El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, March 14, 2018 – 5:30pm
El Camino Hospital | Conference Rooms A&B, F&G (ground floor)
2500 Grant Road Mountain View, CA 94040

Bob Rebitzer will be participating via teleconference from 28 Seaverns Ave, Jamaica Plain, MA 02130.

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 2018-03* **ATTACHMENT 3**	Cheryl Reinking, RN, CNO	*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.	**COMPLIANCE TRAINING** **ATTACHMENT 5**	Mary Rotunno, General Counsel; Diane Wigglesworth, Sr. Director Corporate Compliance		**information 5:48 – 6:03**
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 6:03 – 6:04**
7.	**ADJOURN TO CLOSED SESSION**	Lanhee Chen, Board Chair		**motion required 6:04 – 6:05**
8.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**6:05 – 6:06**
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 (February 14, 2018)	Lanhee Chen, Board Chair		**motion required 6:06 – 6:08**
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 6:08 – 6:18**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	*Gov't Code Section 54957.6* for a conference with labor negotiator Kathryn Fisk regarding SEIU/UHW West, Local 715 and Professional Resource-Nurses : - Labor Negotiations Update	Kathryn Fisk, CHRO		**discussion 6:18 – 6:28**
12.	*Gov't Code Section 54956.9(d)(2)* – conference with legal counsel – pending or threatened litigation: - IT Security Status Update	Deb Muro, CIO		**discussion 6:28 – 6:58**
13.	*Health and Safety Code Section 32106(b)* for a report and discussion involving health care facility trades secrets; *Gov't Code Sections 54957* and *54957.6* for report and discussion on personnel matters: - CEO Report on New Services and Programs and Personnel Matters	Dan Woods, CEO		**discussion 6:58 – 7:48**
14.	Report involving *Gov't Code Section 54957* for discussion and report on personnel performance matters – Senior Management: - Executive Session	Lanhee Chen, Board Chair		**discussion 7:48 – 7:53**
15.	**ADJOURN TO OPEN SESSION**	Lanhee Chen, Board Chair		**motion required 7:53 – 7:54**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Lanhee Chen, Board Chair		**7:54 – 7:55**
17.	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Hospital Board Meeting (February 14, 2018) b. Community Benefit Mid-Year Metrics ***Reviewed and Recommended for Approval by the Investment Committee*** c. Resolution 2018-04: Required by Premier, Inc. Listing the CEO and CFO as Authorized Individuals to Sell Stock ***Reviewed and Recommended for Approval by the Medical Executive Committee*** d. Medical Staff Report ***Information*** e. FY18 Period 7 Financials	Lanhee Chen, Board Chair	*public comment*	**motion required 7:55 – 7:58**
18.	**CEO REPORT** **ATTACHMENT 18**	Dan Woods, CEO		**information 7:58 – 8:00**
19.	**BOARD COMMENTS**	Lanhee Chen, Board Chair		**information 8:01 – 8:04**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
20.	**ADJOURNMENT**	Lanhee Chen, Board Chair		**motion required 8:04 – 8:05 pm**

Upcoming Meetings: April 18, 2018, May 9, 2018, June 13, 2018
Board/Committee Educational Gatherings: April 25, 2018

RESOLUTION 2018 - 03

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 Emergency Department physicians and staff for providing compassionate, personalized care for patients during this winter's severe flu season. Starting in December and continuing through February, the emergency rooms at El Camino Hospital saw an increased number of patients. From December to February, 208 flu patients were admitted as in-patients, compared to 185 last fiscal year.

The Emergency Department physicians and staff are experts in caring for the community. They are equipped to manage injuries and illnesses that range from minor to life threatening. Their commitment to providing prompt, thorough and advanced care is evident in their daily work. Physicians and staff delivered the best possible care while accommodating more than 13,400 patient visits this winter season. Throughout the surge in patient volume, the physicians and staff worked tirelessly to keep ambulance diversion to a minimum so patients could be treated at El Camino Hospital. The Emergency Department partnered with other hospital departments to perform diagnostic tests, admit patients when appropriate and discharge patients in a timely manner.

Caring for a large number of patients involves everyone in the Emergency Department, from the welcoming staff at registration to the medical directors providing leadership and guidance. Each team member plays a role in caring for each patient with kindness, respect and empathy.

WHEREAS, the Board would like to publically acknowledge the Emergency Department staff and physicians for their work to heal and relieve the suffering of those community members who turned to our emergency rooms for compassionate care this winter.

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

Emergency Department Physicians and Staff

FOR CARING FOR OUR COMMUNITY.

IN WITNESS THEREOF, I have here unto set my hand this **14TH DAY OF MARCH, 2018.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee Chen, JD, PhD
Jeffrey Davis, MD
Neysa Fligor
Peter C. Fung, MD
Gary Kalbach
Julie Kliger, MPA, BSN
Julia E. Miller
Bob Rebitzer
David Reeder
John Zoglin

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

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ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Quality, Patient Care and Patient Experience Committee ("Quality Committee") Report El Camino Hospital Board of Directors March 14, 2018
	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 March 5, 2018 and meets next on April 2, 2018	
	Summary and session objectives: **Summary of March 5, 2018 Meeting:** 1. Patient Story: The Committee discussed a letter written by a family member of an elderly Medicare patient who spent five days at ECH on "outpatient observation" as opposed to "admitted in-patient" status. In the letter, the family member commented that the patient had not received an adequate explanation of the implications of outpatient observation status. Cheryl Reinking, RN, CNO explained that the Grievance Committee reviewed the complaint and (1) work is being done with Care Coordination team to ensure that all patients on outpatient observation status understand the implications and (2) ECH wrote off the patient's portion of the bill, which was much higher than it would have been had the patient been on admitted in-patient status. The Committee discussed the Two-Midnight Rule which, if ECH had adopted it, would have caused the patient to automatically be switched to in-patient after Two Midnights in the hospital. 2. Committee Self-Assessment: The Committee engaged in a detailed discussion of the Committee Self-Assessment and how to address gaps in performance. Comments focused on the following areas: 1) The Committee wants a deep understanding of where the organization is trying to go strategically so it can structure its meetings to connect its work back to governance. The Committee also wants to understand the thinking behind some Board decisions. 2) A desire to have less reporting out by staff and committee materials structured so that it is clear what staff wants the Committee to focus on so that the Committee can engage in dialogue that benefits the organization. 3) The Committee wants more focus on patients and families. Two ideas that surfaced were (a) for the Committee to invite members of the "re-booted" PFAC to get current patient perspectives and (b) for the Committee to revisit the "Big Dot" concept to reassess whether "Patient and Family Centered Care" should be ECH's "Big Dot" and get confirmation from the Board.	

	4) A desire to understand quality, patient safety, and patient experience considerations that go into the capital budgeting process. 5) Decreasing the number of agenda items (decrease frequency of "repeat" items) to provide more time for in depth review and dialogue. 3. FY18 Quality Dashboard: Ms. Reinking reported that ECH is generally doing well with infection prevention, but that CAUTIs remain a challenge. She explained that a policy change to requiring two staff members to insert foley catheters in female patients and a nurse driven protocol to remove them without a physician order if certain criteria are met was recently adopted. At the suggestion of the Committee, the specific results of these efforts will be brought back to the Committee for review. 4. Patient and Family Centered Care: Ms. Reinking reported on enterprise wide Inpatient HCAHPS. Ms. Reinking described efforts in place to improve Responsiveness of Hospital Staff and Communication with Nurses such as purposeful hourly rounding, leader rounding, and education about careful effective listening. 5. Clinical Documentation Improvement (CDI): Shreyas Mallur, MD, Associate CMO, reported that the CDI initiative is critical for several reasons. If all of a patient's medical conditions are not fully and accurately reported in the EHR (1) Medicare assesses the patient as less complex and our case mix index is artificially low, which affects reimbursement, (2) to the outside world, our expected mortality and expected complication rates are lower, and (3) expected length of stay is lower. Staff is working to improve physicians accepting and making changes to documentation based on clinical documentations specialists advice and recommendations. 6. Joint Commission Preparedness: Ms. Reinking described TJC's new methodology for scoring that will almost certainly result in more citations than in the past. ECH had a three day mock survey in early February and processes are in place throughout the organization to address the findings.
	Suggested discussion questions: None.
	Proposed Board motion, if any: None
	Attachment: 1. FY18 Quality Dashboard

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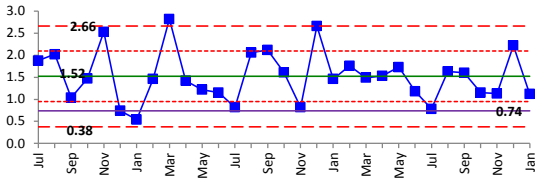
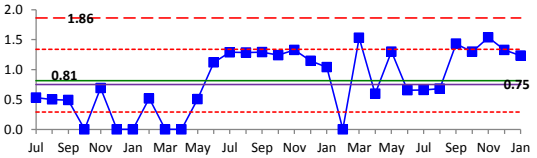
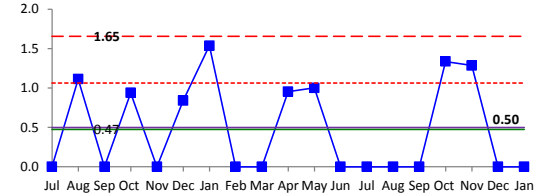
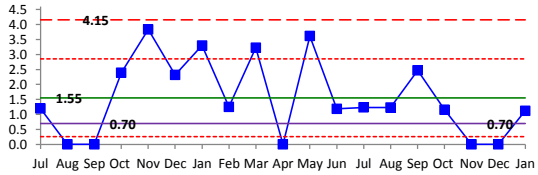
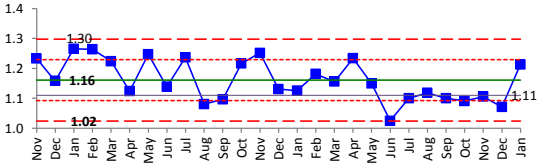
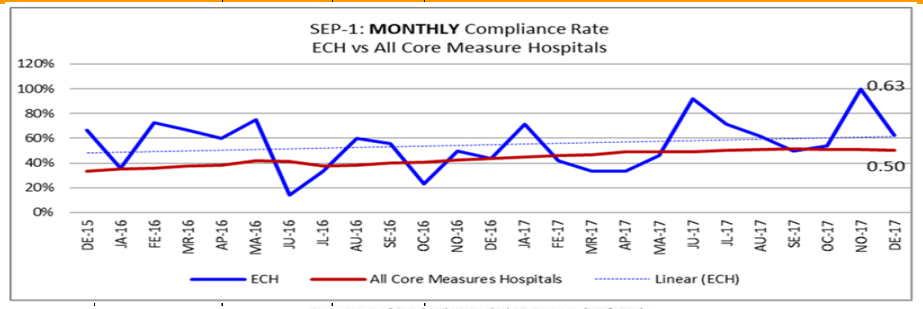
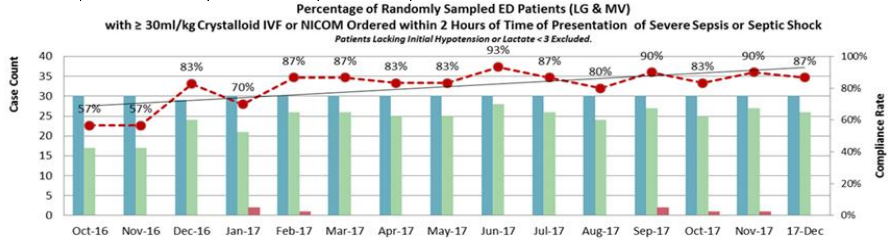
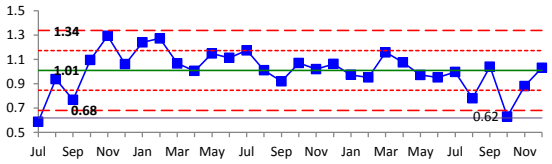
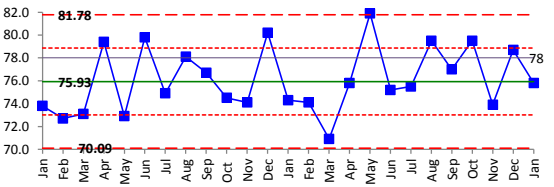
Quality and Safety Dashboard (Monthly)

Reports run: 11/20/17			Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS	Performance Month	Performance FYTD	FY2017 Actual	FY2018 Goal		
1 **Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt. Days* *Date Period: Jan 2018*	1.12 (7/6230)	1.38 (52/37587)	1.49	0.74 (Top decile CALNOC)		Falls dropped by half from 14 to 7. 1 Fall with moderate harm (stitches to scalp- neg . CT scan). RCA completed, pt with Hx of Falls, needed CNA to stay with Pt. when up. Alarms for toilet commode arrived, will allow staff to stand outside bathroom, and react when lifts off commode, affording pt. some privacy during toileting. Planning for nursing education on Hendricks Fall Risk Tool, last provided in 2013.
2 *Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: Jan 2018* *SIR Goal: <= 0.75*	1.23 (2/1,623)	1.16 (12/10358)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		3 new CAUTI's in January: 1) 102 yo female: CAUTI occurred 6 days after insertion. Pt admit with Small bowel obstruction 2) 63 yo male; CAUTI identified 16 days after Foley insertion. Patient Foley justified for output monitoring in critical patients 3) 57 y/o Female on 3AC, F/C inserted without an order. Good Bathing, F/C and Peri care. Symptoms of CAUTI started 4 days after insertion. Remaining Nursing staff assigned new modules for foley insertion, now requires 2 staff.
3 *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: Jan 2018* *SIR Goal: <= 0.50*	0.0 (0/1000)	0.32 (2/6289)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		No new CLABSI infections in December or January ! CLABSI Team adopted Central Line Mgmt. Bundle from Lippincott, All nurses will have 1:1 Peer education on CLABSI dressing changes with their patient, new CLABSI Dressing Kit developed with coaching cards. Adoption of CHG for all Central lines in all locations, dressing change to move to every 7 days (best practice).
4 *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: Jan 2018* *SIR Goal: <= 0.70*	1.12 (1/8930)	1.03 (6/58421)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		1 new C.Diff HAI in January: 63 y/o male admitted with general weakness, groin swelling. Loose stools, Pos. C.diff 6 days after admit and neg. surveillance. 10 doses of ABX, 8 doses Protonix. Hx. Of daily use of Protonix & Prilosec prior to admit.
Efficiency	Performance Month	Performance FYTD	FY17 Actual	FY 2018 Goal		
5 ★Organizational Goal **Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: Jan 2018*	1.21	1.11	1.16	1.11		Increase in LOS due to flu patients who have to stay until Tamiful tx. Complete, high volume, and several very long LOS patients discharged. ALOS up to 5.02.

Reports run: 9/20/17		Baseline	FY18 Goal	Trend	Comments
6	**Sepsis Core Measure** SEP-1 100% or O% *Date Period: Dec 2017*				Non-compliance due to: 4 cases in which ABX not given at correct time, 2 cases no crystalloid fluids given, even though pts physiology, fluids detrimental. Core measure does not recognize this.
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: Dec 2017*				Sepsis TJC Certification application submitted; 2 day survey between April - July. ED physican consistently order appropriate fluids with in 2 hrs of TOP.

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-18
Number of Sampled Cases	30	30	29	30	30	30	30	30	30	30	30	30	30	30	30
Cases with 30ml/kg or NICOM ordered within 2h TOP	17	17	24	21	26	26	25	25	28	26	24	27	25	27	26
Cases with 30ml/kg ordered or NICOM within 3h TOP	0	0	0	2	1	0	0	0	0	0	0	2	1	1	0
Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation	57%	57%	83%	70%	87%	87%	83%	83%	93%	87%	80%	90%	83%	90%	87%

Mortality		Performance Month	Performance FYTD	FY 2017	FY 2018 Goal		
8	**Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: Dec 2017*	1.03 (2.38%/2.31%)	0.90 (1.53%/1.69%)	1.02 (1.88%/1.83%)	0.62		Mortality rate slightly above expected at 1.03, with flu complicating many patients with co-morbidities. January data not availble yet in Premier Quality Advisor due to data refresh back to Nov. 2015 not complete.

SERVICE		Performance Month	Performance FYTD	FY 2017 Actual	FY 2018 Goal		
9	«Organizational Goal **HCAHPS Rate Hospital 0-10** **Top Box Rating 9 and 10** *Date Period: Jan 2018*	75.8 (191/252)	77.1(1656/1277)	76.30	78.0%		The high Jan. volume impacts this measure, as pts. were held in ED waiting for beds, and twice "internal disaster due to pt. surge" occurred. Also discharge lounge was utilized, moving pts. out of their beds before family came.

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Compliance Training El Camino Hospital Board of Directors March 14, 2018
	Responsible party:	Mary Rotunno, General Counsel; Diane Wigglesworth, Sr. Director, Corporate Compliance
	Action requested:	Information
	Background: Because of their oversight responsibilities, boards of directors have a unique opportunity to influence their health care organizations to promote quality of care and embrace compliance with the law. The Office of the Inspector General of the US Department of Health and Human Services recommends that boards receive annual compliance training to bolster an effective compliance program. This education session will focus on: 1. The fiduciary responsibilities of Directors: duty of care, duty of loyalty, and the business judgment rule 2. The most relevant compliance risks to ECH: documentation/coding, billing, physician relationships, and physician financial arrangements 3. How the Board can hold management accountable for an effective compliance program that minimizes organizational risk: consistently asking questions, encouraging a culture of accountability	
	Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
	Summary and session objectives: To conduct annual compliance training with the Board, as recommended by the OIG.	
	Suggested discussion questions: None.	
	Proposed Board motion, if any: None.	
	LIST OF ATTACHMENTS: 1. Compliance Training presentation 2. Additional Appendix OIG Report: Practical Guidance for Health Care Governing Boards on Compliance Oversight	

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Board of Directors Compliance Training

Mary Rotunno, General Counsel
Diane Wigglesworth,
Sr. Director, Corporate Compliance

March 14, 2018

Education Objectives

- Understand the fiduciary responsibilities of corporate directors as they relate to corporate compliance.
- Identify the most relevant legal parameters and compliance risks to the Company's business.
- Highlight what directors can do to hold management accountable for an effective compliance program that minimizes organizational risk.

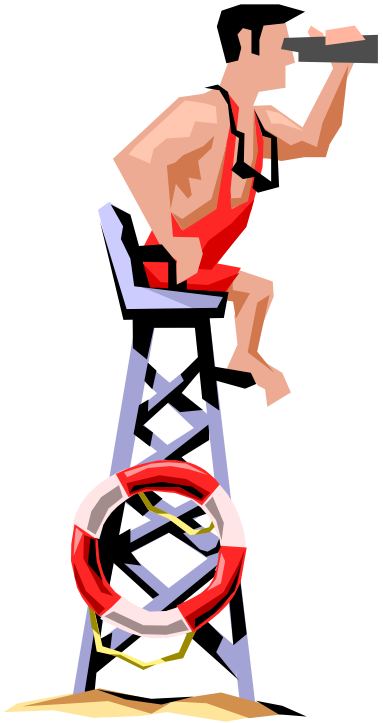
Appendix

- Fiduciary Responsibilities as a Corporate Director
- Corporate Governance Guidelines and Committee Roles
- Board Oversight of the Company Compliance Program: Key Questions to Ask of Leadership and Compliance Teams
- The Importance of Director Vigilance in Mitigating Personal and Organizational Compliance Risks
- Practical Guidance for Health Care Governing Boards on Compliance Oversight (OIG publication)

Fiduciary Responsibilities As A Corporate Director

Understand, Lead and Monitor

Corporate Leadership Responsibility



- Corporate directors have an obligation to act as fiduciaries for the organization.
- This duty includes an obligation to ***actively monitor organizational performance, processes and systems***.
- Failure to monitor organizational performance may result in liability for the corporation and corporate officers and directors.

Your Obligations

- As a Board member, you have ultimate oversight responsibility for the Company's Compliance Program.
- Fiduciary duties cannot be avoided by lack of knowledge.
- Increased funding, better use of technology, and enhanced cooperation and coordination among Government agencies have resulted in more effective and efficient enforcement.

Fiduciary Duties of Directors

- Directors have fiduciary duties to the company
- Directors' fiduciary duties are:
  - Duty of Care
  - Duty of Loyalty

Duty of Care

- Act in good faith with the care an ordinarily prudent person would exercise in similar circumstances.
- Directors must act on an informed basis after due consideration and appropriate deliberation.
- The Board may rely – so long as doing so is reasonable – on:
  - The records of the corporation; and
  - Other information presented by any person if the board reasonably believes:
    - Topics are within the competence of such persons, and
    - Such persons were selected with reasonable care.
- Board may NOT delegate basic duty of care to management or outside advisors.

Duty of Loyalty

- Directors must put the interests of the Company above any personal interests that they may have.
- Directors must disclose the existence and nature of any conflict of interest and any other facts that are material to transactions or other matters before the Board.
  - Where the Board's compliance responsibilities are concerned, this includes disclosure of information regarding potential compliance violations, even if such information might implicate an individual with whom they have a close personal or business relationship.

Overview of Director Responsibilities Under Common Law

- Act in good faith (*e.g.*, disclose any conflict of interest).
- Investigate transactions and other matters within their purview through management and advisors.
- Be satisfied on all key points.
- Ask questions if any point is not clear.
- Exercise independent judgment.

Business Judgment Rule

- State law presumes that, in making a decision, directors acted:
  - On an informed basis;
  - In good faith; and
  - With the honest belief that the action is in best interests of company.
- Courts will defer to directors unless plaintiff overcomes this presumption.
- Courts generally review the process, not the ultimate outcome.
- Where the Board's compliance oversight duties are concerned, it is essential that the Board, through its Committees receive sufficient information about the Compliance function to act on an informed basis.

Corporate Governance Guidelines and Committee Roles

Corporate Governance Guidelines

- The Board's core responsibilities include, but are not limited to, the following:
  - Select, monitor, evaluate and compensate senior management
  - Review the Company's financial controls, reporting systems and enterprise risk management program.
  - Review and monitor:
    - The Company's ethical standards and compliance with applicable healthcare laws, regulations, policies, professional standards and industry guidelines, and
    - The Company's programs, policies and procedures that support and enhance the quality of care provided by the Company
- The Board is authorized to delegate these core responsibilities to one or more Board committees.

Corporate Compliance / Privacy & Internal Audit Committee Role and Responsibilities

- It is the Committee's responsibility to assist the Board in monitoring the Company's compliance with legal and regulatory requirements, including:
  - Review the adequacy and effectiveness of the Company's internal regulatory, corporate compliance and risk management controls, and elicit recommendations for improvement.
  - Review management's response to any such recommendations.
  - Obtain and review reports regarding legal or compliance matters that may have a material effect on the Company's business, financial statements or compliance policies.
  - Review issues reported through the compliance hotline or other channels and the results of any internal investigations regarding any regulatory issues that may have a material effect on the Company's business, financial statements or compliance policies.

- It is the Committee's responsibility to assist the Board in evaluating and monitoring the Company's compliance with applicable healthcare laws, regulations, policies, professional standards and industry guidelines and the Company's Code of Conduct. Specific duties include:
  - Evaluate management's appointment, termination or replacement of the Compliance Officer.
  - Review policies and procedures designed to comply with all applicable health care laws, regulations, professional standards and industry guidelines, as well as the Company's policies and Code of Conduct.
  - Review internal systems and controls to carry out the Company's policies and procedures relating to clinical compliance matters and ethics.
  - Review the steps the Company is taking to educate its employees regarding its Code of Conduct and compliance issues.
  - Review procedures for (i) the receipt, retention and treatment of complaints received by the Company regarding compliance related matters; and (ii) the confidential, anonymous submission by employees of the Company of concerns regarding compliance and ethical issues.
  - Review issues reported through the compliance hotline or other channels and the results of any internal investigations pertaining to clinical outcomes or quality of care-related compliance issues.
  - Apprise the Board on the Company's clinical compliance and performance improvement efforts with appropriate internal and external sources.

Board Oversight of the Company Compliance Program: Key Questions to Ask of Leadership and Compliance Teams

Board Oversight Function: Duty of Inquiry

- Board oversight of the compliance function as it relates to hospital operations is mandatory. The Board, through the Compliance Committee, must ask the right questions to hold Management accountable for an effective compliance program.
- Does the Company leadership team foster a culture that values and even rewards the prevention, detection and resolution of compliance issues?
- Do compensation structures place undue pressure to pursue profit over compliance?
- Does the Company have clear policies and internal controls addressing major risk areas?

Bottom Line: Board should hold the management team accountable for setting the proper "tone at the top" and the Compliance Officer accountable for appropriate policies and internal controls to address risk areas.

Board Oversight Function: Compliance Infrastructure

- Does the Compliance Officer report directly to the Board and CEO on the "state of compliance" at the Company?
- Does the Compliance Officer ensure effective compliance, education, auditing/monitoring of risk areas, investigations and corrective actions?
- Does the Compliance Officer have sufficient authority and resources to perform his/her responsibilities effectively?
- Is there an appropriately configured compliance committee that meets on a regular basis?

Bottom Line: The Board should ensure that Compliance has adequate resources and infrastructure to effectuate an effective compliance program.

Oversight Function: Compliance Education

- Do all the Company employees complete annual compliance training?
- Is compliance training scenario-based and geared to risk areas?
- Are compliance training programs evaluated and updated to maximize effectiveness and reflect regulatory developments?
- Does the Company track attendance and have procedures for follow up with employees who have not satisfied requirements as deadlines approach?

Bottom Line: The Board should be advised of the compliance education curriculum, completion rates and evaluation results.

Board Oversight Function: Effective Lines of Communication

- Does the Company maintain multiple, well-publicized channels for reporting compliance concerns?
- Does the Company maintain and enforce a well-publicized, non-retaliation policy to encourage candid reporting?
- Are there clearly defined channels for employees to seek guidance on the legal/compliance ramifications of potential actions ***before*** they are taken?
- Are significant legal and regulatory developments monitored and communicated to the business and the Board?
- Is the Board actively engaged in discussions regarding appropriate remedies to systemic or material compliance problems?

Bottom Line: The Board should receive statistics regarding reports of suspected non-compliance through various channels and specific information about material risks confronting the Company.

Board Oversight Function: Auditing and Monitoring

- Is there a robust audit plan to test/monitor major risk areas?
- Does the Company adhere to this plan in practice?
- Are audit trends tracked, reported and appropriately addressed?
- When audits reveal issues, are appropriate corrective action plans developed and implemented?
- When audits identify overpayments, are timely reports and refunds made in accordance with regulatory/payor requirements?
- Does the Company conduct periodic compliance program effectiveness reviews?

Bottom Line: The Board should be apprised of the audit plan, audit statistics, audit trends, overpayment refunds and material/systemic risks.

Board Oversight Function: Prompt Response to Suspected Non-Compliance

- Does the Company have an appropriate investigations policy/SOP in place?
- Are reports of suspected non-compliance in fact promptly investigated?
- Does the Company have an appropriate system to log reports of suspected non-compliance, investigation steps, findings and follow up?
- When violations are identified, is a root cause analysis performed and corrective action implemented to appropriately redress issues and prevent recurrence?
- Are investigators appropriately trained and subject to competency testing?
- Are investigation results tracked and trended to identify systemic issues that may pose a material risk to the Company?

Bottom Line: The Board should receive reports with aggregated information regarding investigations and results, as well as more granular information regarding investigation outcomes that pose a material risk to the Company.

Board Oversight Function: Effective Enforcement

- Does the Company establish and disseminate disciplinary policies identifying the consequences of compliance violations?
  - Does the Company have progressive disciplinary procedures while imposing serious sanctions for serious violations and intentional or reckless noncompliance?
- Are disciplinary standards consistently applied and enforced?
- Is the executive/management team held accountable for their own compliance failures, as well as for the foreseeable failures of their subordinates?
- Are there concrete compliance performance review criteria and bonus prerequisites to drive compliance?

Bottom Line: The Board should hold the management team, HR and Compliance accountable for appropriate, consistently enforced disciplinary standards.

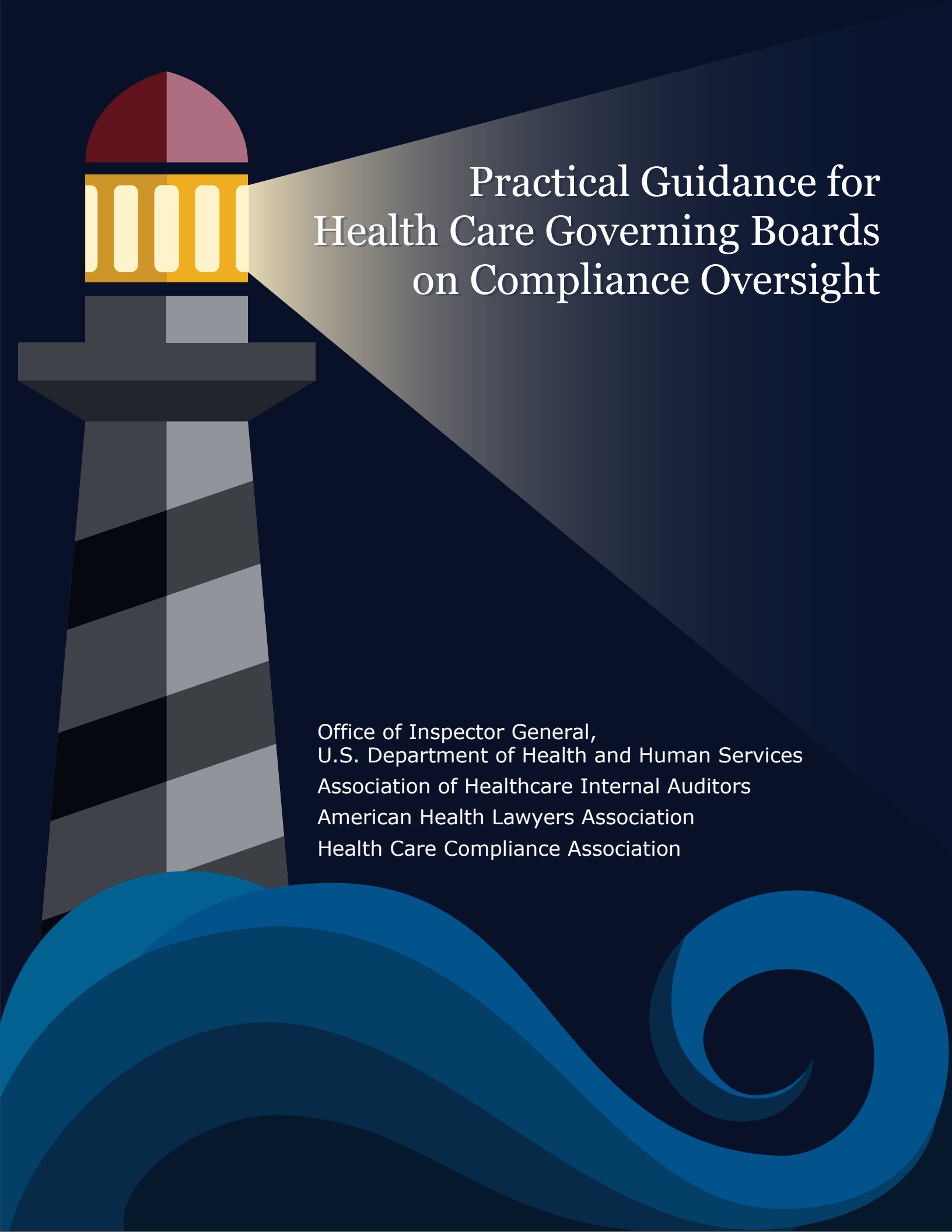
The Importance of Director Vigilance in Mitigating Personal and Organizational Compliance Risks

Corporate Leadership Responsibility

- An effective compliance program minimizes organizational and personal risks in three important ways:
  - Reduces risk that violations will occur
  - When violations do occur, ensures that appropriate corrective actions are implemented to appropriately remediate in accordance with law and prevent recurrence
  - Results in more lenient sanctions under a variety of Governmental guidance detailed later in this presentation:
    - Reduced penalties
    - Reduced risk of corporate integrity agreement ("CIA")

OIG Guidance: Importance of Culture and Leadership

- The U.S. Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") website notes that "because of their oversight responsibilities, boards of directors have a unique opportunity to promote quality of care and embrace compliance with law."
- The OIG Guidance emphasize the importance of leadership and culture:
  - "Leadership should foster an organizational culture that values, and even rewards, the prevention, detection, and resolution of quality of care and compliance problems."
  - "The organization should endeavor to develop a culture that values compliance from the top down and fosters compliance from the bottom up. Such an organizational culture is the foundation of an effective compliance program."



Practical Guidance for Health Care Governing Boards on Compliance Oversight

Office of Inspector General,
U.S. Department of Health and Human Services
Association of Healthcare Internal Auditors
American Health Lawyers Association
Health Care Compliance Association

About the Organizations

This educational resource was developed in collaboration between the Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

AHIA is an international organization dedicated to the advancement of the health care internal auditing profession. The AHLA is the Nation's largest nonpartisan, educational organization devoted to legal issues in the health care field. HCCA is a member-based, nonprofit organization serving compliance professionals throughout the health care field. OIG's mission is to protect the integrity of more than 100 HHS programs, including Medicare and Medicaid, as well as the health and welfare of program beneficiaries.

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This document is intended to assist governing boards of health care organizations (Boards) to responsibly carry out their compliance plan oversight obligations under applicable laws. This document is intended as guidance and should not be interpreted as setting any particular standards of conduct. The authors recognize that each health care entity can, and should, take the necessary steps to ensure compliance with applicable Federal, State, and local law. At the same time, the authors also recognize that there is no uniform approach to compliance. No part of this document should be taken as the opinion of, or as legal or professional advice from, any of the authors or their respective agencies or organizations.

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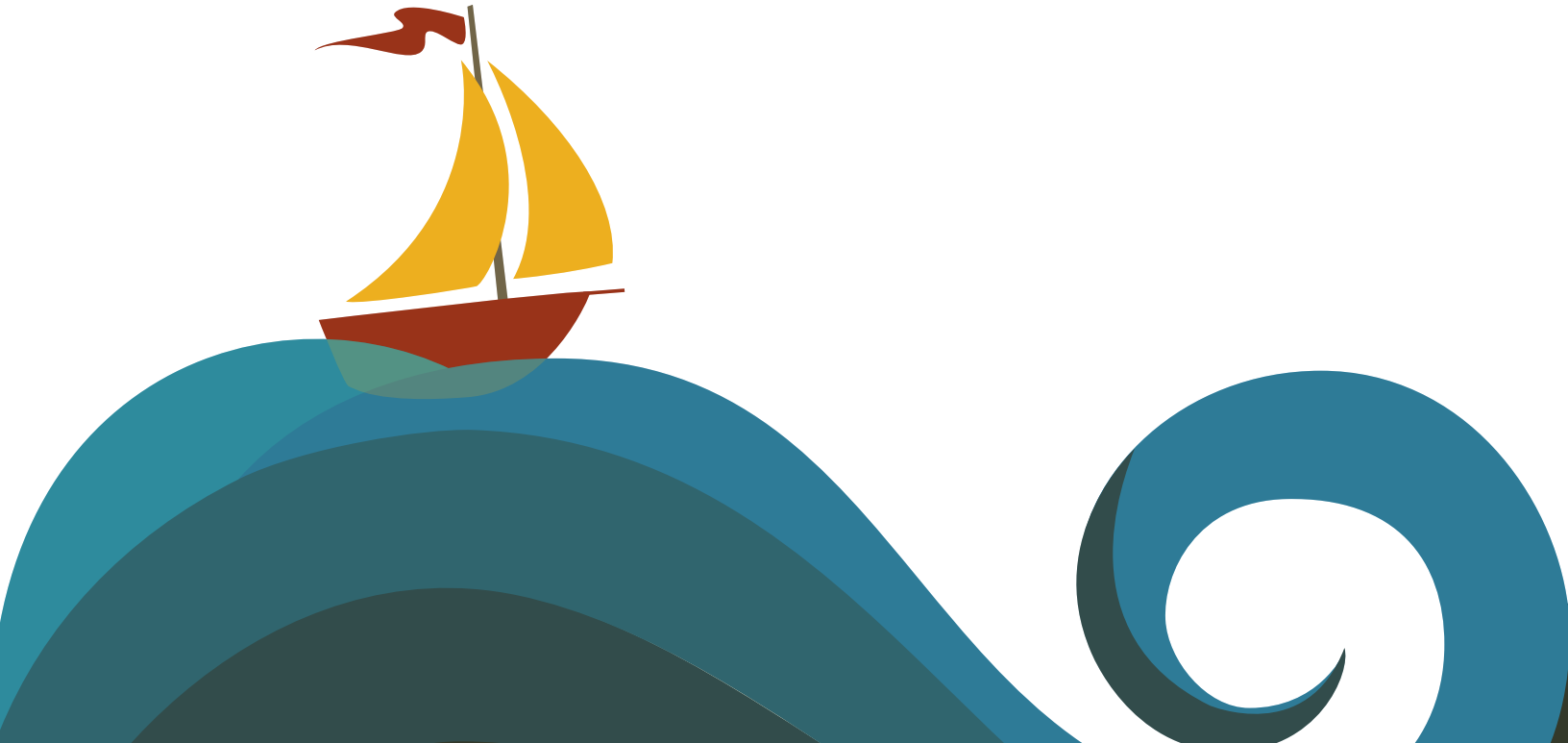

Introduction

Previous guidance[1] has consistently emphasized the need for Boards to be fully engaged in their oversight responsibility. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management. Given heightened industry and professional interest in governance and transparency issues, this document seeks to provide practical tips for Boards as they work to effectuate their oversight role of their organizations' compliance with State and Federal laws that regulate the health care industry. Specifically, this document addresses issues relating to a Board's oversight and review of compliance program functions, including the: (1) roles of, and relationships between, the organization's audit, compliance, and legal departments; (2) mechanism and process for issue-reporting within an organization; (3) approach to identifying regulatory risk; and (4) methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

A critical element of effective oversight is the process of asking the right questions....

1 OIG and AHLA, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003); OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors* (2004); and OIG and AHLA, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* (2007).

Expectations for Board Oversight of Compliance Program Functions

A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.[2] The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations. The Federal Sentencing Guidelines (Guidelines),[3] OIG's voluntary compliance program guidance documents,[4] and OIG Corporate Integrity Agreements (CIAs) can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program. The Guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program."[5] The compliance program guidance documents were developed by OIG to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. CIAs impose specific structural and reporting requirements to

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2 *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996).

3 U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf.

4 OIG, *Compliance Guidance*, https://oig.hhs.gov/compliance/compliance-guidance

5 USSG Ch. 8, Intro. Comment.

promote compliance with Federal health care program standards at entities that have resolved fraud allegations.

Basic CIA elements mirror those in the Guidelines, but a CIA also includes obligations tailored to the organization and its compliance risks. Existing CIAs may be helpful resources for Boards seeking to evaluate their organizations' compliance programs. OIG has required some settling entities, such as health systems and hospitals, to agree to Board-level requirements, including annual resolutions. These resolutions are signed by each member of the Board, or the designated Board committee, and detail the activities that have been undertaken to review and oversee the organization's compliance with Federal health care program and CIA requirements. OIG has not required this level of Board involvement in every case, but these provisions demonstrate the importance placed on Board oversight in cases OIG believes reflect serious compliance failures.

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort....

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. Ensuring that management is aware of the Guidelines, compliance program guidance, and relevant CIAs is a good first step.

One area of inquiry for Board members of health care organizations should be the scope and adequacy of the compliance program in light of the size and complexity of their organizations. The Guidelines allow for variation according to "the size of the organization."[6] In accordance with the Guidelines,

6 USSG § 8B2.1, comment. (n. 2).

OIG recognizes that the design of a compliance program will depend on the size and resources of the organization.[7] Additionally, the complexity of the organization will likely dictate the nature and magnitude of regulatory impact and thereby the nature and skill set of resources needed to manage and monitor compliance.

While smaller or less complex organizations must demonstrate the same degree of commitment to ethical conduct and compliance as larger organizations, the Government recognizes that they may meet the Guidelines requirements with less formality and fewer resources than would be expected of larger and more complex organizations.[8] Smaller organizations may meet their compliance responsibility by "using available personnel, rather than employing separate staff, to carry out the compliance and ethics program." Board members of such organizations may wish to evaluate whether the organization is "modeling its own compliance and ethics programs on existing, well-regarded compliance and ethics programs and best practices of other similar organizations."[9] The Guidelines also foresee that Boards of smaller organizations may need to become more involved in the organizations' compliance and ethics efforts than their larger counterparts.[10]

Boards should develop a formal plan to stay abreast of the ever-changing regulatory landscape and operating environment. The plan may involve periodic updates from informed staff or review of regulatory resources made available to them by staff. With an understanding of the dynamic regulatory environment, Boards will be in a position to ask more pertinent questions of management

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7 Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59436 (Oct. 5, 2000) ("The extent of implementation [of the seven components of a voluntary compliance program] will depend on the size and resources of the practice. Smaller physician practices may incorporate each of the components in a manner that best suits the practice. By contrast, larger physician practices often have the means to incorporate the components in a more systematic manner."); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289 (Mar. 16, 2000) (recognizing that smaller providers may not be able to outsource their screening process or afford to maintain a telephone hotline).

8 USSG § 8B2.1, comment. (n. 2).

9 *Id.*

10 *Id.*

and make informed strategic decisions regarding the organizations' compliance programs, including matters that relate to funding and resource allocation. For instance, new standards and reporting requirements, as required by law, may, but do not necessarily, result in increased compliance costs for an organization. Board members may also wish to take advantage of outside educational programs that provide them with opportunities to develop a better understanding of industry risks, regulatory requirements, and how effective compliance and ethics programs operate. In addition, Boards may want management to create a formal education calendar that ensures that Board members are periodically educated on the organizations' highest risks.

Finally, a Board can raise its level of substantive expertise with respect to regulatory and compliance matters by adding to the Board, or periodically consulting with, an experienced regulatory, compliance, or legal professional. The presence of a professional with health care compliance expertise on the Board sends a strong message about the organization's commitment to compliance, provides a valuable resource to other Board members, and helps the Board better fulfill its oversight obligations. Board members are generally entitled to rely on the advice of experts in fulfilling their duties.[11] OIG sometimes requires entities under a CIA to retain an expert in compliance or governance issues to assist the Board in fulfilling its responsibilities under the CIA.[12] Experts can assist Boards and management in a variety of ways, including the identification of risk areas, provision of insight into best practices in governance, or consultation on other substantive or investigative matters.

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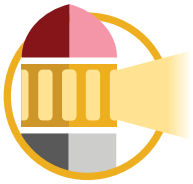
11 *See* Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

12 *See* Corporate Integrity Agreements between OIG and Halifax Hospital Medical Center and Halifax Staffing, Inc. (2014, compliance and governance); Johnson & Johnson (2013); Dallas County Hospital District d/b/a Parkland Health and Hospital System (2013, compliance and governance); Forest Laboratories, Inc. (2010); Novartis Pharmaceuticals Corporation (2010); Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2010); Synthes, Inc. (2010, compliance expert retained by Audit Committee); The University of Medicine and Dentistry of New Jersey (2009, compliance expert retained by Audit Committee); Quest Diagnostics Incorporated (2009); Amerigroup Corporation (2008); Bayer HealthCare LLC (2008); and Tenet Healthcare Corporation (2006; retained by the Quality, Compliance, and Ethics Committee of the Board).

Roles and Relationships

Organizations should define the interrelationship of the audit, compliance, and legal functions in charters or other organizational documents. The structure, reporting relationships, and interaction of these and other functions (e.g., quality, risk management, and human resources) should be included as departmental roles and responsibilities are defined. One approach is for the charters to draw functional boundaries while also setting an expectation of cooperation and collaboration among those functions. One illustration is the following, recognizing that not all entities may possess sufficient resources to support this structure:



The compliance function promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program.

The legal function advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted.

The internal audit function provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Internal audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional

Board oversight may be required. Internal audit helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Internal audit can fulfill the auditing requirements of the Guidelines.

The human resources function manages the recruiting, screening, and hiring of employees; coordinates employee benefits; and provides employee training and development opportunities.

The quality improvement function promotes consistent, safe, and high quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize risk of patient harm.

Boards should be aware of, and evaluate, the adequacy, independence,[13] and performance of different functions within an organization on a periodic basis. OIG believes an organization's Compliance Officer should neither be counsel for the provider, nor be subordinate in function or position to counsel or the legal department, in any manner.[14] While independent, an organization's counsel and compliance officer should collaborate to further the interests of the organization. OIG's position on separate compliance and legal functions reflects the independent roles and professional obligations of each function;[15]

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13 Evaluation of independence typically includes assessing whether the function has uninhibited access to the relevant Board committees, is free from organizational bias through an appropriate administrative reporting relationship, and receives fair compensation adjustments based on input from any relevant Board committee.

14 *See* OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors*, 3 (2004) (citing Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998)).

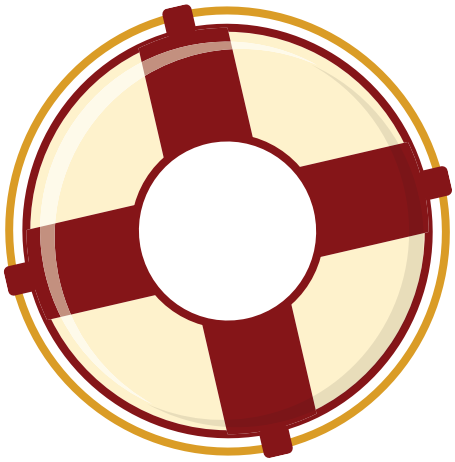
15 *See, generally, id.*

the same is true for internal audit.[16] To operate effectively, the compliance, legal, and internal audit functions should have access to appropriate and relevant corporate information and resources. As part of this effort, organizations will need to balance any existing attorney-client privilege with the goal of providing such access to key individuals who are charged with the responsibility for ensuring compliance, as well as properly reporting and remediating any violations of civil, criminal, or administrative law.

The Board should have a process to ensure appropriate access to information; this process may be set forth in a formal charter document approved by the Audit Committee of the Board or in other appropriate documents. Organizations that do not separate these functions (and some organizations may not have the resources to make this complete separation) should recognize the potential risks of such an arrangement. To partially mitigate these potential risks, organizations should provide individuals serving in multiple roles the capability to execute each function in an independent manner when necessary, including through reporting opportunities with the Board and executive management.

Boards should also evaluate and discuss how management works together to address risk, including the role of each in:

1. identifying compliance risks,
2. investigating compliance risks and avoiding duplication of effort,
3. identifying and implementing appropriate corrective actions and decision-making, and
4. communicating between the various functions throughout the process.



16 Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998) (auditing and monitoring function should "[b]e independent of physicians and line management"); Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,424 (Aug. 7, 1998) (auditing and monitoring function should "[b]e objective and independent of line management to the extent reasonably possible"); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,302 (Mar. 16, 2000).

Boards should understand how management approaches conflicts or disagreements with respect to the resolution of compliance issues and how it decides on the appropriate course of action. The audit, compliance, and legal functions should speak a common language, at least to the Board and management, with respect to governance concepts, such as accountability, risk, compliance, auditing, and monitoring. Agreeing on the adoption of certain frameworks and definitions can help to develop such a common language.

Reporting to the Board

The Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology. By engaging the leadership team and others deeper in the organization, the Board can identify who can provide relevant information about operations and operational risks. It may be helpful and productive for the Board to establish clear expectations for members of the management team and to hold them accountable for performing and informing the Board in accordance with those expectations. The Board may request the development of objective scorecards that measure how well management is executing the compliance program, mitigating risks, and implementing corrective action plans. Expectations could also include reporting information on internal and external investigations, serious issues raised in internal and external audits, hotline call activity, all allegations of material fraud or senior management misconduct, and all management exceptions to the organization's

The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts....

code of conduct and/or expense reimbursement policy. In addition, the Board should expect that management will address significant regulatory changes and enforcement events relevant to the organization's business.

Boards of health care organizations should receive compliance and risk-related information in a format sufficient to satisfy the interests or concerns of their members and to fit their capacity to review that information. Some Boards use tools such as dashboards—containing key financial, operational and compliance indicators to assess risk, performance against budgets, strategic plans, policies and procedures, or other goals and objectives—in order to strike a balance between too much and too little information. For instance, Board quality committees can work with management to create the content of the dashboards with a goal of identifying and responding to risks and improving quality of care. Boards should also consider establishing a risk-based reporting system, in which those responsible for the compliance function provide reports to the Board when certain risk-based criteria are met. The Board should be assured that there are mechanisms in place to ensure timely reporting of suspected violations and to evaluate and implement remedial measures. These tools may also be used to track and identify trends in organizational performance against corrective action plans developed in response to compliance concerns. Regular internal reviews that provide a Board with a snapshot of where the organization is, and where it may be going, in terms of compliance and quality improvement, should produce better compliance results and higher quality services.

As part of its oversight responsibilities, the Board may want to consider conducting regular "executive sessions" (i.e., excluding senior management) with leadership from the compliance, legal, internal audit, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called.

Identifying and Auditing Potential Risk Areas

Some regulatory risk areas are common to all health care providers. Compliance in health care requires monitoring of activities that are highly vulnerable to fraud or other violations. Areas of particular interest include referral relationships and arrangements, billing problems (e.g., upcoding, submitting claims for services not rendered and/or medically unnecessary services), privacy breaches, and quality-related events.

The Board should ensure that management and the Board have strong processes for identifying risk areas. Risk areas may be identified from internal or external information sources. For instance, Boards and management may identify regulatory risks from internal sources, such as employee reports to an internal compliance hotline or internal audits. External sources that may be used to identify regulatory risks might include professional organization publications, OIG-issued guidance, consultants, competitors, or news media. When failures or problems in similar organizations are publicized, Board members should ask their own management teams whether there are controls and processes in place to reduce the risk of, and to identify, similar misconduct or issues within their organizations.

The Board should ensure that management consistently reviews and audits risk areas, as well as develops, implements, and monitors corrective action plans. One of the reasonable steps an organization is expected to take

under the Guidelines is "monitoring and auditing to detect criminal conduct."[17] Audits can pinpoint potential risk factors, identify regulatory or compliance problems, or confirm the effectiveness of compliance controls. Audit results that reflect compliance issues or control deficiencies should be accompanied by corrective action plans.[18]

Recent industry trends should also be considered when designing risk assessment plans. Compliance functions tasked with monitoring new areas of risk should take into account the increasing emphasis on quality, industry consolidation, and changes in insurance coverage and reimbursement. New forms of reimbursement (e.g., value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations) lead to new incentives and compliance risks. Payment policies that align payment with quality care have placed increasing pressure to conform to recommended quality guidelines and improve quality outcomes. New payment models have also incentivized consolidation among health care providers and more employment and contractual relationships (e.g., between hospitals and physicians). In light of the fact that statutes applicable to provider-physician relationships are very broad, Boards of entities that have financial relationships with referral sources or recipients should ask how their organizations are reviewing these arrangements for compliance with the physician self-referral (Stark) and anti-kickback laws. There should also be a clear understanding between the Board and management as to how the entity will approach and implement those relationships and what level of risk is acceptable in such arrangements.

Emerging trends in the health care industry to increase transparency can present health care organizations with opportunities and risks. For example, the Government is collecting and publishing data on health outcomes and quality measures (e.g., Centers for Medicare & Medicaid Services (CMS) Quality Compare Measures), Medicare payment data are now publicly available (e.g.,

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17 *See* USSG § 8B2.1(b)(5).

18 *See* USSG § 8B2.1(c).

CMS physician payment data), and the Sunshine Rule[19] offers public access to data on payments from the pharmaceutical and device industries to physicians. Boards should consider all beneficial use of this newly available information. For example, Boards may choose to compare accessible data against organizational peers and incorporate national benchmarks when assessing organizational risk and compliance. Also, Boards of organizations that employ physicians should be cognizant of the relationships that exist between their employees and other health care entities and whether those relationships could have an impact on such matters as clinical and research decision-making. Because so much more information is becoming public, Boards may be asked significant compliance-oriented questions by various stakeholders, including patients, employees, government officials, donors, the media, and whistleblowers.

Encouraging Accountability and Compliance

Compliance is an enterprise-wide responsibility. While audit, compliance, and legal functions serve as advisors, evaluators, identifiers, and monitors of risk and compliance, it is the responsibility of the entire organization to execute the compliance program.

Compliance is an enterprise-wide responsiblity.

In an effort to support the concept that compliance is "a way of life," a Board may assess employee performance in promoting and adhering to compliance.[20] An organization may assess individual, department, or facility-level performance or consistency in executing the compliance program. These assessments can then be used to either withhold incentives or to provide bonuses

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19 *See* Sunshine Rule, 42 C.F.R. § 403.904, and CMS *Open Payments*, https://www.cms.gov/newsroom/press-releases/affordable-care-act-sunshine-rule-increases-transparency-health-care

20 Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,298-14,299 (Mar. 16, 2000).

based on compliance and quality outcomes. Some companies have made participation in annual incentive programs contingent on satisfactorily meeting annual compliance goals. Others have instituted employee and executive compensation claw-back/recoupment provisions if compliance metrics are not met. Such approaches mirror Government trends. For example, OIG is increasingly requiring certifications of compliance from managers outside the compliance department. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards have multiple incentives to build compliance programs that encourage self-identification of compliance failures and to voluntarily disclose such failures to the Government. For instance, providers enrolled in Medicare or Medicaid are required by statute to report and refund any overpayments under what is called the 60 Day Rule.[21] The 60-Day Rule requires all Medicare and Medicaid participating providers and suppliers to report and refund known overpayments within 60 days from the date the overpayment is "identified" or within 60 days of the date when any corresponding cost report is due. Failure to follow the 60-Day Rule can result in False Claims Act or civil monetary penalty liability. The final regulations, when released, should provide additional guidance and clarity as to what it means to "identify" an overpayment.[22] However, as an example, a Board would be well served by asking management about its efforts to develop policies for identifying and returning overpayments. Such an inquiry would inform the Board about how proactive the organization's compliance program may be in correcting and remediating compliance issues.

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21 42 U.S.C. § 1320a-7k.

22 Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012) (Under the proposed regulations interpreting this statutory requirement, an overpayment is "identified" when a person "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.") disregard or deliberate ignorance of the overpayment."); Medicare Program; Reporting and Returning of Overpayments; Extensions of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).

Organizations that discover a violation of law often engage in an internal analysis of the benefits and costs of disclosing—and risks of failing to disclose—such violation to OIG and/or another governmental agency. Organizations that are proactive in self-disclosing issues under OIG's Self-Disclosure Protocol realize certain benefits, such as (1) faster resolution of the case—the average OIG self-disclosure is resolved in less than one year; (2) lower payment—OIG settles most self-disclosure cases for 1.5 times damages rather than for double or treble damages and penalties available under the False Claims Act; and (3) exclusion release as part of settlement with no CIA or other compliance obligations.[23] OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations.[24] Boards should ask management how it handles the identification of probable violations of law, including voluntary self-disclosure of such issues to the Government.

As an extension of their oversight of reporting mechanisms and structures, Boards would also be well served by evaluating whether compliance systems and processes encourage effective communication across the organizations and whether employees feel confident that raising compliance concerns, questions, or complaints will result in meaningful inquiry without retaliation or retribution. Further, the Board should request and receive sufficient information to evaluate the appropriateness of management's responses to identified violations of the organization's policies or Federal or State laws.

Conclusion

A health care governing Board should make efforts to increase its knowledge of relevant and emerging regulatory risks, the role and functioning of the organization's compliance program in the face of those risks, and the flow and elevation of reporting of potential issues and problems to

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23 *See* OIG, *Self-Disclosure Information*, https://oig.hhs.gov/compliance/self-disclosure-info/

24 *See id.*, at 2 ("we believe that using the [Self-Disclosure Protocol] may mitigate potential exposure under section 1128J(d) of the Act, 42 U.S.C. 1320a-7k(d).")

senior management. A Board should also encourage a level of compliance accountability across the organization. A Board may find that not every measure addressed in this document is appropriate for its organization, but every Board is responsible for ensuring that its organization complies with relevant Federal, State, and local laws. The recommendations presented in this document are intended to assist Boards with the performance of those activities that are key to their compliance program oversight responsibilities. Ultimately, compliance efforts are necessary to protect patients and public funds, but the form and manner of such efforts will always be dependent on the organization's individual situation.

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Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, February 14, 2018
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	None
Jeffrey Davis, MD (via teleconference)		
Neysa Fligor		
Peter C. Fung, MD		
Gary Kalbach		
Julie Kliger, RN		
Julia Miller, Secretary		
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. Director Fligor joined the meeting at 5:34pm and Director Rebitzer joined the meeting at 5:37pm during Agenda Item 4: Quality Committee Report. Director Davis joined the meeting via teleconference at 5:57pm during Agenda Item 5: Advisory Committee Self-Assessments. All other Board members were present at roll call.	
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. Director Fung reported that he has a conflict with Agenda Item 26: Approval of ED On-Call Stroke & Neurology Panel. No other conflicts were reported.	
3. QUALITY COMMITTEE REPORT	Director Reeder, Chair of the Quality Committee, shared a patient story from the Committee's materials. He also highlighted the Heart & Vascular Institute's Annual Heart Forum and the recognition of the Pain Management A3 team at ECH's Employee Service Awards. He reported that the Committee received a presentation from Fabio Komlos, MD and Bart Dolmatch, MD about ECH's interventional radiology services and from Wendy Ron, a Quality Committee member, who shared her personal patient experience at ECH. He explained that currently the only unfavorable performance on the quality dashboard is for catheter-associated urinary tract infections, and described staff education efforts in this area. He also described the organization's standardized infection rates. In response to Director Zoglin's questions, Director Reeder described the addition of interventional radiology physicians to the medical staff, and noted that quality benchmarks may be discussed further during the strategic discussion in closed session.	
4. FY18 PERIOD 6 FINANCIALS	Iftikhar Hussain, CFO, reviewed the FY18 Period 6 Financials, noting that: - ECH is $34 million ahead of plan for operating margin due to $13.4 million in unusual items (IGT and PRIME funding, late charge accrual and credit balance valuations which have been corrected), and good revenue cycle operations and charge capture processes. - Inpatient volume is 5.1% ahead of budget	***FY18 Period 6 Financials approved***

	- On a volume-adjusted basis, labor expenses are at target. In response to Director Rebitzer's question, Mr. Hussain noted that the growth this year is different than in prior years due to a combination of sustainable growth from service line recruitments and newer technologies as well as a very severe flu season. **Motion:** To approve the FY18 Period 6 Financials. **Movant:** Zoglin **Second:** Reeder **Ayes:** Chen, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	
5. ADVISORY COMMITTEE SELF-ASSESSMENTS	Director Fung, Chair of the Governance Committee, and JoAnn McNutt from Nygren Consulting provided an overview of the Advisory Committee Self-Assessments and Committee Structure Survey. The Board's discussion focused on two areas: 1) improving feedback to the Advisory Committees from the Board, and 2) considering delegating authority to the Committees. Ms. McNutt and the Board discussed communication from the Board to the Committees and what form would be most useful. The Board agreed that the Board members serving on each Committee will provide verbal updates to the rest of the Committee about the Board's discussions and intent regarding Committee's recommendations. Director Zoglin requested additional information from legal counsel about what information from the Board's closed session can be shared with the Committees, and whether that discussion should be in open or closed session. Ms. McNutt encouraged the Board to purposefully use the joint Board and Committee Educational Gatherings.	***Staff to provide additional information about Reports on Board Actions***
6. EXECUTIVE COMPENSATION COMMITTEE REPORT	Bob Miller, Chair of the Executive Compensation Committee, outlined the proposed changes recommended by the Executive Compensation Committee as further detailed in the materials related to: 1. Executive Compensation Philosophy: expanding to reflect total cash compensation and total remuneration 2. Executive Base Salary Administration: allowing for more differentiation 3. Executive Performance Incentive Plan: adding a variable financial metric; modifying the weighting of individual incentive goals and using CEO discretion as a modifier In response to Director Davis' question, Mr. B. Miller explained that the budget threshold for all individual goals to receive any incentive payment will be retained in the proposed policy. He also further explained the proposed addition of a variable organizational financial goal. Director Reeder voiced his support of the combination of the individual goals and discretionary component. Director Zoglin expressed concerns about target executive compensation above the 50th percentile (up to the 75th percentile), which could result in increases for executives above the rest of the organization, including the	***Resolution 2018-02 approved***

contracted increases for union employees.

Mr. B. Miller commented that the base salary philosophy would be still be targeting the 50th percentile on average, not by individual, which would allow for differentiation based on performance and experience. He noted that executives differ because they have incentive opportunities, which are designed to reward extraordinary performance (through total cash compensation as outlined in the proposed changes).

Director Zoglin expressed concerns about what "extraordinary performance" could mean, especially with ECH's payor mix.

The Board discussed how best to motivate management to perform and how to reward excellent performance in a given year. Director Rebitzer expressed concerns about incentives drifting up over time without underlying performance driving them. Mr. B. Miller commented that if goals are designed properly, on average, there should be achievement at maximum 1 or 2 out of every ten years, and no payment 1 or 2 out of every ten years.

In response to Director Rebitzer and Director Kliger's questions, Mr. B. Miller explained that base salaries, salary ranges, target bonuses, and benefits are competitive and are analyzed by a third party every year for reasonableness. He noted that the proposed changes would allow for differentiation between executives and bonus payments above target if the organization and an individual perform well.

Motion: To approve the proposed changes to the Executive Compensation Philosophy policy.

Movant: Kalbach
Second: Fligor
Ayes: Chen, Davis, Fligor, Fung, Kalbach, Kliger, Rebitzer, Reeder
Noes: Zoglin
Abstentions: Miller
Absent: None
Recused: None

The motion passed.

Motion: To approve the proposed changes to the Executive Base Salary Administration policy.

Movant: Reeder
Second: Kalbach
Ayes: Chen, Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin
Noes: None
Abstentions: None
Absent: None
Recused: None

The motion passed.

Motion: To approve the proposed changes to Executive Performance Incentive Plan policy.

Movant: Reeder
Second: Kalbach

Director Fligor suggested that discussion be referred back to the Executive Compensation Committee to clarify the language regarding "up to the 75th

	percentile." Mary Rotunno, General Counsel, advised that the compensation philosophy was addressed in the first motion, which was already approved. In response to Chair Chen's question, she stated that Directors could change their votes before the next agenda item. In response to Director Miller's question, Mr. B. Miller described safeguards built into the philosophy and the effects on executive compensation when the organization performs poorly. **Ayes:** Chen, Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None The motion passed. After consultation with counsel, the vote was retaken on the motion to approve the proposed changes to the Executive Compensation Philosophy: **Ayes:** Chen, Davis, Fung, Kalbach, Kliger, Reeder **Noes:** Fligor, Rebitzer, Zoglin **Abstentions:** Miller **Absent:** None **Recused:** None The motion passed.	
7. PUBLIC COMMUNICATION	Director Miller reported that she received a note and a donation to the ECH Foundation from Mr. Michael Fox.	
8. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:45 pm pursuant to *Gov't Code Section 54957.2* for approval of the Minutes of the Closed Session of the Hospital Board Meeting (January 10, 2018), Minutes of the Closed Session of the Special Meeting to Conduct a Study Session of the Hospital Board (January 20, 2018) and Minutes of the Closed Session of the Executive Compensation Committee Meeting (November 9, 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 54957.6* for a conference with labor negotiator Dan Woods: Labor Negotiations Update; 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 Sections 54957* and *54957.6* for report and discussion on personnel matters: FY18 CIO Base Salary; pursuant to *Gov't Code Sections 54957* and *54957.6* for report and discussion on personnel matters: FY18 SVMD President Base Salary; pursuant to *Gov't Code Section 5496.9(d)(2)* – conference with legal counsel – pending or threatened litigation: Consider Delegation of Authority to Executive Compensation Committee; pursuant to *Health & Safety Code Section 32106(b)* for a report and discussion involving health care facility trade secrets: Marketing and Branding Education; pursuant to *Gov't Code Section 5496.9(d)(2)* – conference with legal counsel – pending or threatened litigation, *Health and Safety Code 32106(b)* for a report involving health care facility trade secrets: CEO Report on New Services and Programs and Legal Issues; pursuant to *Gov't Code Sections 54957* and *54957.6* for report and discussion on personnel matters: Proposed First Amendment to Executive Employment Agreement; pursuant to *Gov't Code Section 54957*	***Adjourned to closed session at 6:45 pm***

	for discussion and report on personnel performance matters: Executive Session. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Davis, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
9. AGENDA ITEM 20: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 9:10pm by Chair Chen. Director Davis did not attend the second open session. Agenda items 9-19 were addressed in closed session. During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (January 10, 2018), Minutes of the Closed Session of Special Meeting to Conduct a Study Session of the Hospital Board (January 20, 2018), Minutes of the Closed Session of the Executive Compensation Committee Meeting (November 9, 2017), and the Medical Staff Report by a unanimous vote in favor of all members present (Directors Chen, Davis (via teleconference), Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, and Zoglin).	
10. AGENDA ITEM 21: 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 (January 10, 2018); Minutes of the Open Session of the Special Meeting to Conduct a Study Session of the Hospital Board (January 20, 2018); Government Investigations Policy; Physician Financial Arrangements Policy; Minutes of the Open Session of the Executive Compensation Committee Meeting (November 9, 2018); PACS and Image Archive System Replacement ($2.2m); Acute Rehabilitation Agreement (LG): ED On-Call Interventional Radiology Panel (LG); ED On-Call Interventional Radiology Panel (MV); ED On-Call Urology Panel (MV); ED On-Call Urology Panel (LG); Community Benefit Grants Policy; FY18 Period 5 Financials; Appointment of Directors to Advisory Committees; Approval of Revised Board and Committee Education Policy; and the Medical Staff Report. **Movant:** Zoglin **Second:** Reeder **Ayes:** Chen, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	***Consent calendar approved***
11. AGENDA ITEM 22: APPROVAL OF FY18 CIO BASE SALARY	Chair Chen noted that Cindy Murphy, Director of Governance Services, had hard copies of the proposal available for the public. **Motion:** To approve the FY18 CIO Base Salary. **Movant:** Fligor **Second:** Kalbach **Ayes:** Chen, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None	

	Absent: Davis **Recused:** None	
12. AGENDA ITEM 23: APPROVAL OF FY18 SVMD PRESIDENT BASE SALARY	Chair Chen noted that Cindy Murphy, Director of Governance Services, had hard copies of the proposal available for the public. **Motion:** To approve the FY18 SVMD President Base Salary and the exception to the severance policy. **Movant:** Miller **Second:** Kliger **Ayes:** Chen, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	
13. AGENDA ITEM 24: CONSIDER DELEGATION OF AUTHORITY TO EXECUTIVE COMPENSATION COMMITTEE	**Motion:** To refer back to the Executive Compensation Committee further discussion regarding the delegation of authority to the Committee. **Movant:** Zoglin **Second:** Fung **Ayes:** Chen, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	
14. AGENDA ITEM 25: PROPOSED FIRST AMENDMENT TO EXECUTIVE EMPLOYMENT AGREEMENT	**Motion:** To approve the Proposed First Amendment to Executive Employment Agreement. **Movant:** Miller **Second:** Kalbach **Ayes:** Chen, Fligor, Fung, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** None	
15. AGENDA ITEM 26: APPROVAL OF ED ON-CALL STROKE & NEUROLOGY PANEL	Director Fung left the meeting. **Motion:** To approve the ED On-Call Stroke & Neurology Panel renewal. **Movant:** Kalbach **Second:** Reeder **Ayes:** Chen, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Davis **Recused:** Fung	
16. AGENDA ITEM 27: CEO REPORT	Dan Woods, CEO, highlighted current progress toward achievement of the FY18 organizational goals, the re-application for Magnet Designation, a revamped employee engagement and recognition program, and recent Town Hall meetings. He also recognized participants in the Foundation's Employee Giving Campaign and the Auxiliary's contribution of 6,300 volunteer hours in December.	
17. AGENDA ITEM 28: BOARD COMMENTS	There were no additional comments from the Board.	

18. AGENDA ITEM 29: ADJOURNMENT	**Motion**: To adjourn at 9:17pm. **Movant:** Reeder **Second:** Kalbach **Ayes:** Chen, Fligor, Kalbach, Kliger, Miller, Rebitzer, Reeder, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung, Davis **Recused:** None	***Meeting adjourned at 9:17 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

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	FY18 Community Benefit Midterm Grant Results El Camino Hospital Board of Directors March 14, 2018
	Responsible party:	Cecile Currier, VP Corporate and Community Health Services and President, CONCERN, EAP Barbara Avery, Director, Community Benefit
	Action requested:	For Information Only
	Background – FY18 Midterm Grant Results: As part of the application process, prospective grantees are required to establish relevant metrics that speak to the quality and quantity of services being provided. It is the role of Community Benefit staff to hold grantees accountable to the approved metrics and provide assistance wherever possible. The Community Benefit staff assesses performance against metric targets in the current year as well as tracking year-over-year results. There are 43 grants in the current portfolio, which is a 23% increase over FY17. New programs comprise 35% of all programs, a 114% increase from the prior year. Overall, grantees performed well against established FY18 metric targets. Of the 127 midterm metrics, a 21% increase over FY17, 87% were either met or exceeded. 31 out of 43 (72%) of grants met at least 90% of their established metrics. Targets were increased for 47% of the midterm metrics, a 42% increase over FY17. Community Benefit staff will continue to monitor and work with underperforming grants.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None	
	Summary and session objectives: To inform the Board about the FY18 Community Benefit Midterm Grant results.	
	Suggested discussion questions: None	
	Proposed board motion, if any: None	
	LIST OF ATTACHMENTS: 1. FY18 Year-over-Year Midterm Dashboard	

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Community Benefit FY18 Midterm Summary

"My family has really enjoyed the experience of learning to grow our own veggies! My main reason for joining the program was to be able to give my family a chance at more healthy choices, eating more veggies…. I have also noticed the program has had a profound impact on my neighborhood as well. The neighborhood children enjoy helping me water our garden. I've even caught one grabbing a snack of my scrumptious little cherry tomatoes! It warmed my heart!" **– Participant of Valley Verde's San Jose Garden's for Health program**

"We're so grateful for having the clinic around. It really is the only spot here. The psychiatrist here, he's the only hookup we've got to mental health services. He's helped to get a lot of us leveled out." – **Peninsula Healthcare Connection patient and formerly homeless community member**

"I am dealing with diabetes and high blood pressure issues, and the staff have always been extremely caring, attentive and thorough regarding all of my medical and other needs. Without the opportunity to stay at the Medical Respite Center, I would have to ride VTA buses all night, and probably would not have survived during the month of November. Thank you again for everyone's role in saving the lives of people on the street (like me) and for treating us with respect." **– Medical Respite patient**

"My healing began when I started coming to support groups at Next Door Solutions. I remember crying the whole time, listening to women telling their stories. At that moment, I realized I'm not alone." **– Participant, Next Door Solutions**

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Community Benefit
FY18 Midterm Summary

Grant Program & Metric Performance Summary

Grant programs **43**

New programs **15 (35%)**

Grant programs that met at least 90% of their program's midterm metrics (see column W of Dashboard)	**72%**
Total individual midterm metrics across all 43 grant programs (see column C of Dashboard)	**127**
Individual midterm metrics that achieved midterm targets (see column V of Dashboard)	**87%**
Total individual metrics that were new or revised to be more robust	**43%**
Total individual year-over-year (trending) metrics	**57%**

Individual trending midterm metric targets that:

Increased **47%**

Decreased **18%**

Remained the same **34%**

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Community Benefit
FY18 Midterm Summary

FY18 Expanded Dashboard Guide

The FY18 Expanded Annual Dashboard provides data for programs funded in FY18, FY17, and/or FY16.

Column C: All FY18 metrics

Columns D – X: 6-month and annual targets and actuals, and percent of all metrics achieved by grant

FY16 6-month target and actual (Columns D & E)

FY16 annual target and actual (Columns H & I)

FY17 6-month target and actual (Columns L & M)

FY17 annual target and actual (Columns P & Q)

FY18 6-month target and actual (Columns T & U)

FY18 annual target (Column X)

FY16, FY17 and FY18 6-month & annual percent of metrics met (Columns G, K, O , S & W)

Note: Only those with FY18 trending metrics appear on this dashboard

A dash "– " represents either 1) agency is a new FY18 partner so no metrics from prior years, or 2) new metric with no previous data

- A metric receives a "green dot" if the target was met, exceeded or within 10% of the target goal
- A metric receives a "red dot" if the target was not met in excess of 10% of the target goal

N/A There are some 6-month metric targets with "N/A" because the client/patient has not had significant exposure to the intervention in order to accurately evaluate effectiveness or because activities or surveys are not scheduled until the second half of the year

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Health Priority Area *(Column A)*	Partner *(Column B)*	Metrics *(Column C)*	FY16 6-month target *(Column D)*	FY16 6-month actual *(Column E)*		FY16 %of ALL 6-month metrics met *(Column G)*	FY16 Annual target *(Column H)*	FY16 Annual Actual *(Column I)*		FY16 % of ALL annual metrics met *(Column K)*	FY17 6-month target *(Column L)*	FY17 6-month actual *(Column M)*		FY17 % 6-month metrics met *(Column O)*	FY17 Annual Target *(Column P)*	FY17 Annual Actual *(Column Q)*		FY17 % Annual metrics met *(Column S)*	FY18 6-month target *(Column T)*	FY18 6-month actual *(Column U)*		FY18 % 6-month metrics met *(Column W)*	FY18 Annual Target *(Column X)*	Supporting Details for Variance and Trending *(Column Y)*
HEALTHY BODY	**5-2-1-0** FY18 Requested:15,000 FY18 Approved: $15,000 FY17 Approved: $20,000 FY17 Spent: $15,181 FY16 Approved: $29,500 FY16 Spent: $2,638 New Metrics: 0 of 3	Students served	3,500	4,066	●	100%	4,562	6,500	●	100%	3,700	5,300	●	100%	6,300	8,800	●	100%	4,000	4,120	●	100%	6,500	Redefined criteria for volume resulting in lower number than previous years.
		Students who report being active one or more hours per day after 5210 engagement	N/A	N/A			50%	53%	●		N/A	N/A			53%	59%	●		N/A	N/A			56%	
		Students who report the knowledge to limit sweetened beverage to 0 per day after 5210 engagement	N/A	N/A			70%	68%	●		N/A	N/A			70%	71%	●		N/A	N/A			75%	
	BAWSI Girls Program FY18 Requested: $19,200 FY18 Approved: $16,000 FY17 Approved: $16,000 F17 Spent: $16,000 FY16 Approved: $15,000 FY16 Spent: $15,000 New Metrics: 0 of 3	Youth served	55	61	●	100%	110	128	●	100%	60	65	●	100%	120	133	●	100%	60	62	●	100%	120	
		Average weekly attendance	80%	88%	●		80%	82%	●		80%	88%	●		80%	89%	●		80%	90%	●		80%	
		Focus Girls who are observed to have improved behavior or attitudes after each season	80%	100%	●		80%	100%	●		90%	85%	●		90%	93%	●		90%	83%	●		90%	
	BAWSI Rollers Program FY18 Requested: $16,300 FY18 Approved: $16,300 New Metrics: N/A	Youth served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	25	11	●	33%	25	Enrollment of special education students eligible for the program was lower this school year.
		Students who report they want to exercise more like they do at BAWSI	-	-			-	-			-	-			-	-			90%	75%	●		90%	
		Students who are observed to have improved behaviors/ attitudes including increased participation, confidence, and social behaviors.	-	-			-	-			-	-			-	-			80%	100%	●		80%	
	Breathe California FY18 Requested: $60,000 FY18 Approved: $ 50,000 FY17 Approved: $50,000 FY17 Spent: $49,994 FY16 Approved: N/A FY16 Spent: N/A New Metrics: 0 of 3	Parents, children, teachers, and care providers served through air quality assessment and asthma management training	-	-		New Partner in FY17	-	-		New Partner in FY17	80	87	●	100%	650	767	●	100%	225	296	●	33%	800	In the second year of this program, midyear targets were set higher than year 1 (FY17) when midyear targets were set conservatively while program ramped up in new locations, establishing new relationships for service delivery. Year 2 targets were based on strong performance by end of year 1 and refined program, which continues to reach a good number of children.
		Trained parents, teachers, and childcare providers who gain at least a 35% increase in knowledge of asthma management, environmental triggers and remediation steps.	-	-			-	-			55%	70%	●		55%	58%	●		60%	40%	●		60%	Agency experienced challenges with survey methods, primarily incomplete surveys and parents having a higher baseline knowledge of asthma than anticipated leaving less room for improvement. Agency is revising survey tools to correct these issues.
		Parents reporting their children gained at least a 30% increase in knowledge/skills after receiving multi-session education	-	-			-	-			45%	83%	●		45%	72%	●		50%	30%	●		50%	
	Cambrian School District School Nurse Program FY18 Requested: $116,315 FY18 Awarded: $116,315 New Metrics: N/A	Students served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	805	1,268	●	50%	2,110	
		Students who have failed health screenings who saw a healthcare provider	-	-			-	-			-	-			-	-			20%	0%	●		40%	All screenings completed, followed-ups started in second half of year. Forecasting challenges as this is the first year the school has had a nurse.
		School staff who received CPR/AED training during Staff Development Days and who reported increased knowledge and confidence in the ability to perform CPR and use of an AED	-	-			-	-			-	-			-	-			10%	9%	●		30%	
		Teachers/staff at target schools that receive training on severe allergies, anaphylaxis, and EpiPen usage	-	-			-	-			-	-			-	-			15%	10%	●		30%	Training to be completed in the second half of the school year.
	Campbell Union School District School Nurse Program FY18 Requested: $225,000 FY18 Approved: $ 225,000 FY17 Approved: $215,000 FY17 Spent: $215,000 FY16 Approved: $225,000 FY16 Spent: $225,000 New Metrics: 1 of 5	Students served	2,051	2,380	●	100%	4,102	4,512	●	80%	2,060	2,073	●	100%	3,924	3,942	●	80%	2,060	1,883	●	66%	4,560	
		Uninsured students who have applied for healthcare insurance	30%	46%	●		65%	73%	●		35%	38%	●		70%	64%	●		35%	61%	●		70%	
		Students with a failed health screening who saw a healthcare provider	20%	18%	●		70%	76%	●		20%	45%	●		72%	75%	●		40%	33%	●		72%	
		Students identified as needing urgent dental care through on-site screenings who saw a dentist	N/A	N/A			80%	81%	●		N/A	N/A			80%	68%	●		N/A	N/A			60%	
		Rosemary and Lynhaven students who receive fluoride varnish during onsite screenings	-	-			-	-			-	-			-	-			N/A	N/A			20%	
	Challenge Diabetes Program FY18 Requested: $192,290 FY18 Approved: $ 192,290 FY17 Approved: $200,922 FY17 Spent: $200,922 FY16 Approved: $168,953 FY16 Spent: $113,731 New Metrics: 4 of 6	Clients served in the program	300	458	●	100%	300	458	●	100%	375	542	●	100%	375	542	●	100%	420	520	●	100%	520	Program Coordinator expanded outreach and programming in multiple languages which has helped to retain clients from prior years.
		Clients post-screened for HbA1c	N/A	N/A			300	358	●		N/A	N/A			250	405	●		N/A	N/A			360	
		Participants who experience at least a 0.10 percentage point decrease in HbA1c	-	-			-	-			-	-			-	-			N/A	N/A			25%	
		Participants who improve by at least 1-point on the self-efficacy scale	-	-			-	-			-	-			-	-			N/A	N/A			30%	
		Participants who report at least 15 – 30 minutes of physical activity at least 4 – 5 times a week	-	-			-	-			-	-			-	-			N/A	N/A			75%	
		Participants who score at least 70% on survey about diabetes risk and prevention	-	-			-	-			-	-			-	-			N/A	N/A			68%	

Community Benefit Dashboard Notes

● A metric receives a "green" dot if the target was met, exceeded or within 10% of the target goal

● A metric receives a "red" dot if the target was not met by an excess of 10% of the target goal

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	Cristo Rey Network FY18 Requested: $32,076 FY18 Approved: $10,000 FY17 Approved: $27,402 FY17 Spent: $26,102 FY16 Approved: N/A FY16 Spent: N/A New Metrics: 0 of 3	Students served	-	-		New Partner in FY17	-	-		New Partner in FY17	82	82	●	100%	82	82	●	100%	19	18	●	100%	25	
		Physical activity sessions provided	-	-			-	-			656	809	●		1,610	1,635	●		17	23	●		46	
		Students who show improved Body Mass Index per scoring in the healthy range of 14-23	-	-			-	-			50%	53%	●		70%	73%	●		26%	56%	●		35%	
	Cupertino Union School District FY18 Requested: $72,481 FY18 Approved: $ 72,481 FY17 Approved: $68,997 FY17 Spent: $68,997 FY16 Approved: $103,233 FY16 Spent: $103,233 New metrics: 0 of 4	Students served	1,000	1,088	●	100%	2,200	2,225	●	100%	554	538	●	100%	1,482	1,411	●	100%	550	597	●	100%	1,211	Trending on this metric not applicable; school district requested changes in the schools served by grant to reflect the shifting needs.
		Students who failed a mandated health screening who saw a healthcare provider	35%	50%	●		80%	77%	●		40%	71%	●		75%	84%	●		60%	67%	●		82%	
		Kindergarteners identified as needing early intervention or urgent dental care through on-site screenings who saw a dentist	N/A	N/A			55%	81%	●		N/A	N/A			75%	86%	●		N/A	N/A			80%	
		Teachers/staff at target schools that receive training on severe allergies, anaphylaxis, and EpiPen usage	-	-			-	-			50%	87%	●		75%	87%	●		75%	96%	●		80%	Trainings occur during staff meetings; due to the hire of many new teachers, there were more staff meetings at the beginning of the year. Additionally, although the training is voluntary, more staff want to learn how to respond to students' needs.
	Gardner Family Health Network FY18 Requested: $214,140 FY18 Approved: $ 185,000 FY17 Approved: $180,000 FY17 Spent: $180,000 FY16 Approved: $160,600 FY16 Spent: $149,229 New Metrics: 0 of 4	Patients served	600	86	●	25%	600	513	●	40%	250	664	●	100%	600	1,341	●	100%	500	956	●	100%	1,000	This two-year old program struggled at the beginning but has continued to develop and refine programming. There is tremendous support for the program due to the epidemic diabetes burden among the population served. Redefined criteria for volume to include pre-diabetic patients, resulting in a higher than anticipated performance.
		Services provided, including patient visits with a Registered Dietitian and/or Wellness Coordinator	1,600	162	●		1,800	1,878	●		750	995	●		1,800	2,762	●		700	1,030	●		2,100	
		Patients demonstrating a reduction in body weight	N/A	N/A			50%	25%	●		15%	55%	●		30%	60%	●		50%	49%	●		50%	
		Patients demonstrating a reduction in HbA1c levels	N/A	N/A			50%	25%	●		15%	51%	●		30%	47%	●		45%	71%	●		45%	Program was able to retain patients from the prior year who successfully decreased their HbA1c levels.
	GoNoodle FY18 Requested: $110,000 FY18 Approved: $ 110,000 FY17 Approved: $110,000 FY17 Spent:$110,000 FY16 Approved: $74,000 FY16 Spent: $74,000 New Metrics: 0 of 4	Schools served	184	184	●	100%	184	184	●	100%	183	183	●	100%	183	183	●	100%	183	236	●	50%	183	Middle School teachers are now accessing GoNoodle along with the SCC County Office of Education.
		GoNoodle physical activity breaks played	45,000	98,929	●		90,000	227,697	●		100,000	161,211	●		200,000	299,311	●		150,000	130,973	●		275,000	Target based on previous year when many new programs were released. Go Noodle expects to meet annual target.
		Teachers who believe GoNoodle benefits their students' focus and attention in the classroom	N/A	N/A			80%	96%	●		N/A	N/A			90%	96%	●		N/A	N/A			92%	
		Teachers who agree that GoNoodle Plus physical activity breaks are a valuable resource in helping their students succeed in core subjects	N/A	N/A			80%	98%	●		N/A	N/A			90%	90%	●		N/A	N/A			92%	
	Healthier Kids Foundation DentalFirst Program FY18 Requested: $20,000 FY18 Approved: $20,000 New Metrics: N/A	Children screened (ages 6 months to 18 years old)	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	225	218	●	100%	450	
		Of those who received a referral, the percent that received dental treatment	-	-			-	-			-	-			-	-			55%	74%	●		55%	At the midyear, about half of the dental cases are still open and case mangers are still working with the families. For dental, the cases that are the first to close are the cases in which the child received minor treatment quickly. At the end of the fiscal year, there will be a more representative depiction of what happened with all cases because the majority of cases will be closed at that time.
	Indian Health Center FY18 Requested: $70,000 FY18 Approved: $70,000 New Metrics: N/A	Individuals served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	60	122	●	100%	160	Outreach efforts and referrals were more effective than anticipated. Forecasting was a challenge for this new program.
		Services provided	-	-			-	-			-	-			-	-			676	652	●		1,510	
		Participants who decrease their BMI percentile	-	-			-	-			-	-			-	-			10%	32%	●		20%	Staff worked to ensure patients were very engaged and motivated to make this change.
		Participants who are diagnosed with pre-diabetes or diabetes that decrease their HbA1c by at least 0.1 percentage points	-	-			-	-			-	-			-	-			30%	83%	●		70%	Nearly all of the patients in the program were able to lower their HbA1c but because the number of cohort participants was small the percentage achieved is quite large.
	Medical Respite FY18 Requested: $13,500 FY18 Approved: $13,500 FY17 Approved: $13,500 FY17 Spent: $13,500 FY16 Approved: $13,500 FY16 Spent: $13,500 New Metrics: 0 of 3	Patients served	70	71	●	100%	145	250	●	100%	70	111	●	100%	145	221	●	100%	100	134	●	100%	200	Decreased length of stay freed up more beds for new admissions.
		Program patients linked to Primary Care home	92%	93%	●		92%	87%	●		92%	91%	●		92%	90%	●		92%	90%	●		92%	
		Hospital days avoided for total program	250	260	●		530	1,025	●		275	444	●		550	884	●		400	536	●		800	Increase in the number of patients served resulted in more hospital days avoided.
	Playworks FY18 Requested: $112,000 FY18 Approved: $112,000 FY17 Approved: $110,000 FY17 Spent: $110,000 FY16 Approved: $105,000 FY16 Spent: $105,000 New Metrics: 3 of 4	Students served	2,305	2,333	●	100%	2,305	2,325	●	100%	2,710	2,690	●	100%	2,710	2,690	●	100%	2,326	2,696	●	100%	2,326	
		School staff that report Playworks helps teach students cooperation and respect	-	-			-	-			-	-			-	-			N/A	N/A			90%	Organization developed new national metrics.
		Teachers reporting that overall student engagement increased use of positive language, attentiveness and participation in class	-	-			-	-			-	-			-	-			N/A	N/A			75%	
		Teachers/administrators reporting that Playworks positively impacts school climate																					90%	

HEALTHY BODY

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	SCCOE: Early Head Start FY18 Requested: $278,037 FY18 Approved: $ 40,000 FY17 Approved: $40,000 FY17 Spent: $40,000 FY16 Approved: $80,724 FY16 Spent: $69,956 New Metrics: 0 of 4	Individuals served	88	88	●	100%	88	88	●	100%	38	33	●	75%	38	38	●	100%	33	33	●	100%	38	
		Services provided	370	375	●		500	519	●		360	327	●		564	564	●		327	341	●		564	
		Children meeting the Child Health and Disabilities Prevention periodicity schedule on time as required by age	80%	78%	●		95%	97%	●		80%	80%	●		95%	95%	●		80%	80%	●		95%	
		Children who are not up to date on recommended procedures who come under medical care	50%	54%	●		90%	91%	●		50%	50%	●		90%	100%	●		50%	50%	●		90%	
	Vision to Learn FY18 Requested: $47,164 FY18 Approved: $47,164 FY17 Approved: $34,226 FY17 Spent: $15,510 FY16 Approved: N/A FY16 Spent: N/A New Metrics: 0 of 2	Free eye exams provided	-	-		New Partner in FY17	-	-		New Partner in FY17	100	95	●	100%	441	195	●	0%	100	49	●	0%	616	Agency has exceeded 6-month metrics for the District grant. For this grant, screenings are scheduled in Campbell Union School District for winter/spring. Scheduling in-process for other school districts.
		Free eyeglasses provided	-	-			-	-			100	91	●		353	180	●		80	43	●		490	
	AACI - Healthy IDEAS FY18 Requested: $40,000 FY18 Approved: $40,000 FY17 Approved: $50,000 FY17 Spent: $50,000 FY16 Approved: $50,000 FY16 Spent: $50,000 New Metrics: 0 of 4	Seniors screened for depression	75	124	●	100%	150	203	●	80%	75	77	●	100%	150	158	●	100%	75	80	●	100%	150	
		Participants who enroll in the Healthy IDEAS program	20	38	●		40	71	●		20	36	●		40	53	●		20	28	●		40	
		Healthy IDEAS services provided	195	314	●		390	470	●		195	252	●		390	465	●		195	178	●		390	
		Participants who demonstrate at least a one-point decrease in score on Geriatric Depression Scale	N/A	N/A			85%	74%	●		N/A	N/A			85%	90%	●		85%	78%	●		85%	
	Almaden Valley Counseling Services FY18 Requested: $73,755 FY18 Approved: $46,000 FY17 Approved: $43,457 FY17 Spent: $43,457 FY16 Approved: N/A FY16 Spent: N/A New Metrics: 0 of 4	Students served	-	-		New Partner in FY17	-	-		New Partner in FY17	100	126	●	100%	290	187	●	75%	100	62	●	50%	270	The program has focused on addressing the immediate needs of students in crisis, delaying the formation of group sessions. Agency expects to meet annual targets.
		Counseling sessions provided	-	-			-	-			600	756	●		2,030	2,711	●		600	550	●		2,100	
		Students who show an increase in at least 50% of the 7 relevant External Developmental Assets for their age group	-	-			-	-			N/A	N/A			70%	90%	●		N/A	N/A			80%	
		Teachers of the elementary school youth who state that the child shows an improved attitude in school	-	-			-	-			N/A	N/A			70%	90%	●		N/A	N/A			80%	
	Alum Rock Counseling Center FY18 Requested: $30,000 FY18 Awarded: $20,000 New Metrics: N/A	Youth served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	10	10	●	100%	10	
		Services provided	-	-			-	-			-	-			-	-			203	280	●		628	
		Students who will report not drinking alcohol, smoking cigarettes, or using drugs in the previous 30 days	-	-			-	-			-	-			-	-			75%	100%	●		90%	
	Bill Wilson Center FY18 Requested: $25,000 FY18 Awarded: $25,000 New Metrics: N/A	Youth served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	6	6	●	100%	12	
		Services provided	-	-			-	-			-	-			-	-			70	81	●		140	
		Clients who report demonstrating improvement in their coping skills	-	-			-	-			-	-			-	-			75%	100%	●		75%	
	Cambrian School District Mental Health Counseling Program FY18 Requested: $103,685 FY18 Awarded: $103,685 New Metrics: N/A	Students served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	40	55	●	50%	110	
		Services provided	-	-			-	-			-	-			-	-			128	95	●		323	Forming groups was challenging during first half of the year, which was the category of services lowering the total. Projections may have been too high for the first year of this grant program. However, the school district anticipates forming more group sessions during the second half of the year.
		Students who improved by at least 3 points from pre-test (at the beginning of counseling services) to post-test (prior to termination of services) on the Strength and Difficulties Questionnaire and Impact Assessment based on teacher report (for students age 10 and under)	-	-			-	-			-	-			-	-			N/A	N/A			50%	
		Students who improved by at least 3 points from pre-test (at the beginning of counseling services) to post-test (prior to termination of services) on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report (for students age 11-17)	-	-			-	-			-	-			-	-			N/A	N/A			50%	

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HEALTHY MIND	**Child Advocates of Silicon Valley** FY18 Requested: $25,000 FY18 Awarded: $25,000 New Metrics: N/A	Foster children served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	107	157	●	100%	137	The number of foster children aged 11 - 18 needing services was higher than anticipated.
		New volunteer Court Appointed Special Advocates (CASAs)	-	-			-	-			-	-			-	-			35	54	●		76	Agency recruited a higher number of Advocates from one of the Fall trainings than anticipated.
		CASA high school seniors who earn their diploma or equivalent	-	-			-	-			-	-			-	-			N/A	N/A			80%	
	Cupertino Union School District FY18 Requested: $123,000 FY18 Approved: $123,000 FY17 Approved: $105,000 FY17 Spent: $105,000 FY16 Approved: $100,000 FY16 Spent: $100,000 New Metrics: 1 of 5	Students served	80	93	●	100%	170	133	●	75%	80	73	●	100%	170	143	●	50%	92	88	●	100%	2,000	
		Services provided	750	780	●		2,300	2,282	●		750	832	●		2,300	2,176	●		-	-			-	Between FY17 and FY18, school mental health programs transitioned to a consistent measure of services by hours.
		Service hours provided	-	-			-	-			-	-			-	-			751	1,371	●		2,000	This is a new, shared metric with other school-based mental health programs making it difficult to forecast. For example, program provided more case management hours than anticipated.
		Students who improved by at least 3 points from pre-test (at the beginning of counseling services) to post-test (prior to termination of services) on the Strength and Difficulties Questionnaire and Impact Assessment based on teacher report (for students age 10 and under)	-	-			-	-			-	-			-	-			N/A	N/A			50%	
		Students who improved by at least 3 points from pre-test (at the beginning of counseling services) to post-test (prior to termination of services) on the Strength and Difficulties Questionnaire and Impact Assessment based on self-report (for students age 11-17)	-	-			-	-			-	-			-	-			N/A	N/A			50%	
		Students who improve on treatment plan goals by 20% in 6 months and 50% by the end of the school year as measured by counselor report	60%	59%	●		90%	85%	●		60%	63%	●		90%	73%	●		60%	66%	●		90%	
	Hope Services FY18 Requested: $37,739 FY18 Approved: $25,000 New Metrics: N/A	Individuals served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	6	6	●	66%	22	
		Services provided	-	-			-	-			-	-			-	-			40	39	●		175	
		Counselees who report a 15% improvement in quantity and quality of sleep after at least 6 sessions.	-	-			-	-			-	-			-	-			25%	16%	●		40%	
	Momentum for Mental Health FY18 Requested: $26,000 FY18 Approved: $26,000 FY17 Approved: $26,000 FY17 Spent: $26,000 FY16 Approved: $26,000 FY16 Spent: $26,000 New Metrics: 0 of 3	Patients served	16	15	●	100%	22	23	●	100%	16	17	●	100%	22	22	●	100%	16	23	●	100%	22	There were more patients with greater need than anticipated. Majority of these are continuing from previous year.
		Services provided	90	97	●		180	190	●		90	191	●		180	331	●		90	349	●		180	Greater number of clients in crisis. Counseling sessions needed to be extended and more patients required more services.
		Patients who avoid psychiatric hospitalization for 12 months after admission after beginning services with Momentum	90%	100%	●		90%	100%	●		95%	100%	●		95%	100%	●		97%	100%	●		97%	
	Peninsula HealthCare Connection FY18 Requested: $90,000 FY18 Approved: $90,000 FY17 Approved: $90,000 FY17 Spent: $90,000 FY16 Approved: $80,202 FY16 Spent: $80,202 New Metrics: 0 of 4	Patients served	75	121	●	100%	150	367	●	100%	85	103	●	100%	170	325	●	100%	100	95	●	100%	200	
		Visits including psychiatry, therapy, and case management	260	321	●		520	581	●		275	281	●		550	532	●		322	293	●		645	
		Actively managed patients who obtain permanent housing	6	9	●		12	13	●		6	8	●		12	11	●		7	7	●		14	
		Psychiatric patients not hospitalized in a 12 month period	85%	89%	●		85%	87%	●		85%	97%	●		85%	91%	●		85%	87%	●		85%	
HEALTHY MIND	**Uplift** *(formerly EMQ)* FY18 Requested: $230,000 FY18 Approved: $230,000 FY17 Approved: $230,000 FY17 Spent: $230,000 FY16 Approved: $150,000 FY16 Spent: $150,000 New Metrics: 5 of 8	Students served with individual and/or group counseling and classroom presentations	900	1,224	●	100%	2,415	2,621	●	100%	1,200	1,034	●	60%	3,000	2,745	●	100%	1,125	1,064	●	100%	2,900	
		Service hours provided																	1,040	960	●		2,290	
		Services provided	1,100	990	●		2,975	3,121	●		1,500	1,231	●		3,500	3,211	●		-	-			-	
		Youth participating in classroom presentations who show an increase in knowledge which may improve behaviors related to high risk activities	-	-			-	-			85%	87%	●		85%	86%	●		85%	77%	●		85%	
		Parents/caregivers who show an increase in knowledge of the topics presented and a better understanding of how to access services for youth	95%	95%	●		95%	95%	●		95%	95%	●		95%	96%	●		95%	95%	●		95%	
		Students who reduce high risk behaviors by at least 25%	-	-			-	-			-	-			-	-			5%	90%	●		65%	
		Students who decrease exposure to violence by at least 25%	-	-			-	-			-	-			-	-			5%	100%	●		65%	
		Students who increase their use of coping skills for trauma, depression, anxiety and/or anger by at least 25%	-	-			-	-			-	-			-	-			18%	92%	●		75%	
		Students who decrease their suicidal thoughts and feelings by at least 25%	-	-			-	-			-	-			-	-			18%	100%	●		75%	

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HEALTHY COMMUNITY	**Cancer CAREpoint** FY18 Requested: $25,310 FY18 Approved: $22,000 FY17 Approved: $20,000 FY17 Spent: $20,000 FY16 Approved: N/A FY16 Spent: N/A FY16 Approved: N/A FY16 Spent: N/A New Metrics: 0 of 3	Individuals served	-	-		New Partner in FY17	-	-		New Partner in FY17	50	151	●	100%	130	419	●	100%	150	152	●	100%	400	
		Nutrition class services provided	-	-			-	-			440	465	●		900	1,380	●		648	644	●		1,296	
		Participants who report at least a moderate increase in understanding how nutrition may affect cancer treatments and medications	-	-			-	-			50%	94%	●		50%	91%	●		90%	93%	●		90%	
	Chinese Health Initiative FY 18 Requested: $30,000 FY18 Approved: $30,000 FY17 Approved: $30,000 FY17 Spent: $30,000 FY16 Approved: $30,000 FY16 Spent: $30,000 New Metrics: 0 of 3	Individuals served	60	80	●	67%	125	216	●	100%	60	65	●	100%	125	145	●	100%	75	80	●	100%	150	
		Services provided	125	100	●		250	272	●		125	120	●		250	315	●		150	135	●		300	
		Participants who strongly agree or agree that the program's health education or screening helps them better manage their health	N/A	N/A			85%	96%	●		N/A	N/A			85%	86%	●		N/A	N/A			90%	
	Health Library Resource Center, Los Gatos FY18 Requested: $69,702 FY18 Approved: $69,702 FY17 Approved: $63,672 FY17 Spent: $63,672 FY16 Approved: $63,672 FY16 Spent: $63,672 New Metrics: 1 of 3	Individuals served	700	762	●	100%	1,400	1,363	●	100%	702	664	●	100%	1,404	1,270	●	100%	708	680	●	100%	1,416	
		Individuals who strongly agree or agree that eldercare referrals appropriate to their needs	N/A	N/A			95%	100%	●		N/A	N/A			96%	87%	●		N/A	N/A			95%	
		Community members who strongly agree or agree that eldercare referrals are appropriate to my needs	-	-			-	-			-	-			-	-			N/A	N/A			95%	
	Latinas Contra Cancer FY18 Requested: $44,638 FY18 Approved: $44,000 New Metrics: N/A	Community members educated about breast cancer, screening and prevention	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	60	37	●	66%	150	Agency experienced scheduling challenges but expects to meet annual target.
		Participants who receive a Clinical Breast Exam	-	-			-	-			-	-			-	-			13%	88%	●		80%	
		Participants who receive a mammogram	-	-			-	-			-	-			-	-			13%	60%	●		80%	
	Next Door Solutions FY 18 Requested: $75,000 FY18 Approved: $75,000 FY17 Approved: $75,000 FY17 Spent: $75,000 FY16 Approved: $50,000 FY16 Spent: $50,000 New Metrics: 1 of 4	Adults served through the Comprehensive Services For Victims of Domestic Violence Program	-	-		80%	-	-		100%	-	-		100%	-	-		100%	77	126	●	100%	154	Program saw significant increase in demand for walk-in crisis counseling, particularly legal services. The continuing rise in cost of housing has also influenced more people coming for services.
		Adults served through the FY16 Support Group and Crisis Support Program	700	1,215	●		1,300	1,988	●		170	191	●	100%	340	344	●		-	-			-	
		Services provided	-	-			-	-			833	779	●		1,665	1,623	●		564	819	●		1,133	
		Surveyed participants who report that they have gained at least one strategy to increase their safety or their children's safety	67%	98%	●		67%	97%	●		65%	95%	●	100%	65%	92%	●		80%	93%	●		80%	
		Clients newly engaged in Self-Sufficiency Case Management who will complete a risk assessment, safety planning, and a self-sufficiency action plan	-	-			-	-			50%	50%	●		50%	56%	●		50%	48%	●		50%	
	Prediabetes Initiative (Hill and Company) FY18 Requested: $207,288 FY18 Approved: $150,000 FY17 Approved: $204,596 FY17 Spent: $204,596 FY16 Approved: N/A FY16 Spent: N/A New Metrics: 1 of 5	Community members reached through Promotores outreach program	-	-		New Partner in FY17	-	-		New Partner in FY17	1,500	3,468	●	67%	3,000	5,754	●	100%	1,000	1,414	●	100%	2,500	
		Pre-diabetes outreach events	-	-			-	-			50	119	●		185	211	●		75	106	●		136	
		CDC Risk-Assessments Administered	-	-			-	-			900	2,993	●		3,000	4,535	●		800	1,134	●		2,000	
		Text messages delivered	-	-			-	-			-	-			-	-			1,000	9,717	●		3,500	A portion of these text messages are instructional for interactive responses on behavior change.
		Impressions through culturally relevant radio ads	-	-			-	-			195,600	92,000	●		391,200	460,000	●		359,000	338,200	●			
	Racing Hearts FY18 Requested: $25,000 FY18 Approved: $25,000 FY17 Approved: $25,000 FY17 Spent: $25,000 FY16 Approved: N/A FY16 Spent: N/A New Metrics: 0 of 3	School Districts served	-	-		New Partner in FY17	-	-		New Partner in FY17	5	11	●	100%	10	13	●	100%	31	31	●	100%	31	The County Sheriff program, which deploys AEDs in Sheriff vehicles, was completed in the first half of the grant year.
		AEDs placed	-	-			-	-			100	214	●		200	373	●		100	186	●		200	
		Teachers and/or staff who attend an AED orientation will report knowing 3+ steps to do when an AED is needed.	-	-			-	-			60%	92%	●		80%	94%	●		85%	88%	●		85%	

Community Benefit Dashboard Notes

● A metric receives a "green" dot if the target was met, exceeded or within 10% of the target goal

● A metric receives a "red" dot if the target was not met by an excess of 10% of the target goal

N/A There are some 6-month metric targets with "N/A" because the client/patient has not had significant exposure to the intervention in order to accurately evaluate effectiveness or because activities or surveys are not scheduled until the second half of the year

El Camino Hospital® THE HOSPITAL OF SILICON VALLEY

Health Priority Area *(Column A)*	Partner *(Column B)*	Metrics *(Column C)*	FY16 6-month target *(Column D)*	FY16 6-month actual *(Column E)*		FY16 %of ALL 6-month metrics met *(Column G)*	FY16 Annual target *(Column H)*	FY16 Annual Actual *(Column I)*		FY16 % of ALL annual metrics met *(Column K)*	FY17 6-month target *(Column L)*	FY17 6-month actual *(Column M)*		FY17 % 6-month metrics met *(Column O)*	FY17 Annual Target *(Column P)*	FY17 Annual Actual *(Column Q)*		FY17 % Annual metrics met *(Column S)*	FY18 6-month target *(Column T)*	FY18 6-month actual *(Column U)*		FY18 % 6-month metrics met *(Column W)*	FY18 Annual Target *(Column X)*	Supporting Details for Variance and Trending *(Column Y)*
HEALTHY COMMUNITY	**Second Harvest Food Bank** FY18 Requested: $40,000 FY18 Approved: $40,000 New Metrics: N/A	Nutrition education services provided to individuals	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	3,600	9,511	●	100%	7,200	Agency recruited more Health Ambassadors who were able to deliver services at a greater number of sites than projected.
		Clients who report that half of each meal should include fresh fruits and vegetables	-	-			-	-			-	-			-	-			N/A	N/A			30%	
		Clients who report that their family eats more fruits and vegetables through participation in the program	-	-			-	-			-	-			-	-			N/A	N/A			70%	
	Silicon Valley Bicycle Coalition FY18 Requested: $30,000 FY18 Approved: $30,000 New Metrics: N/A	Individuals served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	100	30	●	0%	300	Hiring delay for key staff role to execute this program caused a delay in start of services. The program has strong momentum now with many rides and workshops scheduled during winter/spring - 8 already conducted as of mid February. Expect to meet year-end targets.
		Services provided	-	-			-	-			-	-			-	-			165	39	●		500	
		Participants who report riding 6-10 times per year	-	-			-	-			-	-			-	-			5%	N/A			20%	Program delay meant post- surveys did not occur.
	South Asian Heart Center FY18 Requested: $360,000 FY18 Approved: $240,000 FY17 Approved: $360,000 FY17 Spent: $360,000 FY16 Approved: $400,000 FY16 Spent: $400,000 New Metrics: 0 of 6	Individuals served	625	680	●	100%	1,250	2,250	●	100%	625	657	●	100%	1,250	1,356	●	83%	208	222	●	100%	383	
		Services provided	2,500	2,610	●		7,000	6,475	●		2,750	2,607	●		7,500	6,468	●		814	888	●		2,044	
		Improvement in average level of weekly physical activity from baseline	-	-			-	-			14%	18%	●		16%	17%	●		19%	21%	●		20%	
		Improvement in average levels of daily servings of vegetables from baseline	-	-			-	-			11%	18%	●		13%	14%	●		18%	20%	●		20%	
		Improvement in levels of HDL-C as measured by follow-up lab test	-	-			-	-			3%	5%	●		4%	4%	●		4%	5%	●		5%	
		Improvement in cholesterol ratio as measured by follow-up lab test	-	-			-	-			5%	6%	●		6%	6%	●		7%	7%	●		7%	
	Teen Success, Inc. FY18 Requested: $20,000 FY18 Approved: $20,000 New Metrics: N/A	Individuals served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	10	10	●	100%	10	
		Services provided to teen mothers	-	-			-	-			-	-			-	-			80	74	●		160	
		Individuals who are enrolled in school and working towards graduation or receive their high school diploma or GED	-	-			-	-			-	-			-	-			95%	92%	●		95%	
	Valley Verde FY18 Requested: $35,000 FY18 Approved: $35,000 New Metrics: N/A	Individuals/households served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	81/18	82/17	●	100%	216/48	
		Services provided	-	-			-	-			-	-			-	-			48	46	●		132	
		Participants reporting increased food security for themselves and their children by at least on level on the USDA range, as measured by pre- and post-participation surveys	-	-			-	-			-	-			-	-			80%	84%	●		80%	
		Participants reporting an increase in their knowledge of nutrition and healthy cooking, as measured by pre- and post-participation surveys and final focus group	-	-			-	-			-	-			-	-			80%	84%	●		80	
	West Valley Community Services - CARE FY18 Requested: $150,000 FY18 Approved: $150,000 FY17 Approved: $150,000 FY17 Spent: $150,000 FY16 Approved: $150,000 FY16 Spent: $150,000 New Metrics: 0 of 4	Households served	60	66	●	80%	120	125	❄	100%	60	66	●	100%	120	128	●	100%	63	63	●	100%	122	
		Households that receive intensive Case Management services	40	41	●		60	61	●		30	30	●		60	63	●		30	30	●		60	
		Case managed clients who increased in 3 of the 18 domains measured by Self Sufficiency Index	N/A	N/A			80%	80%	●		N/A	N/A			80%	80%	●		N/A	N/A			80%	
		Program participants who will improve 1 point in the health domain through supportive services	-	-			-	-			N/A	N/A			60%	80%	●		N/A	N/A			80%	
	West Valley Community Services - CARE Senior Services FY18 Requested: $25,000 FY18 Approved: $25,000 FY17 Approved: $25,000 FY17 Spent: $25,000 FY16 Approved: $25,000 FY16 Spent: $25,000 New Metrics: 1 of 3	Individuals served	10	10	●	100%	20	25	●	100%	10	10	●	100%	22	22	●	100%	10	10	●	100%	22	
		Encounters provided	120	128	●		240	250	●		120	130	●		240	278	●		125	130	●		245	
		Case managed clients who increased in 3 of the 18 domains measured by Self Sufficiency Index	-	-			-	-			-	-			-	-			N/A	N/A			90	
	YWCA Silicon Valley FY18 Requested: $25,000 FY18 Approved: $20,000 New Metrics: N/A	Individuals served	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	-	-		New Partner in FY18	4	13	●	66%	10	Adding facilitators for Chinese and Vietnamese clients increased number served.
		Services provided	-	-			-	-			-	-			-	-			40	32	●		100	
		Individuals completing the program	-	-			-	-			-	-			-	-			60%	93%	●		60%	Program design was revised to offer services in multiple languages, decrease the number of weeks in the cohort and meet more frequently and with smaller groups. These changes serve to increase the number of individuals completing the program.

Community Benefit Dashboard Notes

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N/A There are some 6-month metric targets with "N/A" because the client/patient has not had significant exposure to the intervention in order to accurately evaluate effectiveness or because activities or surveys are not scheduled until the second half of the year

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Approval of Resolution 2018-04 Required by Premier, Inc. Listing the CEO and CFO as Authorized Individuals to Sell Stock El Camino Hospital Board of Directors March 14, 2018
	Responsible party:	Iftikhar Hussain, CFO
	Action requested:	Approval
	Background: El Camino Hospital own 238,000 shares of Premier, Inc. stock. 130,000 shares are eligible for sale with a value of $4.2 million. The sale does not change the vendor relationship with Premier. The value of the stock has been trending favorably compared to history and given that ECH is only a passive investor it seems prudent to sell at this time. The sale allows the investment to be moved into the surplus cash pool where our investments are managed with the oversight of the Investment Committee.	
	Board Advisory Committees that reviewed the issue and recommendation, if any: This document will be updated with the Investment Committee's recommendation following consideration of this matter at its upcoming meeting on March 12, 2018.	
	Proposed Board Motion: To approve Resolution 2018-04	
	LIST OF ATTACHMENTS: 1. Draft Resolution 2018-04	

Draft

Resolution Granting Authority to Sell Securities

EL CAMINO HOSPITAL
RESOLUTION 2018-04

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL GRANTING AUTHORITY TO SELL SECURITIES.

WHEREAS, the Board of Directors ("Board") of El Camino Hospital ("Hospital") has determined it is in the best interest of the Hospital to authorize certain officers to transfer, convert, sell and assign any securities in the name of the Hospital; now, therefore, be it

RESOLVED, that the Chief Executive Officer of the Hospital or the Chief Financial Officer of the Hospital be and they hereby are each, separately, authorized to transfer, convert, sell and assign any securities in the name of the Hospital; be it further

RESOLVED, that the Chief Executive Officer of the Hospital or the Chief Financial Officer of the Hospital be, and hereby are, authorized and empowered to execute, sign and deliver assignments or any other required instruments for any securities standing in the name of the Hospital by affixing thereto the name of the Hospital and the individual signature of such officer.

Duly passed and adopted at a regular meeting held on this ____ day of _____, 2018, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____

Julia E. Miller
Secretary, ECH Board of Directors

ECH BOARD MEETING AGENDA ITEM COVER SHEET

	Item:	Medical Staff Report – Open Session El Camino Hospital Board of Directors March 14, 2018
	Responsible party:	Rebecca Fazilat, MD, Chief of Staff Mountain View J. Augusto Bastidas, MD, Chief of Staff, Los Gatos
	Action requested:	Approval
	Background: The Medical Executive Committee met on February 22, 2018. We received the following reports: 1. The Manager of Palliative Care reported on the development and testing of a Trigger Tool for Palliative Care which prescribes criteria for Palliative Care referral. 2. Director of Medical Staff Report a. Development of clear processes related to LOA's is underway. b. Quarterly New Practitioner Orientation Program and Ongoing Medical Staff Updates have been instituted. 3. Medical Staff Bylaws Committee meeting scheduled for March 1st to review revisions needed to create a Credentials Committee. 4. CNO Report – Review of processes for reviewing consent and equipment prior to surgery. 5. Medical Staff Officer Elections are coming up. We approved the following: Patient Care Policies, Protocols, ADT's (aka Scope of Services), and Plans.	
	Board Advisory Committee(s) that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives: To obtain approval of the Medical Staff Report.	
	Proposed Board motion: To approve the Medical Staff Report.	
	LIST OF ATTACHMENTS: 1. Patient Care Policy Summary and Policies, ADTs (aka Scope of Services), and Plans	

SUMMARY OF POLICIES/PLANS/SCOPE FOR REVIEW AND APPROVAL - BOARD

Feb-18

NEW POLICIES/PROCEDURES			
Document Name	**Department**	**Type of Document**	**Summary of Document Changes**
DOCUMENTS WITH MAJOR REVISIONS			
Document Name	**Department**	**Type of Document**	**Summary of Policy Changes**
Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA)	Administrative	Policy	Policy rewritten to make it easier to read and updated with current site locations
DOCUMENTS WITH MINOR REVISIONS			
Document Name	**Department**	**Type of Document**	**Summary of Policy Changes**
NICU: Admission, Discharge and Transfer Criteria (ADT) LG Only	NICU LG	ADT	Combined ADT Admission and ADT Discharge, minor changes to the procedure
Infection Control Plan	Infection Control	Plan	Yearly updates, attached the Infection Control Plan Evalulation Annual Report FY 2017
Admission, Discharge, Transfer (ADT) ICU LG	ICU	ADT	Revised Statement and Procedure
Admission, Discharge, Transfer (ADT) Short Stay Nursing Unit	Short Stay	ADT	Revised Statement and Procedure
Admission, Discharge, Transfer (ADT) PACU	PACU	ADT	Revised Discharge Criteria
DOCUMENTS WITH NO REVISIONS			
Document Name	**Department**	**Type of Document**	**No Revisions**
DOCUMENTS FOR INFORMATION ONLY			
Document Name	**Department**	**Type of Document**	**Summary of Policy Changes**

POLICY/PROCEDURE TITLE: Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA)

TYPE:	☑ Policy ☐ Protocol ☐ Practice Guideline ☐ Standardized Procedure ☐ Procedure ☐ Plan ☐ Scope of Service/ADT
SUB-CATEGORY:	*Patient Care Services*
OFFICE OF ORIGIN:	*Emergency Department*
ORIGINAL DATE:	

I. COVERAGE:

All El Camino Hospital Employees and Medical Staff

II. PURPOSE:

Provide guidance to ECH staff and physician on obligations under the Emergency Medical Treatment and Labor Act (EMTALA).

III. POLICY STATEMENT:

It is the policy of El Camino Hospital to comply with state and federal laws regarding EMTALA in accordance with the policy below. ECH will provide emergency services and care without regard to an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender orientation), preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical disability, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

IV. DEFINITIONS

Full glossary of terms used in this policy is found in Appendix A.

V. APPLICABILITY

A. This policy applies to anyone who requests evaluation for an Emergency Medical Condition (EMC-see Appendix A for definition) who presents to the Emergency Department, OB Emergency Department (OBED) or the Labor and Delivery units on campus.

B. Individuals requesting or in need of evaluation and treatment for a potential EMC who present in areas on hospital property other than the ED and L&D units are governed by *Administrative policy: EMTALA-Providing Emergency Services to Individuals outside the Emergency Department*.

C. This policy does not apply to inpatients or outpatients receiving treatment in the hospital or clinic. If an emergency medical condition develops during an outpatient encounter,

appropriate policies should be followed which may include referring the patient to the nearest Emergency Department.

D. This EMTALA policy does not apply when the Secretary of HHS declares a public health emergency and the hospital has received a waiver of EMTALA requirements for the area in which the Hospital is located. The waiver of the Hospital's EMTALA requirements applies only for the period during which the waiver is in effect. Refer to procedure: *EM - Surge Plan - 03.07 Alt Care Sites – 1135 Waiver* for more information.

VI. PROCEDURE: EMTALA REQUIREMENTS

A. Screening Requirements:

1. All individuals who come to the ED, OB ED or L&D unit requesting or in need of examination or treatment of a medical condition shall receive an appropriate medical screening examination (MSE). An MSE is provided without discrimination to the individual and is the same provided to any individual coming to the ED/OBED/L&D unit with similar signs and symptoms. The hospital shall not delay in providing the MSE or necessary stabilizing treatment in order to inquire about an individual's method of payment or insurance status.

2. A MSE is performed by a physician or a qualified medical professional, as defined in the Medical Staff bylaws, rules and regulations, as a credentialed MD, DO, certified nurse midwife, Emergency Department physician assistants under appropriate supervision and within scope of practice, or, in the case of a patient presenting with pregnancy and/or signs and symptoms of labor, RNs who have demonstrated current competency (per hospital policy) in assessing the laboring patient.

3. A MSE is performed to determine within reasonable clinical confidence, whether an EMC exists. The scope of the examination must be tailored to the presenting complaint and the medical history of the patient.

4. The MSE includes the provision of all services available within the capabilities of the Hospital, which, in the judgment of the ED physician or other treating Physician or qualified medical professional are necessary to screen and/or stabilize an individual with an EMC. The process may range from simple examination such as brief H&P to complex examination that may include lab tests, diagnostic imaging and the use of on call specialty Physicians. If the physician or qualified medical professional determines that the patient requires the services of an on call physician, the on call physician shall be contacted. Documentation to support the process and evaluation taken as part of the MSE shall be appropriately documented in the EHR.

B. Registration

1. The hospital shall not delay in providing a MSE or necessary stabilizing treatment in order to inquire about an individual's method of payment or insurance status. Requests for any payment or payor authorization are not to be made prior to the MSE and initiation of any stabilizing treatment.

2. If a patient asks whether the hospital accepts their health plan or raises other financial matters, staff may answer the patient's inquiry. However, staff should reaffirm (and so document) the offer to provide a MSE and take reasonable steps to encourage the patient to remain for the examination. If after this discussion a patient is unwilling to proceed with the MSE for any reason, the patient's refusal to be examined should be documented in the medical record and the *EMTALA-Refusal of Medical Screening* policy should be followed.

C. Patients Who Do Not Have an EMC or Whose Condition Has Been Stabilized

Once the MSE is completed and there is a determination the patient does not have an EMC or the EMC has been stabilized, the patient, in accordance with applicable policies governing the situations below, may be:

1. Treated;
2. Discharged so long as the patient has reached a point clinically where further care is not needed or may be reasonably performed on an outpatient basis or later scheduled on an inpatient basis and the patient is given a reasonable plan for appropriate follow up care and discharge instructions; or
3. Transferred for continued care.

D. Patients Who Have An EMC

1. When a Physician or Qualified Medical Professional determines that the patient has an EMC, the Hospital shall:

    a) Within the capability of the staff and facilities, stabilize the patient's condition to the point where the EMC is stabilized (see Paragraph C above for further treatment, discharge or transfer); or

    b) Admit the patient as an inpatient, or if the hospital does not have the capability to stabilize the EMC, provide for an appropriate transfer of the unstabilized patient to another medical facility pursuant to Section E below.

E. Transfer of Patients with Unstabilized EMC

1. Eligibility for Patient Transfer. The hospital may not transfer a patient with an unstabilized EMC except under the following circumstances:

a. The patient or surrogate requests the transfer after being informed of the hospital's obligations and the risks of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he/she is aware of the risks and benefits of the transfer.

b. With physician certification documenting that the medical benefits expected from transfer outweigh the risks.

c. Complete documentation regarding the transfer shall be in EHR.

2. Transfer Requirements for Patients with an Unstabilized EMC.

a. The hospital shall provide that treatment which is within the capacity of the hospital to minimize the risk of transfer to the patient.

b. Contact a receiving hospital that has the capacity (available beds and personnel) and has agreed to treat the patient and receive acceptance of the patient. It is recommended that communication between accepting physicians and nursing staff occur.

c. Transfer all medical records of the encounter

d. Use qualified personnel, equipment, and mode of transport based on the clinical presentation of the patient, including use of necessary and medically appropriate life support measures during the transfer. The physician is responsible for determining the mode of transport.

e. A physician has signed the transfer certification that the benefits of the transfer of the patient to another facility outweigh the risks and provide the medical reason for the transfer, the risk and benefit analysis upon which the decision is based. It is not necessary to repeat information in the medical record, however, the certification must provide a complete picture of the expected benefits from appropriate care at the receiving facility, and risks associated with the transfer. The certification shall be timed and dated close to the time of actual transfer.

f. The patient's vital signs are taken at time of transfer.

F. Refusal of Medical Screening Exam, Treatment or Transfer

1. If the patient or surrogate refuses the MSE, staff shall follow the ***EMTALA-Refusal of Medical Screening Exam policy***.
2. If the patient refuses recommended treatment or transfer, the physician should be contacted to inform the patient or surrogate of the risks and benefits of performing

the examination and stabilizing treatment **AND** document a statement to this affect in the patient's medical record, and take all reasonable steps to secure the patient's or surrogate's written informed consent to refuse examination and treatment following appropriate hospital procedures.

G. On-Call Physician Obligation:

1. The hospital shall maintain a list of Physicians who are on-call to provide service after the initial examination for providing consultation or treatment necessary to stabilize the patient with a potential EMC. The physician or qualified medical professional performing the medical screening examination has the ultimate authority to decide whether an EMC is present and that there is need for the immediate services of the on-call specialist and whether onsite presence of the on call specialist is required.

2. Once the on call physician is contacted, the on-call specialist is to respond within the defined response time pursuant to the applicable on call contract with the hospital.

3. The on-call physician has the responsibility to inform the ED if unable to respond when on-call and should make effort to find coverage. Valid examples include:
   a. Circumstances beyond his/her control
   b. Currently performing elective or emergency surgery and cannot respond in person within a clinically timely manner to evaluate or treat the patient
   c. On-call MDs can attend to their private practices, but may not "stack" surgeries on their on-call day. The physician would be expected to interrupt the schedule or arrange for a back-up physician to be on-call
   d. It is the responsibility of the on-call physician to notify the ED when s/he has made changes to the schedule. The on call physician must provide the ED with his/her replacement's name
   e. The hospital should make appropriate arrangements to safely care/transfer the patient when there is not an on-call physician available.
   f. Physicians can be on call simultaneously at other hospitals, but the on-call physician has the duty to inform all hospitals involved of his/her schedule.
   g. The medical staff by-laws, rules and regulations should state the allowed exemptions for on-call duty.

4. On-call physicians shall not engage in:
   a. delay tactics such as debating with the ED physician or qualified medical professional on the necessity of coming to the hospital
   b. asking about payment status or any other non clinically relevant information about the patient
   c. only offering office follow-up
   d. insist on another specialist consult before coming to the hospital

5. Concerns regarding on call physician compliance with responding to ED requests for service shall be reported through appropriate chain of command and incident reports.

6. EMTALA obligates the transferring emergency physician to report if an on-call physician neglects to fulfill his/her on-call duties. EMTALA requires that the patient's medical record be sent along with the patient transfer. That medical record must contain "the name and address of any on-call physician who has refused or failed to appear within are reasonable time to provide necessary stabilizing treatment."

H. General Policies:

1. **Signage:** The hospital shall post required signage conspicuously in required areas in the required form required by CMS that specifies the rights of individuals to examination and treatment for EMCs and that ECH participates in the Medicaid program.

2. **Central Log:** Each department where a patient may present for emergency services (e.g., Emergency Department, OB-ED, Labor and Delivery unit) shall maintain a central log recording the names of individuals who come to the applicable department for services. In addition, the log shall contain information about whether the person refused treatment, was refused treatment by the hospital or whether the individual was stabilized and transferred, admitted to the inpatient area, or discharged.

3. **Maintenance of Records:** Medical and other records (such as transfer logs, on-call lists and changes to the on-call list and central logs) will be maintained in accordance with ECH record-retention policies, but not less than five years.

4. **Disputes:** In the event of any concern over emergency services to an individual, or a dispute with another facility regarding a transfer or a concern about ECH compliance with EMTALA, staff and physicians will refer the dispute to the Director, Regulatory and Accreditation or Compliance Officer.

5. **Reporting EMTALA Violations:** ECH will report to CMS or the Department of Public Health if it has a reason to believe that it has received an individual who has been transferred in an unstabilized EMC from another facility. All hospital personnel who believe that an EMTALA violation has occurred will report the violation to the Emergency Department Manager, Compliance Officer or Director, Regulatory and Accreditation.

6. **Retaliation:** ECH will not retaliate, penalize or take adverse action against any physician or qualified medical person for refusing to transfer an individual with an emergency medical condition that has not been stabilized, or against any ECH employee for reporting a violation of EMTALA or state laws to a governmental enforcement agency.

Applicable Regulations:

EMTALA Statute: United States Code, Title 42, Section 395dd.

POLICY/PROCEDURE TITLE:Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA Regulations: Code of Federal Regulations (CFR) 42, Sections 489.20 and 489.24, 2009.

California Licensing Laws on Emergency Services and Care: California Health and Safety Code, Sections 1317, 1317.2, 1317.2a, and 1317.4.

APPROVAL	APPROVAL DATES
Originating Committee or UPC Committee:	10/2017
Emergency Department Panel/Medical Committee:	10/2017
OB Executive Committee:	1/2018
ePolicy Committee:	
Medical Executive Committee:	
Board of Directors:	

Historical Approvals: (Note this policy is a combination of previously approved policies , all receiving Medical Executive Committee and Board of Directors Approvals with last approval date: 5/2010.)

Emergency Department Physician Panel,
Patient Care Management Council, 3/12
Medical Executive Committee, 04/26/2012
Board of Directors, 05/2012, 2/2015

ATTACHMENTS:, ADDENDUMS:, EXHIBITS:, OR APPENDICES:

Appendix A

KEY DEFINITIONS:

1. **Appropriate Transfer:** Means a transfer of an individual with an emergency medical condition that is implemented in accordance with EMTALA standards.

2. **Campus:** The buildings, structures and public areas of the hospital located on hospital property (see definition of hospital property below). Off-Campus means the buildings, structure and public areas of the hospital that are located off-site of the hospital property but are owned or operated by the hospital.

3. **Capability:** Refers to the physical space, equipment, staff, supplies and services (e.g., surgery, intensive care, pediatrics, obstetrics, and psychiatry), including ancillary services available at the hospital.

4. **Capacity:** The ability of the hospital to accommodate an individual requesting or needing examination or the treatment of a transferred individual. Capacity encompasses the number and availability of qualified staff, beds, equipment

and the hospital's past practices of accommodating additional individuals in excess of its occupancy limits.

5. **Central Log:** All dedicated emergency departments (DED) must maintain a log that documents each individual who comes to the DED, or individuals referred to the DED that arrived at another location on the hospital property seeking emergency assistance.

6. **Comes to the Emergency Department:** Under the EMTALA regulations a person is considered to come to the emergency department under any of the following circumstances:
   a. A person who presents to a dedicated ED and:
      i. Requests examination or treatment for a medical condition; or
      ii. Has a request made on his/her behalf for examination or treatment for a medical condition; or
      iii. A prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition
   b. A person who presents on hospital property (other than a dedicated ED)
      i. Requests examination or treatment for what may be an emergency medical condition; or
      ii. Has a request made on his/her behalf for examination or treatment for what may be an emergency medical condition; or
      iii. A prudent lay-person observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for what may be a emergency medical condition
   c. Is in a ground or air ambulance owned and operated by the hospital regardless of the location of the ambulance. Except:
      i. If the ambulance is operated under a community wide emergency medical service (EMS) protocol that direct the ambulance to transport the patient to another hospital
      ii. The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance
   d. A person who is a patient in an ambulance not owned or operated by the hospital, but is on hospital property for the purpose of examination or treatment for a medical condition at the hospital's dedicated ED.

7. **Compliance:** A Medicare participating hospital that has a dedicated ED must comply with EMTALA. The Federal Regulations Code states: A participating hospital has entered into a provider agreement mandated by Section 1866 of the Social Security Act, as amended, and regulations adopted by the Centers for Medicare and Medicaid Services (CMS), and applicable state laws governing the provision of emergency services and care." (Moy, 2009).

8. **Dedicated Emergency Department, (DED):** A hospital department or facility, either on or off the main hospital campus, and meets one of the following requirements:
   a. The department or facilities is licensed by the state as an emergency department
   b. The department is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
   c. During the immediately preceding calendar year, it provided (based on a representative sample) at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

9. **Department of the Hospital**: A hospital facility or department that provides services under the name, ownership, provider number, financial and administrative control of the hospital. For purposes of EMTALA, a department of the hospital does not include a skilled nursing facility, home health agency, rural health clinic, free-standing ambulatory surgery center, private physician office or any other provider or entity that participates in the Medicare program under a separate provider number that is different from the hospital provider number.

10. **Emergency Medical Condition (EMC):** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably expect to result in:
    a. Placing the individual (or, with respect to a pregnant woman), the woman or her unborn child in serious jeopardy
    b. With respect to a pregnant woman who is having contractions:
       i. that there is inadequate time to effect a safe transfer to another hospital before delivery; or
       ii. that transfer may pose a threat to the health or safety of the woman or unborn child
    c. Serious impairment to bodily functions
    d. Serious dysfunction of any body organ or part

11. **EMTALA:** Means the Emergency Medical Treatment and Labor Act codified in §1866 and 1867 of the Social Security Act (42 U.S.C. §1395dd), and the regulations and interpretive guidelines adopted by CMS hereunder. EMTALA is also referred to as the “patient anti-dumping” law.

12. **Enforcement:** CMS and the Office of the Inspector General (OIG) of the U. S. Department of Health and Human Services are responsible for the enforcement of EMTALA. Violations of EMTALA may be reported to other federal and state agencies and to the Joint Commission (TJC).

13. **Hospital Property:** Means the entire main hospital campus, including areas and structures that are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office, to be part of the main hospital's campus. Hospital property includes offices that are part of the main hospital's campus. Hospital property includes the parking lots, sidewalks, and driveways on the hospital main campus.

14. **Inpatient:** Means an individual who is admitted to the hospital for bed occupancy for purposes of receiving inpatient services with the expectation that he/she will remain at least overnight and occupy a bed, even though the individual may be later discharged or transferred to another facility and does not actually use a hospital bed overnight. The EMTALA obligation does not apply once the patient is admitted from the ED, when sent from the MD office or nursing home as direct admissions to the inpatient setting. CMS and the state agree with this definition of inpatient.

15. **Labor:** Labor includes the latent or early phase of labor and continues through the delivery of the placenta. A woman experiencing contractions is in true labor, unless a physician, certified nurse mid-wife, or other qualified medical person acting within his/her scope of practice as defined by the hospital medical staff by- laws and State law, certifies that, after a reasonable period of observation, the woman is in false labor.

16. **Medical Screening Examination (MSE):** The process required to reach within reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. The MSE is an ongoing process, including monitoring of the individual, until the individual is either stabilized or transferred. The basics of the MSE are:
    a. To determine if an emergency medical condition exists
    b. The medical staff by-laws, rules and regulations state who can perform the MSE
    c. Is an ongoing process and must be provided in the same manner to all individuals presenting with similar complaints. It is a screening process that is reasonably calculated to determine whether an emergency medical condition exists.
    d. It is part of the permanent medical record

17. **Non-Discrimination:** ECH will provide emergency services and care without regard to an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), preexisting medical condition, physical or mental disability, insurance status, economic status or ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

18. **On-Call List:** A list of physicians who are "on-call" after the initial medical screening examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.

19. **Outpatient:** An individual who has begun to receive outpatient services as part of an encounter, other than an encounter that triggers the EMTALA obligations. An "encounter" is a direct personal contact between an outpatient and a physician or qualified medical person who is authorized by state law to order or furnish hospital services for the diagnosis or treatment of the outpatient.

20. **Physician:** Means: a doctor of medicine or osteopathy; a doctor of dental surgery or dental medicine; a doctor of podiatric medicine; a doctor of optometry, each acting within the scope of his/her respective licensure and clinical privileges.

21. **Physician Certification:** Means the written certification by the treating physician ordering a transfer and setting forth, based on the information available at the time of transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer.

22. **Qualified Medical Person:** Means an individual other than a physician who is licensed or certified by the state; practices in a category of health professionals that has been designated by the hospital and the medical staff bylaws, rules and regulations, to perform medical screening examinations; has demonstrated current competence in the performance of medical screening examinations within his/her health profession; and as applicable, performs the medical screening examination in accordance with protocols, standardized procedures or other policies as may be required by law or hospital policy. A qualified medical person may include registered nurses, nurse practitioners, nurse midwifes, psychiatric social workers, psychologists and physician assistants.

23. **Sanctions:** Failure to comply with EMTALA may result in termination by CMS of the hospital's participation in the Medicare and Medical programs, as well as civil monetary penalties imposed by the OIG for both the hospital and physicians of up to $104,826 and possible exclusion from Medicare/Medical. Failure to comply with state laws on emergency services is subject to licensing enforcement action. A violation of EMTALA is also subject to civil lawsuits against the hospital for damages

24. **Signage:** Signs will be posted by the hospital in its dedicated emergency department(s) and in a place or places likely to be noticed by all individuals entering the dedicated emergency department(s) (including waiting room,

admitting area, entrance and treatment areas), that inform individuals of their rights under EMTALA.

25. **Stabilized:** Means, with respect to an emergency medical condition, that no material deterioration of the condition is likely within reasonable medical probability, to result from or occur during the transfer of the individual from the hospital or in the case of a woman in labor, that the woman delivered the child and the placenta. An individual will be deemed stabilized if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

26. **To Stabilize:** With respect to an emergency medical condition, to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the hospital, in the case of a woman in labor, that the woman has delivered the child and placenta.

27. **Stable for Discharge:** Following a determination by the treating physician within reasonable clinical confidence, that an individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions.

28. **Transfer:** The movement (including the discharge) of an individual outside the hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead or who leaves the hospital against medical advice or without being seen.

29. **Triage:** A process to determine the order in which individuals will be provided a medical screening examination by a physician or qualified medical person. Triage is not the equivalent of a medical screening examination and does not determine the presence or absence of an emergency medical condition.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	NICU_ Admission Discharge and Transfer Criteria (ADT) - LG Only
CATEGORY:	Patient Care Services
LAST APPROVAL:	2/2015

TYPE:	☐ Policy ☑ Procedure ☐ Protocol ☐ Practice Guideline ☐ Standardized Procedure ☐ Plan ☑ Scope of Service/ADT
SUB-CATEGORY:	NICU
OFFICE OF ORIGIN:	LG NICU
ORIGINAL DATE:	6/2009

I. COVERAGE:

All El Camino Hospital Staff

II. PURPOSE:

To establish criteria for admission and discharge to the El Camino Hospital Los Gatos Neonatal Intensive Care Unit (NICU) and transfer to a higher level of care in the neonatal population served by El Camino Hospital Los Gatos.

III. POLICY STATEMENT:

- A NICU RN may directly admit an infant to the NICU based on established criteria (see section "Admission"; #2). The physician shall be **immediately** notified and expected to examine and evaluate the infant **within 30 minutes** of admission to the NICU.
- Infants will be discharged from the NICU when physiologically stable.
- When an infant requires neonatal intensive care greater than the capabilities of El Camino Hospital Los Gatos, neonatal transport to the nearest available higher level (3 or 4) NICU will be initiated.

IV. REFERENCES:

AAP Committee on Fetus and Newborn and ACOG Committee on Obstetric Practice (2017). *Guidelines for Perinatal Care* 8th ed.

California Children's Services Manual of Procedures (1999). *Standards for Neonatal Intensive Care Units (NICUs).* Chapter 3.25.3, pages 1-30.

V. PROCEDURE:

A. Admission

1. The following may be cared for in the LG NICU:
    a. Infants born at or beyond 32 weeks of gestation and weighing 1,500 grams or more at birth who have physiologic immaturity (e.g. apnea of prematurity) or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis.
    b. Infants requiring continuous positive airway pressure (CPAP) or mechanical ventilation for a brief period (less than or equal to 4 hours).

~~b.~~c. Infants on CPAP who are deemed stable by the Neonatologist.
~~c.~~d. Infants convalescing after intensive care (i.e. transports in from tertiary center)

2. Infants will be **directly** admitted to the LG NICU for the following:
    a. All infants on IV antibiotics. *Please refer to the "Management of Infant Sepsis Screening" Policy.*
    b. Hypoglycemia, per the "*Management of the Neonate at Risk for Hypoglycemia" Protocol.*
    c. Symptomatic i~~I~~nfants with a birthweight < 2,000 grams
    d. Infants born between 32-34 completed~~5~~ weeks of gestation
    e. Infants requiring prolonged resuscitation after birth (greater than 10 minutes) and/or requiring Code White--Infant team intervention.
    f. Any infant > 35 weeks of gestation with respiratory distress (e.g. grunting, flaring, and/or retracting) and not improving and/or not resolved within six ~~one~~ hours after delivery.
    g. All infants with congenital anomalies. If sub-specialty consults are needed, transfer to a tertiary center should be considered.
    h. All infants with persistent color changes (i.e. pallor, cyanosis).
    i. Infants requiring IV medication and/or fluids.
    j. Transports from other institutions who meet the criteria for inborn admission.
3. The above criteria are not all inclusive and are not meant to limit admission only to the outlined diagnoses. Admits are considered based upon:
    a. Availability of medical expertise
    b. NICU census and acuity
    c. NICU staffing
4. All transports in must be accepted for care by the NICU Medical Director or designee.

B. Discharge
1. Infants discharged from the NICU will fulfill the following criteria:
    a. Physiological Parameters:
        i. The infant has received a physical examination by a ~~physician ? on the day of (within 24 hours of)discharge per our BY Laws.~~physician within 24 hours of discharge.
        ii. Physical examination reveals no abnormalities that require continued hospitalization or problems that may require ongoing close surveillance.
        iii. The infant is stable physiologically and is able to maintain body temperature without cold stress when the amount of clothing worn and the room temperature are appropriate.

iv. The infant's weight has been assessed by the physician prior to discharge. ~~is adequately gaining weight per physician ordered feeding regimen.~~
v. The infant is able to feed without physical compromise.
vi. If the infant's clinical condition precludes adequate nipple feeding, the parents are competent in alternative feeding techniques.
vii. The infant is free of apnea or can be monitored at home.
viii. If circumcision is done on the day of discharge, there will be no excessive bleeding at the site for at least two hours.

b. Laboratory and Evaluation Parameters
i. Maternal Hepatitis B surface antigen status will have been ascertained.
ii. Cord or infant blood type and direct Coombs test has been done~~passive~~ if clinically indicated.
iii. California State Newborn Metabolic Screening Test has been completed.
iv. Initial Hepatitis B vaccine has been administered (unless the parent signs a refusal).
v. Newborn Hearing Screen has been done
vi. Car Seat Trial has been passed, if test is deemed necessary. *Please refer to "Infant Car Seat Trial" Policy.*
vii. CCHD screening or echocardiogram have been completed.

c. Follow Up Care
i. A physician has been identified for continuing medical care.
ii. Family, environmental, and social risk factors have been assessed. When risk factors are present, the discharge should be delayed until they are resolved or a plan to safeguard the infant is in place.
iii. The parent/guardian's knowledge, ability, and confidence to provide adequate care for the infant are documented by the fact that they have received the following teaching:
A. Preparation, dosing accuracy, and proper storage and administration of medication, if needed.
B. Ability to provide adequate nutrition to the infant, including understanding of preparation, frequency and volume of feeding.
C. Recognition of signs of acute illness and acute deterioration.
D. Proper infant safety, including car seat adaptations for infants weighing < 2,000 grams, and recommended sleep positions for ~~premature~~ infants.
iv. Referrals to specialty clinics, physicians, developmental clinics, and outside agencies have been made as appropriate.

v. Referrals for home health follow-up have been made, if needed.

d. Special Considerations for Preterm Infants
   i. Respiratory rate and effort is such that breathing does not compromise the infant's ability to feed, and the infant can maintain normal oxygen saturations during normal activities of daily living (i.e. sleeping, feeding, and crying).
   ii. For all infants where reflux is suspected and be contributing to apnea and bradycardia episodes, reflux will be deemed under control prior to discharge.

e. Social Services
   i. All parents or guardians have had a social service consultation at the discretion of the RN or physician that is documented in the medical record prior to discharge.
   ii. Families that require support to assist them with their high risk infant have been referred to the appropriate resources prior to discharge.

f. The infant will be discharged in the arms of a parent/guardian, seated in a wheelchair.

g. Documentation:
   i. The physician will document his/her physical exam in the infant's permanent record.
   ii. The RN taking care of the infant will document in the flow sheet, NICU discharge planning and education record the adequacy of the infant's feedings, vital signs, and daily weight.
   iii. If any family, environment, and social risk factors have been identified, the Social Worker will document in the EMR the assessment, interventions, and plan of action.
   iv. Home health and equipment needs and arrangements if needed, are documented in the EMR by the Social Worker.
   v. The Social Worker will document any specialty clinic, developmental clinic, and outside agency referrals in the EMR.

C. Transfer
   1. Neonatal conditions requiring transport to a higher level of care are as follows, but not limited to:
      a. All infants born at < 32 weeks of gestation.
      b. All infants born at < 1,500 grams
      c. Infants with complex medical or surgical conditions, regardless of gestational age, requiring specialty consultation and intervention. This includes infants with feeding complications requiring a modified barium swallow study.
      d. Infants who are candidates for extracorporeal membrane oxygenation (ECMO).

e. Infants who are candidates for total body cooling.
f. Infants requiring ~~CPAP or m~~mechanical ventilation greater than 4 hours.
~~f.~~g. Infants with severe hyperbilirubinemia, requiring an exchange transfusion.

2. A physician's clinical judgment may either expand or curtail this policy based upon:
   a. Available medical expertise
   b. NICU census and acuity
   c. NICU staffing

VI. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	1/2018
Peds Medical Committee:	1/2018
ePolicy Committee:	2/2018
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	6/2009, 11/2012, 2/2015

POLICY/PROCEDURE TITLE: Infection Control Plan

CATEGORY: Infection Control
LAST APPROVAL DATE: 4/17
☐Policy ☐Procedure ☐Protocol ☐ Standardized Procedure ☐Scope of Service
☐ Practice Guideline ☑Plan

SUB-CATEGORY: Infection Control Program
ORIGINAL DATE: 1/96

COVERAGE:

All El Camino Hospital staff

PURPOSE:

1. To plan, coordinate and monitor policies, procedures and practices related to the identification, control and prevention of hospital associated infections.
2. To identify areas of improvement and appropriate changes in the plan that would increase the effectiveness of the infection prevention and control program.

STATEMENT:

The El Camino Hospital Infection Control and Prevention Plan is a comprehensive, dynamic document which is based on a risk assessment for acquiring and transmitting infections within the hospital environment.

The El Camino Hospital Infection Prevention & Control Program primary function is to prevent transmission of infectious agents among patients, staff and visitors. It is the goal of the Infection Prevention and Control Department to reduce infection and infectious risk through strategic plans for surveillance and control of healthcare-associated infection; to identify trends and patterns in antimicrobial resistance; to address epidemiologically important issues; and to advise hospital employees, departments and services in developing policies, procedures, and practices which reflect current infection control guidelines and standards of care.

Goals to reduce the possibility of transmitting infections will be set based upon the identified risks. The plan includes risk reduction strategies supported by evidence based guidelines and expert consensus. At least annually, and whenever risks significantly change, an evaluation of the effectiveness of the infection prevention and control plan will be completed. This evaluation will include a review of the prioritized risks, the goals, objectives, and the infection prevention strategies. The results of the evaluation will be used to make revisions to the plan. The revised plan will be communicated to the organization.

POLICY/PROCEDURE TITLE: Infection Control Plan

Evaluation of the Infection Control Plan shall be done at least annually or upon changes in the scope of the Infection Control Program or changes in the risk analysis. Assessment of the prevention strategies will be based on their effectiveness at preventing and controlling infection. The Infection Prevention Department reports all communicable diseases to the Public Health Departments to help prevent spread of certain infections within the public at large.

The Infection Prevention and Control Plan evaluates the risk of communicable disease transmission based on the following:

- Santa Clara County geographic location and demographics
- Mountain View demographics
- Santa Clara County Community health status assessment
- TB Risk Assessment: California and Community profiles
- Threats facing Santa Clara County

Santa Clara County Geographic Location and Demographics:
https://www.census.gov/quickfacts/fact/table/santaclaracountycalifornia/PST045216

With 1.98 million residents, Santa Clara County is the sixth most populated of California's 58 counties and the most populated in the Bay Area. More than one-third (37%) of county residents are foreign-born. The largest percentage of foreign-born residents were born in Mexico (21%), followed by Vietnam (15%), India (13%), the Philippines (9%), and China, excluding Hong Kong and Taiwan (8%).
Santa Clara County encompasses 1,312 square miles and runs the entire length of the County from north to south, ringed by the rolling hills of the Diablo Range on the east, and the Santa Cruz Mountains on the west. Salt marshes and wetlands lie in the northwestern part of the county, adjacent to the waters of San Francisco Bay. Nearly 92% of the population lives in cities.
The local industry of the County of Santa Clara is dominated by the technology sector. The County has three main interstate highways; 280, 680, and 880, one U.S. Route (101), and the following CA State Routes; 9, 17, 82, 85, 87, 130, and 237.
Airports include: Norman Y. Mineta International Airport, Moffett Federal Airfield, and three County airports: Reid Hillview, Palo Alto, and South County.

Mountain View Demographics:
https://www.census.gov/quickfacts/fact/table/mountainviewcitycalifornia,santaclaracountycalifornia/
~~*(Source: US Census Bureau. State and County Quick Facts. January 2014)*~~
The resident population of Mountain View is approximately 76,260. More than half the population is between 20 and 54, while nearly 25% is in the 25 to 34 year age bracket. The median age is 34.6 years old.

Los Gatos Demographics: ~~need to add as above~~
https://www.homefacts.com/demographics/California/Santa-Clara-County/Los-Gatos.html
(~~*Source: US Census Bureau. State and County Quick Facts. January 2014)*~~
The resident population of Los Gatos is approximately 30,705. The median age resident is 45.4 years young. The largest racial/ethinc groups are White (73.8%) followed by Asian (14.5%) and Hispanic (6.3%)

Santa Clara County Community Health Status Assessment:

(Data: 2014 Santa Clara County Community Assessment Project Survey

Access to Care	87% of adults have health insurance
Chronic Disease	8% of adults have diabetes. Heart disease: 22% of the death among county residents.
Overweight and Obesity	Over 50% of adults and over 33% of adolescents in the county are overweight or obese
HIV/ AIDS	Over 3342 adults in Santa Clara County are living with HIV (61% Sexual transmission; 33% unknown, 6% IV Drug use
Tobacco use	1 in 10 adults and 1 in 12 adolescents in the county smoke cigarettes

TB Risk Assessment: *(retrieved from Santa Clara County TB Control Report; based on CY 2016~~5~~)*

California Overview

- CA reported ~~2,137~~ 2,062 new TB cases in 2016~~5~~ compared to 2,13~~1~~4 cases in 2015~~4.~~
- California's annual TB incidence remained at 5.~~5~~2 cases per 100,000 persons.
- An estimated $7~~2~~ 0 million was spent on medical management of TB cases in CA during 2016~~5~~.
- TB cases were reported in 50~~42~~ of California's 61 (82%) local health jurisdictions, but 29 (48%) jurisdictions reported fewer than 5 cases.
- ~~Of 24 jurisdictions that reported at least 10 cases in 2015, 11 (46%) experienced an increased from 2014~~
- Among California's TB cases, and estimated 7% were imported from outside of the United States, 13% resulted from recent transmission and 80% were due to reactivation of latent tuberculosis infection (LTBI)
- More than 2 million Californians (6% of the population) are estimated to have LTBI which can progress to active TB without diagnosis and treatment.

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- ~~The percentage of CA TB cases occurring in foreign-born persons increased from 78% in 2014 to 80% in 2015.~~

COMMUNITY TB PROFILE

www.SCCPHD.ORG

- Santa Clara County (SCC) has the ~~third~~ fourth highest number of cases among all jurisdictions in California, after Los Angeles and San Diego and Orange counties.
- Santa Clara County (SCC) had ~~198~~ 160 cases of active tuberculosis in 201~~5~~6, which decreased comparted with 2015 (197 TB cases) and was similar compared with 2014 (162 TB cases).
- ~~22% increase compared with 162 cases in 2014~~
- This represents a ~~C~~case rate of ~~10.5~~ 8.4 per 10,000 residents. ~~which is 1.9 times as high as the overall CA rate~~
- The case rate is 1.5 times as high as the overall California rate (5.2/100,000 persons) and 2.9 times as high as the national rate (2.9 per 100,000 persons).
- Case fatality rate of 4.4% (reported 7 deaths in 2016)
- ~~California rate 5.5/100,000 persons~~

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El Camino TB Profile : Medium Risk Facility

In 2016, ECH MV had 13 total cases with 7 INPATIENT and 6 OUTPATIENTS which is a decrease from 25 cases in 2015. El Camino Mountain View is considered a medium risk facility for TB based on a community rate of infection.

Year	Total Patients	In Patient	Out Patient	Pulmonary	Extra-pulmonary
2016	13	7	6	11	2
2015	25	13	12	22	3
2014	16	9	7	9	7
2013	10	6	4	8	2
2012	18	4	14	16	2
2011	12	8	4	7	5
2010	6	3	3	3	3

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Threats facing Santa Clara County:

1. Major Earthquake

The Operational Area is in the vicinity of several known active and potentially active earthquake faults including the San Andreas, Hayward, and Calaveras faults.
Two major local earthquakes that have impacted the County include:

- The San Francisco Earthquake (1906), magnitude 7.8, approximately 3000 fatalities
- The Loma Prieta Earthquake (1989), magnitude of 6.9, 63 fatalities.

Other significant local earthquakes near or within the County include:

- The Concord Earthquake (1955), magnitude 5.4, 1 fatality
- The Daly City Earthquake (1957), magnitude 5.3, 1 fatality
- The Morgan Hill Earthquake (1984), magnitude 6.2, no fatalities
- The Alum Rock Earthquake (2007), magnitude 5.6, no fatalities.

2. Wild land Urban/Interface Fire

The months of August, September and October have the greatest potential for wild land fires as vegetation dries out, humidity levels fall, and off shore winds blow.

3. Hazardous Material Incident

There are four major highways in the county that carry large quantities of hazardous materials: U.S. 101, I-880, and I-680, and I-280. Truck, rail, and pipeline transfer facilities are concentrated in this region, and are involved in considerable handling of hazardous materials.

5. Flood

There are approximately 700 miles of creeks and rivers in the County, all of which are susceptible to flooding. An Emergency Action Plan exists for the Anderson Dam and a general Dam Plan exists which includes other dams within Santa Clara County. These plans are maintained by the Santa Clara Valley Water District.

6. Landslide

For Santa Clara, the hillside areas in the Los Gatos areas have the greatest potential for economic loss due to landslides. The winters of 1982, 1983, 1986, and 1996/1997 provided a reminder of the degree of hazard from landslides in Santa Clara County

POLICY/PROCEDURE TITLE: Infection Control Plan

PROCEDURE:

1. Purpose

- To plan, coordinate and monitor policies, procedures and practices related to the identification, control and prevention of hospital associated infections.
- To identify areas of improvement and appropriate changes in the plan that would increase the effectiveness of the infection prevention and control program.

2. Objectives

a. Maintain Enterprise Central Line Associated Bloodstream Infection (CLABSI) rate below Standardized Infection Ratio (SIR) SIR < 0.50~~1~~ with a goal of "0" CLABSI's.

b. Maintain Neonatal Intensive Care Unit (NICU) CLABSI rate below SIR < 0.50 ~~1.0~~ with a goal of "0" CLABSI's

c. Achieve 95% bundle compliance rate with Central Line Insertion Practice (CLIP) organization-wide.

d. Maintain Enterprise hospital onset *Clostridium difficile* ~~infection rate to ≤ 5.0 /10,000 patient days.~~ Rate below Standardized Infection Ratio (SIR) < 0.70

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e. Maintain Enterprise hospital onset Methicillin Resistant *Staphylococcus aureus* (MRSA) infection rate to ≤ 0.70~~9~~ /10,000 patient days.

f. Maintain Enterprise MRSA screening compliance rate to 91~~0~~% or more.

g. Maintain Enterprise hospital onset Multi- Drug Resistant Gram Negative Rods (MDRGNR) infection rate to ≤ 0.5 / 10,000 patient days.

h. Maintain Coronary Artery Bypass Graft (CABG) SSI rate at or below NHSN Rates/Risk of SIR <1.00 (MV campus).

i. Maintain Total Knee Surgical Site Infection rate at or below NHSN Rates/Risk of SIR <1.00. (MV and LG campus).

j. Maintain Total Hip Surgical Site Infection rate to at or below NHSN Rates/Risk of SIR <1.0. (MV and LG campus).

k. Maintain laminectomy surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).

l. Maintain spinal fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR < 1.00. (MV and LG campus).

m. Maintain spinal re-fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).

n. Maintain hand hygiene compliance at ≥ 95%.

o. Maintain Personal Protective Equipment (PPE) compliance at ≥ 95%.

p. Maintain Enterprise Catheter Associated Urinary Tract Infection ~~(CAUTI) rate at ≤ 0.23 1000 Foley catheter day~~ Rate below Standardized Infection Ratio (SIR) < 0.75

~~p.~~q.

~~q.~~r. Flu Vaccination rate: Maintain Enterprise Vaccination Rate of __-LG: 96%/MV: 90%

3. Goals

a. Recommend methods for early identification of infections using epidemiological and scientific methodologies.

b. Analyze practices that have the potential to affect hospital onset infection rates and recommend changes.

c. Provide advice and consultation as appropriate to other departments including but not limited to: Nursing, Employee Wellness and Health Services, Clinical Laboratory, Environmental Services, Sterile Processing Department and Safety/Emergency Management.

d. Monitor compliance with hospital regulatory reporting requirements to various public health agencies, National Healthcare Safety Network (NHSN), California Department of Public Health (CDPH), Santa Clara County Public Health Department (SCCPHD), Santa Clara County TB Control, Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality (IQR).

e. Coordinate monitoring and surveillance activities for targeted infections and microorganisms selected by Infection Control Committee based on annual Risk Assessment monitor infection control practices of healthcare workers. Provide feedback and education with recommendations for improvement.

f. Provide guidelines on infection prevention and control and how to reduce the spread of infections at the general hospital orientation in for all employees.

g. Review and revise infection control policies every three years, or as needed.

h. Recognize and maintain an awareness and working knowledge of guidelines and recommendations that are published by Centers for Disease Control, Occupational Safety and Health Administration, The Joint Commission, Association of perioperative Registered Nurses (AORN), Society for Healthcare Epidemiology of America (SHEA) and the Association of Professionals in Infection Control and Epidemiology (APIC)that impact infection control. Maintain and enhance own knowledge of infection control and epidemiology.

i. Provide liaison activities with community health care providers that impact our ability to control communicable diseases. Continue to expand infection control role over the continuum of care with the assistance of Public Health Department.

j. Provide input and education on infection control issues related to construction and renovation within the hospital. Perform infection control risk assessment prior to start of construction projects and monitor construction sites for compliance with infection control practices.

4. Infection Prevention and Control Program and the Infection Control Committee (ICC)

(1) The responsibility for monitoring the Infection Prevention and Control Program is invested in the Infection Control Committee (ICC). The Infection Control (IC) Medical Director has the authority to institute any appropriate control measures or studies when a situation is reasonably felt to be a danger to any patient, Healthcare Worker (HCW) or visitor, or in the event of an infection control crisis situation (The committee functions as the central decision and policymaking body for infection control). The Infection Control Committee shall meet not less than quarterly.

(2) The ICC shall be a multi-disciplinary committee consisting of representatives from at least the Clinical Laboratory, Quality Department administration, Sterile Processing Department, Perioperative services, Nutrition Services, Environmental Services, Employee Wellness and Health and the Infection Prevention Nurses. The Chairman is the Infection Control Medical Director, a physician with knowledge of and special interest in infectious disease. Representatives from key hospital departments such as but not limited to Facilities Services, Pharmacy, and shall be available on a consultative basis when necessary.

c. The Infection Prevention and Control Department will collaborate with the ICC in developing a hospital-wide program and maintain surveillance over the program.

d. The Infection Prevention and Control Department in collaboration with the ICC shall develop a system for reporting, identifying and analyzing the incidence and cause of all hospital onset infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.

e. The Infection Prevention and Control Department in collaboration with the ICC shall develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating isolation precautions and cleaning and disinfection techniques. Such techniques shall be defined in written policies and procedures.

f. The Infection Prevention and Control Department shall develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.

g. The Infection Prevention and Control Department will collaborate with the ICC to identify new indicators and thresholds of diseases, recommend and assess corrective measures based upon the analysis of relevant data, and communicate its findings and interventions to the appropriate departments.

h. The Infection Control Medical Director of the Infection Control Committee is responsible for medical direction and decisions as required for the review, analysis and presentation of data to the Medical Staff.

i. The committee minutes shall be reviewed by the Medical Executive Committee.

5. Infection Prevention Department

a. The Director ~~Manager~~ of Infection Prevention is responsible for the
b. development, implementation, and evaluation of the infection prevention performance improvement activities, ensuring that they are based upon accurate data collection, analysis, and interpretation.
c.
d. Provides input and assistance in the revision, updating and formulation of policies and procedures related to infection prevention and control.

e. Identifies possible trends and risks of disease transmission through ongoing surveillance process.

f. Participates with members of Infection Control Committee to provide solutions to potential infection control problems.

g. Communicates potential infection control risks to appropriate departments either verbally or through written report.

h. Notifies the Santa Clara County Public Health Department, The Santa Clara County TB Control Department and the California Department of Public Health, either verbally or by written communication for mandatory disease reporting.

i. Provides education for all staff, patients and families regarding infection prevention and control principles that reduce the spread of disease.

j. Acts as consultant in the management of patient's infection problem while in the hospital or upon discharge.

6. Scope of Services

a. The infection control program is divided into functional groups of routine activities that address the integrated facets of surveillance and prevention of infections, monitoring and evaluation, epidemiological investigation, risk reduction, consultation and education.

b. Hospital Onset Infection Surveillance and Prevention

1) For the purpose of surveillance, hospital onset infections shall be clinically active infections occurring in hospitalized patients in whom the infection was not present or incubating at the time of admission.
2) Infections with endogenous organisms of the patient and those organisms transmitted either by healthcare workers or indirectly by a contaminated environment shall be included. Some hospital onset infections are potentially preventable-while others may be considered inevitable.
3) Strict criteria shall be used for assessment in regard to targeted hospital onset infections. Not all hospital onset infections in the hospital shall be counted and presented for statistical analysis. The type of data collection to be used and analyzed shall be determined by the Infection Control Committee (ICC) based upon the annual Risk Assessment.
4) The criteria written by the Center for Disease Control and Prevention (CDC) shall be used when calculating infection rates for statistical analysis.

7. **General Surveillance Activities**

8. Active infection surveillance within the hospital shall be an ongoing observation of the occurrence and distribution of disease or disease potential and of the conditions that increase or decrease the risk of disease transmission.

   a. The surveillance of patients, staff and environment shall ensure appropriate patient placement, initiation of appropriate isolation or special precautions, identification of patient care problems associated with hospital infection control, prevention of targeted hospital onset infections in high risk, high volume procedures, facilitation of data collection for selected quality indicators and the collection of required information for reporting to the Public Health Department.

   b. Daily laboratory reports, utilization review reports and verbal communications with staff shall be reviewed routinely by the Infection Prevention Nurses. Surveillance shall be a blend of

routine physical presence in all areas of the facility and the use of clinical and laboratory computer information systems.

c. The amount of time spent on infection surveillance, control and prevention activities is based upon the following:

- Acute Care Hospital Services:
  El Camino Hospital is a General Acute Care Community hospital with 2 campuses serving Santa Clara County, a large urban area in Northern California.
  - Licensed beds:
    El Camino Hospital Mountain View:
    275 General Acute Care
    44 Perinatal Services
    24 Intensive Care
    20 Intensive Care Newborn Nursery
    7 Pediatric Services
    180 Unspecified General Acute Care
    25 Acute Psychiatric
    El Camino Hospital Los Gatos:
    143 General Acute Care
    30 Rehabilitation Center
    14 Perinatal Services
    8 Coronary Care
    7 Intensive Care
    2 Intensive Care Newborn Nursery
    82 Unspecified General Acute Care
  - Patient Population:
    a. Various ages, ethnic, socio-economic backgrounds
  - Risk factors of the population:
    Infectious agents related to the population~~construction~~
    a. Tuberculosis
    b. MRSA
    c. Carbapenem-resistant enterobacteriaceae (CRE)

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d. Extended spectrum beta-lactamase (ESBL)
e. Multi-Drug Resistant Gram Negative Rods (MDRGNRs)
f. *Clostridium difficile*
g. ~~*Vancomycin Resistant Enterococcus (VRE)*~~

- Complexity of the services provided:
  a. Basic Emergency Medical Services
  b. Behavioral Health
  c. Cardiac Catheterization Lab
  d. Cardiovascular Surgery
  e. Critical Care- adult and NICU
  f. Dialysis-inpatient
  g. General Surgery (including Bariatrics)
  h. Infusion Center (outpatient)
  i. Medical / Surgical
  j. Oncology – inpatient and outpatient
  k. Nuclear medicine, radiology, diagnostic imaging
  l. Radiation oncology (outpatient)
  m. Rehabilitation Services
  n. Senior Health Center

o. The selection of clinical indicators is determined by the Infection Control Committee and is based upon the assessment of problem prone, high risk/high volume services provided. Results of these measures are reported in rates rather than raw numbers using valid epidemiological methods. Results are evaluated annually using data trend analysis generated by surveillance activities during the year and shall reflect changes in the hospital's assessed needs.

a. Surgical Site Infection Surveillance

b. Specific surgical site infection surveillance in accordance with California Department of Public Health Senate Bill 1058 requirements shall be monitored and reported to NHSN on a monthly basis. Surveillance activities include: daily census review of admission diagnosis, daily review

of positive cultures and review of post discharge surveillance letters to surgeons.

c. Targeted "high-risk" surgical procedures are monitored for surgical site infections and results are reported quarterly to the Infection Control Committee. Surveillance activities include: daily census review of admission diagnosis, daily review of positive cultures and review of post discharge surveillance letters to surgeons.

8. Targeted Surveillance Indicators for upcoming Calendar Year based upon the annual evaluation of the IC plan:

a. Monitor targeted hospital and community onset infections and specific organisms as determined by the annual Risk Assessment.

b. Surveillance for FY 2018~~7~~**:**

1. Surgical site infections of high-risk procedures: Total knee, total hip, laminectomy, fusion, refusion and CABG procedures.
2. Marker organisms: MRSA, *C. difficile* and MDR GNRs
3. Blood Stream Infections related to central lines hospital-wide
4. Foley catheter related Urinary Tract Infections hospital-wide

c. Active disease surveillance at both campuses

1. Daily surveillance of MRSA, C difficile, Multi-Drug Resistant Organisms (MDRO), Tuberculosis, & other communicable diseases
2. Active surveillance of Surgical Site Infections (SSI), Central Line-Associated Blood Stream Infection (CLA-BSI), Catheter-Associated UTI (CA-UTI)
3. Carbapenem Resistant Enterobacteriacae (CRE) surveillance (patients hospitalized outside the U.S. within 6 months, admissions from skilled nursing facilities with patients identified with CRE)
4. Tracking: mold-related organisms in construction areas

5. Evaluation/segregation of persons at risk
6. Specialized response to exposure & outbreaks

9. **C. Diff Prevention Strategy** Plan: Use Clostridium rates as quality indicators to evaluate the effectiveness of compliance with transmission-based precautions and cleaning and decontamination protocols. Goal is to reduce hospital onset infections of *C. difficile.*

a. Do: (1) Determine number of new *C. difficile* cases per 10,000 patient days. (2) Track daily C.diff patients by room location.

b. Study: Review and analyze data on a quarterly basis to identify trends and potential high-risk areas.

c. Act: (Clostridium difficile) – Staff to cleanse hands of patients with soap and water before each meal. Place patient on Contact Precautions. Provide education to patient and family on Clostridium difficile infection. Bathe patient daily. Change linens daily or when soiled. Clean/disinfect patient room with bleach product and UVC (ultraviolet disinfection) upon transfer/ discharge or clearance. Provide education to staff, physicians, patients, and families

10. Data Collection Methods

a. All identified cases related to targeted infections and communicable diseases will be maintained in a database. Specific methods used by infection control to obtain surveillance data include daily lab reports, patient census reports, daily serological reports, patient charts, referred cases from case managers and verbal communication with staff and physicians.

b. Surveillance shall be a blend of routine physical presence in all area of the facility and use of clinical and laboratory computer information systems.

11. **Investigation of Disease Clusters (Outbreak Control)**

a. The Infection Control Infection Control Medical Director in coordination with the ~~Manager~~ Director of Infection Control shall have ultimate authority and responsibility for investigating epidemic/outbreak situations and implementing appropriate interventions in order to prevent and to control further disease and to identify factors that contributed to the outbreak. (See Infection Control ~~Policy and~~ Procedure Outbreak Investigation).

12. Reporting to Outside Agencies

a. Specified communicable diseases (in accordance with Title 17, California Code of Regulation) identified at El Camino Hospital shall be reported to the Santa Clara Department of Public Health (SCDPH) in the required timelines to prevent the spread of certain communicable diseases to the public at large. (See Infection Control ~~Policy and~~ Procedure on Communicable Disease Reportings~~s~~).

b. El Camino Hospital shall provide follow-up management for pre-hospital caregivers who may have been exposed to a communicable disease during the performance of their duties and reporting of these exposures to the proper authorities. (See Infection Control ~~Policy and~~ Procedure Pre-hospital Communicable Disease Exposure).

c. El Camino Hospital shall report to NHSN the following:

- Hospital Onset and community onset MRSA BSI's
- Hospital Onset and community onset VRE BSI's
- Hospital Onset and community onset CRE-Klebsiella BSI's
- All Hospital cases of *Clostridium difficile* infections
- Hospital wide CLABSI's
- Hospital Wide CAUTI's
- Number of Operative procedures identified by CDPH as consistent with meeting the requirements of Health and Safety Code (HSC) Section 1288.55 for reporting SSI's.
- All Healthcare associated Surgical Site infections of deep incisional or organ space surgical sites, healthcare associated infections of orthopedic surgical sites, cardiac

surgical sites, and gastrointestinal surgical sites designated as clean and clean-contaminated as outlined in HSC 128.55.

13. Education

a. Orientation for all hospital employees shall include general information on potential infection risks, transmission routes, and infection prevention measures, proper hand hygiene, isolation precautions, and environmental cleaning and disinfection.

b. Annual review of infection control principles shall be done through a computer-based learning system (Health Stream) and tracked by the Education Department.

c. Department specific education shall be done as deemed necessary by the Infection Control Medical Director and/or the Infection Prevention Nurses, working in conjunction with department managers.

d. Training material in all areas of education shall be kept current and conform to current information pertaining to the prevention and control of infectious diseases. Infection Control Nurses shall attend annual hospital-funded continuing education programs to maintain current in principles of Infection Prevention and Control and epidemiology.

e Quarterly In-service presentations are provided to the Infection Control Resource Groups (ICRG). The ICRG is comprised of staff members from all nursing departments and ancillary departments (Lab, RT, etc.).

14. ECH Infection Prevention and Management Infection Control Committee Involvement– FY 2017

a. The Infection Prevention Nurses are active members of the following committees:

1) CAUTI Reduction Task Force
2) CLABSI Reduction Taskforce
3) SSI Reduction Task Force: Los Gatos Campus
4) Critical Care Committee
5) Antibiotic Stewardship
6) Emergency Management
7) Sepsis Committee
8) Value Analysis

15. Research

a) Research and investigate unusual cases, infections, or issues pertaining to Infection Control through ongoing literature review and web-based search activities.
b) Identify and report unusual cases, infections, or trends at scientific meetings or in the medical literature.
c) Participate in any regional or national Infection Control projects as is feasible and appropriate.
d) Participate in government- or pharmaceutically-sponsored clinical research projects pertaining to Infection Control as feasible and appropriate.
e) Identify opportunities for independent directed clinical research and focused projects within the hospital and surrounding facilities as feasible and appropriate.
f) Lend knowledge and practical support to other departments or units participating in clinical research studies including but not limited to the Microbiology Laboratory, Employee Health Services, Pharmacy Services, and Patient Care Services.

16. Liaison

a) Provide ongoing expert advice and consultation as appropriate to other departments including but not limited to Microbiology Laboratory, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
b) Coordinate Infection Control activities with other departments or units including but not limited to Dialysis Services, Patient Care Services, Microbiology Laboratory, Pathology, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.

c) Function as a liaison to the Santa Clara Public Health Department and other agencies.
d) Function as a liaison to Infection Control Programs at other hospitals and long-term care facilities.

17. Policy Formation

a) Policies and procedures shall be reviewed on a regular basis with changes made as new guidelines and information become available.
b) Standard Precautions shall be practiced in all areas of the hospital and are the basic standard of care for all patients.
c) Additional transmission-based precautions shall be used in addition to standard precautions for specific diseases or organisms to prevent their transmission.
d) Infection control departmental policies are found on the toolbox.

18. Quality Improvement

a) Provide ongoing evaluation and assessment of the goals and accomplishments of the Infection Control Program to ensure that it meets the needs of the hospital, employees, physicians, patient population, and visitors.
b) Evaluation of the Infection Control Plan shall be done at least annually or when a change in the scope of the Infection Control Program or in the Infection Control risk analysis occurs. Assessment of Infection Control strategies shall also be evaluated for their effectiveness at preventing infections.

19. Environmental Conditions

a. To ensure a safe environment during times of construction and or remodeling, protective measures shall be approved by the Infection Control Staff and implemented before the project commences. All construction projects will have an Infection Control Risk Assessment (ICRA) performed by the Infection Control staff prior to start of construction.

b. Routine microbiological surveillance of the inanimate hospital environment or of personnel, with the exception of

research purposes, shall be done on an as needed basis (to be determined by the Infection Control Nurse).

c. Sterile Processing: Cleaning, disinfection and sterilization. Steam, Sterrad and ETO sterilizers shall be monitored according to current best practice guidelines. Instrument cleaning, disinfection and sterilization procedures shall be performed according to the manufacturer's recommended instructions for use.

d. Endoscopes: Instrument cleaning, disinfection and sterilization shall be monitored each cycle by Steris/ Medivators quality indicators according to current best practice guidelines and manufacturer's instructions for use.

e. All probes & TEE scopes: Instrument cleaning, disinfection and sterilization shall be monitored each use by quality indicators according to current best practice guidelines and manufacturer's instructions for use.

f. Water used to prepare dialysis fluid shall be tested according to current AAMI standards. Current testing includes at least once a month. It shall contain a total viable microbial count not greater than < 100 cfu/ml; Endotoxin level < 0.25 EU/MI).

20. Reporting Mechanisms

a. Patients admitted with a reportable or communicable disease or who develop such a disease while hospitalized shall be reported to Infection Control by admitting staff, care coordinators, case managers or direct care providers.

b. Physicians shall be encouraged to report infections that occur after discharge that could be related with a recent hospitalization.

c. Suspected exposure of pre-hospital care providers to infectious diseases shall be reported to infection control by emergency department staff or by the designated officer of the pre-hospital care giver. Each case shall be evaluated

and exposure confirmation determined. The proper forms shall be sent to the designated officer and to the Public Health Department. (See ~~Policy &~~ Procedure Pre-hospital Communicable Disease Exposure.)

d. A report regarding all infection control activities shall be made each quarter to the Infection Control Committee. The report shall include appropriate results related to routine surveillance, sentinel organisms, emerging pathogens, public health issues, employee health issues and special studies or reports. Copies of the committee meeting minutes shall be forwarded to the Medical Executive Committee. *C. diff* and MRSA Hospital Onset incidence rates and prevalence (new and old cases) shall be reported to individual departments on a quarterly basis. MRSA Screening compliance, Hand Hygiene/PPE compliance, Blood Stream infection rates are also reported to individual departments on a quarterly basis

POLICY/PROCEDURE TITLE: **Infection**

APPROVAL	APPROVAL DATES
Infection Control Committee	1/2018
ePolicy Committee:	2/2018
MEC:	
Board of Directors:	

Historical Approvals:
Board of Directors: 5/01, 7/9/03, 3/2/05, 10/5/05, 1/4/06, 5/11/07, 11/14/07, 9/9/09, 4/14/10, 5/11/11, 10/12, 2/14, 2/15, 1/2016, 4/2017

REFERENCES:

1. Deborah Yokoe et al. Compendium of Strategies to Prevent Hospital Acquired Infections in Acute Care Hospitals ICHE 2008:29; S12-S21.
2. Jonas Maschall et al. Strategies to Prevent Central Line Associated Blood Stream Infections in Acute Care Hospitals ICHE 2008:29; S22-S30.
3. Susan Coffin et al. Strategies to Prevent Ventilator Acquired Pneumonia in Acute Care Hospitals ICHE 2008:29; S31-S60.
4. Deverick J. et al. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals ICHE 2008:29; S51-S61.
5. David Calfee et al. Strategies to Prevent Transmission of Methicillin Resistant *Staphylococcus aureus* in Acute Care Hospitals ICHE 2008:29; S62-S80.
6. Erik Dubberke et al. Strategies to Prevent *Clostridium difficile* Infection in Acute Care Hospitals ICHE 2008:29; S81-S92.

ATTACHMENTS: See top right hand corner Attachments tab
IC Plan Evaluation-Annual Report FY 2017

Infection Control Risk Assessment

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

POLICY/PROCEDURE TITLE: **Infection**

Enterprise Risk Factor/Event *Measurement* *FY17 Rate*	**FY17 Goal**	**Probability Risk Will Occur** *(1=low, 2=mod, 3=high)*	**Potential Severity if Risk Occurs** *(1=low, 2=mod,*	**Stability of Process** *(1=high, 2=needs*	**FY17 Outcome** *(compared to annual goal or*	**Priority Rank** *The higher the score the greater the risk of HAIs.*	**FY18 Goal / Benchmark**	**Comments:**
Acute HO Foley Cath Urinary Tract Infection **MV:# 20/LG:# 1** *New Infections/1000 Cath Days rate: 1.06*	Rate: 0.23 SIR < 1.0	3	3	2	2	10	SIR ≤0.75	**Rate increased from FY 16 to FY 17 FY16: 0.36 vs FY17: 1.06** *Enterprise: FY16 (8) vs FY17 MV: (20)/LG: (1)* CAUTI Task Force in place. Daily tracking of Foley Catheters. New NPSG for CAUTI Prevention. Provide education to patients. Provide education to physicians. Provide education to nurses. Partner with nursing to evaluate patient hygiene management policy
Total Knee Surgical Site Infection **MV:#0/LG# 3** *New Infections/100 Procedures 0.34/LG-SIR 1.73*	SIR ≤1.0	3	3	2	2	10	SIR < 1.0	**Enterprise rate increased from FY16: 0.34 vs FY17: 0.56** *FY16: MV (0)/LG:* (2) vs FY17 MV: (0)/LG: (3) NHSN -LG had (1) more Knee infection than expected, Goal: SIR rate <1.0. Strategies: Start SSI Reduction Task Force at LG to include Peri-op, Medical Director of Quality, Risk Management to work on best pracice guidelines to reduce SSI.

POLICY/PROCEDURE TITLE: **Infection**

Total Hip Surgical Site Infection **MV:#3/LG:#0** *New Infections/100 Procedures rate: 0.68/-SIR ≤1.0*	SIR ≤1.0	3	3	2	2	10	SIR < 1.0	**Enterprise rate decreased from FY16: 0.68 vs FY17:0.51** *FY16 MV (3)/LG: (1) SSI's/FY17: MV:(3) /LG (0)* GOAL: **SIR Rate < 1.0** Continue to investigate SSI to determine best practice guidelines to decrease SSI. Med. Dir. to follow-up with surgeons. Start Nose-to-toes program - Enterprise
Spinal Fusion Surgical Site Infection **MV:# 0/LG# 1** *New Infections/100 Procedures Rate 0.17/ SIR ≤1*	SIR ≤1.0	2	3	1	1	7	SIR < 1.0	**Enterprise rate decreased from FY16: 0.66 vs FY17:0.17** FY16 MV (1)/LG: (2) SSI's/FY17: MV:(0) /LG (1) **Goal: SIR Rate < 1.0** Continue to investigate SSI to determine best practice guidelines to decrease SSI. Med. Dir. to follow-up with surgeons. Start Nose-to-toes program - Enterprise
Laminectomy Surgical Site Infection **MV:#0/LG:1**-*New Infections/100 Procedures 0.23/SIR ≤1*	SIR < 1.0	2	3	1	1	7	SIR < 1.0	**Enterprise rate decrease FY16: 0.23 vs.FY17: 0.20** *MV: FY16 (0) vs. FY17 (0) LG: FY16 (1) vs. FY17 (1)* MV: met goal, post discharge surveillance monitoring for identifying SSI in place. Implemented SSI reduction taskforce with neurosurgeons, ID and periop director, established strategies to decrease spine SSI. Accomplished goal of providing CHG Scrubs, in pre-op to spine patients.

CLABSI **MV:#6/LG:#1** *Infections/1000 Central Line Days* *0.57*	SIR ≤1.0	2	3	1	2	8	SIR < 0.5	***Increased FY16: rate 0.08 to FY17: 0.57*** *MV: FY16 (1)/LG: (0) vs MV: FY17 (6)/ LG: (1)* Improved outcome was the result of the CLABSI Reduction Task Force. Multiple measures were implemented to re-educate the nursing staff on best practice guidelnes for: CVL, linecare, dressing changes, blood draws
MDRGNR: Hospital Onset Infections **MV:#1/LG:#0** Infections/*10,000 Patient Days* *Rate:0.10*	1.40	1	2	1	1	5	0.50	Met goal. Continue to work to sustain improvement with current measures. **Enterprise rate decrease FY2016: 0.11 vs FY2017: 0.10** MV: decrase FY16 (1) cases vs. FY17 (1) case Note: Increase risk of CRE in local SNF. Strategy to screen patients on admission from high risk facilites
MRSA: Hospital Onset Infections **MV:#3/LG:#3** *Infections/10,000 Patient Days* *Rate: 0.50*	1.40	1	2	1	1	5	0.90	Met goal. Continue to work to sustain improvement with current measures. **Enterprise rate FY2016: 0.56 vs FY2017: 0.50**
***Clostridium difficile*: Hospital Onset** **MV:#18/LG:#1** *Infections/10,000 Patient Days* *1.69*	≤7.0	2	1	1	1	5	SIR ≤ 0.7	**Decreased HO rate FY16 rate: 1.96. vs FY17 1.69** *Enterprise: FY16 (17) vs. FY17 (19)* **S**ustain improvement with current measures. Daily tracking of all C. diff patients. Process in place for notifying clinical managers , unit staff, EVS and MD attending on all HO cases to provide education on transmission and hand hygiene compliance. Surveillance system in place to test high risk patients on

								admission. IC nurse member of the Antibiotic stewardship committee to present C.diff data.
Operating Room/ IUSS	IUSS <5.0%	1	2	1	1	5	IUSS <5%	Sustained improvement with current measures. Daily huddle with SPD staff and OR Staff
Personal Protective Equip *% Observed Compliance* *100%*	95%	1	2	1	1	5	1.00	PPE/ Isolation education to all staff during general hospital orientation. PPE education to visitors and patients in isolation. Monitoring system in place; follow up process for notification of non-compliant staff.
Hand Hygiene *% Observed Compliance* *Entry: 97%* *Exit: 96%*	95%	1	2	1	1	5	95%	Monitoring system in place; follow up process for notification of non-compliant staff. Ongoing yearly hand hygiene campaign during IC week in Oct. Provide education/ demonstration to staff on WHO hand hygiene guidelines during general hospital orientation.
MRSA Screening *% "At Risk" with Screen Ordered* *91%*	90%	1	1	1	1	4	90%	Met goal. Continue daily census audit for high-risk patients. Documentation of MRSA education by IC Nurses/staff nurses.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	ADT ICU-LG
CATEGORY:	Patient Care Services
LAST APPROVAL:	

TYPE:	☐ Policy ☐ Protocol ☐ Practice Guideline ☐ Standardized Procedure ☐ Procedure ☐ Plan ☑ Scope of Service/ADT
SUB-CATEGORY:	Patient Care Services
OFFICE OF ORIGIN:	P & P Workgroup LG
ORIGINAL DATE:	

I. COVERAGE:

All LG El Camino Hospital staff

II. PURPOSE:

- To establish criteria for the admission/discharge/transfer of patients to/from the Intensive Care Unit (ICU) LG.
- To define patient populations which are appropriate for admission to the ICU.
- To identify any exclusion criteria for ICU.

III. POLICY STATEMENT:

~~It is the procedure of El Camino Hospital regarding ICU admissions, to ensure patient safety~~ Patient admissions, discharges and transfers to/from Intensive Care Unit(ICU) will be in accordance with the established admission, discharge and transfer criteria.

IV. PROCEDURE:

A. Admission to the ICU

1. ~~The Intensive Care Unit (ICU) provides extraordinary care for critically ill patients.~~ All admissions are screened for appropriateness by a ICU charge RN or ~~Nursing Unit Coordinator (NUC)~~designee~~.~~ Admissions or transfers who do not clearly meet the admission criteria are referred to the Medical Director/designee for review and approval.
   Transfers from other hospitals are referred to an attending ~~primary MD~~physician~~-~~caring for the patient and transfers are coordinated by an ICU charge RN and/or Assistant Hospital Manager/Supervisor. ~~(in collaboration with the Pre-Admission Coordinator~~). ~~The ICU charge RN conducts daily rounds with the Medical Director to identify patients ready for transfer/discharge and to review pending admissions~~. ~~During times of high census, the Charge RN and~~

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~~Medical Director triage patients as often as necessary to avoid Emergency Department ambulance diversions. It is the responsibility of the ICU Medical Director to decide if a patient meets eligibility requirements for the ICU. In cases of conflict, the medical director will decide which patients have priority for placement in the ICU and if a primary physician is in disagreement with the director's decision, he/she may appeal the case to the Medical Chief of Staff. The case will be reviewed by the Special Services Committee.~~

B. Admission Exclusion Criteria:

1. Irreversible primary pathology which will lead to imminent demise despite therapy. e.g. "Comfort Care Patients"
2. Children less than 13 years of age and weighing less than ~~eighty pounds~~36 kilograms.
3. Patients not requiring critical care nursing/NIM < ~~4~~3
4. ~~Hours of nursing care less than a 1RN per 2 patient ratios~~

C. Admission Criteria:

1. Includes but is not limited to:
2. Acute respiratory distress requiring continuous intervention/nursing observation and/or intubation.
3. Impending respiratory failure for:
   a. Respiratory muscle fatigue with associated tachypnea/O2 de-saturation
   b. Acute hypoxia
   c. X-ray or endoscopic evidence of airway narrowing and/or imminent occlusion with/without stridor
   d. Acute hypercapnia (pH less than 7.3 with corresponding pC02 elevation).

~~4.~~ IV vasoactive drugs ~~requiring frequent titration and/or monitoring.~~

~~5.~~4. Treatment of ~~shock~~Severe Sepsis/Septic Shock per protocol:

~~a. Impending shock unresponsive to a fluid bolus.~~
~~b. Overt shock with impaired mentation~~
~~c. urine output < 0.5cc/kg/hr~~
~~d. Mean BP<65 and/or SBP<20mm Hg below patient's norm.~~

5. Active hemorrhaging

~~6.~~5. Hemodynamic evaluation requiring the use of specialized critical care equipment:
- ~~-IABP~~
- ~~-PA line~~
- -ICP
- ~~-CVVH~~
- -Continuous Cardiac Output monitoring
- -Continuous ScVo2 monitoring
- ~~—~~

~~7.~~6. Status post Cardio Pulmonary Resuscitation and/or Therapeutic Hypothermia.

~~8. Immediate post-op coronary artery bypass graft (CABG) or Cardio/Thoracic/vascular surgeries.~~

7. Cardio/Thoracic/Vascular surgeries

~~9.~~8. Neuro~~/~~neuro-surg~~e~~ical~~ry~~ patients with uncontrolled seizures, invasive monitoring systems, or frequent monitoring of unstable respiratory/neuro status.

~~10.~~9. Life threatening unstable dysrhythmia requiring frequent clinical intervention(s).

~~11.~~10. Acute/unstable myocardial infarction (AMI).

~~12.~~11. High probability R/O MI or unstable angina with:
a. ST segment elevation or depression and/or
b. Positive cardiac injury markers and/or
c. High risk coronary disease with ongoing chest pain and/or
d. Treatment with intravenous vasoactive medications

~~13.~~12. Transvenous or percutaneous cardiac pacemaker with underlying life threatening dysrhythmias.

~~14.~~13. Close observation for severe metabolic and/or chemical imbalances. (DKA/ Hyperglycemia/Hypoglycemia etc) requiring frequent pharmacological interventions.

~~15.~~14. Drug overdose patients requiring:
a. Airway management or ventilatory support
b. Hemodynamic stabilization.
c. Arrhythmia observation and/or intervention
d. ~~Restraints (Medically Necessary) for agitated/combative behaviors~~.

~~16. Dialysis patients requiring pressor support during or post dialysis.~~

~~2) All pediatric patients meeting the minimum age and weight requirement of 80# and/or 13 years of age. All pediatric patients will have a pediatrician in attendance.~~

~~3)~~2) High risk Post-Operative patients ~~at high risk for complications.~~

~~4)~~3) Thrombolytic therapy for pulmonary embolism, AMI, or any other embolic event

~~5)~~4) ~~Severe Sepsis /Septic Shock~~

D. Discharge and Transfer Criteria:

A patient is appropriate for discharge or transfer from the ICU when medical criteria has been met. Discharge and transfer evaluations occur daily and are the responsibility of attending physician in collaboration with consultant physicians.

Patients for discharge and transfer from the ICU must meet the following medical criteria:

1. Patients must have a stable airway which includes:
   a. Breathing spontaneously without mechanical ventilation for a minimum of 4 hours following extubation.
   (b) O2 Saturations >~~90~~88%, Respiratory rate(> 8 or <32/min) with or without supplemental O2
      i. (c) absence of signs/symptoms of respiratory distress

2. Patients who achieve hemodynamic stability and no longer require vasoactive drug ~~titration~~ therapy.
~~Once a vasoactive drug has been weaned and discontinued~~, a patient must remain in ICU a minimum of ~~four~~ 4 hours~~. to insure hemodynamic stability prior to transfer~~. .

~~b. (3) Patients who are hemodynamically stable for 4 hours and~~
~~(1) have:~~
~~(2) Mean BP greater than 65 and/or~~
~~(3) Mean BP within 10mm Hg of the patient's norm~~
~~(4)~~b. ~~and/or~~
   i. (c) ~~Urine output greater than 0.5 cc/kg/hr except for those patients in acute or chronic renal failure.~~

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(d) ~~**Blood Pressure/Pulse rate parameters ordered by a physician if (a),(b) and are not m**~~

APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	1/2018
ePolicy Committee:	2/2018
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	

New: 06/09, 03/2012.
Special Services: 8/00, 10/03, 11/06, 02/09
Patient Care Management Council: 12/00, 10/03, 02/05, 11/06, 01/09, 03/2012
Medical Executive Committee: 02/04, 03/05, 11/06, 02/09, 04/12,2/15
Board of Directors: 03/04, 04/05, 12/06, 03/09, 05/09/2012, 3/15

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	ADT Short Stay Nursing Unit
CATEGORY:	Patient Care Services
LAST APPROVAL:	5/2012

TYPE:	☐Policy ☐Protocol ☐Practice Guideline ☑Standardized ☐Procedure ☐Plan ☐Scope of Service Procedure/ADT
SUB-CATEGORY:	***ADT Short Stay Nursing Unit***
OFFICE OF ORIGIN:	
ORIGINAL DATE:	02/2009

☑

I. COVERAGE:
Short Stay Nursing Unit/Outpatient Surgery Department

II. PURPOSE:
- To establish criteria for the admission/transfer/discharge of patients to/from Short Stay Nursing Unit/Outpatient Surgery Department
- To define patient populations which are appropriate for admissions to the Short Stay Nursing Unit/Outpatient Surgery Department
- To identify any exclusion criteria for Short Stay Nursing Unit/Outpatient Surgery Department

III. **STATEMENT:** Patient admissions, discharges and transfers to/from short stay department will be in accordance with the established admission, discharge and transfer criteria.

IV. PROCEDURE:

A. Admission to Short Stay Nursing Unit/Outpatient Surgery Department

All admissions will be approved for appropriateness by the charge nurse or Clinical Manager. The Hospital Supervisor- - may also be utilized to evaluate admissions.

B. Admission Criteria: **ADULT**
1. Short stay patients/Outpatients undergoing interventional radiology - requiring routine pre-procedure and post-procedure care.
2. Surgical patients requiring routine pre-~~operative~~ and post-operative care.
3. Endoscopy/Bronchoscocpy requiring pre and post-procedural care (LG only)
4. Post cardiovascular procedure patients requiring local telemetry monitoring and planned for same day discharge. Limited to the following elective

procedures without complications: radial PCI, electrophysiology studies, electrophysiology ablations, cardiac rhythm management devices. (MV only)

C. Admission Criteria: **–PEDIATRIC PATIENTS**

1. The Short Stay Nursing Unit/Outpatient Surgery Department delivers care to -pediatric patients. All admissions and transfers will be approved for appropriateness by the charge nurse or nurse manager. Any admissions which do not clearly meet the admission criteria will be referred to the Hospital Supervisor for final review and approval. Transfers from other hospitals will be referred to the ~~primary MD~~ attending physician caring for the patient and will be coordinated by the Hospital Supervisor.

D. Exclusion Criteria: **ADULT PATIENTS**

1. Patients who require frequent observations and interventions beyond the routine pre-operative and post-operative period.
2. Patients requiring telemetry monitoring (LG only)
3. ~~Any patient H~~hemodynamically unstable patients~~.~~
4. Patients admitted for transfusions/infusions/pain control medications that require frequent monitoring and observation due to complex medical needs.

~~1.~~

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E. Exclusion Criteria:-PEDIATRIC **PATIENTS**

1. Unstable –pediatric patients who require intensive care or frequent monitoring.

F. Transfer Criteria for Short Stay Nursing Unit Outpatient Surgery Department - **ADULT & -PEDIATRIC PATIENTS**

1. Transfer from the Short Stay Nursing/Outpatient Surgery Department within the hospital will be dependent upon special needs of patients and~~,~~ ADT criteria of the unit i.e., acuity level, bed space, staffing levels and the operating hours of the Short Stay Nursing/Outpatient Surgery Department.
2. Transfer from Short Stay Nursing Unit/Outpatient Surgery Department to another facility. ~~See Patient Care Services Policy & Procedure Manual ADT: Transfer to Other Acute Care Facilities~~.

~~2.~~3.

G. Discharge Criteria for Short Stay Nursing/Outpatient Surgery Department– **ADULT & PEDIATRIC-PATIENTS**

1. Patients who exhibit their optimal level of functioning and can manage ADL/self-care or have caretakers(s) providing such may be discharged home.
2. Patients and/or caretaker/parent, family have an understanding of:
   a. -Activity and diet orders
   b. - Physician follow-up
   c. Medications-
   d. Potential complications and reporting mechanism.
3. Discharge Process
   a. Patients/responsible adult have ~~and/or caretaker/parent, family have had~~ -written discharge instructions and medication reconciliation form reviewed, ~~and~~ verbalized understanding and signed. ~~voiced~~
   b) Patients/ responsible adult ~~and /or caretaker/parent, family~~ have any supplies as needed

H. Exclusion Criteria for discharge in Short Stay/Outpatient Surgery Department-ADULTS AND PEDIATRIC PATIENTS
   1. Any patient without discharge order post-operative/post-procedure

~~A. Applicable Regulations:~~
   a. ~~(TJC) JOINT COMMISSION~~
   b. ~~Title XXII~~

V. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Originating Committee or UPC Committee	12/2017
ePolicy Committee:	2/2018
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	*4/2009, 5/2012*

VI. ATTACHMENTS (N/A):

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	ADT PACU
CATEGORY:	Patient Care Services
LAST APPROVAL:	3/2015

TYPE:	☐ Policy ☐ Protocol ☐ Practice Guideline ☐ Standardized ☐ Procedure ☐ Plan ☑ Scope of Service/ADT Procedure
SUB-CATEGORY:	PACU
OFFICE OF ORIGIN:	PACU
ORIGINAL DATE:	5/1995

I. COVERAGE:

All El Camino Hospital Staff

II. PURPOSE:

To establish appropriate standards and safety of patients during admission and discharge from the PACU unit.

III. STATEMENT:

It is the policy of El Camino Hospital regarding Admission to and Discharge from the PACU to ensure patient safety.

IV. DEFINITIONS:

- PACU- Post Anesthesia Care Unit
- PONV- Post Operative Nausea and Vomiting
- POSS- Pasero Opioid Sedation Scale
- MAC - Monitored Anesthesia Care

V. REFERENCES:

Perianesthesia Nursing Standards and Practice Recommendations ~~2010-2012;~~ 2012-2014; ASPAN (American Society of PeriAnesthesia Nurses; McLaughlin M, Standards and Guidelines Committee Chair.

A Competency Based Orientation and Credentialing Program for the Registered Nurse in the PeriAnesthesia Setting, 2009 Edition; ASPAN (American Society of PeriAnesthesia Nurses; Godden B, Editor.

VI. PROCEDURE:

A. Admission Criteria:

1. Patients passing exclusion criteria.
2. General, MAC, or Regional Post Anesthesia patients.

3. Moderate Sedation patients with unstable vital signs, loss of protective reflexes, or unstable level of consciousness, and/or Modified Aldrete Score less than 8.
4. Exclusion criteria: Patients not intended to be extubated before or during post anesthesia care phase.

B. Discharge:

~~1.~~ Discharge criteria are established by Department of Anesthesia ~~and reviewed annually.~~
2. The PACU nurse will call patient report ~~on the patient~~ to receiving ~~a~~ nurse~~nursing unit~~ after the patient meets discharge criteria.
3. ~~Patients not meeting discharge criteria will be assessed by an anesthesiologist.~~

C. Discharge Criteria:

1. Airway is patent and protective reflexes are intact
2. Respirations are effective with visible chest rise and fall; oxygen saturation is equal to or greater than 92% on room air or low flow oxygen support or to pre-anesthesia baseline;
3. Vital Signs are stabilized to pre-anesthesia baseline and/or Post-Anesthesia Status Score is equal to or greater than 8. POSS score 1 or 2
4. Thermoregulation: Temperature is greater than 36 degrees C or 96.8 degrees F.
5. Pain/comfort: managed using appropriate pain scale ~~Patients able to verbalize or communicate tolerable pain level with optimal function.~~
6. Sensory/motor function: Returned to pre-anesthesia baseline or has descended to spinal level T-10 or below after Epidural/Spinal.
7. Surgical site/dressing: is clean/dry/intact or reinforced. Line and tubes are intact and patient.
8. Patient is observed for peak effect of narcotic.
9. Patient is observed for two hours after administration of Naloxone or Flumazenil or transferred to same level of care.

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VII. APPROVAL:

Approving Committees and Authorizing Body	Approval Dates
Originating Committee or UPC Committee	12/2017
ePolicy Committee:	2/2018
Medical Executive Committee:	
Board of Directors:	
Historical Approvals:	3/2004, 4/205, 12/2006, 3/2009, 5/2012, 3/2015

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	ADT PACU
CATEGORY:	Patient Care Services
LAST APPROVAL:	3/2015

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Summary of Financial Operations

Fiscal Year 2018 – Period 7
7/1/2017 to 1/31/2018

Financial Overview

- **Volume:**

- For the year, overall volume, measured in adjusted discharges is 5.9% higher than budget.
- IP cases are 5.1% over budget, specifically Neurosciences, HVI, BHS, Oncology and General Medicine. Deliveries are slightly lower to prior year and 2.9% below budget
- OP cases are higher than budget in General Surgery, General Medicine, Emergency, Lab, Imaging Services, MCH, Rehab, Outpatient Clinics and Urology.

- **Financial Performance:**

- Operating income is $4.4M over budget. Revenue for the month include -$453K in unusual items. For the year op margin is $38.5M ahead of target

- **Payor Mix:**

- Commercial insurance is 0.1% more of the Payor Mix in January than budget where Medicare has decreased .6%.

- **Cost:**

- Prod Hrs/APD for January is 28.5 and better than budget . YTD we are slightly better than budget

- **Balance Sheet:**

- Net days in AR is 48.1 which is .1 days more than budget.

Dashboard - ECH combined as of January 31, 2018

	Month				YTD			
	PY	CY	Bud/Target	Variance CY vs Bud	PY	CY	Bud/Target	Variance CY vs Bud
Volume								
Licenced Beds	443	443	443	-	443	443	443	-
ADC	257	261	255	7	235	244	236	8
Utilization MV	71%	70%	71%	0%	64%	67%	65%	2%
Utilization LG	31%	35%	30%	5%	29%	30%	29%	2%
Utilization Combined	58%	59%	57%	2%	53%	55%	53%	2%
Total Discharges (Excl NNB)	1,802	1,836	1,707	129	11,372	12,081	11,516	565
Financial Perf.								
Total Operating Revenue	69,528	78,848	72,943	5,905	488,297	540,540	499,101	41,438
Operating Income $	9,347	10,397	5,962	4,435	62,425	87,043	48,508	38,535
Operating Margin	13.4%	13.2%	8.2%	5.0%	12.8%	16.1%	9.7%	6.4%
EBITDA %	19.8%	18.9%	15.3%	3.5%	19.2%	21.9%	16.8%	5.1%
Payor Mix								
Medicare	51.2%	50.7%	47.4%	3.3%	47.3%	46.8%	47.4%	-0.6%
Medi-Cal	7.5%	8.7%	7.2%	1.5%	7.2%	7.9%	7.2%	0.7%
Total Commercial	38.8%	38.5%	42.9%	-4.4%	43.0%	43.0%	42.9%	0.1%
Other	2.5%	2.0%	2.5%	-0.5%	2.5%	2.3%	2.5%	-0.2%
Cost								
Total FTE	2,527.8	2,599.8	2,569.8	30	2,479.9	2,573.6	2,512.1	62
Productive Hrs/APD	29.5	28.5	29.5	(1)	30.4	29.9	30.8	(1)
Balance Sheet								
Net Days in AR	44.8	48.1	48.0	0	44.8	48.1	48.0	0
Days Cash	444	486	266	220	444	486	266	220
Affiliates - Net Income ($000s)								
Hosp	21,393	39,597	6,187	33,410	86,923	147,285	50,085	97,200
Concern	255	82	97	(14)	725	1,111	855	255
ECSC	(1)	(1)	0	(1)	(54)	(21)	0	(21)
Foundation	147	627	(22)	650	1,675	2,217	392	1,824
SVMD	200	(332)	6	(338)	190	134	(7)	141

Budget Variances

Fiscal Year 2018 YTD (7/1/2017-01/31/2018) Waterfall

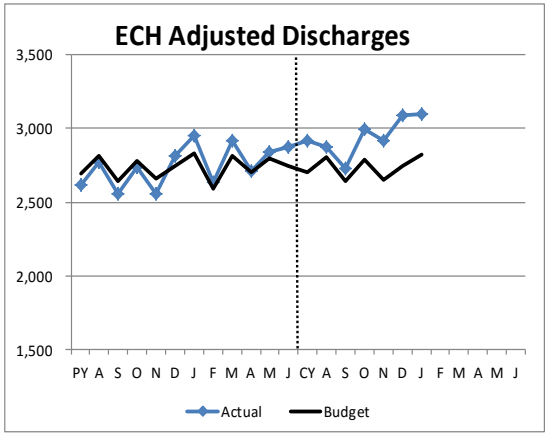
(in thousands; $000s)	Year to Date (YTD) Net Income Impact	Year to Date (YTD) % Net Revenue
Budgeted Hospital Operations FY2018	**48,508**	**9.7%**
Net Revenue - Favorable due higher volume, favorable payor mix and $13 million unusual items	41,438	7.7%
Labor and Benefit Expense Change - Labor favorable vs budget after adjusting for higher volume	(2,933)	-0.5%
Professional Fees & Purchased Services -Recruiting costs and backfill for vacant position;	(2,389)	-0.4%
Supplies - unfavorable due to increase in surgical and other general supplies, offset by savings in Spine supplies as well as Drugs. Higher volumes also driving increase.	(2,290)	-0.4%
Other Expenses - primarily due to no strategic fund expenses offset with property tax retro payment and regular payment for half year.	788	0.1%
Depreciation & Interest - Favorable due to delay in Parking Structure as well as LG projects	3,920	0.7%
Actual Hospital Operations FY2018	**87,043**	**16.1%**

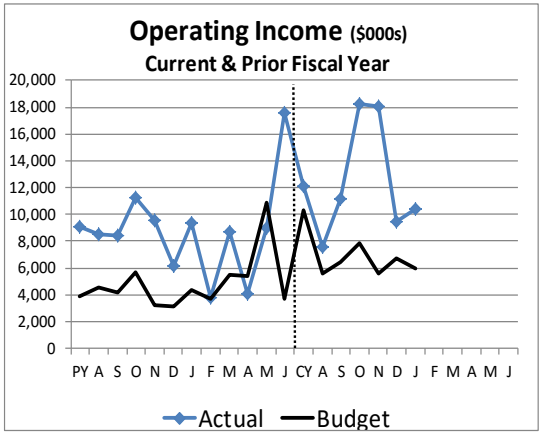
El Camino Hospital ($000s)

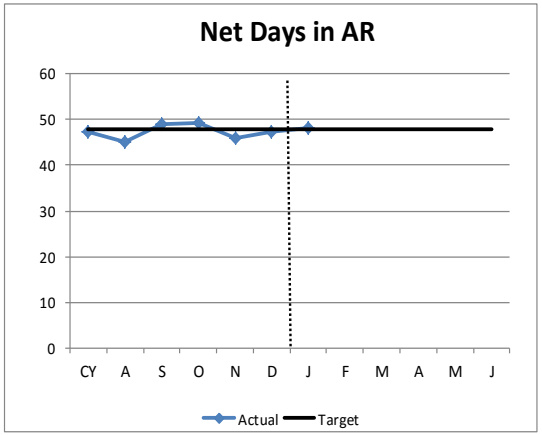
7 months ending 01/31/2018

Period 7 FY 2017	Period 7 FY 2018	Period 7 Budget 2018	Variance Fav (Unfav)	Var%	$000s	YTD FY 2017	YTD FY 2018	YTD Budget 2018	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
268,834	291,509	275,872	15,636	5.7%	**Gross Revenue**	1,719,213	1,942,283	1,854,256	88,027	4.7%
(200,008)	(214,583)	(204,784)	(9,799)	1.0%	**Deductions**	(1,246,351)	(1,419,472)	(1,368,942)	(50,529)	3.7%
68,826	**76,925**	**71,088**	**5,837**	**8.2%**	**Net Patient Revenue**	**472,861**	**522,811**	**485,313**	**37,498**	**7.7%**
702	1,923	1,855	68	3.7%	**Other Operating Revenue**	15,436	17,728	13,788	3,940	28.6%
69,528	**78,848**	**72,943**	**5,905**	**8.1%**	**Total Operating Revenue**	**488,297**	**540,540**	**499,101**	**41,438**	**8.3%**
					OPERATING EXPENSE					
35,920	41,150	40,884	(266)	-0.7%	**Salaries & Wages**	258,173	275,114	272,180	(2,933)	-1.1%
9,650	11,779	10,789	(989)	-9.2%	**Supplies**	65,356	73,109	70,820	(2,290)	-3.2%
7,763	8,904	7,798	(1,106)	-14.2%	**Fees & Purchased Services**	54,659	57,739	55,350	(2,389)	-4.3%
2,420	2,132	2,293	161	7.0%	**Other Operating Expense**	16,418	16,217	17,005	788	4.6%
444	256	725	470	64.8%	**Interest**	2,979	2,861	5,078	2,217	43.7%
3,984	4,231	4,492	261	5.8%	**Depreciation**	28,286	28,457	30,161	1,703	5.6%
60,181	**68,451**	**66,981**	**(1,470)**	**-2.2%**	**Total Operating Expense**	**425,872**	**453,497**	**450,594**	**(2,903)**	**-0.6%**
9,347	**10,397**	**5,962**	**4,435**	**74.4%**	**Net Operating Income/(Loss)**	**62,425**	**87,043**	**48,508**	**38,535**	**79.4%**
12,046	29,200	225	28,975	12860.7%	**Non Operating Income**	24,497	60,242	1,577	58,665	3719.9%
21,393	**39,597**	**6,187**	**33,410**	**540.0%**	**Net Income(Loss)**	**86,923**	**147,285**	**50,085**	**97,200**	**194.1%**
19.8%	18.9%	15.3%	3.5%		**EBITDA**	19.2%	21.9%	16.8%	5.1%	
13.4%	13.2%	8.2%	5.0%		**Operating Margin**	12.8%	16.1%	9.7%	6.4%	
30.8%	50.2%	8.5%	41.7%		**Net Margin**	17.8%	27.2%	10.0%	17.2%	

Monthly Financial Trends







Volume is higher than budgeted for the month and the year. High inpatient volume is in Inpatient Behavioral Health, HVI, Neurosciences and General Medicine. High Outpatient volume is General Medicine, Imaging Services, MCH, Lab, Outpatient Clinics, General Surgery, Emergency and Rehab

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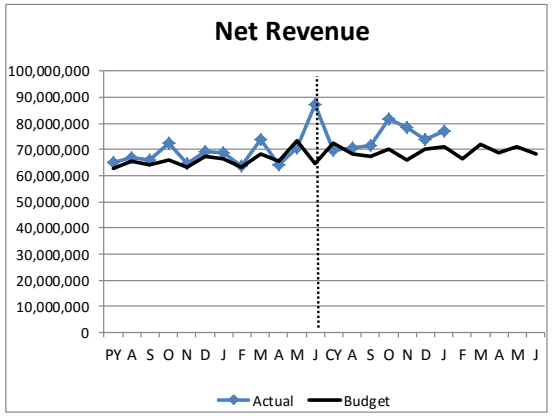
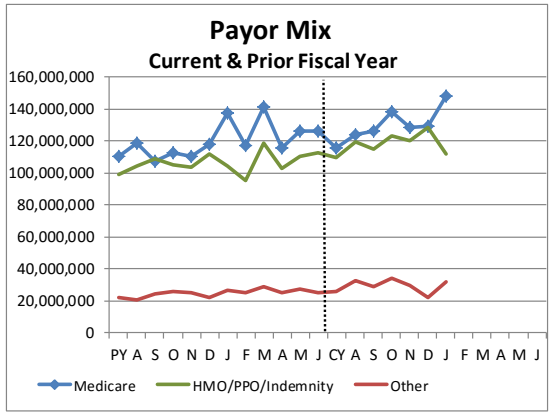
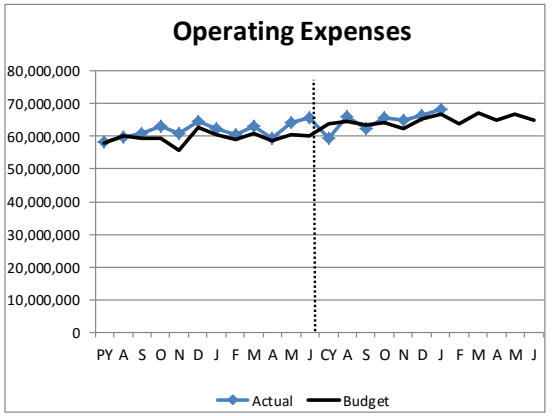
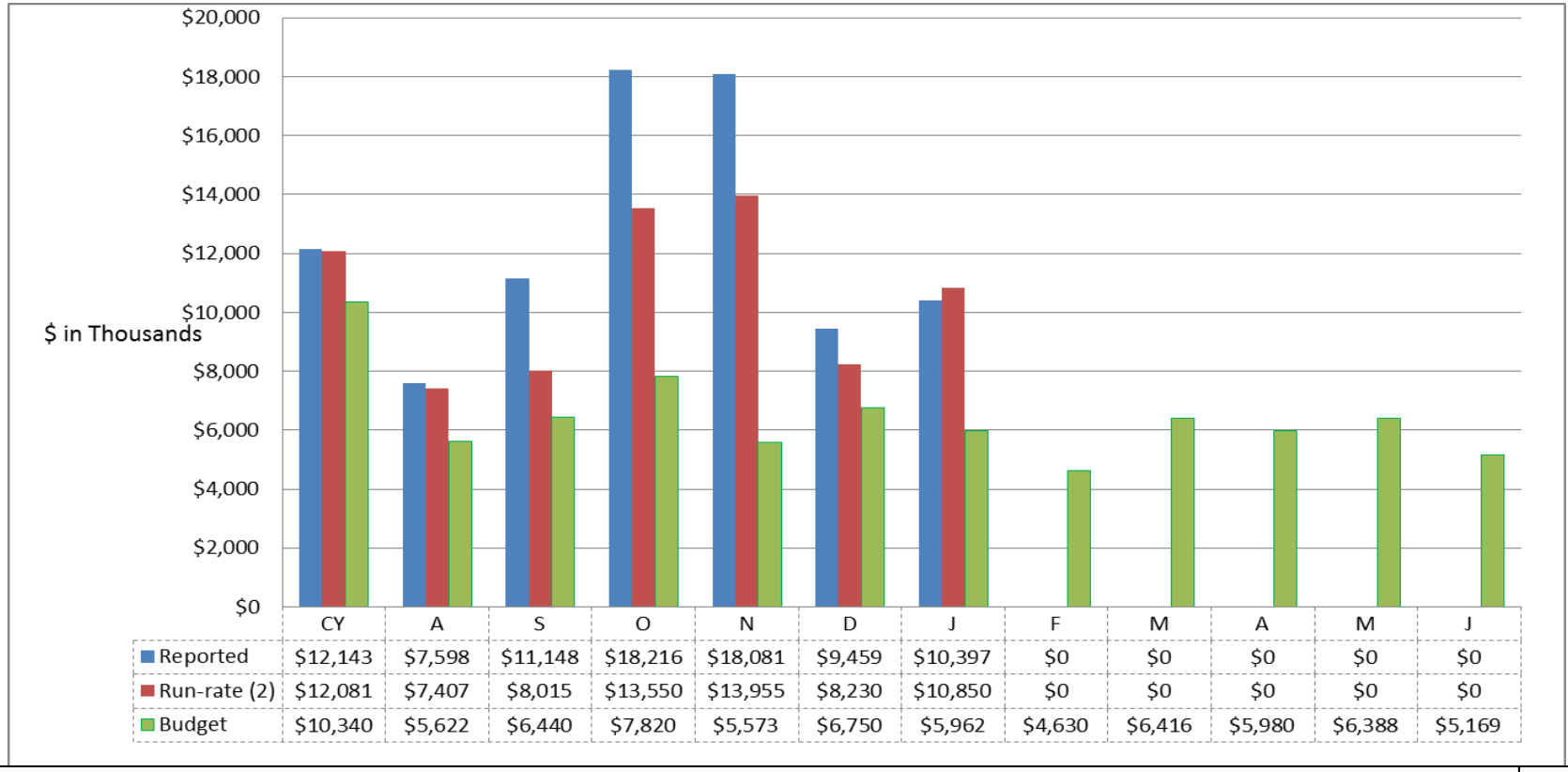






ECH Operating Margin

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	$18,216	$18,081	$9,459	$10,397	$0	$0	$0	$0	$0
Run-rate (2)	$12,081	$7,407	$8,015	$13,550	$13,955	$8,230	$10,850	$0	$0	$0	$0	$0
Budget	$10,340	$5,622	$6,440	$7,820	$5,573	$6,750	$5,962	$4,630	$6,416	$5,980	$6,388	$5,169

FY 2018 Actual Run Rate Adjustments (in thousands) - FAV / <UNFAV>

Revenue Adjustments	J	A	S	O	N	D	J	YTD
Insurance (Payment Variance)	-	-	-	611	-	669	28	1,309
Mcare Settlmt/Appeal/Tent Settlmt/PIP	54	155	905	54	184	81	396	1,830
Hospital Fee	-	-	-	712	1,024	-	-	1,736
PRIME Incentive	-	-	-	-	2,902	-	-	2,902
Credit Balance Quarterly Review	-	-	2,201	-	-	472	-	2,673
Late Charge Accrual	-	-	-	3,283	-	-	-	3,283
Various Adjustments under $250k	9	36	27	6	16	8	(878)	(777)
Total	**63**	**191**	**3,134**	**4,667**	**4,126**	**1,229**	**(453)**	**12,955**

Updated Quarterly
Last update 12/31/17

El Camino Hospital Investment Committee Scorecard

December 31, 2017

Key Performance Indicator	Status	El Camino	Benchmark	El Camino	Benchmark	El Camino	Benchmark	FY18 Year-end Budget	Expectation Per Asset Allocation
Investment Performance		4Q 2017		Fiscal Year-to-date		5y 2m Since Inception (annualized)			2017
Surplus cash balance*		$872.0	--	--	--	--	--	$926.1	--
Surplus cash return		2.6%	2.7%	5.4%	5.6%	6.0%	5.9%	1.9%	5.7%
Cash balance plan balance (millions)		$259.2	--	--	--	--	--	$257.1	--
Cash balance plan return		2.9%	3.3%	6.3%	6.7%	8.4%	7.9%	6.0%	6.1%
403(b) plan balance (millions)		$441.7	--	--	--	--	--	--	--
Risk vs. Return		3-year				5y 2m Since Inception (annualized)			2017
Surplus cash Sharpe ratio		1.16	1.19	--	--	1.44	1.42	--	0.46
Net of fee return		5.5%	5.6%	--	--	6.0%	5.9%	--	5.7%
Standard deviation		4.4%	4.4%	--	--	3.9%	4.0%	--	7.2%
Cash balance Sharpe ratio		1.13	1.16	--	--	1.51	1.47	--	0.43
Net of fee return		6.7%	6.5%	--	--	8.4%	7.9%	--	6.1%
Standard deviation		5.6%	5.3%	--	--	5.3%	5.1%	--	8.7%
Asset Allocation		4Q 2017							
Surplus cash absolute variances to target		5.9%	< 10%	--	--	--	--	--	--
Cash balance absolute variances to target		7.5%	< 10%	--	--	--	--	--	--
Manager Compliance		4Q 2017							
Surplus cash manager flags		21	< 19 Green < 23 Yellow	--	--	--	--	--	--
Cash balance plan manager flags		23	< 20 Green < 25 Yellow	--	--	--	--	--	--

*Excludes debt reserve funds (~$245 mm), District assets (~$31 mm), and balance sheet cash not in investable portfolio (~$124 mm).
Includes Foundation (~$26 mm) and Concern (~$13 mm) assets. Budget adds back in current Foundation and Concern assets and backs out current debt reserve funds.

PAVILION

1

El Camino Hospital

Capital Spending (in millions)

	Category	Detail	Approved	Total Estimated Cost of Project	Total Authorized Active	Spent from Inception	2018 Current Proj Spend	FY18 Orig Proj Spend	Variance Between Current Proj Spend and Orig Proj Spend	FY 18 YTD Spent
CIP	EPIC Upgrade				1.9	1.0	1.9	1.9	0.0	1.0
IT Hardware, Software, Equipment & Imaging*					12.2	1.0	12.2	12.2	0.0	1.0
Medical & Non Medical Equipment FY 17**					14.0	12.8	8.6	0.0	8.6 [2]	7.4
Medical & Non Medical Equipment FY 18***					5.6	1.8	5.6	5.6	0.0	1.8
Facility Projects										
	1245	Behavioral Health Bldg	FY16	96.1	96.1	32.3	27.0	51.4	-24.4 [1]	14.7
	1413	North Drive Parking Expansion	FY15	24.5	24.5	23.4	2.6	3.4	-0.8	3.6
	1414	Integrated MOB	FY15	302.1	302.1	77.2	72.0	130.1	-58.1 [1]	31.3
	1422	CUP Upgrade	FY16	9.0	9.0	3.7	5.5	4.0	1.5	1.5
	1430	Women's Hospital Expansion	FY16	120.0	6.0	2.6	3.6	7.0	-3.4	2.2
	1425	IMOB Preparation Project - Old Main	FY16	20.0	0.0	2.7	0.0	0.0	0.0	0.1
	1502	Cabling & Wireless Upgrades	FY16	0.0	0.0	2.5	0.0	0.0	0.0	0.1
	1525	New Main Lab Upgrades		3.1	3.1	1.8	2.5	0.0	2.5	1.3
	1515	ED Remodel Triage/Psych Observation	FY16	5.0	0.3	0.0	0.4	0.0	0.4	0.0
	1503	Willow Pavilion Tomosynthesis	FY16	0.8	0.0	0.3	0.0	0.0	0.0	0.0
	1602	JW House (Patient Family Residence)		6.5	0.5	0.0	0.5	0.5	0.0	0.0
		Site Signage and Other Improvements		1.0	0.0	0.0	0.3	1.0	-0.8	0.0
		Nurse Call System Upgrades		2.4	0.0	0.0	0.1	0.0	0.1	0.0
	1707	Imaging Equipment Replacement (5 or 6 rooms)		20.7	0.0	0.0	0.3	0.1	0.2	0.0
	1708	IR/ Cath Lab Equipment Replacement		19.4	0.0	0.0	0.3	2.0	-1.8	0.0
		Flooring Replacement		1.6	0.3	0.0	0.4	0.0	0.4	0.0
	1219	LG Spine OR	FY13	0.0	0.0	3.7	0.0	0.0	0.0	0.3
	1313	LG Rehab HVAC System & Structural	FY16	0.0	0.0	4.1	0.0	0.0	0.0	0.4
	1248	LG Imaging Phase II (CT & Gen Rad)	FY16	8.8	8.8	8.1	0.6	0.7	-0.1	0.7
	1307	LG Upgrades	FY13	19.3	19.3	16.5	4.9	5.0	-0.1	2.7
	1508	LG NICU 4 Bed Expansion	FY16	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	1507	LG IR Upgrades		1.3	0.0	0.0	0.0	0.0	0.0	0.0
	1603	LG MOB Improvements (17)		5.0	5.0	4.3	3.5	3.5	0.0	4.0
	1711	Emergency Sanitary & Water Storage		1.4	0.3	0.1	0.2	3.2	-3.0	0.1
		LG Modular MRI & Awning		3.9	3.9	0.0	0.4	0.0	0.4	0.0
		LG Nurse Call System Upgrade		2.8	0.0	0.0	0.0	0.0	0.0	0.0
		LG Observation Unit (Conversion of ICU 2)		1.8	0.0	0.0	0.8	0.0	0.8	0.0
	1712	LG Cancer Center		2.4	0.3	0.0	0.4	0.0	0.4	0.0
		All Other Projects under $1M		5.6	0.4	27.0	1.8	0.0	1.8	3.1
				684.4	479.6	210.3	128.0	211.9	-83.9	66.1
GRAND TOTAL					**499.4**	**227.0**	**156.5**	**231.7**	**-75.2**	**77.3**

* Excluding EPIC

** Unspent Prior Year routine used as contingency

*** Includes 2 robot purchases

1 Variance due to delay in MV campus plan

2 Initial assumption was to spend all FY17 in FY17

Balance Sheet (in thousands)

ASSETS

		January 31, 2018	Audited June 30, 2017
	CURRENT ASSETS		
	Cash	112,739	125,551
	Short Term Investments	151,829	140,284
	Patient Accounts Receivable, net	119,840	109,089
	Other Accounts and Notes Receivable	2,706	2,628
	Intercompany Receivables	1,635	1,495
(1)	Inventories and Prepaids	57,690	50,657
	Total Current Assets	**446,437**	**429,705**
	BOARD DESIGNATED ASSETS		
(2)	Plant & Equipment Fund	148,795	131,153
	Women's Hospital Expansion	9,298	9,298
(3)	Operational Reserve Fund	127,908	100,196
(4)	Community Benefit Fund	19,087	12,237
	Workers Compensation Reserve Fund	21,147	20,007
	Postretirement Health/Life Reserve Fund	19,529	19,218
	PTO Liability Fund	22,737	23,409
	Malpractice Reserve Fund	1,634	1,634
	Catastrophic Reserves Fund	19,174	16,575
	Total Board Designated Assets	**389,308**	**333,727**
(5)	**FUNDS HELD BY TRUSTEE**	**234,534**	**287,052**
	LONG TERM INVESTMENTS	**307,269**	**256,652**
	INVESTMENTS IN AFFILIATES	**33,315**	**32,451**
	PROPERTY AND EQUIPMENT		
(6)	Fixed Assets at Cost	1,251,050	1,192,047
	Less: Accumulated Depreciation	(557,018)	(531,785)
	Construction in Progress	147,153	138,017
	Property, Plant & Equipment - Net	**841,185**	**798,279**
	DEFERRED OUTFLOWS	28,610	28,960
	RESTRICTED ASSETS - CASH	0	0
	TOTAL ASSETS	**2,280,658**	**2,166,825**

LIABILITIES AND FUND BALANCE

		January 31, 2018	Audited June 30, 2017
	CURRENT LIABILITIES		
(7)	Accounts Payable	25,200	38,457
(8)	Salaries and Related Liabilities	21,710	25,109
	Accrued PTO	22,737	23,409
	Worker's Comp Reserve	2,300	2,300
	Third Party Settlements	9,942	10,438
	Intercompany Payables	73	84
	Malpractice Reserves	1,634	1,634
	Bonds Payable - Current	3,850	3,735
(9)	Bond Interest Payable	2,222	11,245
	Other Liabilities	6,522	4,889
	Total Current Liabilities	**96,190**	**121,299**
	LONG TERM LIABILITIES		
	Post Retirement Benefits	19,529	19,218
	Worker's Comp Reserve	18,847	17,707
	Other L/T Obligation (Asbestos)	3,812	3,746
	Other L/T Liabilities (IT/Medl Leases)	-	-
	Bond Payable	522,071	527,371
	Total Long Term Liabilities	**564,259**	**568,042**
	DEFERRED REVENUE-UNRESTRICTED	500	567
	DEFERRED INFLOW OF RESOURCES	10,666	10,666
	FUND BALANCE/CAPITAL ACCOUNTS		
	Unrestricted	1,219,735	1,132,525
	Board Designated	389,308	333,726
	Restricted	0	0
(10)	**Total Fund Bal & Capital Accts**	**1,609,044**	**1,466,251**
	TOTAL LIABILITIES AND FUND BALANCE	**2,280,658**	**2,166,825**

JANUARY 2018 El Camino Hospital Comparative Balance Sheet Variances and Footnotes

(1) The increase is due to three quarterly pension fundings of $2.6M in July, October and January.
(2) The increase is due 6 months of funded depreciation contributions (130% of straight depreciation expense. Note this amount also contains $14M reserved for BHS replacement building currently under construction, in conjunction with bond proceeds.
(3) The increase here is to reset the Operational Reserve (to cover 60 days of operating expenses) for FY2018. The prior year balance hadn't been reset in a couple of years.
(4) The increase is due to an approved addition of $5 million to the Community Benefit Board Designated Endowment as an outcome of the FY2018 budget process to generate additional investment income for the Community Benefits program.
(5) The decrease is due to additional draws from the 2017 bond financing Project Funds in support of monthly payments to contractors involved with the construction projects at the Mountain View campus. As these projects are now in full progress greater amounts will be withdrawn in future periods.
(6) The increase is due to the capitalization of the Parking Structure expansion in August and CT upgrades at LG in September.

(7) The decrease is due to the significant General Contractor construction payments being accrued at year end, along with associated retentions and other general accounts payable activity that were subsequently relieved in this first quarter of fiscal year 2018.
(8) This decrease is primarily due to the annual 403B match funding that occurred in January
(9) The significant decrease is due to semi-annual 2015A and 2017 Bond interest payments having been paid in January.
(10) The increase is attributable to the first seven periods of financial performance producing an operating income of $87 million and non-operating of $60 million (mostly from unrealized gains on investments).

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)

7 months ending 01/31/2018

Period 7 FY 2017	Period 7 FY 2018	Period 7 Budget 2018	Variance Fav (Unfav)	Var%	$000s	YTD FY 2017	YTD FY 2018	YTD Budget 2018	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
220,743	238,824	227,287	11,537	5.1%	**Gross Revenue**	1,413,282	1,586,778	1,521,987	64,791	4.3%
(162,494)	(176,741)	(169,500)	(7,241)	4.3%	**Deductions**	(1,020,465)	(1,159,093)	(1,127,639)	(31,455)	2.8%
58,248	**62,083**	**57,787**	**4,296**	**7.4%**	**Net Patient Revenue**	**392,817**	**427,685**	**394,349**	**33,336**	**8.5%**
664	1,762	1,638	125	7.6%	**Other Operating Revenue**	14,293	16,552	12,290	4,262	34.7%
58,913	**63,845**	**59,425**	**4,420**	**7.4%**	**Total Operating Revenue**	**407,110**	**444,237**	**406,639**	**37,598**	**9.2%**
					OPERATING EXPENSE					
29,836	34,171	34,233	62	0.2%	**Salaries & Wages**	214,818	228,833	227,782	(1,050)	-0.5%
7,521	9,255	8,719	(536)	-6.2%	**Supplies**	53,420	58,680	57,015	(1,664)	-2.9%
6,378	7,285	6,514	(771)	-11.8%	**Fees & Purchased Services ***	45,282	48,254	46,347	(1,907)	-4.1%
822	677	760	83	10.9%	**Other Operating Expense**	4,935	5,125	6,067	943	15.5%
444	256	725	470	64.8%	**Interest**	2,979	2,861	5,078	2,217	43.7%
3,482	3,536	3,724	188	5.0%	**Depreciation**	24,609	24,429	25,079	650	2.6%
48,483	**55,180**	**54,675**	**(505)**	**-0.9%**	**Total Operating Expense**	**346,043**	**368,181**	**367,369**	**(812)**	**-0.2%**
10,429	**8,665**	**4,750**	**3,915**	**82.4%**	**Net Operating Income/(Loss)**	**61,067**	**76,056**	**39,270**	**36,786**	**93.7%**
12,046	29,200	225	28,975	12860.7%	**Non Operating Income**	24,508	60,287	1,577	58,710	3722.7%
22,475	**37,865**	**4,975**	**32,890**	**661.1%**	**Net Income(Loss)**	**85,575**	**136,343**	**40,847**	**95,496**	**233.8%**
24.4%	19.5%	15.5%	4.0%		**EBITDA**	21.8%	23.3%	17.1%	6.2%	
17.7%	13.6%	8.0%	5.6%		**Operating Margin**	15.0%	17.1%	9.7%	7.5%	
38.1%	59.3%	8.4%	50.9%		**Net Margin**	21.0%	30.7%	10.0%	20.6%	

El Camino Hospital – Los Gatos($000s)

7 months ending 01/31/2018

Period 7 FY 2017	Period 7 FY 2018	Period 7 Budget 2018	Variance Fav (Unfav)	Var%	$000s	YTD FY 2017	YTD FY 2018	YTD Budget 2018	Variance Fav (Unfav)	Var%
					OPERATING REVENUE					
48,091	52,685	48,585	4,099	8.4%	**Gross Revenue**	305,930	355,505	332,268	23,236	7.0%
(37,514)	(37,842)	(35,284)	(2,558)	7.2%	**Deductions**	(225,886)	(260,378)	(241,304)	(19,075)	7.9%
10,577	**14,843**	**13,301**	**1,541**	**11.6%**	**Net Patient Revenue**	**80,044**	**95,126**	**90,965**	**4,162**	**4.6%**
38	160	217	(57)	-26.2%	**Other Operating Revenue**	1,143	1,176	1,498	(322)	-21.5%
10,615	**15,003**	**13,518**	**1,485**	**11.0%**	**Total Operating Revenue**	**81,187**	**96,302**	**92,462**	**3,840**	**4.2%**
					OPERATING EXPENSE					
6,083	6,979	6,651	(328)	-4.9%	**Salaries & Wages**	43,356	46,281	44,398	(1,883)	-4.2%
2,129	2,524	2,071	(453)	-21.9%	**Supplies**	11,936	14,430	13,805	(625)	-4.5%
1,385	1,619	1,283	(335)	-26.1%	**Fees & Purchased Services ***	9,376	9,485	9,003	(482)	-5.4%
1,598	1,455	1,533	78	5.1%	**Other Operating Expense**	11,483	11,092	10,938	(154)	-1.4%
0	0	0	0	0.0%	**Interest**	0	0	0	0	0.0%
503	694	768	74	9.6%	**Depreciation**	3,677	4,028	5,081	1,053	20.7%
11,698	**13,271**	**12,306**	**(965)**	**-7.8%**	**Total Operating Expense**	**79,829**	**85,316**	**83,225**	**(2,091)**	**-2.5%**
(1,082)	**1,732**	**1,212**	**520**	**42.9%**	**Net Operating Income/(Loss)**	**1,358**	**10,986**	**9,237**	**1,749**	**18.9%**
0	0	0	0	0.0%	**Non Operating Income**	(10)	(45)	0	(45)	0.0%
(1,082)	**1,732**	**1,212**	**520**	**42.9%**	**Net Income(Loss)**	**1,347**	**10,942**	**9,237**	**1,704**	**18.4%**
-5.5%	16.2%	14.6%	1.5%		EBITDA	6.2%	15.6%	15.5%	0.1%	
-10.2%	11.5%	9.0%	2.6%		Operating Margin	1.7%	11.4%	10.0%	1.4%	
-10.2%	11.5%	9.0%	2.6%		Net Margin	1.7%	11.4%	10.0%	1.4%	

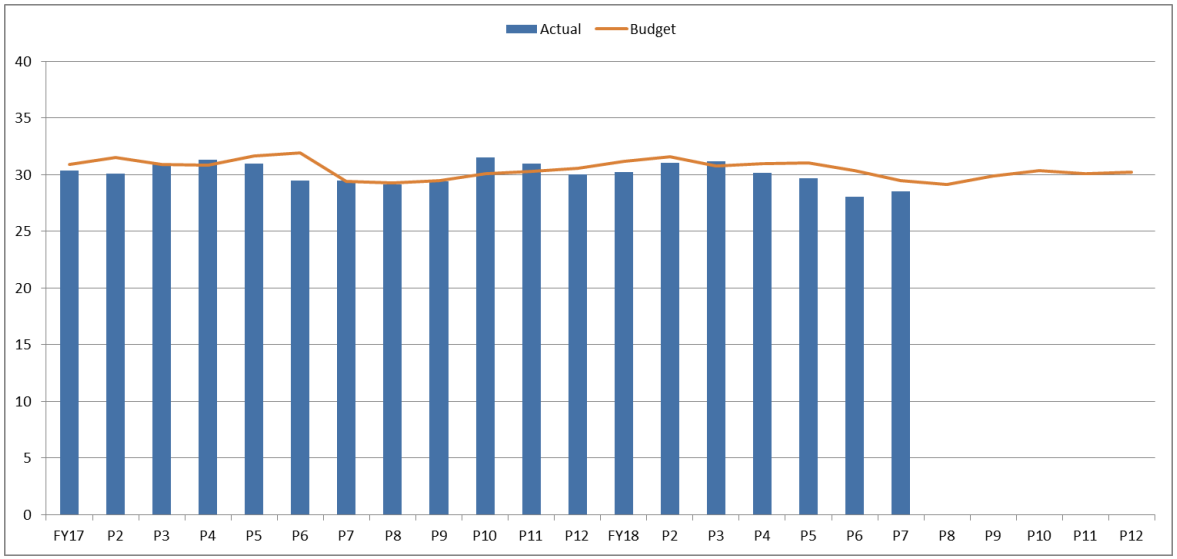
Non Operating Items and Net Income by Affiliate

$ in thousands

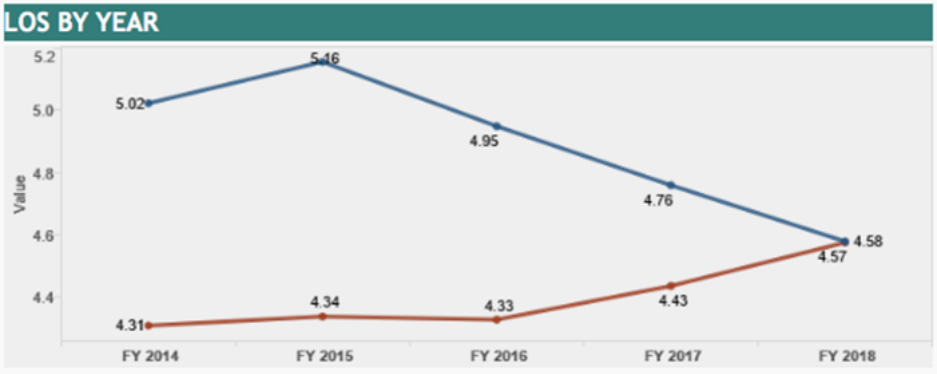
	Period 7 - Month			Period 7 - FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Income (Loss) from Operations						
Mountain View	8,665	4,750	3,915	76,056	39,270	36,786
Los Gatos	1,732	1,212	520	10,986	9,237	1,749
Sub Total - El Camino Hospital, excl. Afflilates	**10,397**	**5,962**	**4,435**	**87,043**	**48,508**	**38,535**
Operating Margin %	**13.2%**	**8.2%**		**16.1%**	**9.7%**	
El Camino Hospital Non Operating Income						
Investments	28,633	1,516	27,118	63,433	10,609	52,825
Swap Adjustments	842	0	842	1,450	0	1,450
Community Benefit	(36)	(283)	247	(2,205)	(1,983)	(222)
Pathways	101	42	59	423	292	132
Satellite Dialysis	0	(35)	35	(97)	(248)	151
SVMD Funding	(99)	(589)	490	(624)	(4,122)	3,498
Other	(241)	(424)	184	(2,137)	(2,970)	833
Sub Total - Non Operating Income	**29,200**	**225**	**28,975**	**60,242**	**1,577**	**58,665**
El Camino Hospital Net Income (Loss)	**39,597**	**6,187**	**33,410**	**147,285**	**50,085**	**97,200**
ECH Net Margin %	**50.2%**	**8.5%**		**27.2%**	**10.0%**	
Concern	82	97	(14)	1,111	855	255
ECSC	(1)	0	(1)	(21)	0	(21)
Foundation	627	(22)	650	2,217	392	1,824
Silicon Valley Medical Development	(332)	6	(338)	134	(7)	141
Net Income Hospital Affiliates	**377**	**81**	**296**	**3,440**	**1,240**	**2,200**
Total Net Income Hospital & Affiliates	**39,974**	**6,268**	**33,706**	**150,725**	**51,325**	**99,400**

Productivity and Medicare Length of Stay

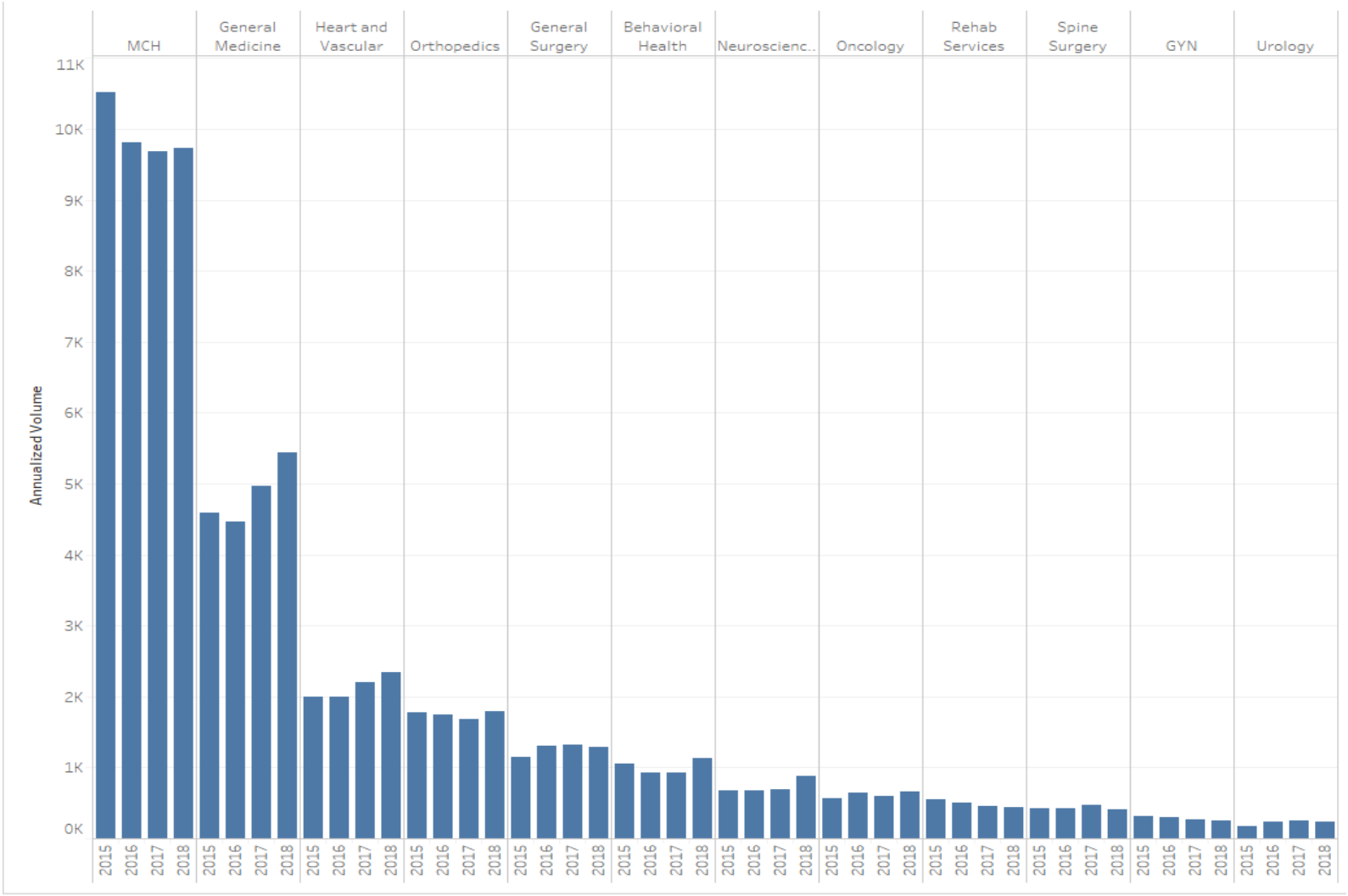
Work hours per adjusted patient day in January is under budget by -1. Overall the month of January is 28.5 worked hours per adjusted patient day



ALOS vs Milliman well-managed benchmark. Trend shows remarkable and steady improvement with FY 2018 at benchmark.
Increase in benchmark beginning in FY 2017 due to Clinical Documentation Improvement (CDI)

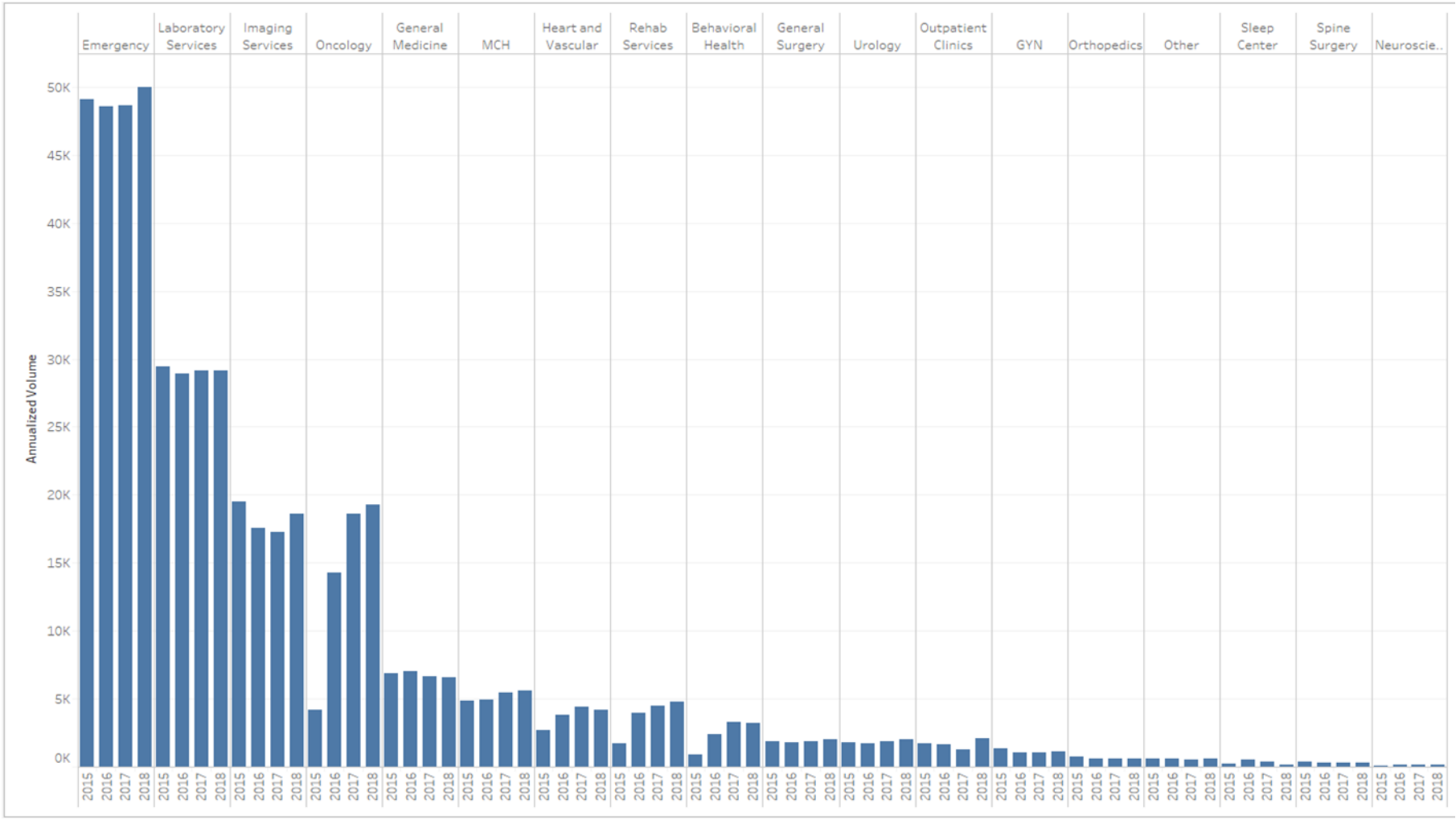


El Camino Hospital Volume Annual Trends – Inpatient
FY 2018 is annualized



- General Medicine, HVI, Behavioral Health, and Neuroscience display an increasing trend.
- Conversely, Rehab Services and GYN show a decreasing trend.
- The remaining service lines are staying flat.

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



- Comparing year-over-year Oncology, MCH, Rehab Services, Emergency and Outpatient Clinics are all increasing in volume. All others are remaining flat or decreasing.

Medicare data excludes Medicare HMOs

Capital Spend Trend & FY18 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	14,275
Non CIP Land, Land I , BLDG, Additions	-	4,189	-	-
Facilities	38,940	48,137	82,953	128,030
GRAND TOTAL	86,789	96,740	97,923	156,465
*Includes 2 robot purchases in 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**
Land Acquisition (1550)	0	0	0	24,007	0
828 S Winchester Clinic TI (1701)	0	0	0	0	145
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**
Subtotal Facilities Projects CIP	**9,294**	**13,753**	**38,940**	**24,130**	**82,808**
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
March 14, 2018
Dan Woods, CEO

Organizational Goal Update Through January (SIR) and February (Others) 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%
Standarized 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

Quality and Safety

The Joint Commission (TJC) Survey Preparation: Leadership expects the next triennial survey of both hospitals to take place sometime between August 2018 and January 2019. A mock joint commission survey was conducted at both campuses February 6th, 7th, and 8th. A governance structure is in place to provide executive support to the managers, directors and front line staff. Action plans are being executed by members of the Continuous Readiness Team.

A new tele-psychiatry vendor will be used to provide psychiatric consultations in the Emergency Departments at both MV and LG beginning April 1, 2018. ECH has been using a different vendor for tele-psychiatry in the MV ER for a number of years, but the service was not as prompt as we expect, thus a move to a new vendor. In addition, the service will extend to the ECH LG Emergency Department.

Patient Experience

The patient experience roadmap for the final 6 months of FY 18 is being executed. Leader rounding refresher training is occurring the week of March 13 and Nursing Communication Training is kicking of March 1st. The Patient and Family Advisory Council is being re-booted as well to engage more patients and families in the improvement work throughout the organization. As well, performance improvement management initiatives are making a difference with improving patient flow and overall satisfaction in several areas as appropriate, including ongoing average length of stay (ALOS) reductions, reducing the door-to-treatment time in the Emergency Department, reducing 30-day readmission rates in urology and heart failure, and improving pain management and timely intervention in the behavioral medicine department.

We have added some new language to our patient statements to (1) include the new feature in myChart for patients to review their detailed bill and (2) provide information about our new

online Patient Tools as well as Pay-by-phone. We have started to assist patients with enrollment in myChart during the scheduling and registration process in main registration; we will expand this to all registration sites in March. Our implementation plan for MyChart Bedside includes having patients using Apple iPads to access it in their patient rooms by end of 2018.

Operations

The FY19 planning and budgeting process is in full swing as the management team works through department planning, volume projections, revenue and expense estimates, and other resource allocation needs. The service line leaders recently reported on operations from the first half of the fiscal year and plans for the second half of FY18. Leadership efforts have focused on strengthening physician relations, growing market share, and improving efficiency (i.e. removing barriers to timely scheduling of diagnostic testing and surgical procedures) at both the Mountain View and Los Gatos hospital campuses. Los Gatos surgical volumes have increased by 9 percent and Mountain View surgical volumes have increased by nearly 3 percent.

The College of American Pathologist (CAP) survey in the Laboratory in Los Gatos occurred on February 28th. There were several findings. CAP is a very detailed survey with 3000 items on their checklist. The laboratory leadership will await the final report and develop action plans to address the findings.

Workforce

In 2017, Cal-OHSHA enacted to regulations that requires hospitals to report incidents of workplace violence against employees and to develop and implement a workplace violence prevention program. We are in the process of completing our departmental risk assessments and finalizing our prevention plan which includes required training for all hospital staff, with a focus on high risk areas. We began reporting all incidents of unwanted contact between employees and patients on July 1, 2017 and since then there have been 46 reports made to Cal OSHA. Of the 46 reported incidents 14 employees were treated for minor injuries. Compliance with the new regulations will be regularly monitored by the Central Safety Committee for the Environment of Care.

Financial Services

Cash collections for February were $71,334,693 million and $7,560,245 over goal. Our front end (self-pay) collections are on track to achieve $1million above our goal for the year. Denial Recoveries midyear were $9.8 Million compared to our goal of $7 Million in recoveries. Our cost initiative reduction goal is proceeding well. As of March 1, 2018, we have implemented $4,445,671 of our $4.8 M savings challenge.

Information Services

Four physicians are now live on Community Connect with a 5 physician practice expected to go live by the end of FY18 for a total of 9 physicians using the El Camino Community Connect Epic system in their office by July 2018.

Dashboards (Service Line, Departmental, and Executive) will be activated this week to enable real time operational metrics, including a dashboard for the Nursing Department to track key metrics.

Corporate and Community Health (CONCERN and Community Benefit)

CONCERN: EAP, Digital Transformation: Our top priorities for our new engagement platform will focus on reaching more users for greater well-being and mental wellness, along with personalization to guide employees to the appropriate resources, and easy access to clinical care at precisely the time it is needed.

Community Benefit ECH Operations Report: El Camino Hospital and El Camino Healthcare District's Community Benefit Program received 121 grant applications for FY19 through the new user-friendly online platform that was launched in January. This represents a 21% increase over last year.

Philanthropy

During period 7 of FY18, the Foundation secured $436,942. The total revenue received for the annual El Camino Heritage Golf Tournament, held in October 2017, was $333,650, which is 111% of goal. Proceeds benefited the Taft Center for Clinical Research. The total revenue received for the 6th annual Norma's Literary Luncheon (held on 8th February) by end of period 7 was $162,770, which exceeds the fundraising goal. Thanks to a generous gift from the Melchor family to underwrite all expenses, all ticket sales, sponsorships, and donations have been earmarked for a proposed new patient family residence on the Mountain View campus.

Auxiliary

Our very dedicated Auxiliary contributed 7,154 volunteer hours in January 2018.

El Camino Hospital Auxiliary

Membership Report to the Hospital Board
Meeting of March 14, 2018

Combined Data as of January 31, 2017 for Mountain View and Los Gatos Campuses

Membership Data:

Senior Members

Active Members	349	-7 Net change compared to previous month
Dues Paid Inactive	87	(Includes Associates & Patrons)
Leave of Absence	11	
Subtotal	**447**	

Resigned in Month	9
Deceased in Month	0

Junior Members

Active Members	252	-3 Net Change compared to previous month
Dues Paid Inactive	0	
Leave of Absence	0	
Subtotal	**252**	

Total Active Members	**601**
Total Membership	**699**

Combined Auxiliary Hours from Inception (to January 31, 2018): 5,872,930
Combined Auxiliary Hours for FY2017 (to January 31, 2018): 50,429
Combined Auxiliary Hours for January 31, 2018: 7,154

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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: February 28, 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 7

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 7 of FY18, the Foundation secured $436,942.

Upcoming Events

March 17, 2018 – Scarlet Ball at the Dolce Hayes Mansion, benefiting the South Asian Heart Center. Cost per ticket is $500 ($400 tax deductible).

May 5, 2018- Spring Forward, a gala to fulfill the promise, benefiting mental health and addiction services at El Camino Hospital. Attendance will be limited to 225 guests. Cost per ticket is $1,000 (tax deductible donation still to be determined).

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: February 28, 2018

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 7

ACTION: For Information

During the month of January, El Camino Hospital Foundation secured$436,942, bringing the total raised by close of period 7 to $4,466,667, which is 73% of the FY18 goal.

FY 18 Period 7 Fundraising Performance

Major & Planned Gifts
The Foundation secured $12,194 in January, which included a $10,000 gift for the South Asian Heart Center. The remaining revenue was from sponsorship payments and ticket purchases for the Allied Professionals Seminar, which was held on February 13.

Special Events

- **Spring Forward** – The Foundation is creating a brand new gala, Spring Forward to fulfill the promise, benefiting mental health and addiction services at El Camino Hospital. It will be held at the Morgan Estate, a private mansion in Los Altos Hills, on Saturday evening, May 5, 2018. As we introduce this new concept, and due to the space constraints of the venue, we will be limiting attendance to no more than 225 guests, with a higher per person ticket price. Save the dates were mailed in early February and the invitation will follow in mid-March.

- **22nd Annual El Camino Heritage Golf Tournament** – During the month of January, the Foundation received the remaining $2500 sponsorship commitment for the golf tournament, which was held on October 23, 2017. This brings total revenue received for the tournament to $333,650, which is 111% of goal. Proceeds benefited the Taft Center for Clinical Research.

- **Scarlet Ball** – The annual gala benefit for the South Asian Heart Center will be held on March 17, 2018 at Dolce Hayes Mansion in San Jose. As of January 31, the Foundation received $118,571 in sponsorships and ticket sales.
  .

- **Norma's Literary Luncheon** – During the month of January, the Foundation received $60,515 in ticket purchases, table sponsorships, and donations for the 6th annual Norma's Literary Luncheon. This brings total revenue received for the event by end of period 7 to $162,770, which exceeds the fundraising goal. Two hundred women attended the event, which was held on February 8 at Sharon Heights Golf & Country Club. Thanks to a generous gift from the Melchor family to underwrite all expenses, all other ticket sales, sponsorships, and donations will directly benefit a new patient family residence on the Mountain View campus.

- **Allied Professionals Seminar** – The 26th annual Allied Professionals Seminar was held at Palo Alto Hills Golf & Country Club on February 13. Nearly 100 lawyers, accountants, financial advisors and other allied professionals attended. Clinical bioethicist Viki Kind spoke about guiding clients and their families to meaningful and financially appropriate decisions at the end of life, and how to create documents that medical personnel will understand and honor. In the afternoon, she spoke to 45 Foundation donors at Los Altos Golf & Country Club about how to create a personalized, quality-of-life statement to include with your advance directive to enhance medically appropriate and compassionate health care decisions. Both talks supported the hospital's current focus on teaching caregivers how to have these important conversations with patients and families. In November, the Foundation made an allocation of unrestricted funds to underwrite this work.

Annual Giving

The annual giving line increased $172,379 in January, primarily due to 2018 employee giving payroll donation commitments, which totaled $136,336. Although the campaign concluded in December, any new or continuing payroll donation commitments are projected out through the current calendar year and included in the Annual Giving totals beginning in January. The Foundation raised an additional $36,043 in annual gifts from H2H membership renewals, Path of Hope, Circle of Caring, responses from the calendar year-end direct mail, Healthy Giving Newsletter, and online donations. The Foundation raised a total of $481,123 through annual giving by January 31, 2018.

FOUNDATION PERFORMANCE

FY18 Fundraising Report through 1/31/18

ACTIVITY		FY18 YTD (7/1/17 - 1/31/18)	FY18 Goals	FY18 % of Goal	Difference Period 6 & 7	FY17 YTD (7/1/16 - 1/31/17)	FY16 YTD (7/1/15 - 1/31/16)
Major & Planned Gifts		$2,870,202	$3,750,000	77%	$12,194	$3,929,932	$1,801,663
Special Events	**Spring Event**	$1,000	$600,000	0%	$0	$21,250	$40,700
	Golf	$333,650	$300,000	111%	$2,500	$273,100	$326,205
	South Asian Heart Center Event	$118,571	$300,000	40%	$14,700	$113,395	$68,991
	Norma's Literary Luncheon	$162,770	$150,000	109%	$60,515	$94,020	$132,259
Annual Gifts		$481,123	$550,000	87%	$172,379	$442,083	$429,005
Grants*		-	-	-	-	-	$52,083
Investment Income		$499,351	$500,000	100%	$174,654	$863,336	$456,946
TOTALS		***$4,466,667***	***$6,150,000***	***73%***	***$436,942***	***$5,737,116***	***$3,307,852***

*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 1/31/18

Board Designated Allocations	$1,209,482
Donor Endowments	$3,319,558
Operational Endowments	$15,762,427
Pledge Receivables	$4,778,425
Restricted Donations	$9,537,726
Unrestricted Donations	$1,031,427

6.3% Investment Return looking back over the last 12 months.