REFERENCES:**

- : [Health and Safety Code 1259](#)
- : [JC RI 01.01.03](#)

## **PROCEDURE:**

- A. [The Patient Guidebook, provided to patients upon admission, contains information about hospital's](#)

interpreting services. When possible, patients are asked to notify Patient Registration staff of interpreting needs prior to admission or visit.

- B. The need for an interpreter is assessed at the time of admission and throughout the patient's stay. This is documented in the electronic health record (EHR) under either the Communication or Cares/Safety tab under Interpreting Services. See Appendix for screenshot of sample documentation. Any patient who requires or requests interpreting services will be informed of the availability of the interpreter service.
- C. Primary consideration will be given to the individual's preferred communication method or interpreter.
- D. To assist in effective communication between the care team and the patient, the hospital intranet offers access to communication cards that contain commonly used words with corresponding image in various languages, including pain scale. These files are accessible to staff/medical staff. To access, visit intranet, go to "Patient Education" on home page, next select "Communication Board" and desired language.
- E. When interpretation is needed, only certified medical interpreters shall be used.
  - 1. The hospital has and will maintain a contractual agreement with an Interpreter Services Vendor to provide certified interpreter services in accordance to state, local and federal laws.
  - 2. Instructions on how to access interpreter services will be provided to all staff based on the current vendor services provider.
  - 3. Interpretation services are available 24 hours per day. Services include telephone interpreters and secure Video Remote Interpretation
- F. Hearing Impaired Patients:
  - 1. Our Interpreter Services Vendor offers American Sign Language interpreting via secure connection through Video Remote Interpreting.
  - 2. Hearing impaired patients are identified on admission and interpreter needs documented in the patient's electronic health record. The patient's ability to use other forms of communication will also be documented in the EHR., including lip reading, written notes and or assisted hearing devices.
  - 3. At the patient's request, a T.T.Y. phone will be installed at the patient's bedside for use during the hospital stay. It is requested and obtained by staff from Central Supply.
  - 4. For additional services related to interpreting services, please contact Assistant Hospital Manager/Hospital and or Patient Experience.
- G. Vision Impaired Patients:
  - 1. Audio and braille options available upon request for conditions of admission and required registration forms. Braille forms are available in select Registration / Patient Access areas. The Audio file deployed to Patient Access areas located in the shared drive.
  - 2. Patient can elect authorized representative for signature consent.
- H. Documentation and Refusal of Interpreter:
  - 1. The need for an interpreter is assessed at the time of admission and throughout the patient's stay. All use of interpreters shall be documented in the patient's EHR as

outlined.

2. Patients may refuse to use the hospital interpreter services and request that an adult family member be used. Minor children are never allowed to be used as an interpreter regardless of patient preference. Staff must document in the EHR flow-sheet under either Communication or Cares/Safety tab under Interpreting Services, and patient refused and requested an adult family member.

## APPENDIX

Now in **Cares/Safety Flowsheet** for easy access  
(It's in the **Communication Flowsheet** in L&D/ MBU)

City Assess	Blood	I/O	Home Infusion	IV Assessment	<b>Cares/Safety</b>
<b>Interpreting Services</b>					
Was a Hospital Interpreting Service Used?	No				
Reasons Why Hospital Interpreting	Patient Designated Int...				
Information Interpreted	Medications				
Interpreter Name / ID Number or Relationship	Patient's daughter				
Type of Interpreter Services Used	In Person				
Communication Needs	Family;Hearing Aid				

**Interpreting Services**

Was a Hospital Interpreting Service Used?  Yes  No

Information Interpreted

Admission  Assessment  Consent (Interpreting Service)  Diagnosis  Discharge Instructions  Education  Medications  Patient's Rights  Plan of Care

Other (Comment)

Interpreter Name / ID Number or Relationship

Type of Interpreter Services Used

Language Line  In Person  Hearing Impaired Service  Visual Impaired Service  Other (Comment)

Communication Needs

Braille  Communication Board  Family  Hearing Aid  Interpreter (Legal)  Sign Language  Other (Comment)  None

Create Note

Restore Close Cancel Previous Next

*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

[Communication Board.pdf](#)

[English\\_icon images.pdf](#)

[iPad Voyce Instructions - One pager for devices.pdf](#)

[Language Access Poster](#)

[LanguageLine InSight Video Interpreting - iPad](#)

[Pain Assessment Card.pdf](#)

[Telephone Audio Interpretation Instructions](#)

## Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	08/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2022
	Christine Cunningham: Chief Experience and Performance Improvement Offic [PS]	03/2022

## History

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**Edited by Cunningham, Christine: Chief Experience and Performance Improvement Offic** on 9/1/2021, 5:41PM EDT

removed name of vendor - made it genera

**Last Approved by Cunningham, Christine: Chief Experience and Performance Improvement Offic** on 9/1/2021, 5:41PM EDT

**Administrator override by Hanley, Jeanne: Policy and Procedure Coordinator** on 9/16/2021, 11:44AM EDT

Changed from Procedure to Policy per Regulatory



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Sending back to Christine for edits requested by Regulatory

**Draft saved by Shah, Sheetal: Dir Risk Mgmt & Patient Safety** on 10/28/2021, 6:45PM EDT

**Draft saved by Hanley, Jeanne: Policy and Procedure Coordinator** on 11/11/2021, 1:03PM EST

**Edited by Hanley, Jeanne: Policy and Procedure Coordinator** on 11/11/2021, 1:17PM EST

Added Medical Staff to coverage, added Patient Guidebook information and added documentation and refusal of interpreter

**Last Approved by Cunningham, Christine: Chief Experience and Performance Improvement Offic** on 11/11/2021, 1:18PM EST

**Last Approved by Hanley, Jeanne: Policy and Procedure Coordinator** on 11/11/2021, 1:19PM EST

ePolicy 9.9.2021

**Last Approved by Carson, Catherine: Senior Director Quality** on 11/22/2021, 1:36PM EST

MEC 11.18.2021

**Approval flow updated in place by Hanley, Jeanne: Policy and Procedure Coordinator** on 11/22/2021, 4:23PM EST

**Draft saved by Shah, Sheetal: Dir Risk Mgmt & Patient Safety** on 12/13/2021, 5:55PM EST

**Administrator override by Hanley, Jeanne: Policy and Procedure Coordinator** on 12/30/2021, 10AM EST

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**Administrator override by Hanley, Jeanne: Policy and Procedure Coordinator** on 1/5/2022, 1:47PM EST

Updated per Sheetal's email

**Administrator override by PolicyStat Staff** on 1/8/2022, 2:36PM EST

PolicyStat performed system maintenance. One or more images have been converted to inserted image attachments. To learn more visit our article "[Why were my images updated by System Maintenance?](#)"

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 2/23/2022, 12:49PM EST

Updated per email from Elena Gonzalez

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**Sent for re-approval by Santos, Patrick: Policy and Procedure Coordinator** on 2/23/2022, 1PM EST

Restarting approval process; needs to go back to ePolicy for review.

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Updated per ePolicy Committee

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Added attachment

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Transferred draft version content (re: TTY).

**Draft saved by Santos, Patrick: Policy and Procedure Coordinator** on 8/2/2022, 12:28PM EDT

**Draft discarded by Santos, Patrick: Policy and Procedure Coordinator** on 8/2/2022, 12:28PM EDT

**Draft saved by Gonzalez, Elena: Manager Patient Experience** on 8/3/2022, 4:04PM EDT

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Updated subsection G (Vision Impaired Patients).

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ePolicy 8/5/22

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 8/26/2022, 9:39AM EDT

COPY



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Last Revised 06/2022  
Next Review 3 years after approval

Owner Krishna Wittman  
Area Scopes of Service  
Document Types Scope of Service/ADT

## Scope of Service - Acute Rehab Center

### ~~I. COVERAGE:~~

### COVERAGE:

All El Camino and Contracted Staff

### ~~II. PURPOSE:~~

### PURPOSE:

To provide the framework for the scope of services provided at the Acute Rehab Center and describe the program philosophy).

### ~~III. POLICY STATEMENT:~~

### STATEMENT:

It is the policy of El Camino Hospital to comply with all mandatory reporting requirements for provision of Acute Rehab Services.

## **IV. PROCEDURE:**

### **PROCEDURE:**

## **OUR COMMITMENT TO YOU**

It is the policy of the Rehabilitation Center at El Camino Hospital Los Gatos that all team members will act in a manner consistent with the mission, philosophy, and operating policies of the program. In accordance with these principles and policies, team members will:

- Show respect for the dignity of the individual, whether patient, family member, co-worker, client, or any other person.
- Provide the highest quality clinical and customer-related services.
- Demonstrate fairness and honesty in all interactions with the public.
- Adhere to their professional codes and practice guidelines
- Provide an accurate portrayal of the services and outcomes of the program.
- Be ethical in all marketing and public relations activities.

## **PERSONS SERVED**

Comprehensive inpatient rehabilitation services are provided to adult and adult geriatric patients with neurological and other medical conditions of recent onset or regression and who have experienced a loss of function in activities of daily living, mobility, cognition, or communication. This program serves persons who are eighteen years of age or older and accepts persons served of varying cultural backgrounds. All patients are medically stable but have sufficient medical acuity to warrant an ongoing hospital stay.

Diagnoses of persons served include, but are not limited to, those who have experienced any of the following: cerebral vascular accident, spinal cord injury (Traumatic or Non-traumatic SCI, Complete or Incomplete at or below T1 level), traumatic brain injury, amputation, multiple traumas, hip fracture or joint replacement, arthritis, congenital deformity, burns, or other progressive, neurological syndromes such as Guillain-Barre, Parkinson's disease and Multiple Sclerosis.

## **METHODS USED TO ASSESS AND MEET PATIENT NEEDS**

Pre-admission screening is provided prior to admission, during which current functional status is evaluated and discharge goals are delineated. A comprehensive assessment of each patient's medical, physical, and cognitive condition and psychosocial and cultural background is a prerequisite for the formation of a course of rehabilitation. A patient's psychological status is also considered when determining whether he or she could benefit from admission.

The Team Admission Assessment, including objective and subjective data, is initiated within:

- Eight (8) hours of admission by nursing
- Within thirty-six (36) hours by midnight of the day admitted to the rehabilitation unit for physical therapy, occupational therapy or speech-language pathology
- Within 72 hours of physician order for social work/discharge planning.

## **SCOPE AND COMPLEXITY OF PATIENT CARE NEEDS**

As a result of the conditions and impairments leading to the admission of a patient, the patient is called upon to address activity limitations by developing new skills, and re-learning previous skills. Patient must also make a series of life adjustments. Such adjustments can best be facilitated by the combined efforts of the patient, family, and interdisciplinary professional rehabilitation staff. Coordination of the efforts of this interdisciplinary rehabilitation team leads to the highest possible rehabilitation outcomes attainable by each patient, limiting participation restrictions. Such treatment requires a highly individualized and holistic approach.

A wide range of services is needed to address the multitude of treatment goals identified in the assessment. The goal of each service is to maximize the individual's potential in the restoration of function or adjustment by integrating with other services. Every effort is made to discharge persons served back into the community.

## **SCOPE OF FAMILY/SUPPORT SYSTEM SERVICES**

The supportive involvement of family or other support networks is recognized as a key component in the success of the individuals return to the most independent and appropriate discharge environment. The team will assess the family's ability and willingness to support and participate in the plan of care. Education, physical training, advocacy training and supportive counseling will be provided to prepare them for the needs of the patient moving forward.

## **APPROPRIATENESS, CLINICAL NECESSITY, AND TIMELINESS OF SUPPORT SERVICES**

Ancillary services are provided including, but not limited to, medical nutritional therapy/dietary services, pharmaceutical services, respiratory therapy, diagnostic radiology, dental services, pathology, laboratory services, audiology, driver education, and chaplaincy services/pastoral care. In addition, prosthetics, orthotics, vocational rehabilitation, audiology, and rehab engineering are provided when necessary through affiliate agreements or arrangements with external organizations. The time frame for provision of such services is determined by the interdisciplinary team.

## **AVAILABILITY OF NECESSARY STAFF**

A minimum staff complement includes a Rehabilitation Physician (who visits patients a minimum of three times per week), nurses (available 24 hours per day, 7 days per week), and occupational therapy and physical therapy. Social work and speech-language pathology services are also available. Staffing patterns are based upon census, diagnosis, severity of illness, and intensity of services required by each

patient admitted, as well as by state practice guidelines for each discipline. Contract staff is available for coverage. Therapy services are available at least 5 days per week from approximately 7:30am to 4:30pm. Based upon each patient's needs, therapy services are also available on the weekend. Social work/case management services are available 7 days per week with regular and on call staff. Patients will receive therapy treatments typically once or twice per day by each therapy discipline identified by their treatment plan. Staff competencies include growth and development for adult and adult geriatric patient, functional measurement scoring, cardiopulmonary resuscitation, and discipline-specific skills.

## **EXTENT TO WHICH LEVEL OF CARE OR SERVICES MEETS PATIENT NEEDS**

It is the practice of this unit to seek input from persons served in the following manner:

- Patient Satisfaction Questionnaires (at discharge)
- Two-week follow-up calls for all patients
- 90-Day Follow up calls for all patients
- Patient Complaint/Grievance Procedure
- Patient/family feedback through team conferences, support groups, etc.
- Stakeholder feedback

Reassessment of patients is conducted weekly and documented through the interdisciplinary treatment plan, progress notes, a clinical staffing summary, discharge summary.

The milieu of the Inpatient Rehabilitation Facility is warm, open, and supportive as patient, family, and the staff become partners in skill development. The emphasis throughout is on the accomplishment of treatment goals. Focusing on abilities rather than disabilities is promoted, as energy diverted to the disability hinders the lifelong rehabilitation process.

Successful rehabilitation requires reintegration of the individual and family into their home/community. The transition from hospital to home requires the support of the professional rehabilitation staff, and is accomplished via passes to home and within the community and through a formalized program that allows a gradual separation from the hospital with the development of community support systems.

By addressing the multiple effects that disability has on the patient and family, and by integrating the combined resources of patient, family, and interdisciplinary rehabilitation team, comprehensive rehabilitation programming can maximize the abilities and esteem of the patient and family and foster a healthy reintegration into the community. The prevention/minimization of participation restrictions is the ultimate goal of rehabilitation. As rehabilitation specialists, our focus is to help patients attain, maintain, or restore health and to maximize participation in order for patients to function in life's roles. The team will work closely with the patient and family to identify the most appropriate discharge environment for the patient at the completion of the acute rehabilitation phase of recovery. If additional therapeutic interventions are required, the team will assist in identifying sources for the services.

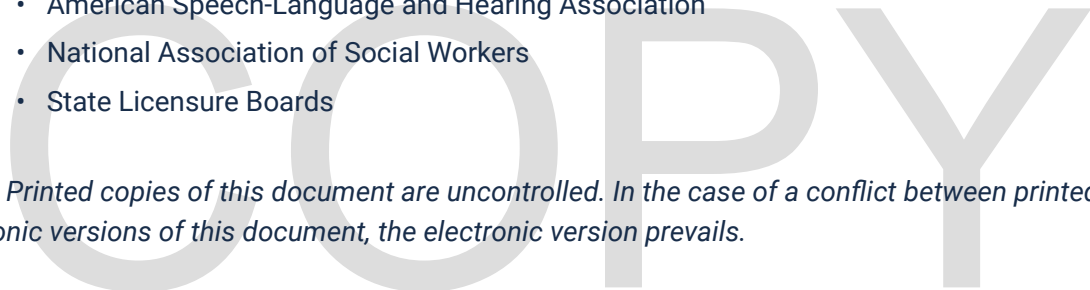
# PAYERS/FEES

Inpatient rehabilitation services are typically covered by Medicare and Medicaid as well as commercial insurers based on qualifying criteria. Physicians are independent contractors and will bill for their services separate from the hospital services directly to your insurance carrier. Patients will receive information regarding any fees for which they might be responsible as part of the admission process.

# ~~RECOGNIZED~~ STANDARDS ~~OR~~ OF PRACTICE GUIDELINES

- Centers for Medicare/Medicaid Services
- Commission on Accreditation of Rehabilitation Facilities
- Joint Commission on Accreditation of HealthCare Organizations
- Association of Rehabilitation Nurses
- American Occupational Therapy Association
- American Physical Therapy Association
- American Speech-Language and Hearing Association
- National Association of Social Workers
- State Licensure Boards

*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.*



## Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	08/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	06/2022
Department Medical Director or Director for non-clinical Departments	Krishna Wittman: Program Director	05/2022
	Krishna Wittman: Program Director	05/2022



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## History

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Updated document type and subsection titles.

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Updated title; formatting

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ePolicy 6/3/22

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MEC 8/25/22



Origination	10/2018	Owner	Xifeng Xu
Last Approved	N/A	Area	Scopes of Service
Effective	Upon Approval		
Last Revised	05/2022		
Next Review	3 years after approval		

## Stroke Program

### Types and Ages of Patients Served

The Stroke Program at El Camino Hospital provides comprehensive services to adults with neurovascular diseases. Services focus on rapid recognition of acute stroke, effective care coordination, early and optimal treatment during acute phase, and referral for post stroke rehabilitation.

### Assessment Methods

Patients are assessed using specific evidence based tools and algorithms. These assessments are conducted by multiple professionals including ED physicians, neurologists, neuro-interventionists, neurosurgeons, intensivists, hospitalists, advanced nurse practitioners, registered nurses, pharmacists, care coordinators, social workers, nutritionists, rehabilitation team and other healthcare professionals, as appropriate and according to the scope and dictates of their professional practice.

### Scope and Complexity of Services Offered

Stroke Program provides services to all levels of stroke patients including complex stroke patients. Complex stroke patients are defined as all stroke patients that require care in the Critical Care unit, including, but not exclusive of patients with:

- Subarachnoid Hemorrhage**
  - Thrombectomy with or without intracranial stent(s)
- AVM**
  - Intracerebral Hemorrhage
  - Large volume ischemic stroke

- Ischemic stroke treated with ~~t~~PA/TNKase
- Stroke with multiple comorbidities

24/7 imaging services include, but not limited to:

- CT
- CTA
- CTP
- MRI
- MRA
- EEG
- X-ray

Treatment provided, but not limited to:

- Medical management
- Thrombolytic Therapy
- Thrombectomy
- Hemicraniectomy
- Conventional cerebral angiogram with/without intervention
- ~~Aneurysm coiling~~
- ~~Aneurysm clipping~~
- Intracranial hematoma evacuation
- ICP management and monitoring
- External Ventricular Drain management

Current processes to ensure quality of services provided:

- Develop and revise policies, procedures, and protocols related to clinical practice
- Implement performance improvement methodology on a continuous basis
- Coordinate with Santa Clara County Emergency Medical Services (EMS) to promote communication and quality continuum of care
- Promote high quality and safe patient care through educational events:
  - ~~Weekly stroke~~Stroke education rounds by Stroke Program Medical Director ~~in CCU, PCU, and 3C Telemetry/ Stroke Unit~~ or designee
  - Stroke/Neurointerventional Services Case Review meetings
  - Quarterly Interdisciplinary Stroke Education offerings
  - Annual sponsorship of regional stroke conferences
  - ~~Regularly scheduled additional stroke education for Stroke Resource RNs~~
  - Support of staff who are interested in attending other professional national/ international stroke conferences

- [Annual ED physician and hospitalist stroke education](#)
- [Scheduled new RN orientation](#)
- [Planned annual stroke education for all stroke units RNs and other staff](#)
- Emergency Neurological Life Support (ENLS) education offerings for ED physicians, CCU physicians, ED RNs, CCU RNs, RRT RNs
- ~~Unit specific education for all RNs who take care of stroke patients~~
- General hospital staff education
- ~~Certified Nurse Assistants (CNA) education~~
- Public and community education
- Continually incorporate the most recent evidence-based clinical practice guidelines to guide clinical practice
- Utilize registry data, core measures, quality measures, and outcomes metrics to identify performance improvement initiatives
- Respond to stroke quality related incidents via root cause analysis and/or clinical case reviews, investigate and/or report potential patient safety and quality issues for review
- Work with care coordinators and acute rehabilitation team to facilitate post stroke recovery

## Appropriateness, Necessity and Timeliness of Services

Understanding that stroke is an emergency and treatments and outcomes are based on responding as quickly as possible is at the heart of all care provided. The American Heart/Stroke Association provides clinical practice guidelines that are followed, in conjunction with El Camino Hospital's stroke specific policies, procedures and protocols. Each patient is assessed to ensure individualized care is appropriate, necessary, and timely. This theme is carried out in specific processes that eliminate ineffective time and allow for the fastest possible care.

## Staffing/Staff Mix

The ECH Stroke Program core team members include: [Advanced Practice Nurse/Stroke Program Coordinator](#), ~~Advanced Nurse Practitioner~~[Clinical Data Specialist](#), and Medical Director. The program is overseen by the program medical director, quality director, and service line ~~director~~[directors](#).

## Other clinical and support staff providing services to patients in this area may include, but are not limited to:

- ~~Data Abtractor~~
- Imaging

- Laboratory
- Pharmacy
- Rehabilitation
- Care Coordination
- Ultrasound
- EEG
- Clinical Effectiveness and Quality
- Palliative Care
- Chaplain
- Medical Staff Office
- Marketing
- Information Systems and Information Technology
- Purchasing and Finance
- Health Information Management Systems

## Requirements for direct care staff

- All staff must complete hospital and department specific orientation.
- All staff who care for stroke patients will have annual stroke related education
- Safety/Emergency policies and procedures are reviewed by all staff
- All clinical staff will be licensed or certified according to El Camino Hospital Policies and Procedures

## Level of Service Provided

The stroke program provides services under hospital and departmental policy and procedure guidelines.

## Standards of Practice

Where applicable, the Stroke Program 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 The 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.*

## Approval Signatures

**Step Description**

**Approver**

**Date**

Board	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	08/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	07/2022
Department Medical Director or Director for non-clinical Departments	Xifeng Xu: CNS/NP	06/2022
	Xifeng Xu: CNS/NP	05/2022

## History

**Edited by Xu, Xifeng: CNS/NP** on 5/18/2022, 1:21PM EDT

multiple minor changes made based on our current practice, please refer to track changes

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**Last Approved by Xu, Xifeng: CNS/NP** on 6/7/2022, 4:22PM EDT

draft reviewed by Dr. Lindsey Pierce, Alicia Potolsky, and Nate Sigler with no further revisions.

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 7/27/2022, 10:52AM EDT

ePolicy 7/15/22

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 8/26/2022, 9:45AM EDT

MEC 8/25/22



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Last Revised 08/2022  
Next Review 2 years after approval

Owner Melinda Porter  
Area Admission, Discharge, Transfer (ADT)  
Document Types Scope of Service/ADT

## NICU: Admission, Discharge, and Transfer Criteria (ADT) - MV Only

### COVERAGE:

All El Camino Hospital [Mountain View \(MV\) Neonatal Intensive Care Unit \(NICU\)](#) Staff

### PURPOSE:

To provide a consistent process for admission ~~to the~~, [discharge, and transfer to and from the MV](#) NICU.

### POLICY STATEMENT:

~~It is the policy of El Camino Hospital to provide a consistent and thorough process for admission to the NICU.~~

- [A. It is the policy of El Camino Hospital to provide a consistent and thorough process for admission, discharge, and transfer to and from the MV NICU.](#)
- [B. When an infant requires neonatal intensive care greater than that available at El Camino Hospital, or when the infant's medical or surgical circumstances require continued attendance by trained personnel not available at El Camino Hospital, neonatal transport to the nearest appropriate Neonatal Intensive Care Unit \(NICU\) will be deemed necessary.](#)
- [C. Mid Coastal California Perinatal Outreach Program at Stanford University Medical Center is contracted for neonatal critical care transport from the Mountain View NICU.](#)

## REFERENCES:

- A. Child Passenger Safety (2018). Pediatrics, 142 (5).
- B. National Highway Traffic Safety Administration (n.d.) Child Passenger Safety. Retrieved June 17, 2019 from <http://www.nhtsa.gov>

## PROCEDURE:

### Criteria for Admission Decision

#### A. Consider for admission

1. ~~Infants at risk for sepsis~~
2. ~~Infants with potential or existing metabolic complications (notably hypoglycemia\* in infants of diabetic mothers or with intrauterine growth restriction). \*See "Management of the Neonate at Risk for Hypoglycemia" protocol.~~
3. ~~Infants with difficult delivery and Apgar scores less than 4 at 1 minute or less than 7 at 5 minutes.~~
4. ~~Infants requiring CODE WHITE - NEONATAL team intervention.~~
5. ~~Term infants with tachypnea.~~

#### B. Direct admit to the NICU

1. ~~All symptomatic infants less than 37 weeks gestation or less than 2000 grams.~~
2. ~~All infants less than 35 weeks gestation (or unable to take nipple feeds).~~
3. ~~Infants with low Apgar scores requiring prolonged resuscitation (more than 10 minutes).~~
4. ~~Any term infant with respiratory distress (grunting, flaring, retracting) not improving and/or not resolved in one hour.~~
5. ~~All infants with multiple congenital anomalies.~~
6. ~~All infants with persistent color changes (pallor, cyanosis).~~
7. ~~\*Transports from other institutions who meet the criteria for inborn admission.~~
8. ~~\*All transports in must be accepted for care by the Medical Director or designate.~~

#### C. These criteria are not all inclusive and are not meant to limit admission only to the outlined diagnoses. Admits are considered based on:

1. ~~Availability of medical expertise~~
2. ~~NICU census and acuity~~
3. ~~NICU staffing~~

#### A. Admission

##### 1. Admit

- a. All infants less than 2000 grams.



b. All infants less than 35 weeks gestation (or unable to take nipple feeds).

2. Consider for admission

a. Infants at risk for sepsis

b. Infants with potential or existing metabolic complications (notably hypoglycemia\* in infants of diabetic mothers or with intrauterine growth restriction). \*See "Management of the Neonate at Risk for Hypoglycemia" protocol.

c. Infants with difficult delivery and Apgar scores less than 4 at 1 minute or less than 7 at 5 minutes.

d. Infants requiring CODE WHITE - NEONATAL team intervention.

e. Any infant with respiratory distress (grunting, flaring, retracting) not improving and/or not resolved during transition period or at neonatal provider discretion.

f. All infants with multiple congenital anomalies.

g. All infants with persistent color changes (pallor, cyanosis).

h. \*Transports from other institutions who meet the criteria for inborn admission.

i. \* All transports in must be accepted for care by the Medical Director or designate.

3. These criteria are not all inclusive and are not meant to limit admission only to the outlined diagnoses. Admits are considered based on:

a. Availability of medical expertise

b. NICU census and acuity

c. NICU staffing

B. Discharge

1. Discharge criteria:

a. Physiological Parameters:

i. The infant has received a physical examination by a physician within 24 hours of discharge.

ii. Physical examination reveals no abnormalities that require continued hospitalization.

iii. The infant is stable physiologically and is able to maintain body temperature without cold stress when the amount of clothing worn and the room temperature are appropriate.

iv. The physician has assessed the infant's weight prior to discharge.

v. The infant is able to breast feed or bottle feed in a safe manner without physical compromise.

- vi. If the infant's clinical condition precludes adequate nipple feeding, the parents are competent in alternative feeding techniques.
- vii. The infant is free of apnea or can be monitored at home.
- viii. If circumcision is done day of discharge, there is no excessive bleeding at site for at least two hours.

b. Laboratory and Evaluation Parameters:

- i. Maternal hepatitis B surface antigen status will have been ascertained.
- ii. Cord or infant blood type and direct Coombs test is done if clinically indicated.
- iii. Newborn metabolic screening test is completed in accordance with state regulations.
- iv. Depending on infant's length of stay, administration of other vaccines may be appropriate.
- v. Hearing screen has been completed and a follow-up with audiology has been arranged, if deemed necessary.
- vi. Ophthalmologic assessment of newborns born at less than 32 weeks gestation or weighing 1500 grams or less at birth is complete or scheduled as out-patient.
- vii. A critical congenital heart disease (CCHD) screening or echocardiogram has been completed.

c. Follow Up Care

- i. A physician directed source of continuing medical care has been identified.
- ii. Family, environmental, and social risk factors have been assessed. When risk factors are present, the discharge should be delayed until they are resolved or a plan to safeguard the infant is in place.
- iii. The parent's knowledge, ability, and confidence to provide adequate care for their infant are documented by the fact that they have received the following teaching:
  - a. Information about medication, preparation, dosing accuracy, and proper storage and administration of medication.
  - b. Use of oxygen therapy and monitoring equipment if necessary.
  - c. Ability to provide adequate nutrition to the infant, including frequency and volume of feeding and if giving formula, the ability to mix formula.

- d. Recognition of signs of acute illness and acute deterioration.
- e. Proper infant safety, including car seat adaptations for infants weighing less than 2000 gm, and recommended sleep positions for all infants.
- iv. Referrals to specialty clinics, physicians, developmental clinics, and outside agencies have been made, or recommendations have been relayed to the primary physician, as appropriate.
- v. Referrals for home health follow-up have been made.
- vi. A car seat trial has been done per protocol, if necessary.

d. Special Considerations for Preterm Infants

i. Respiratory

- a. Respiratory rate and effort is such that breathing does not compromise the infant's ability to feed, and the infant can maintain normal oxygen saturations during normal activities of daily living (e.g.: sleeping, feeding, and crying).
- b. For chronic lung disease: infant's oxygen requirements and medication regime is stable for 3-4 days prior to discharge.
- c. For apnea and bradycardia: infants are not routinely discharged before 35 weeks corrected age because of the potential for apnea and bradycardia.

ii. Retinopathy of Prematurity

- a. Continued hospitalization and continuous monitoring of oxygen saturations and intermittent retinal examinations to monitor the progression of retinopathy may be required for those infants whose disease has progressed to a point that laser surgery may be necessary to prevent retinal detachment.
- b. Infants whose disease is resolving, with or without surgery, and are no longer at risk for retinal detachment, may be considered for discharge once cleared by the ophthalmologist and assuming other discharge criteria have been met.

iii. Social Services

- a. Parents or guardians have had a social service consultation that is documented in the medical record prior to discharge, as deemed necessary.
- b. Families that require support to assist them with their high risk infant have been referred to the appropriate

resources prior to discharge.

e. Mode of Discharge

- i. The infant will be discharged in the arms of a parent/guardian, who is seated in a wheelchair.

f. Documentation

- i. The physician will document his/her physical exam in the patient's permanent record.
- ii. The RN taking care of the infant will complete the Discharge Checklist flowsheet in the electronic health record (EHR), and record the adequacy of the infant's feedings, vitals signs, and daily weight..
- iii. The RN taking care of the infant will document in the EHR Education Record that discharge teaching has been completed.
- iv. If any family, environmental, and/or social risk factors have been identified, the Social Worker will document in the EHR: the assessment, interventions, and plan of action.
- v. The Social Worker will document specialty clinic, developmental clinic, and outside agency referrals in the EHR.
- vi. Home health and equipment needs and arrangements are documented in the EHR by the Case Manager.
- vii. A copy of the hospitalization summary has been provided to the primary physician.

C. Transfer

1. Neonatal conditions requiring transport to regional neonatal intensive care unit from the MV NICU are:
  - a. Infants with multisystem failure requiring sub-specialist consultation not available on site.
  - b. Infants with extreme respiratory difficulty who are candidates for extracorporeal membrane oxygenation.
  - c. Cardiac conditions requiring catheterization, surgical intervention, or complex medical management.
  - d. Major pediatric surgical problems.
  - e. Major neurological problems.
2. A physician's clinical judgment may either expand or curtail this policy based upon:
  - a. Available medical expertise
  - b. NICU census and acuity
  - c. NICU staffing

*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.*

## Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	08/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2022
MCH Exec	Nikki Le Bautista: Medical Staff Coord	06/2022
Peds. Dept.	Melinda Porter: CNS/NP	05/2022
UPC	Melinda Porter: CNS/NP	04/2022
	Melinda Porter: CNS/NP	04/2022

## History

**Draft saved by Porter, Melinda: CNS/NP** on 4/19/2022, 7:38PM EDT

**Edited by Porter, Melinda: CNS/NP** on 4/28/2022, 3:35PM EDT

Combining with Transfer and Discharge policies so MV NICU has one ADT policy. Los Gatos NICU already has an ADT policy.  
MV NICU UPC 4/28/22

**Last Approved by Porter, Melinda: CNS/NP** on 4/28/2022, 3:35PM EDT

**Administrator override by Porter, Melinda: CNS/NP** on 4/28/2022, 3:41PM EDT

Changed workflow to NICU for this round because we're archiving 2 policies and I want Peds Exec to see and approve this change.

**Sent for re-approval by Porter, Melinda: CNS/NP** on 4/28/2022, 3:43PM EDT

**Last Approved by Porter, Melinda: CNS/NP** on 4/28/2022, 3:43PM EDT

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**Last Approved by Porter, Melinda: CNS/NP** on 4/28/2022, 3:44PM EDT

MV NICU UPC 4/28/22

**Administrator override by Porter, Melinda: CNS/NP** on 5/24/2022, 7:03PM EDT

Changed the admission criteria to remove duplicate entries and clarify some language as mentioned at Peds Exec 5/12/22

**Last Approved by Porter, Melinda: CNS/NP** on 5/24/2022, 7:12PM EDT

Peds Exec approval with changes 5/12/22

**Administrator override by Porter, Melinda: CNS/NP** on 5/26/2022, 1:18PM EDT

Changed neonatologist to neonatal provider as we just hired hospitalists to cover the NICU who are not neonatologists.

**Comment by Porter, Melinda: CNS/NP** on 5/26/2022, 1:19PM EDT

Re-approved by MV NICU UPC 5/26/22 with above mentioned changes.

**Last Approved by Le Bautista, Nikki: Medical Staff Coord** on 6/3/2022, 3:29PM EDT

Approved on 6/2/2022

**Administrator override by Porter, Melinda: CNS/NP** on 6/13/2022, 5:26PM EDT

Moved infants < 2000 g and < 35 weeks to category of "admit" not "consider for admission" after discussion with medical director Dharshi Sivakumar today. She was not at the last MCH Exec meeting. MCH Exec knew I would seek her approval before bringing to ePolicy.

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 8/5/2022, 3:06PM EDT

ePolicy 8/5/22

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 8/26/2022, 9:39AM EDT

MEC 8/25/22

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 8/26/2022, 12:02PM EDT

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 8/26/2022, 12:03PM

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EDT

Updated approval workflow

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 8/26/2022, 12:04PM EDT**

COPY



Origination: 08/2022

Effective: 08/2022

Last Approved: 08/2022

Last Revised: 08/2022

Next Review: 08/2025

Owner: Abigail Robles: Manager  
Strategic Sourcing - Supply Chain

Area: Supply Chain

Document Types:

## Vendor Sanction Screening Policy

### COVERAGE:

Supply Chain Department

### PURPOSE:

- To ensure that all contractor and vendors with whom El Camino Hospital does business with are properly screened for exclusions and are authorized to participate in federal and State healthcare programs.

### DEFINITIONS

**List of Excluded Individuals/Entities (LEIE):** The OIG established a program to exclude individuals and entities who have been found to have violated federal law and/or regulations. The OIG has been granted a number of legal authorities under the Social Security Act to affect sanctions and maintains a list of excluded individuals and Entities (LEIE). The effect of an OIG exclusion from Federal health care programs is that no Federal health care program payment may be made for any items or services (1) furnished by an excluded individual or entity, or (2) director or prescribed by an excluded physician (42 CFR 1001.1901). This payment ban applies to all methods of Federal program reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system (PPS). Any items and services furnished by an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner or supplier that is not excluded.

**General Services Administration (GSA) Sanction List:** The GSA maintains the sanction list to provide a single comprehensive list of individuals and firms excluded by Federal government agencies from receiving federal contracts or federally approved subcontracts and from certain types of federal financial and nonfinancial assistance and benefits. The sanction list was created for information and use by Federal agencies.

**Medicaid State Sanction Data:** Many states maintain their own database of individuals and entities they sanction. Several call for or require health care entities to screen against this list. This is in addition to and not in lieu of screening against the Federal sanction information.



## REFERENCES:

42 U.S.C ss1320A-7B (2006); <http://frwebate2.access.gpo.gov/cgi-bin/TEXTgate.cgi?WAISdocID=cEcmOj/0/1/0&WAISaction=retrieve>

Department of Health and Human Services Office of Inspector General. OIG Supplemental Compliance Guidance for Hospitals; <http://oig.hhs.gov/fraud/docs/complianceguidance/012705hospsupplementalguidance.pdf>

Department of Health and Human Services Office of Inspector General. Publication of the OIG Compliance Program Guidance for Hospitals. <http://oig.hhs.gov/authorities/docs/cpghosp.pdf>

Department of Health and Human Services Office of Inspector General. Special Advisory Bulletin. <http://oig.hhs.gov/exclusions/files/sab-0592013.pdf>>

Centers for Medicaid and CHIP Services. "Migration of the Excluded Parties List System (EPLS) to the System for Award Management (SAM)." CMCS Informational Bulletin (8.1.2012)

Centers for Medicare & Medicaid Service. State Medicaid Director Letter (SMDL #09-001), <http://www.cms.gov/SMDL/downloads/SMD011609.pdf>

Department of Health and Human Services Office of Inspector General. "The Effect of Exclusion from Participation in Federal Health Care Programs." Special Advisory Bulletin, Health Care Programs." Special Advisory Bulletin. [http://oig.hhs.gov/fraud/alerts/effect\\_of\\_exclusion.asp](http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp)

Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities. <http://oig.hhs.gov/fraud/exclusions.asp>

U.S. General Services Administration's System for Award Management, [www.sam.gov/portal/public/SAM/](http://www.sam.gov/portal/public/SAM/)

## PROCEDURE:

- A. Prior to establishing employment or a business relationship with any individuals, medical professionals, or outside entities, El Camino Hospital will screen them against the current List of Excluded Individuals and Entities (LEIE) of the OIG.
- B. El Camino Hospital shall also screen on a quarterly basis those individuals and entities whom it has engaged or otherwise has a business relationship.
- C. If it is determined upon reasonable due diligence that an individual or entity is listed as excluded by the OIG, the relationship shall be immediately terminated and the El Camino Hospital Compliance Officer will be notified.
- D. Prospective employees and vendors who have been officially reinstated into the Medicare and Medicaid programs by the OIG may be considered for employment, medical privileges or a contractual relationship upon proof of such reinstatement and a determination that there are no other impediments to such action.
- E. El Camino Hospital shall screen all contractors, consultants, vendors, joint venture parties and affiliates providing ancillary medically related services or products against the General Services Administration (GSA) System for Award Management (SAM) exclusion list. If it is determined that an individual or entity is under debarment, we shall follow the guidance offered by the GSA on their website and by CMS.
- F. El Camino Hospital will exercise reasonable due diligence to verify that any party found on an exclusion

list is the same individual or entity noted.

- G. El Camino Hospital will not employ or engage in a business relationship with anyone who is currently under sanction or exclusion by the Department of Health and Human Services Office of Inspector General (OIG) and any other duly authorized enforcement agency or licensing and disciplining authority.
- H. El Camino Hospital shall not engage in a business relationship with any individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as excluded or otherwise ineligible for participation in federal healthcare programs.
- I. El Camino Hospital shall remove individuals or terminate business with individuals with direct responsibility for or involvement in any federal healthcare program, as well as those pending the resolution of any criminal charges or proposed exclusion sanction. Contractors under pending criminal charges shall be suspended from continued work until the matter is resolved in the court of law.

*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
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2022
	Abigail Robles: Manager Strategic Sourcing - Supply Chain	07/2022

# The Great Attrition is making hiring harder. Are you searching the right talent pools?

**People keep quitting at record levels, yet companies are still trying to attract and retain them the same old ways. New research identifies five types of workers that employers can reach to fill jobs.**

*by Aaron De Smet, Bonnie Dowling, Bryan Hancock, and Bill Schaninger*

**It's the quitting trend** that just won't quit. People are switching jobs and industries, moving from traditional to nontraditional roles, retiring early, or starting their own businesses. They are taking a time-out to tend to their personal lives or embarking on sabbaticals. The Great Attrition<sup>1</sup> has become the Great Renegotiation.

Competition for talent remains fierce. For certain categories of workers, the barriers to switching employers have dropped dramatically. In the United States alone, there were 11.3 million open jobs at the end of May—up substantially from 9.3 million open jobs in April 2021.<sup>2</sup> Even as employers scramble to fill these positions, the voluntary quit rate is 25 percent higher than prepandemic levels.<sup>3</sup> At the current and projected pace of hiring, quitting, and job creation, openings likely won't return to normal levels for some time.

What we are seeing is a fundamental mismatch between companies' demand for talent and the number of workers willing to supply it. Employers continue to rely on traditional levers to attract and retain people, including compensation, titles, and advancement opportunities. Those factors are important, particularly for a large reservoir of workers

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<sup>1</sup> Aaron De Smet, Bonnie Dowling, Marino Mugayar-Baldocchi, and Bill Schaninger, "'Great Attrition' or 'Great Attraction'? The choice is yours," *McKinsey Quarterly*, September 8, 2021.

<sup>2</sup> "Table A. Job openings, hires, and total separations by industry, seasonally adjusted," Job Openings and Labor Turnover Survey, US Bureau of Labor Statistics, July 6, 2022.

<sup>3</sup> US Bureau of Labor Statistics quits levels and rates data, December 2019 through May 2022.

we call “traditionalists.” However, the COVID-19 pandemic has led more and more people to reevaluate what they want from a job—and from life—which is creating a large pool of active and potential workers who are shunning the traditionalist path.

As a result, there is now a structural gap in the labor supply because there simply aren't enough traditional employees to fill all the openings. Even when employers successfully woo these workers from rivals, they are just reshuffling talent and contributing to wage escalation while failing to solve the underlying structural imbalance.

To close the gap, employers should try to win back nontraditional workers. But how?

To better understand who might fill all the open jobs, we examined economic and labor statistics; conducted a large global survey to learn more about what is driving people to stay, leave, or return; and applied advanced analytics to define specific segments of the workforce, both active and latent (see sidebar, “About the research”).

Our analysis of workers in six countries focuses on which job attributes are motivating them, both positively and negatively. We asked survey participants in various phases of job churn why they left or would consider leaving and what would make them want to stay or come back. It turns out that many workers want more than the usual compensation and job advancement carrots.

To get at these priorities, we sorted respondents into smaller groups who shared the same set of primary needs that they want an employer to meet. Then we looked at whether these workers also shared demographic similarities. These groups of like-minded respondents became our “personas”—distinct pools of workers that employers can target in their search for talent. While most of these groups valued workplace flexibility highly, they differed in how they rated mental-health support, meaningful work, and career advancement.

These differences show that no single solution is going to attract enough people to fill all the job openings and retain a productive workforce. Instead, employers can take a multipronged approach to reach different talent pools. This doesn't mean that organizations have to change their mission, values, or purpose. Rather, they can showcase different facets of their employee value proposition to a broader number of workers and get more creative in their offers to current and potential employees.

In this article, we take a closer look at five crucial employee personas that companies must understand to solve the attrition and attraction problem for the longer term.

## **New trends make the employment picture more complex**

Despite significant changes in the economy since the onset of the Great Attrition (or what many call the Great Resignation), the share of workers planning to leave their jobs remains unchanged from 2021, at 40 percent. That's two out of five employees in our global sample who said that they are thinking about leaving in the next three to six months.

# About the research

**To better understand** what continues to spur voluntary attrition and other shifts in the labor market, we surveyed 13,382 employees in Australia (n = 593), Canada (n = 1,935), India (n = 766), Singapore (n = 652), the United Kingdom (n = 3,142), and the United States (n = 6,294). The survey data, collected from February 15 to April 2, 2022, included people of working age across 16 industries.

However, the past year has revealed nuances of the larger trend:

- **Reshuffling.** Employees are quitting and going to different employers *in different industries* (48 percent of the job leavers in our sample). Some industries are disproportionately losing talent, others are struggling to attract talent, and some are grappling with both.
- **Reinventing.** Many employees leaving traditional employment are either going to nontraditional work (temporary, gig, or part-time roles) or starting their own businesses. Of the employees who quit without a new job in hand, 47 percent chose to return to the workforce. However, only 29 percent returned to traditional full-time employment.
- **Reassessing.** Many people are quitting not for other jobs but because of the demands of life—they need to care for children, elders, or themselves. These are people who may have stepped out of the workforce entirely, dramatically shrinking the readily available talent pool.

## **Globally, employees are considering their options**

While there is ample evidence that this workforce discontent is a global phenomenon, the situation has further deteriorated in certain markets. In India, more than 60 percent of respondents expressed a desire to leave their current posts, well above their counterparts in Australia, Canada, the United Kingdom, and the United States. Workers in Singapore showed the second-highest level of job discontent, at 49 percent (Exhibit 1).

Respondents across the six countries showed a consistently high desire for work that is better paying, more satisfying, or both, as well as a conviction that they can find better jobs elsewhere. As our research has shown, some workers are leaving their jobs *and* the workforce, ready for a break and confident in their ability to find another job when they want to. Indeed, almost three-quarters of employed respondents believe that it would not be difficult to find a job that pays the same or better, with the same or better benefits.

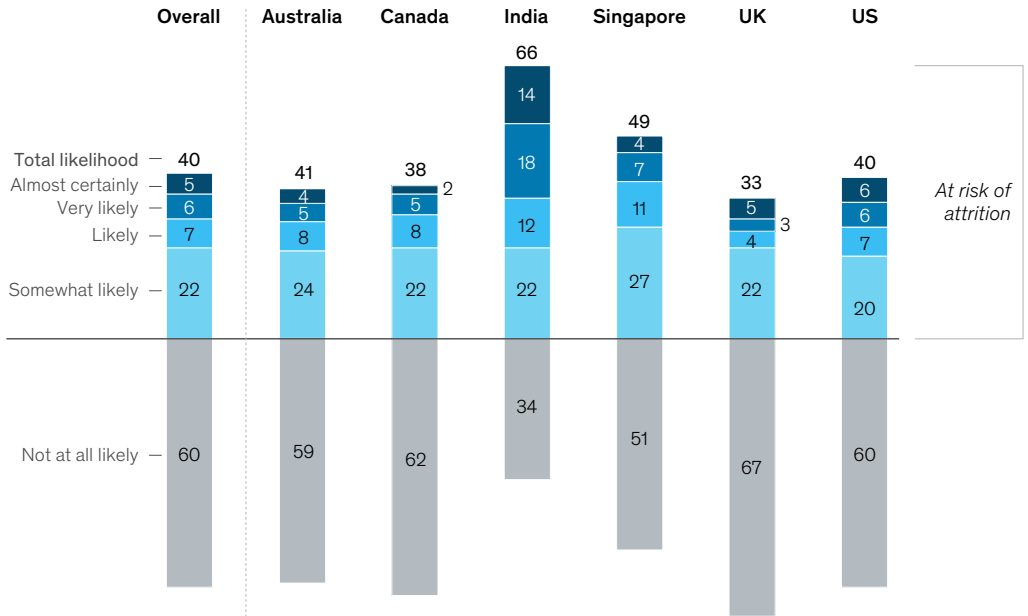
## **Mobility between industries is high**

Vitaly, companies can no longer assume that they can fill empty slots with workers similar to the ones who just left. Globally, just 35 percent of those who quit in the past two years

Exhibit 1

**Forty percent of workers globally say that they might leave their jobs in the near future.**

Likelihood that respondents will leave their current job in next 3–6 months, %



Note: Figures may not sum to total, because of rounding.  
 Source: Subset of respondents from McKinsey's 2022 Great Attrition, Great Attraction 2.0 global survey who were employed at the time of the survey, which was conducted between Feb 2022 and Apr 2022 (n = 12,378)

took a new job in the same industry. In finance and insurance, for instance, 65 percent of workers changed industries or did not return to the workforce. In the public and social sector, the exodus was even greater, at 72 percent (Exhibit 2).

In some areas, these losses may reverberate for some time. In travel, healthcare, and consumer retail—industries hit hard during the pandemic—at least 18 percent of respondents who quit their jobs are choosing to forgo employment entirely rather than work in the same or any other industry again.<sup>4</sup>

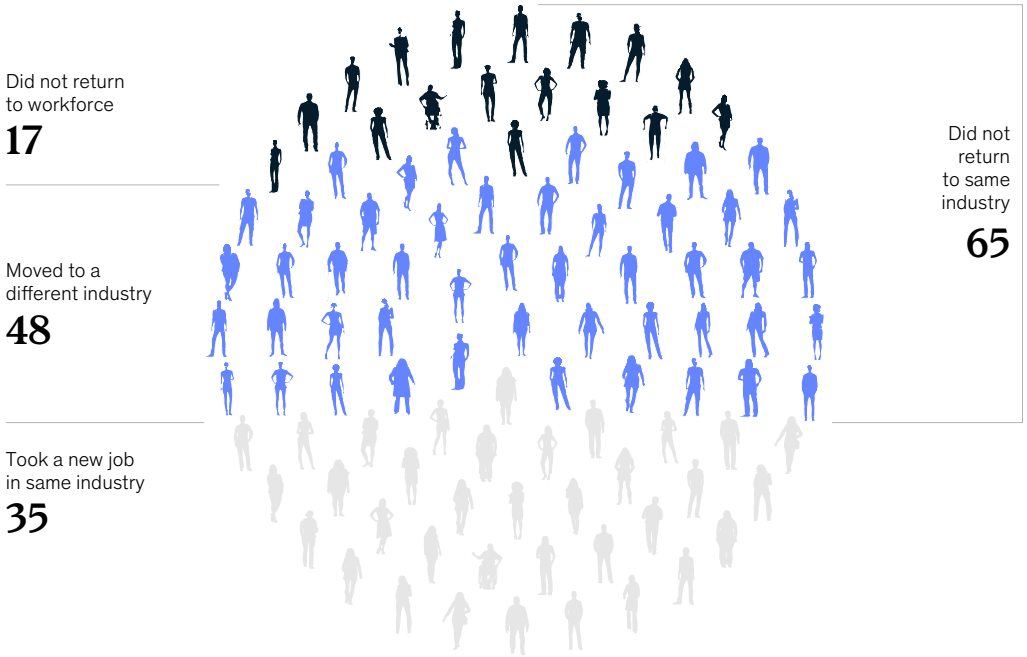
There are bright spots for workers, however. For those with sought-after skills such as data scientists and programmers, the hurdles to changing industries are lower. Companies are more focused on hiring people for their skills rather than their industry experience, and the most talented individuals with the most sought-after skills will be able to continue to explore options to find the best fit. There is less of a stigma attached to job hopping or gaps in a résumé, and joining companies in other geographies without relocating has become easier than ever, making it possible for people to jump from one employer to another.

<sup>4</sup>According to McKinsey's Great Attrition, Great Attraction 2.0 global survey, 18 percent of respondents in healthcare and pharmaceuticals did not return to the workforce; 18 percent of respondents in travel, transport, and logistics did not return; and 24 percent of respondents in consumer retail did not return.

Exhibit 2

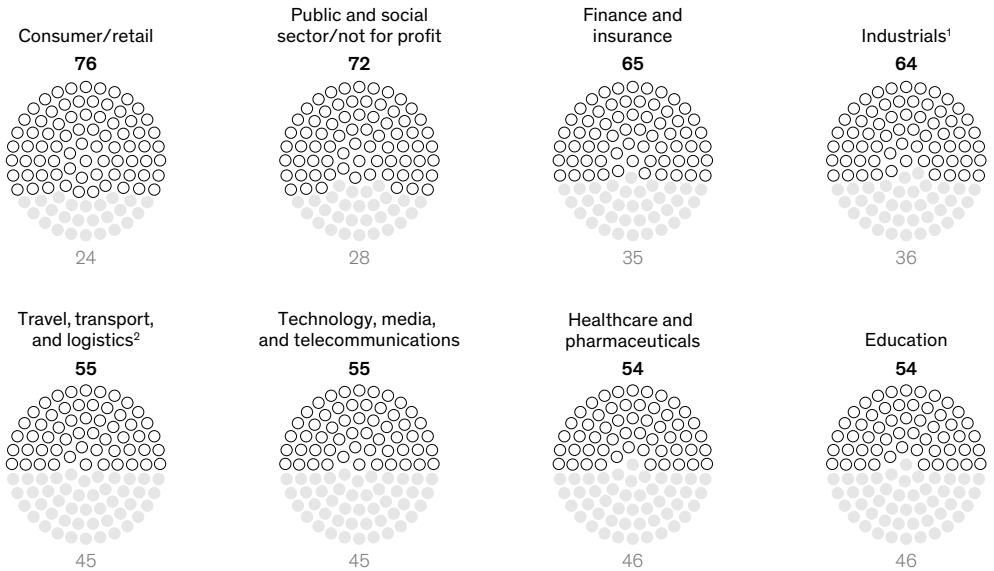
**The majority of people who quit their jobs in the past two years are not returning to the industries they left.**

Status of respondents who had quit their jobs between Apr 2020 and Apr 2022, global, %



Status of respondents who had quit their jobs between Apr 2020 and Apr 2022, selected industries, %

○ Did not return to same industry (moved to a different one or did not return to workforce) ● Took a new job in same industry



<sup>1</sup>Includes advanced industries, energy and materials, and professional, scientific, and technical services.

<sup>2</sup>Includes infrastructure.

Source: Subset of respondents from McKinsey's 2022 Great Attrition, Great Attraction 2.0 global survey (n = 1,831)

These factors create a new playing field for hiring, since employers find themselves competing not only within their industry, as in the past, but also across industries.

## **Five personas: A new way to target the employee value proposition**

To navigate this new playing field successfully, hiring managers can look beyond the current imbalance in labor supply and demand and consider what different segments of workers want and how best to engage them.

To do this, employers should understand the common themes that reveal what people most value, or most dislike, about a job. For instance, it cannot be overstated just how influential a bad boss can be in causing people to leave. And while in the past an attractive salary could keep people in a job despite a bad boss, that is much less true now than it was before the pandemic. Our survey shows that uncaring and uninspiring leaders are a big part of why people left their jobs, along with a lack of career development. Flexibility, on the other hand, is a top motivator and reason for staying (Exhibit 3).

### **1. The traditionalists: The star of the classic labor pool won't be enough to fill all the jobs**

Traditionalists are career-oriented people who care about work–life balance but are willing to make trade-offs for the sake of their jobs. They are motivated to work full-time for large companies in return for a competitive compensation package and perks, a good job title, status at the company, and career advancement.

Roughly 60 percent of the traditionally employed, full-time workforce have not quit their jobs during the Great Attrition, according to the US Bureau of Labor Statistics. We estimate that the majority of these individuals can be classified as traditionalists. They have been more risk averse, more likely to stick with their current employer, and less likely to quit without another job lined up. If they did leave their jobs, most have likely returned, wooed by a traditional value proposition such as higher pay.

Employers like traditionalists because these employees are easier to find through common recruitment strategies, and what these workers want matches what companies have historically offered to hire and retain people. Unfortunately, this method of securing workers is like playing a game of Whac-A-Mole: when one company hires traditionalist employees, rivals fight back with promotions and higher pay to try to retain and attract the same scarce talent. Companies that use these levers to pursue traditionalist workers end up contributing to wage inflation but fail to solve the problem of employer and job “stickiness” (Exhibit 4).

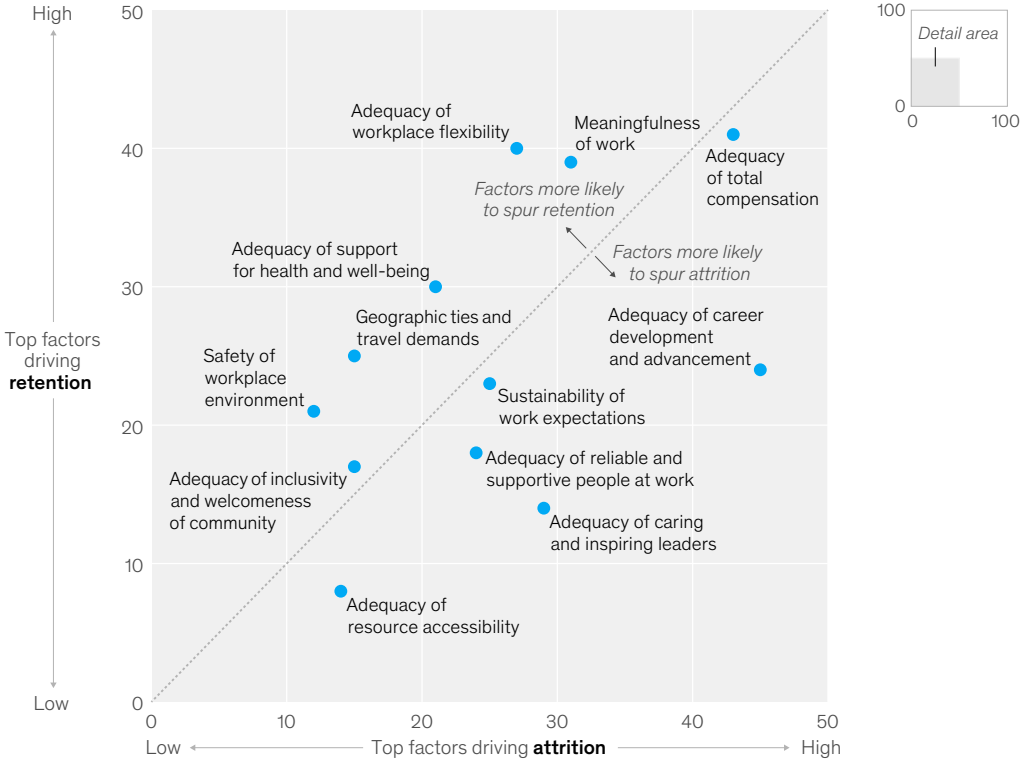
Whereas traditionalists are a relatively monolithic bunch, the remainder of the workforce is more varied. Some are self-employed, others are doing gig or freelance work. There are students, temporary workers, on-call workers. There are those who have left their jobs but could be coaxed back under the right conditions, and those who say they won't ever come back. Together, they make up the majority of the *potential* talent pool, and they deserve a much closer look.



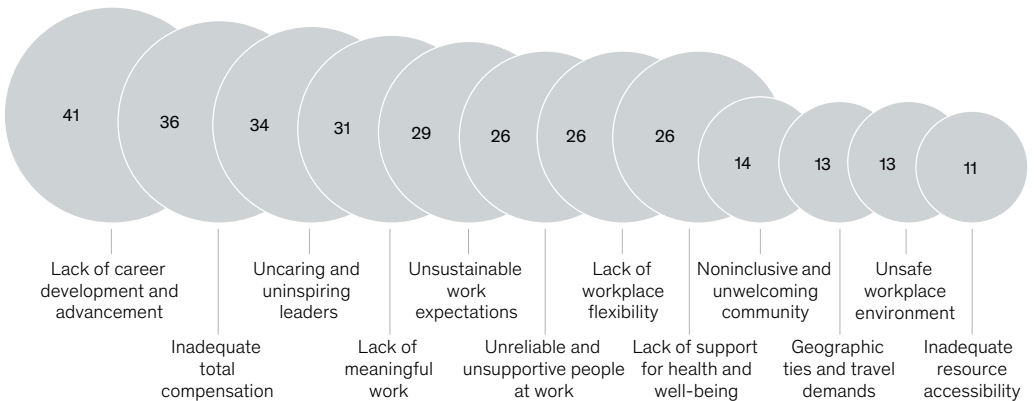
Exhibit 3

## Push and pull: Employers should understand the motivating factors that keep people in jobs—and the demotivators that drive workers away.

Employee experience factors driving attrition and retention,<sup>1</sup> % of respondents



Top reasons for quitting previous job, Apr 2021–Apr 2022, %



Source: Subset of respondents from McKinsey's 2022 Great Attrition, Great Attraction 2.0 global survey (n = 13,382), including those currently employed and planning to leave (n = 4,939), those currently employed and planning to stay (n = 7,439), and those who quit their previous primary jobs between Apr 2021 and Apr 2022 (n = 1,154)

Of those who have left full-time jobs over the past two years—a status that described 21 percent of the global workers we surveyed—many quit for similar reasons.

Early in the Great Attrition, exiting workers told us that relationships in their workplace were sources of tension and that they didn't feel that their organizations and managers cared about them. In this latest round, respondents again cited uncaring leaders (35 percent listed it as one of their top three reasons for leaving), but they added a new range of top motivators, including inadequate compensation, a lack of career advancement, and the absence of meaningful work.

In other words, plenty of employees say that they see no room for professional or personal growth, believe that there is better money to be made elsewhere, and think that leaders don't care enough about them—tried-and-true reasons for disgruntlement, to be sure, but ones that are now being acted upon broadly.

Fortunately, many of those who left traditional employment indicated that they could be coaxed back under the right conditions. These nontraditional workers make up the rest of our five key personas. Here we take a closer look at these groups and what they value (Exhibit 5).

Exhibit 4

## Strategies that attract traditional workers are not enough to entice other groups back to traditional employment.

Employee experience factors driving appeal for traditional and nontraditional workers, ranking

Factors	Reasons people who quit took a new traditional job <sup>1</sup>	Reasons nontraditionalists would return to a traditional job <sup>2</sup>
Career development and advancement	1	7
Adequate total compensation	2	2
Meaningful work	3	3
Workplace flexibility	4	1
Reliable and supportive people at work	5	5
Support for health and well-being	6	4
Sustainable work expectations	7	9
Caring and inspiring leaders	8	10
Inclusive and welcoming community	9	8
Geographic ties and travel demands	10	11
Safe workplace environment	11	6
Resource accessibility	12	12

<sup>1</sup>Respondents who quit a job anytime between Apr 2021 and Apr 2022 and took a new traditional job (n = 799).

<sup>2</sup>Respondents who would consider returning to a traditional job (n = 1,963).

Source: Subset of respondents from McKinsey's 2022 Great Attrition, Great Attraction 2.0 global survey (n = 13,382)

## 2. The do-it-yourselfers: Anything for autonomy

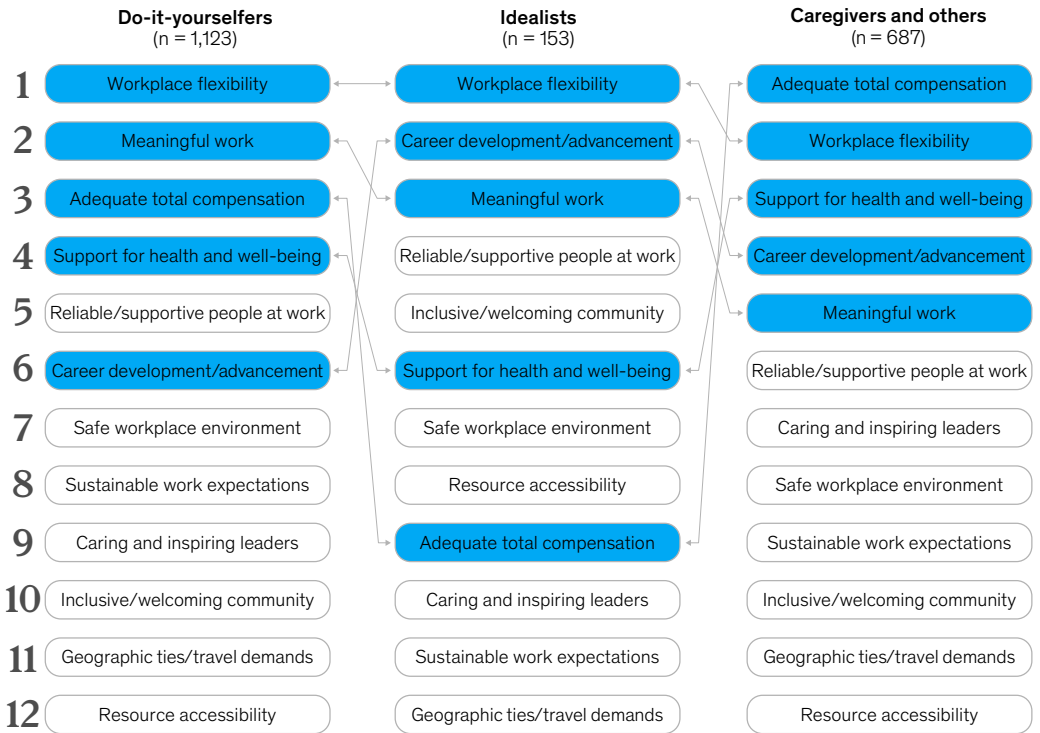
This persona, comprising the largest share of respondents, values workplace flexibility, meaningful work, and compensation as the top motivators for potentially returning to the traditional workforce. They tend to be 25 to 45 years old and run the gamut from self-employed to full-time employed in nontraditional roles to gig and part-time workers.

Exhibit 5

### What would it take to bring three nontraditionalist personas back to a traditional job?

Among respondents who are at least somewhat likely to return to traditional employment in next 3–6 months,<sup>1</sup> ranking

■ Top factors, ranked, for 3 nontraditionalist personas



#### Relaxers (n = 864)

This persona includes retirees and others who have exited the workforce and are not actively looking to return to a traditional job. Thus, they were not asked to list their top three motivators for returning to traditional employment. However, when asked, "What are the top three reasons you would take a new job?" they ranked meaningful work and workplace flexibility highest, followed by career development/advancement. Their survey responses, as well as interviews and other data, have given us enough insights into members of this critical group to warrant including them in our analysis.

<sup>1</sup>Nontraditionalists who indicated being at least somewhat likely to return to traditional employment in the next 3 to 6 months answered the following question: "Below are 12 broad aspects of the employee experience. Please choose the top 3 categories that an employer would need to provide for you to return to traditional employment."

Source: Subset of respondents from McKinsey's 2022 Great Attrition, Great Attraction 2.0 global survey (n = 2,827)

This group wants flexibility above all else. During the pandemic, workload-related stress, toxic managers, a desire for autonomy, and a feeling of not being appreciated led many people to look for something different. Over 2.8 million more people in the United States submitted start-up applications in 2020 and 2021 than in 2019. Others found that part-time or gig opportunities gave them greater autonomy to set their own hours and the freedom to decide what kind of work they would do.

Attracting this cohort may be difficult, because organizations must show that what they offer is better than what these workers have created for themselves. Companies can provide the freedom that these workers crave *and* a sense of purpose, as well as a compensation package beyond what they have on their own.

One way to achieve that is through modularized work—defining discrete meaningful tasks that can be accomplished independently. This decouples goal setting and the completion of tasks from the traditional five-day workweek with set hours in an office. Another way is to manage according to outcomes rather than to activities, ratcheting up accountability for impact but allowing workers and their teams to dictate for themselves when and how the task gets done. To make it work, employers should embrace flexibility from the outset—even by asking job candidates how many interviews they would prefer to have and whether they would rather do them remotely or in person.

Many companies are starting to explore various forms of radical flexibility. For example, Airbnb CEO Brian Chesky recently announced that the company's employees will be able to work from anywhere and abolished the idea of location-based pay. In the days after his announcement, Airbnb's recruitment page received more than a million visitors.<sup>5</sup>

### **3. The caregivers and others: At home but wanting more**

More than two years after the start of the pandemic, this persona needs little introduction. Members of this group are motivated by compensation but have another constellation of priorities for returning to their jobs: workplace flexibility, support for employee health and well-being, and career development.

These are people who have decided to sit it out at home, with some actively looking for work and others who are passive job seekers hoping to find an opportunity that would justify reentering the paid labor force. The predominant age group is between 18 and 44, with more women than men, many who are parents or other caregivers. A lot of the people in this group needed more flexibility and support than traditional employment offered and left to care for children, parents, or themselves.

People in this profile are ready to lend their time and talents to companies that are willing to work with their schedules. For them, workplaces that are inflexible and that don't provide a pathway to advancement aren't worth the sacrifice of going back to work while continuing their caregiving duties. These employees are asking for dedicated support that will allow them to fulfill the responsibilities outside their jobs while being recognized for their contributions at work. They could be coaxed back with part-time options, four-day workweeks, flexible hours, or expanded benefits packages.

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<sup>5</sup> Belinda Luscombe, "The office as we know it is over," says Airbnb CEO Brian Chesky," *Time*, May 8, 2022.

Many organizations recognize this growing cohort of potential workers and are responding accordingly—for example, by normalizing and widening the use of parental leave and by offering parents more flexibility around school holidays.<sup>6</sup> Companies such as Google, Cisco Systems, and Patagonia offer employees benefits such as on-site childcare, physical therapy, and subsidized housecleaning services.

#### **4. The idealists: Students and younger part-timers**

Those in our idealist persona tend to be younger, aged 18 to 24, and many are students or part-time workers. Mostly unencumbered by dependents, mortgages, and other responsibilities, this group emphasizes flexibility, career development and advancement potential, meaningful work, and a community of reliable and supportive people, with compensation far lower on the list.

To woo them, companies have to offer flexibility, of course, but also demonstrate a willingness to invest in this group's development and create a strong organizational culture that emphasizes meaning and purpose. This persona ranked belonging to an inclusive and welcoming community more highly than the other personas—squaring with our research showing that younger workers value diversity in the workplace.<sup>7</sup>

An appealing value proposition for these workers would include pairing traditional tuition subsidies with flexible work schedules to accommodate classes, along with development programs that offer clear advancement trajectories. Anchoring these measures in purpose and investing heavily in the day-to-day interactions that build a high-quality culture can help create an even more enticing recruitment package.

#### **5. The relaxers: Career doesn't come first anymore**

In contrast to the previous personas, the people in this cohort are a mix of retirees, those not looking for work, and those who might return to traditional work under the right circumstances. We call this latter group the “Gronks,” referring to the American football player Rob Gronkowski, who retired but returned at the urging of his former teammate Tom Brady and the promise of not only pay but also a flexible contract with a great team. Gronkowski recently retired again—but who knows what the future holds?

Like many who retired early during the pandemic, Gronks have completed their traditional careers and might not need more money to live comfortably. So they will want more than the traditional value proposition to be enticed back into the workforce—including the promise of meaningful work. Comprising both early retirees and natural-age retirees who still have many productive years left, they represent the largest segment of the latent workforce.

There are interesting dynamics at play here. After a surge in retirement during the early months of the pandemic, the rate of retired workers returning to the job market has slowly been increasing.<sup>8</sup> Some have been enticed by higher wages or an improved pandemic outlook, while others have felt the effects of inflation and a need to return to work as their nest egg dwindles faster than anticipated. But with estimates of just one in five of these “pandemic retired”<sup>9</sup> looking to return to the workforce, there are plenty more out there for companies to attract.

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<sup>6</sup> Alina Dizik, “Parents seek more support from employers during school holidays,” *Wall Street Journal*, June 10, 2022.

<sup>7</sup> Bryan Hancock and Bill Schaninger, “The elusive inclusive workplace,” McKinsey, March 23, 2021.

<sup>8</sup> Denitsa Tsekova, “Older workers are ‘unretiring’ after leaving the workforce during the pandemic,” Yahoo, November 16, 2021.

<sup>9</sup> “Due to inflation, 1 in 5 retirees likely to go back to work this year,” ResumeBuilder.com, May 2, 2022.

Organizations have not pursued these seasoned workers as hard as they might. Employers who had positive relationships with employees they lost should consider reaching out to them to see if they can find the right balance to win those people back

## **Organizations have to focus on the right employee pools**

The pressure that companies face in attracting and retaining workers stems in large part from the fundamental shift over the past two years in how people have come to view their jobs and their employers. But it is also the result of the unprecedented demands of a hot job market leading to record numbers of job openings.

The US employment picture is a good example. As we noted earlier, there were more than 11 million job openings across the United States at the end of May. While inflation is forcing some people back into the traditional workforce, those numbers are insufficient to fill the open jobs sustainably. And even if the economic picture worsens, many companies are likely to find that job openings will persist in crucial positions, a problem they can't fix by simply reshuffling their current workforces.

Automation and increased immigration can help with some of the jobs shortfall. But companies need to hire from the existing employee pool, not the one they wish for. That may mean lowering or changing job requirements for some roles—by not requiring a college degree, for example, or by reaching out to workers with a criminal record, part of a recent uptick in “fair chance” hiring.<sup>10</sup> While taking these steps, companies can make sure they maintain the right value proposition to meaningfully expand the pool of workers.

Employers should continue to value their traditionalists, but as the personas reveal, they also need to look beyond them to the workers who want flexible, supportive work arrangements. These people are out there, in greater numbers than before, and they can be courted with the right strategies.

To address this attrition–attraction problem for the long term, companies can take four actions.

First, they can sharpen their traditional employee value proposition, which, as we've discussed, involves focusing on title, career paths, compensation, benefits, having a good boss, and the overall prestige of the company.

Second, they can build their nontraditional value proposition, which revolves around flexibility, mental- and behavioral-health benefits, a strong company culture, and different forms of career progression. The value proposition itself and the way that companies pursue these prospective employees should be more creative—and more personalized. The sheer volume of churn in the labor market and at organizations means that a massive portion of the workforce is and will remain new. For companies, this means that the culture passed on through traditions and behavioral norms will mean much less unless organizations make the relevance of that culture clear to new joiners from the start.

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<sup>10</sup> Emily Peck, “Workers with criminal records are getting a chance,” Axios, June 14, 2022.

Third, companies can broaden their talent-sourcing approach, especially since some nontraditionalists are not actively looking but would come back for the right offer. A better understanding of these five personas can help companies tailor their sourcing strategies toward different types of workers.

Finally, organizations can make jobs “sticky” by investing in more meaning, more belonging, and stronger team and other relational ties. Building these organizational attributes will also make it harder for traditionalists to go elsewhere for a bit more pay.

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The COVID-19 pandemic has been brutal in so many ways. It has also spurred feelings of liberation for millions of workers who can now envision what they want their jobs to be, not what they have been. Companies don’t have to reinvent their employee value proposition to meet this moment. In fact, they should double down on what that proposition is—a core representation of their culture, purpose, and values—while also expanding their reach into multiple talent pools. This outreach must be creative and authentic. Workers know the difference, and they are voting with their feet. [Q](#)

**Aaron De Smet** is a senior partner in McKinsey’s New Jersey office, **Bonnie Dowling** is an associate partner in the Denver office, **Bryan Hancock** is a partner in the Washington, DC, office, and **Bill Schaninger** is a senior partner in the Philadelphia office.

The authors wish to thank Marino Mugayar-Baldocchi, Laura Pineault, Pawel Poplawski, and Jane Qu for their contributions to this article.

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# El Camino Health

## Summary of Financial Operations

*Fiscal Year 2023 – Period 1  
7/1/2022 to 07/31/2022*

*Please Note: Period 1 results are pending review / approval by Finance Committee which is scheduled for September 29, 2022.*



# Executive Summary - Overall Commentary for Period 1

- **Financial Results for Period 1:**

- Revenue favorability to budget driven by both Inpatient and Outpatient performance
- Continued effective cost control
  - Cost per CMI Adjusted Discharge was 3.6% favorable to budget
- Gross charges were favorable to budget by \$27.3M / 6.7% and \$36.6M / 9.2% higher than the same period last year.
  - Inpatient charges were favorable by \$18.0M / 8.9% while Outpatient charges were favorable by \$9.3M / 4.6%.
- Net patient revenue was favorable at budget and \$6.7M / 6.6% higher than the same period last year.
- Operating margin was favorable to budget by \$3.7M / 36.7% and \$1.2M / 9.8% higher than the same period last year.
- Operating EBIDA was favorable to budget by \$3.9M / 22.0% and \$2.9M / 15.6% higher than the same period last year.
- Net income was favorable to budget by \$36.5M / 283.8% and \$40.9M / 478.1% higher than the same period last year. This is attributed to strong performance by our investment portfolio.

# Operational / Financial Results: YTD FY2023 (as of 07/31/2022)

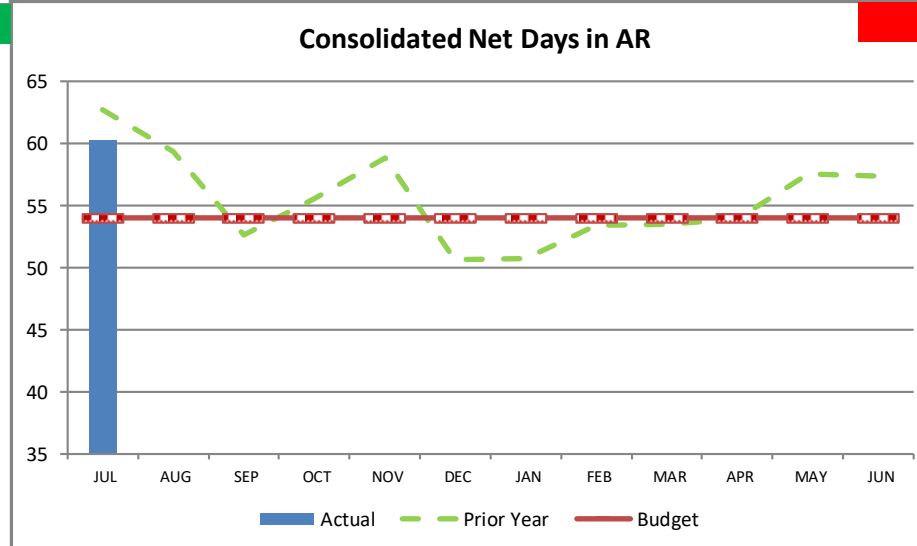
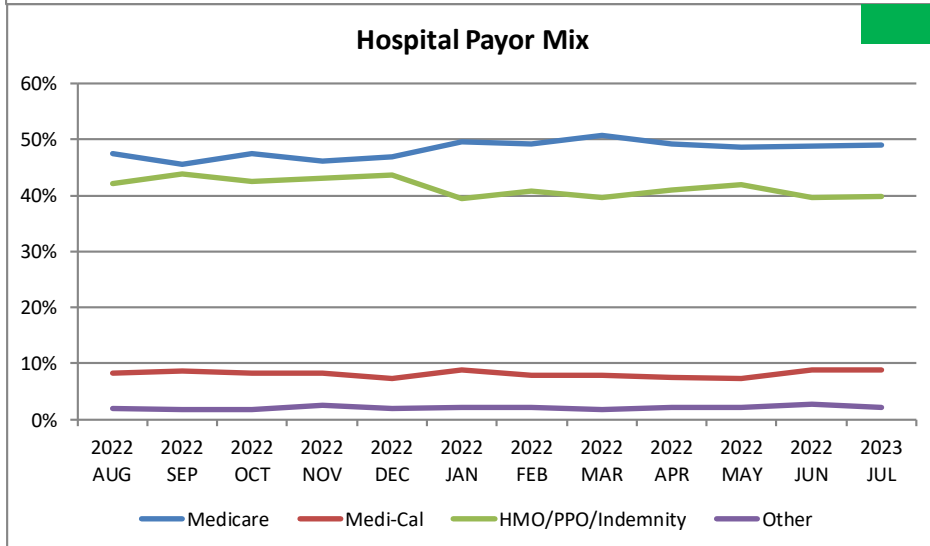
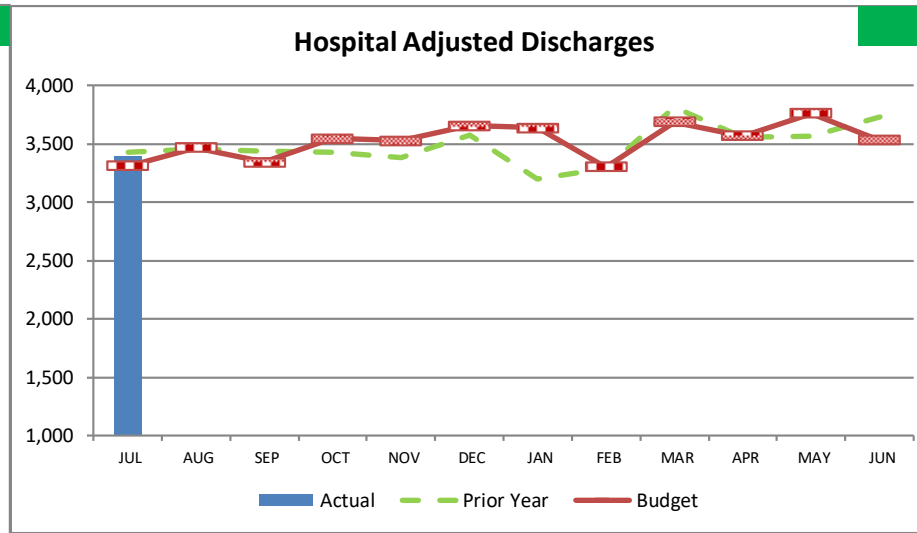
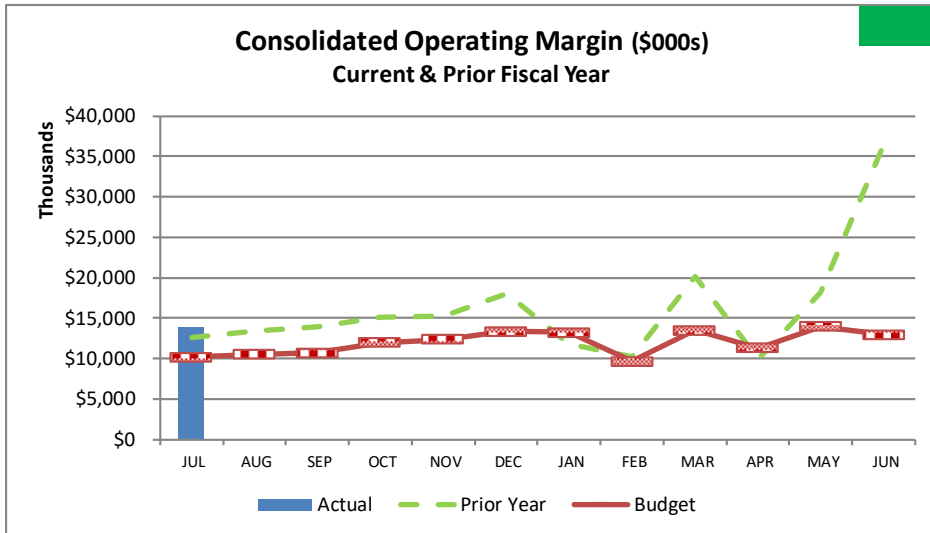
(\$ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's	S&P	Performance to Rating Agency Medians
									'A1'	'AA'	
Activity / Volume	ADC	282	247	35	14.3%	256	27	10.4%	---	---	---
	Total Acute Discharges	1,746	1,670	76	4.6%	1,705	41	2.4%	---	---	---
	Adjusted Discharges	3,400	3,315	85	2.6%	3,428	(28)	(0.8%)	---	---	---
	Emergency Room Visits	5,345	5,406	(61)	(1.1%)	5,022	323	6.4%	---	---	---
	OP Procedural Cases	11,620	12,952	(1,332)	(10.3%)	12,059	(439)	(3.6%)	---	---	---
	Gross Charges (\$)	441,741	414,454	27,287	6.6%	406,295	35,446	8.7%	---	---	---
Operations	Total FTEs	3,220	3,156	64	2.0%	2,946	274	9.3%	---	---	---
	Productive Hrs. / APD	28.4	31.7	(3.3)	(10.4%)	28.3	0.1	0.3%	---	---	---
	Cost Per CMI AD	17,388	18,036	(648)	(3.6%)	15,593	1,795	11.5%	---	---	---
	Net Days in A/R	60.3	54.0	6.3	11.7%	62.8	(2.4)	(3.9%)	47.7	49.7	---
Financial Performance	Net Patient Revenue (\$)	108,509	108,319	191	0.2%	101,774	6,736	6.6%	138,547	82,105	---
	Total Operating Revenue (\$)	112,566	112,220	346	0.3%	104,889	7,677	7.3%	151,909	109,602	---
	<b>Operating Margin (\$)</b>	<b>13,891</b>	<b>10,162</b>	<b>3,730</b>	<b>36.7%</b>	<b>12,648</b>	<b>1,244</b>	<b>9.8%</b>	<b>1,915</b>	<b>3,836</b>	---
	<b>Operating EBIDA (\$)</b>	<b>21,725</b>	<b>17,813</b>	<b>3,912</b>	<b>22.0%</b>	<b>18,793</b>	<b>2,932</b>	<b>15.6%</b>	<b>11,188</b>	<b>10,741</b>	---
	Net Income (\$)	49,420	12,876	36,545	283.8%	8,549	40,872	478.1%	8,124	7,343	---
	<b>Operating Margin (%)</b>	<b>12.3%</b>	<b>9.1%</b>	<b>3.3%</b>	<b>36.3%</b>	<b>12.1%</b>	<b>0.3%</b>	<b>2.3%</b>	<b>1.9%</b>	<b>3.5%</b>	---
	<b>Operating EBIDA (%)</b>	<b>19.3%</b>	<b>15.9%</b>	<b>3.4%</b>	<b>21.6%</b>	<b>17.9%</b>	<b>1.4%</b>	<b>7.7%</b>	<b>8.3%</b>	<b>9.8%</b>	---
	DCOH (days)	291	325	(34)	(10.4%)	364	(73)	(20.0%)	306	355	---

**Moody's Medians:** Not-for-profit and public healthcare annual report; September 9, 2021.

**S&P Medians:** U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021.

DCOH total includes cash, short-term and long-term investments.

# YTD FY2023 Financial KPIs – Monthly Trends



# Period 1 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 07/31/2022)

(\$000s)

	Period 1- Month			Period 1- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>El Camino Hospital Operating Margin</b>						
Mountain View	11,544	10,178	1,366	11,544	10,178	1,366
Los Gatos	4,902	3,470	1,432	4,902	3,470	1,432
<b>Sub Total - El Camino Hospital, excl. Affilates</b>	<b>16,446</b>	<b>13,648</b>	<b>2,798</b>	<b>16,446</b>	<b>13,648</b>	<b>2,798</b>
<b>Operating Margin %</b>	<b>15.2%</b>	<b>12.7%</b>		<b>15.2%</b>	<b>12.7%</b>	
<b>El Camino Hospital Non Operating Income</b>						
<b>Sub Total - Non Operating Income</b>	<b>33,339</b>	<b>2,402</b>	<b>30,937</b>	<b>33,339</b>	<b>2,402</b>	<b>30,937</b>
<b>El Camino Hospital Net Margin</b>	<b>49,785</b>	<b>16,051</b>	<b>33,735</b>	<b>49,785</b>	<b>16,051</b>	<b>33,735</b>
<b>ECH Net Margin %</b>	<b>46.0%</b>	<b>14.9%</b>		<b>46.0%</b>	<b>14.9%</b>	
Concern	521	84	436	521	84	436
Foundation	1,688	12	1,676	1,688	12	1,676
El Camino Health Medical Network	(2,574)	(3,271)	698	(2,574)	(3,271)	698
<b>Net Margin Hospital Affiliates</b>	<b>(365)</b>	<b>(3,175)</b>	<b>2,810</b>	<b>(365)</b>	<b>(3,175)</b>	<b>2,810</b>
<b>Total Net Margin Hospital &amp; Affiliates</b>	<b>49,420</b>	<b>12,876</b>	<b>36,545</b>	<b>49,420</b>	<b>12,876</b>	<b>36,545</b>

**CEO Report**  
**September 14, 2022**  
**Dan Woods, Chief Executive Officer**

## **Operations**

The California Perinatal Quality Care Collaborative (CPQCC) recognized Mountain View Neonatal Intensive Care Unit for providing outstanding care in key measures, including 100% antenatal steroid use and ZERO hospital-associated infections in the past year – supporting El Camino Health’s High-Reliability Organization (HRO).

Our perinatal diagnostic center is expanding to support diabetic patients with the addition of a “Sweet Success” program. The center supports high-risk patients with a safe plan of care for delivery.

## **Finance**

For the month ending July 31, 2022, produced net operating revenue, after expenses, of \$13.9 million. Net income of \$49.4 million was favorable to budget by \$36.5 million and \$40.9 million better than the same period last year, which is mainly attributed to the instability in the capital markets. Please note that these results have not been presented/approved by the Finance Committee.

Our external auditors (Moss Adams) initiated onsite fieldwork the second week of August. We expect them to finalize their review by the second week of September with a presentation of findings to CAC at the September 28<sup>th</sup> meeting.

## **Corporate & Community Health Services**

Concern won a contract with a large local city and is bidding on another large public sector opportunity. We have achieved significant recognition with cities across California due to our high-quality first responder program.

The South Asian Heart Center engaged 435 new and prior participants in screening, education, and coaching programs to prevent heart disease and diabetes and completed 916 consultations and coaching sessions. We hosted six lifestyle workshops and health information/screening events attended by 206 community members. We received CDC’s National Diabetes Prevention Program Full Plus Recognition for STOP-D, our program to prevent or delay the onset of diabetes.

The Chinese Health Initiative launched a 15-week Diabetes Prevention Series focusing on diabetes prevention and overall health enhancement through the four pillars of health: diet, exercise, sleep, and stress reduction, with 165+ attendees. In addition, CHI continued its partnership with the Mountain View Library and provided a webinar by a registered dietitian about cholesterol and fat to promote healthy eating.

## **Information Services**

As early adopters of Epic’s HEDIS Dashboard functionality supporting case management in the ECHMN clinics, we can now view detailed information for Healthnet patients and evaluate their care according to NCQA specifications. The HEDIS Dashboards ensure we meet patient care goals,



identify care gaps and provide tools for patient outreach and analysis. The dashboard and reports include external claims data supplied by Healthnet via our third-party aggregator AllCareToYou, combined with Epic information and Care Everywhere data from local healthcare systems (Stanford, Sutter, UCSF, Kaiser, Santa Clara County, etc.) to evaluate compliance with HEDIS quality metrics.

ECH is one of the first hospitals in the country to offer a new service through our partnership with Scanslated that transforms imaging and cardiology (ECHO) results into a patient-friendly, interactive report within the myCare patient portal! ECH patients with a myCare account can now view easy-to-read explanations of medical terms and simple anatomy diagrams alongside their imaging and cardiology results. These new patient-friendly reports empower our patients to better understand their results, have more meaningful conversations with their doctors, and fully engage in their care at ECH. When patients log in to their myCare portal to view test results, a link is available at the top of the page to view the patient-friendly report. Patient feedback in the Metrics Report below highlights the value of translating results into understandable terms. Click the following link to learn more - [Scanslated – Patient-centered Radiology Reporting](#)

## **Marketing and Communications**

Optimization and tracking continue for the “Accept Nothing Less” brand and service line campaigns in the market. Urgent care marketing campaign continues to do well.

For social media this month, our top performing stories were the “Orthopedic Surgery Completes 1000<sup>th</sup> Mako Robotic-Arm Assisted Joint Replacement” story and the announcement of our new COO. Other post topics included immunization awareness month, Jazz on the Plazz, patient stories, and HealthPerks related content. Our Facebook posts reached more than 582,000 people and saw a 36% uptick in page views. On LinkedIn, we gained 237 new followers and saw a 3% uptick in unique visitors.

## **Nursing**

Cheryl Reinking, DNP, RN, Chief Nursing Officer at El Camino Health, and Carla Martin, MS, RN, the Associate Chief Nursing Officer at the University of California Davis Medical Center, were selected to present a poster at the annual Magnet Conference in Philadelphia the week of October 10th. The Magnet Conference is one of the largest nursing conferences in the world, with 10,000 RNs in attendance. Their abstract was one of 120 selected out of 1600 abstract submittals. The poster is titled “Command, Control, Communicate: The 3 C’s of COVID”. Since UC Davis and ECH, two Magnet hospitals in northern California, were the first hospitals in the country to care of community-acquired COVID cases and shared best practices in the early days of the pandemic, we decided to submit an abstract together.

## **Philanthropy**

In July, El Camino Health Foundation received a \$1 million gift designated for the Women’s Health Fund from a new donor, Connie Lurie. The gift will be recognized in the Women’s Imaging Center. Mrs. Lurie toured the Women’s Imaging Center in July and also met with Ken King, who gave a presentation about the Orchard Pavilion renovation and expansion.

Mrs. Lurie was introduced to the foundation by John Sobrato. Mr. Sobrato and CEO Dan Woods accompanied her on the Women’s Imaging Center tour, which was conducted by service line



director Josh Schreckengost. Foundation President Andrew Cope and Senior Philanthropy Officer Lindsay Ehrman advanced the gift throughout the process.

The foundation is grateful to Julia Miller, whose stewardship of John Sobrato and support for the foundation's fundraising efforts played a major role in securing this gift.

El Camino Hospital Board												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/17	9/14	10/12	11/16	12/7	JAN	2/8	3/8	4/5	5/10	6/14
<b>STANDARD</b>												
Public Communication		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Committee Reports (Informational and Consent item, unless requested)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Consent Approvals (recommended by Committees) <sup>1</sup>		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Executive Session		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
CEO Report <sup>2</sup>		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
<b>STRATEGY</b>												
Strategic Planning <sup>3</sup>		✓			✓			✓			✓	
Board Retreat									✓			
<b>QUALITY<sup>4</sup></b>												
Quality Committee Report			✓		✓			✓			✓	
Medical Staff Report			✓		✓			✓		✓		
<b>FINANCE<sup>4</sup></b>												
Financials <sup>5</sup>		✓		✓				✓			✓	
Budget Review & Approval												✓
<b>COMPLIANCE</b>												
Annual Corporate Compliance Summary					✓							
<b>GOVERNANCE</b>												
Board Self-Assessment & Action Plan			✓			✓						
Director, Committee Member, and/or Chair Appointments												✓
Committee Charter Review												✓
<b>EXECUTIVE PERFORMANCE</b>												
CEO Performance Evaluation & Compensation				✓								

1: Includes credentialing and privileging report, polices, physician agreements, etc.

2: Includes organizational reports on Foundation, CONCERN, Pathways, etc.

3: Includes strategy implementation (as needed), and reports on Performance & Strategic Goals, El Camino Health Medical Network, Enterprise Risk Management, etc.

4: On off months, materials are provided in the Board meeting packet, but will not be reviewed as part of the agenda.

5: Includes capital expenditures, investment committee update, and audited financials in October