AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, November 6, 2019 – 5:30pm
El Camino Hospital | Conference Rooms A&B, F&G (ground floor)
2500 Grant Road Mountain View, CA 94040

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Lanhee Chen, Board Chair		**5:30 – 5:31pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information 5:31 – 5:32**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.* b. Written Correspondence	Lanhee Chen, Board Chair		**information 5:32 -5:35**
4.	**BOARD RECOGNITION** *Resolution 2019-11* **ATTACHMENT 4**	Kathryn Fisk, CHRO; Cheryl Reinking, RN, CNO	*public comment*	**motion required 5:35 – 5:40**
5.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 5**	Julie Kliger, Quality Committee Chair; Mark Adams, MD, CMO		**discussion 5:40 – 6:10**
6.	**GOVERNANCE COMMITTEE REPORT** a. System Governance i. Recommended Revisions to SVMD, LLC Operating Agreement ii. Draft Revised Committee Charters b. Board Action Plan c. Draft Revised Process for Election and Re-Election of Non-District Board Members to the El Camino Hospital Board of Directors	Gary Kalbach, Governance Committee Vice Chair	*public comment*	**possible motion(s) 6:10 – 7:00**
7.	**APPROVAL OF RESOLUTION 2019-12:** Proposed Hedge Related to 2015 Revenue Bonds and Possible Issuance of New Debt **ATTACHMENT 7**	Iftikhar Hussain, CFO	*public comment*	**possible motion 7:00 – 7:15**
8.	**ADJOURN TO CLOSED SESSION**	Lanhee Chen, Board Chair	*public comment*	**motion required 7:15 – 7:21**
9.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information 7:21 – 7:22**
10.	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board Meeting (10/10/2019)	Lanhee Chen, Board Chair		**motion required 7:22 – 7:24**

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy two (72) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	*Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Report	Imtiaz Qureshi, MD, Enterprise Chief of Staff; Linda Teagle, MD, Los Gatos Chief of Staff		**motion required 7:24 – 7:39**
12.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: - FY20 Strategic Plan Metrics Update	Dan Woods, CEO		**discussion 7:39 – 8:24**
13.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets; *Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters; *Gov't Code Section 54956.9(d)(2)* – conference with legal counsel – pending or threatened litigation: - CEO Report on Legal Update, Quality Update, and New Services and Programs,	Dan Woods, CEO		**discussion 8:24 – 8:39**
14.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: - Executive Session	Lanhee Chen, Board Chair		**discussion 8:39 – 8:44**
15.	**ADJOURN TO OPEN SESSION**	Lanhee Chen, Board Chair		**motion required 8:44 – 8:45**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Lanhee Chen, Board Chair		**information 8:45 – 8:46**
17.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Hospital Board Meeting (10/10/2019) b. Minutes of the Open Session Joint Meeting to Conduct a Study Session of the Hospital Board and the Quality Committee (10/23/2019) c. Approval of Revised Pathways Home Health and Hospice Budget ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** d. Annual Safety Report for the Environment of Care ***Reviewed and Recommended for Approval by the Medical Executive Committee*** e. Medical Staff Report ***Information*** f. FY20 Period 3 Financials g. Executive Compensation Committee Report	Lanhee Chen, Board Chair	*public comment*	**motion required 8:46 – 8:48**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
18.	**CEO REPORT** **ATTACHMENT 18**	Dan Woods, CEO		**information** **8:48 – 8:52**
19.	**BOARD COMMENTS**	Lanhee Chen, Board Chair		**information** **8:52 – 8:54**
20.	**ADJOURNMENT**	Lanhee Chen, Board Chair	*public comment*	**motion required** **8:54 – 8:55pm**

Upcoming Meetings:

Regular Meetings: December 11, 2019; February 12, 2020; March 11, 2020; April 15, 2020; May 13, 2020; May 26, 2020*; June 10, 2020 *Joint Meeting with Finance Committee

Education Sessions: April 22, 2020

RESOLUTION 2019-11

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE TO THE COMMUNITY

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

WHEREAS, the Board wishes to honor and acknowledge the employees who coordinated the hospital's participation and attendance at the 2019 Nurses Night Out at Oracle Park.

Christine Huntsman, Jackie Keane, and Athena Lendvay embraced a unique opportunity hosted by the San Francisco Giants and planned an off campus activity for nurses and staff to enjoy. Planning for the event started in March 2019. On August 6, 2019, 340 employees and guests from both campuses, across departments and including executives, managers and staff attended the baseball game.

Prior to the start of the game, the planning team organized and hosted a tailgate party for more than 250 employees and their guests. The tailgate party included music, grilled hot dogs, a photobooth, and goodie bags containing a baseball cap and an assortment of snacks including the required peanuts and cracker jacks. Hospital administration helped sponsor the tailgate.

During the bottom of the fifth inning, a message from Cheryl Reinking and administration appeared on the scoreboard for all in attendance to see: "El Camino Health salutes our nurses and staff!"

WHEREAS, the Board would like to commend Christine Huntsman, Jackie Keane and Athena Lendvay for bringing nurses and staff together for a fun and entertaining teambuilding activity outside of the hospital.

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

Christine Huntsman, Jackie Keane and Athena Lendvay

IN WITNESS THEREOF, I have here unto set my hand this **6TH DAY OF NOVEMBER, 2019.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

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

El Camino Health

JULIA E. MILLER
SECRETARY/TREASURER,
EL CAMINO HOSPITAL BOARD OF DIRECTORS

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Mark Adams, MD, CMO
Date: November 6, 2019
Subject: Strategic Quality and Safety Plan

Purpose:

To review and discuss the long term Strategic Quality and Safety Plan.

Summary:

1. Situation: While El Camino Health has a financial strategic plan and an operational strategic plan there has not been a long term quality and safety strategic plan.

2. Authority: The Committee and the Board requested to see, discuss and give feedback on the plan.

3. Background: The Quality Committee is tasked with overseeing the quality and safety activities and outcomes of the organization on behalf of the Board. To achieve top tier quality and safety, a long term quality and strategic plan is necessary to achieve this goal. The Quality Committee will have discussed the plan at its September 9, 2019 and November 4, 2019 meetings.

4. Assessment: This plan has been developed over the past several months with extensive input from many parts of the organization. The plan identifies five strategic opportunities for improvement.

5. Other Reviews: N/A

6. Outcomes: Obtain feedback from the Quality Committee regarding the plan and review the timeline with deliverables.

List of Attachments:

1. Executive Summary
2. Roadmap
3. FY20 Quality Dashboard (September data)

Suggested Board Discussion Questions:

1. What is the Board's role in overseeing implementation and success of the plan?
2. How is the Board's role different from the Quality Committee's role?

El Camino Quality Safety Strategic Plan

Executive Summary

In January 2019, El Camino Health engaged Progressive Healthcare, Inc. to prepare an enterprise-wide, long-range Strategic Plan for Quality and Safety and to create a "next generation" quality management program and aspirational vision for quality and safety excellence. This represents an executive summary of the final report of this work.

An initial deliverable for this work was to assess El Camino Health's Current State by viewing it through both external and internal lenses. El Camino's external metrics showed generally average performance on publicly reported measures for quality and safety. The most recent examples are the Spring 2019 Leapfrog scores that show no consistent trend in El Camino's system performance when compared to last year's scores, i.e., Mountain View's score declined from an overall B to a C, while the Los Gatos score improved from a C to a B. Similarly, the 2019 Watson Top 100 Report shows a negative performance trend in most measures other than financial performance. This reinforces that small declines in quality performance metrics, or no/little positive change in metrics when compared with peers (that are improving faster), has negative consequences to the external view. Internal benchmarks (not publicly reported) are similarly average in comparison to leading practices.

El Camino Health has several cultural challenges that must be addressed to achieve its desired quality and safety transformation. These include but are not limited to 1) the evolution of the Board's role to support quality and safety across the rapidly expanding enterprise that includes a new employed medical group this year, expanded behavioral and maternal health facilities that are soon to open and addressing seismic compliance issues at our Los Gatos Campus; 2) engaging a medical staff that is very large for the size of the enterprise, shows polarity between the current two hospital campuses and includes many physicians who are relatively unfamiliar with the organization's quality processes

Fortunately, the El Camino team widely aspires to be a "top tier" organization, one that management and multidisciplinary Quality / Safety Workshop participants described as empowered to achieve an enterprise vision "to consistently deliver the highest quality care with zero preventable harm." El Camino has many excellent staff, medical staff, and leaders at all levels who are energized to provide an increasing scope of leading-edge healthcare offerings and service excellence to address the health care needs of the area's aging, multicultural community, while simultaneously engaging the market's many large, high-tech employers in exciting innovation work.

To accomplish this "top tier" organizational performance vision, five (5) essential strategic opportunities must be addressed:

1. Revise the current Governance, Leadership, and Management structures for quality to meet the needs for alignment and coordination of quality efforts across the growing El Camino Health enterprise that, by definition, involves a myriad of stakeholders. Of the five strategic opportunities presented this one will be most relevant to the work of the Board. It will be addressed in part by:
    a. Establishing an Enterprise Quality Committee that reports to the Board Quality Committee and is responsible for:

i. Establishing the annual quality plan, and

ii. Designing, prioritizing, and resourcing quality initiatives to fulfill the plan

b. Establishing an Office of the Quality Executive that is responsible to facilitate, coordinate, integrate, and communicate quality and safety throughout the enterprise

c. Creating a Board development plan for quality and safety that includes endorsing the vision statement and managing the various knowledge and skills gaps

d. Developing a longitudinal plan to achieve a top decile performance designation, thereby addressing all measures in addition to quality

e. Ensuring the overall organizational structure fully supports a "quality / safety first" culture and achievement of top tier performance. This includes a thorough review of organizational charts with specific attention to all leadership roles, including physicians, e.g., medical staff leaders, department chairs, and medical directors; as well as structural and functional organization of both hospital campus medical staffs.

2. Enhance the operational organization of the quality department and committees by ensuring adequate multidisciplinary participation by physicians, nurses, administration, staff, patients/families, etc. This will be addressed by:

3. Similar to leading organizations, establish a rigorous continuous performance improvement "business system" to focus efforts and accelerate quality improvement, creating greater efficiency and more consistent outcomes. This will be addressed by:

4. Begin the journey to become a high reliability organization by adopting and managing the enterprise to the final "roadmap". This will be addressed by:

5. Develop a self-propagating culture of quality and safety to ensure a successful and sustained transformation to top-tier designation for quality and safety. This will be addressed through:

El Camino has attempted to "reboot" a central quality and patient safety focus several times during the past 5 years. Therefore, it is important for El Camino's leadership to demonstrate a highly visible and sustained commitment to quality and patient safety via culture change from the top. A single, powerful change in structure, process or protocols can signal to all stakeholders the importance of the start of El Camino's quality and high reliability journey and set the stage for renewed organizational focus and enthusiasm for each individual to internalize the quality vision. El Camino leaders must select and implement at least one significant change that can be rapidly designed and implemented. Many examples of such "low-hanging fruit" surfaced during the current state assessment.

Leadership, through the Enterprise Quality Committee, must also immediately lay the groundwork for several intermediate (6-9 month) projects that demonstrate sustained and visible efforts and lead to FY20 goal achievements. While these projects will take additional time to plan and resource, they will demonstrate a meaningful commitment to sustainment while inspiring organizational excellence.

This strategy was developed using a highly inclusive and consensus-driven approach in an effort to create a viable and sustainable transformation plan. To ensure that planning and initial execution are successful, several critical factors must be actively and skillfully managed in support of the roadmap.

These include but are not limited to appointing an owner, engaging MEC leadership, investing in Board and c-suite development, maintaining a sense of urgency, and ensuring resource availability.

Through targeted reorganization, communication, and multidisciplinary integration of people, processes, and technology, El Camino will achieve its aspirational top tier quality and zero preventable harm (True North) goals.

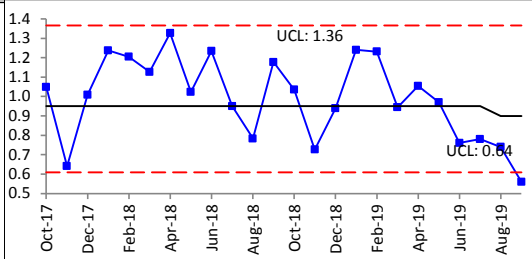
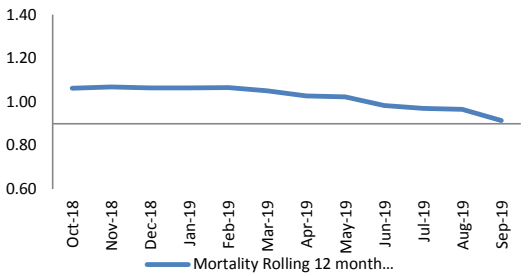
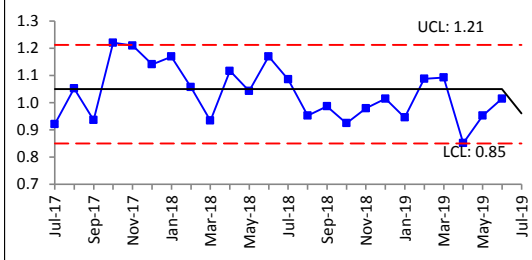
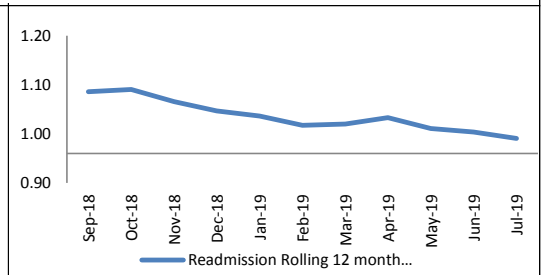
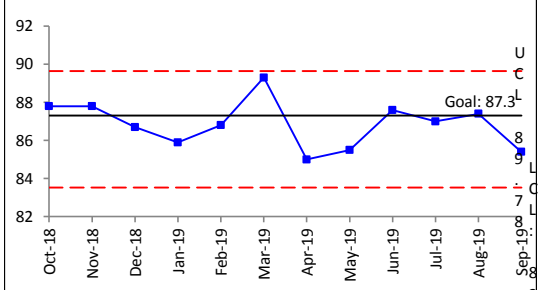
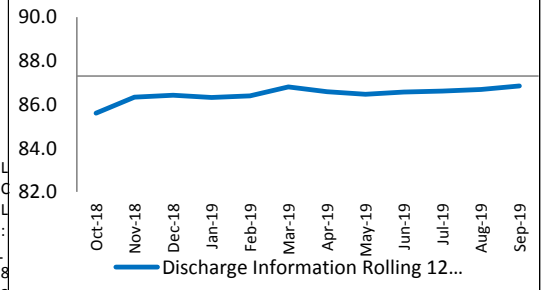
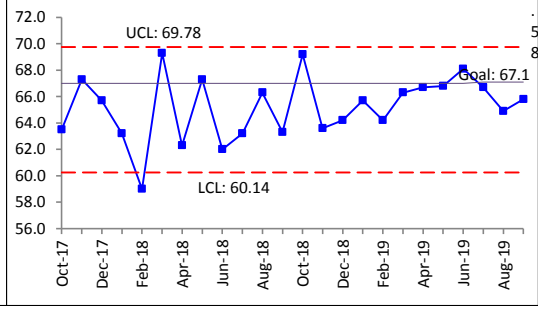
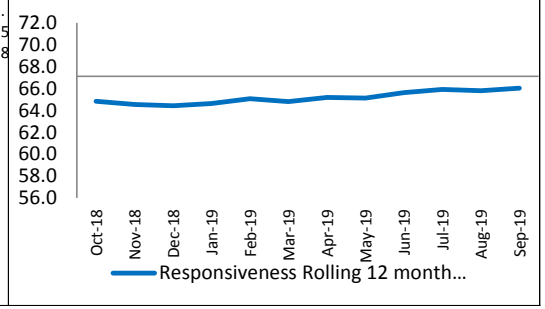
	Task Name	Start Date
		09/01/19
1.	**Leadership, Governance, and Management**	10/29/19
	Establish Enterprise Quality Committee (EQC)	10/29/19
	Clarify the roles of existing enterprise quality-related committees	10/29/19
	Ensure Organizational Structure and Function Support of "Quality and Safety First" Culture	10/29/19
	Create and Manage Board Development Plan for Quality and Safety	12/06/19
	Design Annual Quality Plan with Broad Stakeholder Input	01/01/20
	Implement a longitudinal plan to achieve top decile performance	03/03/20
2.	**Quality Organization Integration**	10/29/19
	Create, present, and periodically update required quality and safety training for all stakeholders	10/29/19
	Develop, implement, and maintain a longitudinal Medical Staff Leadership Development Program	10/29/19
	Align Quality and Safety Goals of the Enterprise (Leaders, Providers, Staff) with Annual Quality Plan	12/10/19
	Align and Enhance Process Improvement (PI) support to Support Enterprise-wide Quality - Safety Transformation	12/10/19
	Enhance Project Management Structure and Resources to Support Enterprise-wide Quality - Safety Transformation	12/10/19
	Optimize Resource Distribution and Reporting Structures via project management, etc.	06/09/20
3.	**Performance Improvement Methods and Metrics**	09/01/19
	Create Triad Leadership Teams (Physician, Nurse, Admin or PI) for all Quality / Safety Committees / Teams	09/01/19
	Create / Leverage Existing Structures to Promote Innovation, Best Practice Use, & Engagement with Ext Leading Quality Orgs	10/01/19
	Institute / Train on Standard Quality / High Reliability Improvement Methods, e.g., ACA, RCA, CCA, FMEA, etc.	10/01/19
	Establish & Maintain Ongoing Proactive Identification of Improvement Opportunities via multi-stakeholder input & tools	02/04/20
	Manage Prioritization of Quality Initiatives through Service Lines / other Multidisciplinary Teams	03/17/20
	Use Structured Process to Allocate Analytic / Reporting Resources; Implement Dashboards / Scorecards	06/02/20
4.	**Journey to become a High Reliability Organization**	09/01/19
	Redefine the "Daily Huddle" to focus on Safety and Train / Implement Safety Leadership Behaviors	09/01/19
	Define Safety as a Core Value and the "Burning Platform" for the Quality / Safety Transformation	09/01/19
	Develop / Implement / Maintain Safety Communication Tools / Dashboards / Recognition Programs, e.g., SSER	10/29/19
	Establish Key Safety Leadership Roles, e.g., Medication Safety Officer and Chief Surgeon (or "Surgeon of the Day")	10/29/19
	Develop / Implement a Series of Error Prevention Behavioral Tools and Expectations for all Stakeholders	11/01/19
	Enhance Environment Reliability and Emergency Preparedness	06/02/20
5.	**Culture of Quality and High Reliability**	10/29/19
	Demonstrate Meaningful Leadership Commitment to a Self-Propagating Culture of Quality and Safety	10/29/19
	Refine HR / Med Staff Recruiting / Credentialing / Peer Review to emphasize Quality Values / Cultural Fit	10/29/19
	Optimize Meaningful Quality and Safety Reward and Recognition Programs for all Stakeholders	10/29/19
	Implement and Promote "Fair and Just Culture" Practices	11/01/19
	Increase Transparency of Quality and Safety Outcomes	02/11/20
	Increase Stakeholder Involvement in Quality / Safety Activities, especially by Patients / Families / Caregivers	02/11/20

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

September 2019 (Unless otherwise specified)

Month to Board Quality Committee: November, 2019

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Months Average
Quality		Current month	FYTD				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: September 2019*	0.58 (1.13%/1.94%)	0.62 (1.11%/1.80%)	0.97	0.90		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: July 2019*	1.03 (8.13%/7.90%)	1.03 (8.13%/7.90%)	0.99	0.96		
Service		Month	FYTD				
4	* Organizational Goal **HCAHPS Discharge Information** **Top Box Rating of Always** *Date Period: September 2019*	85.4	86.7	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: September 2019*	65.8	65.8	65.7	67.1		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	The effect of transferring patients who qualify and accept GIP (inpt hospice) is clear since May 2019. Another factor is the better documentation of the complexity of each patient by the physician and encouraged by CDI.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Readmission Index (All Patient All Cause Readmit) Observed/Expected	The number of readmissions has increased as well as the index since a low in April.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
HCAHPS Discharge Information Domain Top Box Rating of Always	• Attended PFAC meeting for patient feedback to inform upcoming initiatives • Modifying AVS to better serve patient needs • Publishing discharge checklist in Patient Guide Books to help include patients in the process • Modifying inpatient handbook to make it more patient-friendly • Evaluating feasibility of different programs to follow-up on patients post-discharge • Rewards and recognition for affirming best practices	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	• Added Patient and Family Advisory Council (PFAC) member in workgroup • Confirmed via call light audit the reasons patients ask for help (bathroom, pain) • Leader rounding questions on call lights and staff responsiveness • Reinforcing Enhanced Interactions Healthstream education • Implemented No Pass Zone on all inpatient units; more education to follow • Rewards and recognition for affirming best practices	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Peter C. Fung, MD, Governance Committee Chair
Date: November 6, 2019
Subject: Governance Committee Report Section 6(a)(i)

Purpose:

To provide recommendations for enhanced SVMD governance and regular reporting by SVMD to ECH Board and Committees. Based on direction from the ECH Board at this meeting, revisions will be made to SVMD's Amended and Restated Limited Liability Company Operating Agreement which will be brought to the ECH Board for approval in December.

Summary:

1. Situation: El Camino Hospital ("ECH") is the sole member of Silicon Valley Medical Development, LLC ("SVMD") which currently operates 12 clinics and a managed care organization. ECH has governance oversight and reserved powers under SVMD's current Amended and Restated Operating Agreement. The Governance Committee appointed a System Governance Ad Hoc Committee to review the governance oversight of ECH affiliated entities including SVMD and to propose an enhanced SVMD governance structure and reporting.

2. Authority: It is within the Governance Committee's Charter to make recommendations to the ECH Board with respect to the governance of ECH affiliated entities.

3. Background: At its October 15, 2019 meeting, the Governance Committee discussed proposed revisions to the governance structure of SVMD including expansion of the SVMD Board of Managers, clarification of the reserved powers of ECH Board, creation of SVMD Quality and Credentialing Committee and oversight of SVMD by ECH Board Committees. The attached summary entitled SVMD Governance reflects a proposal that will be incorporated into revisions to the SVMD Amended and Restated Operating Agreement based upon the ECH Board's direction.

4. Assessment: Proposed SVMD Governance structure includes:

- Expansion of SVMD Board of Managers from 5 to 9 members
- Creation of SVMD Quality and Credentialing Committee with one nominee from ECH Quality Committee
- One physician member of SVMD's Quality and Credentialing Committee appointed to ECH Quality Committee
- ECH Board reserved powers to include annual approval of SVMD Strategic Plan and Budget and approval of SVMD Board of Managers
- Semi-Annual reporting on SVMD strategic metrics to ECH Board
- SVMD reporting to ECH Quality and Finance Committees quarterly and Compliance Committee annually

5. Other Reviews: None

6. Outcomes: Efficient and effective governance oversight by ECH as sole corporate member of SVMD.

List of Attachments:

1. SVMD Governance Presentation

Suggested Board Discussion Questions:

1. Does the proposed SVMD Governance structure provide sufficient governance oversight by ECH as sole member of SVMD?

El Camino Health

SVMD Governance

Governance Committee Recommendation

Introduction

- Silicon Valley Medical Development, LLC ("SVMD") owns and operates multi-specialty clinics as unlicensed 1206 (g) clinics with an educational affiliation.
- SVMD currently operates:
  - 12 clinic sites with approximately 80 physicians employed by two medical groups SJMG and ECMA
  - A managed care organization with approximately 200 contracted providers
- The sole member of SVMD is El Camino Hospital
- An Amended and Restated Operating Agreement between El Camino Hospital and SVMD defines the terms and governance relationship between the affiliated entities.

SVMD Board of Managers

The SVMD Board of Managers retains overall responsibility for the governance of SVMD

- The SVMD Board shall consist of nine (9) Directors each of whom shall have one (1) vote with respect to all matters or actions submitted to the Board
- Two of the SVMD Board members are community-based individuals and may be ECH Board members, appointed by ECH's CEO
- Four are appointed by the ECH CEO from ECH management and may include the hospital CEO, CFO, CMO, and/or COO
- One is the President of SVMD
- Two are practicing physicians with a medical group affiliated with SVMD who are appointed by the SVMD Board of Managers. (Not more than forty-nine percent (49%) of the Directors at any given time may be interested persons or physicians in active medical practice in the community served by the Corporation). These physicians may be excused by the Board for topics which may present a conflict.
- The ECH Board shall ratify or approve the Board of Managers.

SVMD Board of Managers

Responsibilities:

- Oversight and governance of all operations of SVMD
  - Recommend Approval of the SVMD strategic plan to ECH Board
  - Approve strategic plans of affiliated medical groups
  - Approve affiliations with new medical groups
  - Recommend Annual Budget to ECH Finance Committee
  - May create committees, approve committee charters and appoint committee members
    - Quality and Credentialing Committee
    - Finance Committee (consideration for future)
    - Compliance Committee (consideration for future)

SVMD Board Meetings

Annual Meeting

- An annual meeting of the Board of Managers shall be held each year at a time and place to be determined by the Board of Managers from time to time

Regular Meetings

- Such meetings shall be held not less frequently than quarterly
- The Board of Managers may approve items by resolution in lieu of regular meetings of the Board

Special Meetings

- Special meetings of the Board of Managers may be called at any time by the Chair, the SVMD President or by any two (2) or more Directors

El Camino Hospital Board

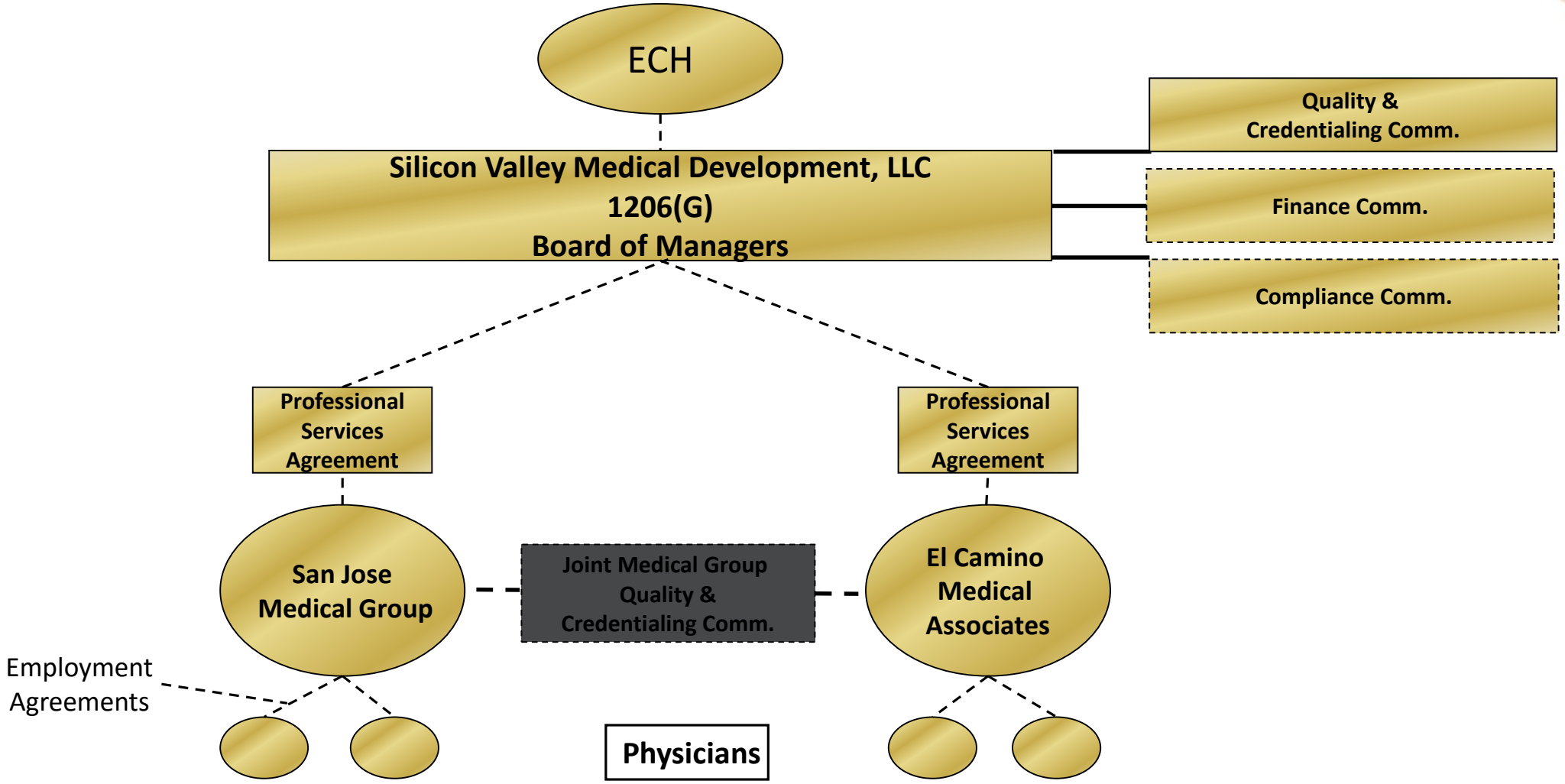
Reserved Powers of El Camino Hospital Board:

- Approves annual SVMD Strategic Plan as recommended by SVMD Board of Managers
- Approves annual Operating and Capital Budget as recommended by SVMD Board of Managers
- Approves unbudgeted expenses above $1million and capital expenditures greater than $5million
- Approves any merger, consolidation, reorganization or dissolution of SVMD and any amendment or restatement of the Operating Agreement
- Approves any transfer, sale or disposition of SVMD's assets
- Approves any action of SVMD that potentially violates ECH's tax-exempt purposes

El Camino Hospital Board and Committees are informed and consulted:

- ECH Board: Semi-annual report on SVMD performance to Strategic Metrics
- ECH Quality Committee :SVMD Quality Plan and quarterly report of performance metrics, Ad hoc communication of organizational risks
- ECH Compliance Committee: SVMD Compliance Plan and annual report, Ad hoc communication of organizational risks
- ECH Finance Committee: SVMD financial plan and quarterly report of performance of metrics; SVMD Annual operating and capital budget; SVMD five-year financial plan, Ad hoc updates as requested

Governance Structure



El Camino Health

Quality and Credentialing Committee

- Responsible for the planning, direction, coordination and oversight of SVMD's quality improvement and credentialing activities and the development and oversight of the procedures and infrastructure to ensure SVMD's quality of care including oversight of quality improvement and performance improvement initiatives, customer service and patient satisfaction
- Ensures that all staff and providers have the appropriate skills, knowledge and credentials required to fulfill their roles and responsibilities.
- Ensures that strategies and systems are in place to encourage the pursuit of continuous improvement and excellence.
- Oversees the clinical risk management framework for identifying, monitoring and managing significant risks.
- Assures that insurance arrangements are appropriate for the risk management framework, where appropriate.
- Reports clinical key performance indicators to the SVMD Board of Managers
- Reviews compliance with clinical performance management and reporting requirements
- Identifies that the performance reporting and information that is reported to the SVMD Board uses appropriate benchmarks, targets and trend analysis
- Provides summary reports to SVMD Board related to organizational performance and improvement, adverse events, regulatory encounters and vulnerabilities and environmental safety
- Recommends priorities for quality and safety improvement and commissions all improvement teams to address quality and safety vulnerabilities
- Ensures educational activities are consistent with 1206 (G) requirements

Quality and Credentialing Committee Composition

- One (1) Committee Member nominated by ECH Quality Committee and appointed by the SVMD Board of Managers
- Chief Medical Officer at El Camino Hospital
- Two (2) physician representatives who provide services with a medical group affiliated with SVMD appointed by the SVMD Board of Managers. These physicians must also serve as representatives on the Joint Medical Group Quality and Credentialing Committee. **One of these Physician committee members shall be appointed to the ECH Quality Committee.**
- One (1) other physician representative who provides services with a medical group affiliated with SVMD and serves as the Medical Director of SVMD's managed care organization.
- SVMD Clinical Quality Nurse
- SVMD Chief Medical Information Officer

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Peter C. Fung, MD, Governance Committee Chair
Date: November 6, 2019
Subject: Governance Committee Report Section 6(a)(ii) - System Governance: Draft Revised Committee Charters

Recommendation:

To adopt the proposed revisions to the Finance Committee, Compliance and Audit Committee, Quality, Patient Care and Patient Experience Committee, Governance Committee, Investment Committee, and Executive Compensation Committee Charters.

Summary:

1. Situation: The Governance Committee appointed a System Governance Ad Hoc Committee (Gary Kalbach and Pete Moran) tasked with developing recommendations for ECH Board and Committee oversight of ECH's affiliated entities as ECH grows into a health system providing a broader array of health services "outside the hospital's four walls." The Ad Hoc Committee recommended some changes to the Board's Advisory Committee Charters needed to address system governance issues (*See*, Sections 3(A) and (B) below). For efficiency, staff and the Governance Committee are also proposing that the Board approve some additional changes to the Charters, unrelated to the system governance issues (*See*, sections 3(C) and (D) below).

2. Authority: This is within the scope of the Governance Committee's chartered responsibility to "monitor and recommend improvements or changes to the on-going governance process and procedures of the Hospital Board in order to enhance overall efficiency of the Board and Advisory Committee Structure." It is within the Board's authority to approve revisions to the Committee Charters.

3. Background:

A. Related to the System Governance issues, the following changes are proposed to four of the charters (Finance, Governance, Compliance and Quality):
1. Add the language: "for El Camino Hospital and its affiliated entities where ECH is the sole corporate member ("the Organization")" in the "Purpose" section of each Charter to clarify that the Committees' oversight responsibilities extend to all entities where ECH is the sole corporate members.
2. Provide for a physician member of the El Camino Hospital Board's Quality Committee to also serve as a member of SVMD LLC's Board of Managers' Quality Committee.
3. Replace reference to ECH with "the Organization" also to clarify the breadth of oversight responsibility.

B. Related to the System Governance issues, replace former "Hospital" logo with new "Health" logo and at the same time emphasize the Committees are El Camino Hospital Board Advisory Committees (proposed to all six Committee Charters).

C. Unrelated to the system governance issues, the following change is proposed to all six Committee Charters to clarify and memorialize the process for appointing Committee members. "All Committee members, with the exception of new Community members,

shall be appointed by the Board Chair, subject to approval by the Board. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year expiring on June 30th, renewable annually. The term "Community members" is defined as members of the Committees who are not Hospital Board Directors.

D. Unrelated to the system governance issues, the Compliance and Audit Committee proposed adding (1) Cyber Security (as distinguished from IT Security) and (2) "review of any scope of work for the external auditors outside of the annual financial statement audit" to its oversight responsibilities.

4. Assessment: These changes will enhance and clarify system governance, memorialize the process for Committee appointments in the Charters, and clarify that the Compliance and Audit Committee has oversight responsibility for both IT and Cyber Security.

5. Other Reviews: At our October 15, 2019 meeting, the Governance Committee reviewed and voted to recommend the Draft Revised Charters.

6. Outcomes: N/A

List of Attachments:

1. Draft Revised Committee Charters

Suggested Board Discussion Questions: None.

El Camino Hospital Board of Directors
Finance Committee Charter
Draft Revised 11/6/19

Purpose

The purpose of the Finance Committee (the "Committee") is to assist the El Camino Hospital (ECH) Board of Directors to ("Board") provide oversight, information sharing and financial reviews related to operating and capital budgeting, financial planning, financial reporting, capital structure, banking relationships and certain contractual agreements for El Camino Hospital ~~(ECH) Board of Directors ("Board").~~and its affiliated entities where ECH is the sole corporate member ("the Organization"). In carrying out its review, advisory and oversight responsibilities, the Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

Authority

All governing authority for ~~ECH~~the Organization resides with the Board and, except as specifically provided in Sections E and F of "Specific Duties," the Committee serves as an advisory body only. The Committee will report to the Board at the next scheduled meeting any recommendation made or action taken within the Committee's authority. The Committee has the authority to select, engage, and supervise any consultant it deems necessary to advise the Committee on issues related to its responsibilities. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Finance Committee may also include 2-4 Community~~external (non-Hospital Board member)~~ members[1] with expertise which is relevant to the Committee's areas of responsibility, such as banking, financial management, planning and real estate development, etc.
- All Committee members, with the exception of new Community members, shall be appointed by the Board Chair, subject to approval by the Board~~,~~. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year, expiring on June 30th ~~each year~~, renewable annually.

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair must be a Hospital Board member.

Staff Support and Participation

The CFO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the executive team may participate in the Committee meetings as deemed necessary.

General Responsibilities

The Committee's primary role is to provide oversight and to advise the management team and the Board on matters brought to this Committee. With input from the Committee, the management team shall develop dashboard metrics that will be used to measure and track financial performance for the Committee's review. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for ensuring that performance metrics which are not being met to the Board's expectations are reported to the Board.

Specific Duties

The specific duties of the Committee are:

A. Budgeting

- Review the annual operating and capital budgets for alignment with the mission and vision of ~~ECH~~the Organization and make recommendations to the Board.
- Review any financial requests in excess of the CEO's signing authority and make recommendations to the Board.
- Review ~~ECH's~~the Organization's long-range forecasts and financial plans and make recommendations to management regarding steps advisable to improve ~~ECH's~~the Organization's financial strength.

B. Financial Reporting

- Review each accounting period's financial statements and ensure the Board is advised of any necessary corrective actions.
- Obtain a clear understanding of ~~ECH's~~the Organization's financial reporting process by reviewing the hospital's dashboard items and periodic financial reports and advise management on how to improve its financial reporting in order to improve accountability and ease of reading and understanding.

C. Financial Planning and Forecasting

- Semi-annually receive an update on management's assessment of expected results as well as potential risks related to the payor contracts.

- Evaluate the financial implications of emerging payment processes and provide advice to management regarding associated risk management concerns.
- Evaluate financial planning and forecasting to help ensure it remains in alignment with the mission and strategic direction of ~~ECH.~~the Organization.

D. Treasury, Pension Plans, and Contracting Concerns

- Review and make recommendations to the Board regarding all new debt issuances and derivative instruments in excess of $1 million.
- Monitor compliance with debt covenants and evaluate ~~ECH's~~the Organization's capital structure.
- Review and make recommendations to the Board regarding changes in banking relationships, including, without limitation, depository accounts, investment accounts and major credit facilities. The term "major credit facilities" does not include management-approved trade credit facilities offered in the ordinary course of business by vendors to the hospital. The Committee may recommend delegation of approval authority for specified changes to the CFO, but must maintain reporting and oversight of any such changes
- Review and make recommendations to the Board regarding proposed plan design or benefit design changes in excess of management authority limits to employee retirement plans, excluding changes to investments within those plans.
- Review and make recommendations to the Board regarding contractual agreements with persons considered to be "insiders" under IRS regulations, and those which are in excess of the CEO's signing authority

E. Capital and Program Analysis

- Review and make recommendations to the Board with respect to the business plans of all capital items or proposed business ventures in excess of the CEO's signing authority, and all variances to budget in excess of the CEO's signing authority on projects in process.
- Review retrospective analyses of all strategic business ventures and all strategic capital expenditures in excess of $2.5 million, as presented by management or as per the review schedule set forth by the Committee, to assess the reasonableness of business plans that were developed at the time of original approval and to promote learning as a result of any identified issues or concerns.
- Review and recommend approval for the acquisition or disposition of capital which is in excess of $5 million.
- Approve unbudgeted capital expenditures exceeding the CEO's signature authority but not in excess of $5 million.

F. Physician Financial Arrangements

- Review and recommend for Board approval Physician Financial Arrangements in excess of 75% of fair market value in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.
- Approve Physician Financial Arrangements in excess of 250,000 annually or if upon renewal or amendment, the annual increase is greater than 10% in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.
- Approve the Annual Summary Report of Physician Financial Arrangements.

G. Financial Policies

- Review and recommend approval of any Board-level financial policies, excluding any financial policies for which responsibility has been specifically assigned to another Board Committee.

H. Ongoing Education

- Endorse and encourage Committee education and dialogue relative to emerging healthcare issues that will impact the viability and strategic direction of ~~ECH~~the Organization,

I. Management Partnership

- Work in partnership with the CFO and other hospital executives to assist in the development of financial policies which will help ensure ~~organizational~~the Organization's success.
- Provide ongoing counsel to the CFO regarding areas of opportunity for either personal or organizational improvement.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee strives for continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan and the operational requirements of the organization. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

El Camino Hospital Board of Directors
Executive Compensation Committee Charter
Draft Revised 11-6-19

Purpose

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

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, engage and supervise a consultant to advise the Board and the Committee on executive compensation issues. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Executive Compensation Committee shall be comprised of two (2) or more Hospital Board members. The Committee may also include 2-4 Community[1] members~~external (non-director) members~~ with knowledge of executive compensation practices, executive leadership and/or corporate human resource management.
- Executive compensation consultants will be retained as appropriate and participate as directed.
- The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- All Committee members, with the exception of new Community ~~non-Hospital Board~~ memebrs, shall be appointed by the Board Chair, subject to approval by the Board~~,~~. New Community~~non-Hospital Board~~ members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year expiring on June 30th ~~each year~~, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair must be a Hospital Board member.
- All members of the Committee must be independent directors with no conflict of interest regarding compensation or benefits for the executives whose compensation is reviewed and recommended by the Committee. Should there be a potential conflict, the determination regarding independence shall follow the criteria approved by the Board and as per the Independent Director Policy (*see* attached Appendix).

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

Staff Support and Participation

The Chief Human Resources Officer shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may attend meetings at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

General Responsibilities

The Committee is responsible for recommending to the full Board policies, processes and procedures related to executive compensation philosophy, operating performance against standards, executive development and succession planning.

Specific Duties

The El Camino Hospital Board has adopted Resolution 2018-05 delegating certain decision-making authority to the Executive Compensation Committee. Resolution 2018-05 controls in the case of any inconsistency between this Charter and the Resolution or attachments to the Resolution. The specific duties of the Executive Compensation Committee include the following:

A. Executive Compensation

- Develop a compensation philosophy that clearly explains the guiding principles on which executive pay decisions are based. Recommend the philosophy for approval by the Board.
- Develop executive compensation policies to be approved by the Board.
- Review and maintain an executive compensation and benefit program consistent with the executive compensation policies, which have been approved by the Board. Recommend any material changes in the program for approval by the Board.
- Review the CEO's salary range, performance incentive program, benefit plan, and perquisites. Recommend to the Board any salary change to base salary range and/or base salary as well as performance incentive payouts based on organizational performance.
- Review the CEO's recommendations regarding salary and performance incentive payouts for the upcoming year for the executives whose compensation is subject to review by the Committee based on the CEO's evaluation of the executives' individual performance. Approve recommendations for any salary range or base salary changes and/or any performance incentive payouts within established guidelines based on the CEO's evaluation of the executives' individual performance. Recommend to the Board any salary changes and/or performance incentive payments that are outside established guidelines.
- Periodically evaluate the executive compensation program, including the charter, policies, and philosophy on which it is based, to assess its effectiveness in meeting the Hospital's needs for recruiting, retaining, developing, and motivating qualified leaders to execute the Hospital's strategic and short term objectives..
- Periodically review the total value, cost and reasonableness of severance and benefits for executives.
- Annually review and present for Board acceptance the letter of rebuttable presumption of reasonableness.

- Review market analyses and recommendation of the Committee's independent executive compensation consultant.
- Approve salary ranges for each new executive and approve placement in the range for those executives eligible for the plan within established guidelines. Recommend a salary range to the Board and placement therein for the CEO and or actions for other executives that are outside established guidelines.

B. Performance Goals Setting and Assessment

- Review and provide input into the CEO's recommendations regarding annual organization goals and measures used in the Executive Performance Incentive Plan. Recommend organizational performance incentive goals and measurements for approval by the Board.
- Provide input into establishing the CEO's annual individual performance incentive goals and performance appraisal process to execute the Hospital's strategic plan. Recommend the CEO's individual annual goals and measures for approval by the Board.
- Provide input into establishing the executive team's annual performance incentive goals to execute the Hospital's strategic plan and approve the annual goals and measures.

C. Executive Succession and Development

- Review annually the CEO's own succession plan, including a leadership and professional development plan based on the previous year's talent assessment.
- Review annually the CEO's succession plan for the executive team members, which shall include the process by which potential executives are identified and developed.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and workplan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. In addition, the Committee shall provide counsel and advice to the Board as requested.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all advisory committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of advisory committees may also be called by resolution of the Board and the Committee Chair. Notice of any special meetings of the Committee requires a 24 hour notice.

El Camino Health

Appendix

Definition of Independent Director – Compensation Committee

1. An independent director is a more limited and narrow classification of director than otherwise required by law and is not meant to expand or limit the definition of interested director for purposes of the El Camino Hospital Conflict of Interest Policy or to expand or reduce the scope of any legal duty or otherwise applicable legal obligation of a director. The Board of Directors, by separate resolution, may determine to limit membership on particular committees to independent directors to avoid even the appearance of a conflict of interest.
2. A member of the Board of Directors of El Camino Hospital shall be deemed to be an independent director so long as such director (and any spouse, sibling, parent, son or daughter, son- or daughter-in-law or grandparent or descendant of the director):
    i. has not, within the preceding twelve (12) months, received payments from El Camino Hospital, a subsidiary or affiliate of El Camino Hospital in excess of Ten Thousand Dollars ($10,000), excluding reimbursement of expenses or other permitted payments to a director related to service as a director;
    ii. does not own an interest in an entity, or serve as a Board member or executive of an entity, that is a direct competitor of El Camino Hospital (or an entity controlling, controlled by or under common control with El Camino Hospital) for patients or services, located within ten (10) miles of El Camino Hospital (or an entity controlling, controlled by or under common control with El Camino Hospital). An entity is not a direct competitor if it provides competing services in the above area that do not exceed ten percent (10%) of such entity's revenues.
3. If a director is an owner of an entity, then the amount received from El Camino Hospital during any period shall be determined by multiplying the percentage ownership interest of the director in such entity by the total amount paid by El Camino Hospital to such entity during such period.
4. Each director appointed to the Compensation Committee and the Compliance and Internal Audit Committee shall be, at the time of appointment and while a member of such Committee, an independent director as defined above.
5. **Note**: Other laws may prohibit certain contracts or interests in their entirety and this definition is not intended to narrow or otherwise limit the application of any such law.

El Camino Hospital Board of Directors
Finance Committee Charter
Draft Revised 11/6/19

Purpose

The purpose of the Finance Committee (the "Committee") is to assist the El Camino Hospital (ECH) Board of Directors to ("Board") provide oversight, information sharing and financial reviews related to operating and capital budgeting, financial planning, financial reporting, capital structure, banking relationships and certain contractual agreements for El Camino Hospital ~~(ECH) Board of Directors ("Board").~~and its affiliated entities where ECH is the sole corporate member ("the Organization"). In carrying out its review, advisory and oversight responsibilities, the Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

Authority

All governing authority for ~~ECH~~the Organization resides with the Board and, except as specifically provided in Sections E and F of "Specific Duties," the Committee serves as an advisory body only. The Committee will report to the Board at the next scheduled meeting any recommendation made or action taken within the Committee's authority. The Committee has the authority to select, engage, and supervise any consultant it deems necessary to advise the Committee on issues related to its responsibilities. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Finance Committee may also include 2-4 Community~~external (non-Hospital Board member)~~ members[1] with expertise which is relevant to the Committee's areas of responsibility, such as banking, financial management, planning and real estate development, etc.
- All Committee members, with the exception of new Community members, shall be appointed by the Board Chair, subject to approval by the Board~~,~~. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year, expiring on June 30th ~~each year~~, renewable annually.

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair must be a Hospital Board member.

Staff Support and Participation

The CFO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the executive team may participate in the Committee meetings as deemed necessary.

General Responsibilities

The Committee's primary role is to provide oversight and to advise the management team and the Board on matters brought to this Committee. With input from the Committee, the management team shall develop dashboard metrics that will be used to measure and track financial performance for the Committee's review. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for ensuring that performance metrics which are not being met to the Board's expectations are reported to the Board.

Specific Duties

The specific duties of the Committee are:

A. Budgeting

- Review the annual operating and capital budgets for alignment with the mission and vision of ~~ECH~~the Organization and make recommendations to the Board.
- Review any financial requests in excess of the CEO's signing authority and make recommendations to the Board.
- Review ~~ECH's~~the Organization's long-range forecasts and financial plans and make recommendations to management regarding steps advisable to improve ~~ECH's~~the Organization's financial strength.

B. Financial Reporting

- Review each accounting period's financial statements and ensure the Board is advised of any necessary corrective actions.
- Obtain a clear understanding of ~~ECH's~~the Organization's financial reporting process by reviewing the hospital's dashboard items and periodic financial reports and advise management on how to improve its financial reporting in order to improve accountability and ease of reading and understanding.

C. Financial Planning and Forecasting

- Semi-annually receive an update on management's assessment of expected results as well as potential risks related to the payor contracts.

- Evaluate the financial implications of emerging payment processes and provide advice to management regarding associated risk management concerns.
- Evaluate financial planning and forecasting to help ensure it remains in alignment with the mission and strategic direction of ~~ECH.~~the Organization.

D. Treasury, Pension Plans, and Contracting Concerns

- Review and make recommendations to the Board regarding all new debt issuances and derivative instruments in excess of $1 million.
- Monitor compliance with debt covenants and evaluate ~~ECH's~~the Organization's capital structure.
- Review and make recommendations to the Board regarding changes in banking relationships, including, without limitation, depository accounts, investment accounts and major credit facilities. The term "major credit facilities" does not include management-approved trade credit facilities offered in the ordinary course of business by vendors to the hospital. The Committee may recommend delegation of approval authority for specified changes to the CFO, but must maintain reporting and oversight of any such changes
- Review and make recommendations to the Board regarding proposed plan design or benefit design changes in excess of management authority limits to employee retirement plans, excluding changes to investments within those plans.
- Review and make recommendations to the Board regarding contractual agreements with persons considered to be "insiders" under IRS regulations, and those which are in excess of the CEO's signing authority

E. Capital and Program Analysis

- Review and make recommendations to the Board with respect to the business plans of all capital items or proposed business ventures in excess of the CEO's signing authority, and all variances to budget in excess of the CEO's signing authority on projects in process.
- Review retrospective analyses of all strategic business ventures and all strategic capital expenditures in excess of $2.5 million, as presented by management or as per the review schedule set forth by the Committee, to assess the reasonableness of business plans that were developed at the time of original approval and to promote learning as a result of any identified issues or concerns.
- Review and recommend approval for the acquisition or disposition of capital which is in excess of $5 million.
- Approve unbudgeted capital expenditures exceeding the CEO's signature authority but not in excess of $5 million.

F. Physician Financial Arrangements

- Review and recommend for Board approval Physician Financial Arrangements in excess of 75% of fair market value in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.
- Approve Physician Financial Arrangements in excess of 250,000 annually or if upon renewal or amendment, the annual increase is greater than 10% in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.
- Approve the Annual Summary Report of Physician Financial Arrangements.

G. Financial Policies

- Review and recommend approval of any Board-level financial policies, excluding any financial policies for which responsibility has been specifically assigned to another Board Committee.

H. Ongoing Education

- Endorse and encourage Committee education and dialogue relative to emerging healthcare issues that will impact the viability and strategic direction of ~~ECH~~the Organization,

I. Management Partnership

- Work in partnership with the CFO and other hospital executives to assist in the development of financial policies which will help ensure ~~organizational~~the Organization's success.
- Provide ongoing counsel to the CFO regarding areas of opportunity for either personal or organizational improvement.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee strives for continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan and the operational requirements of the organization. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

El Camino Hospital Board of Directors
Governance Committee Charter
Draft Revised 11/6/2019

Purpose

The purpose of the Governance Committee ("Committee") is to advise the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition~~,~~ (*i.e.*, the nomination and appointment/reappointment process and succession planning for the Board~~.~~) for El Camino Hospital and its affiliated entities where ECH is the sole corporate member ("the Organization"). The Governance Committee ensures the ~~Board and its Advisory committees are~~Organization is functioning at the highest level of governance standards.

Authority

All governing authority for ~~ECH~~ the Organization resides with the Hospital Board for ECH and with the boards of the affiliated entities except that which may be lawfully delegated to a specific ~~Board~~board committee. The Committee will report to the ~~full~~ Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on governance-related issues. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Governance Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be a Hospital Board director who shall be appointed by the Board Chair, subject to approval by the Board. .
- The Governance Committee may also include 2-4 Community~~external (non-Hospital Board member)~~ members[1] with expertise in governance, organizational leadership or as a hospital or health system executive.
- All Committee members, with the exception of new Community members, shall be appointed by the Board Chair, subject to approval by the Board~~,~~ New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year expiring on June 30th each year, renewable annually.
- The Governance Committee shall review and make recommendations to the Board regarding the Board Chair's appointments of Advisory Committee Chairs and Advisory Committee members.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee.

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

- All members of the Governance Committee shall be independent.

Staff Support and Participation

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

General Responsibilities

The Committee is responsible for recommending to the ~~full board~~Board policies, processes and procedures related to board development, board effectiveness, board composition and other governance matters~~.~~ for the Organization.

Specific Duties

The specific duties of the Governance Committee include the following:

A. **Board Composition, Development, and Effectiveness:** Ensure that the Board ~~is~~and the boards of the affiliated entities are committed to the discipline of doing the right things the right way.

Composition

- Define the necessary skill sets, diversity and other attributes required for Board members to support Hospital strategy, goals, community needs and current market conditions.
- Make recommendations to the Board regarding Board Composition.

Orientation, Education and Development

- Adopt the orientation program for newly-appointed members to the Hospital Board of Directors and newly-appointed Board Committee members.
- Recommend a policy, budget and annual plan for Hospital Board and Committee member education, training and development.

Board Evaluation

- Recommend an evaluation instrument and process to be used by the Hospital Board for evaluation of Board governance.
- Ensure there is a board performance evaluation completed on an annual basis, and as appropriate, evaluation of the individual directors, committees and their chairs, and the Board Chair.
- Ensure submission of Hospital Board's annual self-evaluation to the El Camino Healthcare District Board of Directors.

Board Efficiency

- Monitor and recommend improvements or changes to the on-going governance process and procedures of the Hospital Board in order to enhance overall efficiency of the Board and Advisory Committee Structure.
- Ensure the Board develops a master Board meeting calendar to establish a cadence of information flow and dialogue, such that the Board has sufficient time to review the minutes and

recommendations of the committees. The cadence must accommodate a flow of approvals from Committee to the full Board.

B. Support of Board Advisory Committee Alignment with Organizational Strategy and Goals

Development of Process for Advisory Committee Review of Advisory Committee Goals and Charters

- Recommend process for the development of annual Board Advisory Committee goals which includes: 1) Linkage of committee goals to organizational goals and strategy, to the Board; and 2) the Board's review and approval.
- Ensure all Board Advisory committees conduct ~~bi-annual~~biennial review of Advisory committee charters and recommend any changes to the Board for approval.

Development of Board Advisory Committee Membership Succession Plan

- Ensure membership succession plan considers organizational strategy and goals.
- Develop process for Advisory committee use to identify a need for increase or change in membership to further alignment with organizational strategy and goals.

C. Articles of Incorporation, Bylaws, and Policies

- Provide for a review of the Hospital's Articles of Incorporation and Bylaws at least once every three years.
- Provide for a review of Articles of Incorporation and Bylaws of affiliated entities as needed
- Monitor legal and regulatory issues affecting governance~~.~~ of the Organization.
- Recommend updates to ~~Hospital Board~~the Organization's governance policies where necessary and as required by legal and regulatory agencies.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and pacing plan in alignment with the Board and ~~Hospital's~~the Organization's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all Advisory committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of Advisory committees may also be called by resolution of the Board and the Committee Chair. Notice of any special meetings of the Committee requires a 24 hour notice.

El Camino Hospital Board of Directors
Investment Committee Charter
Draft Revised 11/6/2019

Purpose

The purpose of the Investment Committee (the "Committee") is to develop and recommend to the El Camino Hospital (ECH) Board of Directors ("Board") the organization's investment policies, maintain current knowledge of the management and investment of the invested funds of the hospital and its pension plan(s), provide guidance to management in its investment management role, and provide oversight of the allocation of the investment assets.

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee or subcommittee. All of the recommendations of the Committee flow to the El Camino Hospital Board for action. Reports of the Committee will be provided to the subsequently scheduled Board meeting. The Committee has the authority to recommend one or more investment managers for the hospital, monitor the performance of such investment managers, and monitor adherence to the investment policies of the hospital.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

The Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Investment Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Investment Committee may also include 2-4 Community~~external (non-Hospital Board member)~~ members[1] with expertise areas such as finance, banking, and investment management.
- All Committee members, with the exception of new Community members, shall be appointed by the Board Chair, subject to approval by the Board~~,~~. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year expiring on June 30th ~~each year~~, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice Chair must be a Hospital Board member. All members of the Committee must be independent with no conflicts of interest regarding hospital investments. Should there be a potential conflict, the determination regarding independence shall follow the criteria approved by the Board.

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

Staff Support and Participation

The CFO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the management team may participate in the Committee meetings as deemed necessary.

General Responsibilities

The Committee's primary role is to provide oversight and to advise the management team and the Board on matters pertaining to this Committee. With input from the Committee, the management team shall work with its investment advisor(s) to develop dashboard metrics that will be used to measure and track investment performance for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. The Committee is responsible for ensuring that performance metrics are being met to the Board's expectations and that the Board is apprised of any deviations therefrom.

Specific Duties

The specific duties of the Governance Committee include the following:

A. Investment

- Define the necessary skill sets, diversity and other attributes required for Board members to support Hospital strategy, goals, community needs and current market conditions.
- Review and recommend for approval by the Board the investment policies for corporate assets and Cash Balance Plan assets. Review and make recommendations to the Board regarding the selection of an independent investment advisor. The Board will appoint the investment advisor, and management, in consultation with the Committee, will appoint the investment managers.
- Monitor the performance of the investment managers through reports from the independent investment advisor, and make recommendations for change when appropriate.
- Monitor investment allocations and make recommendations to the Board if assets are managed inconsistently with approved investment policies.
- Monitor the financial stability and safety of the institutions which have custody of the Hospital's assets, and make recommendations for change when appropriate.
- Monitor the investment performance of the specific investment vehicles made available to employees through their 403(b) Retirement Plan.
- Review recommendations from the Retirement Plan Administrative Committee (RPAC) regarding the selection of an independent investment advisor for the employees' 403(b) Retirement Plan and make recommendations to the Board. The Board will appoint the investment advisor, and the RPAC will monitor, select, and replace the Core investment choices.

B. Ongoing Education

- Endorse and encourage Investment Committee education and dialogue relative to the work of the Committee.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and pacing plan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair, in collaboration with hospital management, shall determine the frequency of meetings based on the Committee's annual goals and work plan and the operational needs of the organization. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all Advisory committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of Advisory committees may also be called by resolution of the Board or by the Committee Chair. Notice of any special meetings of the Committee requires a 24 hour notice.

El Camino Hospital Board of Directors
Quality, Patient Care and Patient Experience Committee Charter
Draft Revised 11/6/2019

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ~~ECH.~~El Camino Hospital and its affiliated entities where ECH is the sole corporate member ("the Organization"). The Committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the ~~El Camino~~Organization's strategic plan related to delivering high quality healthcare to ~~the~~ all patients ~~that we serve~~. High quality care is defined as care that is: safe, timely, effective, efficient, equitable, and person-centered.

The ~~organization~~Organization will provide to the Committee standardized quality metrics with appropriate benchmarks so that the Committee can adequately assess the level of quality care being provided.

Authority

All governing authority for ~~ECH~~ the Organization resides with the Hospital Board for ECH and with the boards of the affiliated entities except that which may be lawfully delegated to a specific ~~Board~~board committee. The Committee will report to the ~~full~~ Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

~~The Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.~~

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members and shall include a physician who is also a member of the Silicon Valley Medical Development, LLC (SVMD) Quality Committee. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.

- The Quality Committee may also include 1) no more than nine (9) Community~~external (non-Hospital Board member)~~ members[1] with expertise in in assessing quality indicators, quality processes (*e.g.*, LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine Community~~external~~ members are recommended to serve on this committee.
- All Committee members, with the exception of new Community members shall be appointed by the Board Chair, subject to approval by the Board~~,~~. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice Chair of the Committee shall be a Hospital Board Director.

Staff Support and Participation

The Chief Medical Officer (CMO) shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as members of the executive team may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. This may include the Chief/Vice Chief of the Medical Staff.

General Responsibilities

The Committee's primary role is to develop a deep understanding of the ~~organizational~~Organizational strategic plan, the quality plan, and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for 1) ensuring that performance metrics meet the Board's expectations; 2) align those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring that communication to the Board and external constituents is well executed.

Specific Duties

The specific duties of the Committee include the following:

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

- Oversee management's development of a multi-year strategic quality plan (PaCT).
- Review and approve an annual "Quality Dashboard" for tracking purposes.
- Oversee management's development of ~~Hospital's~~the Organization's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services.
- Review reports related to ~~ECH~~Organization-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
    - ~~ECH~~Organization-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - ~~ECH~~Organization-wide patient safety goals and hospital performance relative to patient safety targets.
    - ~~ECH~~Organization-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
    - ~~ECH~~Organization-wide LEAN management activities and cultural transformation work.
    - ~~ECH~~Organization-wide patient satisfaction and patient experience surveys.
    - ~~ECH~~Organization-wide physician satisfaction surveys.
- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to including, but limited to, The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements.
- Review Sentinel Events (SE), Seriously Safety Events (SSE), and red alerts as per the hospital and board policy.
- Oversee organizational quality and safety performance improvement for both ~~hospital~~the Organization's and medical staff activities.
- Ensure that ~~ECH~~the Organization's scope of service and community activities and resources are responsive to community need.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and ~~Hospital's~~the Organization's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Peter C. Fung, MD, Governance Committee Chair
Date: November 6, 2019
Subject: Governance Committee Report Section 6(b) - El Camino Hospital Board 2019-2020 Board Action Plan Review

Recommendation(s):

To approve the 2019-2020 El Camino Hospital (ECH) Board Action Plan.

Summary:

1. Situation: Attached is the 2019-2020 ECH Board Action Plan, which was developed based on the results of the 2019 Board Self-Assessment. It is broken down into the four areas of focus including quality oversight, meeting effectiveness, ongoing education/training, and board culture.

2. Authority: In accordance to ECH policies/practices, the Governance Committee is tasked with reviewing and recommending approval of the annual board action plan.

3. Background: Via Healthcare conducted a comprehensive BSA process for the ECH Board in the summer of 2019. The process included an online survey completed by all Board members as well as interviews with Board member and executive leadership interviews. The results of the assessment and a set of recommendations were developed and presented to the ECH Board in August 2019.

4. Assessment: At the August 21, 2019 ECH Board meeting, Board members discussed the findings, identifying and prioritizing a list of enhancement actions the Board could undertake to improve its effectiveness over the next year. The action plan represents the agreed upon actions that the full Board would like to pursue.

5. Other Reviews: The Governance Committee reviewed and voted to recommend the Board adopt the Plan. We also asked the staff to make some modifications to the Board meeting evaluation form.

6. Outcomes: Upon the approval of the 2019-2020 ECH Board Action Plan, the Governance Committee would be tasked with developing and overseeing the implementation of the annual ECH Board Action Plan. We plan to report progress to the full board on a quarterly basis.

List of Attachments:

1. The 2019-2020 El Camino Hospital Board Action Plan

Suggested Board Discussion Questions:

1. What are the metrics that could be used to evaluate the board's progress and how should those be presented to the board?

Board Action Plan

	What	Who	By When	Current Status
Quality Oversight				
	Adopt a customized, actionable approach to effective quality. • Review and discuss available approaches to quality oversight. Frameworks to consider might include IHI Framework for Governance of Health System Quality, AHRQ High Reliability Organizations, and LEAN Six Sigma among others. • Identify and incorporate aspects from the different frameworks to create a customized approach to quality oversight at ECH.	Quality Committee Chair, CMO	End Q1 2020	
	Hold an educational meeting or series of meetings focused on quality oversight. These sessions will provide: • Additional education on the board's role in quality oversight including information on quality goals, indicators and how to interpret data. • An opportunity to discuss how ECH defines quality and what the organization's approach should be.	Quality Committee Chair, CMO	Scheduled for October 23, 2019	
Meeting Effectiveness				
	Restructure board meeting presentations to improve focus and promote dialogue.	CEO, Dir Gov Services	December 2019	
	Revisit meeting frequency to determine whether current schedule is optimal and adds value.	Board Chair, CEO	End Q2 2020	
	Implement a board meeting evaluation to assess quality of materials, mechanics and results of the meeting.	Board Chair, CEO	September 2019	
Ongoing Governance Education/Training				
	Develop an intentional, multi-year strategy for ongoing board education. The intent would be to identify topics and modalities that would enhance the governance competencies and engagement of the ECH Hospital Board.	Governance Committee	December 2019	
Enhancing Board Culture				
	Convene board members outside the typical board meeting structure to facilitate greater cohesiveness and teamwork on a quarterly or bi-annual basis.	Board Chair, CEO, Dir Gov Services	Ongoing	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Peter C. Fung, MD, Governance Committee Chair
Date: November 6, 2019
Subject: Governance Committee Report Section 6(c) - Process for Election and Re-Election of Non District Board Members (NDBMs) to the El Camino Hospital Board of Directors ("Process")

Recommendation(s):

To recommend that the El Camino Healthcare District Board of Directors continue using the current Process as modified.

Summary:

1. Situation: The Process has been in place since December 2014 with a number of minor revisions, most recently in May 2018.

2. Authority: Each year, we the Governance Committee is asked to review the Process and associated surveys and propose any possible changes to them. (*See*, Process, Section 9) At our August 13, 2019 meeting, the Committee asked members Gary Kalbach and Christina Lai to work with staff to propose some revisions to address concerns expressed by Board and Committee members.

3. Background: The current Process (un-modified) was used by the District Board as it recently considered the re-appointment of Directors Kliger and Rebitzer.

4. Assessment: The Process has generally worked well. One challenge can be dealing with non-alignment of Ad Hoc Committee members when there is no way to break a tie vote. Another challenge has been determining how much weight to assign to the various competency criteria. Also, the general competencies outlined in Section B3-6 are essentially duplicative of or conflict with those set forth in the Competency Matrix. The proposed revisions are designed to address these concerns. In addition, staff suggested some revisions [replace sections A(4)(a) (i) and (ii) with added section A(1) (d) and revised section (A(3)(a)(ii)] to address timing issues and improve the flow of the process.

5. Other Reviews: The Governance Committee voted to recommend that the recommend the Board recommend that the El Camino Healthcare District Board of Directors continue using the current Process as modified.

6. Outcomes: N/A

List of Attachments:

1. Draft Revised Process for Election and Re-Election of Non District Board Members (NDBMs) to the El Camino Hospital Board of Directors ("Process")
2. ECH Board Member Re-election Report Survey

Suggested Board Discussion Questions:
1. Should weighting be assigned to any of the competencies in Sections B, C, or D?
2. Is the ECH Board Member Re-election Report Survey a valuable tool?

3. Should there be any additional provisions for communication with current Board members whose terms are expiring other than those identified in Section A(2)(i) [Conversation with District Board Chair] and Section A(4)(a)(i) [Interview with Ad Hoc Committee and Advisors].
4. Should Section B items 3-6 be eliminated?
5. Are any other changes to the Process warranted?

2500 Grant Road
Mountain View, CA 94040
Phone: 650-940-7300
www.elcaminohealthcaredistrict.org

Process for Re- Election and Election
Of Non-District Board Members
To The El Camino Hospital Board of Directors.*
Draft Revised For Discussion 10_15_19

A. Timeline

1. Previous FYQ4:

   a. The District Board Chair shall appoint a District Director as Chair of an Ad Hoc Committee. In addition to serving as a member of the Ad Hoc Committee, the Ad Hoc Committee Chair's role shall be to set the Ad Hoc Committee's meeting agendas, work with staff to set meeting dates and facilitate the meetings.

   b. T ~~and t~~he Board shall approve the appointment of one additional District Director as a member of the Committee.

   c. The Board shall also approve the appointment of up to two advisors to the Ad Hoc Committee. One advisor should be a Non Hospital Director member of the El Camino Hospital Governance Committee (who has been referred by the Chair of the Governance Committee) and the other should be a Hospital Director who is not a member of the District Board (who has been referred by the Chair of the El Camino Hospital Board).

   ~~a.~~d. The District Board, on the recommendation of the Hospital Board and Hospital Governance Committee, shall approve a Hospital Board Competency Matrix and a Hospital Non District Board Member ("NDBM") Position Description for the upcoming fiscal year.

2. FYQ1 – ~~Regular District Board Meeting:~~
   ~~Prior to Meeting,~~ The District Board Chair (i) asks the El Camino Hospital Director(s), who is an NDBM~~not also a member of the District Board~~ whose term is next to expire ~~(Non District Board Member "NDBM") t~~to declare interest and (ii) informs the Chair of the Ad Hoc Committee~~District Board~~ of intent ~~(via Board packet)~~.
3. FY Q1/Q2 – Regular District Board Meeting:
   a. Prior to the Meeting:
      i. District and Hospital Board Members: Complete the ECH Board Competency Matrix Survey and, unless the Ad Hoc Committee votes not to use it in a given year, ECH Board Member Re-Election Report Survey.
      ii. ~~District Board Members: Review Position Specification in place at time of election to the Hospital Board and the ECH Board Member NDBM~~

~~Job Description.~~ Ad Hoc Committee analyzes survey results, interviews the NDBM, reviews candidate profile (updated resume, candidate questionnaire and attendance report), and develops a recommendation regarding re-election of the NDBM to the Hospital Board

b. ~~At the Meeting: Discuss portfolio of skills needs~~.

4. FYQ2 – Regular District Board Meeting:

~~. Prior to the Meeting:~~

~~. Ad Hoc committee analyzes evaluations, (3) (a) above, interviews the NDBM, and develops recommendation regarding re-election of NDBM to the Hospital Board.~~

~~c. Hospital Board, on the recommendation of the Governance Committee proposes a revised Position Description to the District Board.~~

~~. At the Meeting:~~

~~e.~~a. District Board considers re-election of NDBM.

~~f.~~b. If NDBM is re-elected, the Hospital Board shall be notified.

~~g.~~c. If NDBM is not re-elected, the District Board will authorize external recruitment of a new NDBM.

~~h.~~d. If there are any mid-term vacancies or other open seats on the Hospital Board the District Board will authorize a timeline for recruitment to fill those seats. Any individual may apply and staff shall solicit applications from the public, the ECH Board, the ECH Foundation Board, ECH Board Advisory Committees and the Executive Leadership Team.

5. FYQ2 or Q3 – Begin external search as authorized in Section 4(c) and (d)~~(b)(iii) and (iv) if necessary~~.

6. FYQ2 or Q3 – Regular District Board Meeting:
   a. Ad Hoc Committee to present an interim update to the District Board.
      i. Incorporate Board feedback into further recruitment efforts.
      ii. Plan for interviews – direct staff to schedule.

7. FYQ3 or Q4 – Regular District Board Meeting:
   a. Prior to the Meeting: Ad Hoc Committee to summarize interviews for the Board packet and make a recommendation to the District Board
   b. District Board Considers AD Hoc Committee recommendation and votes to elect new NDBM(s) to the Hospital Board.

8. This process to be confirmed by the District Board annually when the process is complete.

9. The following matters are delegated to the El Camino Hospital Board Governance Committee:
   a. FYQ3 – Review and recommend changes to the survey tools identified in section 3(a)(i).
   b. FYQ3 – Review and recommend changes to this process.
   c. FYQ3 – Review and recommend changes to NDBM Position Specification and Job Description.
   d. Participate in the recruitment effort of new NDBM by referring a member to advise the Ad Hoc Committee as described in #1 above.

B. General (Primary) Competencies
   1. Understanding of the vital role El Camino Hospital plays in the broader region.
   2. Loyalty to El Camino Hospital's charitable purposes.
   3. ~~Knowledge of healthcare reform (Affordable Care Act) implications.~~
   4. Ability to understand and monitor the following:
      a. Diverse portfolio of businesses and programs
      b. Complex partnerships with clinicians
      c. Programs to create a continuum of care
      d. Investment in technology
      e. Assumption of risk for population health
      f. Resource allocation
      g. Quality metrics
   5. Commitment to continuing learning.
   6. Demonstrated strategic thinking.
   7. ~~Efforts to recruit potential Advisory Committee members.~~
   8. Understanding and support of the role the District Board plays in Governance of the 501(c)(3) corporation.

C. Portfolio Skill Set
   1. Complementary to skill sets of other Board members (gap-filling).
   2. Applicable to the then current market. (See, Competency Matrix)

D. Other (Secondary) Criteria
   1. Positive working relationship with other Board members.
   2. Productive working relationship with the El Camino Hospital CEO.
   3. Attendance at Board and Committee meetings.
   4. ~~See, Competency Matrix~~.

**Approved 12/9/2014; revised 3/17/2015; revised 6/14/2016; revised 1/25/2017, revised 10/17/2017; 5/15/2018*

NYGREN CONSULTING

Creating High-Performing Boards

El Camino Healthcare District

El Camino Hospital Board Member Evaluation

Prepared for: El Camino Healthcare District

March 2014

This peer assessment tool is prepared for members of the El Camino Healthcare District for use in the Evaluation of members of the El Camino Hospital Board of Directors. This tool can also be used for self-assessment to compare self-ratings with the average of peer ratings.

Board Member Peer Review

	Strongly Disagree	Disagree	Neither Agree/ Disagree	Agree	Strongly Agree	Not at all/Unable to Judge
Fiduciary and Strategic Oversight						
1. Demonstrates an understanding of fiduciary responsibility and stewardship of ECH's resources.	1	2	3	4	5	N/A
2. Demonstrates loyalty to ECH's charitable purposes.	1	2	3	4	5	N/A
3. Demonstrates an understanding of how ECH's strategic direction compliments the vital role ECH plays in the broader region.	1	2	3	4	5	N/A
4. Offers insights that reflect strategic thinking about the future of the institution.	1	2	3	4	5	N/A
5. Understands the board's role in governance and does not inappropriately intervene in areas delegated to management.	1	2	3	4	5	N/A
Knowledge and Expertise						
6. Brings skills and knowledge that distinctly adds value to the overall competency of the board.	1	2	3	4	5	N/A
7. Demonstrates sufficient knowledge of healthcare reform implications to govern effectively.	1	2	3	4	5	N/A
8. Seeks the appropriate level of information from staff to govern effectively.	1	2	3	4	5	N/A
9. Demonstrates a clear understanding of the role the District Board plays in governance of the 501(c)(3) corporation.	1	2	3	4	5	N/A
10. Is supportive of the role the District Board plays in governing ECH.	1	2	3	4	5	N/A

	Strongly Disagree	Disagree	Neither Agree/ Disagree	Agree	Strongly Agree	Not at all/Unable to Judge
11. Demonstrates ability to understand and oversee the following:						
a. Diverse portfolio of businesses and programs	1	2	3	4	5	N/A
b. Complex partnerships with clinicians	1	2	3	4	5	N/A
c. Programs to create a continuum of care	1	2	3	4	5	N/A
d. Investment in technology	1	2	3	4	5	N/A
e. Assumption of risk for population health	1	2	3	4	5	N/A
f. Resource allocation	1	2	3	4	5	N/A
g. Quality metrics	1	2	3	4	5	N/A
Interpersonal and Communication						
12. Treats others in a respectful manner.	1	2	3	4	5	N/A
13. Creates a blameless culture by giving others the benefit of the doubt; assumes good intent of others before making judgment.	1	2	3	4	5	N/A
14. Takes responsibility for his/her actions; is able to admit mistakes.	1	2	3	4	5	N/A
15. Communicates effectively during meetings.	1	2	3	4	5	N/A
16. Operates in an open and transparent manner.	1	2	3	4	5	N/A
17. Behaves in a manner that models the highest standard of ethics and integrity.	1	2	3	4	5	N/A
18. Possesses self-awareness of his/her strengths and limitations.	1	2	3	4	5	N/A
19. Is able to modify behavior with feedback given by other.	1	2	3	4	5	N/A
Relationships						
20. Has a positive working relationship with fellow board members.	1	2	3	4	5	N/A
21. Has a positive working relationship with the ECH CEO.	1	2	3	4	5	N/A
22. Has a positive working relationship with the management team.	1	2	3	4	5	N/A
23. Is able to foster relationships with others even when styles or personalities may differ.	1	2	3	4	5	N/A
Participation						
24. Comes prepared to meetings.	1	2	3	4	5	N/A

	Strongly Disagree	Disagree	Neither Agree/ Disagree	Agree	Strongly Agree	Not at all/Unable to Judge
25. Participates effectively in board meetings; speaks up and actively listens.	1	2	3	4	5	N/A
26. Participates effectively in committees.	1	2	3	4	5	N/A
27. Adds value in comments to the board.	1	2	3	4	5	N/A
28. Makes an effort to recruit potential Advisory Committee members.	1	2	3	4	5	N/A
29. Demonstrates a commitment to continuous learning.	1	2	3	4	5	N/A
30. Advocates on behalf of ECH.	1	2	3	4	5	N/A
Decision Making						
31. Demonstrates clear, logical thinking when deliberating an issue.	1	2	3	4	5	N/A
32. Demonstrates an ability to identify the costs, benefits, and consequences of Board decisions.	1	2	3	4	5	N/A
33. Weighs all sides of the issue before reaching a conclusion.	1	2	3	4	5	N/A
34. Supports the board once a decision has been made.	1	2	3	4	5	N/A
35. Appropriately questions data and information presented to the Board for its deliberations.	1	2	3	4	5	N/A

1. What do you believe are this Director's greatest strengths?

2. What are his/her areas for development?

If you marked a 1 or 2 on any of the items above, please provide an explanation.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Chad Kenan, Director, Not-For-Profit Healthcare Group Citibank;
Iftikhar Hussain, CFO
Date: November 6, 2019
Subject: Draft Resolution 2019-12: Proposed Hedge Related to 2015 Revenue Bonds and Possible Issuance of New Debt

Recommendation(s):

To approve Draft Resolution 2019-12 Authorizing Forward Starting Interest Rate Hedge.

Summary:

1. Situation: El Camino Hospital is evaluating the cost for future construction projects which will be discussed with the Board in the near future. Interest rates have declined dramatically over the last two months and are near record lows. El Camino Hospital has the opportunity to enter into an interest rate swap to lock in rates today and hedge the cost of borrowing for the future projects. In addition, El Camino Hospital can lock rates to refund the Series 2015A bonds and achieve interest rate savings when the bonds are callable in 2025, currently $17 million or 15% of outstanding par.

2. Authority: Per the Signature Authority Policy, Board approval is required to authorize management to enter into the proposed transaction.

3. Background: Analyses have been performed on the savings that can be achieved on the refunding of the Series 2015A bonds. For the potential new money needs, analyses have been performed to compare interest rate expense comparing the traditional bond market and what can be achieved via an interest rate swap.

4. Assessment: El Camino Hospital already has an interest rate swap in place which is the same structure bong contemplated today. With interest rates near all-time lows and forward premiums also being at all-time lows ECH can lock in rates today for future needs. No payments would be exchanged until the interest rate swap would become effective at a future which ECH can choose (anywhere from 1 week to 5 years forward). When the swap becomes effective ECH will need to issue floating rate debt, the same as the Series 2009A bonds. If no future debt is needed or issued, then ECH can terminate the swap at any time and make/receive a payment based on the market at the time of termination.

5. Other Reviews: At a joint meeting of the Finance and Investment Committees on October 21, 2019, a majority of those present voted to recommend approval of the Resolution.

6. Outcomes: The goal is to get approval to take advantage of the current rate environment at historic lows with minimal payment of locking today for a future date. If rates drop between entering into the interest rate hedge today and when the bonds would be issued then ECH would have been better off waiting to enter the hedge. If rates rise from historic lows then ECH would have been better off executing the interest rate swap in the current market. .

Proposed Hedge related to 2015 Revenue Bonds and Possible Issuance of New Debt
November 6, 2019

List of Attachments:

1. PowerPoint Presentation
2. Draft Resolution 2019-12 Authorizing Forward Starting Interest Rate Hedge

Suggested Board Discussion Questions:

1. What happens if no future debt is needed/issued?
2. What is the cost to terminate the interest rate swap?
3. Where have historic rates been?
4. How does a traditional refunding of the Series 2015A bonds compare to utilizing an interest rate swap?
5. How is the interest rate swap different than what ECH has already executed?
6. What are the out of pocket costs?
7. When do cashflow payments start?
8. What happens as interest rates rise/fall?

El Camino Health

Proposed Hedge to Cover

- Refunding 2015 Revenue Bonds
- Possible Issuance of New Debt

Board Meeting on November 6th, 2019

Presenters:

Iftikhar Hussain, Chief Financial Officer of El Camino Hospital

Chad Kenan, Director at Citigroup

Executive Summary

- Favorable Market Condition
  - Long-term tax-exempt and taxable rates continue to trend near historic lows
    - 30-yr Treasury ("TSY") has decreased 77 basis points year-to-date
    - 30-yr Municipal Market Data ("MMD") has followed a similar trend, decreasing 95 basis points year-to-date
  - Municipal bond funds have now reported 37 consecutive weeks of inflows (cash for fund managers to invest)
    - Cumulative year-to-date weekly inflows total $48 billion
- ECH plans to spend $1.5 billion over the next 8 years (2020-2028) to fund capital and strategic projects
  - Upgrading the Women's Hospital
  - Construct and expand its Los Gatos and / or Santa Teresa sites
- The historically-low interest environment we enjoy today offers an opportunity for ECH to lock in current market interest rates through forward-starting fixed payor swaps
  - Fixed payor swaps can be used to hedge future new money projects or refunding issues
  - Forward premiums are currently at historic lows
  - No cash flows are exchanged at the time of execution
  - On the effective date of the swap, ECH issues variable rate bonds and swap cash flows commence, creating a synthetic fixed rate cost of funds

Impact of Hedging Interest Rates

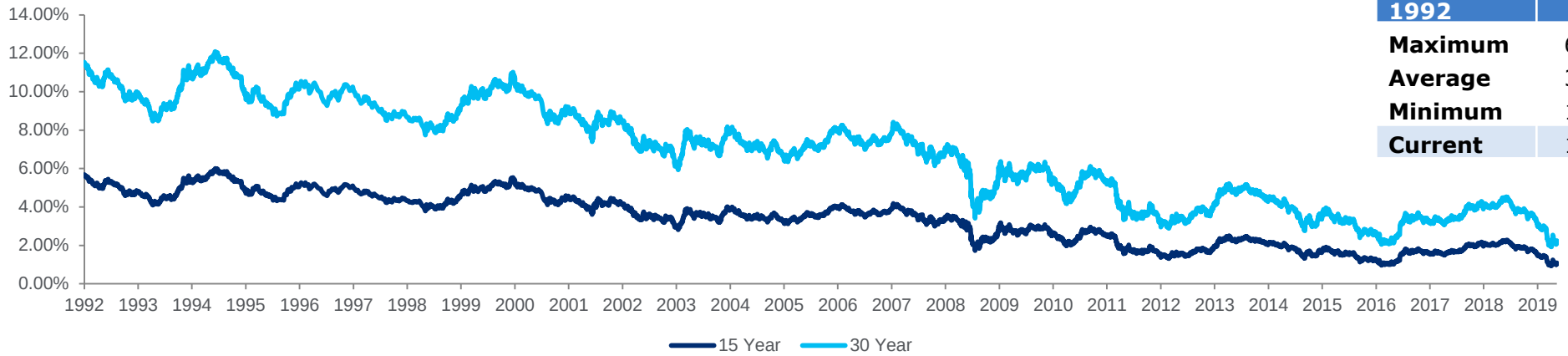
	Lock		Mkt Interest rate after lock		No lock	
Interest rate	2.0%		1.0%	3.0%	1.0%	3.0%
Term - years	30		30	30	30	30
Debt Service - annual	11,934		11,934	11,934	10,357	13,637
Annual interest	5,346		5,346	5,346	2,673	8,019
Loan Amount						
For refunding 2015 bonds	117,290					
New capital projects	150,000					
total	267,290		308,002	233,921	267,290	267,290
Mark to market Gain/Loss			(40,712)	33,369		

- A hedge will lock interest rates for:
  - Refinancing of 2015 bonds on the 2025 call date
  - Issuance of new debt in 2023 or 2024 for the South Market
- The table above shows the impact with and without a lock/hedge.
- Accounting rules require that hedges be valued at market but net cash flow is based on the locked rate

Market Conditions – Swap Rates in Historical Context

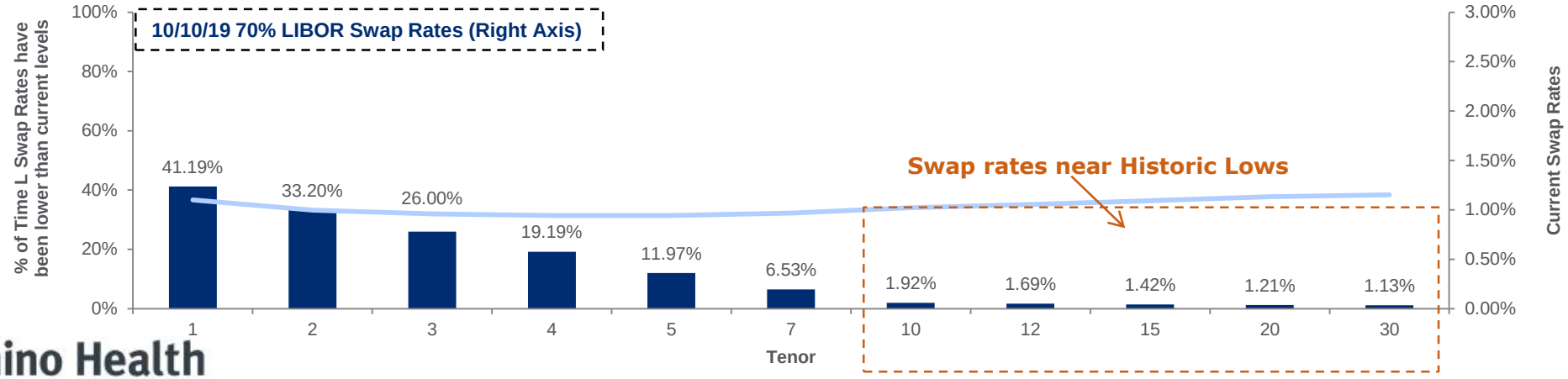
Long-dated 70% LIBOR swap rates have been lower than today less than 2% of the time since 1992.

70% LIBOR Swap Rates (June 1, 1992 – October 10, 2019)



Since 1992	15 Year	30 Year
Maximum	6.08%	6.17%
Average	3.31%	3.44%
Minimum	1.02%	1.07%
Current	1.17%	1.24%

% of Time 70% LIBOR Swap Rates have been Lower Since 1992

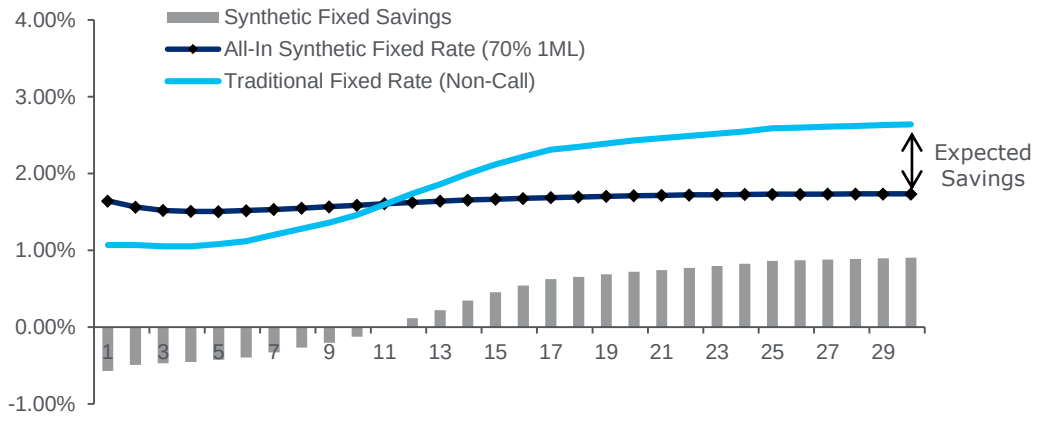


El Camino Health

Rates as of COB 10/10/2019. Assumes 70% 1-Month LIBOR Swap Rates shown at mid-market. Past performance may not indicate future results.

Synthetic Fixed Can Generate Substantial Interest Savings

Traditional Fixed vs. Synthetic Fixed Rate Comparison[1,2,3]



Synthetic Fixed Produces Expected Savings

Term	Traditional Fixed Rate Yields[1]	All-in Synthetic Fixed Rates (70% 1ML)[2,3]	Synthetic Fixed Rate (Cost) / Savings
1	1.07%	1.64%	-0.57%
2	1.07%	1.56%	-0.49%
3	1.05%	1.52%	-0.47%
4	1.05%	1.51%	-0.46%
5	1.08%	1.51%	-0.43%
7	1.20%	1.53%	-0.33%
10	1.46%	1.59%	-0.13%
12	1.74%	1.62%	0.12%
15	2.12%	1.67%	0.45%
25	2.59%	1.73%	0.86%
30	2.64%	1.74%	0.91%

Long-Dated Swap Rates are Historically Low Today (70% 1ML)

30Yr LIBOR (70% LIBOR)	
Max	3.34%
Avg	2.13%
Min	1.07%
Current	1.24%

Forward Premiums Historically Low (3x30 Yr 70% 1ML)

3x30Yr LIBOR (70% LIBOR)	
Max	0.31%
Avg	0.14%
Min	0.00%
Current	0.02%

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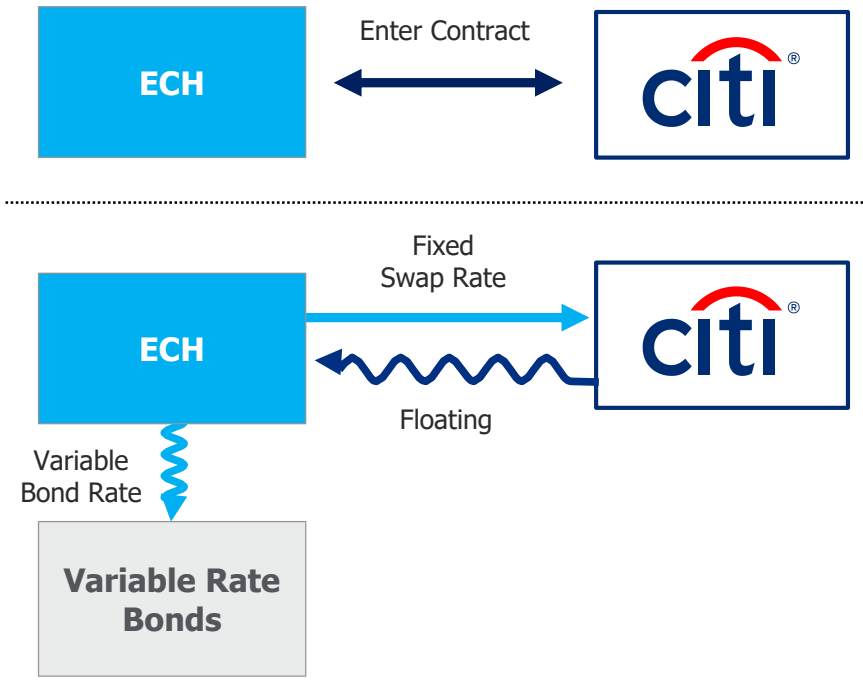
Rates as of COB 10/10/2019. Subject to market conditions, documentation, and credit approval. For illustration purposes only; actual results may differ. Past performance may not indicate future results.
1) Traditional Fixed Rate Yields assume ECH's A1/AA credit ratings and non-call structure.
2) Synthetic Fixed Rates assume 70% 1M-LIBOR floating-to-fixed swap structure. Assumes floating rate received on swap equals variable rate paid on bonds; actual results may vary.
3) Synthetic fixed rates include 0.50% for variable rate support costs. Variable rate support costs are subject to change over the life of the transaction, which could impact DS and PV Savings.

Forward Swaps Can Hedge Interest Rates on Future Issuance

A forward swap can be used to lock in current market interest rates even before the variable rate bonds are issued. A forward swap can thus hedge future new money as well as refunding issues.



Today:

- ECH executes a forward-starting floating-to-fixed swap, presetting the future swap fixed rate
- No cash flows are exchanged

Effective Date:

- ECH issues variable rate bonds (e.g. to refund its Series 2015A Bonds on the call date)
- Swap cash flows commence, creating a synthetic fixed rate cost of funds
- Depending on what variable rate products are available to ECH in the future (if any), basis risk may exist between floating rate received on swap and variable rate paid on bonds

Forward Swap						[A]	[B]	[C] = A + B	[D]	[E] = C + D
Series	Effective	Termination	Fwd Period (Yrs)	Avg Life From Eff.	Notional	Current Starting 70% 1ML FXP Rate	Forward Premium	70% 1ML Fwd FXP Rate	Assumed Support Costs	All-in Synthetic Fixed
Series 2015A Ref	02/01/25	02/01/45	5.3	10.4	$117,290,000	1.171%	0.089%	**1.260%**	0.500%	**1.760%**

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Rates as of COB 10/10/2019. Subject to market conditions, documentation, and credit approval. For illustration purposes only; actual results may differ.
Synthetic Fixed Rates assume 70% 1M-LIBOR floating-to-fixed swap structure. Assumes floating rate received on swap equals variable rate paid on bonds; actual results may vary.
All-in synthetic fixed rates include 0.50% for variable rate support costs. Variable rate support costs are estimates and subject to change over the life of the transaction, which could impact D/S and PV Savings.

Mark-to-Market ("MTM") Risk Analysis

The tables on the next slide show the MTM profile of: 1) ECH's Existing Fixed Payer Swap; 2) Proposed New Forward Fixed Payer Swap (2015A Refunding); and 3) Pro-Forma Combined Swap Portfolio (Existing + New Forward Swap)

- Floating-to-Fixed Swap MTMs are driven by changes in the level of interest rates
- As rates increase, MTM become more of an asset to ECH
- If rates remain the same, the MTM becomes more of a liability to ECH given the fixed rate is marked against swap rates at shorter tenors (i.e. "roll-down") assuming a positively sloped yield curve
- As rates decrease, MTM becomes more of a liability to ECH
- Sensitivity to changes in interest rates reduces over time as the tenor of the swap decreases and the notional amount reduces from amortization
- MTM at trade inception reflects transaction costs (hedging, credit, legal and dealer required return on risk capital)

Rates as of 10/10/2019. Subject to market conditions, documentation, and credit approval. For illustration purposes only.
MTM Grids assume existing $38.225 million 12-year average life 56% 1ML + 0.23% floating-to-fixed swap (fixed rate = 3.204%)
MTM Grids assume current market pricing for the new proposed $117 million 5-year forward, 10-year average life 70% 1ML floating-to-fixed swap with an effective date of 2/1/2025 (fixed rate = 1.260%)
Change in LIBOR assumes a parallel shift of 3M LIBOR forwards.

Mark-to-Market ("MTM") Risk Analysis (cont'd)

MTM in 2019 (Today)

Change in LIBOR	Implied 10YR LIBOR	Existing Swap	New Forward Swap	Combined Portfolio
2.00%	*3.57%*	($3.67)	**$10.65**	**$6.98**
1.50%	*3.07%*	($4.83)	**$8.29**	**$3.46**
1.00%	*2.57%*	($6.07)	**$5.62**	**($0.45)**
0.50%	*2.07%*	($7.41)	**$2.61**	**($4.80)**
0.00%	*1.57%*	($8.84)	**($0.77)**	**($9.61)**
(0.50%)	*1.07%*	($10.37)	**($4.58)**	**($14.95)**
(1.00%)	*0.57%*	($12.01)	**($8.85)**	**($20.86)**
(1.50%)	*0.11%*	($13.44)	**($13.64)**	**($27.08)**
(1.57%)	*0.00%*	($13.65)	**($14.35)**	**($28.00)**

MTM in 2025 (Effective Date)

Change in LIBOR	Implied 10YR LIBOR	Existing Swap	New Forward Swap	Combined Portfolio
2.00%	*3.57%*	($2.41)	**$11.53**	**$9.12**
1.50%	*3.07%*	($3.13)	**$8.39**	**$5.26**
1.00%	*2.57%*	($3.89)	**$5.04**	**$1.15**
0.50%	*2.07%*	($4.70)	**$1.48**	**($3.22)**
0.00%	*1.57%*	($5.55)	**($2.31)**	**($7.86)**
(0.50%)	*1.07%*	($6.44)	**($6.36)**	**($12.80)**
(1.00%)	*0.57%*	($7.39)	**($10.68)**	**($18.07)**
(1.50%)	*0.11%*	($8.39)	**($15.29)**	**($23.68)**
(1.57%)	*0.00%*	($8.53)	**($15.96)**	**($24.49)**

MTM in 2035 (10 Years from Effective Date)

Change in LIBOR	Implied 10YR LIBOR	Existing Swap	New Forward Swap	Combined Portfolio
2.00%	*3.57%*	($0.51)	**$2.87**	**$2.36**
1.50%	*3.07%*	($0.65)	**$1.99**	**$1.34**
1.00%	*2.57%*	($0.78)	**$1.08**	**$0.30**
0.50%	*2.07%*	($0.92)	**$0.13**	**($0.79)**
0.00%	*1.57%*	($1.06)	**($0.84)**	**($1.90)**
(0.50%)	*1.07%*	($1.21)	**($1.85)**	**($3.06)**
(1.00%)	*0.57%*	($1.36)	**($2.89)**	**($4.25)**
(1.50%)	*0.11%*	($1.51)	**($3.98)**	**($5.49)**
(1.57%)	*0.00%*	($1.53)	**($4.13)**	**($5.66)**

El Camino Health

Spectrum of Financing Alternatives (Cost vs. Risk)

Lower Risk — Higher Risk

Risk

	Taxable Fixed Rate Bonds	Tax-Exempt Fixed Rate Bonds	Synthetic Fixed Rate Bonds
Existing ECH Instrument	N/A	Series 2015A & 2017	Series 2009A
Cost of Capital Description	Fixed cost for the life of the bonds		Variable Rate Bonds associated with a swap at a fixed cost
Interest Rate Risk	No	No	No
Variable Rate Support Costs Increase[1]	No	No	✘
Variable Rate Market Access / Put Risk[1]	No	No	✘
Basis Risk / Tax Risk[2]	No	No	✘
Swap Termination / Collateral Posting Risk[2]	No	No	✘
Swap Counterparty Performance Risk[2]	No	No	✘
Considerations	• Current historically low rates • Typical make-whole call provision • May be issued in advance of project needs to increase cash	• Current historically low rates • Timing constraints for issuing new money given expected spend down • No advance refunding under new tax law	• Current historically low rates • Monitoring of counterparty • Ability to access variable rate market for underlying product • Locks rates today with cashflow commencing at a future date at ECH's choosing

Higher Cost — Lower Cost

Cost

El Camino Health

1 See page 19 (General Risks Associated with Tax-Exempt Variable Rate Bonds) for additional disclosure related to tax-exempt variable rate bonds.
2 See page 18 (General Risks Associated with Floating-to-Fixed Swaps) for additional disclosure related to LBOR-based floating-to-fixed swaps.

Decision Points – Forward Starting Floating-to-Fixed Swaps

ECH should consider the benefits and considerations of any transaction prior to execution.

Benefits

- ▲ Hedges interest rate risk in historically low rate environment
- ▲ Forward premiums are historically low
- ▲ Standardized documentation may be executed quickly
- ▲ "Make-whole" call flexibility -- swap may be terminated for market value and the bonds redeemed for par prior to maturity
- ▲ Purchasing cancelation options adds flexibility
- ▲ Diversifies investor universe

Considerations

- ▼ ECH has to fulfill its obligation under the swap agreement even if it does not issue debt
- ▼ Cost of forward premium
- ▼ Structure entails issuance of variable rate bonds, which can require credit support (e.g. VRDOs)
- ▼ Tax-exempt LIBOR-based swap structures can entail tax and basis risk
- ▼ LIBOR-based swap structures entail LIBOR replacement risk
- ▼ Credit risk to Citibank, N.A., rated Aa3 / A+ / A+
- ▼ Potential make-whole payment or receipt upon optional or mandatory early termination
- ▼ MTM / Collateral-posting risk
- ▼ Consult auditors regarding accounting treatment

EL CAMINO HOSPITAL

RESOLUTION OF THE BOARD OF DIRECTORS

AUTHORIZATION OF FORWARD STARTING INTEREST RATE HEDGE

NOVEMBER ___, 2019

Background:

In presentations made on November ___, 2019, the Board of Directors of El Camino Hospital (the "Corporation") has received information from the Corporation's investment banker and management regarding plans to obtain long-term financing for costs of the Corporation's major facilities renovation and replacement projects; such financing will be in addition to the funds to be provided from the proceeds of an issue of general obligation bonds. The proposed plan of finance presented consists of the borrowing of the proceeds of the sale of revenue bonds in total principal amount of approximately $150 million, to be issued and sold by a conduit governmental issuer, plus interest and costs, and approximately $165 million, for the potential refunding of the California Health Facilities Financing Authority Revenue Bonds (El Camino Hospital), Series 2015A, plus interest and costs (together, the "Revenue Bonds"). The proposed plan of finance contemplates one or more non-qualified "forward starting swaps" to manage the risk of increase in interest rates prior to and after the issuance and refunding of the Revenue Bonds (the "Swaps"). The information presented to this board includes, among other matters, data regarding historical and projected long-term tax-exempt interest rates, information provided by the Corporation's financial advisor, the timeline for implementing the Swaps, and information outlining next steps for the implementation of the Swaps.

The purpose of this resolution is to approve the execution of the Swaps and to authorize the Chief Executive Officer and Chief Financial Officer (each an "Authorized Officer") (i) to finalize the terms of the Swaps and (ii) to enter into an ISDA Master Agreement with Citibank, N.A., a Schedule, a Credit Support Annex, one or more Confirmations, and obligations under the Master Trust Indenture (together, the "Swap Agreements") in such form and with such terms as shall be acceptable to the Authorized Officer executing the Swap Agreements.

Accordingly, in reliance on the foregoing, it is hereby

RESOLVED: That it is in the best interest of the Corporation to enter into the Swap Agreements for the purpose of managing the risk of interest rate changes and not for investment or speculation; that each Authorized Officer is authorized, acting singly, with the advice of the Corporation's financial advisor, to agree to or set the notional amounts, trade date, effective date or dates, termination date or dates, payment dates, fixed and floating rates in order to achieve a net interest cost of not more than two percent (2%), optional termination provisions and methods of determining the optional termination payment amount, collateralization and other security requirements, and other terms; and that each Authorized Officer is authorized, in the name and on behalf of the Corporation, to execute and deliver the agreements, certificates, instruments and other documents that he or she may in his or her discretion determine to be necessary or

advisable to carry out the intent of this resolution, including, without limitation, such documents as shall be necessary to issue an obligation under the Master Indenture, execution thereof to be conclusive as to such determination and the approval of the terms thereof by the Corporation.

RESOLVED: That the authority granted to the Authorized Officers to enter into the Swaps shall expire one hundred eighty (180) days from the date of this resolution if unexercised.

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Thursday, October 10, 2019
2500 Grant Road, Mountain View, CA 94040
Conference Rooms F&G (ground floor)

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

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30pm by Chair Chen. A silent roll call was taken. Director Rebitzer arrived at 5:36pm during Agenda Item 6: Quality Committee Report. Director Watters was absent. All other Board members were present at roll call.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. PUBLIC COMMUNICATION	None.	
4. FY20 PERIOD 2 FINANCIALS	Iftikhar Hussain, CFO, reported that ECH is $8 million ahead of plan on operating margin, due to higher volume (in the Emergency Department and related to physician recruitment and new equipment). Cash position remains strong. He also reviewed monthly trends for the current and prior fiscal year. There were no comments or questions from the Board. **Motion**: To approve the FY20 Period 2 Financials. **Movant:** Kalbach **Second:** Po **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Rebitzer, Watters **Recused:** None	***FY20 Period 2 Financials approved***
5. AGENDA ITEM 6: QUALITY COMMITTEE REPORT	This item was taken out of order. Director Kliger, Quality Committee Chair, described the Committee's review and discussion of Performance Improvement Reports, which was recommended by CMS. She noted that the Committee requested 1) review of patient stories orientated toward metrics that the organization is following, 2) annotated run charts, and 3) the inclusion of more contextual information in the materials presented. In response to Director Rebitzer's question, Cheryl Reinking, RN, CNO	

	described the development of the GIP (inpatient hospice) program and its significant effect on the mortality index. Director Rebitzer suggested that baseline for mortality may need to be adjusted. Director Fung reported that the Committee also discussed the potential delegation of oversight of the credentialing and privileging of the Medical Staff. He expressed concerns about the proposal. Director Kliger noted that the discussion will continue when the CMO is present. Cindy Murphy, Director of Governance Services, described the Board's general direction to review potential areas of work for the delegation to the Committees and what the process would look like with the proposed changes, where the Board would still ultimately approve the report, per requirements from The Joint Commission. Director Miller asked for clarification from Legal on direction for delegations of authority. The Board discussed how delegations of authority should work and the Board's responsibility for credentialing and privileging.	***Legal to provide clarification on delegations of authority***
6. AGENDA ITEM 7: FY19 ORGANIZATIONAL GOAL ACHIEVEMENT	This item was taken out of order. Dan Woods, CEO, described the organizational performance in FY19: - Patient Throughput: insight into how efficient we are at providing appropriate care to patients; Q4 FY19 performance: 313 minutes. This metric will continue to be monitored in FY20, though it is not an organizational goal. - Nurse Communication – Service: are we "Always" explaining things clearly our patients; Q4 FY19 performance: 56th percentile. - Nurse Responsiveness – Service: are we "Always" responding quickly to our patients; Q4 FY19 performance: 50th percentile. - Cleanliness of Hospital Environment; Q4 FY19 performance: 68th percentile - Readmission Index: observed over expected, provides a comparable performance metric; 2019 performance: 0.99 - Mortality Index: FY19 performance: 0.97; Mr. Woods described the difference that the inpatient hospice program has made on this metric. Director Rebitzer commented that there is still room for improvement. - Employee Engagement: measure of cultural performance; FY18 performance 79th percentile In response to Director Zoglin's question, Mr. Woods explained that the materials provided included raw scores and the presentation featured percentiles for comparison with other organizations. Mr. Woods and the Board discussed goal setting and comparison with other hospitals in the Bay Area, California, and nationwide. Cheryl Reinking, RN, CNO, noted that Press Ganey does not have information for why Bay Area performance across several domains is less favorable than the nation. **Motion**: To approve the FY19 Organizational Goal Achievement, subject to the Board's approval of the financial audit. **Movant:** Kalbach **Second:** Ting **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***FY19 Org Goal Achievement approved***

7. AGENDA ITEM 5: FY19 FINANCIAL AUDIT	Brian Conner from Moss Adams joined the meeting via teleconference. He noted that Moss Adams met with the Compliance and Audit Committee at its September 26, 2019 meeting. Mr. Conner reviewed the scope of services (consolidated audit for the District, Hospital, Foundation, SVMD, and CONCERN, separate engagement for the Auxiliary). He explained that Moss Adams is providing consulting services to ECH related to business continuity, lean transformation, and property management outsourcing, but that Moss Adams remains independent of the organization for audit purposes. Mr. Conner reported that 1) the opinion given is an unmodified one, which is the highest level of assurance that can be given and 2) Moss Adams found ECH's financial statements to be fairly stated in all material respects. He outlined the FY19 audit results, including: - Relatively flat changes in cash and investments (in FY19, $149 million positive cash flow from operations and $50 million in investment income). - Purchases of $230 million of capital assets, offset by $52 million in depreciation. - Net Patient Service Revenue/Account Receivable, which is reviewed and tested in detail as it is the largest estimate on the balance sheet. Mr. Conner described management's adjustment to ECH's model this year, which is less conservative than the prior year's and closer to Moss Adams' expectations - Income Statement Year-to-Year Comparison: very consistent year over year between categories of where revenue is spent; salaries, wages, and benefits is the most significant category of around 50%. - Community Benefit expense of about $12 million Mr. Conner explained that 1) Moss Adams does not opine on operating effectiveness of internal controls, 2) there were no accounting policy changes, and 3) management judgments and accounting estimates are reasonable. He reported that there was one corrected misstatement related to construction in progress (CIP) retention accrual (5-10% for construction invoices that was not made). There was a $15 million adjustment, which was not material to the consolidated financial statements as a whole. Mr. Conner noted that there were no uncorrected misstatements, and for internal controls, no material weaknesses and one significant deficiency related to cutoff accrual. In response to Director Miller's question, Mr. Conner reported that there was only one corrected misstatement and no uncorrected misstatements, not uncommon for an organization of ECH's size. Mr. Conner explained that there are significant upcoming GASB accounting updates. There were no further questions from the Board.	
8. AGENDA ITEM 8: FY20 ORGANIZATIONAL GOAL METRICS	Dan Woods, CEO, reviewed the FY20 Organizational Goal Metrics, noting that measurement periods are over the whole fiscal year rather than only Q4 performance. He noted that the Board approved the methodology in June 2019 and the numbers presented incorporate FY19 actual performance into the approved formulas.	***FY20 Org Goal Metrics approved***

	Director Zoglin requested, if possible, to see what percentiles ECH is projected to achieve relative to its competitors (Bay Area, California, nationwide) with its FY20 performance. Director Zoglin also requested that the slides on FY19 performance be shared with the Board. Director Rebitzer suggested that FY21 organizational goals include outpatient metrics and more of a system focus. Mr. Woods commented that outpatient metrics are monitored even if they are not part of the organizational goals. **Motion**: To approve the FY20 Organizational Goal Metrics. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	
9. CAPITAL FUNDING REQUEST: MV CAMPUS COMPLETION PROJECT	Ken King, CASO, provided an overview of the initial funding request for the Mountain View campus completion project. He described the two phases of work related to the demolition of the Old Main Hospital Building and the construction of a temporary Shipping & Receiving Yard, including design, permitting, and execution. Mr. King explained that staff is considering options for the final campus configuration (Phase III) and the funding will be requested in early 2020. In response to Director Miller's question, Mr. King described the components of the master campus plan including two phases, Phase I: construction of the parking garage, Taube Pavilion (behavioral health services building) and Sobrato Pavilion (integrated medical office building), and Phase II: the complete demolition of the Old Main Hospital Building and the women's hospital expansion. He noted that this is the first time funding has been requested for Phase II. In response to Director Kliger's question, Mr. King noted that the total cost for Phase III depends on the scope of the project/building development; a straightforward replacement could run between $45-50 million and an expansion could cost around $80-90 million. **Motion**: To approve the initial funding for the Mountain View Campus completion project, covering demolition of the original hospital building and construction of a temporary Shipping and Receiving yard at a cost not to exceed $24.9 million. **Movant:** Fung **Second:** Kalbach In response to Director Miller's question, Mr. King explained that Phase III will cost in the range of $50-90 million and staff will come back a recommendation following the evaluation of the options. **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***MV Campus Completion project funding approved***
10. FY20 CEO	Bob Miller, Executive Compensation Committee Chair, reported that the	

PERFORMANCE REVIEW PROCESS	ECC debriefed with Mercer regarding the FY19 CEO Performance Review Process. One area for improvement is the overall timeline to allow for sufficient time for completion. Mr. Miller noted that staff will come back to the Board in 2020 with a timeline with important dates, including when the Board will approve the evaluation tool, when the CEO will complete the self-evaluation, when results will be reviewed, etc. There were no questions from the Board.	
11. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:49pm pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: FY19 Financial Audit; *Gov't Code Section 54957.6* for conference with labor negotiator Lanhee Chen: FY20 CEO Base Salary; *Gov't Code Section 54957.6* for conference with labor negotiator Lanhee Chen: FY19 CEO Individual Incentive Score; pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (9/11/2019) and Minutes of the Closed Session of the Executive Compensation Committee Meeting (5/30/2019); *Gov't Code Section 54957.6* for conference with labor negotiator Dan Woods: Executive Performance Incentive Score and Payout; pursuant to *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report; pursuant to *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets and *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: CEO Report on New Services and Programs and Quality Update; and pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: Executive Session. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***Adjourned to closed session at 6:49pm***
12. AGENDA ITEM 21: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 9:42pm by Chair Chen. Agenda items 12-20 were addressed in closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (9/11/2019) as amended, the Minutes of the Closed Session of the Executive Compensation Committee Meeting (5/30/2019), and the Medical Staff Report, including the credentials and privileges report, by a unanimous vote in favor of all members present (Directors Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, and Zoglin). Director Watters was absent.	
13. AGENDA ITEM 22: CONSENT CALENDAR	Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. Director Zoglin requested that the FY19 Community Benefit Report be removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting (9/11/2019); Resolution 2019-10: Amending the El Camino Hospital 403(b) Plan Matching Contributions; Minutes of the Open Session of the Executive Compensation Committee Meeting	***Consent calendar approved***

	(5/30/2019); FY20 Period 1 Financials; Cardiology Call Panel (LG) Renewal; Compliance Committee Report | Annual 403(b) Plan Audit, Annual Cash Balance Plan Audit; Medical Staff Report; and for information: Major Capital Projects Update; Finance Committee Approvals; Executive Compensation Committee Approvals; Report on Educational Activity. **Movant:** Miller **Second:** Po **Ayes:** Chen, Kalbach, Miller, Po, Rebitzer, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung, Kliger, Ting, Watters **Recused:** None Director Zoglin suggested that the Board recommend the CBAC review how to provide education about vaping health concerns. Director Kalbach voiced his support this proposal and none of the other Board members expressed any disagreement. In response to Director Zoglin's question, Anne Rabkin, Sr. Community Benefit Specialist, explained that if a grantee does not spend the full amount of money allocated in a particular fiscal year, those funds go back into the fund for the next fiscal year. Director Zoglin requested an annotation showing which grantees will not be funded in the next year. Ms. Rabkin noted that this is reflected in the materials for the District Board's next meeting and will be included in the Hospital Board materials going forward. **Motion:** To approve the consent calendar: for information: FY19 Community Benefit Report. **Movant:** Zoglin **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	
14. AGENDA ITEM 23: FY19 FINANCIAL AUDIT APPROVAL	**Motion**: To approve the FY19 financial audit. **Movant:** Ting **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***FY19 financial audit approved***
15. AGENDA ITEM 24: FY19 CASO INCENTIVE PLAN PAYOUT	**Motion**: To approve the FY19 CASO Incentive Plan Payout of $9,000. **Movant:** Kalbach **Second:** Miller **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***FY19 CASO Incentive Plan Payout approved – note correction below***

16. AGENDA ITEM 25: FY20 CEO BASE SALARY	**Motion**: To approve the FY20 CEO Base Salary of $995,000. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***FY20 CEO Base Salary approved***
17. AGENDA ITEM 26: FY19 CEO INCENTIVE PAYOUT	**Motion**: To approve the FY19 CEO Incentive Payout of $36,000. **Movant:** Kalbach **Second:** Ting **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***FY19 CEO Incentive Plan Payout approved – note correction below***
18. CORRECTIONS to AGENDA ITEMS 24 and 26	Chair Chen explained that the amounts previously approved for the FY19 CEO and CASO Incentive Payouts were not the correct calculation, but rather only a portion of the payouts. He asked for new motions on each item, with the correct amounts. **Motion**: To approve the FY19 CASO Incentive Plan Payout of $59,924. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None **Motion**: To approve the FY19 CEO Incentive Payout of $324,405. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***Corrected FY19 CASO Incentive Plan Payout and FY19 CEO Incentive Plan Payout approved***
19. AGENDA ITEM 27: CEO REPORT	Dan Woods, CEO, highlighted new procedures, the first in human robotic-assisted minimally invasive bronchoscopy and GammaTile Therapy, provided at the Mountain View campus. He encouraged everyone to get their flu shots. He further described 1) online scheduling at the clinics, 2) new employee hires (Andrew Cope, President, Foundation, and Christine Cunningham, Executive Director, Patient Experience), 3) the implementation of Workday, the new enterprise resource planning (ERP) system, and 4) community events including the Chinese Health Initiative's physician appreciation dinner and the Women's Health Fair. He thanked that Auxiliary for over 6,000 hours of volunteer service in September.	

20. AGENDA ITEM 28: BOARD COMMENTS	Director Miller described her attendance at recent community events.	
21. AGENDA ITEM 29: ADJOURNMENT	**Motion**: To adjourn at 9:55pm. **Movant:** Fung **Second:** Kalbach **Ayes:** Chen, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Watters **Recused:** None	***Meeting adjourned at 9:55pm***

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

_____ _____

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services
Sarah Rosenberg, Contracts & Board Services Coordinator

Minutes of the Open Session of the
Special Joint Meeting to Conduct a Study Session of the
El Camino Hospital Board of Directors
and the Quality, Patient Care and Patient Experience Committee
Wednesday, October 23, 2019
2500 Grant Road, Mountain View, CA 94040
Conference Rooms E&F (ground floor)

Board Members Present
Lanhee Chen, Chair
Peter C. Fung, MD
Gary Kalbach
Julie Kliger
Julia E. Miller, Secretary/Treasurer
Jack Po, MD, PhD
Bob Rebitzer
George O. Ting, MD
John Zoglin, Vice Chair

Board Members Absent
Don Watters

Members Excused
None

Committee Members Absent
Caroline Currie

Committee Members Present
Terrigal Burn, MD
Alyson Falwell
Krutica Sharma
Melora Simon

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL/ WELCOME	The Open Session of the Special Joint Meeting to Conduct a Study Session of the El Camino Hospital of Board of Directors and the Quality, Patient Care and Patient Experience Committee (the "Board and Committee") was called to order at 6:00pm by Chair Chen. A silent roll call was taken. Director Watters and Committee Member Caroline Currie were absent. All other Board and Committee members were present at roll call. Leadership Team Members Bruce Harrison, CMO; Jim Griffith, COO; Mark Adams, MD, CMO; Cindy Murphy, Director of Governance Services; Dan Woods, CEO; Mary Rotunno, General Counsel; and Cheryl Reinking, RN, CNO also participated in the Study Session.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen asked if any Board or Committee members may have a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. GOALS OF THE SESSION	Chair Chen welcomed all of the participants to the session. Mr. Woods described the goals for the session and reiterated Chair Chen's comment that this session is a beginning of a discussion about how the Board and the Committee should govern and oversee quality. Mr. Woods also described the quality-related challenges that health care systems across the country are facing and suggested that the Board needs to better understand the process for credentialing the Medical Staff. Dr. Adams commented that that most Quality Committees are charged with the real scrutiny of credentialing.	
4. LEVEL SETTING	Mark Adams, MD, CMO described El Camino's "current state" related to Quality of Care, reviewed the quality pillar that cascades from the organizations' strategic plan, and explained the organization's long-term quality goal of zero preventable harm.	

5. ROUNDTABLE – REACTIONS TO PRE-READING MATERIAL	Guy Masters from Premier, Inc. facilitated a discussion regarding the participants' reactions to the pre-reading materials.	
6. ROLE OF GOVERNANCE IN QUALITY AND SAFETY	Mr. Masters facilitated a discussion about the roles of the Board and the Committee in Governance of Quality Care. The following were presented as Next Steps: 1. Bring Management's Quality and Safety Strategic Plan in a format digestible for the Board to the November 6th Board meeting. 2. Revalidate the metrics management is reporting to the Quality Committee and the Quality Committee is reporting to the Board. - Are the metrics the right ones? - Get consensus on the format - Report the "so what" and the "now what" - How do we compare? 3. Revisit long-term (multi-year) quality goal(s) annually. 4. Establish the scope and responsibility of the Chief Quality Officer. 5. Get to consensus on vision. - Is top performer good enough or top decile? - Cost analysis – resources needed to get to vision 6. Quality Committee to understand its role and function - Purpose - Span of authority - Clarify credentialing process/oversight	
7. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 8:34pm. **Movant:** Kalbach **Second:** Po **Ayes:** Burn, Chen, Falwell, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Sharma, Simon, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Currie, Watters **Recused:** None	***Meeting adjourned at 8:34pm***

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

_____
Lanhee Chen
Chair, ECH Board of Directors

_____
Julia E. Miller
Secretary, ECH Board of Directors

_____
Julie Kliger, MPA, BSN
Chair, Quality, Patient Care and Patient Experience Committee

Prepared by: Cindy Murphy, Director of Governance Services

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Iftikhar Hussain, CFO
Date: November 6, 2019
Subject: Approval of Pathways Home Health and Hospice Operating and Capital Budget for the last 8 months of FY20

Recommendation(s):

To approve the Pathways Home Health and Hospice (Pathways) Operating and Capital Budget for the last 8 months of FY 20.

Summary:

1. Situation and Background: Pathways management is changing to CHI at Home (CHI) effective 11/1/2019. The current management prepared the FY 20 budget for the first months of FY20 and it was approved by the ECH Board at the August 21, 2019 meeting. The CHI team has prepared the attached budget for the remaining eight months. The material also shows the budget for the complete year.

FY20 budget operating margin is $1.9 million improvement from actual FY 19 results before one-time transition expenses. The improvement is achieved primarily by revenue and volume growth. The budget includes $6.2 million in transition expenses. These expenses include $2.2 million in retention and severance costs and $4 million for write-off and replacement of the IT systems.

The attached Proforma shows the recovery plan driven primarily by volume growth. The growth strategies are described in the attached PowerPoint slides.

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

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

4. Other Reviews: The Pathways Board approved the Budget on October 30, 2019.

5. Outcomes: Pathways budget for the remaining eight months of FY20 approved by the ECH Board.

List of Attachments:

1. Pathways FY 20 Budget
2. Proforma - Pathways 5 Year Forecast
3. Pathways Growth Strategies

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

Pathways

FY 2020 Budget with Transition Costs

	Pathways FY 2019 Actual	%	FY 2020 Budget (7/19-10/19)	%	FY 2020 Budget (11/19-6/20)	%	Budget FY 2020	%
Net Revenue	$ 37,509,903		$ 13,174,722		$ 27,745,846		$ 40,920,568	
Cost of Services Provided:								
Salaries, Benefits & Mileage	17,047,383	45.4%	5,999,614	45.5%	12,627,772	45.5%	18,627,386	45.5%
Medical Supplies/Other	3,966,651	10.6%	1,436,161	10.9%	2,917,282	10.5%	4,353,443	10.6%
Total Cost of Services Provided	21,014,035	56.0%	7,435,775	56.4%	15,545,054	56.0%	22,980,829	56.2%
Gross Profit	16,495,868	44.0%	5,738,947	43.6%	12,200,791	44.0%	17,939,738	43.8%
Gross Profit %	44.0%		43.6%		44.0%		43.8%	
Administrative Expenses:								
Branch Salaries & Benefits	7,861,226	21.0%	2,499,662	19.0%	5,799,982	20.9%	8,299,644	20.3%
Facility Charges	2,177,802	5.8%	837,596	6.4%	950,477	3.4%	1,788,073	4.4%
Purchased Services/Professional Fees	1,801,105	4.8%	731,060	5.5%	1,347,091	4.9%	2,078,151	5.1%
Depreciation	1,034,864	2.8%	390,398	3.0%	319,917	1.2%	710,315	1.7%
Back Office Support	5,836,603	15.6%	1,945,534	14.8%	784,764	2.8%	2,730,298	6.7%
Management Fee	-	0.0%	-	0.0%	2,637,461	9.5%	2,637,461	6.4%
Other	811,180	2.2%	276,783	2.1%	564,355	2.0%	841,138	2.1%
Total Administrative Expenses	19,522,779	52.0%	6,681,034	50.7%	12,404,047	44.7%	19,085,081	46.6%
% of Net Revenue	52.0%		50.7%		44.7%		46.6%	
Operating Profit/(Loss)	(3,026,911)	-8.1%	(942,087)	-7.2%	(203,255)	-0.7%	(1,145,342)	-2.8%
% of Net Revenue	-8.1%		-7.2%		-0.7%		-2.8%	
Transitional Expenses	-		-		6,169,345		6,169,345	
Other (Income)/Expense	-	0.0%	-	0.0%	6,169,345	22.2%	6,169,345	15.1%
Net Income/(Loss)	$ (3,026,911)	-8.1%	$ (942,087)	-7.2%	$ (6,372,600)	-23.0%	$ (7,314,687)	-17.9%
% of Net Revenue	-8.1%		-7.2%		-23.0%		-17.9%	

*Excludes net investment income and other revenue. In FY19, this was $963,300 and $32,100, respectively.

Pathways

FY 2020 Budget with Transition Costs

	Pathways FY 2019 Actual	%	FY 2020 Budget (11/19-6/20)	%	Budget Annualized FY 2020	%	Variance
Net Revenue	$ 37,509,903		$ 27,745,846		$ 41,618,769		$ 4,108,866
Cost of Services Provided:							
Salaries, Benefits & Mileage	17,047,383	45.4%	12,627,772	45.5%	18,941,658	45.5%	$ 1,894,275
Medical Supplies/Other	3,966,651	10.6%	2,917,282	10.5%	4,375,923	10.5%	409,272
Total Cost of Services Provided	21,014,035	56.0%	15,545,054	56.0%	23,317,582	56.0%	2,303,547
Gross Profit	16,495,868	44.0%	12,200,791	44.0%	18,301,187	44.0%	1,805,319
Gross Profit %	44.0%		44.0%		44.0%		43.9%
Administrative Expenses:							
Branch Salaries & Benefits	7,861,226	21.0%	5,799,982	20.9%	8,699,973	20.9%	838,748
Facility Charges	2,177,802	5.8%	950,477	3.4%	1,425,715	3.4%	(752,086)
Purchased Services/Professional Fees	1,801,105	4.8%	1,347,091	4.9%	2,020,637	4.9%	219,532
Depreciation	1,034,864	2.8%	319,917	1.2%	479,875	1.2%	(554,989)
Back Office Support	5,836,603	15.6%	784,764	2.8%	1,177,146	2.8%	(4,659,457)
Management Fee	-	0.0%	2,637,461	9.5%	3,956,192	9.5%	3,956,192
Other	811,180	2.2%	564,355	2.0%	846,532	2.0%	35,353
Total Administrative Expenses	19,522,779	52.0%	12,404,047	44.7%	18,606,070	44.7%	(916,709)
% of Net Revenue	52.0%		44.7%		44.7%		-22.3%
Operating Profit/(Loss)	(3,026,911)	-8.1%	(203,255)	-0.7%	(304,883)	-0.7%	2,722,027
% of Net Revenue	-8.1%		-0.7%		-0.7%		66.2%
Transitional Expenses	-		6,169,345		6,169,345		6,169,345
Other (Income)/Expense	-	0.0%	6,169,345	22.2%	6,169,345	14.8%	6,169,345
Net Income/(Loss)	$ (3,026,911)	-8.1%	$ (6,372,600)	-23.0%	$ (6,474,228)	-15.6%	$(3,447,318)
% of Net Revenue	-8.1%		-23.0%		-15.6%		-83.9%

*Excludes net investment income and other revenue. In FY19, this was $963,300 and $32,100, respectively.

Pathways Total
Comparison

	Pathways FY 2019 Actual (7/18-6/19 Actual)	5 Year Pro forma FY 2020 (11/19-6/20)	FY 2021	FY 2022	FY 2023	FY 2024
Net Patient Revenue	$ 37,509,903	$ 27,745,846	$ 45,197,035	$ 49,845,449	$ 55,146,048	$ 57,692,867
Cost of Services Provided:						
Salaries, Benefits & Mileage	17,047,383	12,627,772	20,307,782	22,432,646	24,880,594	25,853,101
Medical Supplies/Other	3,966,651	2,917,282	4,618,781	5,026,901	5,445,995	5,752,773
Total Cost of Services Provided	21,014,035	15,545,054	24,926,562	27,459,547	30,326,589	31,605,875
Gross Profit	16,495,868	12,200,791	20,270,473	22,385,901	24,819,459	26,086,992
Gross Profit %	44.0%	44.0%	44.8%	44.9%	45.0%	45.2%
Administrative Expenses:						
Branch Salaries & Benefits	7,861,226	5,799,982	9,389,117	10,126,280	11,116,765	11,614,856
Facility Charges	2,177,802	950,477	1,250,300	1,275,305	1,300,812	1,326,827
Purchased Services/Professional Fees	1,801,105	1,347,091	1,901,308	2,027,128	2,244,637	2,348,015
Depreciation	1,034,864	319,917	444,022	440,903	249,805	231,040
Back Office Support/Management Fee	5,836,603	3,422,225	5,520,594	6,015,599	6,576,577	6,862,950
Other	811,180	564,355	846,532	846,532	846,532	846,532
Total Administrative Expenses	19,522,779	12,404,047	19,351,873	20,731,747	22,335,128	23,230,220
% of Net Revenue	52.0%	44.7%	42.8%	41.6%	40.5%	40.3%
Operating Profit/(Loss)	(3,026,911)	(203,255)	918,600	1,654,154	2,484,331	2,856,772
% of Net Revenue	-8.1%	-0.7%	2.0%	3.3%	4.5%	5.0%
Transitional Expenses	-	6,169,345	50,368	-	-	-
Other (Income)/Expense	-	6,169,345	50,368	-	-	-
Net Income/(Loss)	$ (3,026,911)	$ (6,372,600)	$ 868,232	$ 1,654,154	$ 2,484,331	$ 2,856,772
% of Net Revenue	-8.1%	-23.0%	1.9%	3.3%	4.5%	5.0%

PATHWAYS
Moving Care Forward

Growth Strategies

Hospice Revenue Growth Strategies

PATHWAYS
Moving Care Forward

- **Hospice Admission Growth** - The budget for hospice is focused on increasing hospice admissions while maintaining the current LOS. The following initiatives will be the primary focus to drive census to 280:
  - Utilizing Trella Health Medicare Claims Data to drive key stakeholder specific conversations with Executives, Case Management Directors/SNF Administrators, and front line referral sources (Case Managers, SNF discharge planners, and Physician staff) to drive change in referral and utilization behavior
  - Redesign the referral to admission process to be more referral source friendly
  - Increase start of care capacity through increased productivity expectations and reduced documentation time. Implementing Homecare Homebase helps facilitate this initiative
  - Change in sales oversight and support
  - Redesign incentive plans to align with growth
  - Implementation of the S4 model which facilitates an earlier and potentially more frequent transitions to hospice

Homecare Revenue Growth Strategies

PATHWAYS
Moving Care Forward

- **Hospital capture rate** – The budget includes $1.0m in growth due to an improvement in capture rate from partner health systems, which represents a 6% improvement
  - Utilizing Trella Health Medicare Claims Data to drive key stakeholder specific conversations with Executives, Case Management Directors/SNF Administrators, and front line referral sources (Case Managers, SNF discharge planners, and Physician staff) to drive change in referral and utilization behavior
  - Increase capacity through improved productivity and reduced documentation time through the implementation of Homecare Homebase (HCHB)
  - Utilizing our Care Pathways and CareLinks - Disease Specific Specialty Programs to address hospital partner penalty DX, LOS and readmission issues
  - Implementing a revised incentive plan for the sales force that drives organic growth
  - Implementation and adherence to the Sales IMPACT training and methodology for current sales force

Homecare Revenue Growth Strategies

PATHWAYS
Moving Care Forward

- **Recertification ('Recert') improvement** – Improve medically appropriate recertification of homecare patients from 23.3% to 25%, through the following initiatives:
  - Increased clinician education
  - Increased clinician capacity as a result of improved productivity and reduced documentation time
  - Clinical manager oversight and the implementation of the Recert/DC Decision workflow in HCHB as well as the Recert Due by Case Manager Report
- **LUPA*** - LUPAs result in a substantial reduction in payment for an episode of care. The Budget has includes a reduction in LUPA to 12.3%. The initiatives around LUPA are as follows:
  - Refined case conference and SOC review with clinical manager
  - Implementing and managing to our front loading visit strategy
  - Decreasing missed visits in first 2 weeks of care.

*A **LUPA** occurs when four or fewer visits are provided in a 60-day episode. Instead of payment being based on the **Health** Insurance Prospective Payment System (HIPPS) code, payment is based on a national standardized per visit payment by discipline instead of an episode payment for a 60-day period.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Ken King, CASO
Date: November 6, 2019
Subject: FY19 Annual Evaluation of the Environment of Care and Emergency Management

Recommendation(s):

To approve the FY19 Annual Evaluation of the Environment of Care & Emergency Management Report.

Summary:

1. Situation: The Annual Evaluation of the Environment of Care provides an overview of the six fundamental elements that ensure a safe and secure physical environment for the care of patients, staff and the public. These elements include the Management of Safety, Security, Hazardous Materials, Fire Safety, Utilities and Emergencies (Disaster Preparedness). The attached report provides both an Executive Summary and detailed information for each element.

2. Authority: The Annual Evaluation of the Environment of Care is required by Joint Commission standards to be reviewed and approved by the Board of Directors. It is the organizations policy that requires a recommendation from the Quality Committee.

3. Background: This is a routine annual report that is prepared by the Manager of Environmental Health & Safety and the Director of Safety and Security. Responsibility for each fundamental element is shared with subject matter experts and is reviewed and approved by the Central Safety Committee.

4. Assessment: As the report indicates we have had a successful year that with a decrease in work related injuries compared to the prior year, along with a very successful outcome with the triennial Joint Commission survey relative to the EOC.

5. Other Reviews: The hospital's Central Safety Committee and Emergency Management Committee have reviewed and approved of this report and recommend approval by the Quality Committee and Board of Directors. The Quality Committee will review this report at its November 4, 2019 meeting.

6. Outcomes: Detailed within the report.

List of Attachments:

1. FY19 Evaluation of the Environment of Care & Emergency Management Report

Suggested Board Discussion Questions:

1. Are there any trends or risks that could affect the organizations provision of care?

El Camino Health

FY-2019 Evaluation of the Environment of Care and Emergency Management

Prepared by:

Steve Weirauch
Manager, Environmental, Health & Safety

Matt Scannell
Director, Safety and Security

Created: 08/22/2019

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Executive Summary

The Safety Program for Managing the Environment of Care is to inform the Hospital Board of Directors of the status of key measurement criteria for the Hospital's safety program implementation that meets Injury and Illness Prevention Program OSHA requirements, and The Joint Commission (TJC) standards.

Safety Management

- The safety program indicators showed a decrease in the rate of all work-related injuries compared to FY-18.
- A significant factor in this decrease is attributed to the Safe Patient Handling program. Patient handling injuries continued to decrease for the 4th straight year.
- Bloodborne pathogen exposures decreased over FY18. One third of the exposures were due to needle sticks. Investigation found a wide variation in the types of needles used across the enterprise which could be a factor in the number of exposures. Work will continue to standardize syringes and ensure staff are trained.

Security Management

- Efforts continued to decrease the number of workplace violence incidents. New procedures and tracking of violence-prone patients has helped decrease the number of incidents by 16% over the FY18 numbers. Efforts are ongoing to continue this trend.
- Code Gray events (aggressive or threatening person) increased during the year. Contributing factors were determined to be:
  - Staff awareness to call for assistance early if patient appears threatening; a positive outcome to ensure staff safety.
  - Multiple incidents involving the same patient. A task force is developing procedures to address and minimize these events.

Hazardous Material Management

- No citations from the Santa Clara County Environmental Resources Agency
- One waste water violation occurred – monthly samples were not collected for a period. This has been corrected.
- Five recordable hazardous materials incidents
  - 2 chemo – MV Infusion center and MV Patient room (no exposure or injuries reported)
  - 3 Formalin – LG OR, MV Imaging, MV OR (one exposure, but no injuries reported)

Fire Safety Management

- One reported fire incident – a patient on oxygen ignited paper causing a small fire. Patient had minor injuries. Mountain View fire responded. Minimal damage, room back in service the same day.

Utility Management

- Two reportable utility incidents – brief power outages

Emergency Management

- Three events requiring the activation of the Hospital Incident Command System (HICS)
  - The Joint Commission tri-annual survey (12/2018)
  - PG&E Power Outage in Mountain View (02/28/2019)
  - CMS Validation Survey (06/2019)

Program Overview

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

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

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

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

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

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

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2019. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

EC 1.0 - Safety Management

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

Scope

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

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

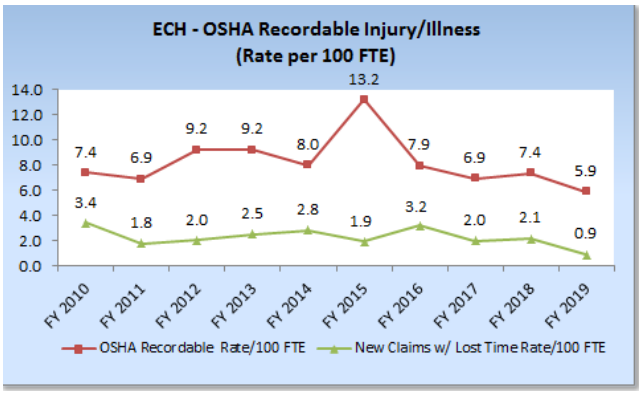
Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-19. This includes data from both the Mountain View and Los Gatos campuses.

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

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE decreased in FY-19 to 5.9 as compared to 7.4 in FY-18. The total *number* of recordable incidents decreased to 145 compared to 176 in FY-18. This is the lowest rate in the last ten years!



The rate of injuries for lost work days for all open claims (per 100 FTEs) decreased significantly to 0.9 in FY-19 from 2.1 in FY-18. Again, this is the lowest rate in the last ten years!

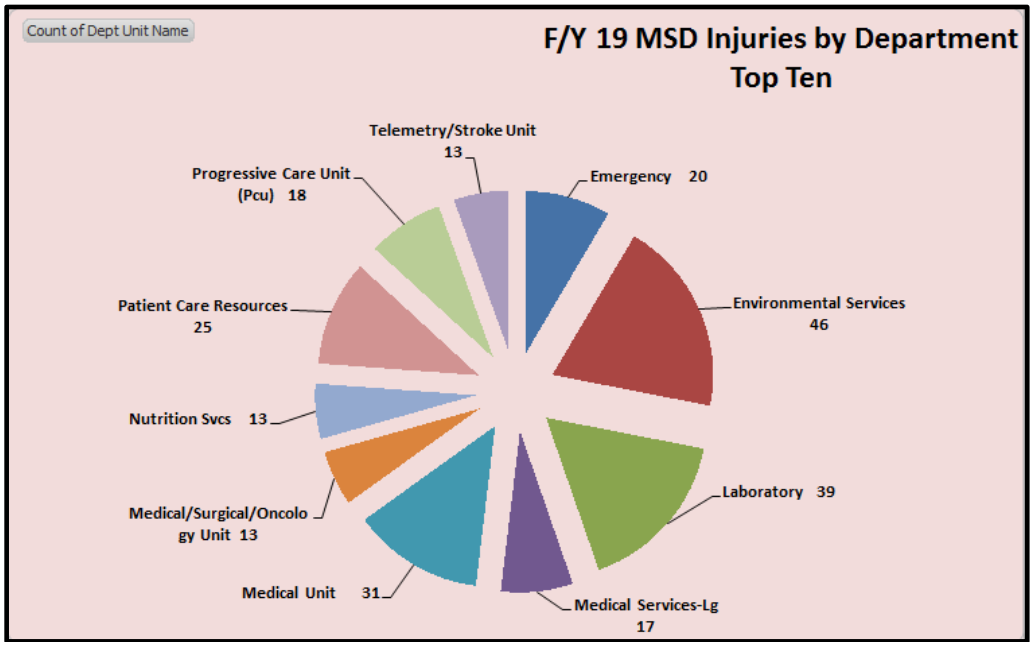
Analysis

- In FY-19 we had a 19% reduction in OSHA recordable injuries compared to FY-18.
- In FY-19 loss time days were reduced by 85% compared to FY-18. In FY-18 we had 1,654 days of loss time compared to 255 in F/Y19. This number directly contributes to the Organization's productivity as we keep our employees at work.
- The decreased in injuries and loss time days are in part due to another great year we had with our Safe Patient Handling Program. This will be explained in detail in the section below.
- Injury Rates: The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were Musculoskeletal Disease (MSD)-not related to patient handling at 38%, exposures at 23% followed by slips/trips/falls at 14%.

EC 1.0 - Safety Management

Improvement Strategies:

We had a total of 235 MSD injuries not related to patient handling in FY-19 (total injuries). Improvement strategies for FY-20 are to target MSD injuries not related to patient handling. The graph below depicts the departments with the highest numbers of MSD injuries not related to patient handling. It is not a surprise that our Environmental Services (EVS) due to the nature of the work they do has the highest incident of this type of injuries.



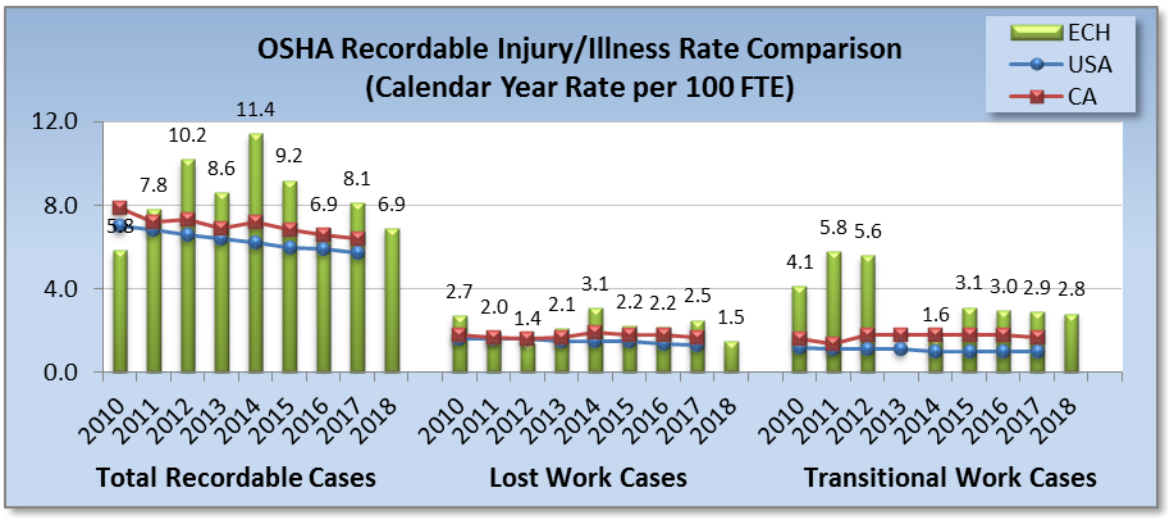
We are partnering with the EVS Department in efforts to reduce MSD injuries. We are conducting an initiative in collaboration with an outside vendor that will include the following deliverables:

1. Complete a musculoskeletal injury risk analysis for primary tasks (job roles or codes may also be used) within the Environmental Services department. The purpose of the analysis is to identify key musculoskeletal risk factors in each job/task. For each job/task reviewed, a mitigation plan using a standard hierarchy of control will be proposed including, when available, engineering, administrative, and work practice controls. Each task analysis will be delivered as a standalone document.
2. Review pertinent injury data, provided by the client, related to sprain/strain or other musculoskeletal injuries sustained in the environmental services department over the past 3 years.
3. Using data, pictures, and information collected in the analysis, will create a PowerPoint based training deck that details job/task specific musculoskeletal risk potential, risk reducing controls and employee expectations. This training may be delivered in person or made available for use in your existing online learning management system.

EC 1.0 - Safety Management

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

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

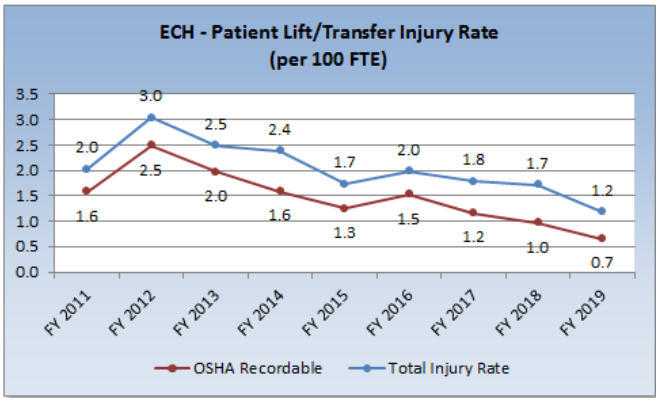


The ECH injury/illness rate in calendar year 18 was 6.9 a little higher than the state and national averages in 2017 (the most recent year available from the BLS). The ECH lost work cases rate was 1.5 close to the national average but a little lower than the state average. Among other reasons, our lower rate in loss time cases is due to ECH robust Transitional Work Assignment Program, showing a commitment to getting people back to work as quickly as possible after an injury or illness. This explains our above average transitional work cases compared to the national and state averages.

C. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- Injury Rates: The rate of OSHA recordable patient lift/transfer injuries per 100 FTEs decreased to 0.7 in FY-19 compared to 1.0 in FY-18. <u>This is the lowest injury rate due to patient handling ever!</u>



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

EC 1.0 - Safety Management

- Total Injuries: There is a persistent downward trend in the total number of patient handling injuries reported, including a record low number of OSHA recordable injuries:

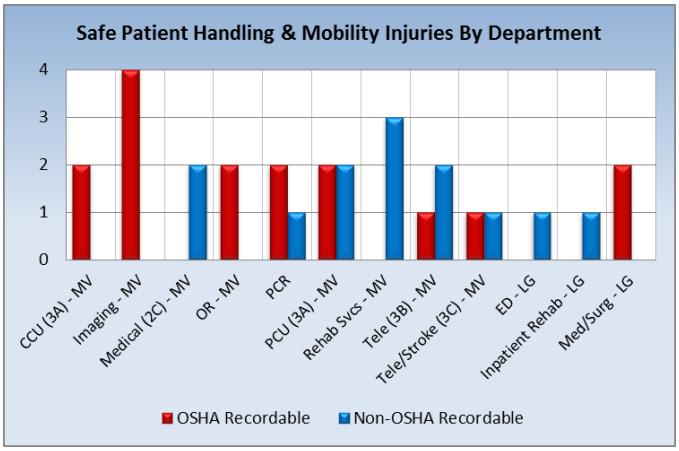
	Total # Injuries	# OSHA Recordable
FY-16	48	34
FY-17	44	29
FY-18	41	23
FY-19	29	16

- Lost Days due to Patient Handling Injuries: There were a record low number of lost days incurred during FY-19 (5 lost days); 98% fewer than in FY-18.
- Injury Types:

Safe Patient Handling & Mobility Injuries by Type

Activity	2015	2016	2017	2018	2019
Combined Transfer	6	8	6	5	5
Cumulative Patient Handling	5	1	5	4	0
Lateral Transfer	8	6	8	1	5
Misc. Patient Handling (e.g., fall, car extraction)	5	6	5	9	8
Patient Holding	2	3	2	3	2
Turning/Pulling	12	12	12	16	5
Vertical Transfer	5	12	5	3	4
Grand Total	43	48	43	41	29

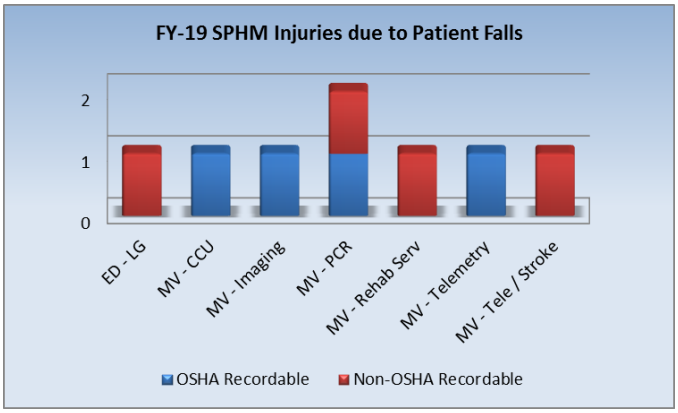
- Injuries by Department
  - CCU had been in the top three departments with SPHM injuries. Partnership with their educator, coaching, plus the trial and introduction of repositioning sheets and a sit/stand/walk aid that promotes early mobility reduced the number of injuries to 2.



  - Inpatient Rehab suffered from the highest incidence of injuries in FY-18. Collaboration with the manager and contracted on-site therapy group to advocate for appropriate use of equipment/training has achieved success reducing the number to 1 non-reportable injury.
  - The Women's Hospital was on an upward trend of injuries until EWHS and an OHN/MSN student performed a needs assessment, equipment trials, and introduction of Sara Stedys and HoverMats with Manager and Educator support. In FY-19 there were no patient hand ling injuries recorded.

EC 1.0 - Safety Management

- Historically, repositioning patients had been the most common cause of SPHM injury, and those from patient falls were among the least.
  - In FY-19, 29% of the injuries were due to patient's falls.



Improvement strategies:

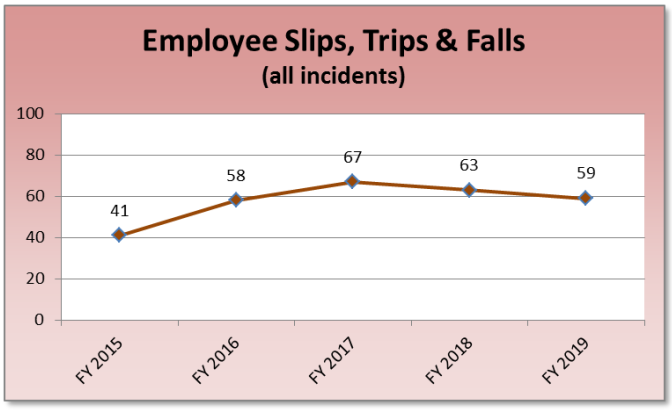
- The Patient Fall Prevention and Employee Fall Prevention Committees have partnered to identify opportunities to decrease risk in both populations.
- Renewed training and mandatory PMAT (Patient Mobility Assessment Tool) documentation is planned to encourage appropriate use of SPHM equipment. This will require robust SPHM committee involvement with collaboration among Nursing, Employee Health, Education, Facilities, Supply Chain, Biomed and Auxiliary.
- SPHM unit champions and shift peer leaders engaged on every unit
- Use of SPHM equipment is the norm; embedded in the culture whereby every lift is a safe lift
- Provide lifts and slings together near the point of care.
- Ensure accessible, appropriate bariatric equipment on-site.
- Include dedicated time for training with hands-on practice off-shift.
- Standardize the method of product trials/evaluation.

EC 1.0 - Safety Management

D. Slips, Trips, Falls Injuries

Analysis

- Injury Rates: The number of slips, trips and falls in the hospital has risen dramatically in the last five years. Last year we started efforts to understand and prevent these injuries. In FY-19 we promoted two enterprise-wide campaigns to encourage staff to cover the cups to prevent spills as contaminants is one of the top two cause of slips/trips/falls.



- Injury Types:
  - 25% of the injuries occurred outside the buildings.

Activity	FY-19
Injury occurred due to contaminant and/or slippery floor	12
Injury occurred due to cords or tubing, bodily reactions, surface irregularities	22
Objects in path	9
Falling from a chair or stool	6
Involving steps or handrails	8
Other *(e.g., tripping on carpeting, lighting, etc.)*	2

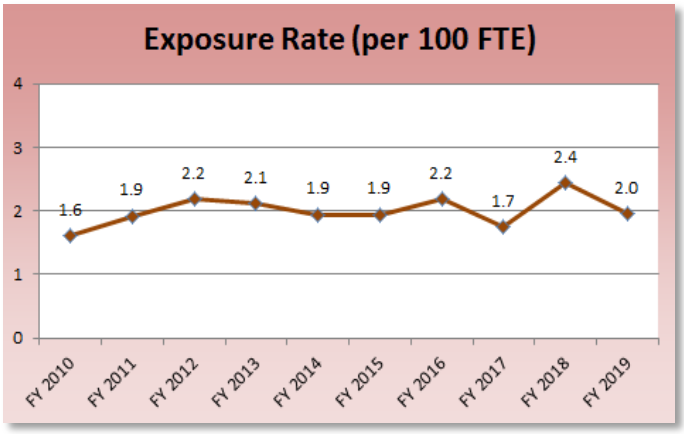
Improvement Strategies:

- The task force is meeting monthly, to investigate all accidents. The manager of each department reporting an injury is encouraged to attend to review the cause and strategize prevention efforts.
- Continue initiatives and awareness campaigns.
- Evaluate the possibility to implement slip-resistant shoes (e.g., Shoes for Crews) for specific departments such as Nutrition Services and EVS.
- Partner with Facilities for ongoing exterior grounds inspections to improve lighting, landscape and stair safety.

EC 1.0 - Safety Management

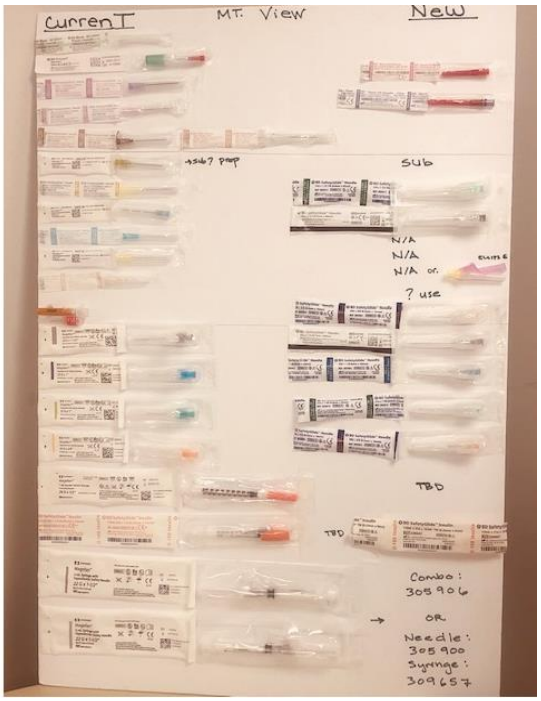
E. Bloodborne Pathogen Exposures

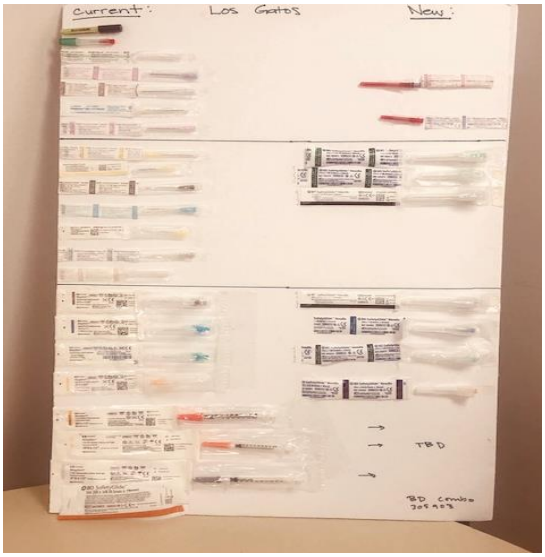
The rate of Blood borne pathogen exposures per 100 FTE decreased to 2.0 in FY-19 compared to 2.4 in FY-18. The total number of exposures for both campuses decreased to 48 exposures in FY-19 compared to 58 in FY-18. Of these, 30 were percutaneous exposures and 18 were body fluid exposures due to splashes.



Analysis:

- 33% of exposures due to needle sticks were the result of handling subcutaneous needles mostly insulin syringes.
- Among the most common root causes failure to engage safety devices immediately after use (recapping) was widespread.
- Switching hand to activate safety mechanism was another prevalent cause
- In FY-19 we established a Sharps Taskforce to look into the insulin syringes and found a variation among floors and between campuses that could directly contribute to staff difficulty engaging the safety device in some instances.
- An insulin syringe trial was completed with the purpose of selecting one product that will be used across the Enterprise.
- In the process we found significant variation among different kinds of needles and other syringes (see images below).





- Bloodborne Pathogen Needle Stick/Sharp by Job Type

Job Title	# Exposures
Behavioral Health Worker	1
Clinical Nurse II	16
Clinical Nurse III	3
Clinical Support (CNA)	1
CT Specialist	1
Lab Tech Support Specialist I	2
Lead Respiratory Therapist	1
Sterile Processing Tech II	1
Supervisor – Environmental Services	1
Surgical Tech I	1
Surgical Tech II	1
Unit Support	1
Total	30

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO.
- New insulin syringe to be deployed in October 2019. One product to be use across campuses & units.
- Full needle conversion to be completed by October 2019.
- Continue to identify causes and how exposure or injury could have been prevented by asking exposed employee what action they will take in the future to prevent the exposure from occurring again should a similar situation arise

F. TB Conversions

There were no known occupational exposure conversions at either campus during FY-19.

G. Safety Training Indicators

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

- New employee orientation: 100% (Target: 100%)
- Life Safety - Non-Clinical: 93.8% (Target: 95%)
- Life Safety - Clinical: 96.0% (Target: 95%)

EC 1.0 - Safety Management

H. Safety Inspections

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

The most noted problems in calendar year 2018 involved:

Problem Type	Category
• Damaged or stained ceiling tiles	*General Safety*
• Damaged walls	*General Safety*
• Isolation and Crash carts stocked and clean (tops of crash carts were dusty)	*Infection Prevention*
• Improper storage of clean linen (not in closed cart or cabinet)	*Hazardous Material/Waste*
• 18" vertical clearance to fire sprinkler heads	*Fire Safety*
• Electrical panels not locked	*Utility Management*
• Paper signage in clinical areas (should be laminated or in plastic sleeves)	*Infection Prevention*

I. Environmental Monitoring

All scheduled environmental monitoring was completed and results were below exposure limits as set by the appropriate regulatory agencies.

Monitor	Location	Results
Anesthetic Gases ○ Nitrous Oxide ○ Sevoflurane	OR, PACU, L&D	 Below Cal OSHA PEL Below NIOSH REL[2]
Formaldehyde	Cytology, Histology	Below Cal OSHA PEL
Lead/Cadmium	Radiation Oncology (MV)	Wipe Samples in all areas except the lid of the molding pot and the surface of the molding board were below the recommended surface contamination levels [3]
Noise	Facilities Personal Monitoring (MV)	Below Cal OSHA Action Level
	Central Plant (MV)	Several locations exceed the action limit (85dBA). "Hearing Protection Required" signs are posted in these areas.
Xylene	Cytology, Histology	Below Cal OSHA PEL

[2] OSHA has not established a Permissible Exposure Limit (PEL) for Sevoflurane.

[3] OSHA has not established regulatory quantitative surface limits for lead and cadmium. As a best management practice, the lead and cadmium surface sample results were compared to the Brookhaven National Laboratory's acceptable surface contamination level.

EC 1.0 - Safety Management

Effectiveness

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

FY 19 Goals

1) Reduce BBP exposures related to splashes due to the lack of Personal Protective Equipment (PPE)

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

   This goal was accomplished. In FY-19 we reduced splashes related to the lack of PPE by 15% compared to FY-18.

2) Expand the incident investigation and corrective action process

   Measurement of success: Seek assistance from an outside consultant to review our "as is" process and help us develop a "future state" with the tools and resources we already have. The deliverable from this process will be a policy outline for incident investigation and action tracking.

   This goal was not accomplished. Due to other priorities during the fiscal year such as preparation for Joint Commission visit and aggressive Enterprise safety goals among others we were unable to secure the adequate time from stakeholders needed to evaluate the current process. We have made some small changes in the documentation utilizing our current AIER System to improve corrective actions documentationFY-18 Goals

EC 2.0 - Security Management

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

Scope

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

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism

Workplace Violence Prevention Plan

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

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

Plan Element: Written Plan	**Status: COMPLETED**
• The written plan has been completed and approved. • The plan requires annual review / update by the Workplace Violence Committee. The plan was reviewed, revised and approved by the Workplace Violence Committee in June of FY 2019.	

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

Plan Element:	**Training (annual)**	**Status: ONGOING**

- The hospital has developed two levels of training.
  1. AVADE – Computer based training module assigned to most staff.
  2. Nonviolent Crisis Intervention (NCI) training – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to:
     - Behavioral Health
     - Emergency Department
     - Facilities Engineering
     - Assistant Hospital Managers (Hospital Supervisors)
     - Security
     - Course is also available as an option to all staff.

EC 2.0 - Security Management

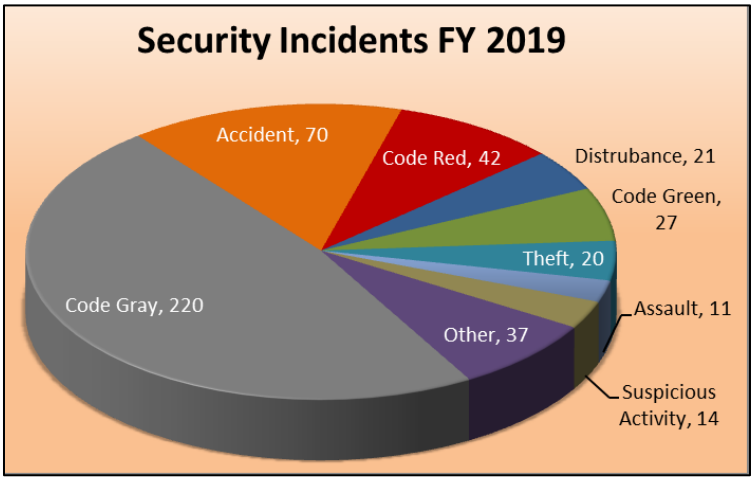
Plan Element: **Reporting:** All physical assaults against staff to OSHA	**Status:** **ONGOING**

- An ongoing WPV Reporting team is ensures reporting is completed as required.
- In FY-19, 51 incidents were reported to OSHA.
  - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
- 41% (21) of incidents resulted in no injury. The remaining events were minor injuries with over half (51%) being bruises or abrasions. No major injuries were reported.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY-19. The data includes activity from both campuses.

There were a total of 462 reported security incidents for FY-19 requiring immediate response. This is an increase from the FY-18 total of 449.



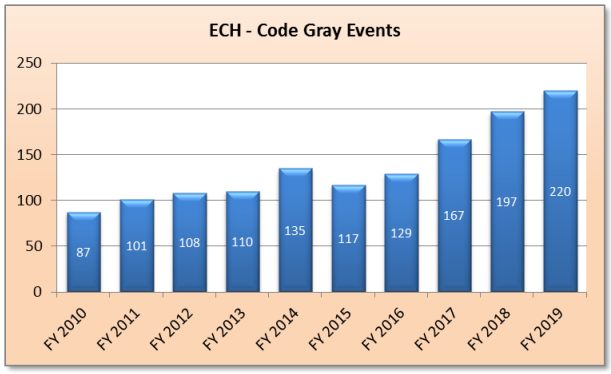
Review of the major FY-19 incidents showed:

- There were 51 Workplace Violence (WPV) incidents reported to CA-OSHA. This is a 16% reduction from FY18. Contributing factors to this decrease in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
  - Monthly Workplace Violence Committee meetings.
  - "Stop Signs" placed on the outside of patient's rooms to alert staff that have been or have the potential to be combative.
  - Adding a "flag" in EPIC to alert staff of the patents potential to be combative during the length of their care and the next time they come back to the Hospital.
  - Formalized and documented rounding by Security to ensure both the Security team and the patient care team are aware of any patient that has the potential to be combative.
- In December of FY 19 we had our Joint Commission accreditation survey. There were no findings in the Security Management portion of the survey.

EC 2.0 - Security Management

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY-19 was 220 compared to 196 in FY-18.



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

- MV Medical Unit (2C) – 18%
- MV Progressive Care unit (PCU) – 17%
- MV Emergency Department (ED) – 15%
- MV Telemetry/Stroke (3C) *[**Note** reduced from 17% to 10% of total.]*

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

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

B. Bulletins, Alerts & Presentations

Security Services issued 3 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 4,635 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 1667 patient watches, standbys and restraints. This was a significant increase over FY 18 which was 965. Hospital Supervisors notify Security of these events which can last several hours. They primarily occur in the Emergency Department, Behavioral Health and on the Medical Units. Patient watches are also handled by the ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 118 fire drills and are 100% up-to-date. A total of 12 fire watches were performed in FY 19.

F. General Assistance

Security Officers performed 94,378 service requests including but not limited to main lobby greeter assistance, directional requests, door locks/unlocks, escorts, issuance of one-day passes.

G. ID Badges

Security Services issued 2,038 Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 2,425 temp badges were issued.

EC 2.0 - Security Management

H. Investigations & Audits

Security Services performed 57 investigations and audits including but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Lost And Found

Security Officers performed 515 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 14,901 (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

K. Loitering

Security Officers responded to 210 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

L. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 149 vehicle-related services including jump-starts, door unlocks and tows. 706 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 48 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

EC 2.0 - Security Management

N. Statistics –Police Department Crime Data

2018 MVPD Annual Report		
Square Miles:	12	11.25
Population:	80,800 (County of Santa Clara 1,937,570)	30,724
Personnel:	148	59 (39 sworn & 20 non-sworn)
Total Calls for Service	6,860	35,524
Statistics ***UCR data includes attempts and actual crimes***		
Part I UCR:	2274 (2103 Property vs. 171 Violent)	488 (477 Property vs. 11 Violent)
Previous Year	2164 (1976 Property vs. 188 Violent)	598 (583 Property vs. 15 Violent)
Part II UCR:	2497	Not Collected
Previous Year	2800	Not Collected
Arrests-Misdemeanor:	1235 (1177 Adult vs. 58 Juvenile)	Not Collected
Previous Year	1553 (1465 Adult vs. 88 Juvenile)	Not Collected
Arrests-Felony:	386 (347 Adult vs. 39 Juvenile)	Not Collected
Previous Year	375 (353 Adult vs. 22 Juvenile)	Not Collected
Traffic Collisions:	467	281
Previous Year	550	Not Collected
Moving Violations:	Not Collected	Not Collected
Previous Year	1827	Not Collected
Non-Moving Violations:	Not Collected	Not Collected
Previous Year	2199	Not Collected
Indexes ***Per 1,000 current year population***		
Violent:[4]	2.11	0.35
Previous Year	2.33	0.48
Property:[5]	26.29	15.53
Previous Year	24.46	18.98

Effectiveness

Key performance indicators were identified in the FY 19 to improve Security Management within the Environment of Care.

FY19 Goals

1) 90% non-medical emergency security response time less than 3 minutes- **This goal was accomplished.**

2) 20% reduction in number of reportable workplace violence incidents- In FY 19 there was a 16% reduction in the number of Workplace Violence reports submitted to CAL-OSHA. **This goal was not met.**

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

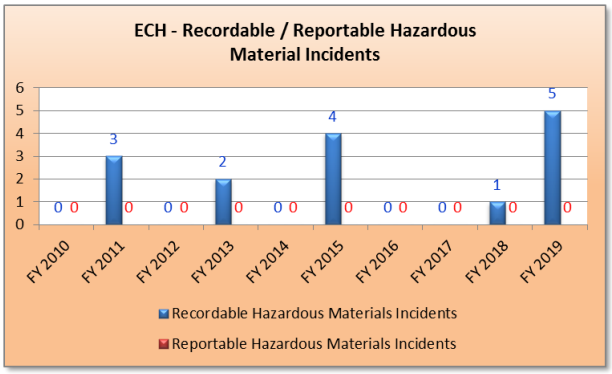
EC 3.0 - Hazardous Materials & Waste Management

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

Scope

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

Performance



A. Hazardous Material Incidents

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

- **Recordable Hazardous Material Incidents[6]:**

  1) Spill in MV Infusion Center – tubing improperly attached causing small spill of chemo agent. Cleanup was handled safely.

  2) Formalin spill in Los Gatos OR – Employee spilled quantity of Formalin while pouring. Employee was contaminated by spill and was decontaminated with no injury. Spill was cleaned up. Reviewed procedures for Formalin handling and recommendations made to improve process.

  3) Small Formalin spill in MV OR – spill was cleaned up by staff in area. Code Orange activation was not necessary.

  4) Small Formalin spill in MV Imaging - spill was cleaned up by staff in area. Code Orange activation was not necessary.

  5) A chemo patient pulled out IV while attempting to use restroom. Cleanup handled safely.

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

B. Waste Water Discharge Violations:

1 – missed 3 monthly sample collections in July 2018. Correcitve measures taken to ensure compliance.

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

EC 3.0 - Hazardous Materials & Waste Management

C. Monitoring and Inspections

- **Hazardous Waste Inspections**-No Inspections for FY-19
- **Santa Clara County Annual Medical Waste Inspections**
  - **Los Gatos**: April 22, 2019: Two minor issues identified. All were corrected and accepted on the date of the inspection
    1) Coached Staff to cover all Bio Barrels completely and snap shut.
    2) Replaced fading signs on Bio Waste storage outside.
  - **Mountain View**: May 29, 2019: Several minor issues identified. All were corrected and accepted on the date of the inspection
    1) Mother-Baby and PACU/OR - Observed a missing absorbent pad in a pharmaceutical waste container in the mother baby unit med room.
    2) Endoscopy - Replace the torn biohazard label on door of the interim storage room.
    3) A container found without lids or a red bag liner. Overfilled secondary container in OR staging area –all corrected immediately
    4) Observed an overfilled pharmaceutical waste container in the Pharmacy Department. Adjacent to the overfilled container, there was a good supply of empty pharmaceutical waste containers. Pharmacy supervisor coached to educate staff to utilize storage of empty containers to prevent overfilling.
- Continued monitoring and education to ensure waste segregation compliance :
  - Annual Waste Management education for staff
  - Daily rounds by EVS supervisors
  - Monthly Safety Rounds that include observation of waste segregation practices
  - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.

D. Radiation Safety Committee

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

EC 3.0 - Hazardous Materials & Waste Management

E. Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[7] training course.

Key indicators were targeted to establish goals for FY-18. The following goals presented opportunities to improve hazardous materials & waste management.

FY-19 Goals:

1) 15% increase in the number of HAZWOPER[2]-certified staff
   - **Measurement of success**: Increasing the total number or HAZWOPER certified employees.
   - ***This goal was accomplished.***
     - Conducted on-site classes April 1 – April 5th, 2019.
     - Results: FY18: 18, FY19: 23; at 28% increase
2) 30% reduction in number of NISOH items that sent to Guaranteed Returns for Enterprise by Pharmacy
   - ***Measurement of Success:*** Implement a check system in the pharmacies to reduce number of NISOH items that had been sent to guarantee return
   - ***This goal was accomplished.*** This goal was accomplished. There was a 55% reduction in the total number of returned items. There were a total of 71 items returned in FY-19 compared to 159 in FY-18.

[7] HAZWOPER: Hazardous Waste Operations and Emergency Response

EC 4.0 - Fire Safety Management

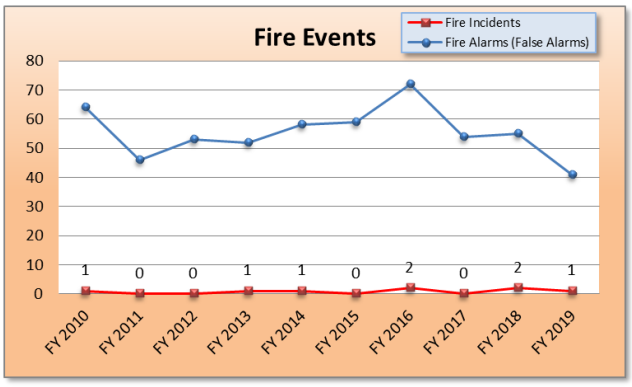
Work Group Chair: ***John Folk***

Scope

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

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY-19.



A. Fire Incidents

There was 1 reported fire incidents in FY-19.

- On Tuesday, September 18th 2018 at approximately 4:35 PM, a smoke detector activated in patient room 3120. Upon responding the alarm, it was found that the room was filled with smoke and a patient had been burned. It was found that the patient, who was on supplemental oxygen, had activated a lighter. The enhanced oxygen atmosphere around the patient intensified the fire, causing burns to the patient's face, chest and arm. Staff quickly and appropriately responded to obtain a fire extinguisher and turn of the oxygen. Upon shutting off the oxygen, no further fire was noted and the extinguisher was not used.

B. Fire Alarm Events

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

The total number of events in FY-19 (41) was significantly lower compared to FY-18 (56). There were 36 events in Mountain View and 5 in Los Gatos. This was accomplished despite heavy construction activity at both hospitals during FY-19. The reduction can be linked to the development of an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.

Fire Drills Completed / Scheduled- All required fire drills (total of 120) were completed in FY-19. For all drills, there were 24 required actions by staff. All issues were fully corrected either on the spot or with further education by the dept. Manager.

EC 4.0 - Fire Safety Management

Effectiveness

Key indicators were targeted to establish goals for FY-19. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 19 Goals

1) Educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new IMOB and BHS buildings.

   Ongoing- Training for all Engineering staff is ongoing as the buildings become closer to completion.

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

   This goal was accomplished. 3 Engineers have received the recommended high rise training.

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

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

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

   This goal was accomplished. Ongoing monitoring and education of contractors is in place.

EC 5.0 - Medical Equipment Management

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

Scope

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

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

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-19.

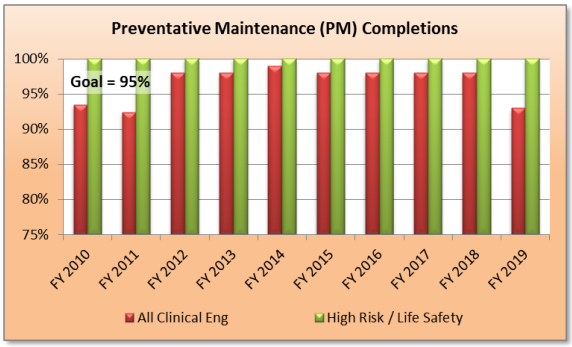
A. Reports to the FDA –

There were 16 reports through the Medwatch[8] system in FY-19. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% in all areas.

- The completion rate for Clinical Engineering achieved 93% for FY-19.
- All high risk, life safety equipment was maintained at 100% completion rates



C. Product Recalls Percentage Closed / Received

For FY-19, there were 83 recorded product recalls; 14 still open.

Effectiveness

Key indicators are targeted to established goals for the fiscal year. Due to multiple changes in Clinical Engineering management a continuum of focus on the indicators was not obtained in FY-19.

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

EC 6.0 - Utilities Management

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

Scope

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

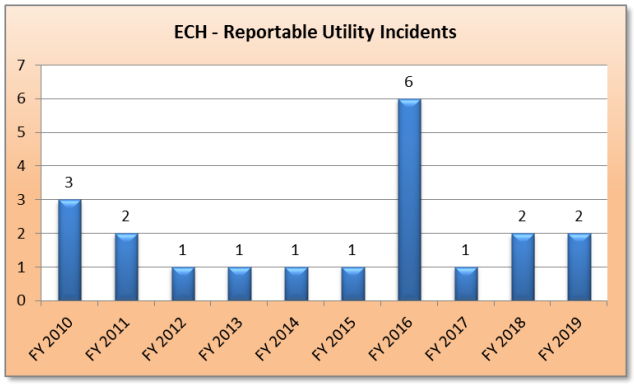
Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-19.

A. Utility Reportable Incidents

There were 2 reportable incidents in FY-19. Both were electrical outages.

1) July, Los Gatos - momentary loss of electrical utility (PG&E) campus wide.
2) September, Mountain View - Loss of electrical to equipment branch at Mountain View Women's Hospital in September due to a mechanical malfunction of an automatic transfer switch



B. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was 97%, which the goal of 95%. Critical systems were maintained as required for the facility operations.

C. Generator Test % completed/scheduled

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

EC 6.0 - Utilities Management

Effectiveness

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

FY 19 Goals

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

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

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

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

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

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

FY 20 Goals

1) Work with PG& E to improve communication related to Planned/Unplanned utility disruption events
2) Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.
3) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

EM – Emergency Management

Committee Chair: ***Steve Weirauch***

Scope

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

Performance

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

A. Activation of Hospital Incident Command System (HICS)

There were three recorded events and/or emergencies during FY-19 requiring activation of HICS and opening of the Hospital Command Center (HCC).

1. **The Joint Commission (TJC) Survey (12/2018)** – the tri-annual TJC survey occurred in December, 2018. During the survey, the HCC was operational during daytime hours to coordinate and provide needed resources.
2. **Power Outage – Mountain View Campus (02/28/2019)** – A PG&E power failure occurred in the early morning of February 28th. Emergency power activated as designed and provided all power to the hospital. The HCC was opened at the beginning of the day shift. Elective surgeries were put on hold pending restoration of power as a precaution. Power was restored about 08:30, and the HCC was closed.
3. **CMS Survey (06/2019)** – CMS conducted a 4-day survey in response to complaints. The HCC in Mountain View was activated during business hours to coordinate and provide resources.

B. Events / Emergencies

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

1. **Code Red (fire) in patient room – Mountain View (09/18/2018)** – A patient on supplemental oxygen activated a cigarette lighter. The enhanced oxygen atmosphere around the patient intensified the fire, causing minor burns to the patient's face, chest and arm. Staff responded and quickly extinguished the fire. The Mountain View Fire Department responded and assisted with ventilating the room.
2. **Hazardous Exposure Incident – Mountain View (09/03/2018)** – Patient presented with exposure to organophosphate. ED staff decontaminated the patient utilizing decon procedures.

3. **Code Orange (chemical spill) – Los Gatos (01/09/2019)** – a spill occurred in the OR while staff was pouring Formalin contaminating them with the chemical. The employee utilized a shower to remove the chemical. No injuries were reported. The spill was cleaned up. An investigation recommended several procedural changes to prevent a future occurrence.
4. **Hazardous Exposure Incident – Mountain View (02/14/2019)** – Law enforcement presented to the hospital with exposure to possible Fentanyl. Staff decontaminated officers prior to admission to emergency department. Follow-up meeting held with agencies to review and improve future responses.
5. **Code Silver (person with weapon) – Mountain View (05/02/2019)** – patient with known aggressive tendencies had several Code Gray (angry/violent person) activations. During one event, patient pulled metal bar from gurney and threatened staff. Team responded appropriately and called for police. Incident was resolved with no physical injury to staff or patient.

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY-19, this requirement was met through the Statewide Medical & Health Exercise in November, 2018 (see below), and a spring exercise in June. These are summarized below. Action items were created in both exercises to improve future responses.

a. **Statewide Medical & Health Exercise (11/15/2018):** Both campuses participated in the statewide exercise. The scenario involved a widespread emerging infectious disease. Caring for infected patients while maintaining the safety and security of the facility provided challenges to both campuses.

b. **Spring Functional Exercises (06/2019)** – A functional exercise was conducted at both campuses involving response to an earthquake. HICS was activated and the HCC opened at both sites. All departments were requested to complete a self-evaluation and report of unit status to the HCC.

- Los Gatos - the scenario included a full evacuation of the Rehab Center. Staff physically evacuated “patients” from the building to test procedures. This also assisted in compliance with CARF requirements for the unit.
- Mountain View - a full evacuation of the Behavioral Health unit and NICU was required. The BHS evacuation was conducted as a tabletop exercise to determine how this would be handled in a real event. The NICU team tested new evacuation equipment and moved “patients” out of the affected areas.

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

c. **Active Shooter Drills – Los Gatos (01/11/2019)** – Tabletop drills were conducted in each department to test staff ability to respond to an active shooter type event. The exercise was designed to be low-stress for staff to foster discussion and learning. Based on feedback from the Los Gatos drill, changes are being implemented prior to conducting these drills at the Mountain View campus.

d. **Code Pink Drills – Mountain View & Los Gatos (09/2018)** - Exercises were conducted at both campuses to test staff’s ability to respond to an infant security band alert.

e. **Decontamination Team Training (04/2019) -** Training and functional exercises were held several times to train and test the ED staff and decontamination teams on proper response to the arrival of contaminated patients to the hospital.

D. Emergency Management Training

- **New hire orientation** (100% for all employees)
- **Safety coordinator meetings** (44% attendance overall for the quarterly meetings). Safety Coordinators unable to attend the meetings are provided with detailed notes and information and are expected to complete all assignments.
- **Advanced HICS Training** – three classes were held for managers to learn/review the operation of the Hospital Incident Command System during emergency events affecting the hospital.

E. Community Involvement

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

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

F. Hazard Vulnerability Assessment (HVA)

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

- There were several changes to the HVAs at both campuses in FY-19. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Person with Weapon	(2) Communication System Failure
(3) Flood - Internal	(3) Information System Failure
(4) Communication System Failure	(4) Electrical Power Failure
(5) Information Management System Failure	(5) Dam Failure

EM – Emergency Management

Effectiveness

Key indicators were targeted to establish goals for FY-19. The following goals presented opportunities to improve emergency management.

FY-19 Goals

1. Continue the replacement of Evacuation litters and chairs with Med Sleds at in Los Gatos and other buildings, as needed.

   This goal was accomplished. Additional Med Sleds were purchased and are being deployed in Los Gatos and other buildings. Plans are in place to add units to the new Taube and Sobrato Pavilions.

2. Expand the use of mass notification system (Everbridge)
   a. Investigate adding users to system to notify more staff of events
   b. Train key staff to be able to use/send alerts

   This goal was not accomplished. Investigated the options for increasing the use of Everbridge notifications by all staff. To utilize the system effectively requires major assistance from IS to network and automate the database maintenance and the additions of additional licenses and modules to our existing contract. This required a major budget request which was submitted for FY20. The additional funds were approved, so this goal will be continued in FY20. Training will also be conducted as the expanded capabilities are brought on line.

FY-20 Goals

1. Expand the use of mass notification system (Everbridge) to all employees
   a. Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
   b. Evaluate and set up logical groups and rules for notifications.
   c. Train key staff to be able to use/send alerts
2. Revise and distribute the Emergency Management Guides for both campuses.
   a. Revision of content to include latest information.
   b. Roll out of app for the guide on Android and iOS devices in addition to wall-mounted guides.
3. Train staff on emergency procedures in new Taube and Sobrato Pavilions.

Attachment 1 - Employee Health Services Definitions

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

Attachment 2a - Safety Trends

	Indicators	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19
E.C. 1.0 - SAFETY MANAGEMENT								
Employee Safety								
1.	Total Injury/Illness Incident Reports	349	458	618	428	470	411	439
2.	OSHA Recordable Injury/Illness (Total)	173	171	306	193	164	176	145
	a. Lost Time	59	61	38	78	45	51	22
	b. No Lost Time	114	110	268	113	119	125	133
3.	Patient Lift/Transfer Injuries (OSHA Recordable)	33	36	27	37	28	23	16
4.	Patient Lift/Transfer Injuries	42	54	37	48	43	41	29
5.	Trip/Slip/Fall	43	50	41	58	67	63	60
Infection Control								
8.	TB Conversions (mo.)/qtr. %	0	0	0	0	0	0	0
9.	Blood & Body Fluid Exp.	45	44	45	53	42	58	48
	a. Percutaneous	30	28	38	39	30	36	30
	b. Skin/Mucus Membrane Contact	15	16	7	14	12	22	18
E.C. 2.0 - SECURITY MANAGEMENT								
1.	Code Grey Incidents	110	135	117	129	167	197	222
2.	Security Response Time < 3minutes (Goal: >90%)	N/A	N/A	N/A	N/A	N/A	N/A	82%
3.	Reportable Workplace Violence Incidents	N/A	N/A	N/A	N/A	N/A	61	51
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT								
1.	Reportable Hazardous Material Incidents	0	0	0	0	0	0	0
2.	Recordable Hazardous Material Incidents	2	0	4	0	0	1	5
3.	Waste Water Discharge Violations	0	0	0	0	0	0	1
4.	Staff ability to locate SDS online	N/A	N/A	N/A	N/A	N/A	N/A	95%
5.	Staff know eyewash rinse time if exposure is 15 minutes	N/A	N/A	N/A	N/A	N/A	N/A	79%
E.C. 4.0 FIRE PREVENTION MANAGEMENT								
1.	Fire Incidents -Actual	1	1	0	2	0	2	1
2.	Fire Alarm Events	52	58	59	72	54	55	41
3.	Fire Drills comp/scheduled	100%	97%	100%	100%	103%	103%	118%
4.	Staff ability to define RACE and PASS	N/A	94%	100%	100%	100%	100%	91%
5.	Staff ability to locate fire extinguishers and pull stations							96%
6.	Staff can define horizontal and vertical evacuations							91%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT								
1.	Reports to FDA	11	2	6	3	6	15	16
2.	PM Completion Rate %							
	a. ECH Life Safety PMs	98%	98%	98%	98%	98%	98%	100%
	b. Vendor/OEM Life Safety PMs	100%	100%	100%	100%	100%	100%	100%
	c. ECH General PMs	99%	99%	99%	100%	100%	100%	03%
	d. Vendor/OEM General PMs	100%	100%	100%	100%	100%	100%	100%
3.	Equipment Unable to Locate	95%	98%	88%	78%	95%	82%	10%
E.C. 6.0 - UTILITIES MANAGEMENT								
1.	Utility Reportable Incidents	0	1	1	6	1	2	2
2.	PM Completion Rate % completed/scheduled	84%	92.7%	90.9%	97%	90%	89%	95%
3.	% of Life Safety Work Order Completions	100%	100%	100%	100	100	100%	90%

Attachment 2b - Safety Trends Definitions

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

Safety Trends Definitions

E.C. 3.0 HAZARDOUS MATERIALS MANAGEMENT	
1. Reportable Hazardous Materials Incidents	Any unauthorized discharge which is determined not to be recordable and must be reported to the City of Mountain View (subsection 24.5.0.a.1 (a) of Mountain View Health and Safety Code) or the Town of Los Gatos.
2. Recordable Hazardous Materials Incidents	An unauthorized discharge of hazardous or other regulated material defined as a discharge from a primary to a secondary container, cleanup of a discharge to a secondary container requiring greater than 8 hours, no increase of fire or explosion nor production of poisonous gas or flame, or no degradation of secondary container, the discharge does not exceed one (1) ounce by weight or can be cleaned up in 15 minutes following deterioration of the primary container.
3. Waste Water Discharge Violations	Monthly sampling analysis > than the Maximum Limit (mg/L): Zinc 2.0; Total Toxic Organic 1.0; Single Toxic Organic 0.75; Formaldehyde 5.0; Copper 0.25.
4. Staff ability to locate SDS online	Staff able to demonstrate ability to look up a Safety Data Sheet through the Toolbox and MSDSOnline program.
5. Staff know eyewash rinse time if exposure is 15 minutes	Staff able to state the minimum required time required to flush a person's eyes after exposure to a hazardous chemical. The requirement is a minimum of 15 minutes.
E.C. 4.0 FIRE PREVENTION MANAGEMENT	
1. Fire Incidents	Number of actual fire incidents/month.
2. Fire Alarm Events	Number of fire/smoke alarms activated by an event not classified as an actual fire or false alarm (example: burnt toast, dust, steam, etc.)
3. Fire Drills Completed/Scheduled	Number of fire drills completed/number scheduled.
4. Staff ability to define RACE and PASS	Staff should be able to define RACE (Remove, Alarm, Confine, Extinguish) for responding safely to a fire and PASS (Pull, Aim, Squeeze, Sweep) when using a fire extinguisher.
5. Staff ability to locate fire extinguishers and pull stations	During regularly scheduled fire drills, staff can locate the nearest fire extinguisher and pull station to their normal work area.
6. Staff can define horizontal and vertical evacuations	Staff are able to define the two types of evacuations • Horizontal - evacuate staff to another smoke compartment on the same floor • Vertical - evacuate the building, floor by floor, starting with the upper levels and proceeding until everyone is out of the building.
E. C. 5.0 MEDICAL EQUIPMENT MANAGEMENT	
1. Reports to FDA	Number of reports to FDA as defined by Safety Medical Device Act requirements. Reported quarterly.
2. PM % Completion	Scheduled preventive maintenance completed. Reported quarterly.
a. ECH Life Safety	All critical, life safety equipment PMs completed by ECH Clinical Engineering
b. Vendor/OEM Life Safety PM	All critical, life safety equipment PMs completed by vendors
c. ECH General PM	Other equipment PMs completed by ECH Clinical Engineering Department
d. Vendor/OEM General PM	Other equipment PMs completed by Vendors
3. Equipment unable to locate	The % of equipment on Clinical Engineering's inventory that are not able to be found.
E.C. 6.0 UTILITIES MANAGEMENT	
1. Utility Reportable Incidents	Utility System incidents with actual or potential significant impact on safe patient care, staff health and safety or resource/property loss.
2. PM Completion rate % Completed	Scheduled preventive maintenance completed with 28 days of the prescribed interval/items scheduled for maintenance. Reported quarterly.
3. % of Life Safety Work Order Completions	The percentage of life safety work orders submitted to Facilities that have been completed.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Imtiaz Qureshi, MD, Enterprise Chief of Staff
Linda Teagle, MD Chief of Staff Los Gatos
Date: November 6, 2019
Subject: Medical Staff Report – Open Session

Recommendation:

To approve the Medical Staff Report, including Policies and Scopes of Service, Bylaws Revisions identified in the attached list.

Summary:

1. Situation: The Medical Executive Committee met on October 24, 2019.

2. Background: MEC received the following informational reports.

a) Quality Council – The Quality Council met on October 2, 2019. Reports and performance dashboards were reviewed and approved from the following ECH Departments/Programs:

i. Care Coordination Department
ii. Nutrition Services (LG and MV)
iii. Heart and Vascular Institute Service Line
iv. Pharmacy Services Department
v. HIM Audit: Medical Staff Closed Record Review

b) Leadership Council- Leadership Council met on October 15, 2019. The LC has assigned a task force to revise the Medical Staff Policy for Medical Record Suspensions. The goal is to revise the policy over the next 90 days to make it easier to enforce per the Bylaws. MEC reviewed the LC recommendations of the revised Medical Staff Code of Conduct and Professional Behavior Policy and Procedure. MEC recommends its approval to the Governing Board.

c) CEO Report – The CEO Report was provided and included the following updates:

i. Opening of the Taube Pavilion-Scrivner Center for Mental Health and Addiction Services. Physician Open House will be held on Friday, October 25 from 1-5 pm.

ii. Opening of the Sobrato Office Building scheduled for December and will include increased parking space leaving old parking structures as options to allocate dedicated physician parking.

iii. Announcement and introduction by photos and brief bios of Andrew Cope, President El Camino Health Foundation; Vineeta Hiranandani, VP Marketing; and Christine Cunningham, Executive Director Patient Experience.

d) CMO Report –

i. The CMO provided a memo to the MEC concerning a proposal for Neurosurgery Call Panel Coverage that would be beneficial for the goal of ECH becoming a Comprehensive Stroke Center. MEC members and the administrative leaders conversed with each other on concerns and ideas on how to manage coverage to provide care for ECH patients with neurological compromise. MEC deferred the matter to LC for further discussion.

ii. The FY 20 Quality Dashboard performance through August was reviewed and provided in the meeting packet for MEC members. Members were informed of the new additional clinical quality goals of SSIs, Elective Delivery prior to 39 weeks and Cesarean Births in nulliparous women. Current performance rates for Mortality Index (below target with two months consecutive decline); Sepsis (below target with two consecutive months of decline); and HAIs – CAUTI (one case- slightly placed outcome above target); no CLABSI or C Diff occurrences for the reporting month) were discussed by members. After three consecutive months of decline, two SSIs occurred (performance below target).

e) Chief of Staff Reports

i. Enterprise – Medical Staff Annual Leadership Retreat took place on September 28, 2019 and was well attended. The attendees received leadership advice regarding high functioning medical staffs, how to influence organizational change then had breakout sessions to discuss the structure on the medical staff among the two campuses. A task force was established to create a conceptual plan over the next 3 months.

1. Members were again reminded to obtain influenza vaccines and provide documentation of compliance to the MSSD.

2. Upcoming National Medical Staff Services Week is November 3 – 9.

ii. Los Gatos – The LG Chief of Staff introduced the idea of changing the membership on medical staff committees from assignment by officer role to nominations and volunteer based upon a member's desire to serve and grow in medical staff leadership. Department chiefs are asked to speak with members of their departments and provide referrals to the officers.

3. Revision to the Medical Staff Bylaws Article – The Chief of Staff and officers recommend combining the Departments of Medicine, Family Medicine and Hospitalist Division into one Department. It is the opinion of the MEC that the union of these departments will be more effective and result in more efficient accomplishment of the assigned department functions.

4. Other Review**:** The MEC approved the Policies and Scopes of Service identified in the attached file.

List of Attachments:

1. Medical Staff Code of Conduct Professional Behavior Policy
2. Revised Bylaws Article 9.2 – Organization of Departments and Divisions

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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Medical Staff- Medical Staff Code of Conduct and Professional Behavior
CATEGORY:	Administration
LAST APPROVAL:	8/2017

TYPE:	☑ Policy ☐ Protocol ☐ Scope of Service/ADT ☐ Procedure ☐ Standardized Process/Procedure
SUB-CATEGORY:	***Medical Staff***
OFFICE OF ORIGIN:	***Medical Staff Services***
ORIGINAL DATE:	October 2008

I. COVERAGE:

El Camino Hospital Medical Staff and Allied Health Clinicians

II. PURPOSE:

The purpose is to ensure a safe, cooperative, and professional health care environment that will ensure optimum patient care and prevent or eliminate (to the extent possible) conduct defined as disruptive or unacceptable behavior as defined below in IV B..

III. POLICY STATEMENT:

It is the policy of the Medical Staff of El Camino Hospital that the physicians and allied health practitioners treat all individuals within its facilities with courtesy, respect, and dignity. To that end, the Board of Trustees requires physicians and privileged licensed practitioners will conduct themselves in a professional and cooperative manner in all El Camino Health facilities and understand and agree to adhere to a code of conduct and professional behavior. New and current practitioners of the El Camino Hospital Medical Staff will sign an acknowledgement of receipt of this policy at the time of appointment and reappointment, respectively.

IV. DEFINITIONS :

A. Acceptable behavior is defined as behavior that enables others to perform their duties and responsibilities effectively, promotes the orderly conduct of the organization, and results in respectful and constructive communication. Examples of acceptable behavior include, but are not necessarily limited to:

1. Demonstration of dignity, respect, courtesy, cooperation and presentation of a positive and professional image when dealing with all patients and coworkers.
2. Respectful communication in a calm and professional manner.
3. Addressing disagreements professionally, factually and timely.
4. Communication with department and intradepartmental team members that is accurate and timely.

B. **Disruptive or inappropriate behavior** is defined as behavior that disrupts the operation of the hospital, affects the ability of others to do their jobs or to practice competently, or creates a hostile work environment for hospital employees, physicians, allied health practitioners, patients or other individuals. The Medical Staff will not tolerate disruptive behavior, which may include but is not limited to:

1. Rude, vulgar or abusive conduct, verbal and/or physical, toward, or in the presence of, patients, nurses, hospital employees, other practitioners or visitors.
2. Non-constructive criticism or disparagement addressed to, or about, a recipient in a way as to intimidate, belittle or to infer stupidity or incompetence.
3. Impertinent and/or inappropriate comments written or illustrated in the patient's medical records or other official documents that impugn the quality of care in the hospital or malign particular practitioners, employees or hospital policy.
4. Deliberate destruction or stealing of hospital property, including medical records.
5. Disrupting hospital case management, committee or peer review functions.
6. Disrupting hospital personnel's ability to perform their assigned functions.
7. Refusal to accept medical staff assignments when required or refusal to participate in committee or departmental affairs in a professional and appropriate manner.
8. Harassment by a medical staff or Allied Health Staff member against any individual (other medical staff member, Allied Health Staff member, hospital employee, patient or visitor) on the basis of race, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, age, religion, or sexual orientation. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment may include, but is not limited to, unwelcome advances, requests for sexual favors, and any other verbal, visual or physical conduct of a sexual nature when 1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or 2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment.

V. PROCEDURE:

A. Reporting. Any physician, allied health practitioner, employee, patient, or visitor may report potential unprofessional conduct of a medical staff member through the following channels: submission of an incident report (QRR) or communication with hospital or medical staff leadership which can be verbal, by email, in writing or in person. The report shall be forwarded to the Clinical Effectiveness Department for documentation. Such documentation shall include:

1. The date, time, and place of the questionable behavior.
2. A statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient.
3. The circumstances that precipitated the situation.
4. A factual and objective description of the questionable behavior.
5. The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations.

~~A.~~6. A record of any actions taken to remedy the situation including the date, time, place, and name(s) of those intervening.

B. Investigation and Actions:

1. ~~1.~~ Once a report of unprofessional behavior regarding a medical staff member is reported, the matter will be referred to the ~~relevant QA Medical Director~~ Chief Medical Officer or his/her designee to investigate the incident. Investigation should include discussion with involved medical staff member and others as deemed appropriate. The medical staff member shall have a full opportunity to respond to the concerns during the entirety of the investigative process. The ~~QA Medical Director~~ Chief Medical Officer or designee shall make a determination of whether the incident requires no action, initial collegial intervention or further review.
2. If no further action is required, then the Chief Medical Officer or designee shall document this outcome and file that in the practitioner's quality file.
3. If initial collegial intervention is required, then the Chief Medical Officer or designee and a second physician will meet with the practitioner to discuss the behavior, provide a copy of this policy and emphasize the need for compliance with this policy going forward. Documentation of this result shall be filed in the practitioner's Quality file and communication of such meeting shall be delivered to the appropriate Department Chief.
4. If the single incident is of great enough severity and/or the incident along with past events signifies a developing pattern of disruptive behavior, the Chief Medical Officer or designee will meet with the Department Chief to discuss the next intervention. They will decide who should meet with the offending individual. They will provide the practitioner with a copy of this policy and inform them that the Board requires compliance with the policy and failure to comply shall be grounds for summary suspension.

   The Chief Medical Officer or designee or Department Chief shall document this meeting and write a follow up letter to the offending individual to document the content of the discussions, the actions that the practitioner has agreed to perform and possible ramifications of compliance failure. This letter shall be kept on file.

   The involved physician or practitioner may submit a rebuttal to the charge which will also be kept on permanent file.

   If the offending behavior continues, the Chief Medical Officer or designee and Department Chief or designee will continue to meet with the practitioner until the behavior stops. The intervention will use increasing severity to achieve this end or the matter will need to be further reviewed at the Leadership Council.

5. If the incident is highly egregious or the behavior has continued despite serial interventions, the matter shall be referred to the Leadership Council for review. Possible actions include development of a behavior contract setting zero tolerant goals for the individual or other Corrective Action such as Summary Suspension in accordance with Medical Staff bylaws may be recommended to the MEC who will be responsible for final recommendations to the Board.

~~The QA Medical Director shall review this determination with the Department Chair. If the Medical Director and Department Chair disagree on the need for further review, the issue shall be referred to and decided by the Leadership Council.~~

~~2. If further review is required, the QA Medical Director shall refer the incident to the appropriate medical staff committee or department for further review and action. The medical staff member shall have the opportunity to respond to concerns at this level, either in accordance with this Policy or the applicable provisions of the Medical Staff Bylaws, Rules and Regulations or Department/Committee policies.~~

~~3. Medical Staff officers may take corrective action up to, and including, termination of the practitioner's membership and privileges in the Medical Staff using processes defined in the Medical Staff Bylaws.~~

9. Appropriate documentation shall be entered in the medical staff member's file.

10. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Medical Staff Office Planning:	5/2017
ePolicy Committee:	6/2017
Medical Executive Committee:	6/2017
Board of Directors:	8/2017
Historical Approvals:	*11/08, 9/10, 11/12,1/15*

11. ATTACHMENTS:

Code of Conduct Acknowledgement Form (See Attachments top right hand corner)

El Camino Health

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

El Camino Hospital Medical Staff
Code of Conduct
Acknowledgement of Receipt

Name_____ **Dept**_____

I understand and agree to adhere to the following behavioral code of conduct.

Acceptable behavior is defined as behavior that enables others to perform their duties and responsibilities effectively, promotes the orderly conduct of the organization, and results in respectful and constructive communication. Examples of acceptable behavior include, but are not necessarily limited to:

- Demonstration of dignity, respect, courtesy, cooperation and presentation of a positive and professional image when dealing with all patients and coworkers.
- Respectful communication in a calm and professional manner.
- Addressing disagreements professionally, factually and timely.
- Communication with department and intradepartmental team members that is accurate and timely.

Disruptive or inappropriate behavior is defined as behavior that disrupts the operation of the hospital, affects the ability of others to do their jobs or to practice competently, or creates a hostile work environment for hospital employees, physicians, patients or other individuals. The Medical Staff will not tolerate disruptive behavior, which may include but is not limited to:

- Rude, vulgar or abusive conduct, verbal and/or physical, toward, or in the presence of, patients, nurses, hospital employees, other practitioners or visitors. ~~employees, other practitioners or visitors.~~
- Non-constructive criticism or disparagement addressed to, or about, a recipient in a way as to intimidate, belittle or to infer stupidity or incompetence.
- Impertinent and/or inappropriate comments written or illustrated in the patient's medical records or other official documents that impugn the quality of care in the hospital or malign particular practitioners, employees or hospital policy.
- Deliberate destruction or stealing of hospital property, including medical records.
- Disrupting hospital case management, committee or peer review functions.
- Disrupting hospital personnel's ability to perform their assigned functions.
- Refusal to accept medical staff assignments when required or refusal to participate in committee or departmental affairs in a professional and appropriate manner.
- Harassment by a medical staff or Allied Health Staff member against any individual (other medical staff member, Allied Health Staff member, hospital employee, patient or visitor) on the basis of race, color, national origin, ancestry, physical disability, mental disability, Medical disability, marital status, sex, age, religion, or sexual orientation. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment may include, but is not limited to, unwelcome advances, requests for sexual favors, and any other verbal, visual or physical conduct of a sexual nature when 1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or 2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment.

I understand that engaging in disruptive and/or inappropriate behavior may result in corrective action up to and including termination of my membership and privileges in the Medical Staff.

Signature_____ **Date** _____

El Camino Health

NOTICE OF PROPOSED REVISIONS TO THE MEDICAL STAFF BYLAWS

To: **Governing Board**

From: **Medical Staff Executive Committee**

Date: **November 6, 2019**

Re: **Proposed Bylaws Changes – Article 9 Clinical Departments and Divisions**

In accordance with Article 9.6 (c) of the Medical Staff Bylaws, the Medical Staff Executive Committee hereby recommends combining of the Medicine, Family Medicine and Hospitalist Division to one Medicine Department.

PROPOSED AMENDMENTS
ARTICLE 9

CLINICAL DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

The unified El Camino Medical Staff will be comprised of a combination of campus-specific departments and enterprise departments. Enterprise departments are those departments that serve constituency at all campuses (including MV & LG). All departments ultimately report to a unified Medical Staff Executive Committee. Each Department shall be organized as a separate part of the Medical Staff and shall have a Chief and a Vice-Chief who are elected and have the authority, duties, and responsibilities specified in Article 10. Each Division of a Department shall be organized as a specialty subdivision within a Department, shall be directly responsible to the Department within which it functions, and shall have a Division Chairman who has the authority, duties, and responsibilities specified in Article 10.

9.2 DESIGNATION

The current departments and divisions are defined as follows:

Campus Departments:

Mountain View (MV): Medicine, Obstetrics/Gynecology, Surgery

Los Gatos (LG): Medicine, Obstetrics/Gynecology, Surgery

Enterprise Departments:

~~Family Medicine~~, Orthopedics, Pediatrics, Psychiatry

Divisions: Divisions reporting to ~~Medical~~Medicine Department – Emergency Medicine, Radiology, ~~Hospitalists~~

Divisions reporting to ~~Surgical~~ Surgery Department – Pathology, Anesthesia

MEC approval: 10.24.29

El Camino Health

Summary of Financial Operations

Fiscal Year 2020 – Period 3

7/1/2019 to 09/30/2019

Financial Overview

Financial Performance

- Strong revenues is fueled by volume growth drove $11.5M operating margin favorable variance. Despite the higher volumes, expenses continue to remained close to budgeted levels.
  - Operating Revenue favorable to budget by $11.9M (4.7%)
  - Other operating revenue is favorable for the month due to Medi-Cal PRIME award and SVMD managed care payment catch-up.
  - Operating expense is at budget level
    - Supplies are higher than budget due to high procedural volume growth
    - Other Operating Expense favorable due to delay in activation costs for Sobrato & Taube Pavilions
- Revenue cycle operations remain strong with low days in AR and high payments.
- Non Operating Income unfavorable variance due to timing of community benefit grants and will normalize over the year

Hospital Volume

- Adjusted Discharges (AD) continues to be favorable to budget 848 ADs (10%) and favorable to prior year by 13%
  - Mountain View: Favorable to budget by 540 ADs (7.7%) and favorable to prior year by 10.0%
    - Infusion Volumes (up 27%), extended hours, new Oncologist and increased productivity
    - Overall procedural volume favorable to budget by 317 cases (5%)
    - OP Emergency Room favorable to budget by 232 visits (3%)
  - Los Gatos: Favorable to budget by 308 ADs 20% and favorable to prior year by 26%
    - Surgeries (up 25%) – Orthopedics (program growth due to purchase of technology), Ophthalmology (program moved from Willow ASC while it is closed for licensing)
    - Overall procedural volume favorable to budget by 183 cases (13%)
    - Op Emergency Room favorable to budget by 290 visits (11%)

Payor Mix

- Medicare mix increased in September due to high volume of general medicine cases from the ED

Productivity

- Year to date FTEs are in line with targets.

Dashboard - as of September 30, 2019

	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Consolidated Financial Perf.								
Total Operating Revenue	74,923	85,471	81,652	3,819	229,559	262,411	250,515	11,895
Operating Margin $	7,585	6,877	3,349	3,528	23,374	23,426	11,958	11,468
Operating Margin %	10.1%	8.0%	4.1%	3.9%	10.2%	8.9%	4.8%	4.2%
EBIDA %	16.1%	13.4%	10.4%	3.0%	16.0%	14.3%	10.8%	3.5%
Hospital Volume								
Licensed Beds	443	443	443	-	443	443	443	-
ADC	228	227	228	(1)	223	227	227	(1)
Utilization MV	63%	63%	60%	2.6%	61%	62%	61%	0.9%
Utilization LG	28%	27%	33%	(6.1%)	28%	29%	31%	(2.4%)
Utilization Combined	52%	51%	51%	(0.3%)	50%	51%	51%	(0.1%)
Total Discharges (Excl NNB)	1,504	1,577	1,547	30	4,572	4,957	4,698	259
Hospital Payor Mix								
Medicare	45.2%	52.5%	48.2%	4.3%	46.0%	49.9%	47.9%	2.0%
Medi-Cal	7.5%	7.7%	7.9%	(0.2%)	8.1%	7.8%	8.0%	(0.2%)
Total Commercial	44.3%	37.6%	41.5%	(3.9%)	43.3%	40.1%	41.6%	(1.5%)
Other	3.0%	2.2%	2.4%	(0.2%)	2.7%	2.1%	2.4%	(0.3%)
Hospital Cost								
Total FTE	2,609.3	2,756.1	2,721.9	(34.2)	2,590.0	2,745.5	2,737.6	(7.9)
Productive Hrs/APD	31.2	32.1	33.2	1.1	31.2	31.6	32.9	1.3
Consolidated Balance Sheet								
Net Days in AR	49.6	48.8	49.0	0.2	47.6	47.8	49.0	1.2
Days Cash	519	471	435	36	519	471	435	36

*Beginning with the June FY 19 report, the Dashboard and the financial report has been updated to show the ECH consolidated results instead of just the Hospitals. The descriptions of the metrics indicate whether the data is hospital only.

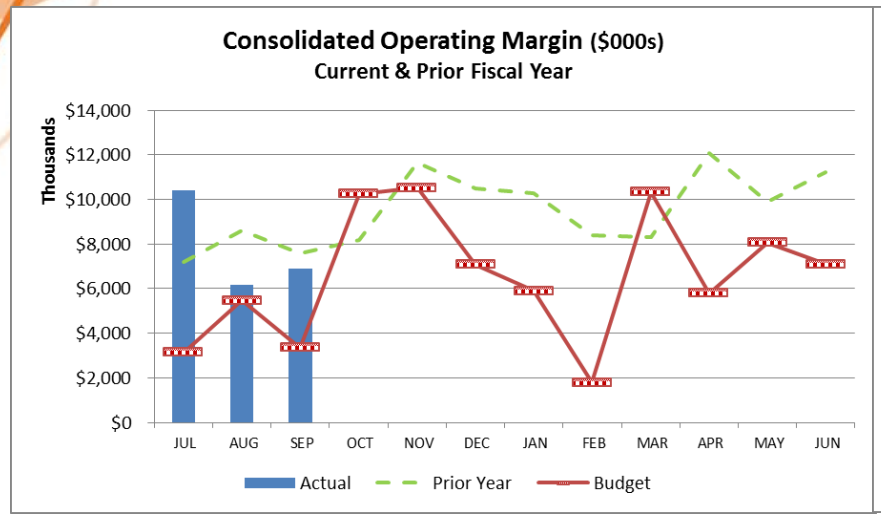
Consolidated Statement of Operations ($000s)

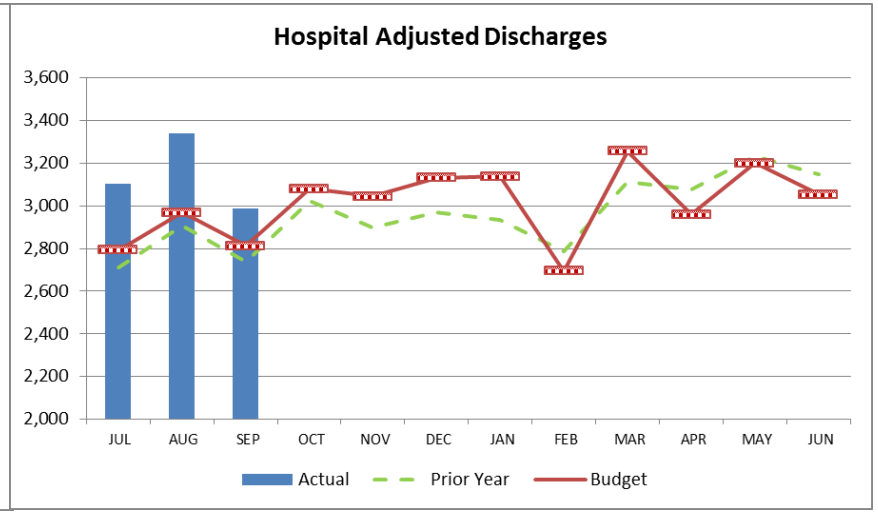
Period ending 09/30/2019

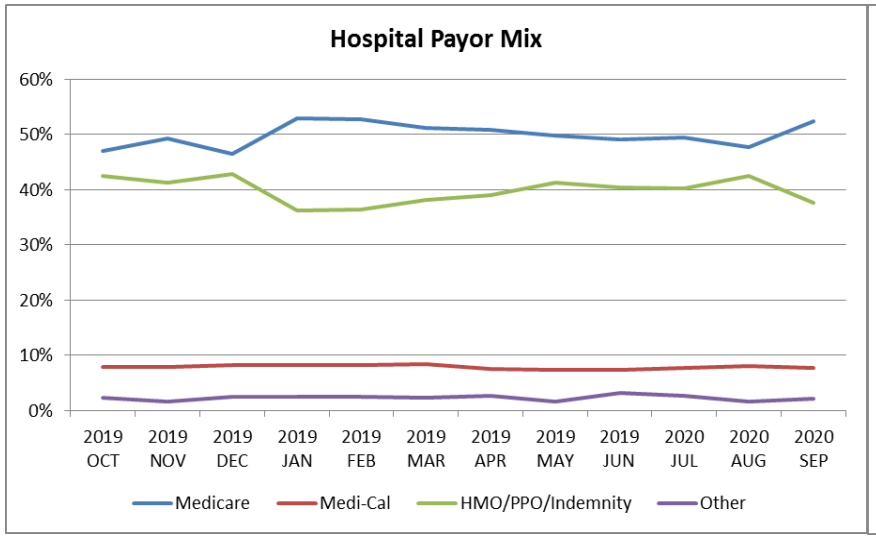
Period 3 FY 2019	Period 3 FY 2020	Period 3 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)
					OPERATING REVENUE				
269,177	312,105	299,217	12,888	4.3%	**Gross Revenue**	826,094	943,255	918,611	24,644
(197,390)	(232,266)	(221,523)	(10,743)	(4.8%)	**Deductions**	(605,759)	(694,407)	(680,068)	(14,339)
71,787	**79,839**	**77,694**	**2,145**	**2.8%**	**Net Patient Revenue**	**220,336**	**248,847**	**238,543**	**10,304**
3,136	5,632	3,958	1,674	42.3%	**Other Operating Revenue**	9,224	13,563	11,972	1,591
74,923	**85,471**	**81,652**	**3,819**	**4.7%**	**Total Operating Revenue**	**229,559**	**262,411**	**250,515**	**11,895**
					OPERATING EXPENSE				
40,979	44,982	44,919	(63)	(0.1%)	**Salaries & Wages**	123,259	136,086	137,070	984
10,271	12,369	11,380	(989)	(8.7%)	**Supplies**	32,690	38,598	34,846	(3,752)
9,337	13,161	12,949	(212)	(1.6%)	**Fees & Purchased Services**	29,594	39,875	39,291	(584)
2,287	3,485	3,928	443	11.3%	**Other Operating Expense**	7,344	10,370	12,319	1,949
174	227	495	268	54.2%	**Interest**	452	696	1,485	789
4,290	4,368	4,631	263	5.7%	**Depreciation**	12,847	13,359	13,546	188
67,338	**78,593**	**78,303**	**(291)**	**(0.4%)**	**Total Operating Expense**	**206,185**	**238,985**	**238,557**	**(428)**
7,585	**6,877**	**3,349**	**3,528**	**105.3%**	**Net Operating Margin**	**23,374**	**23,426**	**11,958**	**11,468**
1,066	2,404	3,094	(690)	(22.3%)	**Non Operating Income**	21,160	7,338	9,176	(1,838)
8,651	**9,281**	**6,443**	**2,838**	**44.0%**	**Net Margin**	**44,535**	**30,764**	**21,134**	**9,630**
16.1%	13.4%	10.4%	3.0%		**EBITDA**	16.0%	14.3%	10.8%	3.5%
10.1%	8.0%	4.1%	3.9%		**Operating Margin**	10.2%	8.9%	4.8%	4.2%
11.5%	10.9%	7.9%	3.0%		**Net Margin**	19.4%	11.7%	8.4%	3.3%

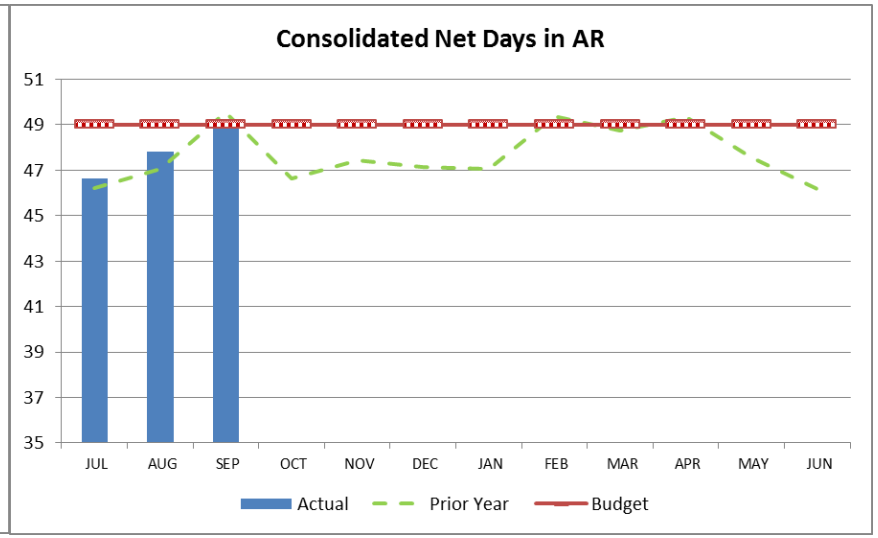
El Camino Health

Monthly Financial Trends







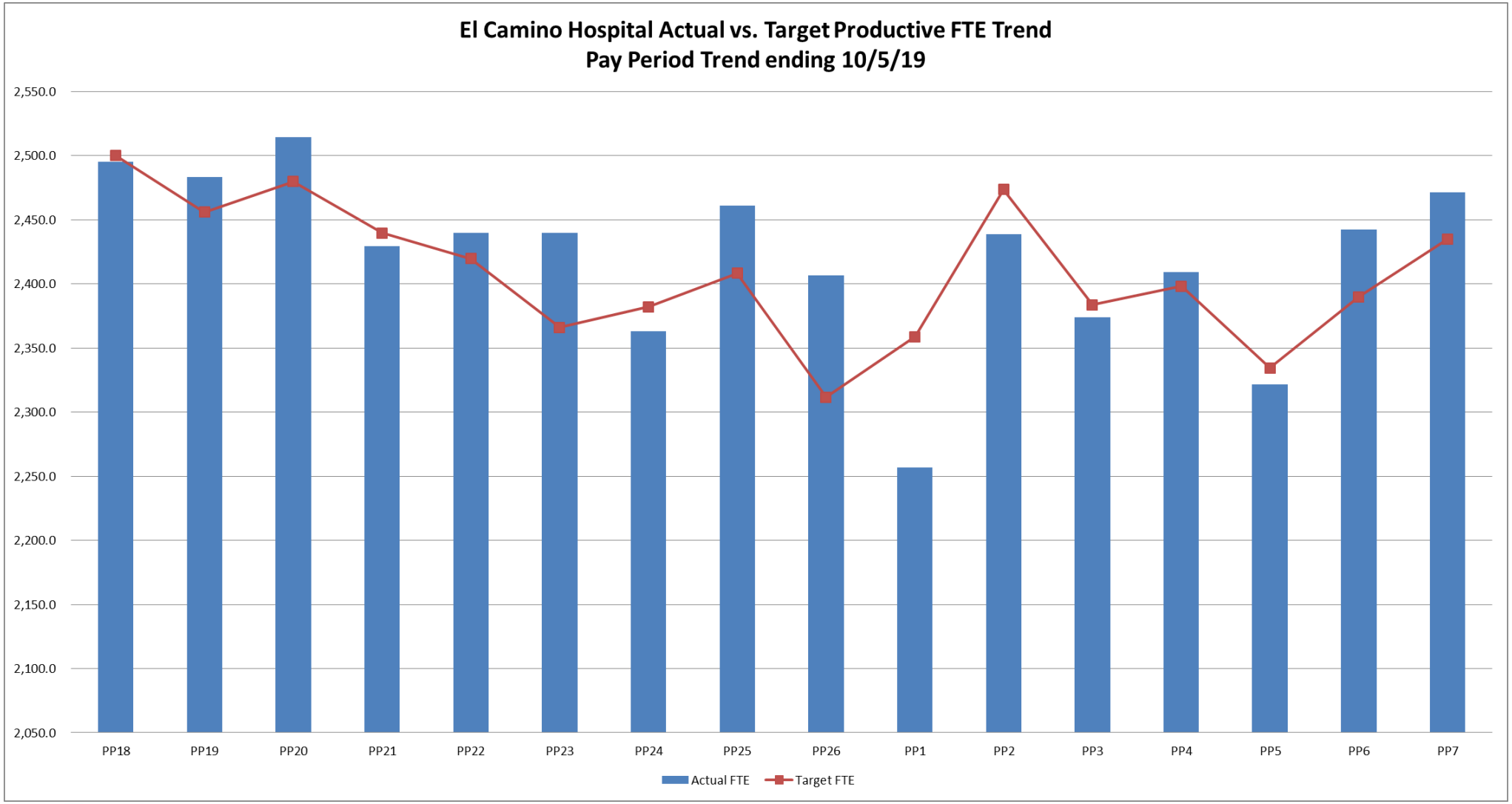


- Operating margin ahead of budget due to strong volume
- YTD volume is still favorable but the gap to budget is narrowing
- Medicare mix increased in September due general medicine cases from the ED.
- Days in AR is at target but climbed from prior month use to insurance payment slowdown due to 5 weekends and the labor day holiday

El Camino Health

Hospital Productivity – Rolling Trend

- Overall FYTD Productive FTEs continue to be favorable to the volume adjusted target by .58%. The biggest factors to the increase in FTE this last month is due to ramping up for Flu season and PI throughput project in the ED.

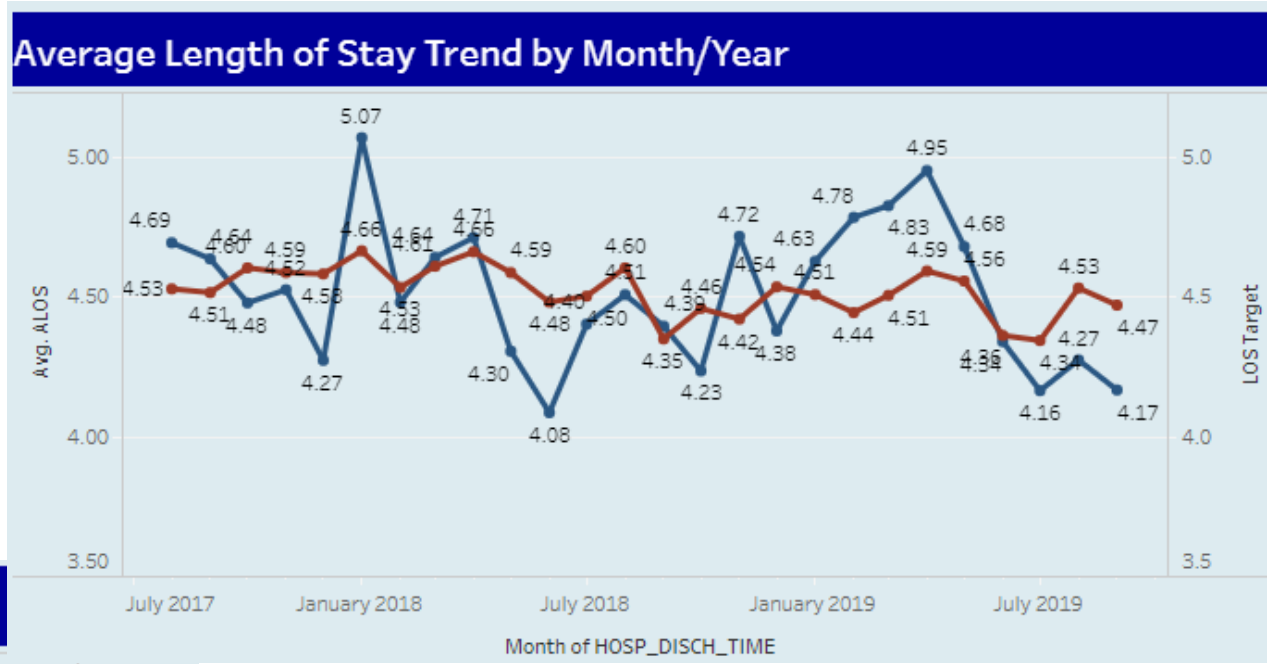


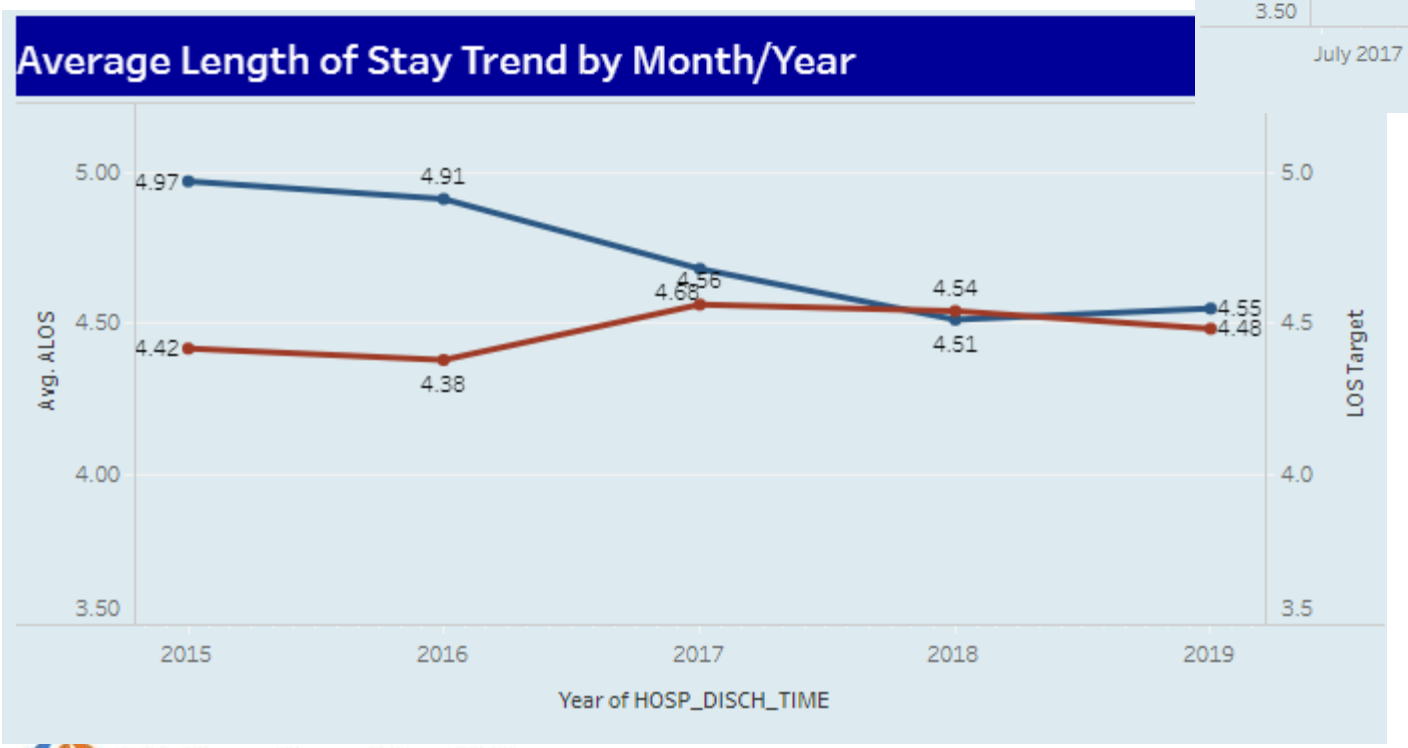
Medicare Length of Stay

ALOS vs Milliman well-managed benchmark (red line). Medicare is our largest book of business and growing due to aging population. Lower length of stay is a key driver for improving the Medicare margin

Calendar 19 ALOS has increased due to long stay outlier cases beginning in January but has been improving since May.

ALOS continues to be ahead of target



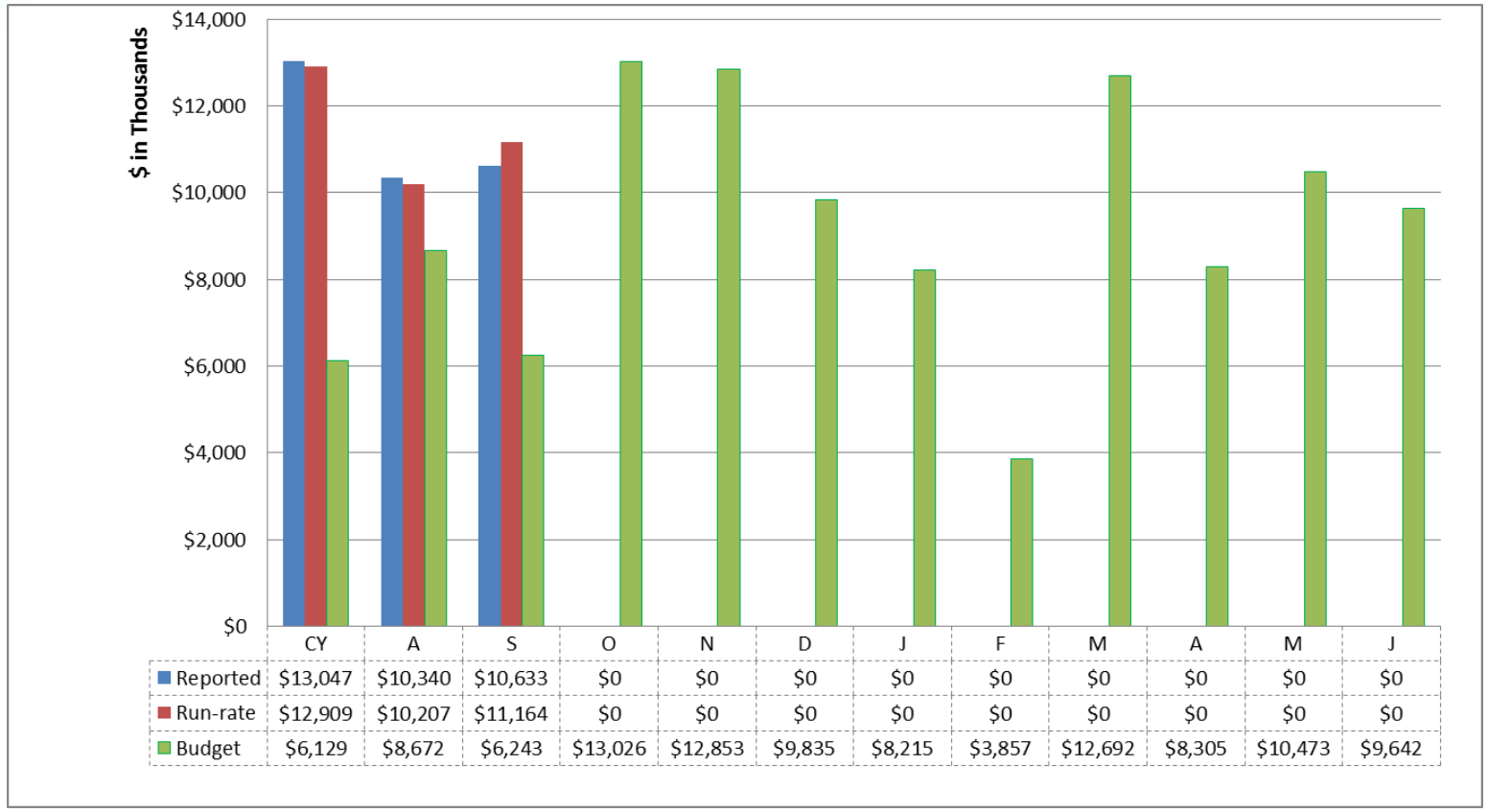


Actual Benchmark

El Camino Health

ECH Hospital Operating Margin

Run rate is booked operating income adjusted for material non-recurring transactions



	CY	A	S	O	N	D	J	F	M	A	M	J
Reported	$13,047	$10,340	$10,633	$0	$0	$0	$0	$0	$0	$0	$0	$0
Run-rate	$12,909	$10,207	$11,164	$0	$0	$0	$0	$0	$0	$0	$0	$0
Budget	$6,129	$8,672	$6,243	$13,026	$12,853	$9,835	$8,215	$3,857	$12,692	$8,305	$10,473	$9,642

FY 2020 Actual Run Rate Adjustments (in thousands) - FAV / <UNFAV>					
Revenue Adjustments		J	A	S	YTD
	Mcare Settlmt/Appeal/Tent Settlmt/PIP	129	129	210	469
	RAC Release	-	-	(746)	(746)
	Various Adjustments under $250k	9	4	5	18
	Total	**138**	**133**	**(531)**	**(260)**

El Camino Health

INVESTMENT SCORECARD AS OF SEPTEMBER 30, 2019

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY19 Year End Budget	Expectation Per Asset Allocation
Investment Performance		**3Q 2019**		**Fiscal Year-to-date**		**6y 11m Since Inception (annualized)**			**2019**
Surplus cash balance*		$1,046.2	--	--	--	--	--	$892.9	--
Surplus cash return		0.8%	0.6%	0.8%	0.6%	5.6%	5.4%	3.2%	5.6%
Cash balance plan balance (millions)		$278.3	--	--	--	--	--	$276.9	--
Cash balance plan return		0.2%	0.5%	0.2%	0.5%	7.5%	6.9%	6.0%	6.0%
403(b) plan balance (millions)		$516.7	--	--	--	--	--	--	--
Risk vs. Return		**3-year**				**6y 11m Since Inception (annualized)**			**2019**
Surplus cash Sharpe ratio		0.92	0.88	--	--	1.01	0.99	--	0.34
Net of fee return		6.4%	6.0%	--	--	5.6%	5.4%	--	5.6%
Standard deviation		5.3%	5.1%	--	--	4.8%	4.7%	--	8.7%
Cash balance Sharpe ratio		0.91	0.87	--	--	1.08	1.04	--	0.32
Net of fee return		7.6%	6.9%	--	--	7.5%	6.9%	--	6.0%
Standard deviation		6.7%	6.1%	--	--	6.2%	5.9%	--	10.3%
Asset Allocation		**3Q 2019**							
Surplus cash absolute variances to target		10.2%	< 10%	--	--	--	--	--	--
Cash balance absolute variances to target		7.7%	< 10%	--	--	--	--	--	--
Manager Compliance		**3Q 2019**							
Surplus cash manager flags		15	< 24 Green < 30 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		20	< 27 Green < 34 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$64 mm), District assets (~$32 mm), and balance sheet cash not in investable portfolio (~$109 mm). Includes Foundation (~$35 mm) and Concern (~$13 mm) assets. Budget adds back in current Foundation and Concern assets and backs out current debt reserve funds.

El Camino Health

FY 20 Capital Cash Flow Projections
Reformatted to separate active and planned facility projects

Capital Spending (in 000's)	Actual FY2017	Actual FY2018	Actual FY2019	Budget Cash Flow 2020
ERP	-	-	5,830	-
IT Hardware / Software Equipment/EPIC	5,414	2,222	7,859	6,000
Medical / Non Medical Equipment	9,556	15,780	12,082	18,000
Facilities Total	82,953	139,434	158,010	244,665
Active				
Mountain View Campus Master Plan Projects	62,493	114,093	140,000	112,700
Mountain View Capital Projects	5,535	7,948	9,620	66,992
Los Gatos Capital Projects	14,780	12,306	6,901	12,773
Placeholder/Deferred				
Other Strategic Capital Facility Projects	145	5,088	1,489	19,200
Other Major Projects				33,000
GRAND TOTAL	97,923	157,435	183,782	268,665

FY20 Detail Facility Cash Flow Projections ($000s)

Mountain View Campus Master Plan Projects	FY 2020 Cash Flow
BHS Replacement	8,143
Integrated Medical Office Building	57,557
Women's Hosp Expansion	33,000
Demo Old Main & Related Site Work	14,000
	112,700

Mountain View Capital Projects	
ED Remodel Triage / Psych Observation	6,106
Willow Pavilion FA Sys and Equip Upgrades	1,400
Willow Surgery Center Improvements	2,000
Site Signage & Other Improvements	1,700
Patient Family Residence	6,150
Nurse Call System Upgrade	2,200
Imaging Equipment Replacement (Imaging Dept. Only)	11,700
IR / Cath Lab Equipment Replacement (5 or 6 Rooms)	9,500
Various Relocation Projects	700
Flooring Replacement	1,180
Emergency Sanitary & Water Storage	2,216
CT Equipment Replacement @ Radiation Oncology	440
Radiation Oncology Equipment Replacement	10,000
MV MOB Upgrades FY 20	500
MV Facilities Planning Allowance FY 20	600
MV Equipment & Infrastructure Upgrades FY 20	900
MV Cancer Center Expansion	1,200
MV Wireless Infrastructure Upgrade	1,000
Other Undefined	500
MV Undefined Annual Forecast	7,000
	66,992

Los Gatos Capital Projects	FY 2020 Cash Flow
LG IR Upgrades	1,250
LG Modular MRI & Awning	3,205
LG Nurse Call System Upgrade	1,000
LG Security System	340
LG Cancer Center	2,598
LG MOB Upgrades FY 20	500
LG Facilities Planning Allowance FY 20	500
LG Equipment & Infrastructure Upgrades FY 20	600
LG Rehab Finish Upgrades	400
LG Campus Signage	500
LG Wireless Infrastructure Upgrades	480
LG Paving Upgrades	800
LG Decontamination in OR	600
	12,773

Other Strategic Capital Facility Projects	
Primary Care Clinic	4,000
New MOB	12,200
SVMD - Facilities Future Years	3,000
	19,200

Other Major Projects & Annual Forcasts	
LG Campus Redevelopment	12,000
Property Acquisitions	21,000
	33,000

TOTAL	244,665

El Camino Health

Consolidated Balance Sheet

(in thousands)

ASSETS

		Unaudited	
	CURRENT ASSETS	**September 30, 2019**	**June 30, 2019**
(1)	Cash	107,779	124,912
(2)	Short Term Investments	193,539	177,165
	Patient Accounts Receivable, net	132,099	132,198
	Other Accounts and Notes Receivable	6,004	5,058
	Intercompany Receivables	4,978	8,549
	Inventories and Prepaids	65,671	64,093
	Total Current Assets	**510,070**	**511,976**
	BOARD DESIGNATED ASSETS		
	Foundation Board Designated	17,253	16,895
	Plant & Equipment Fund	174,105	171,304
	Women's Hospital Expansion	22,430	15,472
(3)	Operational Reserve Fund	144,294	139,057
	Community Benefit Fund	18,021	18,260
	Workers Compensation Reserve Fund	21,232	20,732
	Postretirement Health/Life Reserve Fund	29,522	29,480
	PTO Liability Fund	26,397	26,149
	Malpractice Reserve Fund	1,831	1,831
	Catastrophic Reserves Fund	20,318	19,678
	Total Board Designated Assets	**475,404**	**458,857**
(4)	**FUNDS HELD BY TRUSTEE**	**63,682**	**83,073**
	LONG TERM INVESTMENTS	**359,022**	**375,729**
	CHARITABLE GIFT ANNUITY INVESTMENTS	**589**	**602**
	INVESTMENTS IN AFFILIATES	**35,032**	**38,532**
	PROPERTY AND EQUIPMENT		
	Fixed Assets at Cost	1,325,579	1,317,599
	Less: Accumulated Depreciation	(636,233)	(622,877)
	Construction in Progress	433,927	375,094
	Property, Plant & Equipment - Net	**1,123,273**	**1,069,816**
	DEFERRED OUTFLOWS	33,726	33,876
	RESTRICTED ASSETS	24,986	24,279
	OTHER ASSETS	1,021	1,036
	TOTAL ASSETS	**2,626,806**	**2,597,775**

LIABILITIES AND FUND BALANCE

		Unaudited	
	CURRENT LIABILITIES	**September 30, 2019**	**June 30, 2019**
(5)	Accounts Payable	43,961	38,390
	Salaries and Related Liabilities	29,762	30,296
	Accrued PTO	26,802	26,502
	Worker's Comp Reserve	2,300	2,300
	Third Party Settlements	12,454	11,331
	Intercompany Payables	4,907	8,464
	Malpractice Reserves	1,800	1,800
	Bonds Payable - Current	8,630	8,630
	Bond Interest Payable	6,657	12,775
	Other Liabilities	10,156	10,477
	Total Current Liabilities	**147,429**	**150,966**
	LONG TERM LIABILITIES		
	Post Retirement Benefits	29,522	29,480
	Worker's Comp Reserve	18,932	18,432
	Other L/T Obligation (Asbestos)	4,004	3,975
	Other L/T Liabilities (IT/Medl Leases)	-	-
	Bond Payable	508,645	507,531
	Total Long Term Liabilities	**561,104**	**559,417**
	DEFERRED REVENUE-UNRESTRICTED	1,062	1,113
	DEFERRED INFLOW OF RESOURCES	13,715	13,715
	FUND BALANCE/CAPITAL ACCOUNTS		
	Unrestricted	1,386,535	1,372,823
	Board Designated	475,386	458,839
	Restricted	24,984	24,215
	Capital	100	100
	Retained Earnings	16,490	16,587
	Total Fund Bal & Capital Accts	**1,903,496**	**1,872,563**
	TOTAL LIABILITIES AND FUND BALANCE	**2,626,806**	**2,597,775**

El Camino Health

September 2019 El Camino Hospital Comparative Balance Sheet Variances and Footnotes

(1) The decrease is due to funding of our construction projects and a quarterly pension payment.

(2) The increase is due to the shift from long term investment to short term investments. S-Term has increased by $15M and L-Term has declined by $19M

(3) The increase is due to annual resetting of the 60 day Operational Reserve based on the new FY2019 budget that has started.

(4) Decrease is due to draws from the 2015A/2017 Bond Project funds for the on-going IMOB and BHS construction and semi-annual 2015/2017 bond payment

(5) The increase is due to the accrual of several large construction invoices.

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (1 OF 2)

- **Plant & Equipment Fund –** original established by the District Board in the early 1960's to fund new capital expansion projects of building facilities or equipment (new or replacements). The funds came from the M&O property taxes being received and the funding depreciation expense at 100%. When at the end of 1992, the 501(c)(3) Hospital was performed by the District, the property tax receipts remained with the District. The newly formed Hospital entity continued on with funding depreciation expense, but did that funding at 130% of the depreciation expense to account for an expected replacement cost of current plant and property assets. It is to be noted that within this fund is an itemized amount of $14 million for the Behavioral Health Service building replacement project. This amount came from the District's Capital Appropriation Fund (excess Gann Limit property taxes) of the fiscal years of 2010 thru 2013 by various District board actions.

- **Women's Hospital Expansion –** established June 2016 by the District authorizing the amounts accumulated in its Capital Appropriation Fund (excess Gann Limit property taxes) for the fiscal years of 2014 and 2015 to be allocated for the renovation of the Women's Hospital upon the completion of Integrated Medical Office Building currently under construction. At the end of fiscal year 2019 another $7.2 million was added to this fund bringing it to $22.5 million.

- **Operational Reserve Fund –** originally established by the District in May 1992 to establish a fund equal to sixty (60) days of operational expenses (based on the current projected budget) and only be used in the event of a major business interruption event and/or cash flow.

- **Community Benefit Fund –** following in the footsteps of the District in 2008 of forming its Community Benefit Fund using Gann Limit tax receipts, the Hospital in 2010 after opening its campus outside of District boundaries in Los Gatos formed its own Community Benefit Fund to provide grants/sponsorships in Los Gatos and surrounding areas. The funds come from the Hospital reserving $1.5M a year from its operations, the entity of CONCERN contributing 40% of its annual income each year (an amount it would have paid in corporate taxes if it wasn't granted tax exempt status), that generates an amount of $500,000 or more a year. $15 million within this fund is a board designated endowment fund formed in 2015 with a $10 million contribution, and added to at the end of the 2017 fiscal year end with another $5 million contribution, to generate investment income to be used for grants and sponsorships, in fiscal year 2019 it generated over $872 thousand of investment income for the program.

EL CAMINO HOSPITAL - BOARD DESIGNATED FUND DESCRIPTIONS/HISTORY (2 OF 2)

- **Workers Compensation Reserve Fund** – as the Hospital is self-insured for its workers compensation program (since 1978) this fund was originally formed in early 2000's by management to reserve cash equal to the yearly actuarially determined Workers Compensation amount. The thought being if the business was to terminate for some reason this is the amount in cash that would be needed to pay out claims over the next few years.

- **Postretirement Health/Life Reserve Fund –** following the same formula as the Workers Compensation Reserve Fund this fund was formed in the early 2000's by management to reserve cash equal to the yearly actuarially determined amount to fund the Hospital's postretirement health and life insurance program. Note this program was frozen in 1995 for all new hires after that date. At the end of fiscal year 2018, GASB #75 was implemented that now represents the full actuarially determined liability.

- **PTO (Paid Time Off) Liability Fund –** originally formed in 1993 as the new 501(c)(3) Hospital began operations, management thought as a business requirement of this vested benefit program that monies should be set aside to extinguish this employee liability should such a circumstance arise. This balance is equal to the PTO Liability on the Balance Sheet.

- **Malpractice Reserve Fund –** originally established in 1989 by the then District's Finance Committee and continued by the Hospital. The amount is actuarially determined each year as part of the annual audit to fund potential claims less than $50,000. Above $50,000 our policy with the BETA Healthcare Group kicks in to a $30 million limit per claim/$40 million in the aggregate.

- **Catastrophic Loss Fund –** was established in 1999 by the Hospital Board to be a "self-insurance" reserve fund for potential non-major earthquake repairs. Initially funded by the District transferring $5 million and has been added to by the last major payment from FEMA for the damage caused the Hospital by the October 1989 earthquake. It is to be noted that it took 10 years to receive final settlement from FEMA grants that totaled $6.8 million that did mostly cover all the necessary repairs.

APPENDIX

Non Operating Items and Net Margin by Affiliate

$ in thousands

	Period 3- Month			Period 3- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	10,646	5,304	5,342	30,798	17,869	12,929
Los Gatos	(13)	938	(952)	3,222	3,174	48
Sub Total - El Camino Hospital, excl. Afflilates	**10,633**	**6,243**	**4,390**	**34,020**	**21,043**	**12,977**
Operating Margin %	**13.2%**	**8.2%**		**13.6%**	**9.0%**	
El Camino Hospital Non Operating Income						
Investments	5,097	3,335	1,762	8,910	9,690	(781)
Swap Adjustments	2,104	0	2,104	2,490	0	2,490
Community Benefit[1]	(57)	(309)	252	(2,516)	(927)	(1,589)
Satellite Dialysis	122	42	81	122	83	39
Other	(5,257)	(306)	(4,951)	(3,457)	(877)	(2,581)
Sub Total - Non Operating Income	**2,009**	**2,761**	**(753)**	**5,549**	**7,970**	**(2,420)**
El Camino Hospital Net Margin	**12,641**	**9,004**	**3,637**	**39,569**	**29,013**	**10,556**
ECH Net Margin %	**15.6%**	**11.8%**		**15.8%**	**12.4%**	
Concern	148	(38)	186	544	123	421
ECSC	(1)	0	(1)	(27)	1	(28)
Foundation	258	113	145	992	426	566
Silicon Valley Medical Development	(3,765)	(2,636)	(1,129)	(10,314)	(8,428)	(1,886)
Net Margin Hospital Affiliates	**(3,360)**	**(2,561)**	**(799)**	**(8,805)**	**(7,879)**	**(926)**
Total Net Margin Hospital & Affiliates	**9,281**	**6,443**	**2,838**	**30,764**	**21,134**	**9,630**

[1]Donations to outside organizations for FY20

El Camino Health

El Camino Hospital – Mountain View ($000s)

Period ending 09/30/2019

Period 3 FY 2019	Period 3 FY 2020	Period 3 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
219,350	255,454	236,938	18,515	7.8%	**Gross Revenue**	676,032	757,910	727,409	30,501	4.2%
(161,337)	(189,393)	(176,420)	(12,973)	(7.4%)	**Deductions**	(495,105)	(555,749)	(541,583)	(14,166)	(2.6%)
58,012	**66,061**	**60,518**	**5,543**	**9.2%**	**Net Patient Revenue**	**180,927**	**202,161**	**185,826**	**16,336**	**8.8%**
1,816	2,274	1,678	596	35.5%	**Other Operating Revenue**	4,949	5,169	5,098	72	1.4%
59,829	**68,335**	**62,196**	**6,139**	**9.9%**	**Total Operating Revenue**	**185,877**	**207,331**	**190,923**	**16,407**	**8.6%**
					OPERATING EXPENSE					
33,579	35,747	35,343	(403)	(1.1%)	**Salaries & Wages**	100,899	107,732	107,967	235	0.2%
8,298	10,170	8,977	(1,193)	(13.3%)	**Supplies**	26,218	31,081	27,198	(3,883)	(14.3%)
5,601	5,678	5,885	207	3.5%	**Fees & Purchased Services**	18,560	18,931	17,759	(1,172)	(6.6%)
1,910	2,362	2,602	241	9.2%	**Other Operating Expense**	6,095	7,326	8,113	787	9.7%
174	227	495	268	54.2%	**Interest**	452	696	1,485	789	53.1%
3,509	3,506	3,589	83	2.3%	**Depreciation**	10,503	10,767	10,532	(234)	(2.2%)
53,071	**57,689**	**56,892**	**(797)**	**(1.4%)**	**Total Operating Expense**	**162,728**	**176,533**	**173,055**	**(3,478)**	**(2.0%)**
6,757	**10,646**	**5,304**	**5,342**	**100.7%**	**Net Operating Margin**	**23,149**	**30,798**	**17,869**	**12,929**	**72.4%**
(90)	2,009	2,761	(753)	(27.3%)	**Non Operating Income**	16,320	5,549	7,970	(2,420)	(30.4%)
6,667	**12,655**	**8,066**	**4,589**	**56.9%**	**Net Margin**	**39,468**	**36,347**	**25,839**	**10,508**	**40.7%**
17.5%	21.0%	15.1%	5.9%		**EBITDA**	18.3%	20.4%	15.7%	4.7%	
11.3%	15.6%	8.5%	7.1%		**Operating Margin**	12.5%	14.9%	9.4%	5.5%	
11.1%	18.5%	13.0%	5.5%		**Net Margin**	21.2%	17.5%	13.5%	4.0%	

El Camino Hospital – Los Gatos ($000s)

Period ending 08/31/2019

Period 3 FY 2019	Period 3 FY 2020	Period 3 Budget 2020	Variance Fav (Unfav)	Var%	$000s	YTD FY 2019	YTD FY 2020	YTD Budget 2020	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
48,537	50,374	53,644	(3,270)	(6.1%)	**Gross Revenue**	148,379	167,946	165,050	2,896	1.8%
(35,096)	(38,291)	(39,842)	1,551	3.9%	**Deductions**	(109,451)	(126,333)	(122,534)	(3,799)	(3.1%)
13,441	**12,083**	**13,801**	**(1,718)**	**(12.5%)**	**Net Patient Revenue**	**38,928**	**41,612**	**42,516**	**(904)**	**(2.1%)**
254	410	271	140	51.6%	**Other Operating Revenue**	773	1,175	811	364	44.9%
13,695	**12,493**	**14,072**	**(1,579)**	**(11.2%)**	**Total Operating Revenue**	**39,701**	**42,788**	**43,327**	**(539)**	**(1.2%)**
					OPERATING EXPENSE					
6,780	7,001	7,191	190	2.6%	**Salaries & Wages**	20,615	21,788	21,700	(87)	(0.4%)
1,953	1,785	2,018	233	11.6%	**Supplies**	6,341	6,331	6,451	120	1.9%
2,575	2,526	2,731	204	7.5%	**Fees & Purchased Services**	7,747	8,064	8,209	145	1.8%
217	386	346	(40)	(11.5%)	**Other Operating Expense**	793	953	1,327	374	28.2%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
741	808	847	39	4.6%	**Depreciation**	2,222	2,430	2,466	36	1.5%
12,265	**12,507**	**13,134**	**627**	**4.8%**	**Total Operating Expense**	**37,718**	**39,565**	**40,153**	**587**	**1.5%**
1,429	**(13)**	**938**	**(952)**	**(101.4%)**	**Net Operating Margin**	**1,983**	**3,222**	**3,174**	**48**	**1.5%**
0	0	0	0	0.0%	**Non Operating Income**	0	0	0	0	0.0%
1,429	**(13)**	**938**	**(952)**	**(101.4%)**	**Net Margin**	**1,983**	**3,222**	**3,174**	**48**	**1.5%**
15.8%	6.4%	12.7%	(6.3%)		**EBITDA**	10.6%	13.2%	13.0%	0.2%	
10.4%	-0.1%	6.7%	(6.8%)		**Operating Margin**	5.0%	7.5%	7.3%	0.2%	
10.4%	-0.1%	6.7%	(6.8%)		**Net Margin**	5.0%	7.5%	7.3%	0.2%	

El Camino Hospital Capital Spending (in thousands) FY 2014 – FY 2019

Category	2014	2015	2016	2017	2018	2019
EPIC/ERP (as of FY19)	**6,838**	**29,849**	**20,798**	**2,755**	**1,114**	**5,830**
IT Hardware/Software Equipment	**2,788**	**4,660**	**6,483**	**2,659**	**1,108**	**7,859**
Medical/Non Medical Equipment	**12,891**	**13,340**	**17,133**	**9,556**	**15,780**	**12,082**
Non CIP Land, Land I, BLDG, Additions	**22,292**	-	**4,189**	-	**2,070**	
Facilities Projects CIP						
Mountain View Campus Master Plan Projects						
1245 - Behavioral Health Bldg Replace	1,257	3,775	1,389	10,323	28,676	30,003
1413 - North Drive Parking Structure Exp	-	167	1,266	18,120	4,670	222
1414 - Integrated MOB	-	2,009	8,875	32,805	75,319	108,951
1422 - CUP Upgrade	-	-	896	1,245	5,428	824
Sub-Total Mountain View Campus Master Plan	**1,257**	**5,950**	**12,426**	**62,493**	**114,093**	**140,000**
Mountain View Capital Projects						
9900 - Unassigned Costs	470	3,717	-	-	-	-
0906 - Slot Build-Out	1,576	15,101	1,251	294	-	-
1109 - New Main Upgrades	393	2	-	-	-	-
1111 - Mom/Baby Overflow	29	-	-	-	-	-
1204 - Elevator Upgrades	30	-	-	-	-	-
0800 - Womens L&D Expansion	1,531	269	-	-	-	-
1225 - Rehab BLDG Roofing	241	4	-	-	-	-
1227 - New Main eICU	21	-	-	-	-	-
1230 - Fog Shop	80	-	-	-	-	-
1315 - 205 So. Drive TI's	500	2	-	-	-	-
0908 - NPCR3 Seismic Upgrds	1,224	1,328	240	342	961	150
1125 - Will Pav Fire Sprinkler	39	-	-	-	-	-
1216 - New Main Process Imp Office	1	16	-	-	-	-
1217 - MV Campus MEP Upgrades FY13	181	274	28	-	-	-
1224 - Rehab Bldg HVAC Upgrades	202	81	14	6	-	-
1301 - Desktop Virtual	13	-	-	-	-	-
1304 - Rehab Wander Mgmt	87	-	-	-	-	-
1310 - Melchor Cancer Center Expansion	44	13	-	-	-	-
1318 - Women's Hospital TI	48	48	29	2	-	-
1327 - Rehab Building Upgrades	-	15	20	-	22	-
1320 - 2500 Hosp Dr Roofing	75	81	-	-	-	-
1340 - New Main ED Exam Room TVs	8	193	-	-	-	-
1341 - New Main Admin	32	103	-	-	-	-
1344 - New Main AV Upgrd	243	-	-	-	-	-
1400 - Oak Pav Cancer Center	-	5,208	666	52	156	-
1403 - Hosp Drive BLDG 11 TI's	86	103	-	-	-	-
1404 - Park Pav HVAC	64	7	-	-	-	-
1405 - 1 - South Accessibility Upgrades	-	-	168	95	-	-
1408 - New Main Accessibility Upgrades	-	7	46	501	12	-
1415 - Signage & Wayfinding	-	-	106	58	136	27
1416 - MV Campus Digital Directories	-	-	34	23	95	-
1423 - MV MOB TI Allowance	-	-	588	369	-	-
1425 - IMOB Preparation Project - Old Main	-	-	711	1,860	215	-
1429 - 2500 Hospital Dr Bldg 8 TI	-	101	-	-	-	-
1430 - Women's Hospital Expansion	-	-	-	464	2,763	3,447
1432 - 205 South Dr BHS TI	-	8	15	-	52	-
1501 - Women's Hospital NPC Comp	-	4	-	223	320	49
1502 - Cabling & Wireless Upgrades	-	-	1,261	367	984	-
1503 - Willow Pavillion Tomosynthesis	-	-	53	257	31	-
1504 - Equipment Support Infrastructure	-	61	311	-	60	-
1523 - Melchor Pavillion Suite 309 TI	-	-	10	59	392	-
1525 - New Main Lab Upgrades	-	-	-	464	1,739	495
1526 - CONCERN TI	-	-	37	99	10	-

Category	2014	2015	2016	2017	2018	2019
Facilities Projects CIP cont.						
1602 - JW House (Patient Family Residence)	-	-	-	-	-	132
1707 - Imaging Equipment Replacement	-	-	-	-	-	185
1708 - IR / Cath Lab Equipment Replacement	-	-	-	-	-	1,058
1709 - ED Remodel / CT Triage - Other	-	-	-	-	-	213
1711 - MV Emergency Sanitary & Water	-	-	-	-	-	264
1713 - MV Flooring Replacement	-	-	-	-	-	478
1715 - 125 South Dr CT Replacement	-	-	-	-	-	80
1716 - Melchor Suite 102 SVMD	-	-	-	-	-	142
1800 - MV Pneumatic Tube Upgrades	-	-	-	-	-	109
1801 - Demo Old Main & Related Site Work	-	-	-	-	-	120
1803 - SVMD Melchor Suite 212	-	-	-	-	-	68
1805 - MV SPD Ultrasonic Cleaner	-	-	-	-	-	144
1900 - MV Infrastructure Upgrades	-	-	-	-	-	98
1902 - Site Signage and Other Improvements	-	-	-	-	-	187
1904 - HM FY19 Furniture Inventory	-	-	-	-	-	21
1906 - SVMD 2024 Grant Suite 202 OB/GYN Clinic	-	-	-	-	-	74
1917 - Willow SC Upgrades	-	-	-	-	-	60
Sub-Total Mountain View Projects	**7,219**	**26,744**	**5,588**	**5,535**	**7,948**	**9,620**
Los Gatos Capital Projects						
0907 - LG Imaging Masterplan	774	1,402	17	-	-	-
1210 - Los Gatos VOIP	89	-	-	-	-	-
1116 - LG Ortho Pavillion	24	21	-	-	-	-
1124 - LG Rehab BLDG	458	-	-	-	-	-
1307 - LG Upgrades	2,979	3,282	3,511	3,081	4,551	1,426
1308 - LG Infrastructure	114	-	-	-	-	-
1313 - LG Rehab HVAC System/Structural	-	-	1,597	1,904	550	-
1219 - LG Spine OR	214	323	633	2,163	447	191
1221 - LG Kitchen Refrig	85	-	-	-	-	-
1248 - LG - CT Upgrades	26	345	197	6,669	1,673	106
1249 - LG Mobile Imaging	146	-	-	-	-	-
1328 - LG Ortho Canopy FY14	255	209	-	-	-	-
1345 - LG Lab HVAC	112	-	-	-	-	-
1346 - LG OR 5, 6, and 7 Lights Replace	-	285	53	22	127	-
1347 - LG Central Sterile Upgrades	-	181	43	66	-	-
1421 - LG MOB Improvements	-	198	65	303	356	-
1508 - LG NICU 4 Bed Expansion	-	-	-	207	-	-
1600 - 825 Pollard - Aspire Phase II	-	-	-	80	10	-
1603 - LG MOB Improvements	-	-	-	285	4,593	37
1702 - LG Modular MRI & Awning	-	-	-	-	-	426
1712 - LG Cancer Center	-	-	-	-	-	3,594
1714 - 825 Pollard Men's Health Clinic	-	-	-	-	-	499
1717 - LG Mammography Replacement	-	-	-	-	-	228
1802 - MOB Upgrades (LG Campus)	-	-	-	-	-	233
1901 - LG Infrastructure Upgrades	-	-	-	-	-	73
1909 - LG Campus Planning	-	-	-	-	-	88
Sub-Total Los Gatos Projects	**5,276**	**6,246**	**6,116**	**14,780**	**12,306**	**6,901**
1550 - Land Acquisition	-	-	24,007	-	-	-
1701 - 828 S Winchester Clinic TI	-	-	-	145	3,018	214
1804 - SVMD Clinic @ North First Street	-	-	-	-	-	824
1903 - SVMD Administrative Offices	-	-	-	-	-	291
1910 - SVMD SJMG at McKee	-	-	-	-	-	135
1920 - SVMD Infrastructure Support & Equipment	-	-	-	-	-	25
Sub-Total Other Strategic Projects	**-**	**-**	**24,007**	**145**	**3,018**	**1,489**
Subtotal Facilities Projects CIP	**13,753**	**38,940**	**48,137**	**82,953**	**137,364**	**158,010**
Grand Total	**58,561**	**86,789**	**96,740**	**97,923**	**157,435**	**183,782**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Bob Miller, Executive Compensation Committee Chair
Date: November 6, 2019
Subject: Executive Compensation Committee Report

Purpose:

To report to the Board decisions made at the Executive Compensation Committee (ECC) meeting on September 19, 2019.

Summary:

Pursuant to authority granted to it by the Board, the ECC approved the FY19 Performance Incentive Plan payouts for the executive team. The payouts are based on a direct calculation that reflects the FY19 organizational and individual goal scores, and were paid on October 25, 2019, following the Board' approval of the FY19 organizational goal score and the FY19 financial audit. Incentive payments for the Chief Administrative Services Officer and the Chie Executive Officer were approved by the Board on October 10, 2019.

FY19 Performance Incentive Pay

Job Title	Amount
Chief Financial Officer	$123,104
Chief Human Resources Officer	$93,778
Chief Information Officer	$93,538
Chief Medical Officer	$123,557
Chief Nursing Officer	$92,225
Chief Operating Officer	$98,168
General Counsel	$97,783
President, SVMD	$152,250
VP, Payor Relations	$67,966
VP, Corporate & Community Health Services/ President, CONCERN:EAP	$66,148

List of Attachments: None.

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

El Camino Health

OPEN SESSION CEO Report
November 6, 2019
Dan Woods, CEO

Workforce

In the first month following "go live" on Workday, we have had great employee and manager acceptance and support for our new Enterprise Resource Planner. In addition to the metrics listed below, the paycheck of October 25th included annual employee salary adjustments including base salary increases for PRN nurses. These transactions were undertaken seamlessly and without incident. We will continue to stabilize and begin to optimize the Human Resource and Finance tenets as we prepare to add/implement Supply Chain in 2020. Key metrics include:

- 3,071 unique users logged in
- 16,764 General Ledger transactions posted
- 823 candidates accessed our Job Board
- 6,274 invoices submitted
  - 6,020 approved
- 332 expense reports submitted
  - 293 approved; monitoring remaining approvals

Operations

El Camino Hospital acquired a new computer-guided robotic arm that assists in the location and trajectory of pedicle screws for spine fusion. Evidence shows that robotic-assisted placement is more accurate and has fewer complications than manual screw placement. The new equipment will link to existing stealth navigation computers and will be utilized by multiple surgeons who are already certified in the technology. The acquisition builds on the spine service line strategy of offering meaningful cutting-edge technology and nimble innovation to improve quality.

Dr. Krishna has completed 14 robotic bronchoscopy cases at ECH. We were able to do a FIRST EVER biopsy of 6MM lung nodule on the periphery of the lung and obtain a diagnosis. It was a tremendous result to catch this cancer in a very early stage of development.

A delegation from staff attended the Magnet Conference on October 9-12, 2019. The conference attracts over 10,000 nurses from around the world and typically receives submissions of over 1600 abstracts for poster and podium presentations. ECH was selected to present two podium presentations at the conference. Athena Lendvay, RN presented information on Early Recovery After Surgery (ERAS) protocols we implemented with great success at ECH. Jackie Keane, RN and Patty DeMellopine, RN presented the activities the hospital has been engaged with for the LBGTQ community and the patients served at ECH to become a leader in health care equity. Both presentations were greatly attended with much interest!

Corporate and Community Health Services

Cecile Currier, VP, Corporate and Community Health Services and President, CONCERN EAP, received Momentum for Mental Health's Shining Star Award at its annual Gala. This award recognizes individuals who have made a significant contribution to improving access and quality of services in the behavioral health field.

The FY19 Community Benefit Annual Report was published, went live online, and was presented to both the ECH and ECHD Boards. We will disseminate the FY19 Community Benefit Annual Report, which was published and presented to the Board in October, to the community in November. The microsite is at https://www.elcaminohealth.org/microsites/communitybenefit2019/

West Valley Community Services Agency honored El Camino Health as a Champion of Compassion at their 2019 annual Chef of Compassion event. Jim Griffith accepted the award for the Hospital. Recent El Camino Hospital Sponsorships include:

- Child Advocates Silicon Valley – Wine, Women and Shoes
- Alzheimer's Association – Walk
- Next Door Solutions for Domestic Violence – Light up the Night
- Hispanic Foundation – Annual Ball
- American Cancer Society – Breast Cancer Walk
- YWCA Silicon Valley – Inspire Luncheon

The South Asian Heart Center (SAHC) held a physician continuing medical education event with 64 physicians in attendance and 33 physicians joining the SAHC physician network. The SAHC participated in corporate benefits health fairs resulting in SAHC program signups and cookbook requests at KLA Tencor, and at Oracle locations in Santa Clara and Pleasanton. We also launched new outreach locations at the Foster City and Sunnyvale Farmer's markets.

The Chinese Health Initiative (CHI) held its annual physician appreciation dinner with 30 physicians attending. I presented El Camino Health's branding strategy & new clinical services and Dr. Ed Yu, family medicine, presented CHI's upcoming launch of diabetes prevention program. The Chinese-speaking physician network was launched in 2010 to help Chinese community members connect with physicians from all specialties who speak their language.

CHI also participated at CASPA (largest Chinese engineering professional association in the region) reaching out to high tech professionals to promote diabetes prevention program. We distributed diabetes information to 500+ conference attendees.

The Health Library & Resource Center gave a presentation about its services at the Cancer Center, had information tables at the ECH Benefits Fair in MV and LG and the Saratoga Senior Center and continues weekly information tables at the Mountain View Senior Center and the Indian Community Center.

Marketing and Communications

Marketing, Government Relations and the El Camino Health Foundation collaborated for the Taube Pavilion, Scrivner Center for Mental Health and Addiction Services grand opening events. In addition to an evening VIP program and ribbon cutting on October 24, 2019, we held an open house for physicians and staff on Friday, October 25, followed by a community open house on Saturday, October 26. Saturday's event kicked off with a second VIP program attended by many elected officials, including U.S. House Representative Anna Eshoo State Assemblymembers Berman and Kalra, Santa Clara County Supervisor Joe Simitian and mayors and city councilmembers from several cities. Over the course of the afternoon, several hundred community members attended and received guided tours of Taube Pavilion.

Recent media coverage included articles about the Taube Pavilion in The Los Altos Town Crier and Mountain View Voice with future coverage pending. We distributed a media release for the first GammaTile procedure on the West Coast and a patient story highlighting the impact of bronchial lung volume reduction earned placements in the 10 largest Designated Market Areas in the U.S.: NYC, LA, Chicago, Houston, Philadelphia, Phoenix, San Antonio, San Diego, Dallas, and San Jose. That is a total audience of 82,551,806.

We completed principal production of the new El Camino Health announcement campaign and launched an advertising campaign to support brand awareness for primary care services for El Camino Health. The campaign includes paid media, a dedicated landing page, direct mail and email marketing efforts reaching thousands in the Bay Area.

The marketing team initiated advertising and brand tracking studies to measure corporate brand advertising effectiveness and brand health. We are pursuing drivers and comparative segment analysis for NRC dataset to obtain market insights.

Marketing and HR collaborated to hold seven employee town hall meetings across campuses. 645 individuals attended.

Philanthropy

During Period 3 of fiscal year 2020, El Camino Health Foundation secured $77,343 in donations. Since September investment income is not available yet, the Period 3 fundraising report shows a fundraising total of $1,240,957, which reflects donations through September 30, 2019 but investment income only through August 31, 2019.

Auxiliary

The Auxiliary volunteer hours for October 2019 were not available at the time of publication of this report and will be reported next month.

EL CAMINO HOSPITAL
BOARD MEETING COVER MEMO

To:	El Camino Hospital Board of Directors
From:	John Conover, Chair, El Camino Health Foundation Board of Directors Andrew Cope, President, El Camino Health Foundation
Date:	October 29, 2019
Subject:	Report on El Camino Health Foundation Activities FY20 Period 3

Purpose: For information.

Summary:

1. Situation: During period 3 of fiscal year 2020, El Camino Health Foundation secured $77,343 in donations. September investment income is not available at the time. The period 3 fundraising report therefore shows a fundraising total of $1,240,957, which reflects donations through September 30, 2019 but investment income only through August 31, 2019.

2. Authority: N/A

3. Background:

Major & Planned Gifts

In September, the Foundation received a $3,000 sponsorship for the 2020 Allied Professionals Seminar, which supports planned giving and will be held at Palo Alto Hills Golf & Country Club on February 12, 2020. At this point in the fiscal year, major gift fundraising is focused on securing sponsorships for the upcoming El Camino Heritage Golf Tournament.

Fundraising Events

- *Golf Tournament*
  As of September 30, the Foundation had received $129,002 in support of the 24th annual El Camino Heritage Golf Tournament. The tournament sold out and the additional sponsorships as well as day-of donations will be reflected in future fundraising reports as payment is received. The event was held on Monday, October 28, 2019 at Sharon Heights Golf & Country Club and benefited the Peter C. Fung, MD Stroke Center. It was attended by 128 golfers and 190 dinner guests.

- *Spring Gala*
  This event will take place in the second half of the fiscal year. The donations reflected in the fundraising report are belated fulfillment of commitments to FY19 events.

- *Norma's Literary Luncheon*
  Sponsorship letters were mailed at the end of September. Responses will be reflected on future fundraising reports. However, the Foundation previously received a generous sponsorship from the Melchor family to cover expenses for the 2020 event. Norma's Literary Luncheon will take place on February 6, 2020 at Sharon Heights Golf & Country

Club. Lisa See, author of the bestseller *The Tea Girl of Hummingbird Lane*, will be the featured speaker.

Annual Giving

In September, the Foundation raised $15,093 in annual gifts from Hope to Health membership renewals, Circle of Caring grateful patient gifts, responses from the spring direct mail and online donations. This brings the annual giving total as of September 30 to $87,987. The Foundation's fall annual giving activities, including the Employee Giving Campaign, and direct mail appeals, launched in October and results will be reflected in future fundraising reports.

Stewardship

- Foundation Leadership Reception – The Foundation hosted a reception for Foundation board members, committee members and leadership volunteers on September 17.
- Taube Pavilion Opening – The Foundation hosted grand opening festivities for all Fulfilling the Promise donors on Thursday, October 24.
- Foundation Major Donor Reception – The Foundation will host a reception to honor major and legacy donors on November 14.
- Sobrato Pavilion Opening – The Foundation is planning an opening event, which will take place on November 17.

El Camino Health Foundation

FOUNDATION PERFORMANCE

FY20 Fundraising Report through 9/30/19 - Period 3

ACTIVITY		FY20 YTD (7/1/19 - 9/30/19)	FY20 Goals	FY20 % of Goal	Difference Period 2 & 3	FY19 YTD (7/1/18 - 9/30/18)
Major & Planned Gifts		$583,450	$5,500,000	11%	$3,000	$126,348
Special Events	**Spring Event**	$22,500	$350,000	6%	$0	$500
	Golf	$129,002	$325,000	40%	$59,250	$129,717
	South Asian Heart Center Event	$12,045	$200,000	6%	$0	$5,000
	Norma's Literary Luncheon	$70,000	$200,000	35%	$0	$2,500
Annual Gifts		$87,987	$600,000	15%	$15,093	$58,895
Investment Income*		$335,973	$500,000	67%		$581,260
TOTALS		***$1,240,957***	***$7,675,000***	***16%***	***$77,343***	***$904,220***

*Investment Income as of 8/31/19