El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AMENDED AGENDA

SPECIAL MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, November 8, 2017 – 5:30pm
El Camino Hospital | Conference Rooms EF&G (ground floor)
2500 Grant Road Mountain View, CA 94040

Jeffrey Davis, MD will be participating via teleconference from Cessna Business Park, Sarjapur – Marathahalli Outer Ring Road, Kadubeesanahalli, Bellandur Post, Bengaluru, Karnataka, 560103, India.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Lanhee Chen, Board Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**5:32 – 5:33**
3.	**BOARD RECOGNITION** *Resolution 2017-12* **ATTACHMENT 3**	Deb Muro, Interim CIO	*public comment*	**motion required 5:33 – 5:38**
4.	**QUALITY COMMITTEE REPORT** **ATTACHMENT 4**	David Reeder, Quality Committee Chair		**information 5:38 – 5:48**
5.	**PROPOSED HOSPITAL BOARD AND ADVISORY COMMITTEE ASSESSMENT TOOL** **ATTACHMENT 5**	Peter Fung, MD, Governance Committee Chair	*public comment*	**possible motion 5:48 – 5:58**
6.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.* b. Written Correspondence	Lanhee Chen, Board Chair		**information 5:58 – 6:01**
7.	**ADJOURN TO CLOSED SESSION**	Lanhee Chen, Board Chair		**motion required 6:01 – 6:02**
8.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**6:02 – 6:03**
9.	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board Meeting (October 11, 2017) b. Minutes of the Closed Session of the Special Meeting to Conduct a Study Session of the Hospital Board (October 25, 2017) ***Information*** *Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: c. Organizational Clinical Risks	Lanhee Chen, Board Chair		**motion required 6:03 – 6:05**

A copy of the agenda for the Special Board Meeting will be posted and distributed at least twenty four (24) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
10.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Report	Rebecca Fazilat, MD, Mountain View Chief of Staff; J. Augusto Bastidas, MD, Los Gatos Chief of Staff		**motion required 6:05 – 6:15**
11.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trades secrets: - Marketing Implications for New Programs and Services	Kelsey Martinez, Director, Marketing & Communications		**discussion 6:15 – 6:40**
12.	*Gov't Code Section 54956.9(d)(2)* – conference with legal counsel – pending or threatened litigation; *Gov't Code Section 54957.6* for a conference with labor negotiator Dan Woods; *Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trades secrets: - CEO Report on New Services and Programs, Legal Issues, and Labor Relations	Dan Woods, CEO		**discussion 6:40 – 7:50**
13.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters: - Executive Session	Lanhee Chen, Board Chair		**discussion 7:50 – 7:55**
14.	**ADJOURN TO OPEN SESSION**	Lanhee Chen, Board Chair		**motion required 7:55 – 7:56**
15.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Lanhee Chen, Board Chair		**7:56 – 7:57**
16.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Lanhee Chen, Board Chair	*public comment*	**motion required 7:57 – 7:59**
	Approval a. Minutes of the Open Session of the Hospital Board Meeting (October 11, 2017) b. Minutes of the Open Session of the Special Meeting to Conduct a Study Session of the Hospital Board (October 25, 2017) ***Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee*** c. Annual Safety Report for the Environment of Care ***Reviewed and Recommended for Approval by the Medical Executive Committee*** d. Medical Staff Report ***Information*** e. FY18 Period 3 Financials			

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
17.	**CEO REPORT** **ATTACHMENT 17**	Dan Woods, CEO		**information** **8:00 – 8:04**
18.	**BOARD COMMENTS**	Lanhee Chen, Board Chair		**information** **8:04 – 8:09**
19.	**ADJOURNMENT**	Lanhee Chen, Board Chair		**motion required** **8:09 – 8:10pm**

Upcoming Meetings

- January 10, 2018
- February 14, 2018
- March 14, 2018
- April 11, 2018
- May 9, 2018
- June 13, 2018

Board/Committee Educational Gatherings

- April 25, 2018

EL CAMINO HOSPITAL BOARD

RESOLUTION 2017 - 12

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

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

WHEREAS, the Board wishes to honor and acknowledge the Information Technology (IT) Senior Leadership team for enabling transformational technology that is making it easier for patients, employees, and physicians to interact and improve patient care. The use of innovative technology has earned El Camino Hospital recognition as a 2017 Most Wired hospital by the American Hospital Association's Health Forum.

This designation aligns with El Camino Hospital's rich history of adopting new technology to enhance patient care. In partnership with Lockheed, the hospital implemented the world's first computer aided medical information system in 1971. More recently, the hospital rolled out iCare and received Epic's 2015 and 2016 Good Install award.

The Epic platform has helped El Camino Hospital transform the delivery of care. More than three million patient records have been exchanged with outside entities ensuring that providers have access to critical health information at the time of care. Patients now have the ability to obtain, use, and share their own data and records securely, which enables them to be more involved in their care and the maintenance of their health.

Data from electronic systems is being used to improve decision making and train clinicians on how to use analytics to improve patient care. El Camino Hospital uses analytics and modeling to predict which patients are most at risk of falling or developing sepsis and alert caregivers. Data is also being used to improve operating room workflows by analyzing surgery start times and utilization of surgery block schedules.

El Camino Hospital is also taking security seriously by performing audits, vendor risk assessments, security awareness training, phishing campaigns, and Security Incident Response planning and practice exercises.

WHEREAS, the Board would like to publically acknowledge members of the IT Senior Leadership team for integrating technology and advancing access to data to foster a culture of continuous improvement.

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

James Brummett	Kristy Ikerd	Brad Miller
Susan Bukunt	Craig Joseph	Dave Zucker
	Mike Mellor	

FOR LEADING THE USE OF TECHNOLOGY TO IMPROVE CARE.

IN WITNESS THEREOF, I have here unto set my hand this **8TH DAY OF NOVEMBER, 2017.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee Chen, JD, PhD	Peter C. Fung, MD	Bob Rebitzer
Jeffrey Davis, MD	Julia Miller	David Reeder
Neysa Fligor		John Zoglin

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

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THE HOSPITAL OF SILICON VALLEY

ECH BOARD MEETING AGENDA ITEM COVER SHEET

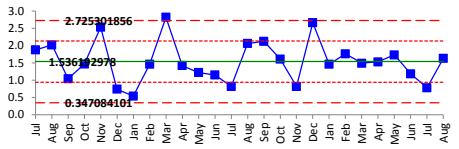
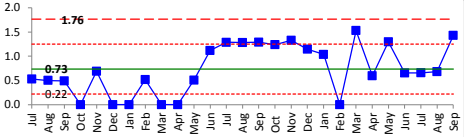
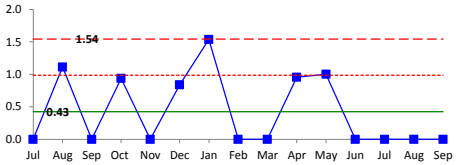
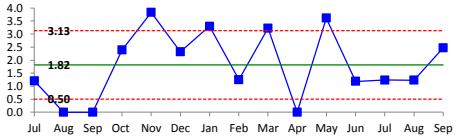
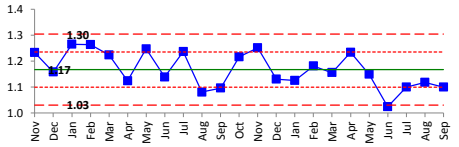
	Item:	Quality, Patient Care and Patient Experience Committee ("Quality Committee") Report El Camino Hospital Board of Directors November 8, 2017
	Responsible party:	Dave Reeder, Quality Committee Chair
	Action requested:	For Information
	Background: The Quality Committee meets 10 times per year. The Committee last met on October 30, 2017 and meets next on December 4, 2017.	
	Summary and session objectives: Summary of October 30, 2017 Meeting - 1. Clinical Program Presentation: Dr. Shaun Cho, Co-Medical Director for Electrophysiology, provided an overview of El Camino's Electrophysiological Services. The service addresses, both diagnostically and therapeutically, the increasingly prevalent problems of atrial fibrillation and other electrical conduction diseases of the heart. Volume for EP services has increased 173% since 2013 with over 340 procedures now done at ECH per year, with excellent outcomes reported on several registries. 2. FY18 Quality Dashboard: Catherine Carson, RN, Senior Director of Quality Improvement and Patient Safety, reviewed the new quality dashboard with the Committee and there are no negative trends. Regarding Hospital Acquired Infections (HAIs), our area of intense organizational focus, we have had no CLABSIs during the first quarter of FY18 but are running slightly above target on CAUTIs, and slightly below target for C. difficile. Ms. Carson also shared, for the first time, ECH's performance on Core Measures from CMS Hospital Compare. 3. Peer Review Implementation Process: Catherine Carson updated the committee on the OPPE process, which will be much more robust in November than ever before due to the implementation of new data extraction software and staffing to create metrics. 4. CDI Dashboard: Jessica Hatala, RN, Interim Manager of Clinical Documentation Improvement, shared significant advances in our clinical documentation program over the past year, with the addition of three concurrent clinical reviewers. This has resulted in millions of dollars of added revenue to the hospital, but just as importantly, our mortality index and expected length of stay have improved because the severity of patient conditions is being captured more completely and accurately. 5. Patient and Family Centered Care: Cheryl Reinking, RN, CNO, shared a partial list of tactics by which we are addressing our HCAHPs performance and patient centered care, including: Increased nursing bedside handoffs, patient-centered discharge rounding combined with an improved discharge instruction method, empathy-building exercises and an expansion of the "Getting to Know You" program, which focuses on specific patient needs.	

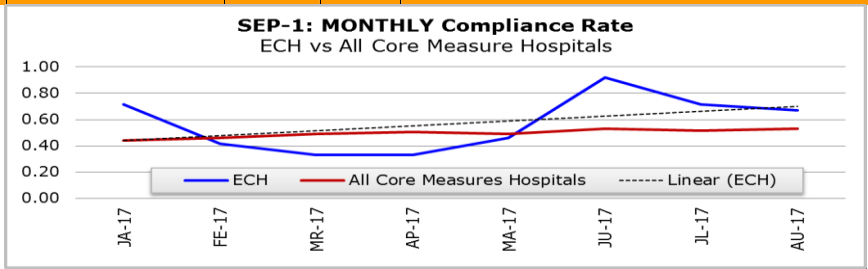
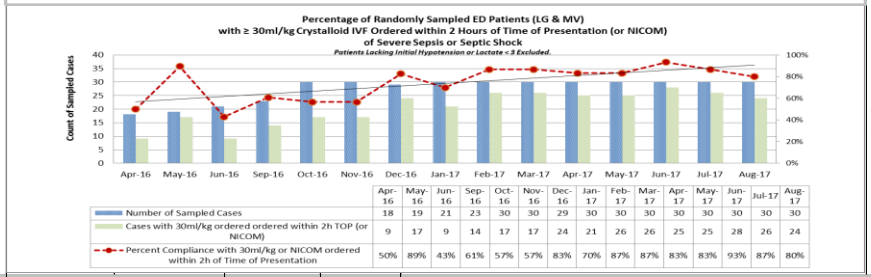
ECH BOARD MEETING AGENDA ITEM COVER SHEET

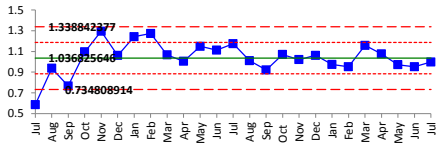
	Suggested discussion questions: None.
	Proposed Board motion, if any: None
	Attachment: 1. FY18 Quality Dashboard

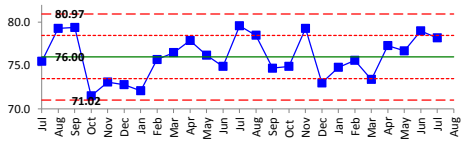
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

Reports run: 10/18/17		Performance		Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS		Month	FYTD	FY2017	FY2018		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: Sep 2017*	1.60 (8/4,990)	1.33 (20/14,990)	1.49	0.74 (top decile CAL NOC		New goal from CALNOC @ 0.74, August result above the mean for July 2015-July 2017. USF Nursing Master students conducting validation on ECH nurses completion of fall risk assessment tool. Tiral of new toilet seat sensor to alarm if pt. raises up from toilet to address falls in bathroom.
2	^Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: Sep 2017* *SIR Goal: <= 0.75*	1.43 (2/1,394)	2.87 (4/4,384)	Rate = 1.09 SIR = 1.06	SIR = 0.75		2 CAUT in Aug. - 2 in Sept. HAI A3 actions: Nurse -driven protocol for foley removal ready for MEC, competency for new foley insertion tray and procedure for ED, Critical Care,and OR, emphasis on daily bath, frequent peri care for pts. w/catheters.
3	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: Sep 2017* *SIR Goal: <= 0.75*	0.00 (0/889)	0.00 (0/2,885)	Rate = 1.09 SIR = 1.06	SIR = <0.5		Zero CLABSI in 1st qtr FY2018. HAI A3 focus on CLIP form insertion observation and insertion bundle, daily assessment of continued need for CVL.
4	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: Sep 2017* *SIR Goal: <= 0.75*	2.47 (2/8,112)	1.66 (4/24,317)	Rate = 1.89 SIR = 0.46	SIR = <0.75		2 C.Diff HAI in September, both related to long or mulitple antibiotic use. ABX Stewardship focused on appropriate ABX use with individual MD discussions.
Efficiency		Month	FYTD	FY17	FY 2018		
5	★Organizational Goal **Arthimetric Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: Sep 2017*	1.10	1.10	1.16	1.11		GMlOS has improved with CDI from FY17 of 4.08 to 4.19 in September. ALOS has also improved to 4.63, thus improving this ratio to below target goal.

Reports run: 9/20/17		Baseline	FY18 Goal	Trend	Comments
6	**Sepsis Core Measure** SEP-1 100% or O% *Date Period: Aug 2017*				Sep-1 Core measure compliance increased to 67% - represents 4 fallouts. All core measure hospitals at 50%.
7	**IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded) *Date Period: Aug 2017*				Compliance at 80% orders for bolus received w/I 2 hrs of TOP.

Mortality	Performance Month	Performance FYTD	FY 2017	FY 2018		
8	**Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: July 2017*	1.00 (1.56%/1.56%)	1.00 (1.56%/1.56%)	1.02 (1.88%/ 1.83%)	0.62		CDI has increased Expected Mortality rate as more co-morbid conditions are documented, increasing the risk of death. 5 high volume DRGs O/E below 1.0 are Heart Failure/shock, Intracranial Hem/Cerebral infarc, Renal Failure w/cc, GI Hemorrhage w/cc, & Septicemia/servere sepsis

SERVICE	Performance Month	Performance FYTD	FY 2017	FY 2018		
9	«Organizational Goal **HCAHPS Rate Hosptal 0-10** **Top Box Rating 9 and 10** *Date Period: August 2017*	80.5 (186/231) (Aug preliminary not avail until 10/27)	79.4 (369/465) (Aug preliminary not avail until 10/27)	76.30			Data for August is premlinary, final data for August not availble unti l10/27, projected data at meeting 10/30 will be final. Nursing team addressing Nurse Communication results with focus on Handoff communication.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Governance Committee Report – Proposed Hospital Board and Advisory Committee Assessment Tool. El Camino Hospital Board of Directors November 8, 2017
	Responsible party:	Peter C. Fung, MD, Chair, Governance Committee
	Action requested:	Possible Motion

Background:

<u>Board and Committee Self-Assessment</u>

Each year the El Camino Hospital Board of Directors participates in a Board Self-Assessment and Board Chair Assessment, and, every other year, the Self-Assessment includes a self - assessment of the Advisory Committees. Last year, the Board conducted only the Board and Board Chair Self-Assessment, and a decision was made to delay taking action on the results until the new CEO was in place.

1. Committee Assessment**:** The Governance Committee has the task, as one of its approved metrics this year, to assess the effectiveness of the Advisory Committee Structure that the Board expanded in 2012. The Governance Committee discussed assessing: 1) The added value of Committees, 2) Efficiency and effectiveness of the Committees, 3) Whether or not the Board utilizes the Committee recommendations and expertise of the Non-Director members, 4) How the Board might improve Committee structure/operations, and 5) Potential areas that would benefit from Committee work and deliberation not covered by the current structure (*e.g.*, strategic planning). To that end, at the request of the Governance Committee, Nygren Consulting developed the attached enhanced Committee Assessment Tool for FY18 and the Committee voted to recommend that the Board adopt it.
2. Board and Board Chair Assessment**:** The Governance Committee discussed at length the value of conducting the full Board and Board Chair assessments this year. For several reasons including the delayed action on last year's self-assessment results, the addition of two new Board members, the hiring of a new CEO, and the recent appointment of Board Chair Chen, the Committee voted to recommend that the Board conduct a limited Board and Board Chair Assessment this year with only a few open ended questions.

Board Advisory Committees that reviewed the issue and recommendation, if any:
The Governance Committee recommended that the Board adopt the proposed Board, Board Chair, and Committee Assessment Tools for FY18.

Summary and session objectives:

To discuss the Governance Committee's recommendation and adopt a Board and Committee Self-Assessment Tool for FY18.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Suggested discussion questions: 1. In light of the fact that action on last year's self- assessment has been delayed, should the Board conduct a Board Self-Assessment this year? 2. If yes, should it be in the shortened (proposed) format? 3. If no, should the Board leverage last year's report and develop an action plan to enhance Board effectiveness? How? 4. Given that Board Chair Chen will only have been in office six months when the assessment is done, is it worthwhile to conduct a lengthy Board Chair Assessment this year? 5. What feedback does the Board have on the proposed Committee assessment tool?
	Proposed Board motion(s) , if any: To adopt the proposed Board and Committee Self-Assessment Tool.
	LIST OF ATTACHMENTS: 1. Proposed FY18 Board and Committee Assessment Tool

PROPOSED Board and Committee Assessment Tool FY2018

El Camino Hospital

Submitted on: October 11, 2017
Prepared for: El Camino Hospital Board of Directors
Prepared by: David Nygren, PhD, and JoAnn McNutt, PhD

Survey Components

There will be separate links for each survey. This will break up the length and make it easier to track who has completed the following surveys:

- **Board Assessment Brief Questionnaire.** This will be completed by the Hospital Board of Directors, the Executive Leadership Team and Chiefs of Staff.
- **Committee Assessments (x6).** This will be completed by Hospital Board of Directors, the members of each committee, and management that serves as staff to each committee.

Board Assessment – modified assessment (only four open questions)

This section is to be completed by the Hospital Board of Directors, the Executive Leadership Team and Chiefs of Staff.

1. As you reflect on the past fiscal year, what has the board done well?
2. What could we have done better as a board? What are the lessons learned, if any?
3. In what ways can we further improve our governance practices and principles?
4. What advice do you have for the board chair?

Committee Performance

A. Evaluating the Overall Effectiveness of the Committee Structure – New Section

This section is to be completed by the Hospital Board of Directors and non-director committee members.

Open-Ended Questions
1. What are the strengths of ECH's committee structure overall?
2. What are your recommendations for how the committees can strengthen their efficiency and effectiveness? Please be as specific as possible. (Consider committee structure, composition, meeting agendas, quality and timing of materials received from staff, quality of recommendations given to the board, annual committee goals, and any other relevant areas.)
3. How effectively does the board take into consideration committee recommendations and the expertise of the non-director members?
4. Are there areas that would benefit from committee work and deliberation not covered by the current structure (e.g., strategic planning)?
5. Do you benefit from the work of committees that you do not sit on?

6. In what ways would cross-committee collaboration enhance your committee's work?
7. For long-term board members: a. Have dynamics changed since the committee expansion? b. Have the committees been meeting their intended purpose? c. Have the community members added distinct value to the committee in terms of discussion, debate, recommendations reached, etc.?

B. Committee Evaluation

This section is to be completed by Hospital Board of Directors.

5-point agreement scale	Corporate Compliance, Privacy, and Audit Committee	Executive Compensation Committee	Finance Committee	Governance Committee	Investment Committee	Quality, Patient Care and Patient Experience Committee
This committee does an effective job of providing clear direction within its scope of responsibilities.						
This committee provides the board with key strategic issues and information for discussion and decision-making.						
This committee chair ensures the board stays adequately apprised of the work accomplished in the committee.						
Overall, this committee provides effective oversight of their functional area.						

C. Committee Self-Evaluation

In this section, individuals will evaluate only the committee(s) on which he/she serves.

Core items for all committees:

1. The committee chair provides effective leadership for this committee.
2. The committee leadership effectively recruits top talent.
3. The committee leadership effectively retains committee members.
4. The committee meets often enough to effectively carry out its duties.
5. Committee members understand the hospital well enough to add value.
6. The committee's meeting agendas focus on the right strategic topics.
7. The committee effectively leverages staff support to get the information it needs in a timely manner.
8. The committee has the resources needed to fulfill its purpose.
9. The committee has a healthy, professional group dynamic that is characterized by active engagement and open discussion.
10. The committee ensures that non value-added work is actively identified and eliminated.
11. The committee's decisions are aligned with board goals and organizational strategy.
12. The committee efficiently reaches consensus on its decisions or recommendations to the board.
13. Open-Ended Question: In what ways can this committee improve its overall performance or working relationship with: ▪ The board? ▪ Other committees? ▪ Support functions?
14. Open-Ended Question: Is the committee receiving the right information from management? If not, how can management improve?
15. Open-Ended Question: Are there any other resources the committee needs to complete its duties?

Committee-specific items:

Quality, Patient Care and Patient Experience Committee
1. The committee effectively oversees management's development of the hospital's goals encompassing the measurement and improvement of quality, patient safety, patient experience, risk and clinical resource utilization.
2. The committee effectively oversees management's development of a multi-year strategic quality plan to benchmark progress using a dashboard.
3. The committee effectively monitors and oversees the quality of patient care and service provided.
4. The committee effectively monitors compliance with accreditation and licensing requirements.
5. The committee effectively reviews sentinel events and the corresponding root cause analyses.
Executive Compensation Committee
1. The committee develops and maintains an executive compensation philosophy that clearly explains the guiding principles on which executive pay decisions are based.
2. The committee develops and maintains executive compensation policies in line with the board-approved executive compensation philosophy.
3. The committee reviews and maintains an executive compensation and benefit program consistent with the board-approved executive compensation policies.
4. The committee oversees the CEO's performance evaluation to inform his/her compensation.
5. The committee effectively reviews and provides input on the CEO's personal succession and development plan.
6. The committee effectively reviews and provides input on the CEO's succession and development plan for senior executives.
Finance Committee
1. The committee effectively advises management regarding what steps it should take to ensure that the hospital remains financially strong.
2. The committee effectively advises management on how to improve its financial reporting in order to ensure accountability and ease of reading/understanding.
3. The committee effectively reviews and provides input on management's assessment of expected results/benefits as well as potential risks related to payer contracts.
4. The committee effectively reviews and makes recommendations to the board regarding all new debt and derivatives.

5. The committee effectively reviews the business plans of all major budgeted capital items to make informed recommendations to the board.
Investment Committee
1. The committee effectively reviews and recommends for approval by the board the investment policies for corporate assets and pension assets.
2. The committee effectively monitors the performance of the investment managers through reports from the independent investment advisor.
3. The committee effectively reviews and makes recommendations to the Finance Committee and the board regarding the selection of an independent investment advisor.
4. The committee consistently seeks input from the Finance Committee.
5. The committee exercises due diligence before recommendations are made to the board.
6. The committee operates on an appropriate level of risk that is beneficial to ECH in the long run.
Governance Committee
1. The committee recommends effective policies, budgets and annual plans for board and committee member orientation, education, training and development.
2. The committee recommends useful updates to hospital board governance policies where necessary and as required by legal and regulatory agencies.
3. The committee effectively oversees and facilitates board evaluations.
4. The committee effectively oversees and facilitates the nomination and selection of board and committee members.
5. The committee effectively facilitates the development and synthesis of annual board and committee goals.
6. The committee effectively monitors board effectiveness and recommends improvements to the board and committees.
Corporate Compliance, Privacy, and Audit Committee
1. The committee effectively oversees and recommends changes to the corporate compliance program.
2. The committee actively encourages continuous improvement of policies and procedures for corporate accountability, integrity, and privacy.
3. The committee effectively oversees and facilitates the work of internal audit, corporate compliance, and patient privacy.

4. The committee serves as an effective escalation and risk mitigation vehicle to identify and address relevant issues from any source.
5. The committee effectively oversees and makes recommendations on the selection and work of the external auditor.
6. The committee effectively assists management in working with the external auditor to resolve any issues brought forth.

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, October 11, 2017
2500 Grant Road, Mountain View, CA 94040
Conference Rooms F&G (ground floor)

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair		None
Jeffrey Davis, MD (via teleconference)		
Neysa Fligor		
Peter Fung, MD		
Julia Miller		
Robert Rebitzer		
David Reeder		
John Zoglin, Vice Chair		

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:30pm by Chair Chen. A silent roll call was taken. Directors Rebitzer and Davis joined the meeting at 5:34pm during Agenda Item 3: Board Recognition. Director Fung was absent. All other Board members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Chen asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. BOARD RECOGNITION	**Motion:** To approve *Resolution 2017-11*. **Movant:** Reeder **Second:** Zoglin **Ayes:** Chen, Fligor, Miller, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis, Fung, Rebitzer **Recused:** None Mick Zdeblick and Shyamali Singhal, MD recognized the Cancer Center at El Camino Hospital for 10 years of providing high quality care.	***Resolution 2017-11 approved***
4. FY18 PERIOD 2 FINANCIALS	Iftikhar Hussain, CFO, outlined the FY18 Period 2 Financials, noting that all indicators (including volume, margin, productivity, days of cash on hand) are doing well and are ahead of last year. There were no additional questions from the Board. **Motion:** To approve the FY18 Period 2 Financials. **Movant:** Zoglin **Second:** Reeder **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***FY18 Period 2 Financials approved***
5. FY17 FINANCIAL AUDIT	Brian Conner and Joelle Pulver of Moss Adams reviewed the results of the financial audits conducted for FY17. Mr. Conner outlined the scope of work performed for ECH including: FY17 consolidated financial statement audits (Hospital and District) and FY17 financial statement audits for the Foundation, CONCERN: EAP, and the Auxiliary. All reports include Moss	

	Adams' unmodified opinion, the highest level of assurance they can provide. Mr. Conner reported that financial statements as prepared by management were fairly stated in all material respects. Ms. Pulver highlighted: - Cash and investments are up substantially, $162 million in cash from operations; capital assets were $112 million offset by depreciation expense. - Current liabilities remain relatively consistent with prior years; she noted that FY17 includes $300 million dollars of debt taken out. - Net patient service accounts receivable, the largest estimate on the balance sheet, was down from 2016; the Epic implementation created delays in billing and collections that were resolved in 2017. In response to Director Davis' question, Ms. Pulver explained that ECH's results are pretty consistent with other organizations with a similar payor mix. - On the income statement, operating revenues were up $63 million; Ms. Pulver noted that operating revenues were largely spent on salaries, wages, and benefits. Mr. Conner reported that management selected and applied accounting policies appropriately and consistent with those of the prior year and that management's estimates are reasonable. Ms. Pulver reported that Moss Adams' proposed adjustments related to charges posted in July related to services in June ($3 million) and negative balances in accounts receivable ($2 million); management considered these to be immaterial and Moss Adams concurred with that assessment. In response to Director Miller's question, Ms. Pulver described Moss Adams' letter related to the two significant deficiencies in FY18, which includes management's response to put a process in place to ensure proper cut off at the end of the year. Director Zoglin commented that the Board should keep in mind the $5 million in unadjusted differences from FY17 when reviewing financial results at the end of FY18.	
6. QUALITY COMMITTEE REPORT	Director Reeder, Chair of the Quality Committee, reported that the Committee received a presentation from Albert Pisani, MD, about the ECH Robotic Surgery program. Director Reeder noted that not all of the FY18 metrics on the Quality Dashboard have data this early in the year. He described the Committee's review of readmission rates by procedure, emergency department patient satisfaction scores, and the Culture of Safety survey results. In response to Director Fligor's question, Director Reeder described the Early Recovery After Surgery (ERAS) program.	
7. GOVERNANCE COMMITTEE REPORT	Due to Director Fung's absence, Chair Chen noted that the discussion on the Board and Committee Self-Assessment Tool will be deferred until the Board's November meeting as the adoption of the tool for FY18 is not urgent at this time. Director Rebitzer, Governance Committee member, provided an overview of the Committee's recommendations on the Proposed Revised ECH Board Member Election and Re-Election Process and the Proposed ECH Board Member Position Description, noting that the 5 top priority competencies	

	were the same as FY17. In response to Director Chen's question, Director Rebitzer reported there were no dissenting opinions regarding the Committee's recommendations. In response to Director Miller's question, Director Zoglin described the District Ad Hoc Committee's reasons for proposing the Governance Committee consider revisions to the Election and Re-Election Process and the value add of having another advisor to the Ad Hoc Committee. **Motion:** To recommend that the El Camino Healthcare District Board of Directors approve the Proposed Revised El Camino Hospital Board Member Election and Re-Election Process. **Movant:** Zoglin **Second:** Reeder **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None **Motion:** To recommend that the El Camino Healthcare District Board of Directors approve the Proposed Revised ECH Board Member Position Description. **Movant:** Reeder **Second:** Davis **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***ECH Board Member Election and Re-Election Process recommend-ed for approval*** ***ECH Board Member Position Description recommend-ed for approval***
8. PUBLIC COMMUNICATION	Ms. Judy van Dyke communicated thanks from community members and District residents to Ken King, CASO and his team for their work on the campus construction projects.	
9. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 5:58 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (September 13, 2017) and Minutes of the Closed Session of the Executive Compensation Committee Meeting (May 23, 2017); pursuant to *Health and Safety Code* 32155 for deliberations concerning reports on Medical Staff quality assurance matters: Organizational Clinical Risks; pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters: FY17 Financial Audit; pursuant to *Gov't Code Section 5496.9(d)(2)* – conference with legal counsel – pending or threatened litigation: FY17 Compliance Summary Report and Semi-Annual Physician Expense Summary Report; pursuant to *Health and Safety Code* 32155 for deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report; pursuant to *Gov't Code Section 54957*and *54957.6* for discussion and report on personnel performance matters: Proposed FY17 Individual Executive Goal Scores; pursuant to *Gov't Code Section 54957*and *54957.6* for discussion and report on personnel performance matters: Proposed FY17 Individual Executive Incentive Payments; pursuant to *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets: Medical Staff Development Plan and Recruitment Budget; pursuant to *Gov't Code Section 54957*and *54957.6* for discussion and report on personnel performance matters and *Health and Safety Code 32106(b)* for a report	***Adjourned to closed session at 5:58 pm.***

	involving health care facility trade secrets: Informational Items; pursuant to *Gov't Code Section 54957* for discussion and report on personnel performance matters: Executive Session. **Movant:** Miller **Second:** Reeder **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	
10. AGENDA ITEM 21: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 8:02pm. Agenda items 10-20 were addressed in closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (September 13, 2017), Minutes of the Closed Session of the Executive Compensation Committee Meeting (May 23, 2017), the FY17 Compliance Summary Report and Semi-Annual Physician Expense Report, the FY17 Individual Executive Goal Scores, and the Medical Staff Report by a unanimous vote in favor of all members present (Directors Chen, Davis, Fligor, Miller, Rebitzer, Reeder, and Zoglin). Director Fung was absent.	
11. AGENDA ITEM 22: CONSENT CALENDAR	Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Hospital Board Meeting (September 13, 2017); Appointment of Chair of Corporate Compliance/Privacy and Internal Audit Committee; HR Leave of Absence Policy; Annual 403(b) Audit; Participant Cash Balance Plan Audit; Minutes of the Open Session of the Executive Compensation Committee Meeting (May 23, 2017); FY18 Period 1 Financials; Level II NICU Call Panel Agreement; Physician Recruitment Loan; Medical Staff Report; and for acceptance: FY17 Community Benefit Plan Report. **Movant:** Zoglin **Second:** Miller **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Consent calendar approved***
12. AGENDA ITEM 23: FY17 FINANCIAL AUDIT APPROVAL	**Motion:** To approve the FY17 Financial Audit. **Movant:** Miller **Second:** Reeder **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***FY17 Financial Audit approval***

13. AGENDA ITEM 24: MEDICAL STAFF DEVELOPMENT PLAN AND RECRUITMENT BUDGET	**Motion:** To approve the proposed physician recruitment plan that includes income guarantees in the areas of Primary Care (4 max), OB/GYN (2 max), General Surgery (2 max), Cardiology sub-specialties (2 max), and Orthopedic Surgery sub-specialties (3 max), and up to 2 additional unspecified specialties with a budget not to exceed $5.9 million for FY18-FY19. **Movant:** Reeder **Second:** Davis **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Medical Staff Development Plan and Recruitment Budget approved***
14. AGENDA ITEM 25: FY17 INDIVIDUAL EXECUTIVE INCENTIVE PAYMENTS	Chair Chen noted that Cindy Murphy, Director of Governance Services, had copies of the proposal available for the public. **Motion:** To approve the FY17 Individual Executive Incentive Payments **Movant:** Zoglin **Second:** Miller **Ayes:** Chen, Davis, Fligor, Fung, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***FY17 Individual Executive Incentive Payments approved***
15. AGENDA ITEM 26: INFORMATIONAL ITEMS	Dan Woods, CEO, outlined the current scoring of the FY18 organizational goals, the recent accreditation surveys, and activities of the Auxiliary and the Foundation as further detailed in the packet. He highlighted ECH's presentations of best practices at the recent Epic User Group Conference.	
16. AGENDA ITEM 27: BOARD COMMENTS	There were no questions or comments from the Board.	
17. AGENDA ITEM 28: ADJOURNMENT	**Motion**: To adjourn at 8:07pm. **Movant:** Miller **Second:** Davis **Ayes:** Chen, Davis, Fligor, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Meeting adjourned at 8:07 pm.***

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

_____
Lanhee Chen
Chair, ECH Board of Directors

_____
Julia Miller
Secretary, ECH Board of Directors

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

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, October 25, 2017
2500 Grant Road, Mountain View, CA 94040
Conference Rooms E, F&G (ground floor)

Board Members Present	Board Members Absent	Members Excused
Lanhee Chen, Chair	**Peter C. Fung MD**	None
Jeffrey Davis, MD	**David Reeder**	
Neysa Fligor	**Bob Rebitzer**	
Julia Miller		
John Zoglin, Vice Chair		

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:40pm by Chair Chen. A silent roll call was taken. Director Fung was absent. Directors Rebitzer and Reeder joined via teleconference only for the closed session. Director Zoglin arrived at 6:20 pm. All other Board Members were present.	
2. CONFLICT OF INTEREST DISCLOSURES	Chair Chen asked if any Board members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. WELCOME	Chair Chen welcomed the Board and other attendees to the meeting.	
4. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:30 pm pursuant to *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets: CEO Report. **Movant:** Davis **Second:** Zoglin **Ayes:** Chen, Davis, Fligor, Miller, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung, Rebitzer, Reeder **Recused:** None	***Adjourned to closed session at 6:30 pm.***
5. AGENDA ITEM 8: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:15pm. Agenda items 5-7 were addressed in closed session. Chair Chen reported that the Board did not take any action during the closed session. Chair Chen left the meeting.	
6. AGENDA ITEM 9: COMMITTEE ROUNDTABLES	Members of the Advisory Committees and Executive Staff gave updates regarding the work of the Committees	
7. AGENDA ITEM 10: ADJOURNMENT	**Motion**: To adjourn at 8:10pm. **Movant:** Davis **Second:** Miller **Ayes:** Davis, Fligor, Miller, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung, Chen, Reeder, Rebitzer **Recused:** None	***Meeting adjourned at 8:10 pm.***

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

_____
Lanhee Chen
Chair, ECH Board of Directors

_____
Julia Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

FY-2017 Evaluation of the Environment of Care and Emergency Management Programs

with

Goals for FY-18

Prepared by:

Steve Weirauch
Manager, Environmental, Health & Safety

Created: August 28, 2017

Table of Contents

Executive Summary

The FY-2017 report of the Safety Program for Managing the Environment of Care is to inform the Hospital Board of Directors of the status of the key measurement criteria for the Hospital's safety program implementation that meets Injury and Illness Prevention Program OSHA requirements, and The Joint Commission (TJC) standards.

The safety program indicators showed a decrease in the rate of all work-related injuries compared to previous years. This includes the patient handling and blood borne pathogen injury rates as well as the overall OSHA-recordable work related injury and illness rate. A continued emphasis on training and the use of proper equipment has been credited with this positive trend.

In FY 2017, a new healthcare workplace violence prevention regulation was adopted by Cal-OSHA. The hospital is on track to meet the compliance dates for all elements of this plan.

In FY 2017, there were:

- No citations from the Santa Clara County Environmental Resources Agency
- No waste water violations
- No reportable hazardous materials incidents
- No reported fire incidents.
- One reportable utility incidents
  - 3-hour power outage in Los Gatos
- Four events requiring the activation of the Hospital Incident Command System (HICS)
  - Patient surge at the Mountain View campus
  - Patient surge at the Los Gatos campus
  - Power outage at the Los Gatos campus
  - Potential ransom ware attack at both campuses

Emergency exercises were conducted during the year to test and improve our response capabilities in the event of a real emergency situation. The major exercises for the year were:

- Participation in the Statewide Medical and Health Exercise at both campuses. This was a mass casualty incident that included the activation of HICS and the opening of the Hospital Command Centers (HCC).
- A tabletop evacuation exercise at the Los Gatos campus. This included activation of HICS and the opening of the HCC.
- A functional evacuation exercise of patients from the tower of the Mountain View campus. This exercise focused solely on the procedures and operations for physically evacuating patients from the building. HICS was not activated, nor was the HCC opened for this drill.

Program Overview

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

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

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

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

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

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2017. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

EC 1.0 - Safety Management *(Interim Work Group Chair: **Tamara Stafford**)*

1. Scope

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

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

2. Performance

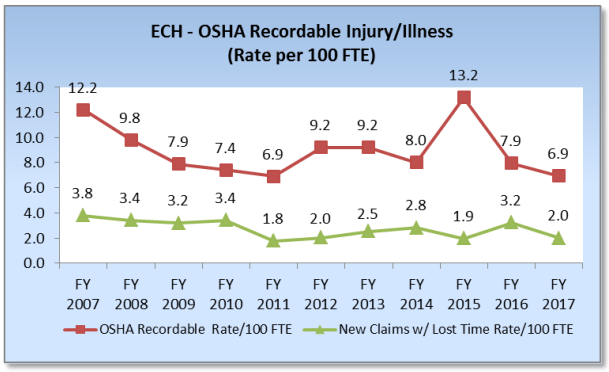
Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-17. This includes data from both the Mountain View and Los Gatos campuses.

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

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE decreased in FY-17 to 6.9 as compared to 7.9 in FY-16. The total *number* of recordable incidents decreased to 167 compared to 193 in FY-16.

The rate of injuries for lost work days for all open claim (per 100 FTEs) decreased by 40% to 2.0 in FY-17 from 3.2 in FY-16.



Analysis

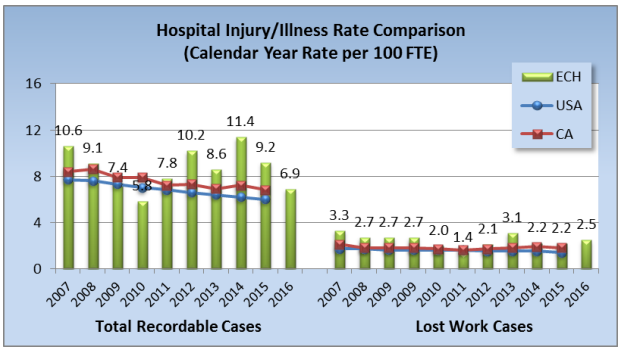
- **Injury Rates:** The two largest injury type contributing to the Cal/OSHA recordable injury and illness rate were strains/sprains (45.28%) and contusions (13.68%).

Improvement Strategies:

Continue the process for early intervention when injuries occur by contacting each injured worker when the Accident/Injury/Exposure Report (AIER) is completed. Encourage the injured employee to be seen in Employee Wellness and Health for an immediate evaluation of the injury and any treatment needed. Minimize late reporting by continuing to educate new hires about safety measures/safety training to take to keep themselves safe at work and to report any injuries immediately to their manager and complete an AIER. Continue to educate managers to contact EWHS when any employee informs them of an injury in order to begin the early intervention process.

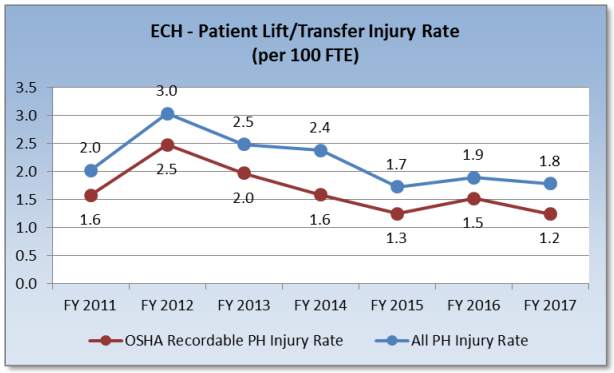
B. OSHA Recordable Injury/Illness Rates as Compared to U.S. & California Hospitals

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



The injury/illness rate for the hospital exceeded the state and national averages in 2015 (the most recent year available from the BLS). However, the hospital actively utilizes a Transitional Work Assignment Program, showing a commitment to getting people back to work as quickly as possible after an injury or illness.

C. Patient Lift/Transfer Injuries



Analysis

- **Injury Rates**: The rate of OSHA recordable patient lift/transfer injuries per 100 FTEs decreased to 1.2 in FY-17 compared with 1.5 in FY-16. The overall rate of patient handling injuries remained decreased from 1.9 in FY-16 to 1.8 in FY-17.

- **Injury Types:** The most common cause of patient handling injuries remain repositioning patients in bed, at 28% of the total. The rate has been consistent at 12 per each of the prior 3 years.

  Similar to prior years, lateral transfers and combined transfers follow, respectively.

  The incidence and rate reduction of vertical transfers (sitting to/from standing), from 25% of the total to 11% (5 total as compared to 12 in 2016 and 9 in 2015) is significant. This may be due to the introduction and robust training of Sara Stedy sit to stand equipment introduced to patient care units, both inpatient and outpatient. Also, older model Sara lifts were removed from inventory and new Sara Plus mechanical lifts were added.

  Injuries resulting from Cumulative Patient Handling rose to 11% of the total, as compared to 2 and 3% the prior 2 years.

  Patient fall prevention continues to be a source of injuries, at almost 10% of the total.

	2015	2016	2017
Repositioning Patients in Bed	32%	25%	28%
Lateral Transfers (assisted patient between bed and gurney)	16%	13%	19%
Combined Transfers (assist patients between lying and sitting	14%	17%	14%
Vertical Transfers (assist patient between sitting and standing)	24%	25%	11%

- **Injuries by Department**: Last fiscal year, Inpatient Rehab had the highest incidence of SPH injuries reported, at 8. This year, focused education and new equipment resulted in fewer than ever: 1 injury report. Rehab Services maintained their improvement with 1 reported.

The Mountain View departments Medical (2C) and Telemetry (3B) are trending up, each with 16% (n = 7 each); and ED and Patient Care Resources with 12% (n = 5 each.)

- **Injuries by Job Class:** Registered Nurses and Unit Support personnel (CNAs) once again incurred 90% of the total safe patient handling injuries, with RNs suffering double the rate: 60% as compared to 30% for CNA's.

Improvement strategies:

- **Education:** The Education Department has successfully rolled out quarterly training to include lift equipment by vendor and lift type and will continue this model. As compared to annual training, quarterly education promotes a consistent emphasis on safe patient handling and advocacy of equipment use.

  Educators report to the Clinical Education Department, rather than individual units, which has promoted consistency in training.

  Focus for prevention strategies in 2018 is patient repositioning and lateral transfers, with an emphasis on use of friction reducing devices such as Z Sliders; clinical techniques for reducing manual handling, such as application of trapeze bars; and increased education and promotion of use of repositioning slings with the overhead lifts in Mountain View. Los Gatos is not equipped with overhead lifts; therefore, they are not an option there.

  Focused education for CNAs is planned for Quarter 1, to include an emphasis on safe patient handling.

  Los Gatos prioritized safe patient handling at their Professional Development Days in quarter 4.

- **PMAT:** The Education Department partnered with the USF Clinical Nurse Leader program to develop, trial, and ultimately introduced the El Camino Hospital **P**atient **M**obility **A**ssessment **T**ool in quarter 3. It is designed to identify and promote appropriate equipment use and concomitantly reduce employee injury related to all transfers and cumulative patient handling and patient falls. It is not mandatory in Epic; consistency is lacking. An analysis has been initiated with plan of action to follow.

- **Equipment:** Hover mats have gained immense popularity and use. As a result of use, ECH qualified for 6 additional pumps at no charge, distributed to inpatient and outpatient areas in need. Unfortunately, a few injuries occurred this year as a result of faulty use or gurney mishap with a Hover mat. Additional HoverTech training is added to the schedule.

  Sling management, labeling and storage continues to be a work in progress.

  Additional sling offerings with the overhead lifts (limb holders) are under consideration for trial.

- **Bariatrics:** Gap analysis revealed need for a mechanical sit to stand device for the bariatric population in MV. Frequency and lack of storage space does not warrant purchase at this time in LG, since rental is an option. The MV campus has had a demonstration and Rehab staff trialed one option under consideration.

- **Department Specific:** Telemetry developed mandatory safe patient handling curriculum for classes held in quarter 4 to target increased injury incidence. ED will be targeted in the fall.

- **Accident Investigations**: Prompt accident investigation by managers improved, with 67% documented within 4 days. This is up from 38% and 43%, respectively, since adding HR Business Partners to the electronic distribution list.

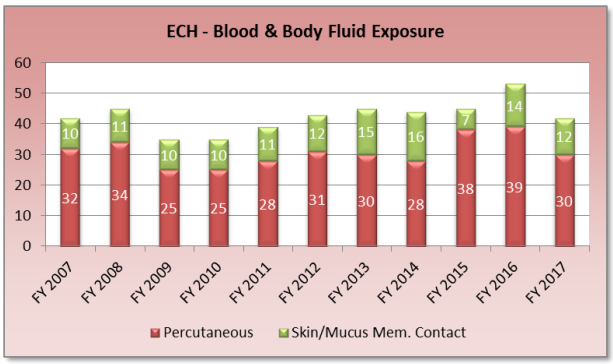
D. Bloodborne Pathogen Exposures

The rate of Blood borne pathogen exposures per 100 FTE decreased significantly to 1.7 in FY-17 compared to 2.2 in FY-16. The total number of exposures for both campuses decreased to 42 exposures in FY-176 compared to 54 in FY-16. Of these, 30 were percutaneous exposures and 12 were body fluid exposures due to splashes. This is the lowest reported rate in seven years.

There have been no significant trends noted involving particular devices.

Analysis:

- 52% of both sharps, contact, and mucous membrane exposures were the result of end user practice failures:
  - Failure to engage safety devices immediately after use (recapping)
  - Not wearing personal protective equipment (PPE) when indicated, particularly face and eye protection, when in areas/units where splashes should be expected.
  - Rushing when handling sharps



- 32% of exposures were caused by agitated or involuntary movement of patients (unsafe action by others).

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO
- Continue in-services for new products or when there is continued/repeated misuse or misunderstanding of a product
- Continue to identify causes and how exposure or injury could have been prevented by asking exposed employee what action they will take in the future to prevent the exposure from occurring again should a similar situation arise
- Explore the possibility of establishing a Needle-stick Prevention Committee as it is estimated that 80% of all exposures from sharps and needle-sticks are preventable.

E. TB Conversions

There were no known occupational exposure conversions at either campus during FY-17

F. Safety Training Indicators

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

- New employee orientation: 100% (Target: 100%)
- Life Safety - Non-Clinical: 96.8% (Target: 95%)
- Life Safety - Clinical: 96.6% (Target: 95%)

G. Safety Inspections

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

The five most noted problems in FY-17 involved:

- Damaged or stained ceiling tiles
- 18" vertical clearance to fire sprinkler heads
- Damaged walls
- Improper storage of clean linen
- Inadequate clearance around fire extinguishers

H. Environmental Monitoring

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

Monitor	Location	Results
Anesthetic Gases	OR, PACU, L&D	
○ **Nitrous Oxide**		Below Cal OSHA PEL
○ **Sevoflurane**		Below NIOSH REL[1]
Formaldehyde	Cytology, Histology	Below Cal OSHA PEL
Lead/Cadmium	Radiation Oncology (MV)	Wipe Samples in all areas except the lid of the molding pot, the counter beneath molding pot dispenser and the surface of the molding board were below the recommended surface contamination levels [2]
Noise	Facilities Personal Monitoring (MV)	Below Cal OSHA Action Level
	Central Plant (MV)	Several locations exceed the action limit (85dBA). "Hearing Protection Required" signs are posted in these areas.
Xylene	Cytology, Histology	Below Cal OSHA PEL

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

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

EC 2.0 - Security Management *(Interim Work Group Chair: **JoAnn Cartoni-Cry**)*

1. Scope

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

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

2. Workplace Violence Prevention Plan

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

In October, 2016, an additional health care workplace violence prevention regulation, Section 3342 of Title 8 of the California Code of Regulations, was adopted. The regulation took effect on April 1, 2017. Major elements of the new law are listed in the table below.

Elements of Regulation	Compliance Deadline	Status
Written Plan: Develop / implement a Workplace Violence Prevention Plan (WVPP). To include an annual review and update of plan	April 1, 2018	Written plan being developed. Requires annual review/update.
Training: Provide training to all staff as required	April 1, 2018	Training being developed
Response: Investigate violent incidents	April 1, 2017	Already in place
Reporting: Report incidents of physical violence against staff to Cal/OSHA	July 1, 2017	Implemented, July 1, 2017
Documentation: All incidents and training	April 1, 2017	Already in place

A task force has been created to oversee the implementation of Workplace Violence Prevention Plan for El Camino Hospital. The elements being addressed are listed below:

2. ***Written Plan*** – The El Camino Hospital WVPP is being drafted and revised.
3. ***Training*** – The law specifies training requirements for staff based on their roles in the hospital. A combination of online training and classroom instruction is being developed.

Group / Role	Included Staff
Anyone doing hospital business at the facility	○ Employees ○ Contractors ○ Physicians ○ Travelers ○ Volunteers
Employees having patient contact	○ Clinical Staff
Employees that respond to violent incidents (Code Gray Team) Employees whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior	○ Emergency Department ○ Behavioral Health ○ Hospital Supervisors ○ Security Officers ○ Facilities Engineers

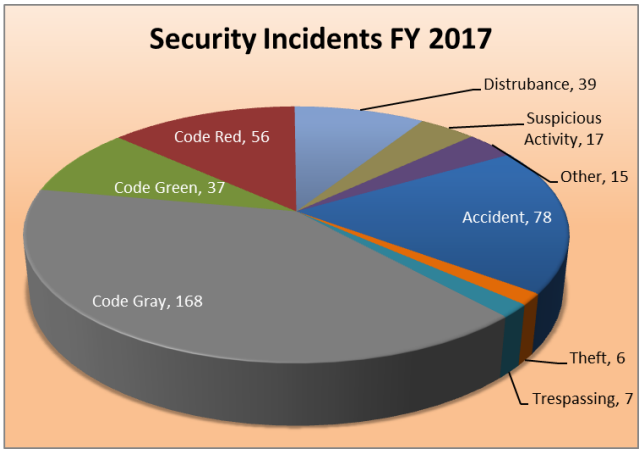
4. ***Reporting*** – Cal-OSHA requires that all incidents of physical violence against staff be reported within 72 hours. If the violence results in hospitalization (other than minor first aid) or a fatality, reporting must be completed with 24 hours. Verb al threats are not reportable to Cal-OSHA, however these are tracked internally.

   Procedures have been created to ensure all reportable incidents are sent to Cal-OSHA as required. A core team is in place to review all incidents to ensure reporting is completed within the time limits.

   Note: The reporting does not include any personal or protected information about patients or staff.

3. Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY-17. The data includes activity from both campuses.



There were a total of 423 reported security incidents for FY-17 requiring immediate response. This is a decrease from FY-16 total of 453.

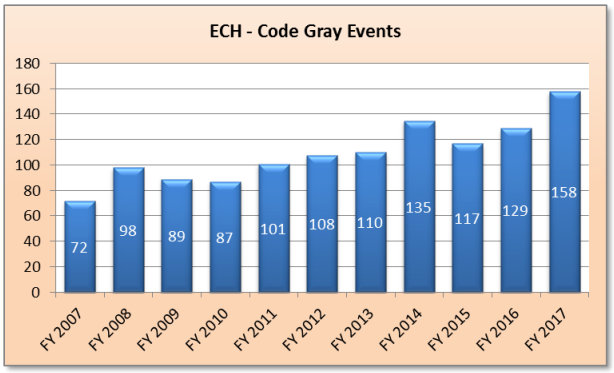
Review of the major FY-17 incidents showed that most incident categories including accidents, disturbances had no discernible trends or patterns.

- Code Gray, Code Red, Code Green, and Accidents accounted for 339 (80%) of the total.
- Code Silver (weapon or hostage situation) increased from 0 in FY-16 to 4 in FY-17. None of the incidents involved a firearm.
- FY-17 did see a decrease in reported thefts, trespassing and suspicious activity.

A. Code Gray Responses

Code Gray responses have remained steady. The total number of incidents in FY-17 was 168 compared to 116 in FY-16.

Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED, Behavioral Health and Medical Units. Responses are tracked and monitored to help identify possible improvements to the process.



The Hospital utilizes the **Non-violent Crisis Intervention® (NCI)** training program for all staff who deal with angry or agitated persons. NCI training is required for all Behavioral Health staff, ED staff, security officers, facilities engineers and clinical managers. Staff in other departments are also encouraged to attend the training.

B. Bulletins, Alerts & Presentations

Security Services issued 10 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 3,910 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Stand-Bys & Restraints

Security Officers performed 1,649 patient watches, standbys and restraints. Hospital Supervisors notify Security of these events which can last several hours. They primarily occur in the Emergency Department, Behavioral Health and on the Medical Units. Patient watches are also handled by the ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 111 fire drills and are 100% up-to-date. 20 fire watches were performed.

F. General Assistance

Security Officers performed 93,625 service requests including but not limited to main lobby greeter assistance, directional requests, door locks/unlocks, escorts, issuance of one-day passes.

G. ID Badges

Security Services issued 2,353 'Dual-sided' Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 1,848 temp badges were issued.

H. Investigations & Audits

Security Services performed 23 investigations and audits including but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Inspections

Security Services performed a total of 15,302 (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

J. Loitering

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

K. Lost And Found

Security Officers performed 847 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

L. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 161 vehicle-related services including jump-starts, door unlocks and tows. 348 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 94 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

N. Statistics – Mountain View Police Department Crime Data (Source: 2016 MVPD Annual Report)

City of Mountain View

Square Miles: 12
Population:.....77,846 (County of Santa Clara 1,919,402)
Personnel: .....Total 145 (90 Sworn vs. 55 Non-Sworn)
Beat No.1: .....6,982 number of dispatched calls, includes El Camino Hospital

Statistics *UCR data includes attempts and actual crimes*

Part I UCR: .....Total 1914 (1781 Property vs. 133 Violent)
Previous Year .....Total 1770 (1614 Property vs. 156 Violent)

Part II UCR: .....Total 2716
Previous Year .....Total 2599

Arrests-Misdemeanor: .....Total 1473 (1376 Adult vs. 97 Juvenile)
Previous Year .....Total 1598 (1397 Adult vs. 201 Juvenile)

Arrests-Felony: .....Total 306 (284 Adult vs. 22 Juvenile)
Previous Year .....Total 664 (610 Adult vs. 54 Juvenile)

Traffic Collisions: .....Total 498
Previous Year .....Total 235

Moving Violations: .....Total 2853
Previous Year .....Total 5990

Non-Moving Violations: Total 3232
Previous Year .....Total 3992

Indexes *Per 1,000 current year population*

Violent:.....1.69
Previous Year 2.02
Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery

Property: 22.79
Previous Year 23.93
Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson
Note: Los Gatos Police Department data and crime statistics not available.

4. Effectiveness

Key indicators were identified to establish goals for FY-17 with opportunities to improve Security Management within the Environment of Care.

FY 17 Goals

1) > 90% non-medical emergency security response time less than 3 minutes
   This goal was accomplished.
2) Create at minimum 4 Security Awareness Pamphlets/Alert Bulletins
   This goal was accomplished.

FY18 Goals

1) 90% non-medical emergency security response time less than 3 minutes
2) Create at minimum 4 Security Awareness Pamphlets/Alert Bulletins

EC 3.0 - Hazardous Materials & Waste Management *(Work Group Chair: **Lorna Koep**)*

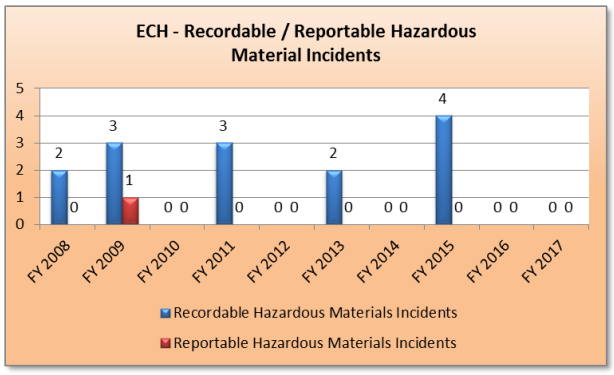
1. Scope

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

2. Performance

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

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



B. Waste Water Discharge Violations – No waste water discharge violations in FY-17.

C. Monitoring and Inspecting

- Hazardous Waste Inspections
  - Mountain View: September 9, 2016
  - Los Gatos: January 18, 2017

  Both Inspections had several findings related to reporting and documentation. All items were corrected and approved by Department of Toxic Substances Control (DTSC).

  One finding in Mountain View noted that, due to increased volumes in the histology lab, the hospital is now considered a large quantity generator of hazardous waste. As such, we are required to submit a Source Reduction Report (SB14). A consultant was brought in to complete this report.

- Santa Clara County Annual Medical Waste Inspections
  - Los Gatos: has not yet been scheduled by the county.
  - Mountain View: November 29, 2016.
    - Three minor issues identified. All were corrected and accepted on the date of the inspection
      1) Found one peeling, faded sticker – replaced immediately.
      2) Overfilled secondary container in OR staging area – corrected immediately.
      3) Recommended placing absorbent pads in Pharmaceutical waste containers to prevent free liquids in the containers of high volume areas identified for wasting medications. Partnering with Stericycle and Talent Development to provide education on the process of wasting controlled substances.

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

- Continued monitoring and education to ensure waste segregation compliance :
  - Annual Waste Management education for staff
  - Daily rounds by EVS supervisors
  - Monthly Safety Rounds that include observation of waste segregation practices
  - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.

D. Radiation Safety Committee

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

3. Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group.

Key indicators were targeted to establish goals for FY-17. The following goals presented opportunities to improve hazardous materials & waste management.

FY-17 Goals:

1) Expand composting program (Phase 2) to include cafeteria waste and restroom paper towels.

   This goal was partially accomplished. Composting containers continue to be used in the kitchen areas. The Mountain View campus expanded the composting program to include all public restrooms in the Old Main building. The measurement of success for this goal was an increase in the number of composting totes collected.
   - Los Gatos (96-gallon totes): increased 25%
   - Mountain View (64-gallon totes): increased 33%

   Efforts are continuing with training, optimization and exploring new opportunities to reduce overall waste. Plans are in place to expand composting to the public restrooms in Los Gatos and Oak Pavilion.

2) Develop a safe transportation process for Histology chemicals and wastes through the hospital. Evaluate the equipment used, process, pathways and secondary containment.

   This goal was partially accomplished. Facilities Engineering fabricated a stainless steel cart, but the weight and maneuverability of the cart did not meet the needs of the Histology staff. Continued investigation eventually located a suitable alternative that will be ordered during the first quarter of FY-18.

FY-18 Goals:

1) Reduction of hazardous chemical waste generated by Histology with the installation of new equipment. This will significantly reduce the volume of Xylene and Alcohol used. It is estimated the new equipment will come on line in Q3, FY-18.
   - Measurement of success: Comparison of the waste quantities generated in in the last half of FY-18 compared to the same period in FY-17.

2) Review and revise the hospital Hazardous Waste Guide with an emphasis on the RCRA List reflecting knowledge gained from Hazardous Waste inspections.
   - Measurement of Success:
     - Completion and distribution of new guides
     - Training for all required staff

EC 4.0 - Fire Safety Management *(Work Group Chair: **Pat DuBridge**)*

1. Scope

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

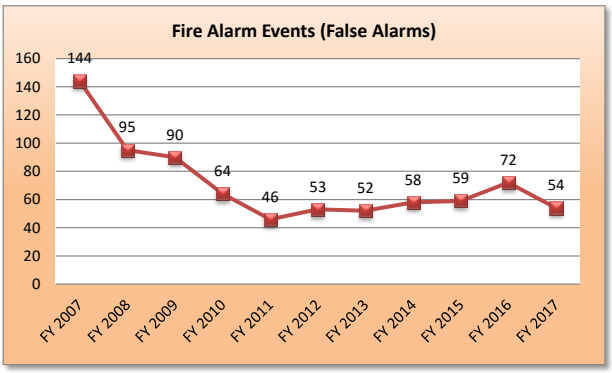
2. Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY-17.

- **Fire Incidents**
  There were no reported fire incidents in FY-17.

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

  The number of events in FY-17 (54) represents a decrease of 25% form FY-16 (72) and is the lowest since FY-13. This was accomplished despite heavy construction activity during FY-17.



- Fire Drills Completed / Scheduled

  103% of fire drills, a total of 110, were completed in FY-17. For all drills, there were 22 required actions by staff. 21/22 issues were fully corrected and the pending item is under review.

3. Effectiveness

Key indicators were targeted to establish goals for FY-17. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 17 Goals

1) In preparation for the construction projects on the Mt. View campus, Interim Life Safety Measure (ILSM) rounds will be conducted at least weekly. Issues identified during the rounds will be reported to the appropriate project manager to assure prompt correction. Unresolved issues will be reported to Central Safety Committee.

   This goal was accomplished. The process for ILSM rounds is working well. ILSM's are being performed and items are being tracked in the TMS database.

2) Maintain the FY-16 rate of fire alarm events (72) during FY-17. The number of major demolition and construction projects occurring in Mountain View makes this a challenge. However, combined with the regular ILSM rounds and follow up we are striving to maintain this current level of fire alarm events.

This goal was accomplished. Despite challenges presented by the volume of construction at both facilities, we had no actual fire events and significantly lowered our fire alarm events. We will continue work closely with the construction Teams in FY-18 to minimize fire risk as well as disruptions due to false alarms.

FY 18 Goals (Preliminary)

1) With continued construction projects at both campuses, Interim Life Safety Measure (ILSM) rounds will be conducted at least weekly. Issues identified during the rounds will be reported to the appropriate project manager to assure prompt correction. Unresolved issues will be reported to Central Safety Committee. This is a continuation of the FY-17 goal.
2) Continue efforts from FY-17 in reducing the number of fire alarm events during FY-18.

EC 5.0 - Medical Equipment Management *(Work Group Chair: **Lisa De La Rosa**)*

1. Scope

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

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

2. Performance

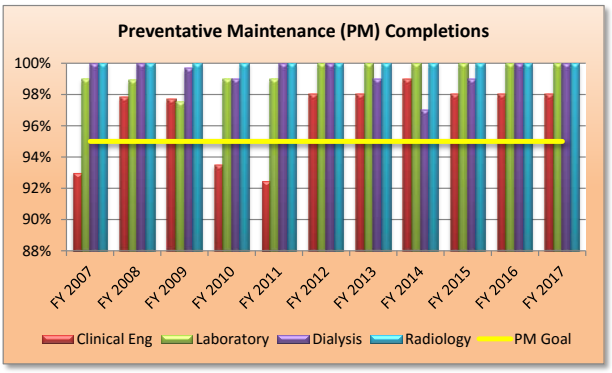
Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-17.

- Reports to the FDA - There were nine reports through the Medwatch[4] system in FY-17. There were no patient deaths associated with any of the reports. The reports included:

  1) User error in using incorrect port on pacemaker device. Reported as potential device design failure. Harm to patient.
  2) Surgical stapler used in robotic lap surgery malfunctioned during surgery.
  3) Morcellator did not work, shocked user.
  4) Biopsy needle broke inside patient. Harm to patient as required operation to remove.
  5) Vacuum breast biopsy equipment failures.
  6) Contaminated Hanks solution

- Preventative Maintenance (PM) Completion Rate Percentage.

  The PM completion rate exceeded the target of 95% in all areas.
  - The completion rate for Clinical Engineering achieved 98% overall for FY-17.
  - All high risk, life safety equipment was maintained at 100% completion rates



- Product Recalls Percentage Closed / Received.

  For FY-17, there were 128 recorded product recalls; 112 have been closed. The 16 pending items require finalizing the paperwork.

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

3. Effectiveness

Key indicators were targeted to established goals for FY-17. The following goals presented a number of opportunities to improve Medical Equipment Management within the Environment of Care.

FY 17 Goals

1. Ensure Medical Equipment is being secured from vulnerability threats.

   This goal was accomplished. Clinical Engineering is meeting on a weekly basis with Information Security and using Nexpose to run vulnerability scans on all networked medical devise. For non-networked equipment, communication has been sent out to each manager to ensure proper handling of PHI on medical equipment.

2. Establish a process in procuring new equipment to ensure if networked connected it has proper processes in place.

   This goal was accomplished. Clinical Engineering worked in collaboration with Information Security in developing Procedures as part of the HITRUST. Each procedure details the steps necessary to be able to establish network connection to medical equipment.

FY 18 Goals

1. Ensure all medical equipment is segregated from other networked devices for system security.
2. Implement a process and timeline to upgrade all Windows XP systems to Windows 7 compatibility.

EC 6.0 - Utilities Management *(Work Group Chair: **John Folk**)*

1. Scope

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

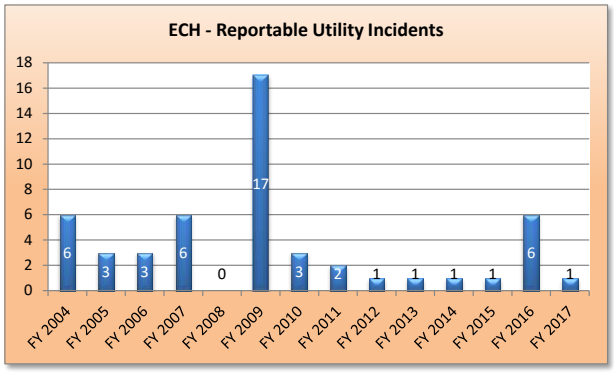
2. Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-17.

- **Utility Reportable Incidents**

  There was 1 reportable incident in FY-17.

  - 4/6/17: Extended PG&E outage at Los Gatos due to severe weather. All systems functioned as designed.



- **PM Completion Rate % completed/ scheduled**

  The Utility Systems PM completion rate was 90%, which did not meet our goal of 95%. Critical systems were maintained as required for the facility operations.

- **Generator Test % completed/scheduled**

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

- **Egress Battery Light Testing % completed/scheduled**

  The percentage of the monthly and annual tests completed was 100%.

3. Effectiveness

Key indicators were targeted to establish goals for FY-17. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 17 Goals

1) Continue to refine an Enterprise wide tool for ensuring TJC compliance for significant Utilities Work Group related Elements of Performance (EP's).
2) Ensure Preventative Maintenance completion rates to achieve annual goal of 95%.
3) *Through pre-planning and collaboration with contractors minimize the risk of unplanned system outages related to construction activities.*

In summary, much work was done between the Development Team and the Engineering Team to formalize and control Utility shutdowns necessary for Construction activities. This has resulted in better planning that has minimized disruptions caused by this type of work. Tracking mechanisms for TJC items have become more robust and continue to be refined. Both of these areas will receive continued focus in FY-18 due to their criticality and the level of Construction activities.

Also, in FY-17, we completed on-going major overhauls to the Los Gatos electrical distribution systems and emergency power plants, which have had significant positive impact on our confidence in these older systems.

EM - Emergency Management *(Work Group Chair: **Steve Weirauch**)*

1. Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal emergencies and mass casualty external emergencies. The Emergency Management Work Group ensures an effective response to disaster or emergencies affecting the Environment of Care. The hospital actively participates with state and local emergency management entities to coordinate community planning efforts and response. Emergency Management is a separate chapter under The Joint Commission; however it continues to report to the Central Safety Committee.

2. Performance

Performance indicators for the Emergency Management program are reported monthly to the Central Safety Committee in the Safety Trends Report. The following Emergency Management indicators were reported in FY-17.

A. Events / Emergencies

There were four recorded events and/or emergencies during FY-17 requiring activation of the Hospital Incident Command System (HICS).

1. **Patient Surge – Mountain View (01/11 – 01/13/2017)** – A sustained surge in patients requiring care necessitated the activation of the Hospital Incident Command System (HICS) and the opening of the Hospital Command Center (HCC) in Mountain View. A coordinated effort by the staff and use of the surge plans developed for Super Bowl 50 enabled the hospital to continue operations and meet the needs of our patients. The HCC was operational during day-shift hours for 4 days.
2. **Patient Surge – Los Gatos (01/23/2017)** – A surge in patients and staff shortage due to sick calls necessitated the opening of the HCC in Los Gatos. Staff were able to draw on plans and adapt to continue operations and provide care to patients. The HCC was operational for approximately 6 hours.
3. **Power Outage – Los Gatos (04/06/2017)** – A power outage at the Los Gatos campus occurred on April 6th. Several issues were identified including the loss of all communications and failure of the electronic door access to the O.R. Corrective actions were already part of planned upgrades to the facility.
4. **WannaCry Ransom ware (05/13 – 05/15/2017)** – The threat of a ransom ware attack initiated a pre-emptive response from the IS department. The command center was activated on Saturday and continued through Monday, May 15th. The IS department patched and update all computers preventing a potentially crippling attack to the network.

B. Exercises / Drills

- The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY-17, this requirement was met through the Statewide Medical & Health Exercise in November, 2016 (see below) and the actual HCC activations due to real patient surges in January, 2017. We conducted a second exercise at each campus; however we were able to focus each drill to the needs of the campus. These are also summarized below.
    a. **Statewide Medical & Health Exercise (November 17, 2016):** Both campuses participated in the statewide exercise. The scenario involved a mass casualty incident

involving a train derailment and school buses filled with children. The treatment of pediatric patients and a potential hazardous material contamination provided challenges to both campuses.

b. **Los Gatos (May 24, 2017):** A tabletop exercise was conducted in the Hospital Command Center involving the full evacuation of the hospital. The HICS team discussed procedures for evacuating patients from the building, setting up alternate care locations and treatment areas for patients until they can be transferred to other facilities and how to ensure staff are trained on these procedures.

c. **Mountain View (May 31, 2017):** The exercise involved evacuation of a medical floor (3C-West) utilizing existing procedures and equipment. A number of "patients" and "visitors" with varying medical issues were evacuated out of the building. The HCC was not opened. Instead, the focus was on the procedures for evacuating patients. In addition to existing equipment, participants also trialed a new evacuation device (Med Sled) that is being considered for replacing the existing equipment.

   Several issues were noted in the exercise, including locating and using the existing equipment and the intense manual lifting required when using the existing evacuation litters and chairs. Corrective actions were also recommended for communications and patient transfer after they leave the building.

- **Tabletop Exercises:** There is a continuous need for staff training on responding to emergency codes. Because of the wide variety of work environments and to reach the largest number of staff we continued with the series of tabletop exercises (TTX) based on each of our emergency codes. This series was begun in FY2015. They are designed to be conducted by the Safety Coordinator and/or manager of each department in a manner that best meets the unit's needs.

  An exercise "kit" is distributed to the Safety Coordinators with the request to complete the exercise during the quarter. The scenarios tested during the past year are Code Purple (missing or abducted child – age 1-17) and Code Red (fire) and Code Silver (Weapon or Hostage).

  Note that while good learning and practice opportunities, tabletop exercises do not meet the Joint Commission standards for exercises so these are above and beyond the requirements.

C. Emergency Management Training

- New hire orientation (100% for all employees)
- Safety coordinator meetings (44% attendance overall for the quarterly meetings). Safety Coordinators unable to attend the meetings are provided with detailed notes and information and are expected to complete all assignments.
- Six decontamination training exercises were conducted for Mountain View. This included online training for new member and refresher training for all participants.

D. Community Involvement

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

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

E. Hazard Vulnerability Assessment (HVA)

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

- There were minor changes to the HVAs at both campuses in FY-17. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Epidemic	(2) Electrical Power Failure
(3) Weapon	(3) Chemical Exposure, External
(4) Evacuation	(4) Dam Failure
(5) Mass Casualty Incident - Medical/Infectious	(5) Mass Casualty Incident – Trauma

3. Effectiveness

Key indicators were targeted to establish goals for FY-17. The following goals presented opportunities to improve emergency management.

FY 17 Goals

1) Develop and implement a hospital Workplace Violence Protection Plan. This will be a joint goal with the Security Management Work Group. Measurable objectives:

   This goal was not accomplished. *Cal-OSHA delayed adoption of the healthcare workplace violence prevention regulations until April, 2017. As such, the requirements and guidance for the plan was not known until late in FY-17. This goal will be carried over to FY-18.*

2) Develop a program to allow non-clinical staff to participate in disaster training (decontamination) at both campuses. Measurable objective. This goal is carried over from FY-16.

   This goal was accomplished. The recruitment and training of additional staff to be part of the decon team has been adapted to allow non-clinical staff to participate without impacting their department's budget. The cost associated with non-clinical staff attendance will be covered by the Safety Cost Center.

FY 18 Goals

1) Develop and implement a hospital Workplace Violence Protection Plan. This will be a joint goal with the Security Management Work Group. Measurable objectives:

2) Replace Breathe-Easy PAPRs used for Decontamination training with Versaflo units.

3) Begin phase-in of new Med Sleds for evacuations

Attachment 1 – Employee Health Services Definitions

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

*** Productive Hours** .....Total number of hours worked for the quarter or year by all organizational employees. Includes overtime but does not include education, vacation, PTO, ESL, or other non-productive time. This does not include outside labor.

Attachment 2a – Safety Trends

	Indicators	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17
E.C. 1.0 - SAFETY MANAGEMENT							
Employee Safety							
1.	Total Injury/Illness Incident Reports	331	349	458	618	428	470
2.	OSHA Recordable Injury/Illness (Total)	137	173	171	306	193	164
	a. Lost Time	34	59	61	38	78	45
	b. No Lost Time	103	114	110	268	113	119
3.	Repetitive Motion Injury- Computer, keyboard, Mouse, Light Pen	10	12	14	5	19	17
4.	Repetitive Motion Injury (RMI) - Non-Computer	13	7	2	19	9	14
5.	Patient Lift/Transfer Injuries (OSHA Recordable)	44	33	36	27	37	28
6.	Patient Lift/Transfer Injuries	N/A	42	54	37	48	43
7.	Trip/Slip/Fall	48	43	50	41	58	67
8.	Staff Assaults by Patients	N/A	N/A	25	17	15	28
Infection Control							
1.	Blood & Body Fluid Exp.	41	45	44	45	53	42
	a. Percutaneous	27	30	28	38	39	30
	b. Skin/Mucus Membrane Contact	14	15	16	7	14	12
2.	TB Conversions (mo.)/qtr. %	0	0	0	0	0	0
Safety Rounds Scoring							
1.	Critical Area Score (# Compliant/total number)	N/A	N/A	N/A	N/A	96%	99%
E.C. 2.0 - SECURITY MANAGEMENT							
1.	Code Grey Incidents	108	110	135	117	129	167
2.	Other Security Incidents	153	127	158	178	324	270
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT							
1.	Reportable Hazardous Material Incidents	0	0	0	0	0	0
2.	Recordable Hazardous Material Incidents	0	2	0	4	0	0
3.	Waste Water Discharge Violations	0	0	0	0	0	0
4.	Eyewash Inspections	N/A	N/A	N/A	N/A	100%	100%
5.	Eyewash Corrective Actions comp/assigned	N/A	N/A	N/A	N/A	86%	85%
E.C. 4.0 FIRE PREVENTION MANAGEMENT							
1.	Fire Incidents -Actual	0	1	1	0	2	0
2.	Fire Alarm Events	53	52	58	59	72	54
3.	Fire Watches (New in FY-14)	N/A	N/A	4	2	8	21
4.	Fire Drills comp/scheduled	100%	100%	97%	100%	100%	103%
5.	Interim Life Safety Measures (ILSM) Tracking	N/A	N/A	94%	100%	100%	100%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT							
1.	Reports to FDA	2	11	2	6	3	6
2.	PM Completion Rate %						
	a. ECH (Clinical Engineering/Bio Med)	98%	98%	98%	98%	98%	98%
	b. Laboratory	100%	100%	100%	100%	100%	100%
	c. Dialysis	100%	99%	99%	99%	100%	100%
	d. Radiology	100%	100%	100%	100%	100%	100%
3.	Product Recalls % (Closed/rec'd)	N/A	95%	98%	88%	78%	95%
E.C. 6.0 - UTILITIES MANAGEMENT							
1.	Utility Reportable Incidents	1	0	1	1	6	1
2.	PM Completion Rate % completed/scheduled	97%	84%	92.7%	90.9%	97%	90%
3.	Generator test % completed/scheduled	100%	100%	100%	100%	100	100
4.	Egress Lighting monthly test % completed	100%	100%	100%	100%	N/A	100%
E.M. EMERGENCY MANAGEMENT							
1.	Drills, Internal & External	22	56	14	75	35	42
2.	Natural Disaster/Actual Event	2	2	0	2	4	4

Attachment 2b - Safety Trends Definitions

E.C. 1.0 SAFETY MANAGEMENT	
Employee Safety	
1. Total Injury/Illness Incident Reports	Total number of injuries/illnesses reported on Accident, Incident and Exposure Report (AIER) and followed up by Employee Wellness & Health Services. Includes first aid cases that do not meet the criteria as OSHA Recordable.
2. OSHA Recordable Injury / Illness (Total)	Total number of employee injuries and illnesses meeting the OSHA recordable definition and as recorded on the OSHA 300 log.
a. OSHA Recordable: Lost Time	Number of injuries/illnesses with days away from work.
b. OSHA Recordable: No Lost Time	Number of injuries/illnesses with no lost work time, includes cases with transitional work (modified work) when there is no lost work time.
3. Repetitive Motion Injury - Computer Keyboard, Mouse	Number of OSHA recordable cases related to use of computer keyboards/mouse use if that use is at least 3 hours of the total workday. Does not include injury/illness as a result of acute injuries or non-keyboard/mouse activities.
4. Repetitive Motion Injury – Non-Computer	OSHA recordable RMI associated with work activities such as using syringes, washing scopes, pushing/pulling equipment, not as result of a specific incident.
5. Patient Handling Injuries (OSHA Recordable)	Number of OSHA recordable injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital. Does not include reported injuries with no specific lift/transfer incident.
6. All Patient Handling Injuries	Total number of injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital.
7. Trip/Slip/Fall (all incidents reported)	Number of Trip/Slip/Fall incidents resulting from the unintended or unexpected change in contact between the feet or footwear and the walking or working surface.(All incidents)
8. Staff Assaults by Patients	Number of staff assaulted by patients – includes hitting, kicking, biting, thrown objects.
Infection Control	
1. Blood & Body Fluid Exposures a. Percutaneous b. Skin, Mucous Membrane Contact	A percutaneous injury (e.g., a needle stick or cut with a sharp object), contact of mucous membranes or non-intact skin (e.g., when the exposed skin is chapped, abraded, or non-intact due to dermatitis), or contact with intact skin when the duration of contact is prolonged, (i.e., several minutes or more) or involves an extensive area, with blood, tissue or other body fluids. Body fluids include: a) Semen, vaginal secretions or other body fluids contaminated with visible blood that have been implicated in the transmission of blood borne pathogens b) Cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids which have an undetermined risk for transmitting HIV.
2. TB Conversion Rate (Monthly number / quarterly rate)	The number of work related* PPD converters by month and quarterly, total of conversions divided by the number of persons receiving PPDs.*Work related PPD conversion is a HCW PPD conversion after contact with a known TB + active case.
Safety Rounds Scoring	
1. Critical Area Score (# Compliant/total number)	Scoring of 25 critical areas, as defined during Joint Commission Inspection. Percentage of items in compliance for all areas inspected.
E.C. 2.0 SECURITY MANAGEMENT	
1. Code Gray Incidents	Code Grey is called when immediate assistance is required to respond to potential or actual violent situations involving visitors, patients, or family members.
2. Security Incidents	Number of security incidents includes reported motor vehicle accidents, patient/visitor disturbance, patient elopement, suspicious person, theft, vandalism and participation in emergency codes (other than Code Gray which is reported separately).

E.C. 3.0 HAZARDOUS MATERIALS MANAGEMENT	
1. Reportable Hazardous Materials Incidents	Any unauthorized discharge which is determined not to be recordable and must be reported to the City of Mountain View (subsection 24.5.0.a.1 (a) of Mountain View Health and Safety Code) or the Town of Los Gatos.
2. Recordable Hazardous Materials Incidents	An unauthorized discharge of hazardous or other regulated material defined as a discharge from a primary to a secondary container, cleanup of a discharge to a secondary container requiring greater than 8 hours, no increase of fire or explosion nor production of poisonous gas or flame, or no degradation of secondary container, the discharge does not exceed one (1) ounce by weight or can be cleaned up in 15 minutes following deterioration of the primary container.
3. Waste Water Discharge Violations	Monthly sampling analysis > than the Maximum Limit (mg/L): Zinc 2.0; Total Toxic Organic 1.0; Single Toxic Organic 0.75; Formaldehyde 5.0; Copper 0.25.
4. Eyewash Inspections	Number of eyewash inspection completed/number scheduled.
5. Eyewash Corrective Actions Completed/Assigned	Number of corrective actions identified in eyewash inspection completed/total number of corrective actions assigned.
E.C. 4.0 FIRE PREVENTION MANAGEMENT	
1. Fire Incidents	Number of actual fire incidents/month.
2. Fire Alarm Events	Number of fire/smoke alarms activated by an event not classified as an actual fire or false alarm (example: burnt toast, dust, steam, etc.)
3. Fire Watches	Number of fire watches initiated during the period. A fire watch is a temporary measure to ensure the continuous surveillance of a building or portion thereof for the purpose of identifying and controlling fire hazards, detecting early signs of fire, and raising an alarm of fire. Fire watches are implemented anytime the fire alarm system is disabled or out of service in an area.
4. Fire Drills Completed/Scheduled	Number of fire drills completed/number scheduled.
5. Fire Drill Corrective Actions (comp/assigned)	Percentage of action items assigned during fire drills that were completed during the month.
6. Interim Life Safety Measures (ILSM) Tracking (Q)	The percentage of ILSM's implemented that noted problems. (# of problems/total #ILSMs). ILSMs are health and safety measures put in place to protect the safety of patients, visitors, and staff during construction or maintenance activities that have an impact on the life safety systems in the hospital. Reported quarterly.
E. C. 5.0 MEDICAL EQUIPMENT MANAGEMENT	
1. Reports to FDA	Number of reports to FDA as defined by Safety Medical Device Act requirements. Reported quarterly.
2. PM % Completion	Scheduled preventive maintenance completed with 10% of the prescribed interval/items scheduled for maintenance. Reported quarterly.
a. Biomed	
b. Lab	
c. Radiology	
d. Dialysis	
3. Product Recalls % Closed	The percent of product recalls closed/completed compared to those received.
E.C. 6.0 UTILITIES MANAGEMENT	
1. Utility Reportable Incidents	Utility System incidents with actual or potential significant impact on safe patient care, staff health and safety or resource/property loss.
2. PM Completion rate % Completed	Scheduled preventive maintenance completed with 28 days of the prescribed interval/items scheduled for maintenance. Reported quarterly.
3. Generator Testing % Completed	Number of completed generator tests/number of scheduled generator tests. Reported quarterly.
4. Egress Lighting monthly test % completed/scheduled (Annual test in **BOLD** text)	Number of completed battery-powered egress lighting tests/number of scheduled tests. Testing required at Rose Garden & Evergreen Dialysis clinics. Reported monthly. Annual testing to be completed in November of each year.
E.M EMERGENCY MANAGEMENT	
1. Exercises, Internal and External	Planned internal/external emergency preparedness exercises completed. (Per The Joint Commission: 2 exercises implementing the hospital disaster plan; DHS Title 22: 1 drill per shift per quarter).
2. Natural Disaster/Actual Event	An internal or external emergency event that requires the activation of HICS.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Board of Directors Open Session – October 11, 2017

To: El Camino Hospital Board of Directors

From: Rebecca Fazilat, MD, Chief of Staff MV
J. Augusto Bastidas, MD, Chief of Staff LG

Date: November 1, 2017

RE: REPORT FROM THE MEDICAL STAFF EXECUTIVE COMMITTEE

This report is based upon the Medical Staff Executive Committee meeting of October 26, 2017.

Request Approval of the Following:

A. Patient Care Policies & Procedures – Policy Summary (p. 2)
- New Policies/Procedures
  - Scope of Service Wound Care Center (3-4)
- Documents with no revisions
  - Involuntary Detention of the Patient on 72 Hour Hold (5-7)

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL - Board

Nov-17

NEW POLICIES/PROCEDURES			
Document Name	**Department**	**Type of Document**	**Summary of Document Changes**
Scope of Service Wound Care Center	WCS	Scope of Service	
DOCUMENTS WITH MAJOR REVISIONS			
Document Name	**Department**	**Type of Document**	**Summary of Policy Changes**
DOCUMENTS WITH MINOR REVISIONS			
Document Name	**Department**	**Type of Document**	**Summary of Policy Changes**
DOCUMENTS WITH NO REVISIONS			
Document Name	**Department**	**Type of Document**	**No Revisions**
Involuntary Detention of the Patient on 72 Hour Hold	BHS	Policy	
DOCUMENTS FOR INFORMATION ONLY			
Document Name	**Department**	**Type of Document**	**Summary of Policy Changes**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

SCOPE OF SERVICE
Wound Care Center

A. Types and Ages of Patient Served

The Wound Care Center (WCC) is an outpatient department of El Camino Hospital (ECH.) The WCC provides comprehensive and coordinated wound care to outpatient adults eighteen years of age and older. WCC focuses on the assessment and treatment of adults with the goal of optimizing complex wound healing in adults of all ages. Types of patients served are described in the scope and complexity of services offered below.

B. Assessment Methods

Patient assessment and care is provided by physicians, registered nurses and licensed vocational nurses as appropriate and according to their scope of practice. Physicians and/or Clinical Manager (RN) provide direct supervision to the registered nurses and licensed vocational nurse in the provision of patient care.

C. Scope and Complexity of Services Offered

The WCC is located at 2660 Grant Road, Suite F, Mountain View, California. The WCC operating hours are Monday - Friday from 8 am to 5 pm. WCC facility is not open on weekends or holidays recognized by El Camino Hospital. Physicians are not available after the WCC operating hours and patients are instructed to contact their primary MD if needed during those hours or to go to the Emergency Room if in need of urgent attention

The WCC has exam rooms for clinical examinations and moderate to complex procedures. The WCC clinical schedule and patient records are maintained in an electronic health record by trained staff.

The following services are provided:

- Comprehensive wound assessment for etiology and characterization of wounds
- Appropriate tissue debridement if needed
- Application of suction devices, compression devices/dressings or therapeutic tissue substitutes when indicated
- Prescribing of oral medications, topical treatments and dressing protocols and referral for diagnostic testing and procedures when appropriate

Patient care is given as directed and prescribed by the physician. The medical staff working in the WCC will have hospital privileges on file in the ECH Medical Staff Office. Staff communicates specific patient needs and coordinates treatment and plan of care with referring and consultative physicians. Services and treatments provided according to department specific procedures and guidelines and ECH policies and procedures.

D. Staffing/Staff Mix

A Clinical Manager (RN) oversees the clinical operations of the Wound Care Center and reports to the Department Director and the Medical Directors. Physicians provide direct care and assessment

with the assistance of an RN and/or LVN. WCC staffing will be determined by patient volume and patient needs.

The competency of the staff is evaluated through observation of performance and skills competency validation. Staff education and training is provided to assist in the achievement of performance standards.

E. Requirements for Staff

- All staff must complete specific orientation.
- The Health Stream safety series as well as Safety/Emergency policies and procedures are reviewed annually by all staff.
- All clinical staff members are required to be Basic Life Support certified.
- All clinical staff will be licensed according to ECH policies and procedures and by the State of California.

F. Level of Service Provided

The level of service is consistent with ambulatory wound care and treatment. The WCC is designed to advocate for and support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a caring and enduring partnership between the care team, patients and the patient's family.

G. Standards of Practice

WCC is governed by state regulations as outlined in Title 22, the Center for Medicare/Medicaid Services.

APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
WCC Medical Directors Tej Singh, MD and Peter Schubart, MD:	9/2017
ePolicy Committee:	10/2017
Pharmacy and Therapeutics (if applicable):	
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Involuntary Detention of the Patient on a 72-Hour Hold

CATEGORY: Patient Care Services
LAST APPROVAL DATE: 10/15

☑Policy ☐Procedure ☐Protocol ☐ Standardized Procedure ☐Scope of Service/ADT ☐ Practice Guideline

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SUB-CATEGORY: Behavioral Health Services
ORIGINAL DATE: 3/19/83

I. COVERAGE:

El Camino Hospital and Medical Staff

II. PURPOSE:

To detain patients legally for psychiatric evaluation and treatment.

III. PROCEDURE:

A. The application for 72-hour detention for evaluation and treatment may be instituted by El Camino Hospital emergency department physicians, psychiatrists, or by designated professional staff of behavioral health services (who are approved by Santa Clara County for this function).

B. The Mountain View El Camino Hospital inpatient psychiatric department is a "designated facility" under the Lanterman-Petris Short Act by the county of Santa Clara. "Designated facility" implies that within the structure of the Hospital there exists the capacity for psychiatric consultation and/or inpatient care on an involuntary basis.

C. Welfare & Institutions Code 5150 requires a sufficiently detailed statement of the circumstances providing probable cause to believe that the person for whom evaluation and treatment is sought is in fact (1) a danger to self, (2) a danger to others, or (3) gravely disabled. The original 72-hour hold application (i.e. 5150 form) is to be in the patients' current medical record at all times.

D. Welfare & Institutions Code 5157 requires that each person, when first detained for psychiatric evaluation and treatment, be given orally information contained in the Patient Advisement which is contained on the 72-hour hold application, when taken into custody. If admitted to the psychiatric department at Mountain View campus on a 72-hour detention, the patient must be advised orally and in writing, utilizing the "Patient Advisement" form created for this purpose. The original advisement form is to be given to the patient.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Involuntary Detention of the Patient on a 72-Hour Hold

E. If it is impossible to complete the advisement at Mountain View campus, due to patient condition or communication barrier, the incomplete advisement is to be noted. Detention may be continued even though the required disclosure cannot be accomplished. Efforts must be made to complete the advisement utilizing the "language line", or attempting again when the patient is able to receive this information

F. For a patient admitted to the hospital, only an El Camino Hospital staff psychiatrist may discontinue a 72-hour hold following a face-face evaluation. For patients in the ED setting, a psychiatrist must be consulted prior to releasing a patient from involuntary detention for evaluation ("5150"). This consultation may be over the phone.

G. For a patient in the Emergency Department at Los Gatos that require admission to an inpatient psychiatric department, the ED physician will contact the admitting staff psychiatrist at Mountain View. If the patient can be admitted, the Los Gatos ED staff will make the arrangements for transportation to the Mountain View Inpatient Unit. If the patient cannot be admitted to Mountain View, the ED physician will contact other inpatient psychiatric departments in the community. The original 72-hour hold application (i.e. 5150 form) is to be in the patients' current medical record at all times.

H. Before, or at the expiration of the 72-hour hold at Mountain View campus, the patient may be discharged, placed on a 14-day hold or changed to voluntary status if the patient is willing and able to be a voluntary patient. If the patient is treated on a medical floor, and the "5150" is expiring or has expired, a new 5150 may be generated until the patient is medically stable enough for psychiatric evaluation and treatment. The patient must sign a consent for voluntary treatment at the time the patient becomes a voluntary patient. In the case where there is an intervening period of voluntary treatment, if a 14-day certification is placed on the patient; all days while voluntary are to be included in the 14 day period.

I. At time of admission at Mountain View campus, present the original of the "Involuntary Patient Advisement" form to the patient, with a copy to the medical record. Explain contents to patient to verify comprehension to the extent possible.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE:Involuntary Detention of the Patient on a 72-Hour Hold

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	
Psych Executive Commitee:	8/2017
ePolicy Committee:	10/2017
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: 3/19/83, 7/06, 1/09, 05/09, 2/12, 4/15,10/15
Department of Psychiatry: 2/12, 4/15
Patient Care Management Council: 01/09 no longer required, process changed
Patient Care Leadership Council: 2/12
Medical Executive Committee:02/09, 04/26/2012,9/2015
Board of Directors: 03/09, 05/09/2012,10/2015

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Summary of Financial Operations

Fiscal Year 2018 – Period 3

7/1/2017 to 9/30/2017

Dashboard - ECH combined as of September 30, 2017

	Annual				Month			YTD		
	2016	2017	2018 Proj.	2018 Bud/Target	PY	CY	Bud/Target	PY	CY	Bud/Target
Volume										
Licenced Beds	443	443	443	443	443	443	443	443	443	443
ADC	242	239	236	240	233	236	237	230	234	232
Adjusted Discharges	32,324	33,837	34,914	34,080	2,627	2,772	2,817	8,165	8,728	8,516
Total Discharges (Excl NNB)	19,171	19,649	19,908	19,695	1,548	1,597	1,627	4,732	4,977	4,914
Inpatient Cases										
MS Discharges	13,026	13,624	13,844	13,544	1,036	1,105	1,111	3,166	3,461	3,338
Deliveries	4,717	4,656	4,672	4,752	421	388	400	1,207	1,168	1,219
BHS	928	908	1,036	902	52	82	75	228	259	229
Rehab	500	461	356	497	39	22	41	131	89	127
Outpatient Cases	139,935	145,960	146,892	147,485	11,743	12,056	12,072	35,714	36,723	36,293
ED	48,609	48,631	47,404	48,975	3,816	3,834	4,009	11,850	11,851	12,054
Procedural Cases										
OP Surg	6,070	4,487	4,548	4,595	337	406	376	1,031	1,137	1,130
Endo	2,324	2,366	2,420	2,134	206	185	175	578	605	525
Interventional	2,021	2,134	2,068	2,130	179	159	175	550	517	524
All Other	80,911	88,342	90,452	89,651	7,205	7,472	7,338	21,705	22,613	22,060
Financial Perf.										
Net Patient Revenues	772,020	832,263	848,624	832,066	66,069	71,716	67,399	198,091	212,156	208,053
Total Operating Revenue	795,657	858,347	874,928	855,195	67,896	73,452	69,964	203,534	218,732	214,301
Operating Expenses	743,044	746,171	751,370	778,105	59,445	62,304	63,523	177,437	187,842	191,896
Operating Income $	52,613	112,176	123,559	77,090	8,451	11,148	6,441	26,097	30,890	22,406
Operating Margin	6.6%	13.1%	14.1%	9.0%	12.4%	15.2%	9.2%	12.8%	14.1%	10.5%
EBITDA $	108,554	161,811	174,978	138,862	13,012	15,468	11,403	39,702	43,744	37,146
EBITDA %	13.6%	18.9%	20.0%	16.2%	19.2%	21.1%	16.3%	19.5%	20.0%	17.3%
IP Margin[1]	-9.8%	5.8%	7.1%	-10.2%	5.8%	7.1%	-10.2%	5.8%	7.1%	-10.2%
OP Margin[1]	35.9%	37.0%	39.4%	31.7%	37.0%	39.4%	31.7%	37.0%	39.4%	31.7%
Payor Mix										
Medicare	46.6%	47.7%	45.9%	47.4%	47.7%	45.0%	47.4%	48.2%	45.9%	47.4%
Medi-Cal	7.4%	7.3%	7.7%	7.2%	7.0%	8.8%	7.2%	6.8%	7.7%	7.2%
Commercial IP	24.0%	22.3%	23.0%	22.6%	22.2%	23.0%	22.6%	22.4%	23.0%	22.6%
Commercial OP	19.3%	20.2%	20.6%	20.3%	20.6%	20.5%	20.3%	20.5%	20.6%	20.3%
Total Commercial	43.3%	42.5%	43.6%	42.9%	42.9%	43.6%	42.9%	42.8%	43.6%	42.9%
Other	2.7%	2.5%	2.8%	2.5%	2.5%	2.7%	2.5%	2.3%	2.8%	2.5%
Cost										
Total FTE	2,509.5	2,506.7	2,548.9	2,529.6	2,473.8	2,548.9	2,524.3	2,470.2	2,548.9	2,524.3
Productive Hrs/APD	30.7	30.3	30.9	31.2	31.0	31.2	30.8	30.5	30.9	31.2
Balance Sheet										
Net Days in AR	53.7	44.8	49.0	48.0	44.8	49.0	48.0	44.8	49.0	48.0
Days Cash	361	444	459	266	444	459	266	444	459	266
Affiliates - Net Income ($000s)										
Hosp	43,043	169,576	190,462	79,793	7,376	19,024	6,666	40,937	47,616	40,937
Concern	1,823	1,556	2,898	1,430	(43)	302	134	461	725	387
ECSC	(282)	(105)	(28)	0	(40)	(2)	0	(43)	(7)	0
Foundation	982	2,420	2,038	737	(84)	334	13	556	510	402
SVMD	156	209	918	(0)	(43)	379	1	100	229	1

Green - Equal to or better than budget; Yellow - Unfav by up to 5%; Red - Greater than 5% unfav

FY2017 budget presented excludes 2016 and 2017 bonds cost of issuance and interest expense

Volume:

- For the year, overall volume, measured in adjusted discharges is 2.4% higher than budget.
- IP cases are 3.6% over budget, specifically Neurosciences, HVI, BHS, Oncology and Urology. However deliveries are lower than prior year by 3.2% and 4.4% below budget
- OP discharges are higher than budget in General Surgery, Imaging Services, MCH, Rehab and Urology.

Financial Performance:

- Septembers operating income is $4.7M over budget, due to favorable revenue and higher volume. Operating margin for the year is $8.5 million ahead of target

Payor Mix:

- Commercial insurance is 0.7% more of the Payor Mix in September than budget.

Cost:

- Prod Hrs/APD for September is 31.2 and slightly worse than budget . YTD we are slightly better than budget

Balance Sheet:

- Net days in AR is 49.0 which is 1 day more than budget.

El Camino Hospital ($000s)

3 months ending 9/30/2017

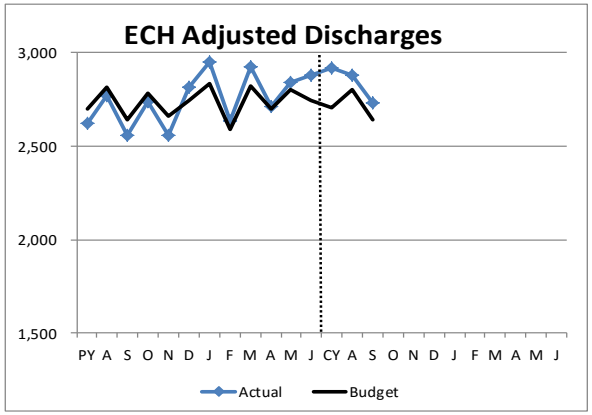
Period 3 FY 2017	Period 3 FY 2018	Period 3 Budget 2018	Variance Fav (Unfav)	Var%	$000s	YTD FY 2017	YTD FY 2018	YTD Budget 2018	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
241,002	270,383	261,191	9,192	3.5%	**Gross Revenue**	715,849	796,950	784,309	12,641	1.6%
(174,932)	(198,667)	(193,793)	(4,875)	1.0%	**Deductions**	(517,758)	(584,794)	(576,255)	(8,538)	1.5%
66,069	**71,716**	**67,399**	**4,317**	**6.4%**	**Net Patient Revenue**	**198,091**	**212,156**	**208,053**	**4,103**	**2.0%**
1,827	1,736	2,565	(830)	-32.3%	**Other Operating Revenue**	5,443	6,576	6,248	328	5.3%
67,896	**73,452**	**69,964**	**3,488**	**5.0%**	**Total Operating Revenue**	**203,534**	**218,732**	**214,301**	**4,431**	**2.1%**
					OPERATING EXPENSE					
35,569	38,311	38,129	(182)	-0.5%	**Salaries & Wages**	106,838	116,127	115,692	(435)	-0.4%
9,320	9,362	9,986	624	6.2%	**Supplies**	27,598	29,032	29,885	853	2.9%
8,197	7,949	8,077	128	1.6%	**Fees & Purchased Services**	22,658	23,316	24,009	693	2.9%
1,798	2,361	2,369	7	0.3%	**Other Operating Expense**	6,737	6,513	7,570	1,057	14.0%
468	298	725	427	58.9%	**Interest**	1,389	1,050	2,176	1,127	51.8%
4,093	4,022	4,237	215	5.1%	**Depreciation**	12,217	11,805	12,564	759	6.0%
59,445	**62,304**	**63,523**	**1,219**	**1.9%**	**Total Operating Expense**	**177,437**	**187,842**	**191,896**	**4,053**	**2.1%**
8,451	**11,148**	**6,441**	**4,707**	**73.1%**	**Net Operating Income/(Loss)**	**26,097**	**30,890**	**22,406**	**8,484**	**37.9%**
(1,076)	7,875	225	7,650	3395.6%	**Non Operating Income**	14,841	16,726	676	16,050	2374.7%
7,376	**19,024**	**6,666**	**12,357**	**185.4%**	**Net Income(Loss)**	**40,937**	**47,616**	**23,081**	**24,534**	**106.3%**
19.2%	21.1%	16.3%	4.8%		**EBITDA**	19.5%	20.0%	17.3%	2.7%	
12.4%	15.2%	9.2%	6.0%		**Operating Margin**	12.8%	14.1%	10.5%	3.7%	
10.9%	25.9%	9.5%	16.4%		**Net Margin**	20.1%	21.8%	10.8%	11.0%	

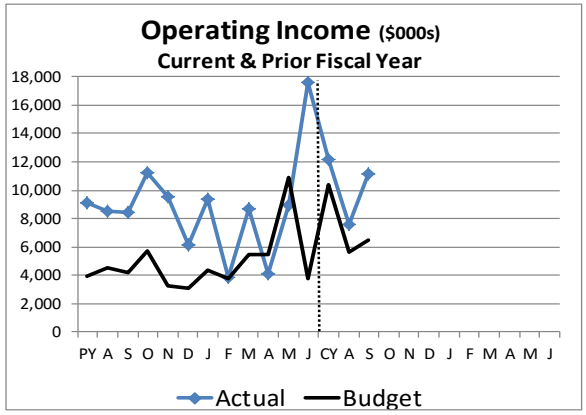
Non Operating Items and Net Income by Affiliate

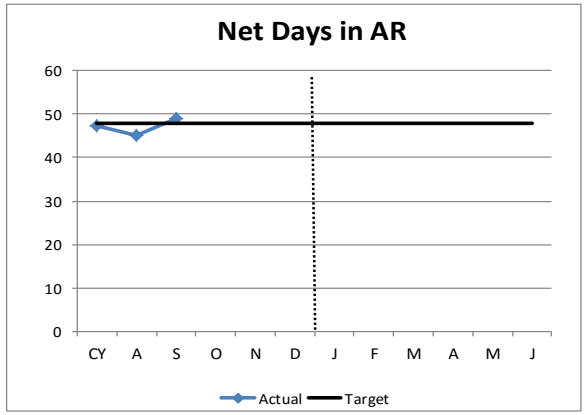
$ in thousands

	Period 3 - Month			Period 3 - FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Income (Loss) from Operations						
Mountain View	9,122	5,078	4,045	27,991	18,583	9,409
Los Gatos	2,026	1,363	662	2,898	3,823	(924)
Sub Total - El Camino Hospital, excl. Afflilates	**11,148**	**6,441**	**4,707**	**30,890**	**22,406**	**8,484**
Operating Margin %	**15.2%**	**9.2%**		**14.1%**	**10.5%**	
El Camino Hospital Non Operating Income						
Investments	7,693	1,516	6,177	19,696	4,547	15,150
Swap Adjustments	614	0	614	95	0	95
Community Benefit	(32)	(283)	251	(2,036)	(850)	(1,186)
Other (Affiliate Funding/Dialysis/Pathways)	(399)	(1,007)	608	(1,029)	(3,021)	1,991
Sub Total - Non Operating Income	**7,875**	**225**	**7,650**	**16,726**	**676**	**16,050**
El Camino Hospital Net Income (Loss)	**19,024**	**6,666**	**12,357**	**47,616**	**23,081**	**24,534**
ECH Net Margin %	**25.9%**	**9.5%**		**21.8%**	**10.8%**	
Concern	302	134	167	725	387	337
ECSC	(2)	0	(2)	(7)	0	(7)
Foundation	334	13	321	510	108	402
Silicon Valley Medical Development	379	149	230	229	1	229
Net Income Hospital Affiliates	**1,013**	**149**	**864**	**1,456**	**496**	**960**
Total Net Income Hospital & Affiliates	**20,037**	**6,815**	**13,221**	**49,072**	**23,577**	**25,495**

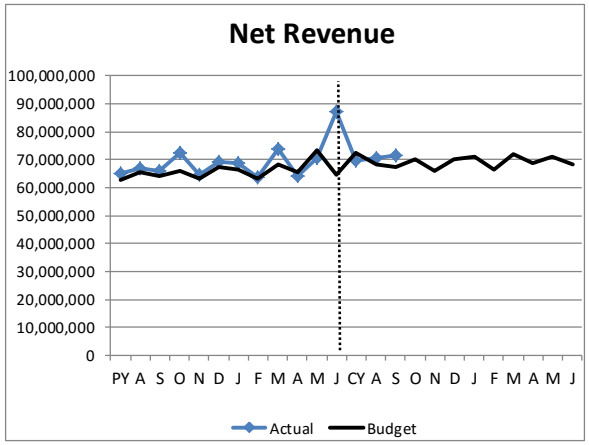
Monthly Financial Trends

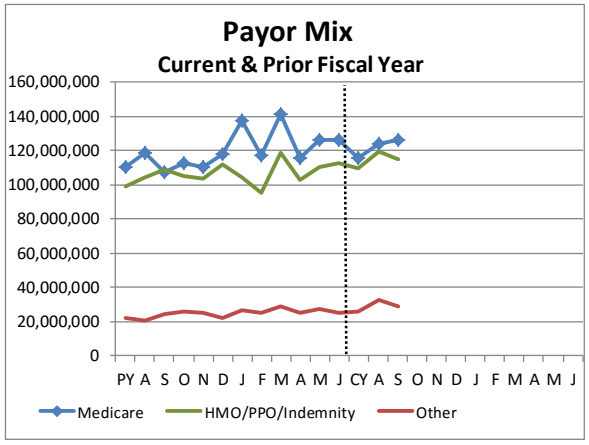


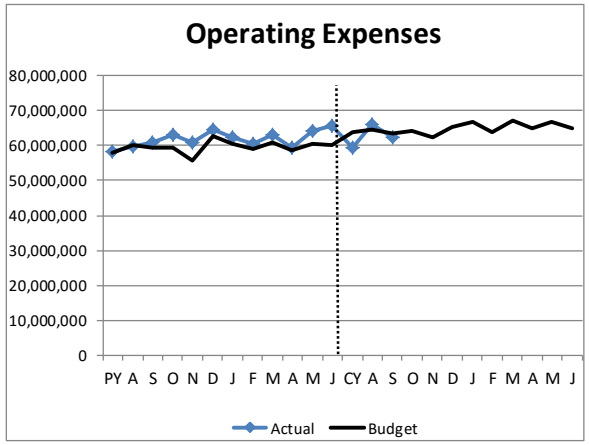




Volume is higher than budgeted for the month and the year. High inpatient volume is in Inpatient Neurosciences, BHS, HVI, Oncology. High Outpatient volume is General Surgery, Imaging Services, MCH, Outpatient Clinics and Urology.

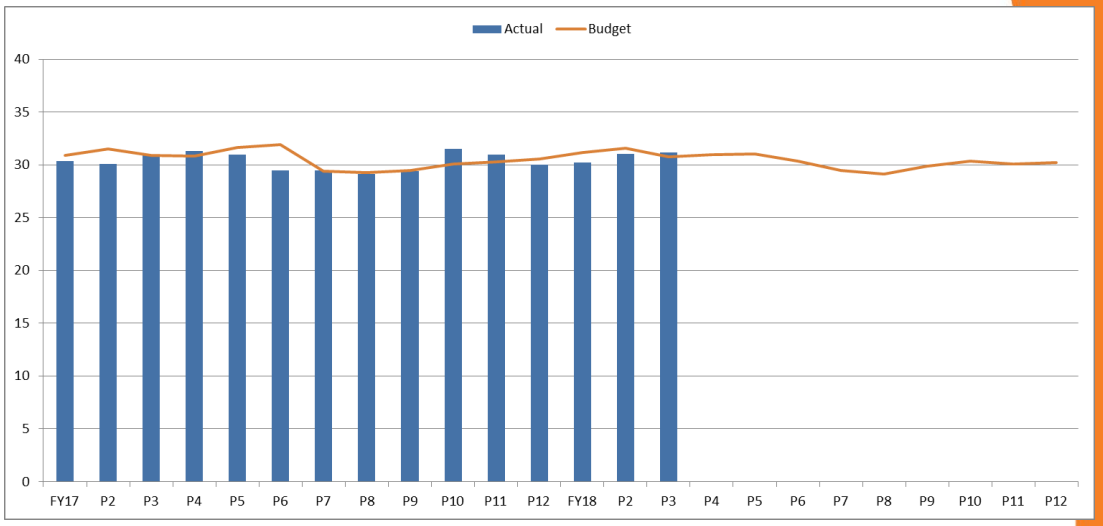




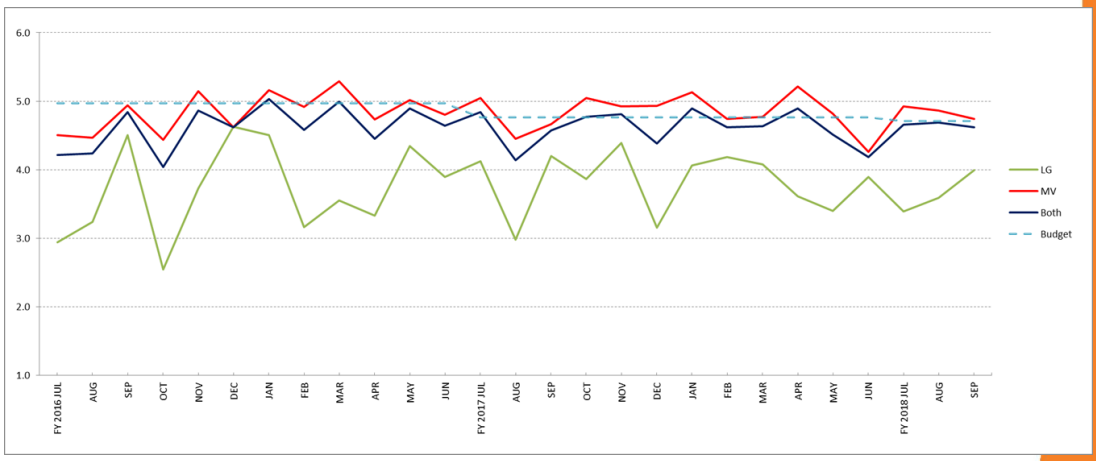


Productivity and Medicare Length of Stay

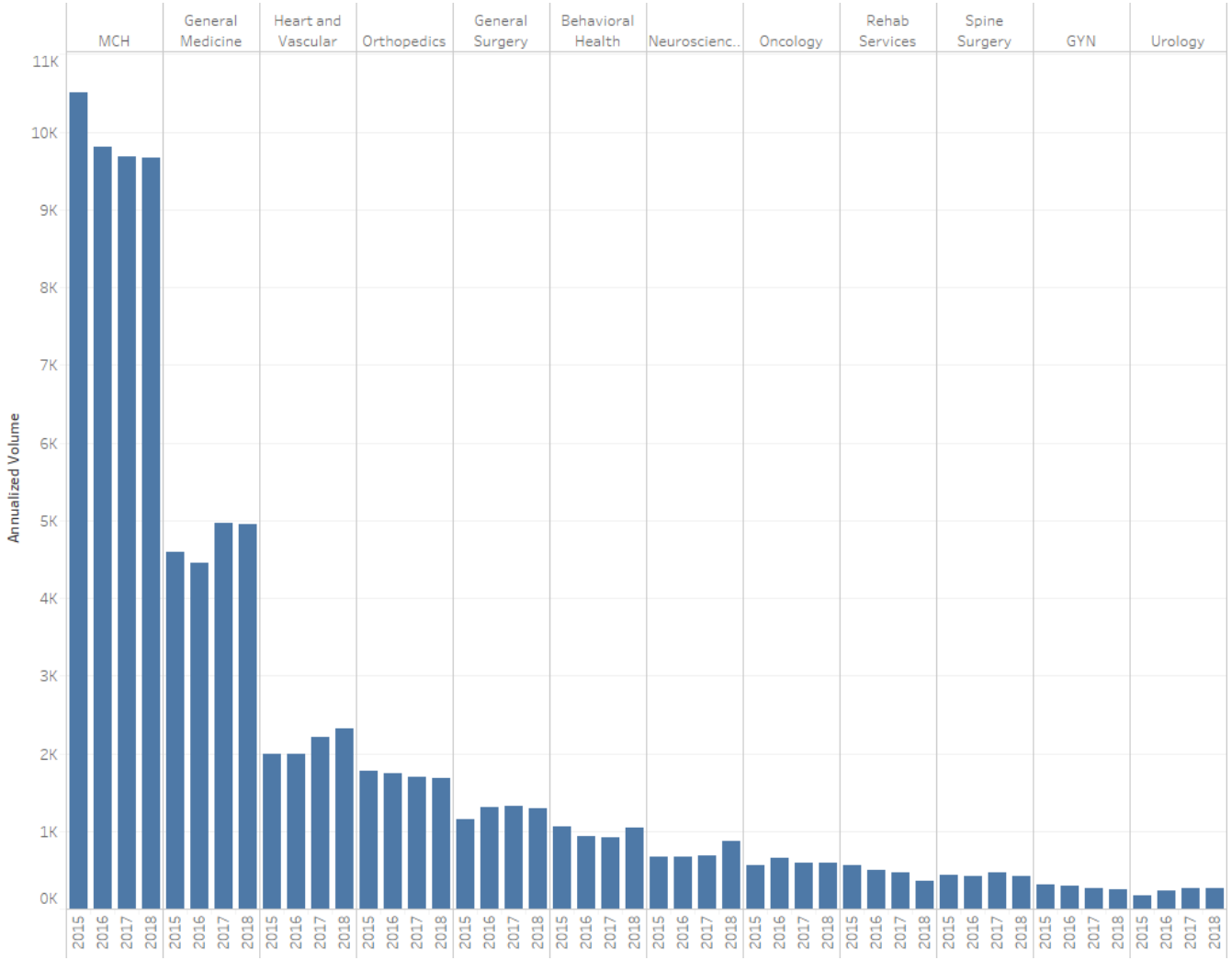
Work hours per adjusted patient day increased in September by 0.2. Overall the month of September is 31.2 worked hours per adjusted patient day.



ALOS remains better than target

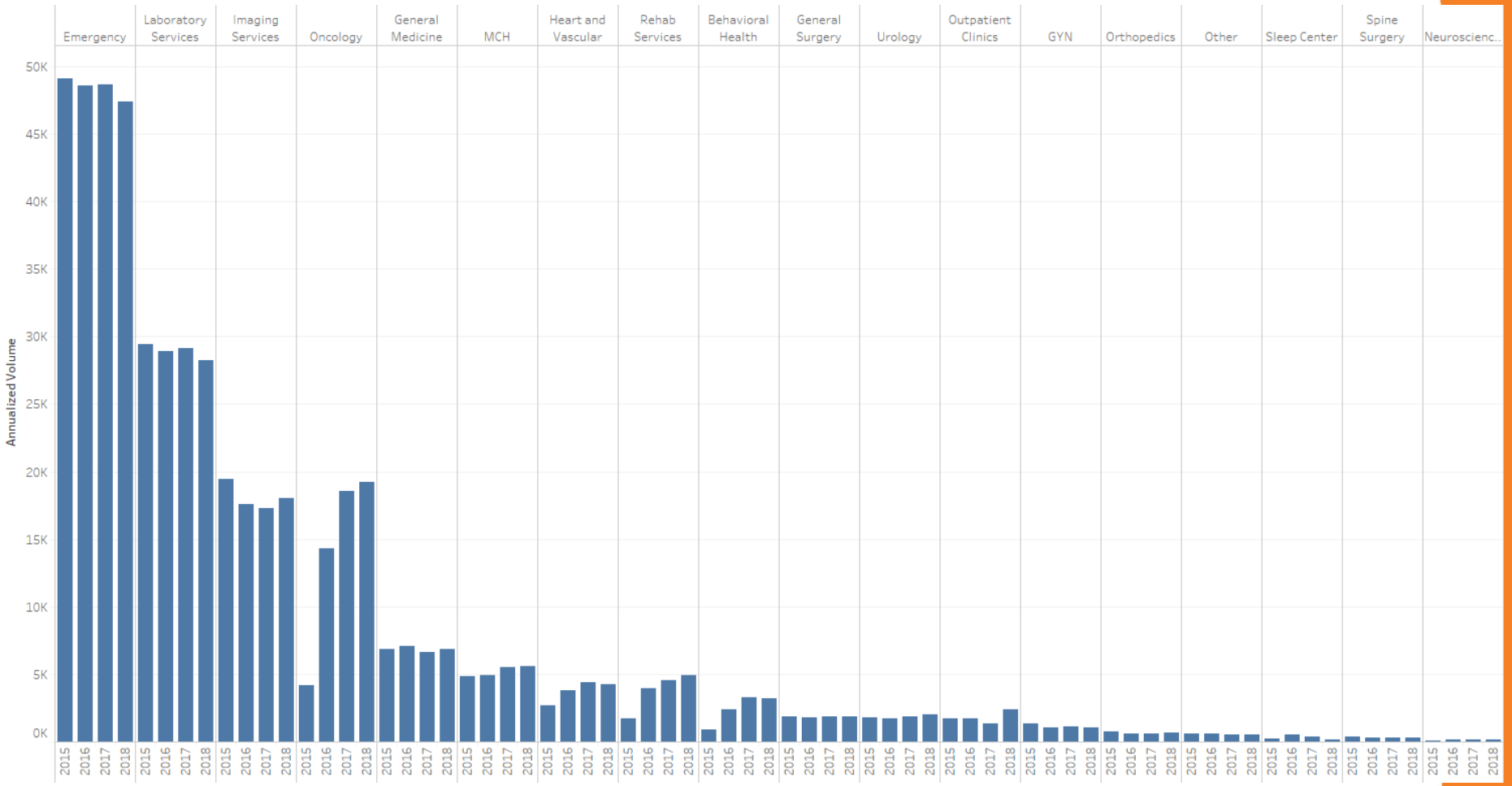


El Camino Hospital Volume Annual Trends – Inpatient
FY 2018 is annualized



- MCH, General Medicine, HVI, Orthopedics, Behavioral Health , Neuroscience and Urology display an increasing trend year to year.
- Conversely, General Surgery, Oncology, Rehab Services, Spine Surgery and GYN show a decreasing trend year to year.

El Camino Hospital Volume Annual Trends – Outpatient
FY 2018 is annualized

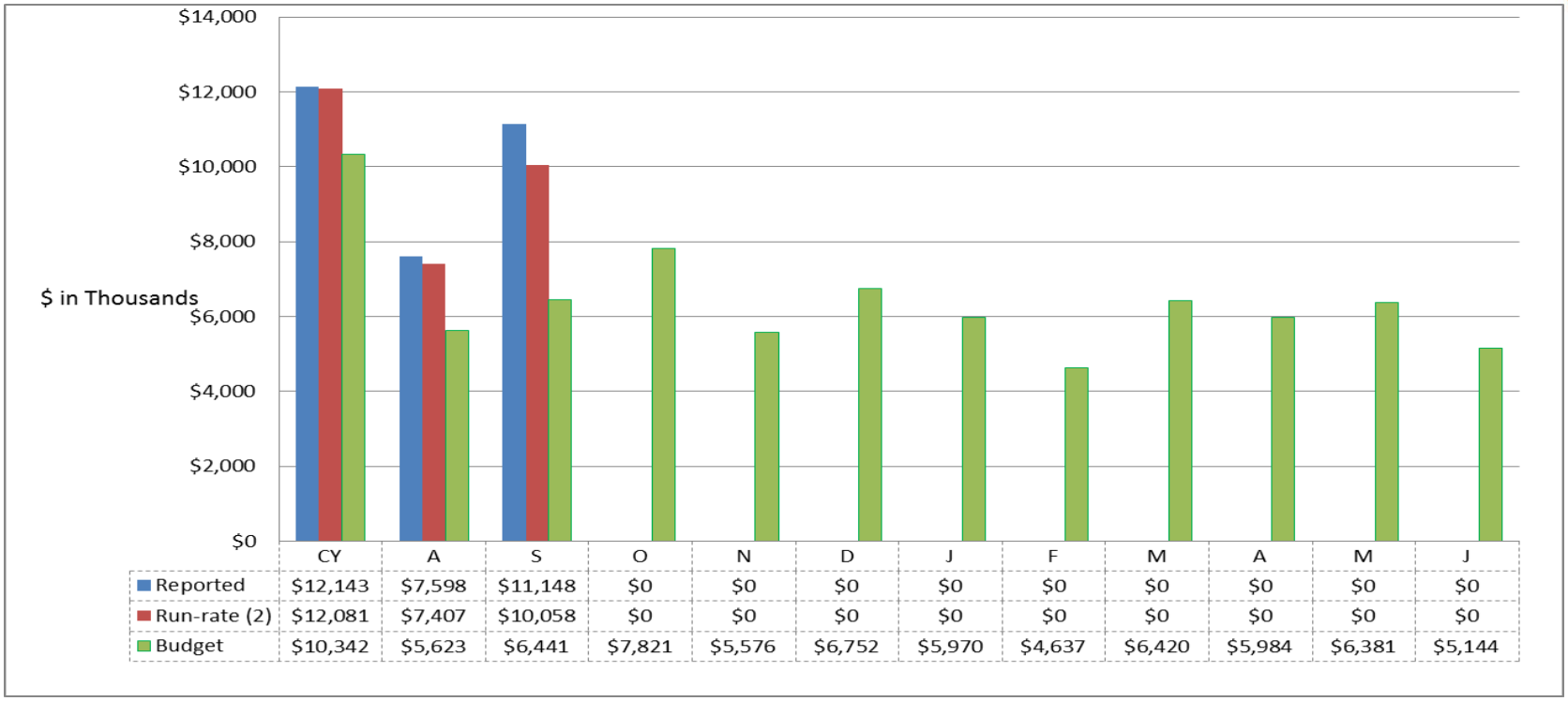


- Comparing year-over-year Imaging Services, Oncology, General Medicine, MCH, Rehab Services, Behavioral Health, Urology, General Surgery, and Outpatient Clinics are all increasing in volume.

Medicare data excludes Medicare HMOs

ECH Operating Margin

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



	CY	A	S	O	N	D	J	F	M	A	M	J
Reported	$12,143	$7,598	$11,148	$0	$0	$0	$0	$0	$0	$0	$0	$0
Run-rate (2)	$12,081	$7,407	$10,058	$0	$0	$0	$0	$0	$0	$0	$0	$0
Budget	$10,342	$5,623	$6,441	$7,821	$5,576	$6,752	$5,970	$4,637	$6,420	$5,984	$6,381	$5,144

FY 2018 Actual Run Rate Adjustments (in thousands) - FAV / <UNFAV>													
Revenue Adjustments	J	A	S	O	N	D	J	F	M	A	M	J	YTD
Insurance (Payment Variance)	-	-	158	-	-	-	-	-	-	-	-	-	158
Mcare Settlmt/Appeal/Tent Settlmt/PIP	54	155	905	-	-	-	-	-	-	-	-	-	1,114
Various Adjustments under $250k	9	36	27	-	-	-	-	-	-	-	-	-	72
Total	**63**	**191**	**1,090**	-	-	-	-	-	-	-	-	-	**1,344**

El Camino Hospital Investment Committee Scorecard

September 30, 2017

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY18 Year-end Budget	Expectation Per Asset Allocation
Investment Performance		3Q 2017		Fiscal Year-to-date		4y 11m Since Inception (annualized)			2017
Surplus cash balance & op. cash (millions)*		$1,158.2	--	--	--	--	--	$1,262.5	--
Surplus cash return		2.7%	2.7%	2.7%	2.7%	5.7%	5.6%	1.9%	5.7%
Cash balance plan balance (millions)		$250.4	--	--	--	--	--	$257.1	--
Cash balance plan return		3.1%	3.1%	3.1%	3.1%	8.2%	7.6%	6.0%	6.1%
403(b) plan balance (millions)		$411.2	--	--	--	--	--	--	--
Risk vs. Return		3-year				4y 11m Since Inception (annualized)			2017
Surplus cash Sharpe ratio		1.08	1.13	--	--	1.36	1.33	--	0.46
Net of fee return		5.0%	5.3%	--	--	5.7%	5.6%	--	5.7%
Standard deviation		4.4%	4.4%	--	--	4.0%	4.1%	--	7.2%
Cash balance Sharpe ratio		1.08	1.07	--	--	1.45	1.39	--	0.43
Net of fee return		6.3%	6.0%	--	--	8.2%	7.6%	--	6.1%
Standard deviation		5.6%	5.3%	--	--	5.4%	5.2%	--	8.7%
Asset Allocation		3Q 2017							
Surplus cash absolute variances to target		8.4%	< 10%	--	--	--	--	--	--
Cash balance absolute variances to target		6.2%	< 10%	--	--	--	--	--	--
Manager Compliance		3Q 2017							
Surplus cash manager flags		19	< 19 Green < 23 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		19	< 20 Green < 25 Yellow	--	--	--	--	--	--

*Includes Debt Reserve funds, excludes District assets, Foundation assets, and Concern.

Balance Sheet (in thousands)

ASSETS

CURRENT ASSETS	September 30, 2017	Audited June 30, 2017
Cash	89,101	125,551
Short Term Investments	116,332	140,284
Patient Accounts Receivable, net	112,881	109,089
Other Accounts and Notes Receivable	2,448	2,628
Intercompany Receivables	1,226	1,495
Inventories and Prepaids	53,854	50,657
Total Current Assets	**375,842**	**429,705**
BOARD DESIGNATED ASSETS		
Plant & Equipment Fund	142,254	131,153
Women's Hospital Expansion	9,298	9,298
Operational Reserve Fund	127,908	100,196
Community Benefit Fund	18,426	12,237
Workers Compensation Reserve Fund	20,550	20,007
Postretirement Health/Life Reserve Fund	19,526	19,218
PTO Liability Fund	23,394	23,409
Malpractice Reserve Fund	1,634	1,634
Catastrophic Reserves Fund	17,014	16,575
Total Board Designated Assets	**380,005**	**333,727**
FUNDS HELD BY TRUSTEE	**262,236**	**287,052**
LONG TERM INVESTMENTS	**293,494**	**256,652**
INVESTMENTS IN AFFILIATES	**32,840**	**32,451**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,227,200	1,192,047
Less: Accumulated Depreciation	(540,366)	(531,785)
Construction in Progress	129,969	138,017
Property, Plant & Equipment - Net	**816,802**	**798,279**
DEFERRED OUTFLOWS	28,810	28,960
RESTRICTED ASSETS - CASH	0	0
TOTAL ASSETS	**2,190,030**	**2,166,825**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	September 30, 2017	Audited June 30, 2017
Accounts Payable	22,116	38,457
Salaries and Related Liabilities	19,135	25,109
Accrued PTO	23,394	23,409
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	11,136	10,438
Intercompany Payables	74	84
Malpractice Reserves	1,634	1,634
Bonds Payable - Current	3,735	3,735
Bond Interest Payable	7,141	11,245
Other Liabilities	5,935	4,889
Total Current Liabilities	**96,601**	**121,299**
LONG TERM LIABILITIES		
Post Retirement Benefits	19,526	19,218
Worker's Comp Reserve	18,250	17,707
Other L/T Obligation (Asbestos)	3,775	3,746
Other L/T Liabilities (IT/Medl Leases)	-	-
Bond Payable	527,276	527,371
Total Long Term Liabilities	**568,827**	**568,042**
DEFERRED REVENUE-UNRESTRICTED	483	567
DEFERRED INFLOW OF RESOURCES	10,666	10,666
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	1,133,448	1,132,525
Board Designated	380,005	333,726
Restricted	0	0
Total Fund Bal & Capital Accts	**1,513,452**	**1,466,251**
TOTAL LIABILITIES AND FUND BALANCE	**2,190,030**	**2,166,825**

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

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

Women's Hospital Expansion – established June 2016 by the District authorizing the amounts accumulated in its Capital Appropriation Fund (excess Gann Limit property taxes) for the fiscal years of 2014 and 2015 to be allocated for the renovation of the Women's Hospital upon the completion of Integrated Medical Office Building currently under construction.

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

Community Benefit Fund – following in the footsteps of the District in 2008 of forming its Community Benefit Fund using Gann Limit tax receipts, the Hospital in 2010 after opening its campus outside of District boundaries in Los Gatos formed its own Community Benefit Fund to provide grants/sponsorships in Los Gatos and surrounding areas. The funds come from the Hospital reserving $1.5M a year from its operations, the entity of CONCERN contributing 40% of its annual income each year (an amount it would have paid in corporate taxes if it wasn't granted tax exempt status), that generates an amount of $800,000 or more a year. $15 million within this fund is a board designated endowment fund formed in 2015 with a $10 million contribution, and added to at the end of the 2017 fiscal year end with another $5 million contribution, to generate investment income to be used for grants and sponsorships, currently anticipated to generate $500,000 a year in investment income for the program.

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

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

Postretirement Health/Life Reserve Fund – following the same formula as the Workers Compensation Reserve Fund this fund was formed in the early 2000's by management to reserve cash equal to the yearly actuarially determined amount to fund the Hospital's postretirement health and life insurance program. Note this program was frozen in 1995 for all new hires after that date.

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

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

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

APPENDIX

El Camino Hospital – Mountain View ($000s)

3 months ending 9/30/2017

Period 3 FY 2017	Period 3 FY 2018	Period 3 Budget 2018	Variance Fav (Unfav)	Var%	$000s	YTD FY 2017	YTD FY 2018	YTD Budget 2018	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
198,553	223,244	214,494	8,750	4.1%	**Gross Revenue**	594,217	655,610	642,999	12,612	2.0%
(143,154)	(164,377)	(159,880)	(4,497)	2.8%	**Deductions**	(430,302)	(480,493)	(473,632)	(6,861)	1.4%
55,399	**58,867**	**54,614**	**4,253**	**7.8%**	**Net Patient Revenue**	**163,915**	**175,118**	**169,367**	**5,751**	**3.4%**
1,647	1,573	2,347	(774)	-33.0%	**Other Operating Revenue**	4,922	6,093	5,616	478	8.5%
57,045	**60,440**	**56,961**	**3,478**	**6.1%**	**Total Operating Revenue**	**168,837**	**181,211**	**174,983**	**6,228**	**3.6%**
					OPERATING EXPENSE					
29,596	32,079	31,935	(144)	-0.5%	**Salaries & Wages**	89,001	96,735	96,794	59	0.1%
7,616	7,795	8,044	249	3.1%	**Supplies**	22,932	23,645	24,007	362	1.5%
7,010	6,823	6,797	(26)	-0.4%	**Fees & Purchased Services**	18,696	19,554	20,118	564	2.8%
318	809	840	31	3.6%	**Other Operating Expense**	2,021	1,913	2,832	919	32.5%
468	298	725	427	58.9%	**Interest**	1,389	1,050	2,176	1,127	51.8%
3,560	3,513	3,542	29	0.8%	**Depreciation**	10,606	10,324	10,473	149	1.4%
48,568	**51,318**	**51,884**	**566**	**1.1%**	**Total Operating Expense**	**144,645**	**153,220**	**156,400**	**3,180**	**2.0%**
8,477	**9,122**	**5,078**	**4,045**	**79.7%**	**Net Operating Income/(Loss)**	**24,191**	**27,991**	**18,583**	**9,409**	**50.6%**
(1,076)	7,875	225	7,650	3395.6%	**Non Operating Income**	14,851	16,771	676	16,095	2381.2%
7,401	**16,998**	**5,303**	**11,695**	**220.5%**	**Net Income(Loss)**	**39,042**	**44,762**	**19,259**	**25,503**	**132.4%**
21.9%	21.4%	16.4%	5.0%		**EBITDA**	21.4%	21.7%	17.8%	3.9%	
14.9%	15.1%	8.9%	6.2%		**Operating Margin**	14.3%	15.4%	10.6%	4.8%	
13.0%	28.1%	9.3%	18.8%		**Net Margin**	23.1%	24.7%	11.0%	13.7%	

El Camino Hospital – Los Gatos($000s)

3 months ending 9/30/2017

Period 3 FY 2017	Period 3 FY 2018	Period 3 Budget 2018	Variance Fav (Unfav)	Var%	$000s	YTD FY 2017	YTD FY 2018	YTD Budget 2018	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
42,449	47,139	46,697	442	0.9%	**Gross Revenue**	121,632	141,339	141,310	29	0.0%
(31,778)	(34,290)	(33,913)	(377)	1.1%	**Deductions**	(87,456)	(104,301)	(102,624)	(1,677)	1.6%
10,671	**12,849**	**12,784**	**65**	**0.5%**	**Net Patient Revenue**	**34,176**	**37,038**	**38,686**	**(1,648)**	**-4.3%**
180	163	218	(56)	-25.4%	**Other Operating Revenue**	521	483	632	(149)	-23.6%
10,851	**13,012**	**13,003**	**9**	**0.1%**	**Total Operating Revenue**	**34,697**	**37,521**	**39,318**	**(1,797)**	**-4.6%**
					OPERATING EXPENSE					
5,973	6,232	6,194	(38)	-0.6%	**Salaries & Wages**	17,838	19,392	18,898	(494)	-2.6%
1,704	1,567	1,942	375	19.3%	**Supplies**	4,666	5,387	5,877	490	8.3%
1,187	1,126	1,280	154	12.0%	**Fees & Purchased Services**	3,962	3,762	3,890	128	3.3%
1,480	1,552	1,529	(23)	-1.5%	**Other Operating Expense**	4,716	4,600	4,739	138	2.9%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
533	509	695	186	26.7%	**Depreciation**	1,610	1,482	2,091	610	29.2%
10,876	**10,986**	**11,639**	**653**	**5.6%**	**Total Operating Expense**	**32,792**	**34,623**	**35,496**	**873**	**2.5%**
(26)	**2,026**	**1,363**	**662**	**48.6%**	**Net Operating Income/(Loss)**	**1,905**	**2,898**	**3,823**	**(924)**	**-24.2%**
0	0	0	0	0.0%	**Non Operating Income**	(10)	(45)	0	(45)	0.0%
(26)	**2,026**	**1,363**	**662**	**48.6%**	**Net Income(Loss)**	**1,895**	**2,854**	**3,823**	**(969)**	**-25.3%**
4.7%	19.5%	15.8%	3.7%		**EBITDA**	10.1%	11.7%	15.0%	-3.4%	
-0.2%	15.6%	10.5%	5.1%		**Operating Margin**	5.5%	7.7%	9.7%	-2.0%	
-0.2%	15.6%	10.5%	5.1%		**Net Margin**	5.5%	7.6%	9.7%	-2.1%	

Capital Spend Trend & FY 18 Budget

Capital Spending (in 000's)	Actual FY2015	Actual FY2016	Actual FY2017	Projected FY2018
EPIC	29,849	20,798	2,755	1,922
IT Hardware / Software Equipment	4,660	6,483	2,659	12,238
Medical / Non Medical Equipment*	13,340	17,133	9,556	5,635
Non CIP Land, Land I , BLDG, Additions	-	4,189	-	-
Facilities	38,940	48,137	82,953	211,886
GRAND TOTAL	86,789	96,740	97,923	231,681

*Includes 2 robot purchases in projected FY2017 & FY2016 Medical/Non Medical Equipment spent FY2017

El Camino Hospital Capital Spending (in thousands) FY 2012 – FY 2017

Category	2013	2014	2015	2016	2017
EPIC	**0**	**6,838**	**29,849**	**20,798**	**2,755**
IT Hardware/Software Equipment	**8,019**	**2,788**	**4,660**	**6,483**	**2,659**
Medical/Non Medical Equipment	**10,284**	**12,891**	**13,340**	**17,133**	**9,556**
Non CIP Land, Land I, BLDG, Additions	**0**	**22,292**	**0**	**4,189**	**0**
Facilities Projects CIP					
Mountain View Campus Master Plan Projects					
1245 - Behavioral Health Bldg Replace	0	1,257	3,775	1,389	10,323
1413 - North Drive Parking Structure Exp	0	0	167	1,266	18,120
1414 - Integrated MOB	0	0	2,009	8,875	32,805
1422 - CUP Upgrade	0	0	0	896	1,245
Sub-Total Mountain View Campus Master Plan	**0**	**1,257**	**5,950**	**12,426**	**62,493**
Mountain View Capital Projects					
9900 - Unassigned Costs	734	470	3,717	0	0
1108 - Cooling Towers	450	0	0	0	0
1120 - BHS Out Patient TI's	66	0	0	0	0
1129 - Old Main Card Rehab	9	0	0	0	0
0817 - Womens Hosp Upgrds	645	1	0	0	0
0906 - Slot Build-Out	1,003	1,576	15,101	1,251	294
1109 - New Main Upgrades	423	393	2	0	0
1111 - Mom/Baby Overflow	212	29	0	0	0
1204 - Elevator Upgrades	25	30	0	0	0
0800 - Womens L&D Expansion	2,104	1,531	269	0	0
1131 - MV Equipment Replace	216	0	0	0	0
1208 - Willow Pav. High Risk	110	0	0	0	0
1213 - LG Sterilizers	102	0	0	0	0
1225 - Rehab BLDG Roofing	7	241	4	0	0
1227 - New Main eICU	96	21	0	0	0
1230 - Fog Shop	339	80	0	0	0
1315 - 205 So. Drive TI's	0	500	2	0	0
0908 - NPCR3 Seismic Upgrds	1,302	1,224	1,328	240	342
1125 - Will Pav Fire Sprinkler	57	39	0	0	0
1211 - SIS Monitor Install	215	0	0	0	0
1216 - New Main Process Imp Office	19	1	16	0	0
1217 - MV Campus MEP Upgrades FY13	0	181	274	28	0
1224 - Rehab Bldg HVAC Upgrades	11	202	81	14	6
1301 - Desktop Virtual	0	13	0	0	0
1304 - Rehab Wander Mgmt	0	87	0	0	0
1310 - Melchor Cancer Center Expansion	0	44	13	0	0
1318 - Women's Hospital TI	0	48	48	29	2
1327 - Rehab Building Upgrades	0	0	15	20	0
1320 - 2500 Hosp Dr Roofing	0	75	81	0	0
1340 - New Main ED Exam Room TVs	0	8	193	0	0
1341 - New Main Admin	0	32	103	0	0
1344 - New Main AV Upgrd	0	243	0	0	0
1400 - Oak Pav Cancer Center	0	0	5,208	666	52

Category	2013	2014	2015	2016	2017
Facilities Projects CIP cont.					
1403 - Hosp Drive BLDG 11 TI's	0	86	103	0	0
1404 - Park Pav HVAC	0	64	7	0	0
1405 - 1 - South Accessibility Upgrades	0	0	0	168	95
1408 - New Main Accessibility Upgrades	0	0	7	46	501
1415 - Signage & Wayfinding	0	0	0	106	58
1416 - MV Campus Digital Directories	0	0	0	34	23
1423 - MV MOB TI Allowance	0	0	0	588	369
1425 - IMOB Preparation Project - Old Main	0	0	0	711	1,860
1429 - 2500 Hospital Dr Bldg 8 TI	0	0	101	0	0
1430 - Women's Hospital Expansion	0	0	0	0	464
1432 - 205 South Dr BHS TI	0	0	8	15	0
1501 - Women's Hospital NPC Comp	0	0	4	0	223
1502 - Cabling & Wireless Upgrades	0	0	0	1,261	367
1503 - Willow Pavillion Tomosynthesis	0	0	0	53	257
1504 - Equipment Support Infrastructure	0	0	61	311	0
1523 - Melchor Pavillion Suite 309 TI	0	0	0	10	59
1525 - New Main Lab Upgrades	0	0	0	0	464
1526 - CONCERN TI	0	0	0	37	99
Sub-Total Mountain View Projects	**8,145**	**7,219**	**26,744**	**5,588**	**5,535**
Los Gatos Capital Projects					
0904 - LG Facilities Upgrade	2	0	0	0	0
0907 - LG Imaging Masterplan	244	774	1,402	17	0
1005 - LG OR Light Upgrd	14	0	0	0	0
1122 - LG Sleep Studies	7	0	0	0	0
1210 - Los Gatos VOIP	147	89	0	0	0
1116 - LG Ortho Pavillion	177	24	21	0	0
1124 - LG Rehab BLDG	49	458	0	0	0
1247 - LG Infant Security	134	0	0	0	0
1307 - LG Upgrades	376	2,979	3,282	3,511	3,081
1308 - LG Infrastructure	0	114	0	0	0
1313 - LG Rehab HVAC System/Structural	0	0	0	1,597	1,904
1219 - LG Spine OR	0	214	323	633	2,163
1221 - LG Kitchen Refrig	0	85	0	0	0
1248 - LG - CT Upgrades	0	26	345	197	6,669
1249 - LG Mobile Imaging	0	146	0	0	0
1328 - LG Ortho Canopy FY14	0	255	209	0	0
1345 - LG Lab HVAC	0	112	0	0	0
1346 - LG OR 5, 6, and 7 Lights Replace	0	0	285	53	22
1347 - LG Central Sterile Upgrades	0	0	181	43	66
1421 - LG MOB Improvements	0	0	198	65	303
1508 - LG NICU 4 Bed Expansion	0	0	0	0	207
1600 - 825 Pollard - Aspire Phase II	0	0	0	0	80
1603 - LG MOB Improvements	0	0	0	0	285
Sub-Total Los Gatos Projects	**1,150**	**5,276**	**6,246**	**6,116**	**14,780**
1550 - Land Acquisition	0	0	0	24,007	0
1701 - 828 S Winchester Clinic TI	0	0	0	0	145
Sub-Total Other Strategic Projects	**0**	**0**	**0**	**24,007**	**145**
Subtotal Facilities Projects CIP	**9,294**	**13,753**	**38,940**	**48,137**	**82,953**
Grand Total	**27,598**	**58,561**	**86,789**	**96,740**	**97,923**
Forecast at Beginning of year	70,503	70,037	101,607	114,025	212,000

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

OPEN SESSION CEO Report
November 8, 2017

Dan Woods, CEO

FY 18 Organizational Goal Status through September 2017

Organizational Goals FY18	2017 ECH Baseline	Target	FY18 through September	
Budgeted Operating Margin	Achieved Budget	95% of Budgeted		Met
Actual Length of Stay (LOS) vs. Expected LOS for Medicare Patients	***1.18***	1.11		1.11
Patient Care Experience Overall Rating Top Box: Rate Hospital 0-10	**75.5**	78		78.2%
Infection Rates: CAUTI, CLABSI, C. Diff	**0.738**	0.602		Total # of Infections: CAUTI: 4 CLABSI: 0 C. Diff: 4

Human Resources

Over 90% of the management team members have completed Crucial Conversations Training as of the end of September. Beginning October 1st, training was offered to supervisors, leads, nursing unit coordinators, and other individual contributors who have roles in influencing hospital endeavors. To address the results of our recent employee engagement survey, thirty managers whose areas have the greatest opportunity for improvement are receiving bi-weekly one-on-one coaching sessions with an employee engagement consultant. The goal is to strengthen these departments through improved communication, feedback and coaching mechanisms to influence power items that most strongly influence employee engagement results as per national average healthcare database results. We are also piloting a new module on managing in a union environment.

To facilitate compliance with the Influenza Vaccination mandate by the Santa Clara County Public Health Department, El Camino Hospital coordinated 17 vaccine clinics at our Mountain View Campus and 5 at our Los Gatos Campus. As of October 24th, 77% of employees had received influenza vaccines either onsite or elsewhere, and we

continue to work towards 100% compliance. On October 27, employees received FY17 management incentive bonuses and non-management "thank you" bonuses totaling $3.65 million.

Community Benefit

Community Benefit provided the Board of Directors with FY17 year-end data on key metric and financial performance through the Community Benefit Annual Report and year-over-year Dashboard. Critical to effective grant making is gathering continuous input from the community. Examples this month included engaging our Community Benefit Advisory Council, hosting a work group of school-based mental health counselors, and participating in a collaborative of community agencies addressing hypertension. To ensure the local network of nonprofits providing critical services remains vibrant, Community Benefit awarded sponsorships to six agencies in October; this funding also increases awareness of ECH's role as a community health leader. To enhance visibility and promote utilization of preventive services made available through the Community Benefit Program, we ensured participation of several grant partners at Supervisor Simitian and Assembly member Berman's Mountain View Health Fair; health needs addressed included diabetes and hypertension. The implementation timeline was completed for the adoption of an industry-standard grants management platform, which is central to both our process improvement and customer service strategies.

Laboratory

On October 17th, both the MV Core Laboratory and the LG Laboratory replaced their Hematology analyzers and automation line with the Sysmex XE-9000 system and began reporting a new expanded comprehensive blood count (CBC). The Sysmex system is the most advanced hematology diagnostics system on the market. The analyzer uses fluorescent flow cytometry and cell counting methods to reliably detect abnormal samples and reduce false positive results.

Outreach and Acknowledgements

Several nurses attended the National Magnet Conference in Houston October 10 -13. El Camino Hospital nurses presented two posters (NICU and Nursing Research) and one podium presentation (Chris Tarver, RN). This is the largest nursing conference in the country with over 8,000 attendees.

We hosted thirteen staff members of state legislators representing Silicon Valley, and the state and regional directors of the California Special District Association, for a hospital tour and to learn about our mission, governance and community benefit activities. Separately, I met with State Senator Jerry Hill. Staff worked on a mental health advocacy campaign with the California Hospital Association, and on drafting a bill to update California's enabling act for healthcare districts. A three-year renewal

application was submitted for the Special District Leadership Foundation's Certificate of Transparency Excellence, and a new section of the ECHD website was created to highlight the District's transparency and accountability to the public: ECHD web page Nine ECH employees were selected for scholarships to attend civic leadership programs in Mountain View, Los Altos/ Los Altos Hills, Sunnyvale, Cupertino, Los Gatos, Santa Clara, Santa Cruz and San Jose. Staff planned agendas and speakers for the health service & policy seminars ECH presents for six city leadership programs, which take place November through May. Board member Neysa Fligor was the "celebrity server" at our table at the Silicon Valley Council of Nonprofit's annual "Be Our Guest" luncheon, with its truly amazing pumpkin decorating contest--one of many community events the Hospital and District sponsored this month.

Information Services Division

The first Community Connect Physician will go live in his office on ECH's Epic system this month and a Physician Electronic Medical Record Efficiency Plan was developed with baseline efficiency metrics obtained. Dashboards (Service Line, Departmental, Executive) have been designed, implementation of the new Epic Data Warehouse to combine clinical, financial and patient satisfaction data is underway, Phase 1 of the Healthy Planet Population Health Management tool in Epic is now functional, 16 Security Projects were completed to support reliability of technology systems, the Epic platform was configured to meet the unique scheduling and reporting needs of the Cancer Clinic Infusion Center, and the Epic System was upgraded to Version 2017 which meets requirements for Meaningful Use Stage 3.

Selection of a new Enterprise Resource Planning System for HR, Finance and Supply Chain Management is on track with implementation to begin in 1st quarter of 2018. Other efforts include the combination of multiple instances of a patient's MyChart record from different health care organizations into a singular view using new Epic functionality called "Happy Together" to provide an improved patient experience. We also decided to implement a national standard from the Sequoia Project called CareQuality to promote interoperability and sharing of patient information to external EMR's, the initiation of the Retail Pharmacy Project to serve patients and employees for medication needs and availability of on-line OB Registration in the Epic system.

Quality and Safety

On October 31st, El Camino Hospital was awarded Leapfrog's highest hospital safety grade of an "A". This is the highest grade awarded by the Leapfrog Group.

Finance

September cash collections were $72 million vs. target of $68 million and we are collecting patient feedback and monitoring use of our new patient price estimator tool. To date, we have identified supply chain saving initiatives yielding $4.2 million of the $4.8 million annual target.

CONCERN

CONCERN has surpassed all of last FY in new organization sales, 17 new account contracts so far this fiscal year, adding 11,000 employees in headcount and is ramping up for increased onsite counselors at a large client organization. We added a large new partnership account that began in October and are experiencing increased efficiency with use of our new EAPExpert database and Provider Portal as staff and providers become more accustomed to the new system, implemented at the end of FY17.

Auxiliary and Philanthropy (Detailed Reports Attached)

The 638 active members of El Camino Hospital's Auxiliary contributed 7,706 volunteer hours in September 2017, for a total of 22,021 FYTD.

During the month of September, the El Camino Hospital Foundation secured a total of $227,093. The Foundation raised a total of $2,006,006 by close of period 3, which is 33% of its goal for FY18. On October 23, 2017, the 22nd annual El Camino Heritage Golf Tournament was held at Sharon Heights Golf & Country Club. Attendees included physicians, vendors, community leaders and major donors. The event was very successful, with brisk raffle sales, a lively live auction, and generous responses to the fund-in-need appeal. Proceeds will benefit the Taft Center for Clinical Research at El Camino Hospital.

El Camino Hospital Auxiliary

Membership Report to the Hospital Board
Meeting of November 8, 2017

Combined Data as of September 30, 2017 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	380	+3 Net change compared to previous month
Dues Paid Inactive	102	(Includes Associates & Patrons)
Leave of Absence	13	
Subtotal	**495**	

Resigned in Month	5
Deceased in Month	0

Junior Members

Active Members	258	-3 Net Change compared to previous month
Dues Paid Inactive	0	
Leave of Absence	3	
Subtotal	**261**	

Total Active Members	**638**
Total Membership	**756**

Combined Auxiliary Hours from Inception (to September 30, 2017): 5,844,523
Combined Auxiliary Hours for FY2017 (to September 30, 2017): 22,021
Combined Auxiliary Hours for September 2017: 7,706
Hooks & Needles hours for August estimated.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Memorandum

DATE: October 24, 2017

TO: El Camino Hospital Board of Directors

FROM: David Reeder, Hospital Board Liaison to the Foundation Board of Directors

SUBJECT: Report on Foundation Activities FY 2018 Period 3

ACTION: For Information

El Camino Hospital Foundation advances health care through philanthropy by raising funds that support El Camino Hospital's strategic priorities, foster innovation, and support patient and family-centered care.

During period three of FY18, the new fiscal year, the Foundation secured $227,093.

The El Camino Heritage Golf Tournament was held on October 23, 2017 to benefit the Taft Center for Clinical Research at El Camino Hospital.

Upcoming Events

Please mark your calendars:

February 8, 2018 – 6th annual Norma's Literary Luncheon featuring mystery writer Jacqueline Winspear, supporting family and patient-centered care at El Camino Hospital.

March 17, 2018 – Scarlet Ball at the Dolce Hayes Mansion, benefiting the South Asian Heart Center

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Memorandum

DATE: October 24, 2017

TO: El Camino Hospital Board of Directors

FROM: Lane Melchor, Chair, El Camino Hospital Foundation Board of Directors
Jodi Barnard, President, El Camino Hospital Foundation

SUBJECT: Report on Foundation Activities FY 2018 Period 3

ACTION: For Information

During the month of September, El Camino Hospital Foundation secured a total of $227,093. The Foundation raised a total of $2,006,006 by close of period 3, 33% of goal for FY18.

FY 18 Period 3 Fundraising Performance

Major & Planned Gifts
The Foundation received $10,000 in September from a major gift commitment to support the South Asian Heart Center. A number of major gifts are in the pipeline to support the mental health initiative and patient family residence project.

Fulfilling the Promise for Mental Health & Addiction Services
The Fulfilling the Promise fundraising initiative has moved into a new phase, intended to broaden the base of support. A cadre of volunteer stakeholders have joined the newly formed "Promise Team" and are helping to organize construction site tours of the new mental health pavilion, "last beam," and ribbon cutting festivities. In addition, the Foundation's spring gala, tentatively scheduled for early May, is being re-invented and will benefit mental health and addiction services. Donna and John Shoemaker will serve as honorary chairs and an event committee will be created once an event date and location are confirmed.

Special Events

- **Golf** – The 22nd annual El Camino Heritage Golf Tournament was held on Monday, October 23, 2017 at Sharon Heights Golf & Country Club. Proceeds will benefit the Taft Center for Clinical Research at El Camino Hospital. During September, the Foundation received $33,900 in sponsorships and donations, bringing the total received by end of period 3 to $100,650. 125 golfers competed and 200 supporters were at the celebration dinner. Attendees included physicians, vendors, community leaders and major donors. The event was very successful, with brisk raffle sales, a lively live auction, and generous responses to the fund-in-need appeal. During the auction, the opportunity to have dinner with new CEO Dan Woods sparked a spirited bidding war, so a second dinner was added

on the spur of the moment. Each dinner sold for $20,000. Final figures will be reflected in future reports.

- **Norma's Literary Luncheon** – The 6th annual luncheon will be held at Sharon Heights Golf & Country Club on February 8, 2018. The featured speaker will be Jacqueline Winspear, author of the best-selling Maisie Dobbs mystery series. In September, the Foundation received $70,000 from the Melchor family to underwrite all expenses for the luncheon. Thanks to this gift, all other proceeds from the luncheon will directly benefit a new patient family residence on the Mountain View campus.

Annual Giving

In September, the Foundation raised $22,227 in annual gifts from Hope to Health membership renewals, Circle of Caring, responses from the spring direct mail appeal, Path of Hope, external fundraising events, and online donations. This brings the total raised by September 30 to $93,272. The fall appeal letter was mailed in October, with donor follow-ups planned through the remainder of the calendar year.

- Path of Hope is part of the Fulfilling the Promise fundraising initiative for the hospital's mental health and addiction services. For a gift of $2,500, donors can inscribe a brick along the walkway into the new mental health pavilion. Each paver will have the donor's name and a unique word of hope. To date, 33 bricks have been donated for a total of $82,500. The Foundation is one third of the way to the goal of selling100 bricks, which will result in $250,000 for the new facility. Some of the words of hope donors have selected are: Aspire, Believe, Brave, Empathy, Grateful, Kindness, Peace, Resilience, Serene, Thrive and Trust.

El Camino Hospital® Foundation
THE HOSPITAL OF SILICON VALLEY

FOUNDATION PERFORMANCE

FY18 Fundraising Report through 9/30/17

ACTIVITY		FY18 YTD (7/1/17 - 9/30/17)	FY18 Goals	FY18 % of Goal	Difference Period 2 & 3	FY17 YTD (7/1/16 - 9/30/16)	FY16 YTD (7/1/15 - 9/30/15)
Major & Planned Gifts		$1,575,372	$3,750,000	42%	$10,000	$3,392,253	$1,170,055
Special Events	Spring Event	$1,000	$600,000	0%	$0	$6,750	$21,500
	Golf	$100,650	$300,000	34%	$33,900	$155,800	$128,025
	South Asian Heart Center Event	$14,500	$300,000	5%	$14,500	$2,500	$5,060
	Norma's Literary Luncheon	$70,100	$150,000	47%	$70,000	$0	$50,000
Annual Gifts		$93,272	$550,000	17%	$22,227	$46,689	$85,408
Grants*		-	-	-	-	-	$26,333
Investment Income		$151,712	$500,000	30%	$76,466	$250,013	$206,081
TOTALS		***$2,006,606***	***$6,150,000***	***33%***	***$227,093***	***$3,854,005***	***$1,692,462***

*Beginning in FY17 Grants is no longer an activity line. Any grants received in the future will either be reflected in the Annual Gifts or Major & Planned Gifts activity line pending funding level.

Highlighted Assets through 9/30/17

Board Designated Allocations	$1,281,430
Donor Endowments	$3,109,564
Operational Endowments	$14,320,505
Pledge Receivables	$4,173,197
Restricted Donations	$9,142,834
Unrestricted Donations	$1,011,038

5.9% Investment Return through 6/30/17