

AGENDA

EXECUTIVE COMPENSATION COMMITTEE OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Thursday, March 22, 2018 – 4:00pm

El Camino Hospital | Conference Room A (ground floor)
2500 Grant Road Mountain View, CA 94040

PURPOSE: To assist the El Camino Hospital (ECH) Board of Directors (“Board”) in its responsibilities related to the Hospital’s executive compensation philosophy and policies. The Executive Compensation Committee shall advise the Board to meet all applicable legal and regulatory requirements as it relates to executive compensation.

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1. CALL TO ORDER/ROLL CALL	Bob Miller, Chair		4:00-4:02pm
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Bob Miller, Chair		4:02 – 4:03
3. PUBLIC COMMUNICATION a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.</i> b. Written Correspondence	Bob Miller, Chair		information 4:03 – 4:06
4. CONSENT CALENDAR <i>Any Committee Member or member of the public may remove an item for discussion before a motion is made.</i> <i>Approval</i> a. Minutes of the Open Session of the Executive Compensation Committee Meeting (January 31, 2018) b. Proposed FY19 Committee Meeting Dates <i>Information</i> c. Progress Against FY18 Committee Goals d. Article of Interest	Bob Miller, Chair	<i>public comment</i>	motion required 4:06 – 4:07
5. REPORT ON BOARD ACTIONS ATTACHMENT 5	Bob Miller, Chair		information 4:07 – 4:10
6. PROGRESS AGAINST FY18 ORGANIZATIONAL GOALS ATTACHMENT 6	Dan Woods, CEO		information 4:10 – 4:20
7. ADJOURN TO CLOSED SESSION	Bob Miller, Chair		motion required 4:20 – 4:21
8. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Bob Miller, Chair		4:21 – 4:22
9. CONSENT CALENDAR <i>Any Committee Member or member of the public may remove an item for discussion before a motion is made.</i> <i>Approval</i> <i>Gov’t Code Section 54957.2:</i> a. Minutes of the Closed Session of the Executive Compensation Committee Meeting (January 31, 2018)	Bob Miller, Chair		motion required 4:22 – 4:23

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
10. Gov't Code Sections 54957 and 54957.6 for report and discussion on personnel matters: - Executive Development Plan and Succession Planning Practices Update	Kathryn Fisk, CHRO; Stephen Pollack, Mercer		discussion 4:23 – 4:48
11. Gov't Code Sections 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation: - Delegation of Authority	Bob Miller, Chair; Mitch Olejko, Buchalter		discussion 4:48 – 5:08
12. ADJOURN TO OPEN SESSION	Bob Miller, Chair		motion required 5:08 – 5:09
13. RECONVENE OPEN SESSION/ REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Miller, Chair		5:09 – 5:10
14. DELEGATION OF AUTHORITY	Bob Miller, Chair	<i>public comment</i>	possible motion 5:10 – 5:12
15. BIENNIAL REVIEW OF COMMITTEE CHARTER ATTACHMENT 15	Bob Miller, Chair	<i>public comment</i>	possible motion 5:12 – 5:17
16. BIENNIAL COMMITTEE SELF-ASSESSMENT RESULTS REVIEW ATTACHMENT 16	Bob Miller, Chair		discussion 5:17 – 5:32
17. FY19 COMMITTEE GOALS ATTACHMENT 17	Kathryn Fisk, CHRO	<i>public comment</i>	possible motion 5:32 – 5:42
18. FY18 PACING PLAN ATTACHMENT 18	Bob Miller, Chair		discussion 5:42 – 5:43
19. CLOSING COMMENTS	Bob Miller, Chair		discussion 5:43 – 5:44
20. ADJOURNMENT	Bob Miller, Chair		motion required 5:44 – 5:45pm

Upcoming Meetings

- May 24, 2018

Board/Committee Educational Gatherings

- April 25, 2018



**Minutes of the Open Session of the
Executive Compensation Committee
Wednesday, January 31, 2018**

**El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040
Conference Room A (administration)**

Members Present

Teri Eyre
Neysa Fligor
Jaison Layney
Bob Miller, Chair
Julia Miller (joined at 4:48 pm during
Agenda Item 6 via teleconference)

Members Absent

Pat Wadors

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Executive Compensation Committee of El Camino Hospital (the " <u>Committee</u> ") was called to order at 4:00 pm by Chair Bob Miller. Julia Miller and Pat Wadors were absent at roll call. All other Committee members were present.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Miller asked if any Committee members may have a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. PUBLIC COMMUNICATION	None.	
4. CONSENT CALENDAR	<p>Chair B. Miller asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed.</p> <p>Motion: To approve the consent calendar: Minutes of the Open Session of the Executive Compensation Committee Meeting (November 9, 2017), and for information: Progress Against FY18 Committee Goals and Article of Interest.</p> <p>Movant: Layney Second: Eyre Ayes: Eyre, Fligor, Layney, B. Miller Noes: None Abstentions: None Absent: Wadors, J. Miller Recused: None</p>	<i>Consent calendar approved</i>
5. REPORT ON BOARD ACTIONS	Cindy Murphy, Director of Governance Services, referred to the recent Board actions as further detailed in the packet. Ms. Fligor reported on the election of Julie Kliger and Gary Kalbach to the El Camino Hospital Board of Directors and Chair B. Miller reported that Board Chair Chen recommended that Director Kliger join the Committee following formal appointment to the Committee by the Board on February 14 th .	
6. REVIEW OF ECH EXECUTIVE COMPENSATION AND BENEFITS PROGRAM AND POLICIES	Stephen Pollack of Mercer reviewed the recommendations to 1) expand the Compensation Philosophy to be more specific about total cash and total remuneration positioning relative to market,(2) allow for greater differentiation in executive base salary within the existing program, and 3) modify the incentive plan to potentially add a variable financial metric (that is not just a trigger goal) and provide for greater CEO discretion in determining the individual score. Mr. Pollack commented that the proposals do not constitute major changes but provide clarification with respect to	

what is currently in practice.

Compensation Philosophy: Mr. Pollack explained that the Philosophy’s silence on positioning of other elements of compensation outside of base salary has led to different interpretations of the policy. He also explained that the proposal would leave base salaries targeted on average at the 50th percentile of market data, but allow for total cash to be targeted at the 50th percentile and up to the 75th percentile, and total remuneration to be targeted between the 50th and 75th percentile of market data, both dependent on individual and organizational performance.

The Committee members discussed the proposed changes noting that “target” means “expected” performance and would be compensated at the 50th percentile, but it will be clear that exceptional performance could be compensated at up to the 75th percentile.

Chair Miller commented that ECH often expects performance at the 75th or 90th percentile and, if that is achieved, compensation at the 50th percentile is out of alignment with that. In response to questions, Mr. Pollack commented that the proposal constitutes a best practice approach.

The Committee members discussed changing Section C of the Executive Compensation Philosophy by adding the following language:

“The target competitive positioning for executive remuneration is:

- Base Salary – Executive base salaries are targeted on average at the 50th percentile of market data.
- Total cash Compensation- Base Salary plus actual performance incentive payouts targeted on average at the 50th percentile and up to the 75th percentile of market data, dependent upon individual and organizational performance
- Total Remuneration – Total Cash plus the value of benefits targeted on average between the 50th and 75th percentile of market data, dependent upon individual and organizational performance.

Base Salary Administration: Mr. Pollack explained that the proposed revisions will allow use of the full salary range and permit executive talent scarcity and organization criticality to be considered as factors in determining appropriate placement in the salary range.

The Committee members discussed the proposed revisions to the Base Salary Administration Policy and requested revisions as follows:

- Section D becomes Section E.
- Section E(1)(a): insert the words “50th percentile” before the word “median.”
- Section E(1)(c):
 - replace the word “establish” with “recommend
 - insert “(for example, when financially prudent) for Board approval) after the word “salaries.”
- Section E(2)(a)
 - Replace the word “is” with “may be”
 - Insert “This may be a new hire or internal promotion” after the first full sentence.
- Section E(2)(b):
 - Replace the word “is” with “may be”
 - Delete “(6-8 years)”

	<ul style="list-style-type: none"> ▪ Change “consistently meeting” to “successful” ▪ Delete “expectations” • Section E(2)(c): Delete “with skills and expertise beyond those normally associated with the position” and replace it with “in roles which are particularly critical for the achievement of strategic objectives or in roles with a highly competitive labor market.” • Section E(2)(d): Replace the first “above” with “outside” and insert “or guidelines” after “range” • Section E becomes Section F. <p>Incentive Plan Design: Mr. Pollack described how the proposed revision would improve the effectiveness of the discretionary element and that use of a variable financial metric (in addition to financial threshold goal) is highly prevalent in health systems.</p> <p>The Committee members discussed the recommendations and the Executive Performance Incentive Plan and suggested the following revisions to the Plan:</p> <ul style="list-style-type: none"> • Section C – Replace the first occurrence of “compensation” with “remuneration” • Section D(4) – After the word “based” insert “which may include a financial measure in addition to the threshold for any payout.” • Section D(5) – Revised to state “at the beginning of the fiscal year, each participant will propose performance goals and measurements that support the strategic/business plan. Whenever possible, each goal will have performance measures for threshold, target, and maximum levels and scores will be on a continuum. Individual goals (maximum of three) are weighted at 30% of target (50% for Presidents of the Foundation, SVMD, and CONCERN:EAP) with CEO discretion used as a modifier for individual goal pay-out ranging from 0% to 150%). The performance goal score multiplied by the CEO’s overall assessment of individual executive performance will determine the overall individual goal score. • Section D(6) – Delete the first sentence. <p>The Committee discussed how the annual budgeting process impacts the flexibility the Committee and the Board to adjust executive base salary each year.</p> <p>Ms. J. Miller joined the meeting via teleconference.</p> <p>Motion: To recommend the Board approve the proposed revisions to the Compensation Philosophy, Base Salary Administration Policy, and Executive Performance Incentive Plan as amended by the Committee.</p> <p>Movant: Fligor Second: Eyre Ayes: Eyre, Fligor, Layney, B. Miller, J. Miller Noes: None Abstentions: None Absent: Wadors Recused: None</p>	
7. ADJOURN TO CLOSED SESSION	<p>Motion: To adjourn to closed session at 5:00pm.</p> <p>Movant: Fligor Second: Layney Ayes: Eyre, Fligor, Layney, B. Miller, J. Miller</p>	Adjourned to closed session at 5:00pm

	Noes: None Abstentions: None Absent: Wadors Recused: None	
8. AGENDA ITEM 13: RECONVENE OPEN SESSION/ REPORT OUT	<p>Open session was reconvened at 5:28pm. Agenda items 8-12 were addressed in closed session.</p> <p>During the closed session, the Committee approved the Minutes of the Closed Session of the Executive Compensation Committee Meeting of September 21, 2017 by a unanimous vote in favor of all members present (Eyre, Fligor, Layney, B. Miller and J. Miller). Ms. Wadors was absent.</p>	
9. AGENDA ITEM 14: CONSIDER DELEGATION OF AUTHORITY TO EXECUTIVE COMPENSATION COMMITTEE	<p>Motion: To recommend that the Board consider delegating authority to the Executive Compensation Committee to make certain decisions about (non-CEO) executive compensation and to provide further direction to the Committee regarding next steps.</p> <p>Movant: Fligor Second: Layney Ayes: Eyre, Fligor, Layney, B. Miller, J. Miller Noes: None Abstentions: None Absent: Wadors Recused: None</p>	
10. AGENDA ITEM 15: FY18 BASE SALARY: CIO	<p>Motion: To recommend that the Board approve the proposed FY18 CIO base salary.</p> <p>Movant: Miller Second: Layney Ayes: Eyre, Fligor, Layney, B. Miller, J. Miller Noes: None Abstentions: None Absent: Wadors Recused: None</p>	
11. AGENDA ITEM 16: FY18 COMMITTEE PACING PLAN	<p>The Committee discussed the FY18 Pacing Plan. Chair B. Miller noted that he asked staff to remove any review of the Executive Benefit Plan from the Pacing Plan and add it back in at a later date. In response to Ms. Fligor's question, Ms. Fisk commented that ECH does not have a rigid succession planning process for the executives due to the size of the organization and availability of Director level employees to remove from their current roles and groom for executive roles without providing backfills for those roles. Ms. Fisk noted that the intention was to focus on an Executive Development Plan as opposed to a true succession plan at the March Committee meeting. Ms. Eyre commented that it would be important for the Committee to work on determining what an appropriate succession planning process for ECH would look like. Other Committee members agreed and requested that staff bring information about succession planning practices at other organizations for the Committee to discuss at the next meeting.</p>	
12. AGENDA ITEM 17: CLOSING COMMENTS	<p>Chair B. Miller commented that it was productive meeting and thanked the Committee members for their work.</p>	
13. AGENDA ITEM 18: ADJOURNMENT	<p>Motion: To adjourn at 5:45 pm.</p> <p>Movant: Fligor Second: B. Miller Ayes: Eyre, Fligor, Layney, B. Miller, J. Miller</p>	<p><i>Meeting adjourned at 5:45 pm</i></p>

	Noes: None Abstentions: None Absent: Wadors Recused: None	
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Attest as to the approval of the foregoing minutes by the Executive Compensation Committee and the Board of Directors of El Camino Hospital.

Bob Miller
Chair, Executive Compensation Committee

Julia Miller
Secretary, ECH Board of Directors

Prepared by: Cindy Murphy, Director of Governance Services

DRAFT

Executive Compensation Committee Meetings

Proposed FY19 Dates

RECOMMENDED ECC DATE THURSDAYS	CORRESPONDING HOSPITAL BOARD DATE
Thursday, September 13, 2018 - OR - Monday, September 17, 2018	Wednesday, October 10, 2018
Thursday, November 8, 2018	Wednesday, November 14, 2018
Thursday, March 28, 2019	Wednesday, April 10, 2019
Thursday, May 23, 2019	Wednesday, June 12, 2019

FY18 COMMITTEE GOALS

Executive Compensation Committee

PURPOSE

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

STAFF: **Kathryn Fisk**, Chief Human Resources Officer; **Julie Johnston**, Director, Total Rewards; **Cindy Murphy**, Director of Governance Services
The CHRO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair’s consideration. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing his/her compensation. The CEO is an ex-officio member of this Committee.

GOALS	TIMELINE by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	METRICS
1. Advise the Board on performance incentive goal-setting and plan design, ensuring strategic alignment and proper oversight of compensation-related decisions.	<ul style="list-style-type: none"> Q2 – Q4 FY18 	<ul style="list-style-type: none"> Recommend FY17 performance goal scores and payouts (Q2) (Complete) Oversee the implementation of changes that impact the FY18 strategic planning, budgeting, and goal setting process (Complete) Recommend FY19 goals and measurements (Q4) (Paced for Q4) Assess the value of long-term incentives to support the achievement of long-term strategies (Complete: Discussed on 11/9)
2. Support successful implementation of executive benefit changes	<ul style="list-style-type: none"> Q3 – Q4 FY18 	<ul style="list-style-type: none"> Review proposed changes to benefits plan policy (Q1) (Complete: LTD revision approved in June 2017) Review consultant analysis of benefit change impact (Q3) (Complete: Included in Reasonableness Opinion Letter)
3. Advise the Board ensuring strategic alignment and proper oversight of compensation-related decisions.	<ul style="list-style-type: none"> Q2 – Q4 FY18 	<ul style="list-style-type: none"> Review base salary administration policy (Q2) (Complete – recommendations made and approved by the Board), review market analysis, and make base salary recommendations to the Board (Q4) (On track to do in Q4) Submit the letter of reasonableness for Board acceptance (Q3) (Complete) Review compensation philosophy and performance incentive plan policies and make recommendation to Board to approve any changes (Q3) Complete – recommendations made and approved by the Board)

SUBMITTED BY:

Lanhee Chen
 Kathryn Fisk

Chair, Executive Compensation Committee
Executive Sponsor, Executive Compensation Committee

Approved by the ECH Board of Directors on June 14, 2017

Hospital Readmissions Reduction Program

Educational Briefing for Suppliers and Service Providers

Executive Summary

The Hospital Readmissions Reduction Program (RRP), introduced in 2012 under the Affordable Care Act (ACA), is a Medicare incentive program intended to lower hospital readmission rates. The program penalizes hospitals up to 3% of total inpatient Medicare revenue for having worse-than-average readmissions rates for select conditions. A [readmission](#) occurs when a patient returns for unscheduled inpatient hospital care within 30 days of a prior acute care stay. In FY 2016, nearly 77% of all eligible hospitals received some degree of readmissions penalty, losing a combined total of \$420 million in Medicare reimbursement. The program will expand to include more conditions in the future, increasing the likelihood that many hospitals will continue to receive Medicare inpatient penalties.

Why is the Readmissions Reduction Program a key issue for providers?

Readmissions are a key driver of high Medicare costs. CMS introduced the RRP as an accountability measure for hospitals to improve care outcomes and thereby reduce overall costs of care. Historically, hospitals have had little financial incentive to reduce readmissions as they profited from reimbursement for each additional service provided. Since the passage of the ACA, readmissions are heavily penalized not only under the RRP, but under the Hospital Value-Based Purchasing (VBP) Program as well. Readmissions increase episodic costs of care, which affects how Medicare reimburses providers. According to the Medicare Payment Advisory Committee, the average Medicare inpatient margin continues to be negative overall. This means that hospitals are facing intense margin pressure that will only worsen if they're unable to decrease their readmissions rates. When looking at reducing cost of care in order to compete in a rapidly changing marketplace, reducing readmissions provides a significant—and increasingly necessary—lever for change.

How does the Readmissions Reduction Program work?

Unlike [Value-Based Purchasing](#), another Medicare program, there are no monetary rewards for high performance. The program penalizes hospitals for readmission rates above the national average for six conditions. Payment reductions were limited to 1% of total Medicare inpatient payments to a hospital in 2013, the first year of the program, 2% in 2014, and then settled at 3% for 2015 and beyond. Some allowances are made for hospitals serving populations with historically higher-than-average rates. This means that the measures are [risk-adjusted](#) for factors that are clinically relevant, including patient demographic characteristics, comorbidities, and patient frailty.

The conditions originally included under RRP were acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN). In 2015, chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA), and total knee arthroplasty (TKA) were added as covered conditions. CMS has also announced the inclusion of coronary artery bypass graft (CABG) surgery as a covered condition beginning in 2017 and may consider adding percutaneous coronary intervention (PCI) in the future.

To determine readmissions penalties for a given fiscal year, Medicare collects hospital data for a rolling three-year period. For example, FY 2016 penalties are based on data from July 1, 2011 to June 30, 2014. As a result of the delayed three-year time frame, hospitals will need to make a long-term commitment to reduce readmissions before their penalties can fall.

Conditions Measured Under the RRP (with fiscal year of starting consideration)



Cardiac:

Acute Myocardial Infarction (2013)
Heart Failure (2013)
CABG (2017)



Pulmonary:

Pneumonia (2013)
COPD (2015)



Orthopedic:

Total Hip Arthroplasty (2015)
Total Knee Arthroplasty (2015)

Conversation Starters with the Hospital C-Suite

- 1 For what conditions are your readmissions highest? What is your reduction goal for this year? For the next three years?
- 2 What clinical efforts have you undertaken to limit readmissions? What are the biggest obstacles you have faced?
- 3 What challenges are you having with promoting patient compliance and healthy habits post-discharge?

How does the Readmissions Reduction Program affect providers?

Clinical

Readmissions occur for a variety of reasons. Some of [these](#) factors are unavoidable, the result of chronically ill patients needing frequent care. Other readmissions can be avoided because they are due to hospital errors or sub-par care. Lastly, many result from patients failing to comply with prescriptions, doctor instructions, follow-up care, or diet recommendations. As a result, the RRP has led hospitals to revamp discharge processes in order to improve compliance. Beyond payment penalties, hospital reputations are also at stake, as readmission rates are published on CMS's [Hospital Compare website](#).

Financial

Over [2,500 hospitals](#) from [across the nation](#) received a penalty in 2016, but hospitals face incentives to keep volumes high because conditions subject to readmissions account for much of total yearly national payments. Hospitals shoulder the financial burden associated with efforts to reduce readmissions, including discharge processes, follow-up phone calls, and home visits. [For FY 2016](#), the majority of hospitals lost between 0% and 1% of their Medicare income, while 1% of hospitals received the maximum 3% penalty. The escalating RRP penalties have forced hospitals to focus on readmissions for heart failure, AMI, pneumonia, COPD, THA, and TKA, even as many remain reliant on the revenue streams from readmissions.

The RRP has had an outsized financial impact on safety net hospitals. In particular, hospitals that serve low-income populations are [2.7 times](#) more likely to have high readmissions than hospitals with a smaller proportion of low-income patients. Even with some CMS adjustments, so-called "safety net" hospitals often receive harsher penalties than hospitals in wealthier areas.

Operational

Hospitals are ramping up efforts to provide discharge instructions and [post-discharge follow-up](#) to ensure that patients comply with physician advice, fill prescriptions, and adopt healthy lifestyles. Prior to discharge, hospitals are [simplifying](#) their instructions to patients and developing better educational materials. Many hospitals have turned to phone calls, emails, or text reminders to maintain contact with discharged patients. Some post-discharge efforts have included daily home [food deliveries](#) to encourage healthy eating and employing [social workers](#) to hold daily meetings with high-risk patients.

How might the Readmissions Reduction Program impact provider-supplier sales relationships?

The RRP plays a key role in hospital budget discussions and affects hospital negotiating patterns. This impact is felt most in the particular service lines where the conditions are judged for the RRP program, such as cardiology, pulmonology, and orthopedics. Be aware of the importance of process change to improve readmissions, not just products and devices.

Readmissions-Reducing Products Command a Premium

- Vendors can develop internal data capabilities or partner with insurers to demonstrate how their products reduce readmissions. Implantable medical device companies in particular have an excellent opportunity to partner if their products reduce readmissions.

Patient Compliance Carries Greater Weight

- Suppliers can focus their natural business acumen and marketing skills to assist hospitals in promoting patient education, coordination across sites of care, and medication compliance.

Prime Opportunity for Supplier-Provider Risk-Sharing

- Because RRP penalties put a dollar value on each readmission, vendors willing to stake part of their contract on product performance can differentiate themselves while helping their hospital customers.

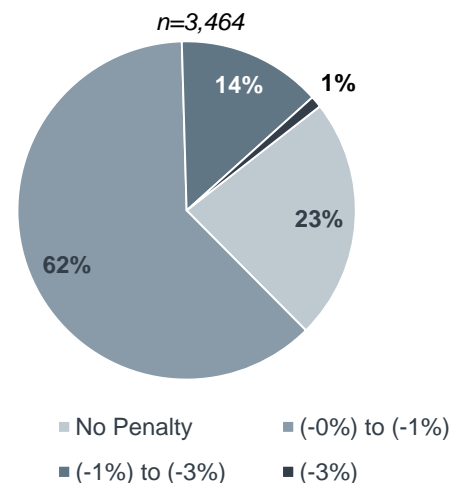
Additional Advisory Board research and support is available



If you would like breakdowns of average readmission rates in a market or hospital-specific readmission penalties, please contact your institution's Dedicated Advisor. To see how the RRP and other Medicare incentive and penalty initiatives are affecting hospitals, please view our [Pay-for-Performance Map](#) and our [Pay-for-Performance Impact File](#).

Source: Advisory Board interviews and analysis.

FY 2016 Final Rule Readmission Penalties
Reflecting July 1, 2011 to June 30, 2014



The HCAHPS Survey – Frequently Asked Questions

What is the purpose of the HCAHPS Survey?

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care. While many hospitals collect information on patient satisfaction, HCAHPS (pronounced “*H-caps*”) created a national standard for collecting and public reporting information that enables valid comparisons to be made across all hospitals to support consumer choice. The HCAHPS sampling protocol is designed to capture uniform information on hospital care from the patient’s perspective.

Three broad goals shape the HCAHPS Survey. First, the survey is designed to produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve quality of care. Third, public reporting serves to enhance public accountability in health care by increasing transparency. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. This methodology and the information it generates are available to the public. More information about the HCAHPS Survey can be found at <http://www.hcahpsonline.org/home.aspx>.

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. Government agency.

What items are on the HCAHPS Survey?

The HCAHPS Survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness of the hospital environment, quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and recommendation of hospital); four items to skip patients to appropriate questions; three items to adjust for the mix of patients across hospitals; and two items to support congressionally-mandated reports. The HCAHPS Survey is available in English, Spanish, Chinese, Russian and Vietnamese in the mail format, and in English and Spanish in the telephone and Interactive Voice Response formats. On average, it takes respondents about seven minutes to complete the HCAHPS survey items. The core set of HCAHPS questions can be combined with customized, hospital-specific items to complement the data hospitals collect to support internal customer service and quality-related activities.

The actual wording of the HCAHPS questions and response categories, as well as the scripts for conducting the survey in the Telephone and Active Interactive Voice Response (IVR) modes, can be found under “Survey Instruments” on the HCAHPS On-line website, <http://www.hcahpsonline.org/home.aspx>. Complete information about how to implement the HCAHPS survey can be found in the HCAHPS Quality Assurance Guidelines, also available on this Web site.

How was the HCAHPS Survey developed?

The Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency in the federal Department of Health and Human Services, to develop HCAHPS. AHRQ carried out a rigorous, scientific process to develop and test the HCAHPS instrument. This process entailed multiple steps, including a public call for measures; literature review; cognitive interviews; consumer testing and focus groups; stakeholder input; a large-scale pilot test and a number of small-scale field tests. In addition, CMS responded to hundreds of public comments generated by several Federal Register notices.

In May 2005, the National Quality Forum (NQF)—which represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, Federal agencies, and research and quality organizations—endorsed the HCAHPS. In December 2005, the federal Office of Management and Budget gave its final approval for the national implementation of HCAHPS. HCAHPS was also endorsed by the Hospital Quality Alliance. CMS commissioned an independent research firm, Abt Associates Inc., to conduct an analysis of the benefits and costs of HCAHPS. The Abt report, which includes detailed cost estimates for hospitals, can be found at:

<http://www.cms.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf>.

When did hospitals begin to implement the HCAHPS Survey?

Voluntary collection of HCAHPS data for public reporting began in 2006, and public reporting of HCAHPS scores began in 2008. Since July 2007, hospitals subject to IPPS payment provisions ("subsection (d) hospitals") must collect, submit and publicly report HCAHPS data in order to receive their full IPPS annual payment update (APU). IPPS hospitals that fail to report the required quality measures, which include the HCAHPS survey, may receive an APU that is reduced by 2.0 percentage points. Non-IPPS hospitals, such as Critical Access Hospitals, can voluntarily participate in HCAHPS. HCAHPS Survey results also form the basis for the Patient Experience of Care domain in the Hospital Value-Based Purchasing program.

Which modes of survey administration can be used for HCAHPS?

Because hospitals and survey vendors survey patients a number of ways, HCAHPS is available in four different modes: Mail Only, Telephone Only, Mail with Telephone follow-up (also known as Mixed mode), and Active Interactive Voice Response (IVR). Detailed information on the proper use of each mode of survey administration can be found in the HCAHPS Quality Assurance Guidelines manual, which is located at "Quality Assurance" at www.hcahpsonline.org.

CMS recognizes that patients' responses to the survey may be affected by the mode of survey administration. For instance, respondents typically give somewhat more positive responses when surveyed by telephone, as compared to mail. Thus, choice of mode of survey administration could potentially affect comparisons of hospitals. CMS conducted a large-scale experiment to test for mode effects, and based on this research an adjustment has been built into the calculation of HCAHPS scores to remove the effect of survey mode on how patients respond to HCAHPS survey items.

The Mode Experiment was based on a nationwide random sample of short-term acute care hospitals. Participating hospitals contributed patient discharges from a four-month period in 2006. Within each hospital, equal numbers of patients were randomly assigned to each of the four modes of survey administration. In total, 27,229 discharges from 45 hospitals were surveyed.

In general, patients randomized to the Telephone Only and active IVR provided more positive evaluations than those randomized to the Mail Only and Mixed modes. Mode effects varied little by hospital. More information, as well as an overview of the results of the mode experiment, can be found under “Mode Adjustment” at <http://www.hcahpsonline.org/home.aspx>.

What must hospitals do in order to participate in HCAHPS?

CMS has developed detailed Rules of Participation and Minimum Survey Requirements for hospitals that either self-administer the survey or administer the survey for multiple hospital sites, and for survey vendors that conduct HCAHPS for client hospitals. The HCAHPS Rules of Participation include the following activities:

- Attend HCAHPS Introduction and Update Training
- Follow the Quality Assurance Guidelines and Policy Updates
- Attest to the accuracy of the organization’s data collection process
- Develop a HCAHPS Quality Assurance Plan
- Become a QualityNet Exchange Registered User for data submission
- Participate in oversight activities conducted by the HCAHPS Project Team.

Hospitals and survey vendors administering the survey must also meet HCAHPS Minimum Survey Requirements with respect to survey experience, survey capacity, and quality control procedures. Details about these activities and requirements can be found in the Quality Assurance Guidelines under “Quality Assurance” at www.hcahpsonline.org.

Note: If a hospital, or its survey vendor, is found to be non-compliant with these rules or requirements, the hospital’s HCAHPS data may not be publicly reported and the hospital may be at risk for an annual payment update (APU) reduction.

Which patients are eligible to participate in HCAHPS?

The HCAHPS survey is broadly intended for patients of all payer types that meet the following criteria:

- 18 years or older at the time of admission
- At least one overnight stay in the hospital as an inpatient
- Non-psychiatric MS-DRG/principal diagnosis at discharge
- Alive at the time of discharge

Patients who meet these criteria (except those that fall into an exclusion category, described below) should be included in the sample frame from which the survey sample is drawn.

A patient's principal diagnosis at discharge is used to determine whether he or she falls into one of the three service line categories (medical, surgical or maternity care) for HCAHPS eligibility. The Medicare Severity-Diagnosis Related Group (MS-DRG) is the preferred method for determining whether the service line is Medical, Surgical or Maternity Care.

Pediatric patients (under 18 years old at admission) and psychiatric patients are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients. Patients whose MS-DRG/principal diagnosis is Medical, Surgical or Maternity Care but who also have psychiatric comorbidities are eligible for the survey. Patients who did not have an overnight stay are ineligible because their experiences and interactions with the staff during the hospital visit may be limited.

There are a few categories of otherwise eligible patients who, because of logistical difficulties in collecting data, are excluded from the sample frame before the random sample is selected. These are:

- Patients discharged to hospice care
- Patients discharged to nursing homes and skilled nursing facilities
- Court/Law enforcement patients (i.e., prisoners)
- Patients with a foreign home address (excluding U.S. territories—Virgin Islands, Puerto Rico, and Northern Mariana Islands)
- “No-Publicity” patients (see below)
- Patients who are excluded because of rules or regulations of the state in which the hospital is located

Complete information about patient eligibility and exclusions for the HCAHPS survey can be found in the Quality Assurance Guidelines under “Quality Assurance” at www.hcahpsonline.org.

Note: A "No publicity patient" is a patient who requests at admission that the hospital: 1) not reveal that he or she is a patient; and/or 2) not survey him or her.

Note: Hospitals must document their use of all patient exclusions.

How are patients sampled for the HCAHPS survey?

The basic sampling procedure for HCAHPS is the drawing of a random sample of eligible discharges on a monthly basis. Smaller hospitals should survey all HCAHPS-eligible discharges. Data are collected from patients throughout each month of the 12-month reporting period. Data are then aggregated on a quarterly basis to create a rolling 4-quarter data file for each hospital. The most recent four quarters of data are used in public reporting. To ensure comparability, hospitals may not switch type of sampling, mode of survey administration, or survey vendor within a calendar quarter. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under “Quality Assurance” at www.hcahpsonline.org.

How is the sample drawn for the HCAHPS Survey?

The basic sampling procedure for HCAHPS entails drawing a random sample of all eligible discharges from a hospital on a monthly basis. Sampling may be conducted either continuously throughout the month, or at the end of the month, as long as a random sample is generated from the entire month.

The target for the statistical precision of the publicly reported hospital scores is based on a reliability criterion. In brief, higher reliability means a higher ratio of “signal to noise” in the data. The reliability target for the HCAHPS global items and most composites is 0.8 or higher. Based on this target, hospitals must obtain at least 300 completed HCAHPS surveys over the 12-month reporting period.

The HCAHPS sample must be drawn according to this uninterrupted random sampling protocol. Hospitals/Survey vendors must sample from every month throughout the entire reporting period and not stop sampling or curtail ongoing interview activities once a certain number of completed surveys has been attained. All completed surveys should be submitted to the HCAHPS data warehouse. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under “Quality Assurance” at www.hcahpsonline.org.

Note: Smaller hospitals that are unable to reach the target of 300 completes in a 12-month reporting period must survey ALL eligible discharges and attempt to obtain as many completes as possible.

When are patients surveyed?

Sampled patients are surveyed between 48 hours and six weeks after discharge, regardless of the mode of survey administration. Interviewing or distributing surveys to patients while they are still in the hospital is not permitted.

Data collection for sampled patients must end no later than six weeks following the date the first survey is mailed (Mail Only and Mixed Modes) or the first telephone attempt (Telephone Only and IVR Modes) is made. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under “Quality Assurance” at www.hcahpsonline.org.

How is the HCAHPS Survey data analyzed?

Data submitted to the HCAHPS data warehouse is cleaned and analyzed by CMS, which then calculates hospitals’ HCAHPS scores and publicly reports them on the Hospital Compare website.

Which results from the HCAHPS Survey are publicly reported?

Hospital-level HCAHPS results are publicly reported on the Hospital Compare website at <https://www.hhs.gov/answers/health-insurance-reform/how-can-i-find-out-if-my-hospital-offers-good-care/index.html>. Results are reported for four quarters on a rolling basis, which means that the oldest quarter of survey data is rolled off as the newest quarter is rolled on. Ten HCAHPS measures are publicly reported on Hospital Compare:

Composite Topics

- Nurse Communication (Question 1, Q2, Q3)
- Doctor Communication (Q5, Q6, Q7)
- Responsiveness of Hospital Staff (Q4, Q11)
- Pain Management (Q13, Q14)
- Communication About Medicines (Q16, Q17)
- Discharge Information (Q19, Q20)

Individual Items

- Cleanliness of Hospital Environment (Q8)
- Quietness of Hospital Environment (Q9)

Global Items

- Overall Rating of Hospital (Q21)
- Willingness to Recommend Hospital (Q22)

All ten HCAHPS measures are publicly reported for each participating hospital, as well as the national and state averages for each measure. The survey response rate and the number of completed surveys (in broad categories) are also publicly reported on Hospital Compare. CMS publicly reports HCAHPS results for hospitals that obtain fewer than 100 completed surveys. However, a footnote is added when public reporting these results to denote the lower level of precision. Additional information about hospital performance on HCAHPS is available under “Summary Analyses” on the HCAHPS On-Line Web site, <http://www.hcahpsonline.org/home.aspx>.

How are HCAHPS results adjusted prior to public reporting?

To ensure that differences in HCAHPS results reflect differences in hospital quality only, HCAHPS survey results are adjusted for patient-mix and mode of data collection. Only the adjusted results are publicly reported and considered the official results. Several questions on the survey, as well as items drawn from hospital administrative data, are used for the patient-mix adjustment. Neither patient race nor ethnicity is used to adjust HCAHPS results; these items are included on the survey to support congressionally-mandated reports. The adjustment model also addresses the effects of non-response bias.

More information about the mode experiment, as well as patient-mix adjustment coefficients for publicly reported HCAHPS results, can be found under “Mode and Patient-Mix Adjustment” at <http://www.hcahpsonline.org/home.aspx>.

Hospital-Acquired Condition Reduction Program

Educational Briefing for Suppliers and Service Providers

Executive Summary

The Hospital-Acquired Condition (HAC) Reduction Program is a mandatory pay-for-performance program established by the Affordable Care Act. The program aims to improve patient safety and reduce the incidence of common but avoidable conditions that patients can contract during hospital stays. The program measures hospital performance on key patient safety measures and issues payment adjustments based on how the hospital score compares to the national average. The quartile of hospitals with the worst patient safety performance face a 1% penalty on the inpatient Medicare revenue.

Why is the HAC Reduction Program a key issue for providers?

The HAC Reduction Program, in tandem with the Value-Based Purchasing (VBP) and Readmissions Reduction programs, incentivizes hospitals to deliver higher quality care. Each year, the program includes more conditions, raising the stakes for hospital performance. Moreover, while hospitals' financial adjustment is based on historical performance, they're also evaluated relative to their peers; avoiding a penalty one year does not exempt hospitals from one the next year.

On their own, reducing HAC prevalence makes good business sense, as HACs often lead to increased length of stay, mortality rates, and total costs. However, it's also important to note that all conditions included in the HAC program are also included within the VBP program, doubling providers' incentive to manage HAC rates.

Metrics Considered in HAC Reduction Program

	Metric	FY 2015	FY 2016	FY 2017
Domain 1	PSI-90	✓	✓	✓
	CLABSI ¹	✓	✓	✓
	CAUTI ²	✓	✓	✓
Domain 2	SSI ³ – Colon		✓	✓
	SSI – Abdominal Hysterectomy		✓	✓
	MRSA ⁴			✓
	C. Difficile ⁵			✓

How does the HAC Reduction Program work?

The HAC Reduction Program evaluates hospitals on performance in two domains:

- Domain 1 is comprised of a single patient safety composite called PSI-90. Beginning in fiscal year (FY) 2018, CMS will use a modified version of PSI-90 that includes 10 component indicators, including pressure ulcer rate, perioperative hemorrhage/hematoma rate, postoperative sepsis rate, and more.
- Domain 2 consists of infection rate measures for major infections tracked by the Centers for Disease Control and Prevention's National Health Safety Network. In fiscal year (FY) 2015, the domain contained only two measures. By FY 2017, that number grew to six.

The Centers for Medicare and Medicaid Services (CMS) calculates providers' domain scores by averaging measure scores within each domain. Each measure is pre-adjusted for risk factors such as age, gender, and patient comorbidities to account for hospitals that serve a disproportionate amount of very sick patients, or that conduct high volumes of surgeries. From there, CMS will calculate hospitals' total HAC scores as a weighted distribution of their Domain 1 and Domain 2 scores. In FY 2015, Domain 1 was weighted at 35% while Domain 2 was weighted at 65%. Each year since, the relative importance of Domain 1 has decreased while the relative importance of Domain 2 has increased. In FY 2018, Domain 1 will be weighted at just 15% while Domain 2 is weighted at 85%.

Conversation Starters with the Hospital C-Suite

- How does your Hospital-Acquired Condition rate compare to your peers?
- What programs, processes, or technologies do you have in place to reduce HACs?
- How are you ensuring that all staff are mindful of HAC prevalence and prevention efforts?

1) Central-line associated blood stream infection.
2) Catheter-associated urinary tract infection.
3) Surgical site infection.
4) Methicillin-resistant Staphylococcus aureus
5) Clostridium difficile colitis.

Source: Advisory Board interviews and analysis.

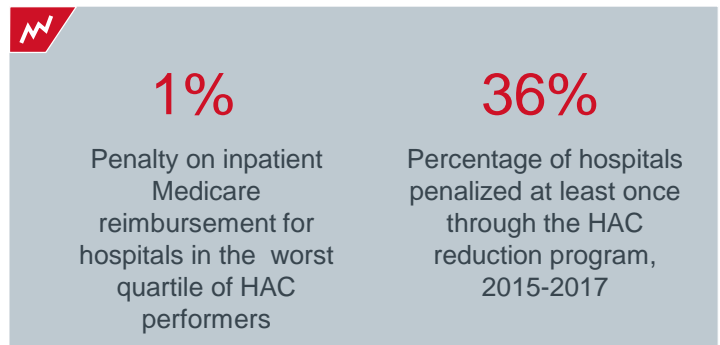
How does the HAC Reduction Program affect providers?

Clinical

As Americans age and the prevalence of chronic diseases increases, providers are tasked with managing a population more prone to complications and adverse events. Thus, it's of growing importance for clinical staff to develop and ensure compliance with hospital protocols aimed at limiting infections. For example, physicians and nurses may monitor excessive catheterization and focus on appropriate catheter insertion and removal to decrease risk of infection. Additionally, clinical staff must ensure they remain up-to-date on regulations related to the HAC Reduction Program as the number and type safety measures evaluated is in constant flux.

Financial

Hospital-acquired infections, which affect five to ten percent of patients each year, result in \$45 billion of additional health care costs. In addition, the emergence of an older and sicker population has led to a growing prevalence of HACs. Through the HAC Reduction Program, hospitals are held accountable for the mounting cost of these preventable infections. Within the program, the worst quartile of HAC performers are subject to a 1% penalty on their inpatient Medicare reimbursement. Since the program was rolled out, more than one third of hospitals have been penalized at least once. Moreover, because all of the HAC Reduction Program measures are included within the VBP Program, providers that fail to maintain low HAC infection rates may be penalized twice.



Operational

To succeed under the HAC Reduction Program, providers must ensure accurate, detailed, and timely documentation. Hospital staff must ensure they properly code patients for illnesses present on admission because failure to do so could result in these non-coded complications eventually being classified as HACs. From a staffing perspective, providers may need to expand their Infection Control Personnel (ICP) to help combat HACs. Inadequate ICP staffing is considerable issue for hospitals as ICPs are responsible for a number of crucial tasks ranging from staff education about antibiotic resistance to infection metric reporting. Emphasis on sterilizing "high risk, high touch" objects (e.g., phones, keyboards, and reusable tools) is also paramount. Finally, providers must ensure all environmental service providers, whether employed by the hospital or a third party, are included in hygiene education efforts and understand their role in boosting patient safety.

How might the HAC Reduction Program impact provider-supplier sales relationships?

While HACs are a longstanding issue, many hospitals are now looking for more inventive strategies to improve patient safety.

Innovative technologies will be in high demand. Hospitals will seek out partners whose products and services can fight infections (e.g. medicines that fight drug-resistant infections) and improve cleanliness. When applicable, providers will ask suppliers and service providers to demonstrate how a given product or service will have a positive impact on the facility's HAC rate.

Enhanced training and care standardization will be of greater importance. Providers may be interested in working with suppliers and service providers that can offer relevant staff education or advanced training. Examples may include online courses about proper central line insertion or checklists that ensure thorough sanitization of hospital equipment.

Providers will focus on promoting hygienic practices throughout their organization. Increasing hand washing compliance can vastly decrease HAC occurrence. Hospitals may add sinks, antibacterial solution dispensers, or non-irritating soaps in order to ensure staff maintain proper hygiene protocols. Some institutions may be interested in using IT services to compile and analyze hygiene practices.

Additional Advisory Board research and support are available.



For more information on regulatory updates to the HAC Reduction Program, please view our webconference on [Medicare Payment Strategy](#). We also encourage you to visit our [Pay-for-Performance File](#) to assess provider performance within the HAC Reduction Program.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Report on ECH Board Actions Executive Compensation Committee March 22, 2018
Responsible party:	Cindy Murphy, Director of Governance Services
Action requested:	For Information
Background: <p>In FY16, we added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. This written report is intended to supplement a verbal report by the Chair of the Committee and/or Board members who also serve on the Committee.</p>	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: <p>None.</p>	
Summary and session objectives: <p>To inform the Committee about recent Board actions.</p>	
Suggested discussion questions: None.	
Proposed Committee motion, if any: None. This is an informational item.	
LIST OF ATTACHMENTS: <ol style="list-style-type: none"> 1. Report on ECH Board Actions 	

February 2018 ECH Board Actions*

1. February 14, 2018
 - a. Approved Changes to Executive Compensation Philosophy, Executive Base Salary Administration Policy and Executive Incentive Plan Policy
 - b. Approved FY18 CIO Base Salary – Deb Muro named CIO
 - c. Approved FY 18 SVMD President Base Salary – Bruce Harrison named President of SVMD
 - d. Approved the Government Investigations and Physician Financial Arrangements Policies
 - e. Approved the PACS Image and Archive System Replacement (\$2.2 million)
 - f. Approved ED Call Panel Agreements for Interventional Radiology, Stroke & Neurology, and Urology at both campuses
 - g. Approved FY18 Period 5 and 6 Financials
 - h. Appointed Director Julie Kliger to the Quality, Patient Care and Patient Experience Committee and the Executive Compensation Committee.
 - i. Considered a proposal to delegate certain decision making authority to the Executive Compensation Committee, and gave direction to the Committee to develop procedures for exercising the proposed authority.
 - j. Approved a revised Board and Committee Education Policy.

*This list is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Update on FY18 Organizational Goals Executive Compensation Committee March 22, 2018
Responsible party:	Dan Woods, CEO
Action requested:	Information
<p>Background: The FY18 Organizational Goals were approved by the Board in June 2017</p> <ol style="list-style-type: none"> 1. Threshold Goal: 95% of Budgeted Operating Margin – met FY18 Budgeted Operating Margin = 9.7 FY18 Operating Margin as of 1/31/18 = 16.1 FY18 % of Operating Margin as of 1/31/18 = 106.4% 2. Efficiency/Affordability Goal: Length of Stay – Currently at Target The external benchmark is from the Centers for Medicare and Medicaid Services (CMS). 3. Service Goal: HCAHPS Rate the Hospital – Currently at Minimum. We are increasing our efforts related to purposeful hourly rounding and leader rounding which we expect to have a positive impact on this goal. The external benchmark is from Press Ganey, the national company engaged to conduct surveys for ECH related to patient satisfaction and employee and physician engagement. 4. Quality Goal: Hospital Acquired Infections – This metric represents an average Standardized Infection Ratio (SIR) for Catheter Associated Urinary Tract Infections (CAUTI), Central Line Associated Blood Stream Infections (CLABSI) and Clostridium Difficile Infections (C. Diff.). Although we are above maximum for the goal and are doing well with C. Diff., we are still very challenged with preventing CAUTI's. We have instituted a new nurse driven protocol that requires two staff members to insert indwelling urinary catheters in female patients and allows nurses to remove them without a physician's order when certain criteria are met. We will be tracking the impact of these changes over the next few months. Although the SIR of CLABSI's is currently above last year's baseline, the number of patients with these types of infections is very low. The external benchmark is from the National Healthcare Safety Network (NHSN), which is a subsidiary of the Centers for Disease Control (CDC). 	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
<p>Summary and session objectives:</p> <p>To update the Committee on our progress achieving the FY18 Organizational Goals</p>	
Suggested discussion questions: None.	
Proposed Committee motion, if any: None.	
<p>LIST OF ATTACHMENTS:</p> <ol style="list-style-type: none"> 1. FY18 Organizational Goals 	

FY18 Organizational Goals

Prepared: 3/2/2018

Organizational Goals FY18		Benchmark	2017 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY18 through Feb	
Threshold Goals										
Budgeted Operating Margin*		95% Threshold	Achieved Budget	95% of Budgeted			Threshold	FY 18		Met
Quality, Patient Safety & iCare										
	Arithmetic Observed LOS Average / Geometric LOS Expected for Medicare Population (ALOS /GMLOS)	External: Expected via Epic Methodology	FY 2016: 1.21 (ALOS 4.86/GMLOS 4.00) FY 2017 YTD April: 1.18 (4.81/4.08)	1.12	1.11	1.09	34%	4Q FY18		1.11
	HCHAPS Service Metric: Rate Hospital	External Benchmark	HCAHPs Baseline: 10/2016-12/2016: 75.5% 1/2017-3/2017: 75.1%	77%	78%	79%	33%	4Q FY18		77%
	Standardized Infection Ratio (SIR)* Observed HAIs/Predicted HAIs (Hospital Acquired Infections)	External Benchmark	July- Dec 2016L CAUTI 1.37, CLABSI 0.25, C.DIFF 0.59 Avg: 0.738	0.670	0.602	0.534	33%	FY18		CAUTI: 1.459 CLABSI: 0.423 C.Diff: 0.30 Avg: 0.525

* These metrics are available through January 2018 only- Updated Infection Data will not available until the end of the Fiscal Year

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Biennial Committee Charter Review Executive Compensation Committee March 22, 2018
Responsible party:	Cindy Murphy, Director of Governance Services
Action requested:	Possible Motion
<p>Background: The Governance Committee’s charter provides that it will ensure that each Board Advisory Committee reviews its Charter every other year. The Executive Compensation Committee (“ECC”) last reviewed its Charter in March 2016. The Governance Committee will review any proposed revisions and make a recommendation to the Board.</p> <p>Aside from any recommendations to revise the Charter related the Proposed Delegation of Authority in the previous agenda item, staff does not have any specific recommendations to revise the Charter at this time.</p>	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
Summary and session objectives: For the Committee to review its Charter and discuss whether (1) it is meeting the mandates of its Charter and (2) any desired changes.	
<p>Suggested discussion questions:</p> <ol style="list-style-type: none"> 1. Are there any ECC activities provided in the Charter that the Committee is not performing? 2. Are there any activities the Executive Compensation Committee should be engaging in that are not provided in the Charter? 	
<p>Proposed Committee motion, if any:</p> <p>None proposed. At the discretion of the Committee.</p>	
<p>LIST OF ATTACHMENTS:</p> <ol style="list-style-type: none"> 1. Current ECC Charter 	

Executive Compensation Committee Charter

Purpose

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

Authority

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

Membership

The Executive Compensation Committee shall be comprised of two (2) or more Hospital Board members. The Committee may also include 2-4 external (non-director) members with knowledge of executive compensation practices, executive leadership or corporate human resource management. The Hospital Board may designate up to two Hospital Board members to serve as alternate Committee members. Alternate Committee members shall serve as full members of the Committee when their attendance is permitted. If there are two alternates, meeting attendance will rotate with assignments made by the Committee Chair upon appointment or reappointment. If an alternate or Hospital Board member is unable to attend any Committee meeting, the unassigned alternate Committee member may attend any Committee meeting so long as the number of Hospital Board members in attendance is less than five.

- Compensation consultants may be retained as appropriate and participate as directed.
- The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.

- All Committee members shall be appointed by the Board Chair, subject to approval by the Board, for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair must be a Hospital Board member.
- All members of the Committee must be independent directors with no conflict of interest regarding compensation or benefits for the executives whose compensation is reviewed and recommended by the Committee. Should there be a potential conflict, the determination regarding independence shall follow the criteria approved by the Board and as per the Independent Director Policy.

Staff Support and Participation

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

General Responsibilities

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

Specific Duties

The specific duties of the Executive Compensation Committee include the following:

A. Executive Compensation

- Develop a compensation philosophy that clearly explains the guiding principles on which executive pay decisions are based. Recommend the philosophy for approval by the Board.
- Develop executive compensation policies to be approved by the Board.
- Review and maintain an executive compensation and benefit program consistent with the executive compensation policies, which have been approved by the Board. Recommend any material changes in the program for approval by the Board.
- Review the CEO's salary range, performance incentive program, benefits, perquisites, and contractual terms. Recommend to the Board any salary changes and/or any performance incentive payouts based on the Committee's evaluation of the CEO's performance.

- Review the CEO's recommendations regarding salary and performance incentive payouts for the upcoming year for the executives whose compensation is subject to review by the Committee based on the CEO and Committee's evaluation of the executive's performance. Recommend to the Board any salary changes and/or any performance incentive payouts based on the Committee and CEO's evaluation of the executive's performance.
- Periodically evaluate the executive compensation program, including the charter, policies, and philosophy on which it is based, to assess its effectiveness in meeting the Hospital's needs for recruiting, retaining, developing, and motivating qualified leaders.
- Periodically review the total value, cost and reasonableness of severance and benefits for executives.
- Annually review and present for Board acceptance the letter of rebuttable presumption of reasonableness.
- Review market analysis and recommendation of the Committee's independent executive compensation consultant.
- Establish salary ranges for each executive and recommend placement in the range for the CEO and those executives eligible for the plan to the Board.

B. Performance Goals Setting and Assessment

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

C. Executive Succession and Development

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

Committee Effectiveness

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

Meetings and Minutes

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

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

Approved as Revised: June 8, 2016

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Biennial Committee Self- Assessment Executive Compensation Committee March 22, 2018
Responsible party:	Cindy Murphy, Director of Governance Services
Action requested:	Possible Motion
Background: El Camino Hospital's Board Advisory Committees conduct a Biennial Self-Assessment. This survey was conducted in December 2017.	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
Summary and session objectives: For the Committee to review its Self-Assessment, to discuss the findings, and decide whether or not to integrate an area for improvement into the Committee's FY19 Goals.	
Suggested discussion questions: <ol style="list-style-type: none"> 1. What does the Committee take away from the findings? 2. Should the Committee integrate any of the possible areas for improvement into its FY 19 Committee Goals? If yes, which one(s)? 	
Proposed Committee motion, if any: None Proposed. At the discretion of the Committee.	
LIST OF ATTACHMENTS: 1. Biennial Committee Self-Assessment Results.	



NYGREN CONSULTING
GOVERNANCE STRATEGY LEADERSHIP

El Camino Hospital

Executive Compensation Committee

FY2017-18 Assessment Report



Submitted on: January 25, 2018
Prepared for: Executive Compensation Committee
Prepared by: JoAnn McNutt, PhD and Zach Morfin, PhD

Introduction

Background

In keeping with the ECH Hospital Board's commitment to effective governance, Nygren Consulting was engaged to conduct the biennial performance assessment of the board committees, providing them with an opportunity to reflect on their performance during the Fiscal Year 2017-2018. The goal of the assessment was to identify the committees' strengths and areas for improvement, which would be integrated into their annual goals. This report provides the results of the Executive Compensation Committee's self-assessment.

Interpreting the Results

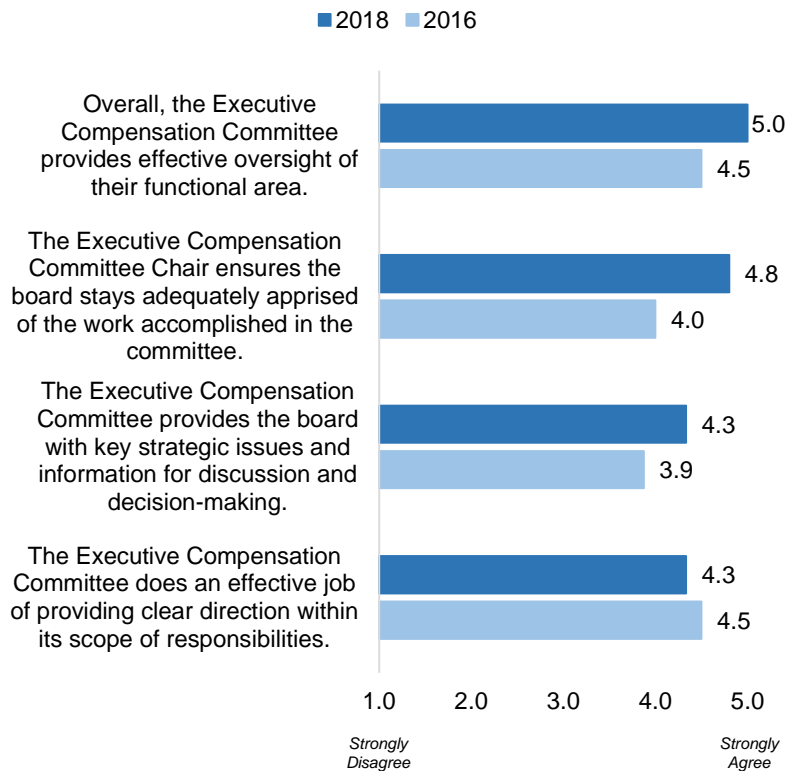
The Executive Compensation Committee assessment tool was comprised of twelve core items and three open-ended questions that applied to all committees, as well as six committee-specific items. Please note that because committee assessments are conducted on a biennial basis, the year-over-year analysis compares the committee's performance in 2018 against 2016.

The purpose of the assessment was to provide directional feedback to the Executive Compensation Committee. The quantitative scores herein are meant to provide insight into how the Executive Compensation Committee perceives its own performance. The assessment is not intended to provide statistically significant results, which cannot be achieved with a small sample size. Average scores are rounded to the nearest tenth decimal point as this will show variation in the ratings.

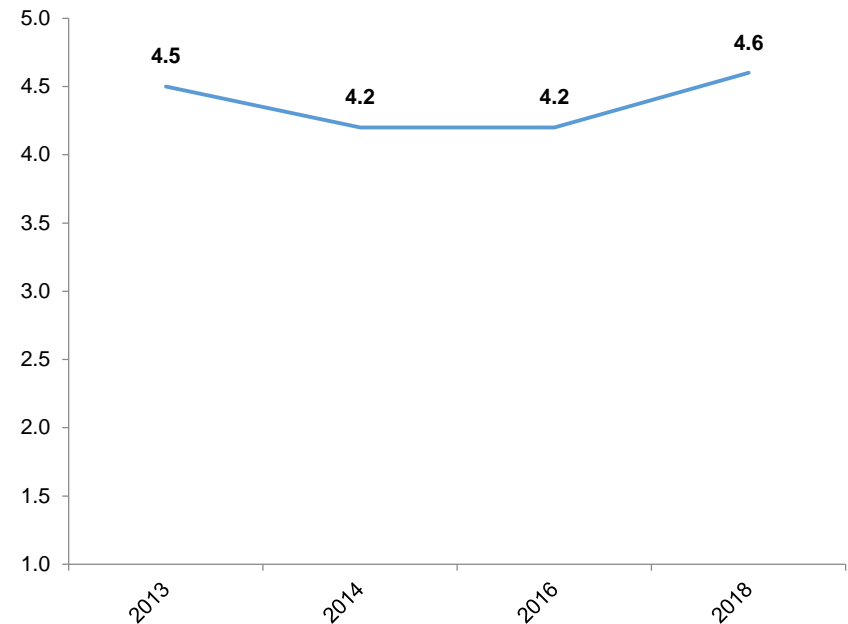
We set 3.5 as the threshold to determine whether a response is favorable. It is rare to achieve a perfect score of 5.0. Occasionally, we see an average score of 4.5 and above on exceptional cases.

Hospital Board's Assessment of the Executive Compensation Committee

Board's Assessment of the Executive Compensation Committee on the Four Standard Items



Board's Assessment of the Executive Compensation Committee Over Time



High-Level Summary of the Committee's Self-Assessment

Participation:

- 9 out of 9 stakeholders participated in the assessment (100%):
 - Non-director committee members = 4
 - Board members = 2
 - Executive leadership team members = 3

Self-Assessment Averages:

2018 = 4.2

2016 = 4.2

2014 = 4.5

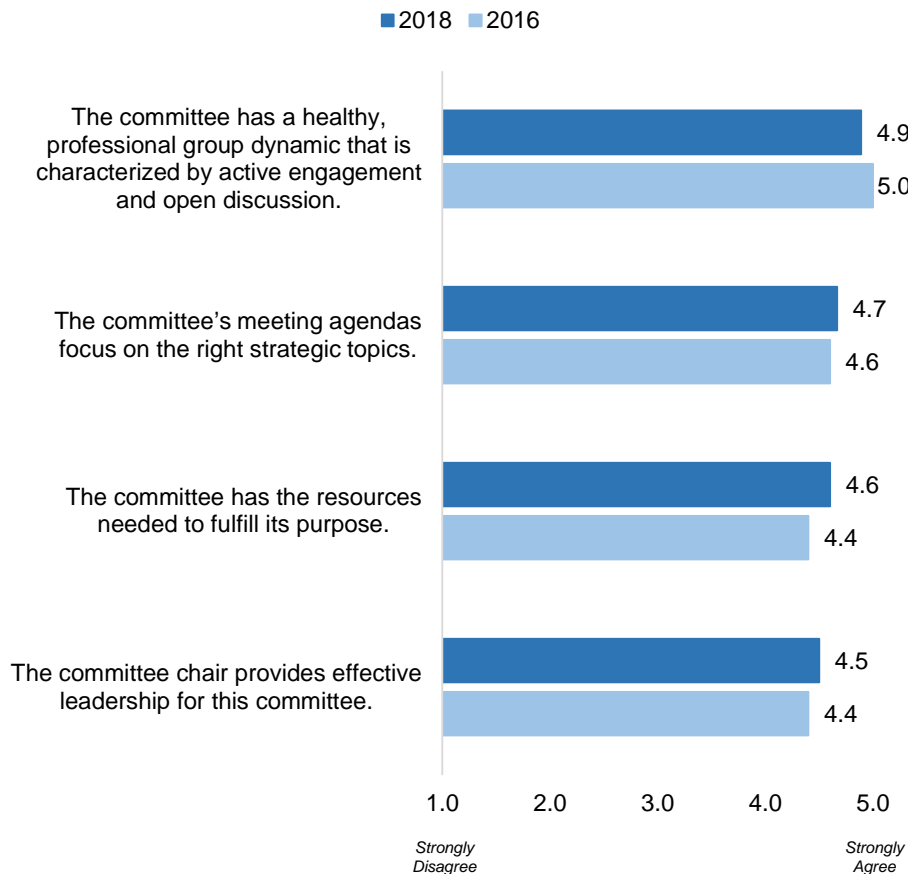
2013 = 4.6

Key Findings:

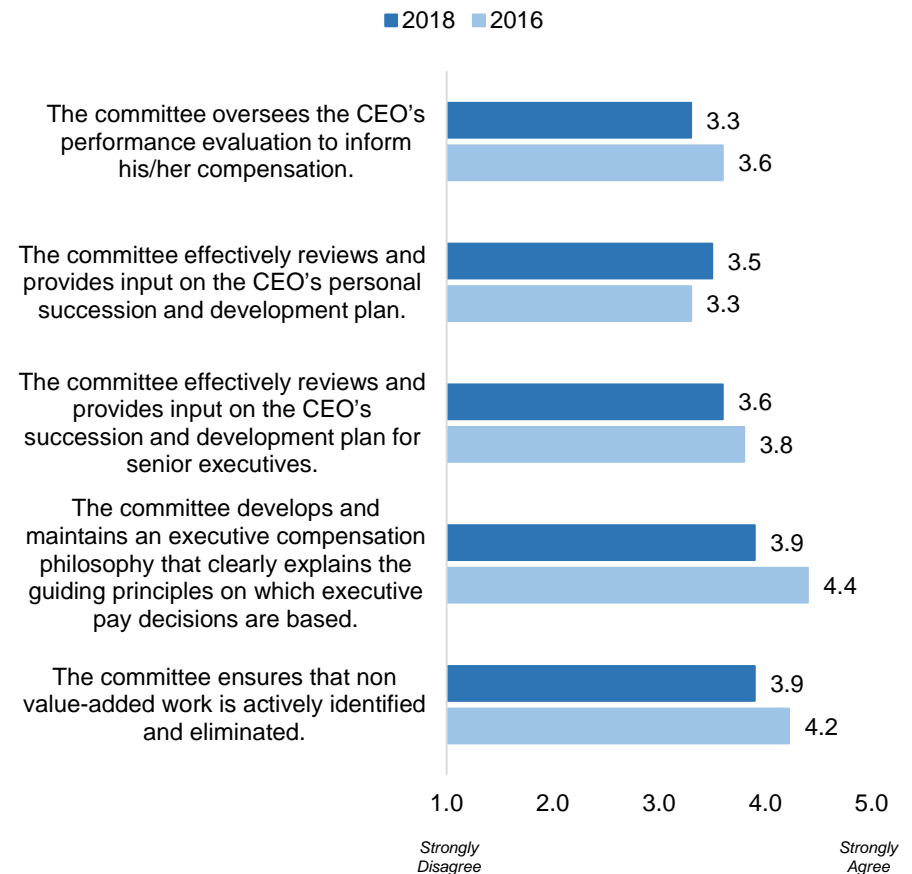
- The committee rated its overall performance the same as in 2016. There was only one item that showed a notable decrease this year:
 - The committee develops and maintains an executive compensation philosophy that clearly explains the guiding principles on which executive pay decisions are based. (-0.5)
- Open-ended comments pointed to the following:
 - Committee members' role vis-à-vis management is clearer and the quality of materials is adequate
 - The committee lacks a clear understanding of the CEO's priorities and board goals, which is needed to articulate what a successful executive compensation and development program looks like
 - Committee recommendations to the board should be clarified or packaged better; ensure the committee has a clear understanding of the board's receptivity to its recommendations
 - The committee should clarify its role when it comes to reviewing the CEO's performance and development plans

Highest and Lowest Rated Items

Highest Rated Items



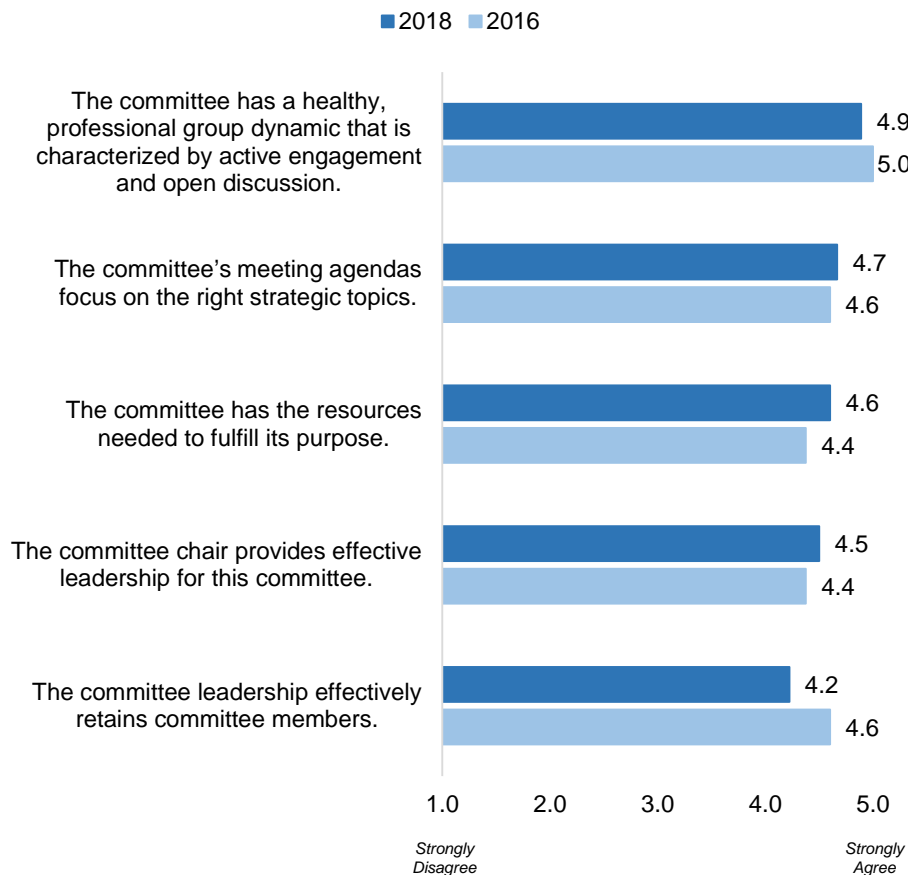
Lowest Rated Items



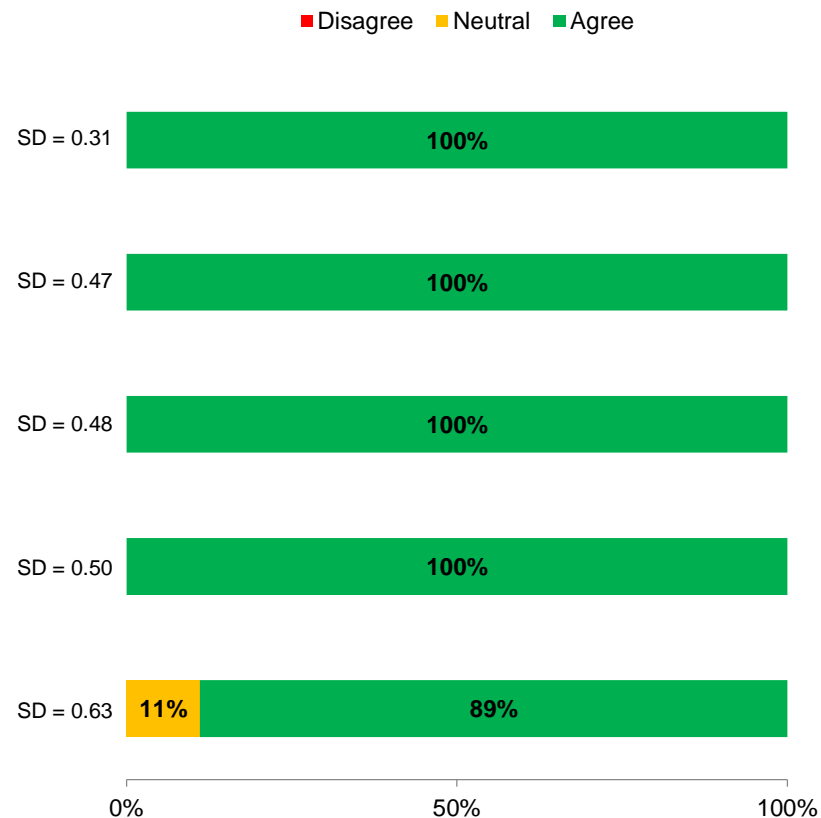
Areas of Greatest Agreement

Areas of agreement are determined by the standard deviation (SD), which is a measure of the dataset's spread around the mean. Higher standard deviations relate to a lower consistency or agreement across ratings for a particular survey item. The lower the SD, the greater agreement there is among respondents. The higher the SD, the less agreement there is among respondents. The distribution of ratings shows the corresponding number of individual ratings of 1 or 2, neutral responses of 3, and favorable responses of 4 or 5.

Areas of Greatest Agreement

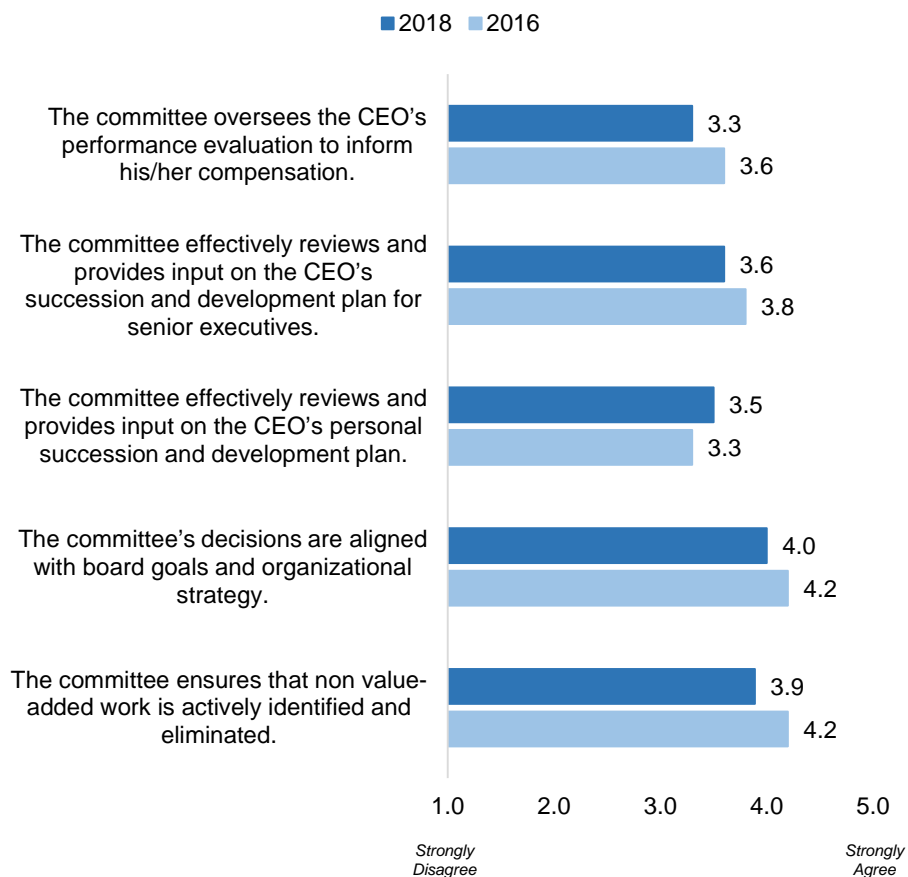


Distribution of Ratings

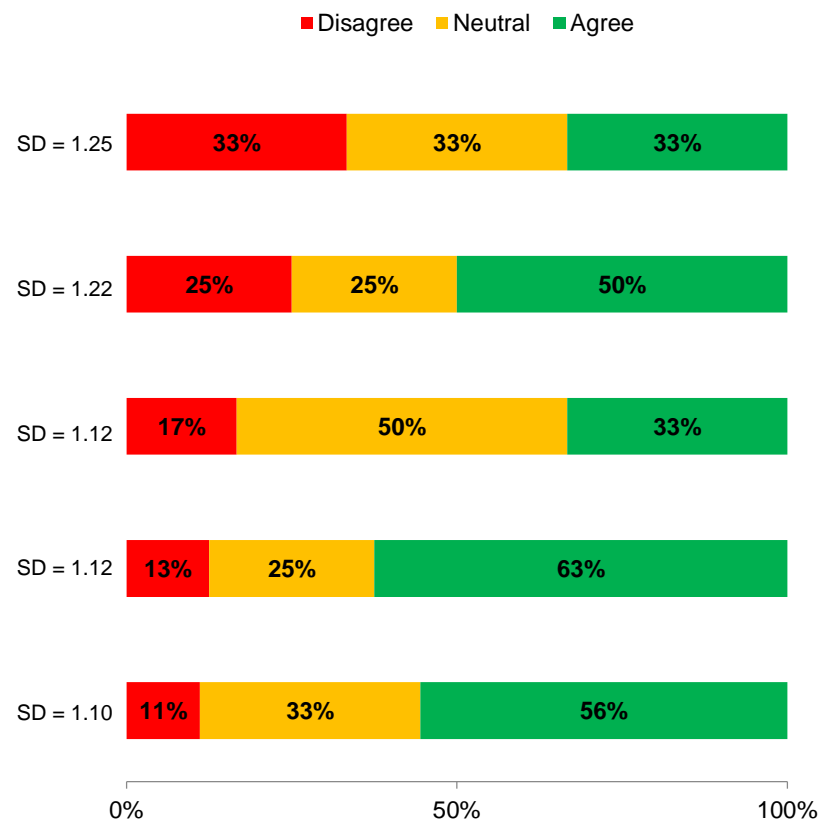


Areas of Least Agreement

Areas of Least Agreement



Distribution of Ratings



Detailed Results by Item

The table below shows all survey items, sorted highest to lowest by 2018 rating. The *Difference* column represents the difference in ratings between the committee's 2018 vs. 2016 ratings. A positive difference indicates items where committee members rated the committee's performance **higher** than in 2016. Conversely, a negative difference indicates where members rated the committee's performance **lower** than in 2016.

Items Sorted Highest to Lowest by Stakeholder Rating	↓ 2018	2016	N	Difference
The committee has a healthy, professional group dynamic that is characterized by active engagement and open discussion.	4.9	5.0	9	-0.1
The committee's meeting agendas focus on the right strategic topics.	4.7	4.6	9	0.1
The committee has the resources needed to fulfill its purpose.	4.6	4.4	8	0.2
The committee chair provides effective leadership for this committee.	4.5	4.4	8	0.1
The committee effectively leverages staff support to get the information it needs in a timely manner.	4.4	4.0	9	0.4
The committee leadership effectively recruits top talent.	4.3	4.1	9	0.2
The committee meets often enough to effectively carry out its duties.	4.3	4.3	9	0.0
The committee efficiently reaches consensus on its decisions or recommendations to the board.	4.3	4.3	9	0.0
The committee reviews and maintains an executive compensation and benefit program consistent with the board-approved executive compensation policies.	4.3	4.4	9	-0.1
The committee leadership effectively retains committee members.	4.2	4.6	9	-0.4
The committee develops and maintains executive compensation policies in line with the board-approved executive compensation philosophy.	4.2	4.2	9	0.0
Committee members understand the hospital well enough to add value.	4.0	4.4	9	-0.4
The committee's decisions are aligned with board goals and organizational strategy.	4.0	4.2	8	-0.2
The committee ensures that non value-added work is actively identified and eliminated.	3.9	4.2	9	-0.3
The committee develops and maintains an executive compensation philosophy that clearly explains the guiding principles on which executive pay decisions are based.	3.9	4.4	9	-0.5
The committee effectively reviews and provides input on the CEO's succession and development plan for senior executives.	3.6	3.8	8	-0.2
The committee effectively reviews and provides input on the CEO's personal succession and development plan.	3.5	3.3	*6	0.2
The committee oversees the CEO's performance evaluation to inform his/her compensation.	3.3	3.6	*6	-0.3

Thematic Summaries of the Qualitative Feedback

Opportunities for Improvement

- The committee is moving in the right direction in terms of clarifying the role of the committee members vs. management, and there appears to be satisfaction with management responsiveness and quality of materials. They encourage management to continue on this path.
- The committee does not have sufficient clarity on the CEO's priorities or the board's goals, which is preventing a fuller understanding of what success looks like from an executive compensation and succession planning perspective.
- The committee is encouraged to clarify its recommendations to the board, ensuring they align with board goals and organizational mission, as well as ensure that the committee has a clear understanding of the board's response to its recommendations.
- The committee does not provide an in-depth review of the CEO's succession and development plans, which one individual shared is not part of the committee's purview.



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Proposed Draft

FY19 COMMITTEE GOALS

Executive Compensation Committee

PURPOSE

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

STAFF: **Kathryn Fisk**, Chief Human Resources Officer; **Julie Johnston**, Director, Total Rewards; **Cindy Murphy**, Board Liaison

The CHRO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair’s consideration. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing his/her compensation. The CEO is an ex-officio member of this Committee.

GOALS	TIMELINE by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	METRICS
1. Advise the Board on performance incentive goal-setting and plan design, ensuring strategic alignment and proper oversight of compensation-related decisions.	<ul style="list-style-type: none"> Review FY 18 Org Scores and Individual Scores – Q1 Receive status update on FY19 progress toward goals and overview of FY20 strategic priorities – Q3 Review Proposed FY20 organizational and individual goals – Q4 	<ul style="list-style-type: none"> Board approves Executive Performance Incentive Scores and Payouts for FY18 – (October 2018) Board approves FY 20 organizational goals – June 2019
2. Support successful implementation of changes in Board’s delegation of authority to the Committee	<ul style="list-style-type: none"> Evaluate effectiveness of changes in process – Q4 Discuss the impact of the delegation change on the effectiveness of the Committee and Committee meetings – Q4 	<ul style="list-style-type: none"> Report to the Board regarding effectiveness of changes and proposed changes or process improvements – June 2019
3. Advise the Board ensuring strategic alignment and proper oversight of compensation-related decisions.	<ul style="list-style-type: none"> Review FY 18 Individual Scores and Payout Amounts – Q1 Receive market analysis and review CEO’s recommendations regarding base salary – Q4 Review Proposed FY20 organizational and individual goals – Q4 	<ul style="list-style-type: none"> Board approves FY 18 incentive payouts – October 2019 Board approves letters of reasonableness – January 2019
4. Evaluate the effectiveness of the independent compensation consultant	<ul style="list-style-type: none"> Survey committee members and administrative staff on performance of current consultant and determine whether or not to conduct an RFP – Q1 If conduct an RFP complete selection process in Q2 	<ul style="list-style-type: none"> Renewal of consulting agreement or selection on another firm no later than December 31, 2018

SUBMITTED BY:

Bob Miller
Kathryn Fisk

Chair, Executive Compensation Committee
Executive Sponsor, Executive Compensation Committee

Drafted by Julie Johnston, Director Total Rewards, 2/24/18

Executive Compensation Committee

Updated 2/20/2018

FY18 ECC Pacing Plan – Q1		
July 2017	August 2017	September 21, 2017
<i>No scheduled meeting</i>	<i>No scheduled meeting</i>	<ul style="list-style-type: none"> - Receive update on Strategic Plan <p>Committee to take action on:</p> <ul style="list-style-type: none"> - Approve Minutes - FY17 Organizational Score - FY17 Executive Individual Scores - FY17 Executive Performance Incentive Payout Amounts
FY18 ECC Pacing Plan – Q2		
October 2017	November 9, 2017	December 2017
<p><i>No scheduled meeting</i></p> <p><i>Board to take action on the following items:</i></p> <ul style="list-style-type: none"> - <i>Accept Moss Adams' financial audit</i> - <i>Approve FY17 Organizational Score</i> - <i>Approve FY17 Executive Individual Scores</i> - <i>Approve FY17 Executive Payout Amounts (discuss in closed, vote in open)</i> - Dan Woods to meet with Mercer about Exec Comp and benefits, Long-Term Incentive Plan (with Bob, Kathryn, and Julie) - Mercer prepares Letters of Reasonableness <p>Wed., 10/25/2017</p> <p>Board & Committee Educational Gathering</p>	<p>Committee to take action on:</p> <ul style="list-style-type: none"> - Approve Minutes - Letters of Rebuttable Presumption - Long Term Incentive Plans in Healthcare (educational session) - Review Compensation Philosophy, Base Salary Administration, and Performance Incentive Plan Policies (including employee performance appraisal process and education on IPI (integrated performance improvement)) 	<p><i>No scheduled meeting</i></p> <ul style="list-style-type: none"> - <i>Mitch Olejko prepares cover letter for rebuttable presumption action</i>

Executive Compensation Committee

Updated 2/20/2018

FY18 Executive Compensation Committee Pacing Plan – Q3

January 31, 2018	February 2018	March 22, 2018
<ul style="list-style-type: none"> - Review Executive Compensation Benefits Plan and Policies - Discuss Possible Delegation of Authority - FY18 CIO and SVMD President Base Salaries - Progress Against Committee Goals <p><i>Board to take action on the following items:</i></p> <ul style="list-style-type: none"> - <i>Accept Letter of Rebuttable Presumption</i> <p><i>*Beginning of benefit/executive benefit plan year</i></p>	<p><i>No scheduled meeting</i></p>	<ul style="list-style-type: none"> - Update on FY18 Strategic Plan <u>Implementation and FY19 Goals</u> - P-progress against FY18 <u>Organizational</u> Performance Incentive Goals - <u>Succession Planning Practices and</u> Update on Executive Development Plan - <u>Delegation of Authority</u> - <u>Biennial Committee Self-Assessment Results</u> <p>Committee to take action on:</p> <ul style="list-style-type: none"> - Approve Minutes - Proposed FY18 Committee Goals - Biennial review of Committee Charter - FY19 Meeting Dates

FY18 Executive Compensation Committee Pacing Plan – Q4

April 2018	May 17, 2018	June 2018
<p>Wed., 4/25/2018</p> <p>Board & Committee Educational Gathering</p>	<p>Committee to take action on:</p> <ul style="list-style-type: none"> - Approve Minutes - Finalize FY19 Pacing Plan - Review and may approve FY19 Salary Ranges - FY19 Executive Base Salaries (review CEO recs, may determine recommendation) - FY19 Organizational and Executive Individual Performance Incentive Goals (review CEO recs, determine recommendation) - CEO's FY19 Base Salary - CEO's FY19 Individual Goals - Review Committee Self-Assessment Results - <u>Review ECC Consultant</u> 	<p><i>No scheduled meeting</i></p> <p><i>Board to take action on the following items:</i></p> <ul style="list-style-type: none"> - <i>FY19 Organizational Goals</i> - <i>FY19 Executive Individual Goals</i> - FY19 CEO Individual Goals - <i>FY19 Executive Base Salaries</i> - <i>FY19 CEO Base Salary</i> - <i>FY19 Committee Goals</i> - <i>FY19 Committee Dates</i>