

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

Wednesday, February 15, 2023 – 5:30 pm

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

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

1-669-900-9128, MEETING CODE: 916-8040-2721# No participant code. Just press #.

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	CALL TO ORDER/ROLL CALL	Bob Rebitzer, Board Chair		5:30 – 5:31 pm
2	POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Bob Rebitzer, Board Chair	Information	5:31 – 5:32
3	PUBLIC COMMUNICATION a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.</i> b. Written Correspondence	Bob Rebitzer, Board Chair	Information	5:32 – 5:35
4	MEDICAL STAFF REPORT	Prithvi Legha, MD, MV Chief of Staff Philip Ho, MD, LG Chief of Staff	Discussion	5:35 – 5:45
5	<u>QUALITY COMMITTEE REPORT</u>	Carol Somersille, MD Quality Committee Chair; Holly Beeman, MD Chief Quality Officer	Discussion	5:45 – 5:55
6	ADJOURN TO CLOSED SESSION	Bob Rebitzer, Board Chair	Motion <i>public comment</i>	5:55 - 5:56
7	POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Bob Rebitzer, Board Chair	Information	5:56 – 5:57
8	<i>Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets:</i> EL CAMINO HEALTH MEDICAL NETWORK SEMI-ANNUAL REPORT	Dan Woods, Chief Executive Officer Shahab Dadjou, President of El Camino Health Medical Network	Discussion	5:57 – 6:32
9	<i>Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets:</i> QUARTERLY FINANCE AND STRATEGIC/ FACILITIES CAPITAL ALLOCATION PROCESS UPDATE	Carlos Bohorquez, Chief Financial Officer	Discussion	6:32 - 6:47
10	<i>Report involving Gov't Code Section 54957(b) and 54956.9(d) for discussion and report on personnel matters and conference with Legal Counsel:</i> CEO REPORT	Dan Woods, Chief Executive Officer	Discussion	6:47 – 6:52
11	Report involving Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management: EXECUTIVE SESSION	Bob Rebitzer, Board Chair	Discussion	6:52 – 7:12

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
12	<p>CONSENT CALENDAR <i>Any Board Member may remove an item for discussion before a motion is made.</i></p> <p><u>Approval</u> <i>Gov't Code Section 54957.2:</i></p> <p>a. Minutes of the Closed Session of the Hospital Board (12/07/2022)</p> <p><i>Reviewed and Approved by the Investment Committee</i></p> <p>b. Surplus Cash – Reserve Fund Investment Policy</p> <p><i>Reviewed and Approved by the Medical Executive Committee</i> <i>Health & Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters:</i></p> <p>c. Credentialing and Privileges Report</p> <p><u>Information</u> <i>Reviewed and Recommended for Approval by the Finance Committee (2nd Open Session)</i></p> <p>d. Psychiatric Telehealth Services Renewal Agreement (Enterprise)</p>	Bob Rebitzer, Board Chair	Motion	7:12 – 7:13
13	ADJOURN TO OPEN SESSION	Bob Rebitzer, Board Chair	Motion	7:13 – 7:14
14	RECONVENE OPEN SESSION/ REPORT OUT	Bob Rebitzer, Board Chair	Information	7:14 – 7:15
	To report any required disclosures regarding permissible actions taken during Closed Session.			
15	<p>CONSENT CALENDAR ITEMS: <i>Any Board Member or member of the public may remove an item for discussion before a motion is made.</i></p> <p><u>Approval</u></p> <p>a. Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings</p> <p>b. Minutes of the Open Session of the Hospital Board (12/07/2022)</p> <p><i>Reviewed and Recommended for Approval by the Medical Executive Committee</i></p> <p>c. Policies, Plans, and Scope of Services</p> <p><i>Reviewed and Recommended for Approval by the Finance Committee</i></p> <p>d. Psychiatric Telehealth Services Renewal Agreement (Enterprise)</p> <p>e. Capital Project Request: MV & LG Pharmacy Upgrades</p> <p><i>Reviewed and Recommended for Approval by the Governance Committee</i></p> <p>f. Rules of Order of the Board of Directors of El Camino Hospital</p> <p>g. Board and Advisory Committee Education</p> <p>h. El Camino Hospital Board Director Compensation and Reimbursement</p> <p>i. Investment Committee Charter</p> <p><i>Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee</i></p> <p>j. Quality Committee Member Appointments</p>	Bob Rebitzer, Board Chair	Motion <i>public comment</i>	7:15 – 7:16
16	<p><u>Information</u></p> <p>k. Article of Interest - Advisory Board Webinar - HLTH State of the Industry</p>			

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
17	CEO REPORT a. Update b. Pacing Plan	Dan Woods, Chief Executive Officer	Information	7:16 – 7:26
18	BOARD COMMENTS	Bob Rebitzer, Board Chair	Information	7:26 – 7:29
19	ADJOURNMENT	Bob Rebitzer, Board Chair	Motion <i>public comment</i>	7:29 – 7:30 pm

Upcoming Regular Meetings: April 5, 2023; May 10, 2023; June 14, 2023

Special Sessions: March 8, 2023 (Board Retreat); August 2023 (Joint Board & Committee Education)

El Camino Hospital Board of Directors

To: El Camino Hospital Board of Directors
From: Carol Somersille, MD, Chair Quality, Patient Care and Patient Experience Committee and Holly Beeman, MD, MBA, Chief Quality Officer
Date: February 15, 2023
Subject: FY23 Second Quarter Board Quality Dashboard (STEEEP)

Purpose: To update the Board of Directors on FY23 Second Quarter Board Quality Dashboard (STEEEP) through end of FYQ2 unless otherwise noted. By striving to deliver care, which is Safe, Timely, Effective, Efficient, Equitable and Patient Centered, El Camino Health is focused on optimizing and improving our performance and processes in these six quality domains

Summary: The second quarter results are shown in green/yellow/red performance scheme. Measures shaded in **GREEN** are at or exceeding target. Those in **YELLOW** are within 5% of the target. Measures in **RED** are off target by greater than 5%.

- Safe Care:** The Hospital Acquired Condition (HAC) metric is a weighted composite of five individual measures. The methodology for this measure is modeled after the CMS 5-Star rating methodology. Second quarter performance is 1.25 (lower is better). HAC Index YTD is at 1.01, which is within 5% of target of 0.986. Below is a table with baseline HAC Index values from final FY22.

FY22 Baseline						
Metric	Num.	Den.	Rate	Weight	Weighted Rate	
C. Difficile Infection	37	patient days	xxx	0.10	0.355	
Surgical Site Infection	18	# surgeries	xxx	0.25	0.06	
nvHospital Acquired Pneumonia	115	patient days	xxx	0.20	0.365	
Falls	153	patient days	xxx	0.20	0.265	
Hospital Acquired Pressure Injury	8	patient days	xxx	0.25	0.022	
HAC Index	Sum »				1.066	

ECH FY23

HAC Index STEEEP Data Legend



Month to Quality Committee of the Board: February, 2023

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance				FYTD	
		FY22 Q1	FY22 Q2	FYTD Q1-2	FY22 Q3	FY22 Q4	FY 22	FY 23	FY23 Q1	FY23 Q2	FY23 Q3		FY23 Q4
Safe Care	HAC Index	1.05	1.3	1.09	1.6	0.86	1.066	0.986	0.90	1.25			1.01
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	8.0	7	14	9.25	8.56	7	13			18.0
	HAC Component: Surgical Site Infections (SSI)	5	4	4.5	7	2	4.5	4.16	6	7			6.5
	HAC Component: nvHAP	36	29	32.5	26	24	28.75	26.59	26	31			18.5
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	37.0	47	32	38.25	35.38	25	30			37.5
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	1.5	3	2	2.00	1.85	3	2			3.0



Cells in top row are values of HAC Index; sum of weighted rates of the five measures.

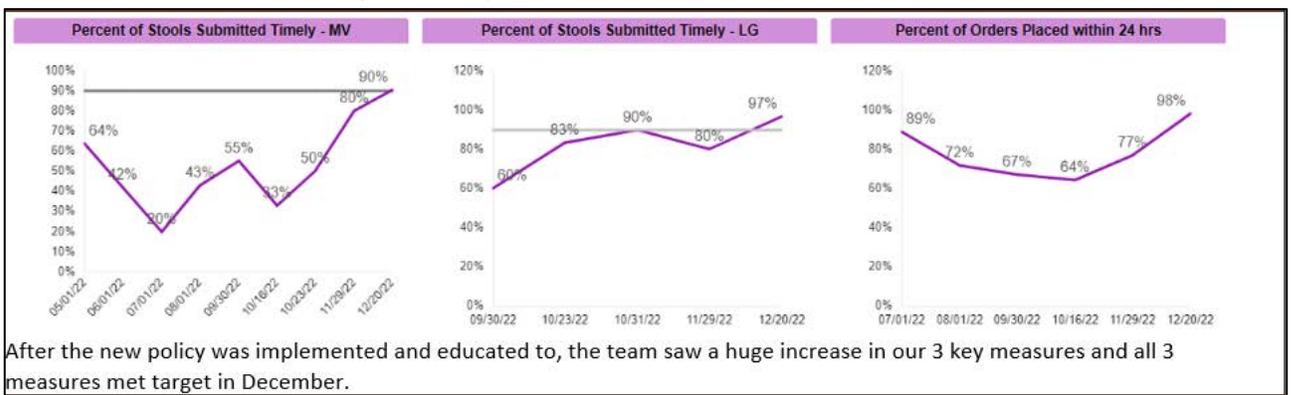


Cells in the individual measures rows are the number of events that occurred in the quarter.

A. **C Difficile Infection (C.Diff)**: Twenty ECH patients have acquired C.Diff since July 2022. Our FY23 target is to have ≤ 34 C. Diff infections. Of these 20 infections, 5 patients likely had C. Diff on admission but stool collection to confirm diagnosis was not performed timely (prior to 3rd midnight of patient's hospitalization). This resulted in these 5 patients' C. Diff infections being considered hospital acquired for reporting and measurement purposes. Fifteen patients 'truly' acquired C. Diff infection during their ECH hospitalization.

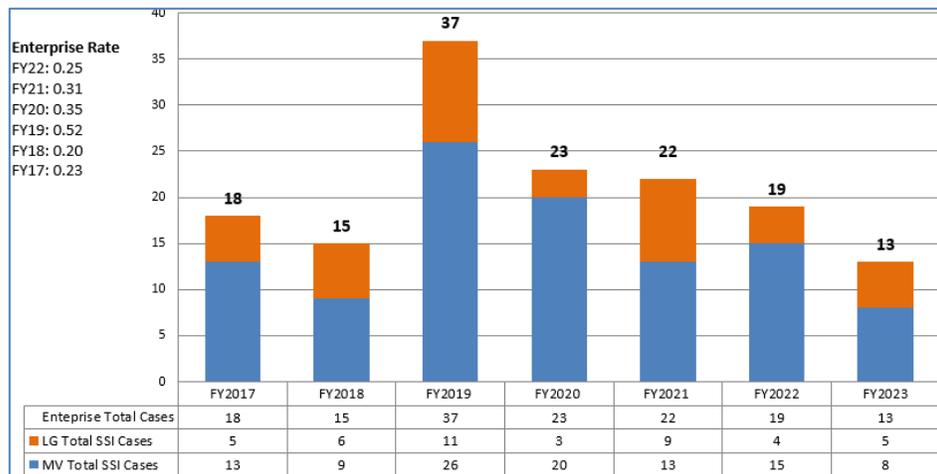
i. Process improvement efforts are focused on two broad opportunities: timely screening & testing of at risk & symptomatic patients and environmental hygiene to avoid nosocomial spread.

1. Timely stool collection from patients with C. Diff symptoms has improved significantly since roll out of new 'standard procedure' in October 2022.



2. Our policy and protocols for hand hygiene, personal protective equipment, and disposable supplies in isolation rooms are not being followed consistently. Focus and a call to action with detailed education, monitoring and improvement plans are in process for all three of these important practices.

B. **Surgical Site Infection (SSI)**: The target for SSI in FY23 is to have ≤ 17 surgical site infections. Year to date we have had 13 surgical site infections through December 2022. During this fiscal year there is a concerning increase in numbers of surgical site infections on our LG campus. There were 4 SSI in Los Gatos in FY22 and the number is at 5 for FY23. The breakdown by type of surgery is; colon surgery (3), hysterectomy (3), knee surgery (3), cholecystectomy (1), spine surgery (2), cesarean section (1). A review of the FY23 SSI and FY22 SSI has not revealed any trends or themes as to possible root causes of the infection. Management is in the process of trending infections going back 5 years to see if there are any surgeon specific patterns.



Current focus is addressing three 'general' opportunities to decrease surgical site infections;

1. Improve compliance with Enhanced Recovery after Surgery (ERAS) elements.
2. Using a clean tray, surgical gown and gloves to 'close' the incisions for appropriate surgical cases.
3. Enforce adherence to pre-surgical hair clipping procedure, so that hair clipping is completed in the pre-op area, not in the operating room.

- C. Non-ventilator Hospital Acquired Pneumonia-The number of patients developing pneumonia per quarter is 28.5, above our target of 26.59 per quarter. Key drivers of the above desired incidence of pneumonia are due to a lack of compliance with the bundle of interventions to decrease the risk of pneumonia. Management is focused on increasing compliance with oral care (4x per day for patients) and ensuring patients are sitting up in a chair for meals and that the head of the hospital bed is elevated.
- D. Falls—We have already missed the FY23 target of having < 35 patient falls per quarter. Year to date, there are 37.5 falls per quarter on our inpatient floors/units. In addition to monitoring compliance with hourly patient rounds, management is rolling out an enterprise-wide mobility initiative, championed by the medical director of Rehab, Dr. Meagan Littlepage. nvPneumonia, falls, pressures injuries are all impacted by our patient's mobility. The less our patients walk/move, the greater their risk of developing these hospital-acquired conditions. Rolling out the Hopkins Mobility program will help ECH manage the fine line between increasing mobility to decrease falls. *"Our current system of "keeping score" of falls has created a strong disincentive for mobilizing patients...Promoting mobility in the hospital while preventing falls aligns well with the broader healthcare missions of maintaining quality, decreasing costs, and enhancing patient-centered care".* (Growdon, 2017)
- E. Hospital Acquired Pressure Injury (HAPI): In FY22 we had 8 hospital acquired pressure injuries. Our performance FY23 is similar to FY22, not improved. Four ECH patients have had stage 3 or 4 pressure injuries YTD through November. There were no pressure injuries in December 2022. Current state assessment of HAPI prevention workflows reveals a gap in nursing training during new hire orientation. When orientation was transitioned from in person to virtual due to the pandemic, HAPI education was removed from general orientation and skills day. The gap in training (new and refresher) is being addressed with deployment of a 5 week "HAC-a-Thon" lead by our education team. There will be hands on skills training, and education on each of the 5 HAC measures, including, HAPI prevention. Kick off the HAC-a-thon is planned for February 2023.

2. Timely Care

- A. ED Imaging Turnaround Time: The FY23 enterprise target for imaging turnaround time in the ED is to have 84% of studies completed and read within 45 minutes. Current performance is not meeting target (78.3%) through November 2022. Drivers of the current performance are difficulty recruiting radiologists, technical and staffing issues of third party vendor performing night reads and the complexity

of radiology call coverage at night. Coverage challenges created a barrier for teams to escalate long reading times and know who in radiology to call to get a study read timely in the middle of the night. Improvement efforts are focused on leveraging technology to expand reading capability to radiologists who are remote from California and having clear escalation process and on-call schedule in “Amion” the platform used hospital wide for other service departments’ call schedules. Our ECH radiologists are proactive and engaged in improving performance.

3. **Effective**

- A. **Risk Adjusted Readmission Index:** Readmission Index for the month of November is 0.96, below (favorable) to our target of 1.00. YTD our index through November is 1.04. The readmission steering team is encouraged by the progress in decreasing readmissions for sepsis patients through collaboration and partnership with our Skilled Nursing Facilities (SNFs). Our sepsis coordinator has been to each of our partner SNFs to provide education, tools, and build relationships with the SNF staff to optimize collaboration between acute and post-acute settings. We are replicating this model for heart failure and oncology patients. As our census of COVID patients decreases, we anticipate a favorable impact on our overall readmission rate after having learned in FY22 that COVID patients are readmitted 26% of the time.
- B. **Risk Adjusted Mortality Index:** The risk adjusted mortality index for Q2 (1.07) is unfavorable to the target of 0.85. This unfavorable increase is attributed to sepsis mortality. 46% of the patients who died in November had sepsis. The next leading ‘cause’ of death was respiratory (24%).
- C. **Sepsis Mortality Index:** FYTD Sepsis Mortality Index for Q2 (1.26) exceeded the FY23 target of 0.98. A drop in compliance with completion of the 3-hour sepsis bundle in MV decreased concomitant with the increase in sepsis mortality. The Emergency Dept. leadership team has gone through a transition due to the passing of Dr. Cook, the previous Medical Director. Duties for improvement work in the ED are divided amongst several physicians. Quality and sepsis team looks to partner with the newly identified ED sepsis champion, Dr. Linker to understand why compliance with the sepsis bundle has declined, and, how we can support improvement efforts.



4. **Efficient**

- A. OP18b: Median Time from ED Arrival to ED Departure: The Q2 performance of 169 minutes is a favorable improvement from 176 minutes in first quarter. In the setting of peak ED census in Q2, the team is encouraged by this progress. The



Process Improvement team is deployed to the ED to complete value stream process walks to identify efficiency opportunities. This work began in January 2023. Four additional treatment areas 'chairs' to use for patients appropriate for 'Treat to Street' evaluation and treatment were deployed in January 2023. Having a dedicated space for this population of ED patients will favorably affect ED throughput. The lower acuity patients will be channeled into this more efficient route to being seen and treated timely.

5. Patient Centered

- A. IP Units –HCAHPS Likelihood to commend. Inpatient units did not meet target. FY23 Q2 performance is 78.8 < target of 81. However, there was improvement from Q1. Los Gatos was not at target the previous month but due to increased effort on nurse leader rounding, bedside shift report and purposeful rounding (known as the Power of 3), Los Gatos did achieve target this month. Los Gatos is also at target for FYTD. In our Mountain View campus, 3B increased substantially due to an increased focus on nurse leader rounding, nurse communication (key drivers) and WeCare behaviors. We will continue to spread and sustain these best practices.
- B. ED Likelihood to Recommend Top Box Rating. We did not meet our target for Q2 of FY23. FYQ2 performance of 72.3 < target of 75.0. Improvement in LTR and our key driver of staff worked together improved from prior quarter. We continue to have high census and acuity which impacts wait times. Only patients admitted to inpatient from the ED receive the survey for their ED experience. For those patients waiting greater than four hours, scores decline substantially. We are working on a plan to discharge lower acuity patients more efficiently. The new ED Navigator has started and is helping with communication about wait times and other customer service issues that arise.

- C. MCH – HCAHPS Likelihood to Recommend. FY23 Q2 performance is lower than goal of 81.5. The drivers of low satisfaction for our MCH patients are unchanged from Q1. These are construction noise, and visitor and family issues related to COVID restrictions. The recent change in our visitor policy helped. As the census increases, there was more patient movement, which resulted in dissatisfied patients and families.
- D. ECHMN Likelihood to Recommend Care Provider. We did not meet our target for Q2. FY23 Q2 performance of 81.6 < target of 83.4. Primary care and urgent care performance improved from Q1.

List of Attachments

Attachment 1—Board Quality Dashboard (STEEEP) FY23 Quarter two.

Bibliography

Growdon, M. S. (2017). The Tension Between Promoting Mobility and Preventing Falls in the Hospital. *JAMA Internal Medicine*, 759-760.



FY23 Quarterly Board Quality Dashboard (STEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance				
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	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	47	32	38.25	35.38	25	50			37.5
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	3	2	2.00	1.85	2	2			2.0
Timely	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	25% (1/4)	10% (1/10)	75.0% (6/8)	0% (0/6)	28.6% (8/28)	50%	50% (4/8)	71.4% (5/7)			60% (9/15)
	Stroke: Door-to-Groin <= 90 minutes	50% (1/2)	28.6% (2/7)	50% (1/2)	25% (1/4)	33.3% (5/15)	50%	100% (2/2)	75.0% (3/4)			83% (5/6)
	Imaging TAT: ED including Xray (target = % completed <= 45 min)	80.35%	79.68%	82.26%	74.14%	79.01%	84%	78.43%	78.34%			78.38%
Effective	Risk Adjusted Readmissions Index	1.05	0.96	1.12	1.06	1.05	1.00	1.02	1.04			1.03
	Risk Adjusted Mortality Index	0.99	0.92	0.99	0.85	0.94	0.85	1.03	1.07			1.05
	Risk Adjusted Sepsis Mortality Index	1.07	1.01	1.10	0.91	1.02	0.98	1.02	1.26			1.14
	PC-02 NTSV C-Section	25.8%	25.0%	24.1%	28.3%	25.80%	23.5%	---	---	---	---	---
Efficient	OP18b: Median Time from ED Arrival to ED Departure (Enterprise)	160 min	156 min	162 min	169 min	162 min	162 min	176 min	169 min			170 min
Equitable	% Patients - Ethnicity documented	98.1%	97.9%	97.8%	97.8%	97.9%	----	97.6%	97.0%			97.3%
	% Patients - Race documented	98.6%	98.5%	98.0%	98.1%	98.3%	----	97.8%	97.3%			97.6%
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	82.0	80.2	81.5	79.4	80.8	81	79.9	78.8			79.4
	ED - Likelihood to Recommend (PG)	73.1	75.8	77.4	71.5	74.5	75	70.3	72.3			71.3
	MCH - HCAHPS Likelihood to Recommend	79.4	81.0	82.1	82.8	81.3	81.5	72.3	71.1			71.8
	ECHMN (El Camino Health Medical Network)	---	---	83.6	82.8	83.2	83.4	81.1	81.6			81.4

Updated: 1/18/23

STEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

Legend:

Green: At or exceeding target
Yellow: Missed target by 5% or less
Red: Missed target by > 5%
White: No target

Cell: N7

Comment: Mary_Mc:

This displays the FYTD quarterly average.

Cell: B16

Comment: Readmission Index FY23Q2: displaying 2 months only; too early to run December '22 Readmission Index. MMc

Cell: B19

Comment: PC-02 Calendar:

FY22Q4 will be submitted to CMS 11/1; then reported on next STEEEP Feb, '23. FY23Q1 will be available for reporting after 2/1/23 upon submission to CMS. MMc

Cell: B20

Comment: Arith Obs LOS/Geo Exp LOS: Sep, '22 previously reported data was based upon all inpatients instead on only Medicare Inpatients. Corrected past data; notified Sr. Leadership. MMc

Cell: B23

Comment: % Ethnicity: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

Cell: B24

Comment: % Race: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

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

To: El Camino Hospital Board of Directors
From: Mary Rotunno, General Counsel
Date: February 15, 2023
Subject: Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings

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

Summary:

1. **Situation:** At the October 13, 2021 Board Meeting, the Board of Directors adopted Resolution 2021-10, which made findings to continue holding virtual public meetings under the Ralph M. Brown Act based on the continued state of emergency due to the COVID-19 pandemic and that either (a) the state of emergency continues to directly impact the ability to meet safely in person, or (b) state or local officials continue to impose or recommend measures to promote social distancing.
This Resolution relies on the September 21, 2021, recommendation by the Health Officer of the County of Santa Clara that public bodies continue to meet remotely due to their unique characteristics, such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to fully participate in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other recommendations at such meetings.
2. **Authority:** On March 17, 2020, in response to the COVID-19 pandemic, Governor Newsom issued Executive Order N-29-20, suspending specific provisions of the Brown Act in order to allow local legislative bodies to conduct meetings telephonically or by other means. On June 11, 2021, Governor Newsom issued Executive Order N-08-21, which placed an end date of September 30, 2021, for agencies to meet remotely. On September 16, 2021, Governor Newsom signed Assembly Bill 361 (2021) ("AB 361"), which allows for local legislative and advisory bodies to continue to conduct meetings via teleconferencing if the Board of Directors, by majority vote, makes the findings set forth in paragraph 1 above, not later than thirty (30) days after teleconferencing for the first time under the AB 361 rules, and every 30 days thereafter.
3. **Legal and Compliance Review:** ECH, outside counsel at Best Best & Krieger, LLP ("BB&K"), reviewed the legislation and prepared Resolution 2021-10.

Attachment:

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

RESOLUTION 2021-10

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOES: None

ABSENT: None

ABSTAIN: None

ATTEST:

DocuSigned by:

Lanhee Chen

71D3D3DB297E475

Chair,
El Camino Hospital Board of Directors

DocuSigned by:

Julia Miller

30CE6DD0430C4ED

Secretary,
El Camino Hospital Board of Directors



**Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, December 07, 2022**

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

Board Members Present

Bob Rebitzer, Chair
Lanhee Chen, JD, PhD
Peter Fung, MD
Julie Kliger, MPA, BS
Julia E. Miller,
Secretary/Treasurer
Carol A. Somersille, MD
George O. Ting, MD
Don Watters
John Zoglin

Others Present

Dan Woods, CEO
Mark Adams, MD, CMO
Meenesh Bhimani, MD, COO
Carlos Bohorquez, CFO
Deanna Dudley, CHRO
Ken King, Chief Administrative
Services Officer
Deb Muro, CIO
Cheryl Reinking, CNO
Andreu Reall, VP of Strategy
Vineeta Hiranandani, VP of
Marketing**

Others Present (cont.)

Priya Shah, Assistant General
Counsel
Shahab Dadjou, Interim President,
El Camino Health Medical Network
Diane Wigglesworth, Senior
Director of Corporate Compliance
Tracy Fowler, Director,
Governance Services
Stephanie Iljin, Manager,
Administration
Brian Richards, Information
Technology

Board Members Absent

Jack Po, MD, Ph.D., Vice-Chair

**via teleconference

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 5:31 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.	Meeting called to order at 5:32 p.m.
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board for declarations of conflict of interest with any items on the agenda. None were reported.	
3. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board, and no comments were made.	
4. DISTRICT BOARD UPDATE	Director Miller provided an update from the El Camino Healthcare District Board. Directors Fung and Ting were re-appointed to the ECHD Board by the Santa Clara County Board of Supervisors on September 13, 2022 and sworn into office on December 5, 2022 at the meeting of the El Camino Healthcare District Board of Directors.	
5. ADJOURN TO CLOSED SESSION	Motion to adjourn to closed session at 5:36 p.m. pursuant to <i>Gov't Code Section 54957.2</i> for approval of the minutes of the Closed Session of the Hospital Board (11/9/2022); pursuant to <i>Health and Safety Code Section 32155</i> for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: (Medical Staff Credentialing & Privileges Report); pursuant to <i>Health and Safety code Section 32106(b)</i> for a report and discussion involving health care facility trade secrets: (Physician Alignment Update); pursuant to Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management (FY22 Annual Compliance Update, and Executive Session).	Adjourned to closed session at 5:36 p.m.

	<p>Motion: to adjourn to closed session at 5:36 p.m.</p> <p>Movant: Miller Second: Fung Ayes: Chen, Fung, Kliger, Miller, Po, Rebitzer, Ting, Watters, Zoglin Noes: None Abstentions: None Absent: Po, Somersille Recused: None</p>	
<p>6. AGENDA ITEM 12: RECONVENE OPEN SESSION/ REPORT OUT</p>	<p>Open Session was reconvened at 6:47 p.m. by Chair Rebitzer. Agenda Items 6-10 were addressed in closed session.</p> <p>During the closed session, the El Camino Hospital Board of Directors approved the minutes of the Closed Session of the Hospital Board (11/9/2022), and the Credentials and Privileges Report, by a unanimous vote of all Directors present (Directors Chen, Fung, Kliger, Miller, Rebitzer, Somersille, Ting, Watters, and Zoglin). Director Po was absent.</p>	
<p>7. AGENDA ITEM 13: CONSENT CALENDAR ITEMS</p>	<p>Chair Rebitzer asked if any member of the Board or the public wished to remove an item from the consent calendar for discussion.</p> <p>Motion: to approve the consent calendar to include:</p> <ol style="list-style-type: none"> a. Minutes of the Open Session of the Hospital Board (11/9/2022) b. Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings c. Affiliate Covered Entity (ACE) Resolution <p><i>The following was reviewed and recommended for approval by the Medical Executive Committee:</i></p> <ol style="list-style-type: none"> d. Policies, Plans, and Scope of Services <p><i>Reviewed and Recommended for Approval by the Finance Committee:</i></p> <ol style="list-style-type: none"> e. Orthopedic Co-Management Agreement <p>Movant: Somersille Second: Fung Ayes: Chen, Fung, Kliger, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin Noes: None Abstentions: None Absent: Po Recused: None</p>	<p>Consent calendar approved</p>
<p>8. AGENDA ITEM 14: CEO REPORT</p>	<p>Mr. Woods provided a brief CEO report including the following highlights:</p> <ul style="list-style-type: none"> • The perinatal diagnostic center moved to an expanded space with Sobrato pavilion and has increased capacity by 30%. The PDC is a multi-disciplinary team 	

	<p>including Maternal-Fetal Medicine specialists (high-risk Obstetricians), ultrasonographers and genetic counselors to support women during high-risk pregnancies.</p> <ul style="list-style-type: none"> • October financial results were favorable to budget by \$16.8 million, but \$8.0 million lower than the same period last year. Favorable net income results to budget were mainly attributed to unrealized gains on investments. • We are now live with Workday Supply Chain as of October 31st. It was a smooth go-live due to the coordination between IT, supply chain, management, and leadership. It was a nine-month project that culminated in our transition off of PeopleSoft, creating a fully integrated Enterprise Resource Plan (ERP) using Workday. • El Camino Health Foundation secured \$270,052. This brings the total fundraising year to date to \$4,747,393, which is 49% of the \$9,620,000 annual goal. • The Auxiliary donated 3,101 volunteer hours for the month of October. 	
<p>9. AGENDA ITEM 15: BOARD COMMENTS</p>	<p>Chair Rebitzer asked if there were any comments from the board members.</p> <p>Board members requested further discussion regarding the behavioral health program and nursing labor force, and tours of new facilities and clinics.</p>	<p><i>Follow-up: Agendize discussion on Behavioral Health Program and Nursing Labor Force.</i></p>
<p>10. AGENDA ITEM 16: ADJOURNMENT</p>	<p>Motion: to adjourn at 6:59 p.m. Movant: Watters Second: Chen Ayes: Chen, Fung, Kliger, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin Noes: None Abstentions: None Absent: Po Recused: None</p>	<p><i>Meeting adjourned at 6:59 p.m.</i></p>

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

Tracy Fowler, Director of Governance Services

Prepared by: Stephanie Iljin, Manager of Administration
Reviewed by: Tracy Fowler, Director of Governance Services



Department	Policy Name	Revised	Doc Type	Notes	Committee Approvals
New Business					
Imaging Services	1. Scope of Service – Imaging Services	Revised	Scope of Svc	<ul style="list-style-type: none">Updated tables (TAT and Hours of Operation)	<ul style="list-style-type: none">ePolicyMEC
Human Resources	2. Human Resources Division Scope of Service	Revised	Scope of Svc	<ul style="list-style-type: none">Minor update	<ul style="list-style-type: none">HR LeadersePolicyMEC



Origination 02/2017
Last Approved N/A
Effective Upon Approval
Last Revised 10/2022
Next Review 3 years after approval

Owner Aletha Fulgham:
Assistant
Director Imaging
Svc
Area Scopes of
Service

Scope of Service - Imaging Services

Scope:

The Imaging Department Scope of Service is provided by ECH to ensure that all patients treated will receive high quality care in an expedient and professional manner. Performance standards and quality initiatives are in place to measure outcomes and meet patient and clinician needs. Patient reports and exam records can be accessed upon request and are stored indefinitely as part of the patient's Electronic Health Record (EHR). Images are stored in the hospital's Picture Archiving and Communication System (PACS).

Patient Types

Exams and procedures are performed on inpatients, outpatients and emergency department patients. Patient age groups served are neonatal, pediatric, adolescent, adult and geriatric.

Imaging Services provides support to all departments located within the two El Camino campuses. Imaging studies are performed upon receipt of a written or electronic request from a physician or licensed independent practitioner.

Services Offered

Imaging Modalities on the **Mountain View** Campus are:

- General Diagnostic Radiography
- Magnetic Resonance Imaging (MRI)
- Nuclear Medicine
- Ultrasound
- Mammography
- Fluoroscopy
- Computerized Tomography (CT)
- PET/CT
- Vascular Imaging
- Interventional Radiology

Imaging Modalities on the **Los Gatos** Campus are:

- General Diagnostic Radiography
- Magnetic Resonance Imaging (MRI)
- Nuclear Medicine
- Vascular Imaging

Interventional Radiology
Fluoroscopy
Computerized Tomography (CT)
PET/CT
Ultrasound
Mammography

Nuclear Medicine-Specifics

Nuclear Medicine-Specifics

On-call services are provided on a limited basis on weekends. The following exams are approved for on-call services:

- A. **GI Bleed:** Patient must be actively bleeding in order for the study to render diagnostic value.
- B. **Lung V/Q Scan**
- C. **Gallbladder (HIDA Scan)**
- D. **Stress Tests, * must be coordinated with Nuclear Medicine and scheduled only if all resources are available.**

Interventional Radiology

Types and ages of patients served:

Adult inpatients and outpatients. Adolescent patients who are at least 13 years of age AND weigh 80 pounds (36.4 kg) or more.

Staffing Guidelines for Operating Room Coverage

At least two (2) radiologic technologists are scheduled to cover the operating room Monday through Friday until 4:30pm at the Mountain View campus, 3:30pm at the Los Gatos campus. After these times and on weekends, the department utilizes the OR call schedule for surgery cases. The surgery department will work very closely with the diagnostic charge tech or modality operations manager during the scheduling of exams that require radiological support.

Appropriateness, Necessity and Timeliness of Services

Imaging Services assesses the appropriateness and necessity of diagnostic and therapeutic procedures by evaluating the patient's clinical history for pertinence to the exam ordered, as well as evaluating the exam history in order to avoid unnecessary duplication of procedures. Prior to interventional or special procedures, the technologist and/or Imaging Services RN will review exam indications as well as any possible contraindications, and bring these concerns to the Radiologist.

The timeliness of radiologic services is addressed in departmental procedures which describe how to contact a radiologist after hours, as well as performance of routine and stat procedures.

STAT exams are to be started within 1 hour of physician's order.

Imaging Services follows hospital-wide policies for reporting incidents by utilizing the electronic incident reporting system.

Radiologists

Diagnostic and therapeutic radiologic services are available by board-certified or board-eligible radiologists. Silicon Valley Diagnostic Imaging (SVDI) is contracted to ensure radiology services are available 24 hours a

day. Licensure information of contracted radiologists is maintained in the Medical Staff office. SVDI provides a Radiation Safety Officer to oversee the Radiation Protection Plan and Radiation Safety Committee.

Service Hours: Hours of service are according to the Radiologists' posted schedule, which includes call hours to provide additional consultation or to perform emergency procedures on site. Teleradiology is available after posted hours seven days a week.

Imaging Reports: Reports for all Imaging exams are generally available within 24 hours; exceptions include the unavailability of comparison exams. STAT interpretations are available for all imaging studies; exceptions include when there are multiple stat patients, issues with patient condition, and/or a delay in securing radioisotopes. Referring physicians may denote their preference for obtaining reports, e.g., fax, or electronic distribution, mail, etc.

Turnaround Times (TAT) Turnaround Times (TAT)		
Patient Class	End Exam to Results	
Target	Max	
ED	30 mins	45 mins
IP <u>STAT</u>	32 hours	6 hours
<u>IP Routine</u>	<u>6 hours</u>	
<u>OP STAT</u>	<u>4 hours</u>	
OP <u>Routine</u> (except mammo)	3 hours	24 hours

Mammography

- A. All BIRADS Results
 - 1. A written lay summary is provided to all patients, and report provided to health care provider within 30 days of examination.
 - 2. Copy of lay letter to patient included in patient's EHR.
- B. "Suspicious" or "Highly suggestive of malignancy"
 - 1. Communicated to patient within five (5) business days from the interpretation date.
 - 2. Communicated to health care provider within three (3) business days from the interpretation date.
- C. BIRADS 0 "Incomplete" or "Needs additional imaging"
 - 1. Communicated to patient within five (5) business days from the interpretation date.
 - 2. Report provided to health care provider within three (3) business days of the interpretation date.

Modality Protocols:

All modality protocols are established based on current standards of practice and other key criteria, which include clinical indication, contrast administration, age, patient size and body habitus. In addition to these key criteria, CT Protocols include the expected radiation dose range.

Protocols are reviewed by the modality Quality Teams and approved by the Radiologist section chief biennially (every 2 years). Protocols are revised as needed in between the regular review period. Modality protocols are maintained by the department and are accessible by all clinical staff members. Clinical situations often warrant protocol adaptation due to unique patient circumstances or presentation.

Staffing/Skill Mix and Requirements

The Senior Systems Director has oversight of entire Imaging Service line across the Health System. The Assistant Director oversees department Operations. The director is further supported by clinical managers. The daily work of each modality is organized by the Charge Technologist in each modality and/or shift.

This department has a Coordinator of Quality and Education that supports the director related to quality, regulatory and compliance activities. The Imaging Services Education Coordinator oversees students from the Foothill College Radiologic Technology Program and assists with onboarding of new staff. Specific sonographers are assigned to work directly with students from the Foothill College Diagnostic Medical Sonography Program.

RNs are assigned from the nursing division to provide nursing care, Monday through Sunday, either scheduled or on call. Off-hour nursing coverage for emergent cases may be provided by direct care nursing staff assigned by the nursing supervisor. Radiology Nurses hold current Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) certification.

Technologists have graduated from an accredited Radiologic Technology program and are registered by the American Registry of Radiologic Technologists (ARRT) in their respective modalities. All Radiologic Technologists hold current Certified Radiologic Technologist (CRT) licenses as required by the State of California, Title 17. In addition, all technologists who perform fluoroscopy or mobile fluoroscopy hold a current Fluoroscopy permit, and Mammographers hold a current state Mammography certificate. Ultrasound procedures are performed or supervised by Sonographers who are registered by the American Registry of Diagnostic Medical Sonographers (ARDMS). Nuclear Medicine procedures are performed by Nuclear Medicine Technologists who hold a current Certified Nuclear Medicine (CNMT) certificate as required by the State of California, Title 17. Scope of Practice or Practice Standards for technologists are established by the professional societies that represent them.

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

Consulting Services, Interventional Radiologists: Routine and emergent interventional procedures are performed by contracted physicians at both campuses.

Consulting Services, Medical Physicists: Imaging Services maintains a contract for consultation on an "as needed" basis and for routine quarterly surveys in Nuclear Medicine, as well as annual surveys for all other equipment, as required. Medical physics assessment requests, such as fetal dose calculation or personnel badge review, may be requested. The Imaging Department retains survey records and annual physics surveys, which are available for review. Physicists supervise equipment monitoring activities, review the findings, and make recommendations regarding radiation exposure factors, ACR quality guidelines, and quality analysis.

Radiation Safety Officer (RSO) AND Radiation Safety Committee:

SVDI provides a Radiation Safety Officer (RSO) for hospital-wide needs. The RSO oversees the Radiation Protection Plan and the Radiation Safety Committee. The Radiation Safety Committee has a multidisciplinary membership that meets quarterly to review any radiation safety concerns.

Clinical Engineering (Imaging Services Equipment):

The Clinical Engineering Department works closely with vendors to provide all equipment preventive maintenance based on the manufacturer's recommendations. These records are retained for review.

Standards of Practice

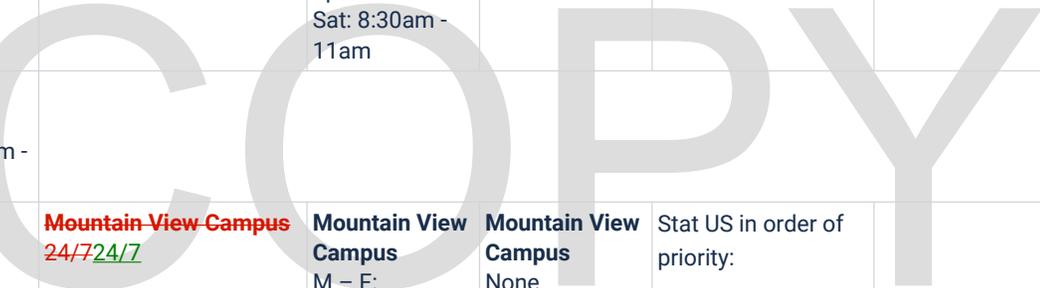
Radiation and radioactive materials are governed by California Department of Public Health, Radiologic Health Branch, state regulations Titles 17 and 22, and the Nuclear Regulatory Commission. The Department follows guidelines set forth by these agencies as well as the American College of Radiology (ACR), and standards established by the Joint Commission.

Security Considerations

Imaging Services follows all hospital security policies and procedures to ensure compliance with hospital security mandates. Radiology applications and PACS user access is available to Imaging Services staff, Radiologists contracted with El Camino Hospital, students, and other El Camino Hospital staff as deemed appropriate by Imaging Services leadership.

Hours of Operation

Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On-Call Services	
Diagnostic Imaging	24/7	Mountain View Campus M - F: 7am - 7pm Mountain View Campus M - F: 7am - 7pm Sat: 8a - 4p	None	OR Cases or Influx of Patients	
Los Gatos Campus M - F: 7am - 7pm					
Computed Tomography	24/7	Mountain View Campus M - F: 8am to 7pm Sat: 8:30am - 11am	None	N/A	
Los Gatos Campus M - F: 7:30am - 7pm					
Ultrasound	Mountain View Campus <u>24/7</u> <u>24/7</u>	Mountain View Campus M - F: 8am-3:30pm	Mountain View Campus None	Stat US in order of priority: 1. Suspected Ruptured AAA, aortic aneurysm 2. Scrotal US: torsion, pain 3. Pelvic US: ectopic, ruptured ectopic, torsion, bleeding in pregnancy	
Los Gatos Campus <u>24/7</u> <u>M - F: 8am - 6:30pm</u> <u>*excludes holidays</u>	Los Gatos Campus <u>MSa/Su: 7am - F: 812am - 3:30pm</u> <u>*excludes holidays</u>	Los Gatos Campus M - F: 4pm - 12am Sa/Su: 7am - 12am			



Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On-Call Services	
Magnetic Resonance Imaging	<u>24/7</u>	Mountain View Campus <u>24/7 M - F: 8am - 5pm</u>	Mountain View Campus <u>M - F: 8am - 4pm</u> <u>None</u>	Mountain View Campus No-Call	<i>MV & LG ED physicians triage and prioritize requests. Stat MRI in order of priority:</i> <ol style="list-style-type: none"> 1. R/O cord compression 2. Stroke/Bleed 3. Compression fracture spine 4. Appendicitis in pregnant patients 5. Others as they come on first come first serve
Los Gatos Campus <u>24/7 M - F: 8:30am - 7pm</u>	Los Gatos Campus <u>MSa/Su: 10a - 4pm</u> <u>F: 8:30am - 6pm</u>	Los Gatos Campus No-Call			
Mammography	N/A	Mountain View Campus <u>M - F: 7:30am - 4pm</u>	N/A	N/A	
Los Gatos Campus <u>M - F: 8am - 3:30pm</u>					
Nuclear Medicine	<u>M - F: 7am - 3:30pm</u>	<u>M - F: 8am - 3:30pm</u>	<u>Sa/Su: 7a - 7p</u>	<i>GI Bleed</i> <i>Lung V/Q Scan</i> <i>Gallbladder (HIDA Scan)</i> <i>Stress Tests must be coordinated with Nuclear Medicine and scheduled only if all resources are available.</i>	
Interventional Radiology (MV)	<u>M - F 7:30am-6:30pm</u> Off-Hours: Cath Lab and/or OR	<u>M - F 7:30am-6:30pm</u> Off-Hours: Cath Lab and/or OR	Holidays and Weekends (Varies) <u>8:00am-6:30pm</u>	<i>Stat Interventional Exams</i>	
Interventional Radiology (LG)	<u>M - F 7:30am - 5:30pm</u> Off-hours: OR	<u>M - F 7:30am - 5:30pm</u>	<u>S/S: 7am - 7pm</u> Off-hours: OR	<i>Stat Interventional Exams</i>	

Modality	Inpatient Hours	Outpatient Hours	Call Hours	Exams Approved by Department for On-Call Services	
		Off-hours: OR			
Radiologist	Review the current Radiologist's schedule for hours and call. https://app.qgenda.com/landingpage/svdi	<i>Stat Fluoroscopy cases after hours</i>			

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Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	01/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2022
Department Medical Director or Director for non-clinical Departments	Aletha Fulgham: Assistant Director Imaging Svc	10/2022
	Aletha Fulgham: Assistant Director Imaging Svc	10/2022

History

Draft saved by Fulgham, Aletha: Assistant Director Imaging Svc on 10/21/2022, 11:36AM EDT

Edited by Fulgham, Aletha: Assistant Director Imaging Svc on 10/21/2022, 11:37AM EDT

Updated Rad TAT
Formatting
Updated Service hours - various

Last Approved by Fulgham, Aletha: Assistant Director Imaging Svc on 10/21/2022, 11:37AM EDT

Last Approved by Fulgham, Aletha: Assistant Director Imaging Svc on 10/21/2022, 11:38AM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 11/9/2022, 12:17PM EST

ePolicy 11/4/22

Last Approved by Encisa, Franz: Director Quality and Public Reporting on 1/5/2023, 12:21PM EST

MEC 11/17/22

Status **Pending** PolicyStat ID **12600167**



Origination 12/2015
Last Approved N/A
Effective Upon Approval
Last Revised 10/2022
Next Review 3 years after approval

Owner Tamara Stafford:
Dir Talent Development & EWHS
Area Scopes of Service
Document Type Scope of Service/ADT

Human Resources Division - Scope of Service

Clients Served

The Human Resources Division provides services to all types of workers at El Camino Hospital including but not limited to employees, retirees and their families, and a limited scope of services to contingent labor agency staff, contractors, volunteers, and students. In addition, the Division interacts with job applicants from the general public.

Scope and Complexity of Services Offered

The Human Resources Division partners with internal and external stakeholders to strategically plan and implement programs and actions which drive organizational results. The Chief Human Resources Officer oversees Talent Acquisition, Human Resources Information Systems, Human Resources Operations which includes Employee and Labor Relations, Total Rewards (compensation & benefits), Employee Wellness & Health Services, **Safety, General Education**, **Talent Development** and Clinical Education. The Division maintains operations at the Mountain View and Los Gatos campuses.

Services include, but are not limited to, partnering with stakeholders on:

- Staffing & recruitment strategies;
- Employee engagement and retention
- Salary administration and compensation analysis;
- Employee benefit and pension programs including counseling employees and retirees;
- Employee relations,
- Performance management and performance improvement;

- Staff development and education
- Employee Wellness
- Employee injury and exposure prevention and management
- Leave and disability management, workers compensation
- Human resources regulatory compliance
- Labor Relations;
- Workforce planning
- Development and interpretation of human resources policies
- Job descriptions and the performance evaluation program

The activities of the Human Resources Division are conducted in compliance with guidelines set forth by laws governing civil rights, wages and hours, labor relations, employee benefits, employee health and safety, and within other federal, state, and local requirements. Division employees interact with all levels of personnel, medical staff, governing board, corporate legal counsel, third party administrators, consultants, representatives of regulatory agencies, insurance companies, and the general public.

Staffing

Services are provided by managerial, human resources business partners and specialists, clinical and general educators, **safety**, **talent development** specialists, and administrative staff.

Level of Service Provided

The Human Resources Division provides services under hospital policy and procedure guidelines.

Standard of Practice

The Human Resources Department is governed by state and federal regulations, including, but not limited to, ERISA, the Fair Labor Standards Act, the Department of Labor, Public Employee Relations Board, and the California Industrial Welfare Commission Wage Orders. The Human Resources Department is also governed by the Department of Health Services and Joint Commission requirements.

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Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	Pending

MEC	Franz Encisa: Director Quality and Public Reporting [PS]	01/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2022
HR Leaders including CHRO	Tamara Stafford: Dir Talent Development & EWHS	11/2022
Contributor Input	Tamara Stafford: Dir Talent Development & EWHS	10/2022
	Tamara Stafford: Dir Talent Development & EWHS	10/2022

History

Comment by Stafford, Tamara: Dir Talent Development & EWHS on 8/20/2021, 4:31PM EDT

I made minor updates to this HR Scope of Service. Note, there are also specific scopes of service for EWHS, Talent Development and Clinical Education.

Comment by Souza, Greg: Chief Human Resources Officer on 8/20/2021, 5:20PM EDT

Looks good to me

Edited by Stafford, Tamara: Dir Talent Development & EWHS on 10/31/2022, 1:40PM EDT

Minor changes to department names

Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 10/31/2022, 1:40PM EDT

Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 10/31/2022, 1:41PM EDT

HR Leaders 10/26/22

Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 11/9/2022, 7:26PM EST

HR Leaders Approval 11/09/22

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 12/14/2022, 12:53PM EST

ePolicy 12/9/22

Last Approved by Encisa, Franz: Director Quality and Public Reporting on 1/5/2023, 12:12PM EST

COPY

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

To: Board of Directors
From: Meenesh Bhimani, COO
Ken King, CAO
Date: February 15, 2023
Subject: Capital Project Requests – MV & LG Pharmacy Upgrades

Recommendation:

The Board Finance Committee recommends the Board’s approval of two regulatory compliance projects, the MV Pharmacy Upgrades Project not to exceed \$7.32 million, and the LG Pharmacy/Pathology Upgrades Project not to exceed \$5.42 million.

Summary:

1. **Situation:** El Camino Health has 4 pharmacy locations where sterile and hazardous drug compounding takes place and only one of these locations meets all of the new United States Pharmacopoeia, USP 797 (Sterile Compounding) & USP po800 (Hazardous Compounding) Standards. The deadline for compliance with these standards was delayed several times over the past three years, however, the November 1, 2022, Final Revisions indicate that compliance becomes official by November 1, 2023.

MV Main Pharmacy	Non-Compliant	Upgrades Required
LG Main Pharmacy	Non-Compliant	Upgrades Required
MV Cancer Center	Partially-Compliant	Upgrades Required (Future Project)
LG Cancer Center	Compliant	

The standards ensure that the process of compounding drugs is safe for pharmacists and patients. Capital funding to support the reconstruction and equipment installations is necessary to create compliant compounding environments, which are similar to “Clean Room” environments.

2. **Authority:** Funding exceeding \$5 million requires Board Approval with a recommendation from the Board Finance Committee.
3. **Background:** Compounding sterile and hazardous medications in California hospitals requires a license issued by the California Board of Pharmacy, which is regulated by the California Department of Public Health. The California Board of Pharmacy has adopted the USP 797 & USP 800 standards established by the United States Pharmacopoeia. These standards include specific requirements for engineered and constructed environments where sterile and hazardous compounding is performed.

We began evaluating our existing environments for compliance with these evolving standards in the summer of 2019. The impacts of the COVID-19 pandemic caused regulators to extend the compliance deadline, which allowed us time to exhaust all possible options for compliance.

In MV, we initially believed that we needed to run new exhaust ducts from the basement to the roof in order to accommodate the exhaust requirements of the safety hoods. Upon detailed analysis and research, we discovered that the single B2 classified safety hood we currently use, could be replaced with two A2 classified safety hoods without new exhaust duct runs. A technical study confirmed that the airflow demand of the B2 classified hood is

Capital Project Requests – MV & LG Pharmacy Upgrades
February 15, 2023

not required for the quantities of hazardous compounding typically performed in a hospital pharmacy. This resulted in a significant reduction in the project cost and operational impact.

In LG, we are severely constrained for space to accommodate a compliant compounding environment in the existing pharmacy, therefore necessitating the relocation of the pathology functions to space across the hall. The result being that both the pharmacy and pathology functions will be in safer, more efficient environments.

OSHPD has reviewed and approved both projects and permits are pending.

4. Assessment: These two projects require demolition and reconstruction of space within and adjacent to the existing pharmacies. The furniture, fixtures, and equipment (FF&E) include the safety hoods and miscellaneous systems furniture. The capital spend for both projects is included in the FY-23 project spend forecast.

The not to exceed the cost of these two projects is as follows:

MV Pharmacy 797/800 Upgrades	
Construction	\$5,355,000
FF&E	\$492,000
Soft Costs	\$1,124,704
Contingency @ 5 %	\$349,860
Total Project Cost	\$7,321,564
Rounded	\$7,320,000

1922 - LG Pharmacy 797/800 & Pathology Upgrades	
Construction	\$3,982,292
FF&E	\$345,881
Soft Costs	\$833,873
Contingency @ 5 %	\$258,102
Total Project Cost	\$5,420,149
Rounded	\$5,420,000

The cash flow projection for these two projects is as follows:

	CASH FLOW PROJECTION		
	Spend to Date	Projected FY-23 Spend	Projected FY-24 Spend
MV Project	\$227,000	\$1,106,000	\$5,900,000
LG Project	\$280,000	\$981,000	\$4,100,000

5. Other Reviews: The Finance Committee and Pharmacy Department leadership and the Executive Capital Committee have reviewed and approved both of these project requests.
6. Outcomes: The target completion date of both projects is 12 months from the start of construction, which will be finalized upon the approval of funding. The critical element is the projected delivery of new safety hoods, which currently have a 6-month lead time from the

Capital Project Requests – MV & LG Pharmacy Upgrades
February 15, 2023

date of order. Upon completion of these two projects, we will have compliant compounding environments in both the MV and LG main pharmacies.

List of Attachments: PowerPoint Presentation



El Camino Health

MV & LG Pharmacy Upgrade Projects

Board of Directors

Meenesh Bhimani, COO

Ken King, CAO

February 15, 2023

The Request

The Board Finance Committee recommends the Boards approval of capital funding for the following two regulatory compliance projects:

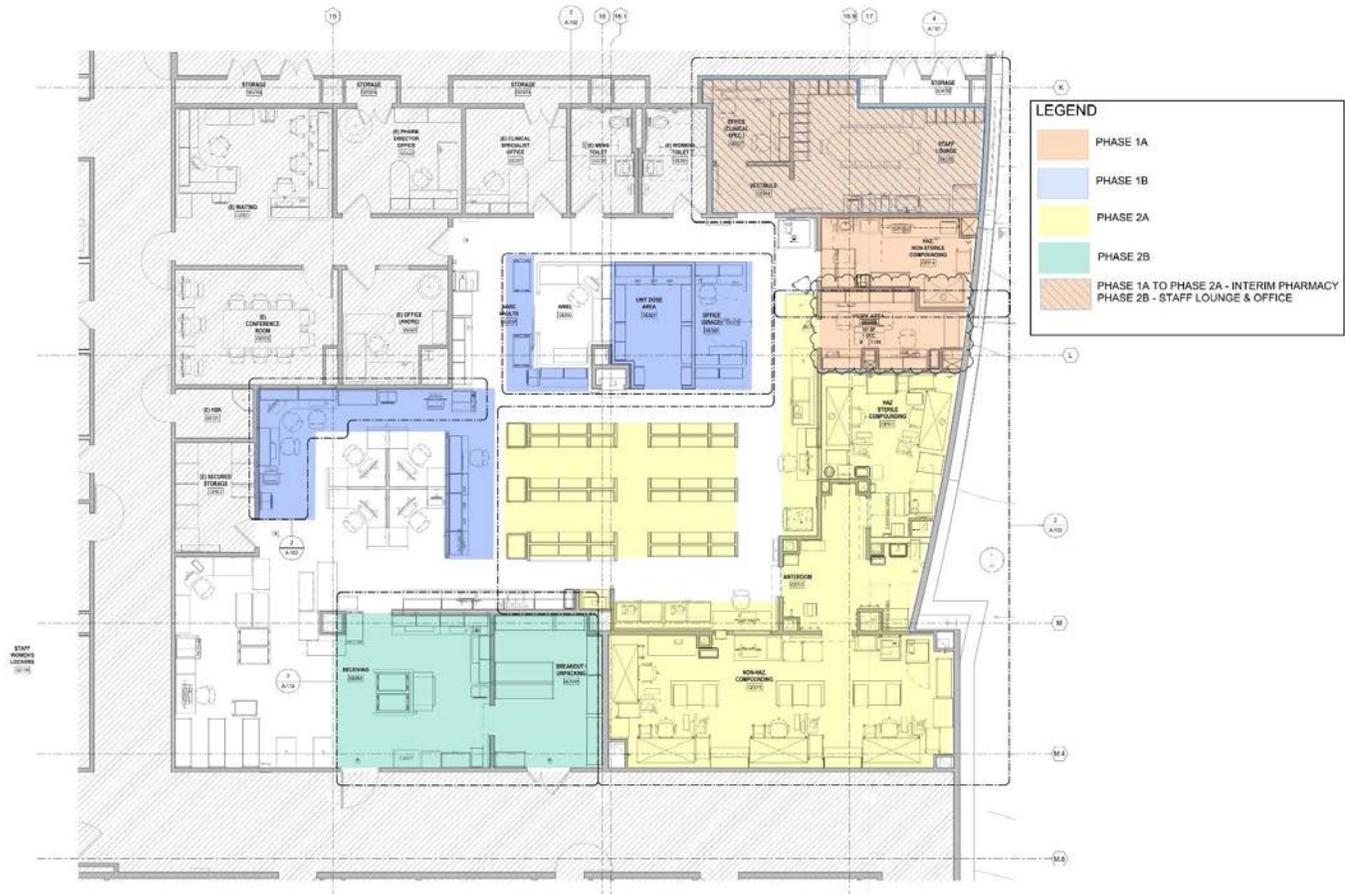
- MV Pharmacy Upgrades Project not to exceed \$7.32 million
- LG Pharmacy/Pathology Upgrades Project not to exceed \$5.42 million

Background

- United States Pharmacopoeia – USP 797 & USP 800 Standards require pharmacies that compound Sterile and Hazardous drugs to be in compliance with the standards, which become official on November 1, 2023.
- Compliance is regulated by the California Board of Pharmacy and the California Department of Public Health.
- The standards have been contemplated for the past few years, but due to the pandemic, compliance dates were extended.
- We began evaluating and planning to implement compliance solutions in the summer of 2019.
- Final solutions involve the installation of certified bio-safety hoods in “Clean Room” environments that must meet very specific specifications.

MV Pharmacy Project Plan

- 4 Phases of Construction & Installation while maintaining safe operations of pharmacy services.



LG Pharmacy Project Plan

- 4 Phases of Construction & Installation while maintaining safe operations of pharmacy services.
- Initial phase is the required relocation of the pathology lab in order to gain area needed to meet the pharmacy requirements.



Project Costs

MV Pharmacy 797/800 Upgrades	
Construction	\$5,355,000
FF&E	\$492,000
Soft Costs	\$1,124,704
Contingency @ 5 %	\$349,860
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	Spend to Date	Projected FY2023 Spend	Projected FY2024 Spend
MV Project	\$227,000	\$1,106,000	\$5,900,000
LG Project	\$280,000	\$981,000	\$4,100,000

- These projects will create a safer environment for compounding drugs as required by licensing standards.
- There is no ROI other than maintaining our licensed status.

Strategic Questions or Implications

- What if we did not implement the upgrades?
 - Risk losing license to compound sterile and hazardous drugs.
- How will the upgrades impact pharmacy operations?
 - Both projects have been designed to maintain pharmacy operations while the upgrades are in process.
 - Once completed pharmacists will have a safe and more efficient environment for compounding drugs.

The Request

The Board Finance Committee recommends the Boards approval of capital funding for the following two regulatory compliance projects:

- MV Pharmacy Upgrades Project not to exceed \$7.32 million
- LG Pharmacy/Pathology Upgrades Project not to exceed \$5.42 million

RULES OF ORDER
OF THE BOARD OF DIRECTORS OF
EL CAMINO HOSPITAL

As of: August 19, 2008
Reviewed: February 1, 2023

PREAMBLE

These Rules of Order are adopted for the general purpose of establishing rules for its proceedings subject generally to:

- (a) Chapter 9 (commencing with Section 54950) of Division 2 of Title 5 of the Government Code (the "Brown Act") as applicable to the Hospital; and
- (b) The Amended and Restated Bylaws of El Camino Hospital, as may be amended from time to time (the "Bylaws").

In the event of any conflict between these rules, the Brown Act or the Bylaws, the Brown Act and the Bylaws, as the case may be, shall prevail.

CHAPTER I
GENERAL PROVISIONS

Section 1. Purpose of Rules. The purpose of these rules is to make it easier for the Board of Directors of El Camino Hospital (the "Board") and the members of the community to work together effectively and to help the Hospital accomplish its purpose.

Section 2. Order by Motions. At a Board meeting, the Board will address only one matter at a time. Therefore, subsequent motions may be entertained by the Board Chair as described in Paragraph 5.1 of Chapter II.

Section 3. Full Discussion. Every matter presented for decision should be discussed fully by the Board. The right of every member of the Board to speak on any issue is as important as each Board member's right to vote.

Section 4. Full Understanding. Every member of the Board has the right to understand the matter considered at a meeting, and to know what effect a decision on the matter will have. A member of the Board always has the right to request information on any motion he or she does not thoroughly understand.

Section 5. Fairness and Good Faith. All meetings of the Board shall be conducted fairly and in good faith.

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CHAPTER II
BOARD MEETINGS

Section 1. Board Chair Presides. The Board Chair, when present, shall preside at all meetings of the Board and shall take the chair at the hour appointed for every Board meeting and shall call the members to order and, except in the absence of a quorum, shall proceed with the business of the Board in the manner prescribed by these rules. In the absence of the Board Chair, the Vice Chair will preside and shall have all the powers and duties of the Board Chair. A majority of the members shall constitute a quorum for the transaction of business.

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Section 2. Agenda. The agenda consists of the items of business to be discussed during a meeting of the Board. Each agenda shall include a brief general description of matters to be considered or discussed and shall contain such other information as may be required by the Brown Act and shall be posted, mailed, and/or delivered as prescribed by the Brown Act. The Board Chair, with assistance of the CEO, shall take appropriate measures to see that a proposed agenda is prepared in advance of each meeting of the Board.

Section 3. Consent Calendar. There will be no separate discussion of Consent Calendar items as they are considered to be routine. Consent Calendar items will be enacted by one motion, a second and a vote. If a member of the Board, the Hospital staff, or the public requests discussion on a particular item, that item will be removed from the Consent Calendar and considered separately.

Section 4. Minutes. The minutes of the meetings of the Board shall record, in summary rather than verbatim, the actions taken by the Board.

4.1. Preparation. The Secretary, with the assistance of the CEO, shall take appropriate measures to see that the minutes are prepared in advance of each meeting of the Board.

4.2. Adoption. If the minutes have been duplicated and circulated to the members of the Board before the meeting, they need not be read at the meeting. The Board Chair shall ask if there are any errors in or omissions from the minutes. Should there be any mistake, appropriate corrections or additions shall be made. Any member of the Board may then move that the minutes be approved as printed or amended.

Section 5. Motions. The business of the Board is accomplished in meetings by means of debating motions, which are formal proposals by two members (the mover and the seconder) that the meeting take certain action. Once a main motion (a motion that brings business before the meeting) has been stated by one member, seconded by another member, and repeated for the meeting by the Board Chair, the meeting cannot consider any other business until that motion has been disposed of, or until some other motion of higher precedence has been proposed, seconded and accepted by the Board Chair. The Board Chair, in his/her sole discretion, may permit discussion of a general topic before a motion is introduced. A main motion must not interrupt another speaker, requires a seconder, is debatable, is lowest in rank or precedence, can be amended, cannot be applied to any other motion, may be reconsidered, and requires a majority vote.

5.1. *Precedence of Motions.* When a motion is before the Board, no motion shall be entertained except the Board Chair shall entertain subsequent motions to adjourn, take a recess, to table a motion, to limit or extend debate, and to amend or substitute a motion. Any question as to the order or precedence of motions shall be referred to the District's legal counsel for a determination based on Robert's Rules of Order. All subsequent motions require a second, are amendable and are debatable.

Section 6. Discussion and Voting.

6.1. *Board Chair to State Motion.* The Board Chair shall assure that all motions are clearly stated before allowing discussion to commence. The Board Chair may restate the motion or may direct the CEO to restate the motion prior to voting.

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6.2. *Board Chair May Discuss and Vote.* The Board Chair may move, second and discuss from the chair, subject only to such limitations of discussion as are by these rules imposed on all members of the Board. The Board Chair shall not be deprived of any of the rights and privileges of a member of the Board.

6.3. *Division of a Question.* If a question contains multiple divisible propositions, each of which is capable of standing as a complete proposition if the others are removed, the Board Chair may, and upon request of a member of the Board, divide the same. The Board Chair's determination shall be appealable by any member of the Board

6.4. *Withdrawal of Motion.* A motion may not be withdrawn by its maker without the consent of the member of the Board seconding it.

6.5. *Change of Vote.* Members of the Board may change their votes before the next item on the agenda is called.

6.6. *Voting.* The vote shall be taken by voice, and a verbal roll call need not be called in voting upon a motion except where specifically required by law or requested by a member of the Board.

6.7. *Silence Constitutes Affirmative Vote.* Members of the Board who are silent during a voice vote shall have their vote recorded as an affirmative vote, except when individual members of the Board have stated in advance that they will not be voting.

6.8. *Abstaining from Vote.* Generally, it is the duty of every member of the Board who has an opinion on a motion before the Board to express it by a vote; however, every member has the right to abstain from voting.

6.9. *Not Participating.* A member of the Board who disqualifies himself or herself because of any financial interest shall disclose the nature of the conflict and may not participate in the discussion or the vote. A member of the Board may otherwise disqualify himself or herself due to personal bias or the appearance of impropriety or to avoid the appearance of a conflict of interest.

6.10. *Tie Votes.* Tie votes may be reconsidered during the time permitted by Section 6.11 of Chapter II on a motion by any member of the Board voting “Aye” or “Nay” during the original vote. Before a motion is made on the next item on the agenda, any member of the Board may make a motion to continue the matter to another date. Nothing herein shall be construed to prevent any member of the Board from adding a matter which resulted in a tie vote to the agenda at a future Board meeting, as provided in the Bylaws.

6.11. *Motion to Reconsider.* A motion to reconsider any action taken by the Board may be made only during the meeting or adjourned meeting thereof when the action was taken. A motion to reconsider requires a second, is debatable and is not amendable. Such motion must be made by one of the prevailing side, but may be seconded by any member of the Board. A motion to reconsider may be made at any time and shall have precedence over all motions, or while a member of the Board has the floor, providing that no vested rights are impaired. If the motion to reconsider fails, it may not itself be reconsidered. Reconsideration may not be moved more than once on the same motion.

6.12. *Appeal ~~From~~ Decision of Board Chair.* When the rules are silent as to questions of order, the Board Chair shall either refer to the Hospital’s legal counsel for an opinion based on Robert’s Rules of Order, Newly Revised, or submit the question to the Board, in which case a majority vote shall prevail.

6.13. *Recognition by Board Chair.* In order for a member of the Board to be recognized, he or she must first request to be recognized for verbal comment by the Board Chair. Once recognized by the Board Chair, the speaker shall confine his/her remarks to the question under debate and shall avoid personal attacks and indecorous language.

6.14. *Interruptions.* Except for being called to order, a member of the Board, once recognized, shall not be interrupted when speaking, except as otherwise provided for in these rules.

Section 7. *Absence.* No member of the Board shall absent himself/herself from any regular or special meeting (except on account of illness or an emergency). If any member of the Board is unable to attend a meeting, he or she shall notify the Board Chair at least one day prior to the meeting and advise him/her of the reasons therefor.

Section 8. *Items to Be Considered After Eleven P.M.* Before 11:00 p.m., the Board will determine whether it will commence any new items after 11:00 p.m. and shall determine which specific items will be taken up.

Section 9. *Adjournment.* The Board may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. When a regular adjourned meeting is adjourned as provided in this section, the resulting adjourned regular meeting is a regular meeting for all purposes.

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CHAPTER III

ORDER AND DECORUM OF BOARD MEETINGS

Section 1. Meeting Powers of the Board Chair. The Board Chair shall possess the powers and perform the duties prescribed as follows:

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- (a) Have general direction over the meeting place;
- (b) In accordance with the Brown Act: preserve order and decorum; prevent demonstrations; order removed from the meeting place any person whose conduct he or she deems objectionable; and order the meeting place cleared whenever he or she shall deem it necessary;
- (c) Assure that attendance of the public at meetings shall be limited to that number which can be accommodated by the seating facilities regularly maintained therein. Stantees may be asked to leave when room capacity exceeds that maximum number set by the Fire Marshal;
- (d) Recess the meeting if deemed necessary due to disturbance.

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Section 2. Removal by the Board Chair. The Board Chair shall order removed from the meeting place any person who commits the following acts in respect to a meeting of the Board:

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- (a) Disorderly, contemptuous or insolent behavior toward the Board or any member of the public or staff, tending to interrupt the due and orderly course of said meeting;
- (b) A breach of the peace, boisterous conduct or violent disturbance, tending to interrupt the due and orderly course of said meeting;
- (c) Disobedience of any lawful order of the Board Chair which shall include an order to be seated or to refrain from addressing the Board;
- (d) Any other unlawful interference with the due and orderly course of said meeting.

Section 3. Clearing of Meeting Place. In the event that any meeting is willfully interrupted by a group or groups of persons so as to render the orderly conduct of such meeting unfeasible and order cannot be restored by the removal of individuals who are willfully interrupting the meeting, the Board Chair may order the meeting place cleared and continue the meeting in executive session. Only matters appearing on the agenda may be considered in such a session. Duly accredited representatives of the press or other news media, except those participating in the disturbance, shall be allowed to attend any session held pursuant to this section.

Any person so removed shall be excluded from further attendance at the meeting from which he or she has been removed, unless permission to attend be granted upon motion

adopted by a majority vote of the Board, and such exclusion shall be effected by the Sergeant at Arms upon being so directed by the Board Chair.

Section 4. Sergeant at Arms. The Sergeant at Arms, who shall be the CEO of the Hospital, or his designee, in attendance at the meeting when his/her services are commanded by the Board Chair, shall carry out all orders and instructions given by the Board Chair for the purpose of maintaining order and decorum at the meeting.

Section 5. Placards, Signs, Posters, Etc. Except with prior authorization of the Board Chair, no placards, signs or posters or packages, bundles, suitcases, balloons or other large objects shall be brought into the meeting place.

Section 6. Seating. Unless addressing the Board or entering or leaving the room, all persons in the audience shall remain sitting in the seats provided. No person shall block the aisles or doorways.

Section 7. Disruption. All demonstrations, including cheering, yelling, whistling, hand clapping and foot stamping are prohibited.

Section 8. Distribution of Literature. Except with prior authorization of the Board Chair, the distribution of literature, of whatever nature or kind, is prohibited. If persons wish to distribute information on matters not on the agenda, they must present themselves at the appropriate time and receive permission from the Board Chair to distribute informational items covered under their three-minute public comment.

Section 9. Public Participation.

9.1. *Policy*. It is the policy of the Board that members of the public have the opportunity to provide comments at any regular or special meeting on any agenda item to be considered by the Board after it is presented, but before or during final consideration of the agenda item.

9.2. *Persons Eligible to Speak*. The Board may exclude all persons who willfully cause a disruption of a meeting so that it cannot be conducted in an orderly fashion. Where removal of the disruptive persons is not sufficient to restore order, the Board may clear the room of all persons, except that media personnel not involved in the disruption will be permitted to remain.

9.3. *Addressing the Board*. No person shall address the Board until he or she has first been recognized by the Board Chair. The decision of the Board Chair to recognize or not recognize a person may be changed by order of the Board. All persons addressing the Board will be asked to give, but are not required to give, their names and addresses for the purpose of the record. No person, other than a member of the Board and the person recognized, shall be permitted to enter into any discussion without the permission of the Board Chair. All remarks shall be addressed to the Board as a body and not to any member thereof. No remarks shall be addressed to the staff of the Hospital.

9.4. *Indecorous Remarks*. All remarks shall avoid indecorous language, personal attacks, or personally disparaging remarks.

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9.5. *Time Limitations.* Each speaker shall have not more than three minutes to address an agenda item. Public comment on a single subject matter shall not exceed fifteen minutes. The Board Chair may, in the interest of facilitating the business of the Board, increase the amount of time spent on a subject matter.

9.6. *Spokesperson for a Group of Persons.* When any group of persons wishes to address the Board on the same subject matter, it shall be proper for the Board Chair to request that a spokesperson be chosen by the group to address the Board.

9.7. *Subject Matter Limitations.* Public comment shall be limited to matters within the subject matter jurisdiction of the Board.

9.8. *Non-Agenda Matters.* Persons desiring to address the Board on any matter not listed on the agenda may do so at regularly scheduled meetings of the Board pursuant to instructions on the printed agenda. Only those matters listed on the agenda of a special meeting of the Board may be addressed by the public. Comments regarding non-agenda matters shall be subject to the provisions of Chapter III, Section 9.

CHAPTER IV

MISCELLANEOUS PROVISIONS

Section 1. Robert's Rules of Order. The proceedings of the Board shall be governed by the provisions of law applicable thereto and, except as herein otherwise provided, by Robert's Rules of Order, Newly Revised. Failure to follow Robert's Rules of Order, Newly Revised, or these rules shall not invalidate any action taken.

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Section 2. Suspension and Amendment of Rules. Except as otherwise provided by law, these rules, or any portion thereof, may be suspended or amended by order of the Board when regularly entered in its minutes.

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Section 3. Dress Code: Members of the Board are expected to wear appropriate business attire at ECH meetings and functions.

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~~Section 2.~~

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TITLE: Board and Advisory Committee Continuing Education Policy
CATEGORY: Administrative
LAST APPROVAL: October 25, 2022

TYPE: Policy Protocol Scope of Service/ADT
 Procedure Standardized Process/Procedure
SUB-CATEGORY: Board
OFFICE OF ORIGIN: Administration
ORIGINAL DATE: November 14, 2012

I. COVERAGE:

All Members of the El Camino Hospital Board of Directors and Board Advisory Committees

II. PURPOSE:

- To set forth the budget parameters for Board and Advisory Committee education, including both in-house training, such as study sessions, and off site programs offered by institutions such as the ~~Estes Park Institute~~ California Special Districts Association, the Center for Healthcare Governance and the Governance Institute.
- To establish procedures for budgeting, reporting back to the Board, and requesting funding and reimbursement for educational activities.

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III. POLICY STATEMENT: It is the policy of the El Camino Hospital Board of Directors to provide Board Directors and Advisory Committee Members with ongoing governance and healthcare education, to strengthen the skill set of each Director and Committee member, and to ensure the Board and its Committees are maintaining contemporary knowledge on topics of general Board duties, changes in the healthcare industry, healthcare governance and other areas specific to Committee responsibility.

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IV. DEFINITIONS:

N/A

V. REFERENCES:

Appendices A and B attached.

VI. PROCEDURE:

- A. Board and Advisory Committee Education Goals:** The Board and Advisory Committees will identify their educational goals both individual and collective, and submit them to the Governance Committee on an annual basis. These goals should ~~be tied to, or in support of~~ in alignment with Board, Committee, or Hospital goals. The Board and Committees should also identify the programs or training opportunities (in-house or off-site) to fulfill their learning objectives.

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TITLE:	Board and Advisory Committee Continuing Education Policy
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LAST APPROVAL:	October 25, 2022

B. Expectations of Board and Advisory Committees:

1. Board of Directors:
 - a. Group Education: El Camino Hospital (“ECH”) will coordinate occasional group training where the full Board, along with the senior management team, can receive education on the latest trends in the healthcare industry and further their understanding of governance. At the Board’s discretion, committee members may be invited to partake in the event.
 - b. Individual Education: Board directors are encouraged to individually attend one off-site program at ECH’s expense, on an annual basis, that best suits their development as a ~~hospital~~ Director.
2. Board Advisory Committees:
 - a. Group Education: In addition to any committee-specific in-house training provided by ECH throughout the year, committees are expected to identify how they can achieve their educational goals. For example, a committee may elect to attend an off-site training event or collaborate with another committee to invite a guest speaker.
 - b. Individual Education: While it is the expectation of the Board that outside committee members keep up with their own continuing education in their professions, the Board recognizes that additional education and training will further enhance their ability to serve on the committees. As such, outside committee members who wish to individually attend an education program/conference may submit a request for funding to their committee chair.

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E.C. Budget and Delegated Authority:

1. The Governance Committee, in collaboration with the CEO and Finance Committee, will develop a budget for Board and committee member education for adoption by the Board, which shall be reviewed in conjunction with review of this policy very third year. This budget will enable both collective and individual educational opportunities. The amounts will be based on market data, while taking into consideration the needs of the Board and committee members.
2. The Board will delegate authority to the Board Chair (and to the Chair of the Governance Committee in the case of the Board Chair’s requests) to approve requests for education by a Board member that exceed the per member/per event limits in the budget. The Board will delegate authority to each

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TITLE:	Board and Advisory Committee Continuing Education Policy
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LAST APPROVAL:	October 25, 2022

committee chair to approve education and training requests up to a specific amount, which the Board will establish annually. The Board will delegate authority to the Board Chair to consider and approve or reject any request above this amount.

3. The total annual budget for Board and Committee member education, as well as the approval limit for Committee chairs, as approved by the Board will be noted, and updated as necessary, in the appendix of this policy.
4. The Governance Committee will recommend to the ~~Board how~~Board how remaining funds, if any, should be managed. Unused funds may not be rolled over into the next fiscal year.
5. ECH shall pay all costs associated with the program, i.e., registration fees, travel and lodging. Directors and Committee members shall adhere to the ECH reimbursement policy.

F.D. Requesting Funding for Training:

1. Directors need only inform the Board Chair of their request to participate in a training event provided that the total fees do not exceed the established event limitation amount set forth in the Appendix to this Policy. If the amount exceeds this limit, the request will be reviewed by the Board Chair and approved, conditioned (e.g., reducing the amount allocated to the Director by the amount of the excess), modified or rejected.
2. Committee members shall submit to their Committee chair a request for training no less than 30 days prior to the program's registration deadline. Upon consideration, the Committee chair may approve the request for training provided that the total costs do not exceed the per Committee member event limit established by the Board. If the amount requested exceeds the limit, the request will be sent to the Board Chair for consideration.
3. Any requests made by the Board Chair for approval of amounts in excess of the limits set forth in the Appendix to this Policy shall be submitted to the Chair of the Governance Committee for approval.
4. Board or Committee members shall request reimbursement by submitting Form 2085 to the CEO for approval within 30 days of completing training.

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G.E. Point of Contact: The ~~Board Liaison~~Director of Governance Services is the primary point of contact for Board and Committee members with respect to the process concerning continuing education and training for Board and Committee members.

VII. APPROVAL:

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TITLE: Board and Advisory Committee Continuing Education Policy
CATEGORY: Administrative
LAST APPROVAL: October 25, 2022

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	Governance Committee
(name of) Medical Committee (if applicable):	N/A
ePolicy Committee:	N/A
Pharmacy and Therapeutics (if applicable):	N/A
Medical Executive Committee:	N/A
Board of Directors:	
Historical Approvals:	11/14/12, 3/12/14, 8/13/14, 5/13/15

VIII. ATTACHMENTS (if applicable):

- Appendix A - Budget for FY ~~2019-2021~~2023
- Appendix B – Report on Educational Activity

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Origination 01/2014
Last Approved 03/2019
Effective 03/2019
Last Revised 03/2019
Next Review 03/2022

Owner **Stephanie Iljin:
Manager
Administration**
Area **Board**
Document Types **Procedure**

El Camino Hospital Board Director Compensation and Reimbursement

I. COVERAGE:

All Members of the El Camino Hospital Board of Directors with the exception of the Chief Executive Officer.

II. PURPOSE:

- A. To define the events for which Board Directors other than the CEO shall receive compensation and reimbursement.
- B. To define the amount of compensation Board Directors shall receive.
- C. To define the procedures necessary to implement this policy.

III. POLICY STATEMENT:

- A. El Camino Hospital shall pay its Board Chairperson an annual stipend in the amount of \$12,000, payable during the third month of each quarter of the fiscal year.
- B. El Camino Hospital shall pay members of its Board of Directors, with the exception of the Board Chairperson, a stipend for **in person attendance** at each of the events listed below, not to exceed seven events per month. However, one of the compensable events per month may be attended by teleconference. Members of the Board of Directors who do not wish to receive such payments may notify the Director of Governance Services and the CEO by submitting a "Board of Directors' Compensation Op-Out" form. Any member not receiving compensation may request to receive such compensation for attendance at future events by notifying the Director of Governance Services and the CEO. Notwithstanding the above, a stipend shall be paid for participation in the event described in Section C(3)(e) for either in person or telephonic attendance.

- C. Events which are subject to compensation include:
1. Board members shall be paid \$200 for attendance at Regular, Special and Emergency Meetings of the El Camino Hospital Board of Directors.
 2. Board members shall be paid \$100 for attendance at meetings of the Standing Board Advisory Committees of which the Director is a member or an alternate.
 3. In addition to the foregoing meetings, the Board, by adoption of this policy, declares that the following events constitute performance of official duties by a member of the Board of Directors for which Board members shall be paid \$100 for attending:
 - a. Meetings of the Board's Ad Hoc Committee established by the Board of which the Director is a member.
 - b. Meetings of the El Camino Hospital Foundation, when the Director is then serving as a liaison to the Foundation Board.
 - c. Meetings of the Community Benefit Advisory Council ("CBAC") if the Director has been appointed as a liaison to the CBAC by the El Camino Hospital Board of Directors.
 - d. Advisory Committee Meeting agenda setting meetings, in person or telephonic, if the Director is the Chair of the Committee.
- D. El Camino Hospital shall also pay to members of its Board of Directors, including the Board Chairperson, (who request such payment reimbursement and submit the required form) an amount equal to his or her actual necessary travel and incidental expenses, including but not limited to travel, lodging and meals incurred (1) as a result of attending events specified in Section B above and (2) as a result of attending educational events funded by El Camino Hospital.
- E. Board members who reside within the El Camino Healthcare District shall not be eligible for reimbursement for mileage to events at El Camino Hospital.
- F. Board members are expected to use prudent judgment in selecting their travel accommodations and otherwise incurring expenses which will be reimbursed by the Hospital.
- G. This policy shall be implemented in accordance with the procedures described in Section VI below.

IV. DEFINITIONS:

N/A

V. REFERENCES:

N/A

VI. PROCEDURE:

- A. Stipends
1. Hospital staff will track Board members' attendance at meetings and, on a monthly basis, provide Board members who have not opted out of the policy with a "Meeting

Attendance Report Confirmation" Form for ~~signature~~confirmation.

2. Upon receipt of the ~~signed~~ Meeting Attendance Report Confirmation and following approval of the ~~Board Chair, (or the Vice Chair, in the case of the Chair's compensation)~~Director of Governance Services, Hospital staff will forward the document to accounting.
3. Stipends paid to Directors are IRS Form 1099 – Miscellaneous reportable. Directors who have not opted out of participation (See, Section III A) and are accepting stipend payments must submit IRS FORM W-9 to ECH Accounting before receiving payment. Annually, ECH will provide IRS Form 1099-Miscellaneous to Directors receiving stipend compensation in excess of \$600.00 in a calendar year.

B. Use of Personal Vehicle for attendance at meetings or educational events.

1. The Hospital will pay the current IRS mileage rate for miles actually traveled, but not more than, from the Board member's home or usual place of business within California to events as defined in Section III B and to educational events funded by the Hospital. Board members who reside within the El Camino Healthcare District shall not be eligible for reimbursement for mileage traveled to events at El Camino Hospital.
2. To be reimbursed, the Board member must complete the Mileage Reimbursement form provided by the Director of Governance Services. ~~The form must be signed by the Board Chair (or the Vice Chair in the case of the Chair's reimbursement) and sent to accounting (OAK200) for processing.~~

C. Educational seminars, conferences, events etc. attended for the benefit of the Hospital and in accordance with the Board and Committee Education Policy.

1. **Seminar/conference fees** will be reimbursed in full or at a pro-rated amount in accordance with the Board and Committee Education Policy.
2. **Air travel** will be reimbursed at "coach" airfare rates. No reimbursement should be claimed for personal convenience fees such as those associated with priority boarding or seating upgrades.
3. **Ground travel** to a seminar or a meeting using the Board member's personal vehicle will be reimbursed as noted in item D.1., at the current IRS mileage rate per mile. Board members should consider use of a rental car in cases where the expenses are expected to be less than the reimbursement for a personal vehicle.
4. **Taxi, bus, rail, limo or rental car service**, if required at the destination, may be reimbursed by the Hospital if necessary for business purposes, as follows:
 - a. Reimbursement for car rental expenses incurred by the Board member will be limited to the amount charged for a standard "intermediate" car unless there is a business need for a larger vehicle (multiple travelers with luggage, for example). If the requester requests a larger automobile than is necessary to meet the business need, he/she is to have the rental agency document what the price would have been for a standard "intermediate" vehicle and seek reimbursement for only the lower amount. If a larger vehicle is required to meet a business need, this need must be documented on the "Business-Education-Travel Reimbursement Authorization" form.

- b. Limousine service is permitted if it is no more expensive than available alternatives.
 - c. Board members should choose the least expensive available alternative suitable for the purpose and situation.
 5. **Lodging** will be reimbursed at the standard private room rate at the selected motel/hotel.
 6. **Meals** will be reimbursed at actual cost plus tip (normally 15%). The maximum reimbursement per day is an average of \$130.00. It is the responsibility of the Board member to decide how he/she spends the average per day maximum allowable amount for meals. Detailed receipts indicating the items purchased must be submitted.
 7. **Alcohol** will not be reimbursed unless approved by the CEO, CFO or Board Chair. Because approval will only be granted in unusual circumstances, it is recommended that Board members request approval in advance of the expenditure. The maximum reimbursement of \$130.00 per day includes any approved expenses for alcohol.
 8. **Telephone calls and Internet Service**, during travel, required for necessary Hospital business will be reimbursed at cost. These expenses should be itemized on the statement. The Hospital will also reimburse expenses for a personal telephone call home each day while on Hospital business. The conversation should be kept to a reasonable length and will be reimbursed at cost.
- D. The Hospital will not advance or reimburse for the following:
1. Any expenses of a spouse or other individual who accompanies the Board member on travel.
 2. Any additional expenses for travel by business or first class, or any charges for special boarding privileges or seats.
 3. Lodging amenities such as subscription television, valet service, cleaning/pressing of clothes (if the function is greater than one week, this service is allowed), concierge, etc. In-room meal service is subject to the normal meal reimbursement rates detailed in D.2.f above.
 4. If an offsite event is within a reasonable radius of the Board member's home or usual place of business **and** the function is starting **after** 7:30 a.m. and/or will be ending **before** 11:30 p.m., the Hospital will not pay for overnight accommodations, as it is expected that the Board member will commute that distance to and from the function within that business day.
 5. Car rental fees on an individual basis where there is the opportunity to share a rental car for a group of participants.
 6. Additional per mileage charge or gasoline expense by a car rental agency for personal pleasure driving.
 7. Any entertainment such as theater, tours, nightclubs, etc.
 8. Discretionary expenses for another Board member or Hospital staff, such as a birthday, holiday (e.g. Christmas), weddings, child birth, special days (i.e.

Administrative Day, or some life event.

9. Professional memberships are generally not reimbursable.

E. Travel Reservations: When booking accommodations and/or air travel, the following points should be noted:

1. If a deposit is required to be made by the Hospital, prior approval of the travel request must be received in sufficient time for Accounting to process the request and ensure that the payment reaches its destination by the required date.
2. When booking air travel utilizing a travel agency, the Hospital's current travel agency must be used. Board members will be given a profile to use the Hospital's current travel agency. Board members may book airfares over the Internet using the Board member's personal credit card. The Board member must then seek reimbursement from the Hospital.
3. In most cases, air travel should be booked as a non-refundable fare. The much-lower cost of these non-refundable fares is normally so great that the extra cost, should a trip be re-scheduled, is still much less than paying a full-price fare.

F. Expense Account Reporting

1. Expense account reporting must be in conformity with minimum IRS standards and all expenses of \$25.00 or greater must be supported by detailed receipts. Expense reports must indicate as a minimum all of the following:
 - a. Business purpose
 - b. Date and location
 - c. Name and position
2. Noncompliance with the above requirements could cause the reimbursement to be considered as additional compensation to the Board member and thus would become taxable (via a W-2 or Form 1099). To avoid this potential problem, the Board member must complete the "Business-Education-Travel Reimbursement Authorization" form and attach all supporting documentation.

G. Procedure for Completing Form

1. All Board members must complete the "Business-Education-Travel Reimbursement Authorization" form (Form 2085). Local business mileage reimbursement may be requested via the use of the Mileage Reimbursement form (form #54.00a).
2. Form #2085 is self-explanatory, but listed below are key points to remember.
 - a. **All** supporting documents must be attached to the request form. Examples of supporting documents include
 - i. Copy of registration form
 - ii. Lodging receipts
 - iii. *Detailed* meal receipts
 - iv. Car rental receipts
 - v. Parking fee receipts

- b. In circumstances where a receipt is not obtainable (or lost), the Board member must attach a statement detailing the expense as to date, place, reason for expense, and amount. All reports with missing receipts require approval by the CFO or CEO.
 - c. Where receipts are given that include non-reimbursable expenses, these expenses must be marked in some fashion and deducted from the total so that only eligible expenses are reimbursed.
 - 3. When travel advances are provided, the recipient must submit a final accounting of his/her expenses on the Business, Education, and Travel Expense form and return any excess advance, no later than 120 days from the date of the event. If this is not done, disciplinary action may be taken. In addition, any undocumented advance will be considered additional income to the recipient and reported as a W-2 or Form 1099 transaction.
 - 4. Signature Authority (approval) for the completed form, as well as travel agency invoices, is as follows:
 - a. Director of Governance Services, Controller or CFO - up to \$25,000 per activity
 - b. CEO - amounts greater than \$25,000.00 per activity.
 - 5. A Board Member cannot approve her/his own reimbursement of funds.
- H. Exceptions: Because it is impossible to foresee every possible situation, it is recognized that exceptions may sometimes be appropriate. As a result, expenses which are not generally reimbursed under this policy may be reimbursed by the Hospital upon determination of the appropriateness and reasonableness of the expenses by the CEO or CFO. Any such exception, including the justification for the exception, shall be attached to the request for reimbursement.

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

Approval Signatures

Step Description

Approver

Date

El Camino Hospital Board of Directors Investment Committee Charter

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 members~~¹ ~~2-5 Community Members~~ 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, 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

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

potential conflict, the determination regarding independence shall follow the criteria approved by the Board.

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 Investment 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
BOARD MEETING COVER MEMO**

To: El Camino Hospital Board of Directors
From: Tracy Fowler, Director of Governance Services
Date: February 15, 2023
Subject: Appointment of Quality, Patient Care and Patient Experience Committee Members

Recommendation(s):

To appoint Pancho Chang and Terhilda Garrido, to the Quality, Patient Care, and Patient Experience Committee.

Summary:

Due to the departure of a number of Committee members, the Quality Committee appointed an Ad Hoc Committee, comprised of Director Carol Somersille, MD, Director John Zoglin, Alyson Falwell, and Krutica Sharma, MD., that was tasked with recruiting new members. Chief Quality Officer, Holly Beeman, MD, worked with Ad Hoc Committee on the recruitment.

The Ad Hoc Committee sought applicants through public advertising, as well as through the Board, Committee and leadership team networks. Their search was focused on the following areas of expertise: demonstrated experience in health equity, patient experience, and ambulatory quality. They received five (9) applications, interviewed four (4) candidates and brought two (2) candidates forward for the full Committee's consideration.

At its December 12, 2022 meeting, the Quality, Patient Care and Patient Experience Committee voted to recommend the Board appoint both candidates to the Committee.

List of Attachments:

1. Candidate CV – Pancho Chang
2. Candidate CV – Terhilda Garrido

FRANCIS ‘PANCHO’ CHANG

EDUCATION AND FELLOWSHIPS

[2009 – 2024] Fulbright fellow, US State Dept., Washington, DC
2020 Fulbright Specialist, Casa de los Amigos, Mexico City, DF, Mexico
2016 Fulbright Specialist, Shanxi Medical University, Taiyuan, Shanxi, China
2013 Fulbright Specialist, SEWA Rural, Jhagadia, Gujarat, India

[2003 - 2008] Wilson National Fellowship Program, Princeton, NJ
Woodrow Wilson Visiting Fellow

[1998 - 2001] Rockefeller Brothers Foundation, New York, NY
Mentor, RBF Minority Teacher Fellows

[1991 - 1994] Boston City Hospital/Kaiser Family Foundation
Kellogg National Leadership Fellow

[1984 - 1985] The Rand Corporation, Santa Monica, CA
Pew Health Policy Career Development Fellow

[1973 - 1976] Legal Services, San Jose and San Francisco, CA
Reginald Heber Smith Community Lawyer Fellow

[1970 - 1973] Boston University Law School, Boston, MA
J.D. 1973
Co-founded legal services office in Boston Chinatown.

[1966 - 1970] Brandeis University, Waltham, MA
A.B. 1970 (Politics and Sociology)

[1957 - 1966] The Fay School, St. Mark's School, Southborough, MA
Scholarship student, National Merit commendation.

PROFESSIONAL EXPERIENCE

[2014 – present] Patient Centered Outcomes Research Institute (PCORI), Washington, DC

Stakeholder reviewer

Grant reviews for IHS, IMRI, Opioids, PCS, PLACER funding mechanisms.

[2014 – 2020] Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), Bethesda, MD

Initial Review Group member, Health, Behavior and Context Subcommittee

Grant reviews for R01, R03, R25, K01, K23, K99 funding mechanisms.

**[2017 – 2018] Ravenswood Family Health Center, East Palo Alto, CA
*Strategic Business Advisor***

Strategic business development for \$27M East Palo Alto federally qualified health center. Began MediCal managed care contracting for Santa Clara County patients.

**[2011 – 2017] Asian Americans for Community Involvement, San Jose, CA
*Chief Operating Officer***

Chief operating officer of \$19M San Jose nonprofit. Led development of integrated mental health/primary care health homes whose provider teams coordinate care with risk attached. Headed patient navigation center, recognized by the Center for Medicare and Medicaid Services with a 2012 Health Care Innovations award. <http://innovations.cms.gov/initiatives/Innovation-Awards/california.html> (Asian Americans for Community Involvement). Managed 2013 - 2014 New Access Point startup of Federally Qualified Health Center. <http://www.hrsa.gov/about/news/2013tables/newaccesspointawards/ca.html> (Asian Americans for Community Involvement). Supervised 2014 electronic health records upgrades across 7 clinical practices, along with clinic renovation, new site startup, and voice/data system upgrades. Oversaw 2015 NCQA Patient Centered Medical Home Level 2 recognition.

**[2001 - 2010] Walter S. Johnson Foundation, Menlo Park, CA
*Executive Director***

Managed \$115M private family foundation, 3 staff.

Retooled grantmaking and budgeting for \$6M grants program. Revamped program areas and grant guidelines, overseeing program shift to education and workforce development for older youth. Moved offices, installed new computer network, renegotiated lease, restructured health benefits. Completed investment manager review, asset allocation review and audit rebid. Hired and trained program and administrative staff.

[1997 - 2001] **S.H. Cowell Foundation, San Francisco, CA**

Senior Program Officer

Managed \$3.8M Public Education, Affordable Housing grants portfolios, staff and consultants.

Brought forward representative grants in student achievement, teacher training and transitional housing for \$150M private family foundation. Developed pre-development revolving funds for charter school construction and for affordable housing site acquisition.

[1993 - 1997] **Kaiser Family Foundation, Menlo Park, CA**

Program Officer

Managed 4 year \$5.5M joint initiative (with the Robert Wood Johnson Foundation) on sociocultural barriers to health care for \$350M private family foundation. Developed guidelines, selected grantees, monitored results, oversaw evaluation and dissemination. Planned and implemented national forum on language services in health care.

Brought forward representative grants in telemedicine, health quality standards and judicial education.

[1991 - 1993] **Boston City Hospital, Boston, MA**

Director of Hospital Community Benefits

Started and accredited public hospital community benefits program for 280 bed public hospital.

Recruited physicians for affiliated health centers. Planned and implemented patient origin study for 16 hospital-based ambulatory clinics.

[1988 - 1991] **Bureau of Primary Care, Rockville, MD**

Acting Deputy, Policy

Policy deputy for federal agency overseeing community health centers.

Oversaw \$3M building rehabilitation/construction technical assistance program. Helped to develop financial performance indicators for 575 community health centers nationally.

[1976 - 1988] **South Cove Community Health Center, Boston, MA**

Executive Director, Assistant Administrator

Led growth of large Asian community health center as it tripled its patient visits to 75,000 per year, doubled its staff to 125 FTEs, and quintupled

its annual revenues to \$5.5M. Added new school health, adolescent, Southeast Asian refugee, and elderly services.

Obtained national foundation funding for community health insurance, elderly living at home and community thalassemia screening and treatment programs.

Helped to found national associations of Asian Pacific community health organizations and Chinese immigrant social service agencies.

**[1975 - 1976] Legal Aid Society of Alameda County, Oakland, CA
*Attorney***

Civil litigation on housing, consumer and domestic issues. Impact litigation on consumer and employment issues.

ACCREDITATIONS

Admitted to practice: California, Massachusetts, US Court of Appeals (1st Cir.), US Supreme Court.

Inactive Member: California State Bar, Massachusetts Bar.

PUBLICATIONS

Kong, G., Chang, Pancho, and Yogi, S., Bay Area Nonprofits: Myths and Realities, Nonprofit Sector Research Fund, The Aspen Institute, 1998.

Chang, Pancho and Fortier, Julia, Language Barriers to Health Care: An Overview. J. Health Care for the Poor and Underserved, 1998;9 (Supplemental):5-20.

Smith, Mark and Chang, Pancho, The Role of Race and Ethnicity in Health Services Research. Health Services Research, 1995;30(1):145-150.

Feldstein, Aaron, Chang, F., and Kucharski, J., Tryptophol-induced sleep in mice. Life Sciences, 1970;9:323-326.

PROFESSIONAL MEMBERSHIPS

Board of Directors, Channing House, Palo Alto, CA (2022 – present)

Finance Committee, The Health Trust, San Jose, CA (2019 – present)

Board of Directors, Cancer Prevention Institute of California, Fremont, CA (2010 – 2021, Audit Committee chair 2012 - 2017)

Board of Directors, Asian Health Services, Oakland, CA (2001 – 2011, President 2005 – 2011)

Board of Directors, Marine Science Institute, Redwood City, CA (2008 – 2010)

Examiner, Baldrige National Quality Award, National Institute of Standards and Technology, Washington, DC (2006, 2007)

Member, Committee on Group Insurance Programs, California State Bar (2003 – 2006)

Treasurer, Asian and Pacific Islander Health Forum, San Francisco, CA (1998 – 2002)

Treasurer, Legal Services section, California State Bar (1998 – 2000)

Executive Committee, Board of Directors, California Rural Legal Assistance, San Francisco, CA (1995 – 1999)

Trustee, The Boston Plan for Excellence in Education, Boston, MA (1990 – 1993)

Commissioner, Massachusetts Group Insurance Commission, Boston, MA (1990 – 1993)

Secretary, Chinatown Neighborhood Council, Boston, MA (1986 – 1993)

Trustee, Bunker Hill Community College, Charlestown, MA (1986 – 1992)

Trustee and President, Association of Asian Pacific Community Health Organizations, Oakland, CA (1984 – 1988)

Invited Reviewer, Community Development Financial Institutions Fund, US Department of the Treasury; Agency for Health Services Research, Bureau of Maternal and Child Health, Bureau of Primary Care, Office of Minority Health, US Department of Health and Human Services; National Endowment for the Arts; National Institutes for Health; Charter School and After-school Units, California Department of Education; Hewlett Foundation (1984 – present)

Chair, Asian Caucus, American Public Health Association, Washington, DC (1978 – 1982)

COMMUNITY ACTIVITIES

Volunteer, Cambodian Cultural Dance Troupe, San Jose, CA (2001 – present)

Committee Chair, Assistant Scoutmaster, Eagle Scout advisor, Boy Scout Troop 87, Mountain View, CA (1996 - 2018)

Trustee, The Brookline Foundation, Brookline, MA (1991 – 1993)

Corporator, The Childrens Museum, Boston, MA (1991 – 1993)

Corporator, New England Home for Little Wanderers, Boston, MA (1991 – 1993)

AWARDS

Brandeis University Distinguished Service award (1984).

Justice in Action award, Harry Dow Memorial Legal Assistance Fund (2010).

Silicon Valley Business Journal Excellence in Healthcare award (2014).

Terhilda Garrido

921 Aquarius Way, Oakland, CA 94611
001.510.847.5077. Email: Terhilda@gmail.com

SUMMARY

A seasoned leader focused on leveraging analytics and digital innovation in a transformation to 'smarter' healthcare.

With over 29 years at Kaiser Permanente, an \$80 BB integrated health care delivery system, developed a deep understanding of healthcare. As VP, Health IT Transformation & Analytics, was responsible for realizing strategic value and maximizing opportunities using HIT and advanced analytics. Awarded KPLA 'Pathmaker Award'. Rounded experience since retirement by working in/with early stage organizations. Governance experience with two boards. Skilled in working with senior management, operations leaders, researchers and MDs; and managing complex decision processes while integrating a range of stakeholder interests. Excel in innovating, developing vision and the tactical planning to achieve. A reputation for strategic planning and execution. Fluent Spanish.

VALUE PROPOSITION

Patient-Centered Care Strategy & Innovation

- As VP, Health IT Transformation & Analytics at KP, led team responsible for realizing value and identifying/maximizing opportunities with KP IT. Led KP business case for \$4 Billion investment in the electronics health record.
- Championed, piloted and evaluated kp.org personal health record which transformed primary care at KP. 51% of all primary care MD contacts are now virtual laying the foundation for telemedicine.
- Developed KP 'Blue Sky Vision' as framework for EHR investment.
- Assessed / advised on early stage healthcare organizations and proposals for GE Ventures, RHIA Ventures and OPTions.

Analytics Leadership

- **Led organizational assessment of analytic tools and the formation of the Analytics Council representing 2000 BI coders and data scientists**
- Built an analytic department (0 to 40 FTEs) that developed population health tools, predictive models for risk, NLP tools to assess free text in the medical record, assessed AI solutions such as IBM Watson and created hundreds of BI reports.
- Assessed / advised early stage organizations leveraging analytic tools in their operations for GE Ventures and RHIA Ventures portfolio.

Healthcare / Equity Range of Experience

- Worked with all members of the clinical leadership at a national, regional and local level across inpatient, outpatient and virtual continuum to solve operational issues.
- Worked in large corporate environment (\$88BB organization) and with small startups. Assessed/advised on early stage healthcare organizations and proposals for GE Ventures, RHIA Ventures and OPTions.
- Led early work on Medicare Risk-sharing products and Medicare 'Meaningful Use'

BOARD EXPERIENCE

Heluna Health, Industry, CA.

2022- Current

National organization that empowers healthcare organizations and researchers to improve the health and well-being of their communities with \$700M in revenues annually. Develops effective partnerships for population health and innovation. The organization builds evidence-based programs, provides fiscal support, and develops custom solutions.

Member of the Board of Directors, Audit committee

CareMessage, San Francisco, CA.

2020- Current

Start-up that partners with Medicaid/FQHC organizations to bring mobile technologies to the underserved and uses their platform to communicate critical health information to their patient populations.

Member of the Board of Directors, Audit committee

Possible Health, Nepal.

2016 - 2020

NGO providing innovative, affordable healthcare in Nepal that leverages technology and the accountable care model.

Member of the Board of Directors

2016-2018

Chair, Board of Directors

2018-2020

Kaiser Foundation Health Plan/Hospitals, Oakland, CA.

Presented to \$3Billion business case to Board of Kaiser Foundation Health Plan.

Presented investment cases to RHIA Ventures Board, Member of Latino Corporate Directors Association. Served on Advisory Board to SAS- Intl, Alumni Society, and InformedDNA. 'Break into the Boardroom' program sponsored by Oxeon/Deerfield.

PROFESSIONAL EXPERIENCE

Rhia Ventures, San Francisco, CA

2018- 2020

Social impact investment firm in women's health. A startup making thesis-driven investment in seed through Series C companies.

Strategic Director, Impact and Digital Access / Consultant

GE Ventures, Menlo Park, CA

2017-2018

Venture Capital group provides access to a global network of GE expertise and resources. Partners and invests in innovative ideas and companies in Health IT, big data analytics and health care improvement.

Executive in Residence

Kaiser Permanente, Oakland, CA

1983-1986 and 1989-2016

Nation's largest managed care org - non-profit insurance company, non-profit hospital system and medical group partnerships. This \$60B/year organization provides for 10M members in CA & nation with 38 hospitals and 17,000 physician partners.

Vice President, HIT Transformation / Analytics – Program Office 2005-2016

- Formed and grew an advanced analytics team focused on self-service business intelligence and deep analytic and statistical work including predictive analytics and NLP.
- Promoted KP's HIT and Analytic leadership role with natl and international speaking appearances. Supported KP policy efforts in Washington, DC.
- Championed data extraction capabilities and provided clinical leaders with new insights from new data. Led work with IT and Research on an Analytics for Care Transformation strategy.
- Leading 'Meaningful Use' efforts in Kaiser for CMS/ONC qualification - to date, yielding \$566million.
- Assessed IBM Watson for KP use/development using an open source leadership model.
- Built a new, highly functioning consulting group focused on developing, evaluating and spreading of promising and strategic KP HC practices to support/change regional inpatient and outpatient operations.
 - **Piloted and amplified use of telehealth at Kaiser** – Our team not only piloted the first telehealth application at Kaiser, but we expanded the term to include a variety of modalities: secure emails, televisits, pre and post visit questionnaires, These required assuring that accountability and fail-safe processes were in place.
 - **Predictive triage analytics** – Identified and/or developed predictive analytics to identify patients at risk and patients that could potentially benefit from treatment interventions.
 - **PROs – Patient reported outcomes.** Using direct patient responses as health outcomes. We piloted the first at Kaiser in oncology.
 - **Clinical decision support** - clinical protocols and judgement can be implemented/supported by technology in many subtle or intrusive ways.
 - **Reports and analytics** to evaluate the effectiveness of the operations, innovation or CDS (clinical decision support) for the ongoing and inevitable adjusting for operations improvement
 - **Natural language processing** – both to improve coding and also to identify key patient signals in progress notes, my team developed NLP code.
- Member of the IOM committee on Health Information Technology and Patient Safety; the IOM committee on EHR Digital Learning Collaborative project on ROI for EHRs

Senior Director, Clinical Systems Planning & Consulting – Program Office 2000- 2005

Ran strategy and analytic consulting department for Sr. VP –Hosp, Quality & Care Delivery Excellence. Initiated and led value realization development and analysis on the Electronic Health Record (EHR).

- Championed, conducted & published original evaluation analysis of EHR regional operations impacts. Led EHR business cases amounting to a projected \$4 billion in benefits realization over the next 10 years.
- Orchestrated the development of the 'Blue Sky Vision' – a strategic vision for the KP's care delivery in 2015.
- Sponsored, implemented and evaluated first KP pilot of the MyChart Personal Health Record and patient portal.

Project Director, Chronic Conditions Management (CCM) Program, TPMG, Northern CA 1999-2000

Managed development, implementation and ongoing support of population management of 9 conditions– a then new operations program to improve quality/efficiency. Coordinated analytic staff, financial staff, IT departments, department of Quality and Util, Health Educ and MD stakeholder groups to support medical centers' reengineering Adult primary care.

Managed strategy; delivered funding decisions for \$37M program investment in population management: Asthma, Diabetes, Heart Failure, CAD, Cholesterol Facilitated initiation of 60+ CCM programs and consequent reporting and monitoring at medical ctrs with 140 staff extending care to 57,000 members.

Director of Business Planning, CA Division - Hospital/Health Plan Organization for California 1997-1999

Focal point for business planning activities for CA operations. Led regional/local efforts on target-setting process for CA Business Plan submission to national organization. Reported to Sr. VP, Planning and Analysis.

Facilitated senior management discussions to develop financial performance challenge framework of turnaround plans for 1998-2001. This work set initial goals for organization (2%, 4% & 6% operating margin for 98-01).

Initiated/coordinated reduction of short/mid-term capital spending plans by \$1.1B (from \$6.3B over 5 years).

Practice Leader for Strategic Alliances, Northern California Hospital and Health Plan 1995-1997

Co-led new inpatient service strategies/implementation. Reported to Managing Director, KP Consulting.

- Led team of medical center operations leadership, financial analysts, contacting specialists, planning consultants, outside consultants in South Bay (3 hospitals). Explored hospital alliance strategy. Coordinated negotiations with Stanford Hospital System enabling leadership to assess potential operations merger.
- Partnered with physician group to develop Inpatient Service Guidelines – thresholds of high volume inpatient services for quality/cost effectiveness for KP Northern California.

KP Health Plan Reengineering Project, Northern California Health Plan 1993–1995

Innovative re-engineering project on health plan services. Recommended and advocated for Member Services Call Center creation.

Planning Manager, Facilities Planning Northern California – KFH/HP 1990-1993

Oversight of planners/analysts facilitating capital decision-making. Supported medical centers with operations planning, space planning, cost/benefit analysis, forecasting of member demand for services/space and cashflow analysis/balancing.

Operations/Utilization Analyst - Medical Economics & Statistics, Northern California – KFH/HP 1983-6

Responsible for rate-setting and long-term capital planning membership, utilization and resource forecasting and reporting along with rates and benefits calculations and patient satisfaction surveys

AT&T, Corporate Headquarters, Basking Ridge, NJ

1987–1989.

Internal Statistical Consultant reporting to Director of Strategic Operations Analysis

Analysys, Limited, Cambridge, England

1986-1987

Consulting firm specializing in telecommunications econometric modeling for European Economic Community (EEC).

EDUCATION

Executive Leadership Program, ELP - Harvard Business School 2008

Masters in Biostatistics – MPH, University of California, Berkeley

Summer Program in Social Sciences in Mexico D.F., Colegio de Mexico

Engineering Degree in Operations Research, B.S.E., Princeton University

PROFESSIONAL DEVELOPMENT

Green Belt Certified – Inst of Industrial Engr	CAP- Certified Analytic Professional: INFORMS Society
Total Quality Management / 6 Sigma	Strategic Decision Making (SDG Group, Palo Alto CA)
Programmed in SAS, Pascal VS, Fortran	Certified Healthcare Insurance Executive – AHIP 2012

AFFILIATIONS / COMMITTEES

KPLA – Kaiser Permanente Latino Association 2005 given the 'KPLA Pathmaker' Award	Princeton Alumni Schools Committee 1988-2018
SAS Customer Advisory Board 2013-5	British NHS Benefits Realisation and Achievement International Network (Brain) Member 2008-10
IOM Committee on Patient Safety & HIT 2010 /11	Health Plan Institute Fellow Latino Corp Directors Assoc. – 2020- current

Personal: Climbed Mt Kilimanjaro; enjoy golf, sports and adventure travel. 2 wonderful children from our 38 year marriage.

SELECTED PUBLICATIONS

- T. Garrido, D. Meng, J. Wang, T. E. Palen, M. Kanter, "Secure emailing between physicians & patients: transformation change in ambulatory care." **J Ambulatory Care Manage**, Vol 37, No 3, pp 211-218 (June 2014)
- T. Garrido, S. Kumar, J. Lekas, M. Lindberg, D. Kadiyala, A. Whippy, B. Crawford, J. Weissberg, "e-Measures: insight into the challenges & opportunities of automating publicly reported quality measures" **J Am Med Inform Assoc** doi:10.1136/amiajnl-2013-001789
- B. Lee, M. Turley, D. Meng, Y Zhou, T. Garrido, A. Lau, L. Radler, "Effects of Proactive Population-Based Nephrologist Oversight on Progression of Chronic Kidney Disease: A Retrospective Control Analysis," **BMC Health Services Research**. 2012, 12:252
- Y. Y. Zhou, R. Unitan, J. J. Wang, T. Garrido, H. Chin, M. Turley, L. Radler "Improving Population Care with an Integrated Electronic Panel Support Tool," **Population Health Management**, 2011 February; 14(1): 3–9
- T. Garrido, A. Chase, "Value and Quality." L. Liang, **Connected for Health**. San Francisco, **Jossey Bass**; 2010; Y. Y. Zhou, M. H. Kanter, J. J. Wang, T. Garrido "Improved Quality at Kaiser Permanente Through E-Mail Between Physicians and Patients," **Health Affairs**, Vol 29, No 7 (2010); 1370-1375.
- C. Chen, T. Garrido, D. Chock, G. Okawa, L. Liang "The Kaiser Permanente Electronic Health Record: Transforming and Streamlining Modalities of Care," **Health Affairs**, Vol 28, No 2, (2009); 323-333.
- T. Garrido, L. Jamieson, Y. Zhou, A. Wiesenhal and L. Liang, "Effect of Electronic Health Records in Ambulatory Care: Retrospective, Serial Cross Sectional Study," **British Medical Journal** 330.7491.581 (2005).
- T. Garrido, B. Raymond, L. Jamieson, L. Liang, A. Wiesenhal, "Making the Business Case for Hospital Information Systems," **Journal of Health Care Finance** 31, no. 2 (2004):16–25.
- R. Brentari, T. Garrido, R. Mittman, L. Liang, A. Weiland, A. Wiesenhal, R. Cordova, in **The Permanente Journal**: "Blue Sky Care Delivery 2015, Part I," Vol 7, No. 4, Fall 2003, pgs 47-50; "Blue Sky Part II: The Health Encounter," Vol. 8, No. 1, Winter 2004, pgs 93-97; "Blue Sky Part III: The Chronic Care Encounter," Vol. 8, No. 2, Spring 2004, pgs 71-75



State of the Industry 2023

Guideposts for strategically reshaping the industry

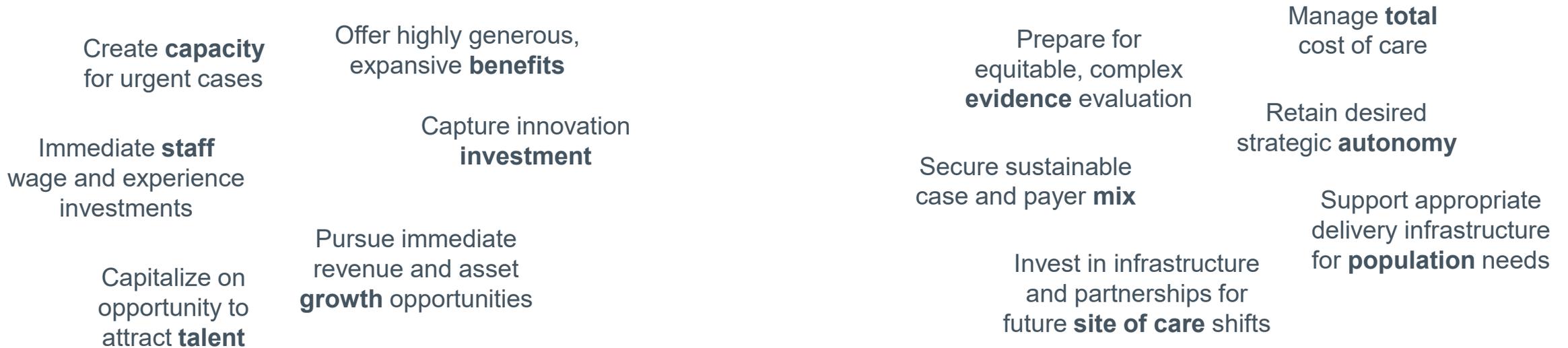
Today's facilitator:



Natalie Trebes
Managing Director,
Executive Strategy Research

Current responses enable—or impede—future ambitions

Current and future priorities of various health care industry organizations



NEAR TERM

Challenges and Opportunities



LONG TERM

Strategic Trajectory

The present feels aggressively urgent

Today's market dynamics put health care organizations in a position of unusually disproportionate focus on short term crises and opportunities. Leaders' strategic choices now will have an outsized impact—positive or negative—on their trajectory toward long-term goals.

The most disruptive market forces the industry faces



Global stressors

- Broader labor and supply pressures raise costs
- Labor shortage exposes structural vulnerabilities and prompts opportunistic recruitment



Demand volatility

- Compounding health crises complicate care delivery response for evolving needs
- Massive shift into Medicaid poised to decline while MA accelerates



Vertical ecosystems

- Health solutions giants continue strides toward vertical integration
- Health systems seek vertical assets but may merge defensively



Innovation investment

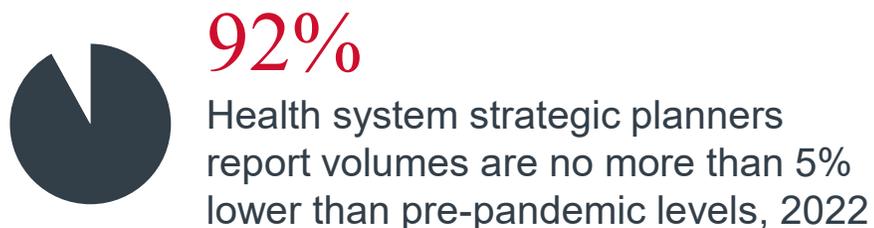
- Unprecedented tech venture investments face increasing scrutiny
- Enormous therapeutic pipeline upcoming will challenge industry capacity

IMMEDIATE IMPACT

BUILDING MOMENTUM

Elevated spending creates a tough business climate

UTILIZATION SPOTLIGHT



EXPENSE SPOTLIGHT

Median labor expense per adjusted discharge



- 69%**
ERODED MARGINS
 Health system strategic planners report operating margins **below** pre-pandemic performance, 2022
- 6.5%**
HIGHER PREMIUMS
 Expected average increase to employer health care benefits costs for 2023
- 375 bps**
CAPITAL SCRUTINY
 Increase in federal funds target interest rate from March to November 2022

Source: 2022 Strategic Planning Survey, Advisory Board, May 2022; "Aon: U.S. Employer Health Care Costs Projected To Increase 6.5 Percent Next Year," Aon, August 2022; Healthcare Dive, May 2022; "The Financial Effects of Hospital Workforce Dislocation," KaufmanHall, May 2022; "Health tech's sky-high projections in 2021 have already been punctured," STAT News, December 2021; "Healthcare investments and exits," Silicon Valley Bank, January 2022.



Vicious staffing cycle difficult for systems to escape

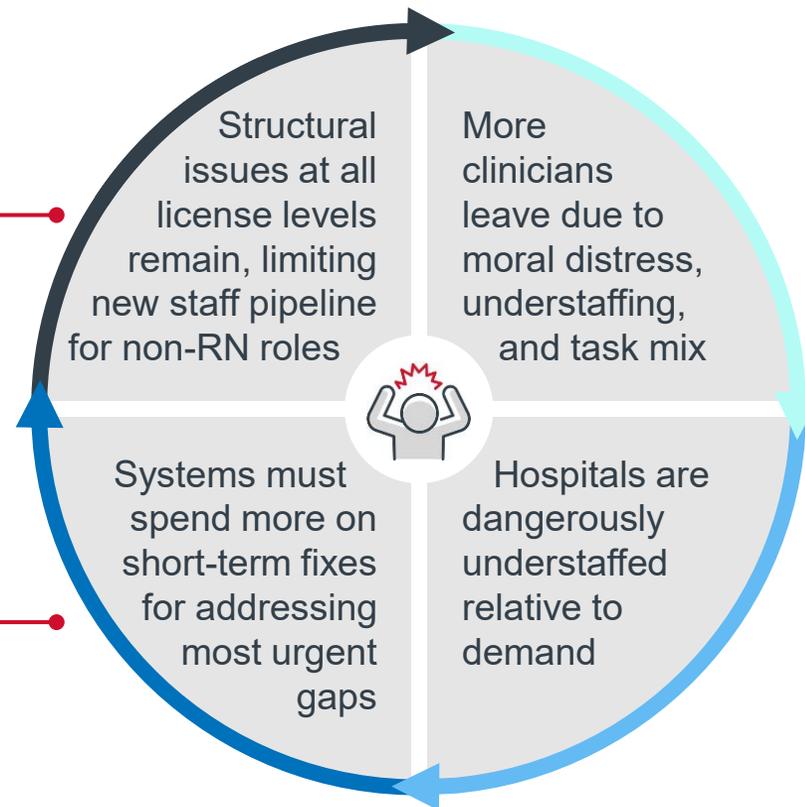
Nursing shortage creates treacherous feedback loop

Top factors nurses report for leaving their job¹

1. **Insufficient staffing**
2. Workload intensity
3. Emotional toll of job
4. Don't feel supported or listened to at work

2x

Increased spending on agency and traveling labor in 2021



Open questions about the future of clinical workforce strategy



Will clinical models adapt to reduced staffing and **solidify lower staffing ratios**?



Will staff maintain their new, **higher expectations for employers**—and at what cost?



Will the industry meaningfully embrace **automation and behavioral health tools** to minimize burnout?

1. Survey conducted spring 2021, n=314.

Source: "2021 Advisory Board hospital turnover and vacancy benchmarks," Advisory Board, March 2022; "Nursing in 2021: Retaining the healthcare workforce when we need it most," McKinsey, 2021.



“Great Resignation” is more likely a great realignment

Relative impact of the workforce crisis on key industry segments

*Staff limitations and margin crunch force some organizations to **pull back on strategic priorities***

*Non-traditional organizations position themselves to **siphon talent from provider organizations***

POTENTIAL TO **LOSE** TALENT

POTENTIAL TO **GAIN** TALENT



 **Hospitals & post-acute care**

- Elevated staffing costs
- Worsened experience-complexity gap
- Capacity constraints

 **Physician practices**

- Care team burnout
- Referral constraints
- Heightened partnership expectations

 **Life sciences**

- Challenge to engage target client base
- Delayed clinical trials
- Difficulty building RWE collection workflows

 **Health plans and purchasers**

- Pressure to offset provider costs
- Membership churn
- Demand for hyper attractive benefits

 **Ambulatory and virtual providers**

- Increased appeal of alternative clinician employment
- Opportunity to capture market share

 **Big tech, big retail, and startups**

- Arms race to attract talent
- Increased urgency and appetite for innovation

STRATEGIC IMPERATIVES AND DISRUPTED INITIATIVES



Compounding crises demand resources and bandwidth

Covid-19 still straining resources

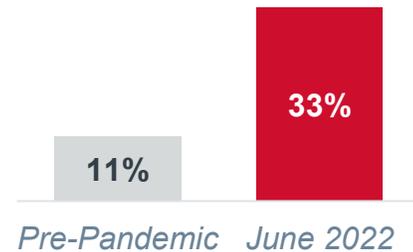
CASE EXAMPLE

Whiteriver, AZ

- November Covid-19 surge brings case rate “essentially **back to where we were** with our last big peak” in February 2022

Behavioral health crisis worsens

Percentage of adults reporting symptoms of anxiety or depression



Reproductive care access shock

“New Insurance to Cover Docs’ Post-Roe Legal Battles Over Abortion”

Washington state’s largest malpractice insurer, Physicians Insurance, will offer the “add-on” rider beginning 2023

Medscape

Pressure from other public health concerns

- Flu season
- R.S.V. surges
- Monkeypox public health emergency
- Opioid epidemic
- Natural disasters

Challenges amid evolving care demand pressures

Staff engagement

Supply management

Clinical quality

Leadership bandwidth

Care complexity

Clinician recruitment

Strategic initiatives

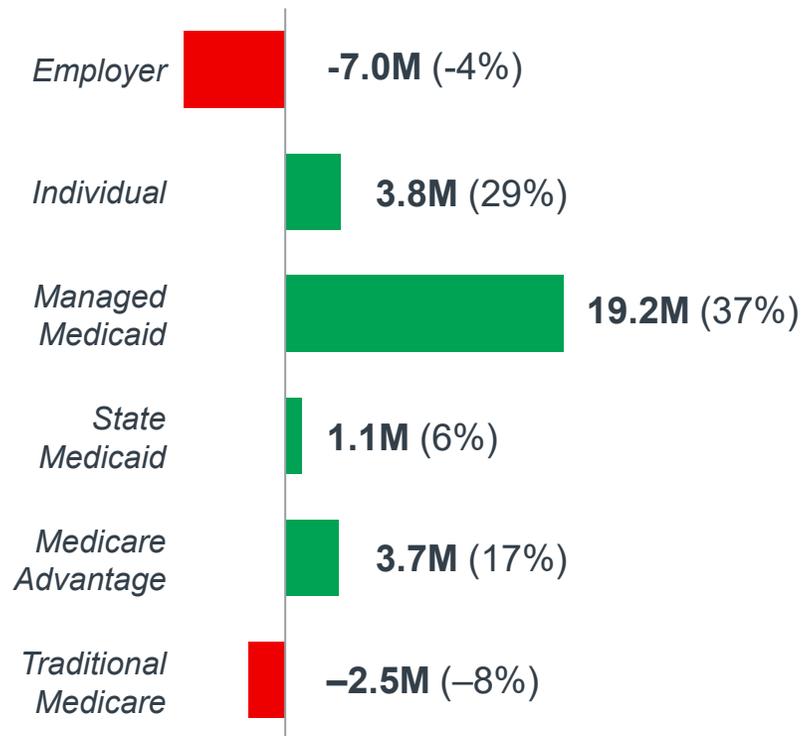
Source: “After a year, omicron still driving COVID surges and worries,” AP News, November 2022; “Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic,” KFF, June 2022; “2022 Monkeypox Outbreak: Global Trends,” WHO, August 2022



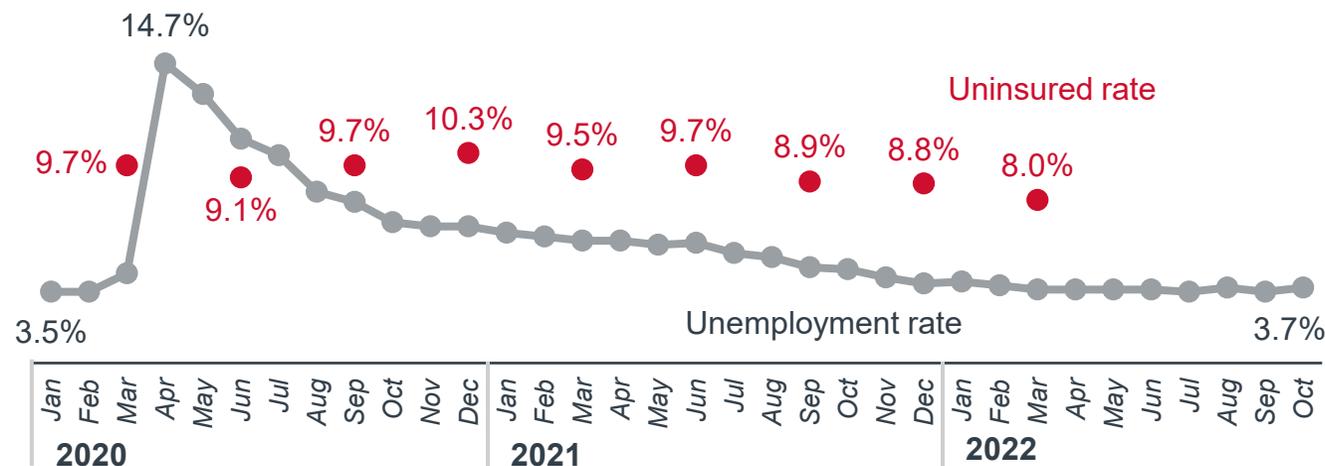
Today's coverage mix is a temporarily skewed picture

Insurance enrollment changes

2019 Q4 to 2022 Q2



Unemployment and uninsured rate



A looming Medicaid coverage cliff?

18M enrollees could lose coverage after Covid PHE¹ ends

65% of adults who could be disenrolled likely eligible for employer coverage

92% decrease in bad debt and charity care as revenue item, March 2020 to April 2022

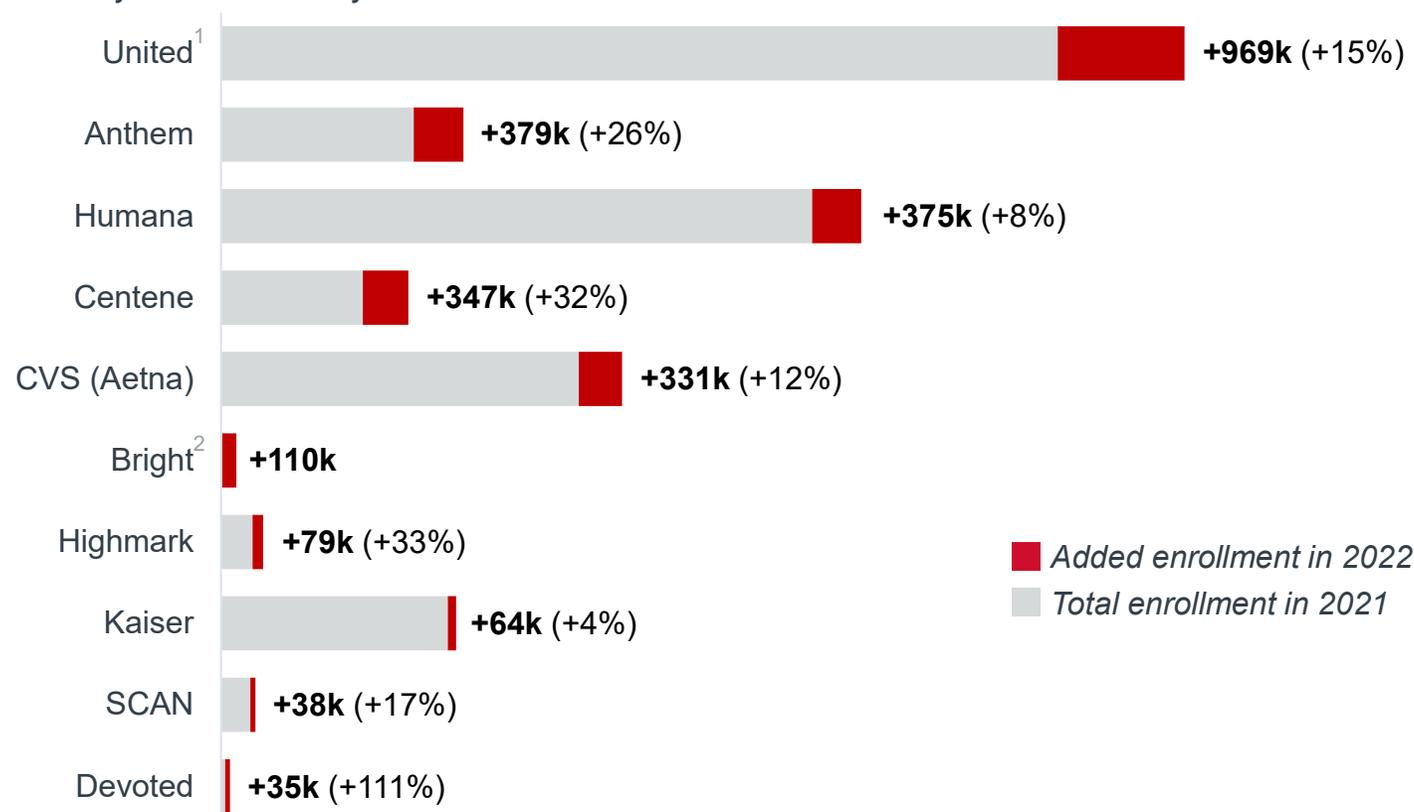
1. Public health emergency.

Source: AIS Directory of Health Plans, 2019 Q4 & 2022 Q2; "Health Insurance Coverage: Estimates from the National Health Interview Survey," CDC; "Labor Force Statistics from the Current Population Survey," BLS; "National Hospital Flash Report," KaufmanHall, April 2022; "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," Urban Institute/Robert Wood Johnson Foundation, December 2022.

Insurance giants and disruptors make leaps in MA

Largest Medicare Advantage enrollment increases

January 2021 to January 2022



1. Advisory Board is a subsidiary of Optum, owned by UnitedHealth Group. All Advisory Board research, expert perspectives, and recommendations remain independent.

2. Bright Health made its main entry into Medicare Advantage in 2021, and thus a percentage calculation is misleading.

MA growth is an integral strategic priority

“

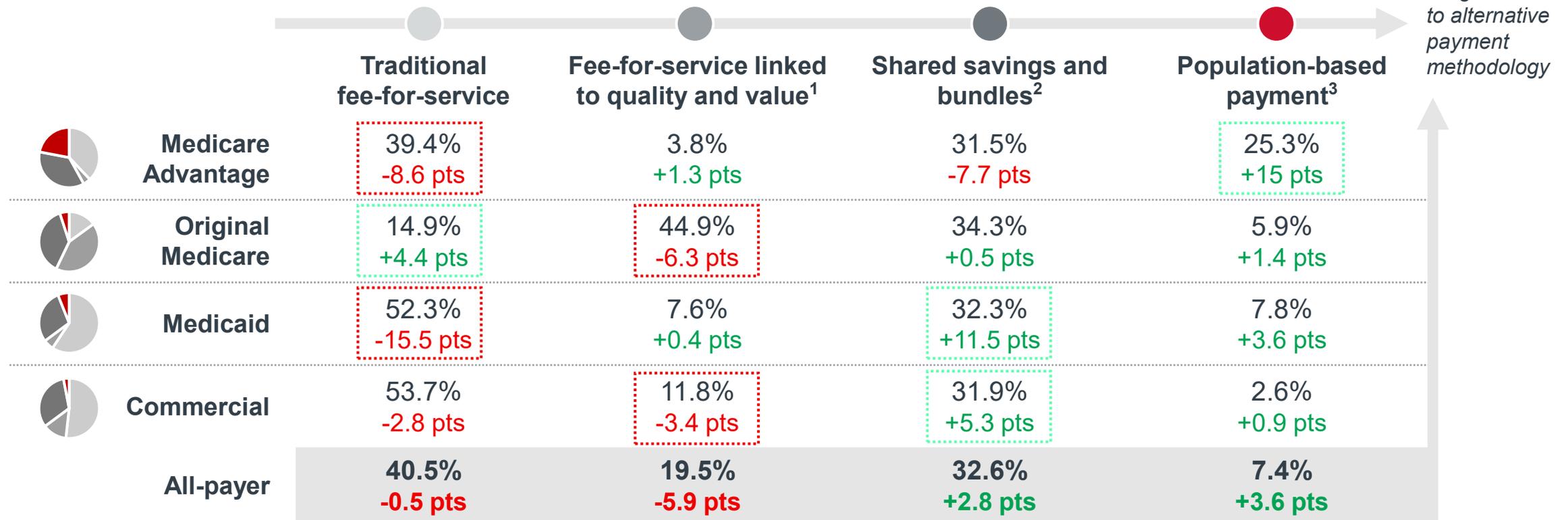
“[We will] create the needed capacity to **fund growth and investments** in our Medicare Advantage business, which we believe will **further drive** significant improvement in our membership growth as well as **further expansion** of our health care service capabilities.”

Bruce Broussard, CEO, Humana

Source: “Quarterly Results,” Humana, Q1 2022; “Monthly Enrollment by Plan,” CMS, January 2021 & January 2022.

Participants keep moving, but overall still sitting at 60%

Payments made in CY 2021 and percentage point change from payments made in 2017



1. Includes foundational payments for infrastructure and operations (e.g., care coordination fees) and fee-for-service plus pay-for-reporting payments and pay-for-performance payments.

2. Includes alternative payment models with shared savings with upside risk only and shared savings with downside risk. These are built on FFS architecture.

3. Includes condition-specific payments (e.g., PMPM for oncology or mental health), comprehensive population-based payment (e.g., global payments), and integrated finance and delivery systems (e.g., global budgets).

Source: "APM Measurement Effort", HCP LAN, 2022; "Progress of alternative payment models," HCP LAN, 2018.

Commercial risk options have tradeoffs on both sides

Follow the **public** sector risk footsteps:

A “glide path” to population-wide models



Options for pursuing commercial risk

Take distinct approach for **commercial** risk:

A focus on high-spend episodic models



Efficiencies from standardized incentives and infrastructure for providers



Results for purchasers and providers



Split focus required across multiple processes and capability needs



Overly broad emphasis on multiple chronic condition management



Tailored to commercial population’s clinical needs and savings opportunities



Industry players **collaborate** to develop uniform care model



Strategic position in ecosystem for success



Industry players **compete** for savings opportunities and strategic partners



Cross-sector alignment on weaving equity into quality

Industry players include health equity in quality performance



Blue Cross Blue Shield of Massachusetts becomes first health plan in market to incorporate equity measures into its payment models

PR Newswire, September 2021

JPMorgan and Kaiser Permanente plan to roll out performance guarantees tied to health equity on certain quality measures for JPMorgan employees.

Fierce Healthcare, January 2022

National Committee for Quality Assurance adds health equity metrics to quality data

Modern Healthcare, August 2022



How it works: BCBSMA's role

Across 2022

- Gather **member demographic data**, including race, ethnicity, and language
- Distribute **tailored reports** to participating provider organizations that highlight disparities in quality within their patient population
- Offer **coaching and support** to help providers organizations reduce disparities in quality

Starting 2023

Begin **tying payments to health equity performance** for participating provider organizations

- *Steward Healthcare Network, Beth Israel Lahey Health, Mass General Brigham, and Boston Accountable Care Organization*

Source: "JPM 2022: Morgan Health, Kaiser Permanente partner on health equity," Fierce Healthcare, January 2022; "BCBSMA signs value-based contracts incorporating equity measures," Healthcare Finance, December 2022.

Patients may be active, but hardly “free market” agents

Necessary conditions for consumer shopping in health care

CONDITION	DESCRIPTION	CURRENT STATE
Options to select	Meaningful differences in price and/or quality across providers	Significant variation across new and existing players
Awareness of choice	Consumer knows the moment they are making a decision	Most services are presented as a default next step
Transparent information	Ability to accurately compare between available options	Price data still messy and quality metrics remain elusive
Financial impact	Consumer has a personal financial stake in specific purchasing process	Incentive to shop limited to services under deductible; coinsurance impact limited
Willingness to self-refer	Consumer feels calm and confident in making a choice for their health issue	Majority of services are for urgent, complex, or undiagnosed conditions



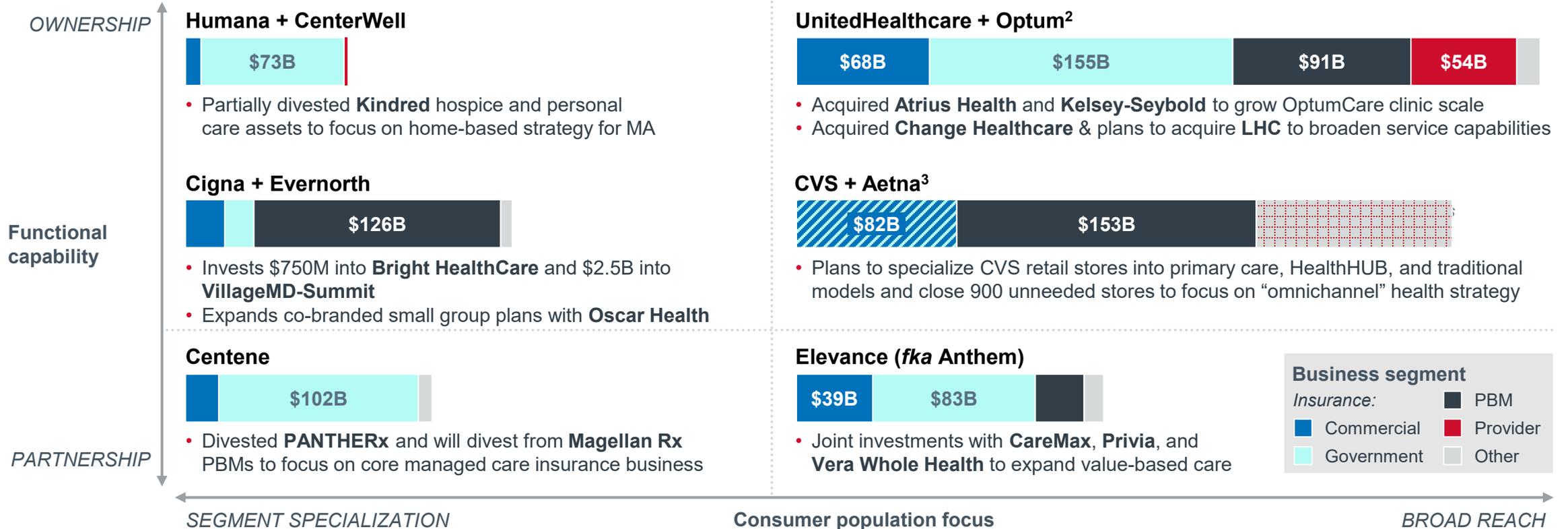
Transparency: The red herring of consumerism

Despite widespread focus on price transparency as an asset for consumers, the data doesn't reflect their shopping experience and lacks crucial context



National plans focus on growth through vertical assets

National health plans' relative vertical integration strategies and 2021 segment revenues¹



Business segment

- Insurance:
 - Commercial (Blue)
 - Government (Cyan)
- PBM (Dark Grey)
- Provider (Red)
- Other (Light Grey)

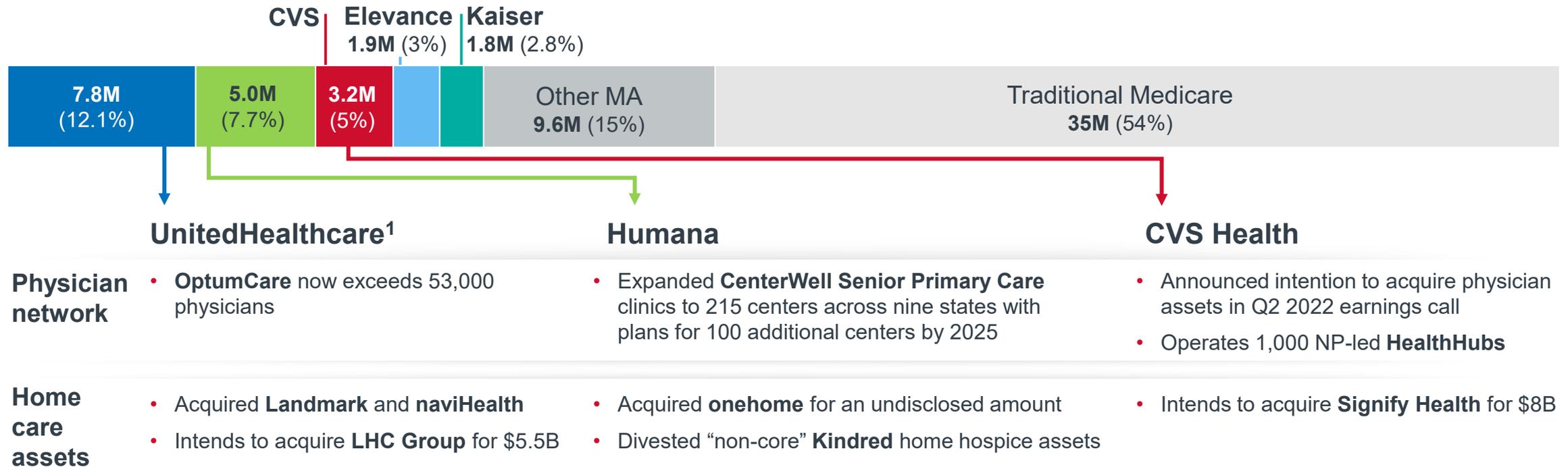
1. Sum of segment revenues is larger than total revenues due to internal transfers and eliminations.
 2. Advisory Board is a subsidiary of Optum, owned by UnitedHealth Group. All Advisory Board research, expert perspectives, and recommendations remain independent.
 3. CVS's 10-K filing does not further break its Aetna insurance business into specific insurance segment revenues.

Source: 2021 year-end earnings reports and 10-K filings from \$ANTM, \$CI, \$CNC, \$CVS, \$HUM, and \$UHC; "Humana Completes Divestiture of Majority Interest in Kindred at Home Hospice and Personal Care Divisions to CD&R," Humana, August 2022; "Bright Health nabs \$750M capital infusion with help from new investor (and competitor) Cigna," Healthcare Dive, December 2021; "What's in it for Evernorth? Cigna's health services arm invests \$2.5B in VillageMD-Summit," Healthcare Dive, November 2022; "CVS to close 900 drugstores under omnichannel health strategy," Supermarket News, November 2021; "Centene completes divestiture of PANTHERx," Centene, July 2022; "Anthem relies on flexible partner-not-build strategy in shift to value," Healthcare Dive, February 2022.

Nearly a third of seniors could be in a home “ecosystem”

Medicare total enrollment by plan and type, September 2022

Total number of enrollees in Medicare Advantage (MA) or Traditional Medicare

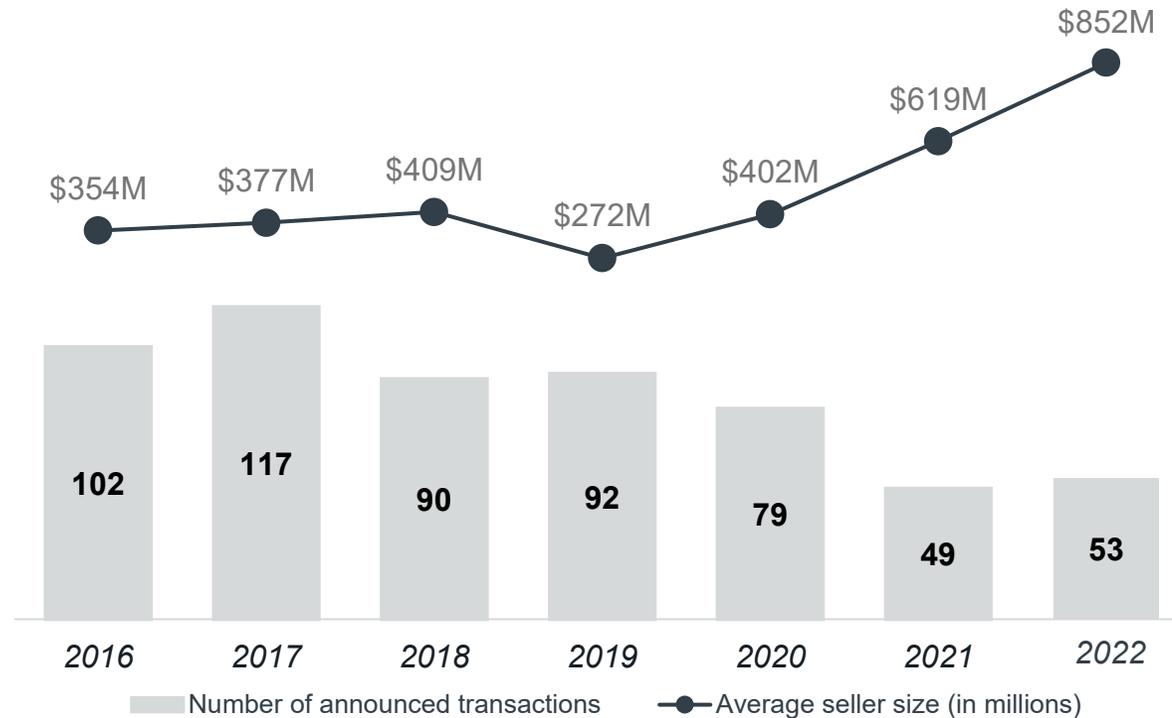


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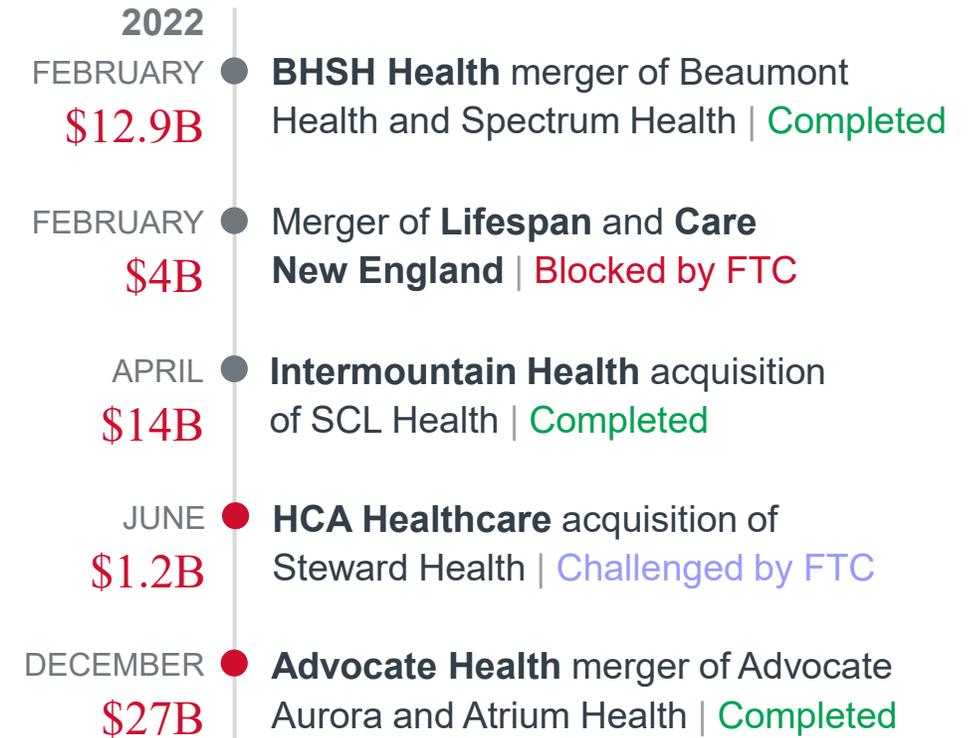
Source: “Monthly Enrollment by Plan,” CMS, 2022; “Medicare Monthly Enrollment,” CMS, May 2022; “Quarterly Results,” Humana, 2022; “UnitedHealth Group Reports First Quarter 2022 Results,” UHG, April 2022; “CVS Health to acquire Signify Health,” CVS, September 2022; “CenterWell Senior Primary Care to Open 9 Senior-Focused Care Centers in and Around Phoenix,” Business Wire, August 2022; Dyrda L, “10 physician networks with over 1,000 members,” Beckers ASC, April 2022.

Megadeal hospital M&A ambitions invite scrutiny

Hospital and health system M&A deal counts and sizes



Recent activities in “mega-merger” deals



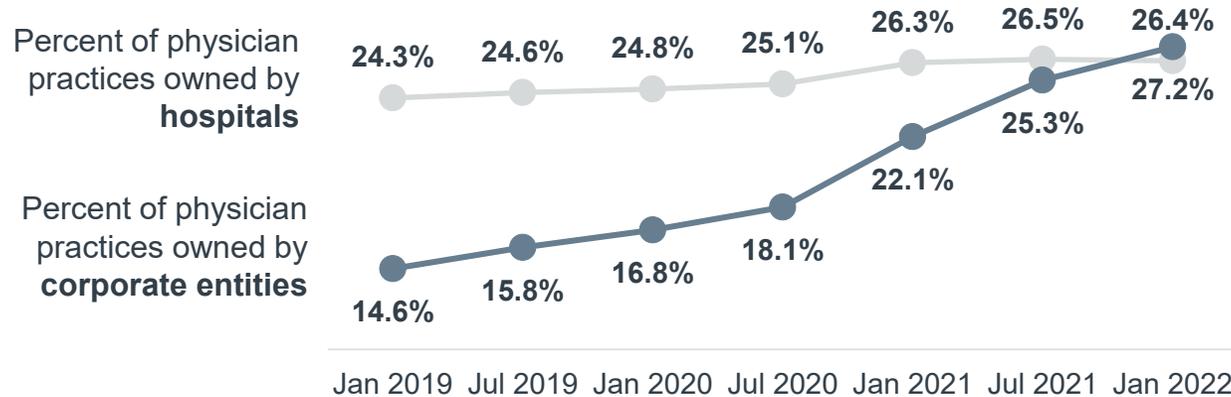
Source: “2021 M&A in Review: A New Phase in Healthcare Partnerships,” KaufmanHall, January 2022; “2022 M&A in Review: Regaining Momentum | Kaufman Hall,” KaufmanHall, January 2023; “M&A Quarterly Activity Report: Q1 2022,” KaufmanHall, April 2022; “M&A Quarterly Activity Report: Q2 2022,” KaufmanHall, July 2022; “M&A Quarterly Activity Report: Q3 2022,” KaufmanHall, October 2022; “The top 10 healthcare M&A deals of 2021” Fierce Healthcare, December 2021; “HCA Healthcare to buy operations of 5 Utah hospitals from Steward Health Care,” Healthcare Finance, September 2021; “Advocate Aurora Health, Atrium Health close mega-merger,” Fierce Healthcare, December 2022.



Practice acquisition is the real alignment shift to watch

Physician practice ownership trends

n= ~248,000 primary practice locations of physicians with NPIs in the IQVIA OneKey database



Large independent groups are....

...hesitant to work with hospitals

“We collaborate where things **have to** be done in the hospital...but if it can be done outpatient, we ignore the system.”

CEO OF A LARGE PRIMARY CARE GROUP

...not afraid to negotiate

Sample partnership deal-breakers:

1. Partnership exclusivity
2. Right of first refusal to employ

...intentionally playing the field

“We work with multiple systems so we aren’t beholden to any single system.”

EXECUTIVE OF A LARGE SINGLE SPECIALTY GROUP

In 2018, practices with 10 or fewer physicians represented:



75% of practices owned by physicians



41% of practices owned by hospitals

Source: “COVID-19’s Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020,” PAI June 2021; PAI-Avalere Health Physician Employment Trends report, April 2022; “Policy Research Perspectives,” AMA, 2019; “Policy Research Perspectives,” AMA, 2021.

The “superpractices” driving physician realignment

National physician superpractice archetypes

PRESERVE AUTONOMY

Service partner

Organization that sells services to physician practices, often forming a loose affiliation between practices

Coalition

Organization formed by physician practices who share knowledge and resources while maintaining individual identities

ENABLE INTEGRATION

Aggregator

Corporate entity that acquires physician practices and strives to create an integrated group at scale

National chain

Corporate entity that seeks to replicate a physician practice model and brand across multiple markets, often through building new practices

Growth trends in representative organizations, 2017-2022

Estimated increase in providers:

- **Summit Health: +1,100**
- **OptumCare¹: +23,000**

Estimated increase in clinics:

- **ChenMed: +50**
- **Oak Street Health: +100**
- **One Medical: +50**

Common features of superpractices



Holistic, coordinated care team



Standardized care pathways



Centralized referral management



Complementary ambulatory infrastructure



Care and risk management analytics



Shared, integrated EHR

1. Advisory Board is a subsidiary of Optum, owned by UnitedHealth Group. All Advisory Board research, expert perspectives, and recommendations remain independent.

Source: “Optum’s \$4.9B deal to buy DaVita Medical Group further expands UnitedHealth’s care delivery portfolio,” Fierce Healthcare, December 2017; “ChenMed Celebrates 28% Membership Growth in 2017,” ChenMed, 2017; “Oak Street Health expanding to Philadelphia,” Philadelphia Business Journal, October 2017; “One Medical opens new tech-driven, membership-based primary care center in Seattle,” Geek Wire, May 2017; Summit Health, 2022, summithealth.com; OptumCare, 2022, optumcare.com; ChenMed, 2022, chenmed.com; Oak Street Health, 2022, oakstreethealth.com; One Medical, 2022, onemedical.com.

A brief history of superpractices in diverse partnerships

Sample partnerships with superpractices

Hospital is the core network partner



“Health First forms strategic partnership with Privia Health”

- Privia assisting system’s owned medical group with population health and care coordination

“Hartford HealthCare, One Medical announce collaboration on coordinated care”

- One Medical will enable primary care coordination with system

“OhioHealth and ChenMed open three dedicated senior medical centers in underserved areas”

- ChenMed training system’s clinicians in high-touch model

Privia

One Medical

ChenMed

Alternative partner seeks to avoid hospitals



“Privia Health inks capitated Medicare Advantage agreements with Humana”

- Privia will take health plan PMPM payments to cover total care cost

“One Medical and ParetoHealth partner to bring innovative healthcare solutions to employers”

- One Medical will be offered to employers seeking lower total costs

“Independence Blue Cross & Miami-based ChenMed form provider partnership”

- Health plan supporting ChenMed’s entry into local market

Source: “Health First Forms Strategic Partnership with Privia Health,” Health First, March 2019; “Privia Health Enters into Capitated Medicare Advantage Agreements,” Seeking Alpha, January 2022; “Hartford HealthCare, One Medical Announce Collaboration on Coordinated Care,” Hartford Healthcare, February 2022; “One Medical and ParetoHealth Partner to Bring Innovative Healthcare Solutions to Employers,” One Medical, March 2021; “OhioHealth and ChenMed Open Three Dedicated Senior Medical Centers in Underserved Areas of Columbus,” Ohio Health, October 2019; “IBC, ChenMed align to expand health care access for seniors,” Philadelphia Business Journal, June 2018.



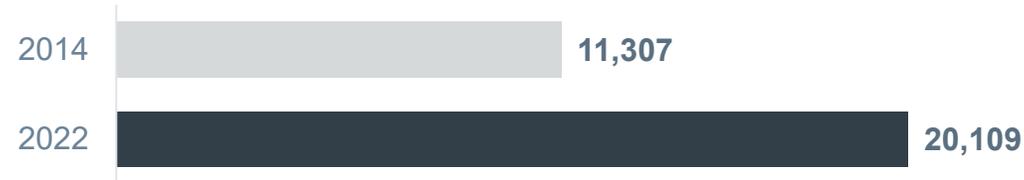
As provider assets grow, different goals emerge

Recent major investment or acquisition activities that align with broader business goals

Investor	VillageMD (Walgreens) with Cigna	CVS	Amazon	Optum (UnitedHealth)
Organization & Deal Value	Summit Health \$9B	Signify Health \$8B	One Medical \$4B	Change Healthcare \$13B
Assets	Population health platform practice with primary, specialty, and urgent care	Value-based care analytics and care coordination tools; national network of home-based care providers	Consumer-focused and tech-enabled hybrid primary care	Electronic data clearinghouse; revenue cycle management service
Investor goals	Deliver value-based primary care	Expand comprehensive, multimodal care reach	Elevate consumer experience in health care	Support administration for strategic provider partners

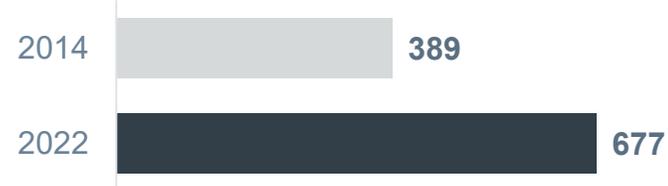
Pharma pipeline will raise revenue and clinical stakes

Total number of drugs in pharmaceutical R&D pipeline



More therapies

Number of rare diseases with active drug R&D



Rarer diseases

Number of clinical trials with decentralized components



Broader populations

Future revenue considerations for major life sciences organizations



\$21-47B

Projected spending on gene and cell therapy in 2026



\$115.5B

Annual sales revenues in 2020 for the top 15 drugs facing patent expirations by 2030

Source: "Pharma R&D Annual Review 2022: Navigating the Landscape," Citeline Informa Pharma Intelligence, March 2022; Casey Quinn et al, "Estimating the Clinical Pipeline of Cell and Gene Therapies and Their Potential Economic Impact on the US Healthcare System" *Value In Health*, June 2019; EvaluatePharma, 2020; "Emerging Therapies: Perspectives from an HSO," OptumRx, March 2021; "The top 15 blockbuster patent expirations coming this decade," Fierce Pharma, July 2021; "Decentralised clinical trials to reach new heights in 2022," Clinical Trials Arena, December 2021.

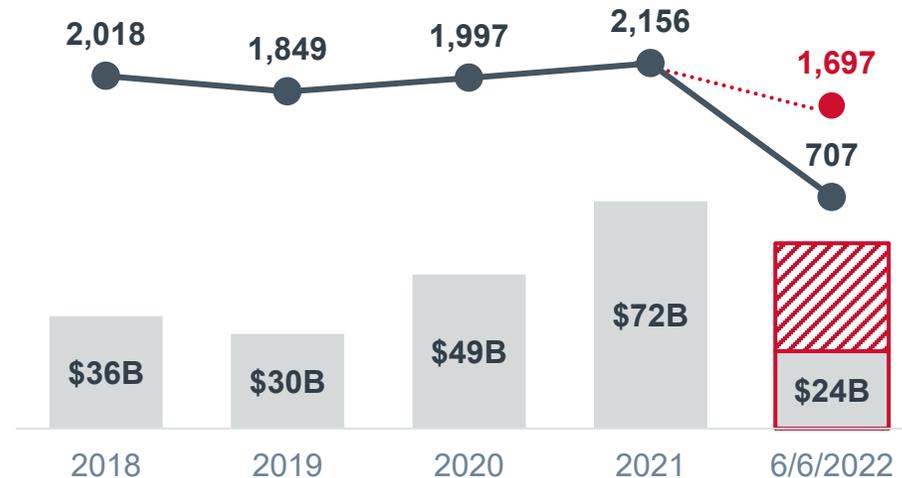
Tumultuous investing will pressure sectors differently

Sector status



BIOTECH VENTURES

Global biotech startup funding and total rounds¹

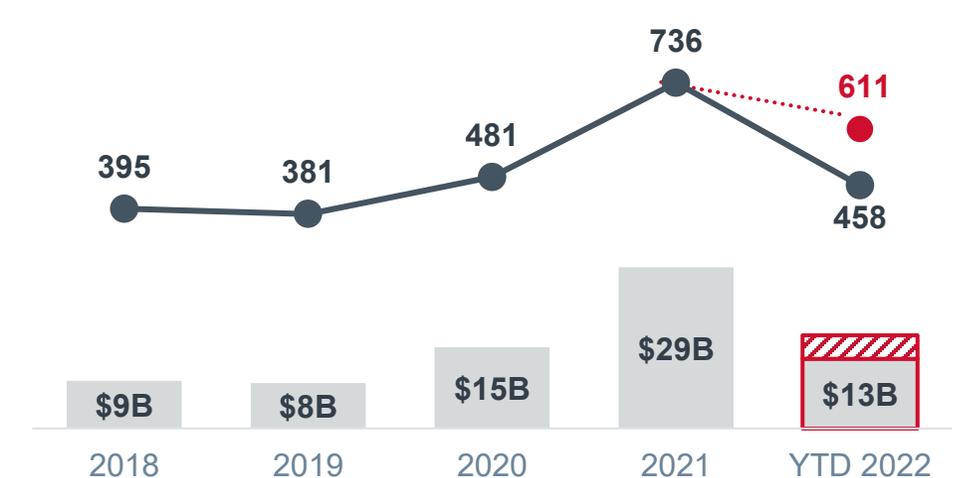


▶ Secure regular buyer for innovation (via sales partnership or acquisition)

❓ How will Big Pharma weigh further valuation drops against need for pipeline diversification?

DIGITAL HEALTH VENTURES

U.S. digital health startup funding and deal counts¹



▶ Demonstrate a sustainable benefit (such as consumer data) that constitutes predictable value

❓ How much will ventures need to integrate into traditional health care business structures?

Business need

Open question

1. Not to scale.

Source: "H1 2022 digital health funding," Rock Health, July 2022; "Biotech Startup Funding Has Also Slowed In 2022," crunchbase, June 2022; "Q3 2022 digital health funding," Rock Health, October 2022.

Service scaling outlook will vary by market and model

Assessment of whether services meet threshold criteria required for widespread growth

Criteria for growth	 SNF-at-home	 Hospital-at-Home	 Home primary and specialty care	 Home dialysis	 Home infusion	 Telehealth	Criteria status
Reimbursement status	✗	⚠️ ¹	⚠️	✓	⚠️	✓	
Staffing supply	✗	✗	✓	✓	✓	✓	✓ Generally met currently
Unpaid caregiver requirements	✗	⚠️	⚠️	✗	✓	✓	⚠️ Some challenges to overcome
Logistics and supplies	⚠️	⚠️	✓	⚠️	⚠️	✓	
Clinician and patient comfort	⚠️	⚠️	✓	⚠️	⚠️	✓	✗ Extreme barriers in place

 Scale of use

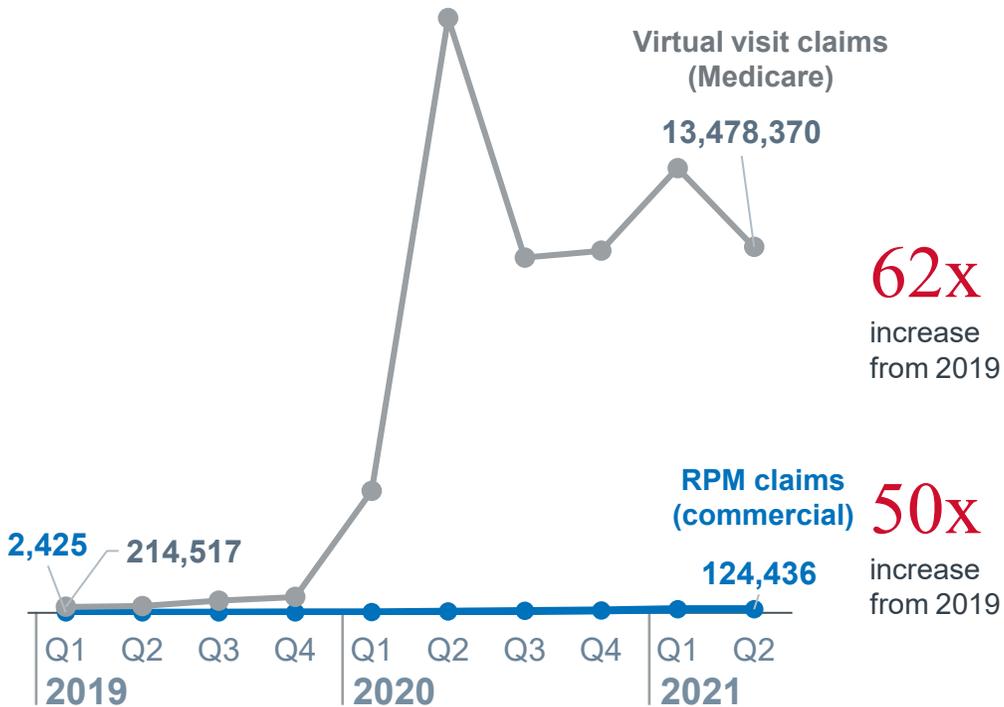
Targeted deployment in markets with capacity constraints or risk payments
 Broad implementation by most providers as a care standard

1. Reimbursement for Hospital-at-Home is currently bolstered by the public health emergency, but may subside in the future.



Still room to go on asynchronous and remote monitoring

RPM and virtual visit service volumes (in FFS)¹



Providers intend to invest in closing their modality gaps

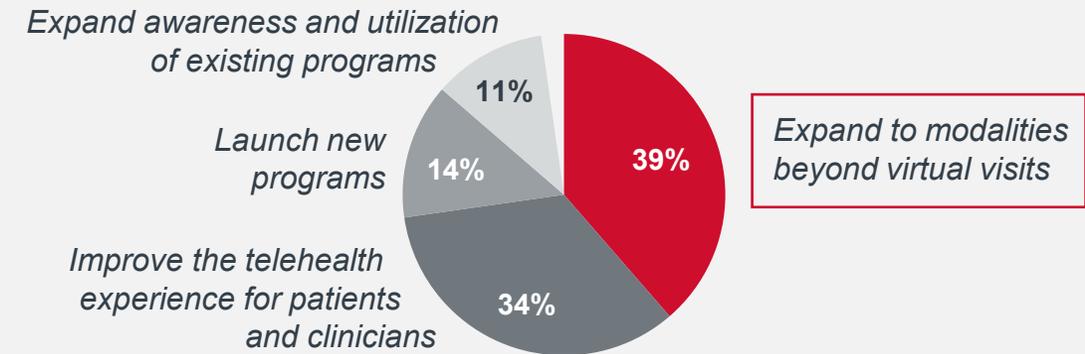
Providers with specific telehealth platforms in place

n=146 leaders from care delivery organizations, 2021



Top provider telehealth investment priority² for 2021

n=44 strategic planning leaders at provider organizations, 2021



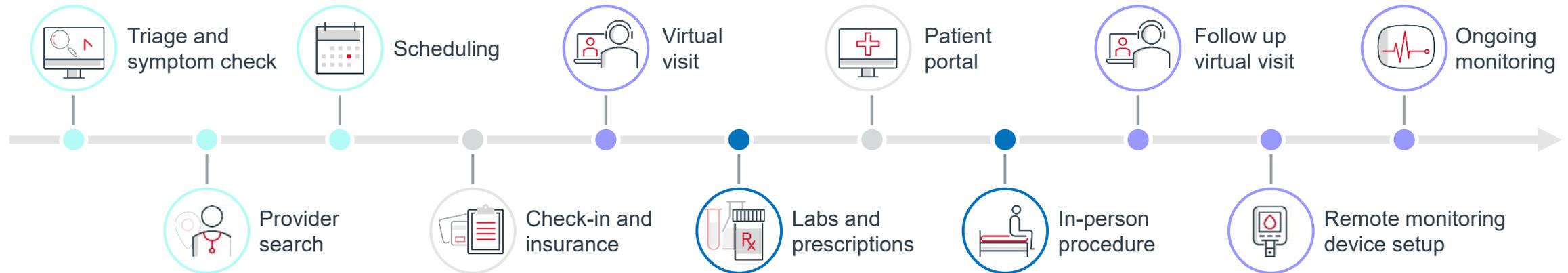
1. RPM claims data retrieved from Chronic Disease Management (CDM) commercial claims dataset and virtual visits data retrieved from CMS' Physician/Supplier Procedure Summary (PSPS) file.

2. "Which telehealth priority will receive the greatest investment and focus in 2021?"

Source: "Telehealth Growth and Development: Telehealth's Place in the Industry Beyond the Pandemic," Xtelligent Healthcare Media, June 2021; 2021 Strategic Planning Survey Results, Advisory Board, March 2021; Optum's de-identified Clinformatics® Data Mart Database; CMS' Physician/Supplier Procedure Summary (PSPS) file.

The broader digital picture offers wider care influence

The modern patient's health care journey



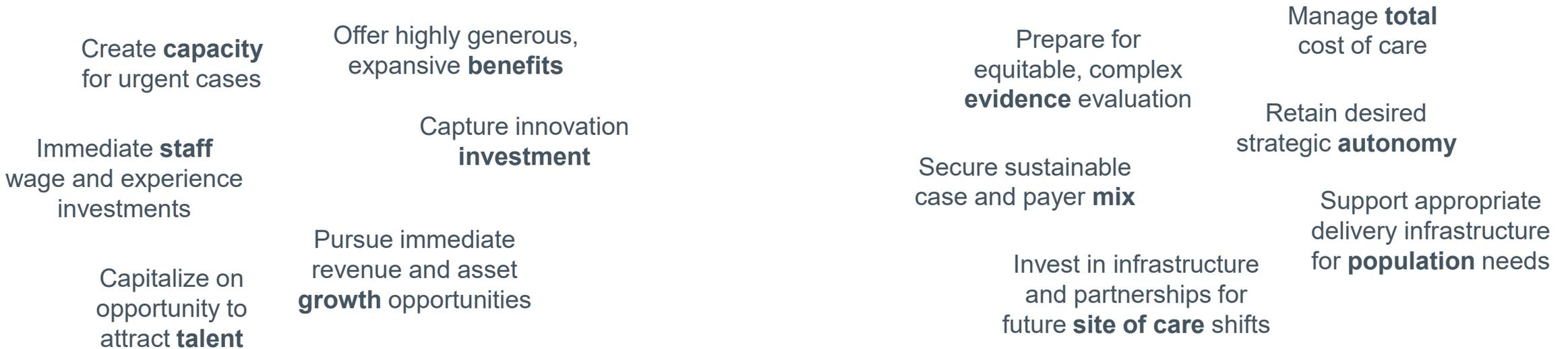
Digital tools with ability to **influence** downstream care

Potential replacements for traditional care services or management, with ability to **influence** downstream care

Downstream care services that often vary in cost and quality

Current responses enable—or impede—future ambitions

Current and future priorities of various health care industry organizations



NEAR TERM

Challenges and Opportunities



LONG TERM

Strategic Trajectory

Guideposts for strategically shaping the industry's future

Structural elements of health care in flux today

GOALS FOR OUTCOMES

STEERAGE MECHANISMS

CARE OPTIONS



Health equity

How far will the business mandate reach?



Physician partnership

How much will market power remain with physician groups?



Telehealth

How will strategic partnerships shape deployment?



Value-based payment

What tradeoffs will maximize sector-wide savings?



Consumer navigation

How will networks influence care choices?



Home-based care

How will market pioneers influence scaling services?

Industry choices may bring fragmentation or control



Flexible Fragmentation

Chaotic competition of diverse, flexible, fragmented players

Solely mission imperative	◀	HEALTH EQUITY	▶	Transformative business imperative
Public and private payers split on risk	◀	VALUE-BASED PAYMENT	▶	Industry-wide reimbursement standard
Hospital systems embrace physician-led care navigation	◀	PHYSICIAN PARTNERSHIP	▶	Industry unifies to circumvent hospitals
Curated choice architecture for procedures	◀	CONSUMER NAVIGATION	▶	Care choices hinge on ecosystem selection
Demands for consumer attention at every step	◀	TELEHEALTH	▶	Universal efficiency in care delivery and management
Cross-industry competitive stressor	◀	HOME-BASED CARE	▶	Standard value-add through coordination



Coordinated Control

Coordinated order controlled by comprehensive, integrated behemoths

The present feels aggressively urgent. Today's market dynamics put health care organizations in a position of unusually disproportionate focus on short term crises and opportunities. Leaders' strategic choices now will have an outsized impact—positive or negative—on their trajectory toward long-term goals.

HEALTH EQUITY

Health equity *may* define your margins.

Health equity is now clearly central to the mission of health care, and the industry is beginning to build it into a business imperative. Early movers are taking steps to integrate health equity into quality metrics—which could form a foundation for transforming the health care business model, or relegate equity initiatives to specific, granular targets.

VALUE-BASED PAYMENT

Decide which cost to target for employers.

While public programs have a clear trajectory toward population-based downside risk, commercial plans and providers have not coalesced around a viable model that meets employers' experience and cost needs. To progress, the industry must decide whether tailoring to utilization trends or standardizing clinical models will yield greater savings.

PHYSICIAN PARTNERSHIP

Practices will inevitably shift volumes.

Physician practices are integrating into well-resourced, innovative “superpractices” which often orient their operations around avoiding hospital care. As payers and financiers increasingly support the models, health systems will have to choose whether to wield their hospital assets in partnership with superpractices—or hyper-consolidate to keep power.

CONSUMER NAVIGATION

Consumer choice gets bigger *and* smaller.

A surge in care options and data is escalating the competition over influencing consumers' care decisions. But as consumers aren't well positioned to shop, health care organizations are focused on curating their navigation experience—and could steer consumers between increasingly granular choices about specific services, or engulf them in a managed ecosystem.

TELEHEALTH

Consumer attention is a tempting goal.

The industry has approached virtual visits as a direct replacement for in-person care, leaving opportunities from remote monitoring and asynchronous tools unexplored. As organizations broaden their telehealth strategy, they are competing to capture consumer attention—possibly at the expense of improved care efficiency.

HOME-BASED CARE

Competing in home care may stress all.

As industry stakeholders push forward their growth ambitions in home-based care, their challenges to scale vary with the diversity of services. Aggressive movers overcome reimbursement barriers by integrating services into total cost of care or high-cost service management levers, but may strain other providers or worsen inequities.



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- Presentations
- Conversations



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Sponsorship opportunities:

Content and events to boost your brand recognition and extend thought leadership across healthcare

Core Research Questions for 2023+

01 Shaping the new era of **value-based care**

- What are the implications of majority **Medicare Advantage** enrollment for VBC?
- What actions could **employers** take to overcome the structural barriers of employer-sponsored insurance in VBC?
- How will **vertical integration** influence success?

02 Addressing the **behavioral health crisis**

- Where should each organization **improve access** to behavioral health care, especially for the most vulnerable patient populations?
- What can different parts of the industry do to **increase the supply** of appropriately trained and supported behavioral health clinicians?
- Where should organizations **look for partners** to help improve outcomes?

03 Balancing **innovation, accessibility, and affordability**

- Will the **next sweep of innovations** replace, add to, or duplicate today's treatments and procedures?
- How do we deliver new innovations to patients when current systems aren't designed to **sustainably** support them?
- Will affordability drive systemic **accessibility challenges** and delay speed of adoption?

04 The future of the health care **workforce**

- Can **technology** help address the labor shortage?
- What health care workforce challenges have effective **technology solutions**?
- How should health care organizations plan for the **disruptive impact** of technology on the workforce?

05 Defining and competing on holistic **women's health**

- How will **Gen Z/Millennial female consumers** shift traditional engagement approaches?
- Is women's health care ripe for **technology-driven disruption**?
- How can industry stakeholders collaborate better to advance better **outcomes**?

06 Forecasting industry **diversification and disruption**

- How will acquisition, consolidation, and funding trends impact **competitive dynamics** across major industry stakeholders?
- Which disruptions and **new market entrants** pose the greatest risk to entrenched stakeholders? Which offer the **cooperative advantages**?
- What **goals** are large diversifying healthcare organizations pursuing (besides revenue growth)? Which strategies will succeed and which will fail?



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Advisory
Board

CEO Report
February 15, 2023
Dan Woods, Chief Executive Officer

Operations

Pharmacy

Due to increased demand for specialized emergency department pharmacists, we have expanded our ED pharmacy coverage to 7 days a week. This demand is trending nationally and having an ED pharmacist allows increased safety and immediate treatment for pediatric patients, critically ill patients, and those with complex medical conditions.

Finance

Through the end of December, patient activity remains strong attributed to COVID, flu and RSV. The month's results had gross charges of \$485.0 million which was favorable to budget by \$25.5 million/ 5.6% and \$52.0 million/12.0% higher than the same period last year. Operating results produced net operating revenue, after expenses, of \$10.3 million which was unfavorable to budget by \$3.0 million. Unfavorable to budget operating performance was attributed to higher use of premium pay, contract labor and high utilization of sitters. Net income was negative \$2.3 million, which was unfavorable to budget by \$18.7 million. Negative net income is attributed to non-operating income of negative \$12.6 million. Operating results for the first six months of FY23 was \$69.6 million which is favorable to budget by \$0.395 million. Management has implemented an operating improvement plan to more effectively manage the impact of labor shortages and ensure FYE results are in-line with budget.

Human Resources

The 56th Annual Employee Service Awards celebration was held on Thursday, February 2, 2023. At this virtual event 195 employees were recognized for celebrating a milestone anniversary of 15 to 45 years—over 4000 combined years of service to El Camino Health.

Information Services

Our ECH intranet, Engage, has 70% of the organization logged in to the platform comprising 249 pages published from 23 sites. One immediate benefit communicated by staff is the ability to see organizational structure, reporting relationships and the ability to search for individuals based upon department location and expertise.

To improve patient access and promote on-line scheduling in the ambulatory clinics, new Primary Care scheduling templates enhance schedule utilization and increase productivity and availability. In addition, clinics have the ability to use analytics to predict likely “No-Show” patients on the schedule and book additional appointments during these timeframes to increase access, revenue and efficiency. This is similar to the approach used by retail for maintaining capacity and volumes.

Marketing and Communications

On the media front, El Camino Health received national coverage on ABC's Good Morning America, in which Nirmaljit Dhami, MD, El Camino Health's Medical Director for Inpatient Perinatal Psychiatry was interviewed as a clinical expert on maternal postpartum depression for a infanticide story. For

social media, Facebook posts saw a 3.6% increase in reach and a 20.4% increase in page visits and on LinkedIn, we saw 23% increase in search appearances.

El Camino Health Foundation

In period 6, El Camino Health Foundation received \$516,782 in donations. This brings total funds raised by December 31, 2022 to \$5,957,844, which is 62 percent of goal for fiscal year 2023.

In January, Pamela and Edward Taft made a \$3 million gift to the Taft Innovation Fund. The intent of the fund is to enable El Camino Health leaders to think boldly and creatively, better plan for the future, and best serve our community. The Foundation has convened a Taft Innovation Fund Committee consisting of ECH executive team members Dan Woods, Dr. Mark Adams, Dr. Meenesh Bhimani, Omar Chughtai, and Deb Muro, Foundation staff members Andrew Cope and Lindsay Ehrman, and Foundation board representative Lane Melchor. The committee evaluated 21 innovation proposals from service line leaders across the enterprise and is moving forward on eight of those projects. All of them utilize technology to revolutionize the patient experience, enhance care coordination, or directly improve clinical outcomes. Per the Tafts' wishes, any announcements to the public will wait until ECH can communicate the first significant use of funds.

Government Relations & Community Benefit

Government Relations

On January 17, Santa Clara County Supervisor Cindy Chavez visited to learn more about our groundbreaking maternal mental health services. Our Maternal Outreach Mood Services (MOMS) Program, a collaborative effort between maternal health services and the Scrivner Center for Mental Health & Addiction Services, includes intensive outpatient care, partial hospitalization and, if needed, a dedicated inpatient perinatal psychiatry unit — only the third such specialty inpatient unit in the U.S. and the only one on the west coast.

Community Benefit

The annual grant application remains live and applications are due by February 24, 2023. Grantees submitted their mid-year reports in January. These reports allow Community Partnerships staff to monitor and to evaluate grant performance.

Corporate & Community Health Services

Concern launched Employee Assistance Programs (EAPs) for two large cities and a major county covering 35,000 employees in January.

The Chinese Health Initiative recruited 18 new volunteers who serve as Patient Ambassadors to visit Chinese patients at ECH.

The South Asian Heart Center engaged 381 new and prior participants in screening, education, and coaching programs to prevent heart disease and diabetes and completed 706 consultations and coaching sessions. We hosted 5 lifestyle workshops and health information events attended by 108 participants and community members.

El Camino Hospital Board												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/17	9/14	10/12	11/9	12/7	JAN	2/15	3/8	4/5	5/10	6/14
STANDARD												
Public Communication		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Committee Reports (Informational and Consent item, unless requested)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Consent Approvals (recommended by Committees) ¹		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Executive Session		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
CEO Report ²		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
STRATEGY												
Strategic Planning ³		✓			✓			✓			✓	
Board Retreat									✓			
QUALITY⁴												
Quality Committee Report			✓		✓			✓			✓	
Medical Staff Report			✓		✓			✓		✓		
FINANCE⁴												
Financials ⁵		✓			✓			✓			✓	
Budget Review & Approval												✓
COMPLIANCE												
Annual Corporate Compliance Summary						✓						
GOVERNANCE												
Board Self-Assessment & Action Plan			✓									
Director, Committee Member, and/or Chair Appointments												✓
Committee Charter Review												✓
EXECUTIVE PERFORMANCE												
CEO Performance Evaluation & Compensation				✓								

Last Update: 01/10/2023

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

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

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

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

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